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Collaboration and emotions to the test: the experience of FILe volunteers in hospices

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Abstract. *Background and aims*: This study seeks to provide an in-depth analysis of care-based interaction in the experiences of volunteers working in lenitherapy (pain therapy) through the case study of hospices in Florence, Italy. *Method*: A qualitative method of data collection was chosen: the field research made use of open-ended questionnaires distributed to trained but unspecialised volunteers (V = 32) and to volunteers with hospital-based medical expertise (PV = 35) acting for the Italian Lenitherapy Foundation (FILe) and operating in hospices within the ex-ASL (Local Health Unit) of Florence. *Results*: By analysing the 67 questionnaires collected, it has been possible to reconstruct and interpret the interactional dynamics that exist between the various figures present within a hospice, bringing into focus the most salient aspects of both the organisational context and emotional setting. *Conclusions*: The research experience, by highlighting everyday unseen aspects that are inaccessible to an 'internal' eye, has made it possible to better characterise the dynamics of unsuccessful collaboration between team members and potential areas of conflict. Finally, where these dynamics have been observed, an attempt has been made to outline priorities for change and possible directions to be taken, so as to promote defusing actions and restore synergy and fluidity to the FILe system.

Key words: care configurations, palliative care, interprofessional équipe, therapeutic alliance, hospice

Background and aims

This article describes the results of research[1] conducted among professionals who are active in the field of healthcare (doctors, nurses, psychologists, physiotherapists, health and social care professionals) and unspecialised volunteers, all of whom are engaged in volunteer work for the Italian Lenitherapy Foundation (FILe), a non-profit-making foundation operating in the field of palliative care, providing support and promoting research, dissemination, training and recurrent training in lenitherapy.

As synonym of palliative care, the term lenitherapy[2] refers to specialised healthcare support aimed

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[1] The research into FILe volunteers was also the subject of reflection of the report 'Volver a organizar la colaboración: interacciones de cuidado en la experiencia de los voluntarios activos en la terapia del dolor // (Ri-)organizzare la collaborazione: interazioni di cura nell'esperienza dei volontari attivi in leniterapia' presented by the author on July 21st 2016 at the conference of the Latin Association for the Analysis of Health Systems – ALASS "O trabalho dos profissionais frente aos desafios dos Sistemas de Saúde" held on July 21st, 22nd and 23rd 2016 at the Faculdade de Ciências da Saúd of the University of Brasilia. The conference proceedings are available at: http://www.alass.org/wp-content/uploads/resum_calass_2016.pdf

[2] On the basis of what is suggested in the Pontignano Paper – the drafting and dissemination of which has been directed, since 2002, by the Regional Committee for Bioethics of Tuscany Region – it is preferable to adopt the term lenitherapy, rather than the more widespread palliative care. For an introduction to end-of-life help and palliative care in Tuscany, see Rodella et al. 2007, for an up-to-date description of hospices and home care at a national level, see Costantini et al. (2010) and Mastroianni and Calvieri (2014).

at maintaining and improving as much as possible the quality of life of the terminally ill and their families (WHO, 2009), preventing and alleviating suffering from first onset until the moment of death, and supporting those who are grieving (Rodella et al., 2007; Horey et al., 2015). Looking at the situation worldwide, the services offered by the various healthcare systems in the field of lenitherapy are shown to be non-homogenous both in terms of their organisational models and in their dedicated lenitherapy facilities (from hospitals to domiciliary care, nursing homes to hospices), but have in common an extensive use of voluntarism[3] (Ranci Ortigosa, Rotondo, 1996; Tritter et al., 2003; Morris et al., 2015; Buralli, Amoroso, 2011).

Considering the Italian case, the National Healthcare System in its current organisational model provides, as is well known, to take on and to take care of the person/patient. All too often and contradictorily, that protocol and the tasks related to it, particularly in cases of chronic illness or of illnesses with a course of therapy designated as having a fatal outcome, come into conflict with the demands of economism and its own priorities and protocols. Starting with the time and resources that are dedicated to communication and mutual listening among members of the healthcare teams, along with the space and attention oriented towards the promotion, collection and evaluation of the patients' own accounts of their experience with illness, is still only rarely implemented as part of clinical procedure.

