

EXECUTIVE SUMMARY

Mind the Gap: Volunteering for HealthFinders Collaborative

Samuel Severtsgaard, two additional authors

Abstract:

This research focuses on the motivations, ideology, and practices of volunteers in a free clinic located rural Minnesota. The impetus for this research was a partnership between St. Olaf college students, and HealthFinders Collaborative, an organization dedicated to providing quality healthcare to those without the financial resources for accessing traditional healthcare systems. This partnership identified several key areas of interest to both parties including, volunteer motivations, clinical atmosphere and efficiency, and volunteer narratives and satisfaction. Utilizing an online survey, interviews, and participant observation our team gathered qualitative data in regards to these areas. The resulting data indicated that many volunteers conceptualized their actions and experiences through a lens of altruism, with virtually none acknowledging any conferred benefits from their volunteering. The clinical setting reflected an organization with limited resources, yet striving to provide a professional level of care. Our volunteers consistently described an overwhelmingly positive experience with their involvement with HealthFinders. Those narratives that ran counter to this trend shared similar critiques, mainly focusing on issues of communication, training, and resources. Our research indicates that the continued growth and vitality of the HealthFinders Collaborative rests solely in its ability to successfully recruit and retain volunteers through the effective use of resources, the maintenance of professional standards, and the improvement of all levels of communication.

For this research project we explored the experience of HealthFinders volunteers. At the beginning of the semester Charlie Mandile, the executive director of HealthFinders Collaborative, came to St. Olaf with the goal of recruiting a team of students to create a comprehensive qualitative analysis of the volunteer experience with HealthFinders. This included seeking volunteer motivations, narratives, challenges, and ideas for improvements. Specifically, HealthFinders desired data in order to facilitate recruitment and retention as well as creating training opportunities for current and future volunteers. Our team created a survey and interview questionnaire that we believed would elicit the most useful and informative data for our research and partners.

Our goals were twofold. First, to analyze the volunteer experience through a sociological framework, exploring volunteer ideology in regards to different forms of capital such as social, economic and symbolic. Secondly, to generate practical and applicable data to aid HealthFinders in understanding and improving their volunteers' experiences.

Overall, our interviewees enjoy volunteering their time at HF. They expressed feelings of gratitude and pride in HF's overall mission and purpose in serving the communities of Rice County. Our data, collected through surveys and interviews, indicated that our hypothesis was not sufficiently supported and lacked the complexity to accurately elucidate the volunteer experience.

FORMS OF CAPITAL

Our interviews with volunteers did not elicit responses that could be easily framed or analyzed through the forms of capital. They predominantly described their actions through a lens of intrinsic altruism. They did not cite the forms of capital as significant influences on why they volunteered. For example, several of our volunteers have gained or improved their Spanish speaking abilities; however, they did not cite this as their motivation for volunteering despite that they gained cultural capital out of it. The majority of the volunteers conceptualize their contribution for volunteering as a means of contributing to the greater good of society rather than gaining personal benefits from the act.

WORK ENVIRONMENT: Pace, Culture, Confort & Structure

As for the work environment, volunteers generally expressed how there was a lack of structure in terms of communication and following basic procedures. A nurse, who has worked in the emergency room for the past decade, is not going to find the HF clinic a stressful and chaotic place to work in. Volunteers who had previous experience in a more fast-paced and intense work environment that has an unusual structure were more adept to volunteering at HealthFinders' clinic. The workplace was also a highly individualized place.

TRAINING

There consist of no formal training for a HF volunteer. Training consists of on the job training—learning from current volunteers as you go. There is a lack of formal written policies, procedures, and guidelines for volunteers to refer to and to reference in regards to their roles and responsibilities at the HF clinics. Volunteers were open to extra training and informational sessions as an option to attend and engage in; however, many were wary of taking on additional commitments.

LIMITATIONS OF RESEARCH

The first and most prominent limited time to conduct research, this includes creating a survey, finding interviewees, literature review, conducting interviews and assessing and analyzing information.

Within a couple of weeks of working with HealthFinders we discovered that our goals, as a qualitative research group, somewhat differed from those of Charlie and Laura. One challenge for this project, as mentioned before was having two interrelated but not identical goals.

We, the research team, sought to pursue a more holistic understanding of the overall volunteer narrative, which includes the motivations behind volunteering, the emotional/spiritual/intellectual. We were interested in Macro level analysis of volunteering, while HF was more interested in a micro level analysis. Meanwhile, HF sought to find ways to improve their organization.

Another significant limitation was our low response both in relations to the survey and interviewees. Lack of adequate interview numbers which includes a lack of responses from former volunteers. Also, Limited scholarly information about the volunteering experience for older and retired professionals.

RECOMMENDATIONS

Communication

Successful communication is the key to sustaining any produced relationship; this is especially true with communication between staff and volunteers. Some volunteers found it difficult to understand the role and expectations from HealthFinders when they first started volunteering due to a lack of written communication. We recommend that HealthFinders staff strive to better their communication with their volunteer through written policies, roles, expectation and reference sheets. This would allow volunteers the information and resources need. We would also recommend that multiple members of the HealthFinders staff continue attending the clinic during hours of operation. Interviewees consistently stated that they found have Charlie or Semeena helpful.