It seems, therefore, that Norbert Elias' writing on the dual process of identification and suppression that modern society and its institutions perform in dealings with serious or end-of-life illness is still relevant today:

The dying person receives the most advanced, scientifically based medical treatment available. But contacts with the people to whom he or she is attached, and whose presence can be of utmost comfort to a person taking leave of life, are frequently thought to inconvenience the rational treatment of the patient and the routine of the personnel. Accordingly, these contacts are reduced or prevented wherever possible (Elias 1985, p.86).

In this scenario, the backstage presence of the volunteers within the healthcare institution may represent a break with its impersonal aspect and the preceding, consolidated relational dynamics. That break may, in turn, translate into higher levels of friction and conflict between those involved; but it may also translate into a new opportunity to shift the hospital mood barometer from a situation of widespread emotive dissonance (Abraham, 1998) to one of resonance (Elias, 1985): this being the outcome of the promotion of dialogue valorisation processes, the building of trust relations, and the successful balancing of the organisation's requirements with the more intimate feelings of individuals.

On the basis of requirements laid out by the FILe Foundation itself, which call for the activity of all its volunteers present within hospices[4] in Florence to be made more synergistic and effective, two objectives were adopted. Firstly: to observe the internal interactional dynamics within 'mixed' teams of volunteer professionals and trained volunteers, and between teams, inpatients and care-giving relatives. Secondly, but not of secondary importance: to observe and analyse the emotions that dominate among volunteers of every professional situation, taking particular account of the inescapable interweaving of the emotions themselves with the forms of interaction with the subjects involved.

Following a qualitative approach to the sociological interpretation of texts (Corbetta, 1999; Cardano, 2004 and 2011; Green, Thorogood, 2014), the work of care-giving has been analysed both in terms of its dynamics of collaboration and support and, in its more conflicting and diverging aspects (Goffman, 1961; Sennett, 2012). In particular, an attempt has been made to identify, within reports of successful or unsuccessful inter-professional collaboration, elements of social ritual and practices that are dense with symbolic meanings (Lusardi, Tomelleri, 2016) and therefore to bring more clearly to light the impact of organisational efficiency on effectiveness.

[3] Although always against the backdrop of a huge variety of forms and levels of training, national and international literature tends to identify four defining elements of the figure of the volunteer: free choice in undertaking the activity; the absence of payment unless in the form of expenses reimbursement; proximity to the care receiver, and an institutional affiliation (cf. Horey et al., 2015).

[4] Ward or facility providing treatment and assistance to terminally ill individuals.

Key concepts such as *emotional dissonance* (Abraham 1998), *emotional resonance* (Elias, 1985), and *emotional education* (Cavell, 1979; Jedlowski, 2005), and sociological papers on the subject of *emotional labour* (Hochschild, 1983 and 1990; Bellé, Bruni, Poggio, 2014; Lusardi, Wherton, Tomelleri, 2016) have enabled an examination of the emotional aspect in addition to the cognitive and physical dimensions of the role played by those working as professionals or volunteers in the field of caring.

Finally, the interpretation of *interaction* between social actors as *performance*, taken from Goffman (1959), covers both the more 'operational' aspects and those relating more properly to care work. Goffman's famous distinction between *onstage* and *backstage* spaces proves still to be a heuristically effective tool for distinguishing between the social circumstances in which individuals act according to formalised and codified roles, putting on 'stage performances' that follow shared and easily recognisable codes of behaviour (norms of courtesy and decorum); and the social circumstances where the impression intended to be made by the performance may be suspended and/or rejected, spaces where the actor is permitted to abandon their 'mask', relax their control, cease playing their role, and come out of character.

Method

The study was carried out over the course of four months between November 2014 and February 2015 and involved all the hospices managed by the Local Health Unit (ASL) of Florence that are located within the urban area[5]: the Oblate Hospice in the Careggi hospital complex; the San Giovanni di Dio Hospice in Torregalli Hospital; and the Carlotta Antinori Memorial Hospice in San Felice a Ema Hospital.

The chosen method of data collection was that of delivering brief, open-ended questionnaires, aimed at bringing to light and observing: a) a (self-)definition of the role of volunteer work in palliative care; b)

the identification of the principal tasks carried out by volunteers in the hospice and in domiciliary care; c) critical elements in relations between volunteers and those who work in the Palliative Care Unit; d) suggestions for consolidating and improving the volunteer-staff and volunteer-patient and relatives relationship. The reference sample comprised around 80 individuals, including trained volunteers[6] (V) and volunteer healthcare professionals (PV) who provide free, specialised assistance to hospital units, with a total of 67 questionnaires collected: 32 from volunteers (7 men, 25 women), 35 from professionals (9 men, 25 women, 1 unanswered).

The interpretation of the answers collected was focused on the tasks the volunteers carried out within the facilities, omitting the spheres of training and domiciliary assistance.

Results

Based on the phrases used by PVs and Vs to define the role and tasks performed by volunteers in palliative care, following the *grounded* method of simultaneous analysis and qualification (Glaser, Strauss, 1967; Cardano, 2011) it has been possible to pinpoint some key categories in the codification of tasks and to reorganise the empirical research material collected (Tab. 1).

There is shown to be a wide range of activities expected within the definition of the role and tasks identified with the figure of the volunteer. What is offered (and required) is, to all intents and purposes, care work: whilst this arises from its more specialised aspects and is expressed in terms of *help*, *support*, *sharing*, *listening*, it proves to be physically intense, emotionally heavy and pervaded by a constant tension between involvement and detachment (Elias, 1956, 1985).

The dynamics involved in approaching the ill person, the related problems of suffering, illness, death, for many professionals the ineffectiveness of treatment itself (seen as a difficult metaphor for the im-

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[5] The Fiore di Primavera Hospice, pertaining to the Local Health Unit of Florence but located in Prato, was not included in this research.

[6] Volunteers from outside the healthcare professions, who have acquired their skills in the support of ill individuals and their relatives through training courses organised by FILe itself.

Table 1. The role and tasks of volunteers in the hospices: key activities

	Volunteers (V)	Volunteer healthcare professionals (PV)
Definition of the role	o Listening o Mediation (between patients, relatives, care providers) o 'Compensatory' interventions aimed at offsetting the potential shortages of other staff	o Bridging activity: volunteer as medium, as a link between patients and care providers o Facilitating the expression and resolution of some of the patient's needs and/or desires
Identification of tasks	o Listening o 'Psychological' and moral support o Care-based tasks and practical help with basic everyday needs	o Welcoming o Listening o Company o Support in everyday life and care (e.g. presence and support at mealtimes)

potence of science), and the constant tension between involvement/empathy and detachment necessitate the management of highly emotionally charged aspects. Contact and interaction with the ill subject and/or care-giving relatives, and more broadly with aspects of health and ill-health, are also confirmed by FILe professionals to be complex and challenging.

If the institutional and relational settings in which such care activity is situated are thus complexly structured and multifarious, it is on that very complexity that this research has been focused and about which the qualitative material collected has proffered important information.

There are two deeply connected principal aspects to consider, but for clarity of analysis and presentation these shall be described separately:

- the first examines those aspects and processes that are most typically representative of the hospital working environment in its specific form of the hospice, and its organisation: bureaucratisation; the importance of organisational settings; the presence, perception and weight of formal (and informal) rules; distance from the role, emotional education and levels of collaboration; and trust and team synergy (Figure 1);
- the second examines those aspects that may be ascribed to the emotional dimension: care work as contact and interaction with the body, illness and death; and emotional dissonance and resonance (Figure 2).

The following diagrams summarise in graphical form the distribution of the most recurrent and/or
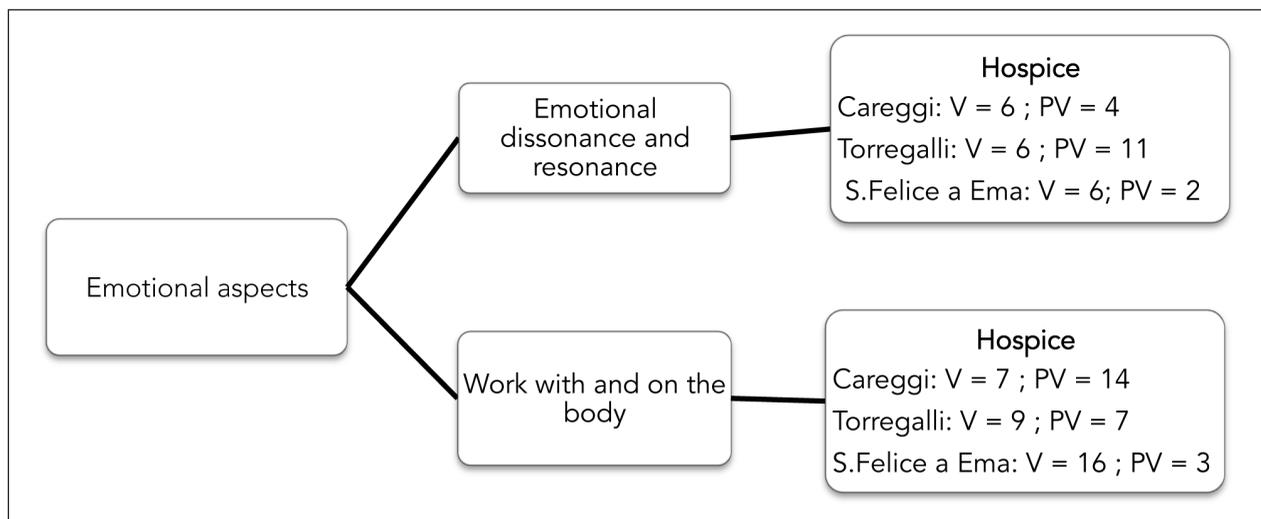

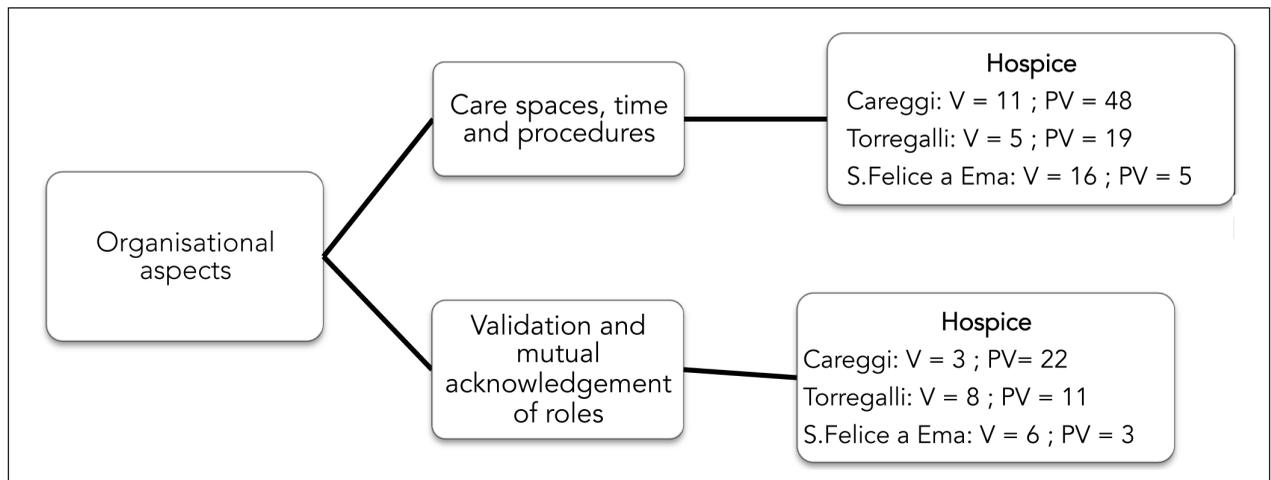**Figure 1.** Centrality of organisational themes in volunteers' words

Figure 2. Centrality of emotional themes in volunteers' words

most evocative key words and expressions subdivided by area, subject, facility, and by the author's role within the hospice.

Organisation of work and bureaucratisation

The gradually tightening mesh of organisational demands and work pace and the considerable level of proceduralisation of care practices, resulting from a further step into the bureaucratisation of the hospital organisation (Tousijn, 2013), characterise and mark time and everyday routines even in hospices.

Such an implementation and/or stiffening of the rules conflicts with the need, expressed by volunteers and also by professionals, to maintain the human aspect of care relations, and with the further need to acknowledge their uniqueness and irreducible plurality, hence the unavoidable situation of unpredictability.

From the data collected there emerges a clear stance against the tendency towards delegitimizing those same individual needs, and concerns and disagreement are expressed with regard to the standardisation of the service, depersonalisation, and what is perceived as the accounting process of experiences and sufferings, along with the related and interrelated privation of space and authority, as much for the basic volunteers as for those professionals who experience it as not only as FILe members, but firstly and more directly as members/staff members of the facility and system.

The not infrequent forays of volunteers between onstage and backstage spaces, facilitated by the less rigorous characteristics and less clear-cut boundaries of their role descriptions, make them direct witnesses (and often confidants) of a patient-caregiver relationship that may at times be lacking on the human level, hurried, and marked by points of antagonism which are in turn put down to needs/demands of autonomy on the part of the ill person or their relatives.

Another critical element concerns time: according to the statements collected, the time available seems «insufficient for building better integrated and more effective relationships»[7]. The work pace in hospices – whilst less rigid than in other hospital situations (Rodella et al., 2007; Costantini et al., 2010) – proves nevertheless prescriptive, and limits the opportunities for meeting and dialogue between hospital staff and volunteers; especially for unspecialised volunteers and those who are less well integrated into the institutional routines and structure, the scarcity of contact and exchange with *insiders* means that adequate information regarding the patients in question is unavailable to them.

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[7] The expressions and phrases collected, where directly quoted, are reported in the text between quotations marks «…», as in this first example. In order to guarantee the privacy of those interviewed it has been preferred not to reference them. This choice does not hinder the attainment of the knowledge goals pursued in this data analysis.

Recognition and Legitimisation

In addition to the lack of communication, collaboration is also inhibited by a pyramidal image of the organisation which sets individuals against one another according to the professional group to which they belong.

The sense that Vs and PVs «operate on parallel planes» is the first indication of a working condition which, when problems of «inadequate mutual awareness» and in terms of the recognition of expertise and/or work that has been carried out are added to those of communication, generates deep misunderstandings, poor management of human resources and, at an individual level, detachment from the role and/or a sense of guilt, revealing the whole set of problems in admissions of «difficulties with integrated and synergistic activity».

In the eyes of professional 'colleagues', and occasionally also for relatives and the ill persons themselves, intervention work by the FILe volunteers is barely visible and is only truly noticed when it is missing or ineffectual.

For the volunteers – particularly for the Vs, less so for the PVs – there is first of all a problem in terms of role recognition and the visibility of expertise and/or work completed.

The sense of belonging and identification with the place, its rules and those who are active within it (in a word, with the institution) is not only impeded and undermined by asymmetries in role recognition.

The limited emotional education (Cavell, 1979; Jedlowski, 2005) between professionals and volunteers – in the sense of an incomplete recognition of, if not genuine indifference towards, needs expressed and even emotions that are more or less permitted to be made known – also has the effect of stirring up and reinforcing dynamics which cause the initial repudiation to be translated into genuine distance and greater, more complex difficulties, both relational and operational: for example, the need for greater mutual attention to be paid with respect to roles and invisible yet well-defined boundaries between onstage and backstage spaces.

The third and final element at play is that of trust[8]. The relationship of trust and mutual respect between team members, when it exists, makes it easier to immediately interpret certain patterns of patient needs and facilitates a more relaxed manner and pace of collaboration and in promoting and recognising those needs. Conversely, the widespread image of gradually impoverishing relations of care and of low levels of general trust – both due to the progressive breakdown of the crucial trust between doctor and patient, or due to the absence of complete trust at all or some of the intersections within the 'three-person' relationship of volunteer-patient-caregiver - engenders a general, two-way degradation of roles and relationships. Difficulties in building a «fruitful relationship of trust between volunteers and new professionals» and «professionals' mistrust of volunteers» therefore constitute current considerable critical elements.

At the partial conclusion of this section on organisational aspects, it becomes clear how, even in hospices, one significant subject is that which comprises the *spatio-temporal programming of roles* and the constant conflict in the execution of the intended task (that of caring, which is surely among the most compelling for those who engage in it), on the one hand among those who fulfil the official professional role, which is properly a working role and institutionally well defined and well anchored, and on the other hand among those who have taken a volunteering approach, but who nevertheless sense the requirements of that conflict and end up playing their part with strong implications in terms of identification (Goffman, 1961).

Building on this, inter-professional collaboration is confirmed as having a dimension of social ritual and practices dense with symbolic meanings (Lusardi, Tomelleri, 2016) and as being difficult to construct but with a proven positive impact on organisational effectiveness and efficiency (Sennett, 2012). For that reason, this kind of collaboration is sought after, and is being researched by means of proposals which are primarily aimed at «consolidating and improving the volunteer-staff relationship», for example through more frequent

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[8] Trust in the common sense of the word, but with undeniable significant connotations associated with terms homonymous to the Italian *fiducia* found in sociological language: for a discussion on this subject, see Antonio Mutti's (1994) definition of *fiducia* in the Enciclopedia delle scienze sociali Treccani (Treccani Encyclopedia of the Social Sciences).

and communal «opportunities for recurrent training to be arranged or reorganised»; with a need to make «pre-shift meetings more structured, effective and with higher levels of participation» and opportunities for new investment in spaces – starting with shared spaces – since their communal nature makes them ideal settings in which to build 'good' interaction.

Physical proximity

Care work, particularly for terminally ill subjects, proves to be physically and emotionally arduous and demanding due both to the direct effects of contact with another person's illness and suffering with the prospect of certain worsening and decline and to the frustrations and discomfort that stem from the gap between the pervasiveness of the responsibilities required and potential lack of valorisation of the role itself (Bellè, Bruni, Poggio, 2014, p. 670). The problem of recognising the work carried out is also posed for FILe volunteers. Volunteer intervention, especially by non-professionals, appears to be barely visible or wholly subsidiary until its importance is felt by its absence or ineffectuality.

In a complex pattern – closely interconnected with all the aforementioned organisational aspects – of coexistence with internal staff, timetables of activities, and the official evaluation of tasks in terms of their credit and usefulness, it transpires that the presence of volunteers is in fact expected in highly critical and/or intimate moments.

Firstly, there is the *turning point* of admission into the hospice. The initial tasks of welcoming and orientation, run by the volunteers, prove to be particularly delicate since, addressing terminally ill persons, they must face up to the prospect of a permanent stay – albeit one likely to be of short duration – dedicated to end-of-life care: there are therefore many social and psychological elements at play (from the loss of one's social status; to the further loss of liberty and self-direction, to the loosening of affective bonds) which can trigger fears and genuine crises in the patient but also in their caregivers. «Giving recommendations and information» proves to be a «support» activity «in a broad sense», which valorises the «relational dimension» and reveals itself to be wholly «rewarding» for those who do so.

Another instance where the presence of volunteers guarantees better quality care provision for those in hospices and allows them to «make up for the "shortages" of other staff members» is in the assistance they provide with administering meals.

The physical proximity experienced in this and other instances, though significant and accompanied by certain risks[9], becomes an opportunity for emotional exchange and, on the one hand, allows the volunteers to establish a relationship of greater empathetic understanding, thus also dedicating time and attention to leisure activities and body care (reading, music, personal care) as well as listening to the person speak or being silent, and 'simply' being present in their company. On the other hand it allows volunteers to fully «interpret» the complex nature of the ill person's «needs» and of the more practical, concrete problems they face, problems related to the body, mind, feelings and perceptions, most of all fear and pain, and allows them to set themselves and the other caregivers the requirement of dealing with any observed emotional, organisational, and practical matters.

Care-giving tasks and emotions

The work of care-giving engages the emotional sphere, in addition to the cognitive and physical one. Anyone working in contact with the ill person and their caregivers requires deep emotional control: consequently, one of the more serious and performative aspects of such a working environment is that of role-play and concealment. On a more strictly personal level, respect for expected behavioural norms is directed towards keeping the private sphere of the caregiver's beliefs and feelings concealed (as much as possible) so as to avoid placing further strain on their self-defence mechanisms against emotional involvement – the ever active filters on what is 'felt', acknowledged and accommodated in the constant flux experienced in the ward – and seek to maintain control of stress levels.

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[9] In addition to the inherent so-called occupational risks of physical exertion and the well-known dynamics of job burnout, the reference here is to the episodes of aggression that may occur in interactions with patients or relatives, starting with verbal aggression.

On the level of 'group' and 'in-group' interactions, this translates into efforts to maintain the barrier between onstage and backstage, to ensure the separation between teams, their procedures and the information they hold and the person being tended to, and their daily lives comprising emotions, demands and needs.

Managing one's emotions and restraining displays of expressive gestures are difficult practices and may have high costs in terms of employees' psychophysical health (Bakker, Heuven, 2006). The very detachment between emotions experienced and emotions expressed may create genuine conflict (Hochschild, 1983 e 1990; Abraham, 1998), making problematic the correspondence between the individual/person and their role, the cohesion between their feelings and the *image of the self* expected of them (Goffman, 1961).

If that is generally true for professionals working in a care-giving environment, it is all the more so for volunteers, for whom a dual problem is posed.

Firstly, there is the problem that can be attributed to their position in terms of expertise and experience. Managing, as layperson, to acquire at least some active listening techniques and skills for managing their emotions, without in the process failing in their 'mission' of empathy, understanding, and closeness to the ill person, and whilst guarding against the higher costs of emotional malaise in carrying out everyday procedures, is the principal problem and complex objective that volunteers must face.

The second problem may be attributed to the volunteers' specific position within the setting and structure of care-giving. Attending to the 'detached' practices between professional workers and ill persons and understanding the dynamics therein, whilst putting themselves in a genuinely supportive position – one of compensation, «buffering», and at times even correction - yet without breaking the game of shared roles, creating obstacles, or leaving space for antagonism or situations of friction, is for the volunteers a complex and difficult task.

Therefore the daily challenge on an emotional level faced by Vs and PVs in their support or care-giving tasks in the ward or in a domiciliary setting concerns: dealing with the frequent contact with suffering, the needs of the organisation, and their own feelings. The ability to identify where there is dissonance and the capacity to manage changes in equilibrium, although never conclusive or complete, is the most powerful resource at the volunteers' disposal to enable them (as far as possible) to protect themselves from work strain, and at the same time enable them to promote new harmonisation in team relations and in the relationship with patients and their relatives.

At the end of this second section on the emotional aspects of volunteer work in the hospices, therefore, the costs and resources involved in following a shared vision of healthcare culture, which places the patient in their entirety and with all their complexity as a person at its centre, come to light more clearly. The care work of the volunteers is focused both on the ill persons and on their families and seeks to relieve both physical and psychological suffering, and also takes the form of simply «being» more than «doing». The investment in the relational sphere, however, proves demanding and lacking any guarantee of reciprocation. Whenever it is forgotten that the professionals are all «there to work», and whenever «respect is lacking in exchanges», the degree of separation (and misunderstanding and unease) between those involved increases. In particular, whenever the «fear of feeling in the way» resurges among volunteers, that is an indication of a profound lack of understanding and of resonance of feeling (Elias, 1985, p. 87): warm feelings of belonging (ibid.) then become unlikely, the integration into the team and interaction with relatives and patients is weakened, and the valorisation of any genuine skills as an added value of the volunteers' presence becomes impossible.

Potential applications

The process of analysis undertaken concludes with a review of the weak points and strong points of team interactions, recalling once again here the expressions and terms used by participants themselves (Tab. 2).

Beginning with the difficult elements which can be observed 'within' care-giving experiences, those perceived by unspecialised volunteers to be the most serious and towards which potential actions of intervention can be directed concern three areas: firstly, the notion of an insufficient sense of belonging and/or recognition on the part of the internal staff; secondly, the lack of genuine collaboration, which translates into the

Table 2. Difficulties and proposals

	Volunteers (V)	Volunteer healthcare professionals (PV)
Difficulties	➤ Sense of belonging and/or legitimisation ➤ Non genuine collaboration ➤ Restricted and poorly coordinated time, pace of work at times unnecessarily stressful	➤ Lack of collaboration ➤ Lack of training ➤ Insufficient time
Proposals	✓ Space set aside for the team ✓ Reorganisation of schedules ✓ Time for Vs and PVs dedicated to meetings, mutual acquaintance and communal training to reorganise shifts and tasks in a clearer and more shared way	✓ Communal targeted training ✓ Dealing with the risk of burnout

sense that volunteers are acting on a parallel, but not integrated, plane; thirdly, the quantity and quality of time spent on the ward, which proves to be restricted and poorly coordinated, marked by a pace of work that is at times unnecessarily stressful.

For the volunteer professionals, however, the first difficulty is epitomised by the poor situation of collaboration: both – with respect to the wards – between volunteers and other staff, and – with respect to the FILe teams – between 'expert' volunteers and newcomers. This may be ascribed, and is strongly connected, to the other two problems identified: that of training, which is all too often insufficient and incapable of clarifying for the volunteer the aims and boundaries of their role; and that of the insufficient time available for building relationships of reciprocal trust and properly integrated modes of working.

The participants themselves, however, also succeed in identifying resources to be promoted and on which to concentrate as a basis for strengthening collaboration and improving the relational atmosphere.

The unspecialised volunteers identify, for example, the matter of utility, and would like to see the creation of communal 'backstage' spaces (such as a common room or dedicated café area) to facilitate contact and exchanges between Vs and PVs in more informal situations and not in the presence of patients and their relatives. Finding not only space and also time dedicated to meetings between volunteers, to their mutual acquaintance, and to collective training would make it possible to reorganise shifts and tasks in a clearer and more communal way. The communal reorganisation of participants' schedules and shared objectives would

then provide a significant support tool for truly synergistic work.

The words *communal* and *schedule* are once again to be found in the professionals' suggestions and wishes.

The professionals also affirm that concentrating on training, and providing for it to be increasingly targeted and collective, is the first step towards reorganising shifts and skills in a more communal and satisfactory way.

The skills involved in their professional role and the experience accrued on the ward also leads them to suggest arranging potential rest periods for recovery, so as to be able to deal with the risk of burnout resulting from the significant physical and emotional impacts of care work for terminally ill persons.

The informative picture obtained therefore offers a further tool for rethinking and rearranging schedules and tasks and modes of interaction at the level of volunteer teams. Lastly there is the final objective of making the tasks of intervention, assistance and guidance more effective, and the immediate aim of allowing space to reflect on any critical elements, with follow-up for the most engaging suggestions.

Conclusions

In line with the aims and objectives of action research, the work here presented, by reconstructing and analysing the dynamics of action and reaction that exist between the various figures present in the hospice environment and interacting within it, has been instrumental first of all in bringing to light and inter-

preting unseen everyday aspects that are inaccessible to an 'internal' eye; secondly, it has made it possible to identify two different, potentially critical areas: on the volunteer-professional volunteer front, that of conflict in interactions within the hospice; on the (professional and unspecialised) volunteer-patient front, that of emotional unease in the carrying out of everyday procedures.

A new focus on training, a more careful renegotiation of tasks, and the development of listening and expressive skills aimed at constructing effective dialogue are identified as priority actions and valuable stimuli, firstly to ensure patients receive support in line with their expectations and needs; to prevent the more serious risks of stress-creation (burnout); to guarantee the synergy and fluidity of the FILe 'system', eliminating or reducing the level of conflict between volunteers (and also between volunteers and other care-givers) and promoting as serene a relational atmosphere as possible.

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