Cultural competency

Cultural competency is pivotal to the success of HealthFinders. On average, most volunteers stated that HealthFinders clinic was a respectful and inclusive facility, however, all applicant stated that some sort of an optional culturally competency program, course or lecture would be beneficial for all staff. We recommend that HealthFinders strive to create a regular course program that teaches staff and volunteers about the culture, practices, and norms practiced by multicultural community represented in the clinic.

Training

A concern that was voiced by the majority of the interviewees was the lack of training upon joining HealthFinders. We recommend that HealthFinders staff create orientation process that is documented and tailors to the needs the new volunteer in his or her specific role. A written pamphlet, document or short guide would ensure that expectations, rules and general information is made clear to the new volunteer and that he or she has a document to reference when questions arise.

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Volunteering for HealthFinders Collaborative

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Sociology 373, Section B

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Abstract

This research focuses on the motivations, ideology, and practices of volunteers in a free clinic located rural Minnesota. The impetus for this research was a partnership between St. Olaf college students, and HealthFinders Collaborative, an organization dedicated to providing quality healthcare to those without the financial resources for accessing traditional healthcare systems. This partnership identified several key areas of interest to both parties including, volunteer motivations, clinical atmosphere and efficiency, and volunteer narratives and satisfaction. Utilizing an online survey, interviews, and participant observation our team gathered qualitative data in regards to these areas. The resulting data indicated that many volunteers conceptualized their actions and experiences through a lens of altruism, with virtually none acknowledging any conferred benefits from their volunteering. The clinical setting reflected an organization with limited resources, yet striving to provide a professional level of care. Our volunteers consistently described an overwhelmingly positive experience with their involvement with HealthFinders. Those narratives that ran counter to this trend shared similar critiques, mainly focusing on issues of communication, training, and resources. Our research indicates that the continued growth and vitality of the HealthFinders Collaborative rests solely in its ability to successfully recruit and retain volunteers through the effective use of resources, the maintenance of professional standards, and the improvement of all levels of communication.

Keywords: volunteer, experience, narrative, nonprofit, health care, clinic volunteers

Setting and Community

Our research was conducted in the cities of Northfield, Faribault, and surrounding county areas. The premise of this project focused around HealthFinders Clinic--a small non-profit organization that provides health care for the uninsured and underinsured residents of these areas--and the volunteers who donate their time, energy and skills in order to provide much needed medical care for underserved populations in Northfield and Faribault Minnesota. The patient population is largely composed of lower income individuals who reside within Rice County, Minnesota and the municipalities of Northfield and Faribault. Patients represent a diverse range of racial and ethnic backgrounds, but are predominantly Hispanic, Somali, and Caucasian.

The city of Northfield is a relatively small town of about 20,000 residents. According to the 2010 census update, the racial demographics of Northfield are as follows: 88.78% (17,763) are racially white people, 8.42% (1,685) are persons of Latino origins, 3.45% (691) are Asian alone, and 1.28% (257) are black or African American alone. Since the year of 2000, Northfield's total population has increased by 2,860 people from 17,147 to 20,007. Within that decade, there was an increase of 703 people of Latino origins ("Northfield, Minnesota population," 2012).

The City of Northfield contains two highly regarded liberal arts colleges, and several other large employers (Malt-o-Meal, Northfield Hospital and Clinics). Northfield notably retains one of the few independent hospitals in southern Minnesota, and also offers the services of several clinics, and an urgent care facility. In addition to those health care related services Northfield is also home to many small businesses. By comparison the majority of residences in

Northfield enjoy on average a higher level of social and economic resources than their Faribault counterparts.

The median household income for Minnesota was \$62,253 in 2009, an increase of \$3,936 over the previous year. As for the racialized breakdown of wealth for Northfield in 2009, the average white family's income was \$63,863, which is \$13,799 more than black residents and \$30,395 more than Hispanic residents. The distribution and variety of employment can account for a portion of this disparity, but not all of it. The most common industries during the period 2005-2009 for men in Northfield were education services (29%), manufacturing (13%) and retail trade (8%). The most common occupations for men in this time frame were postsecondary teachers (8%), and other management occupations exempting farmers and farm managers (6%). For women, the most common industries are education services (40%), health care and social assistance (17%). As for the most common occupations for women in 2005-2009, information and records clerk and administrative support work represented 9%, while secretaries and teachers in preschool through middle school represented 5% ("Northfield, Minnesota," 2012). Although Northfield and Faribault are neighboring cities they share vastly different social frameworks due to differences in income, race and ethnicity, median net worth and education levels of their citizens.

Just Down the Road: Faribault, Minnesota

A bumpy twenty-minute drive going south on Minnesota Highway 3 will land you in Faribault, Minnesota. According to the national census in 2011, Faribault was home to over 23,390 residents with a little over half of the population being males. Faribault enjoys a larger array of diversity than Northfield, with racial and ethnic ratios average 75.3% white, 13% hispanic. 7.4% black, 2.1% Asian and 2.26% of the population identifying as other ("Faribault,"

2012). In 2009, the average household income for Faribault was \$ 55,097, which was \$3,220 less than the Minnesota state average household income, and \$7,156 less than Northfield according to The Department of Numbers. (“Department,” n.d.).

In 2012 Faribault experienced an unemployment rate of 6.5%, which was 0.9% higher than the Minnesota average unemployment rate. Most of the wealth accumulated in Faribault is through manufacturing, construction, healthcare and retail. From 2005 to 2009 Faribault manufacturing industries employed 35% of the male population, while 11% worked in construction. Women on the other hand had a large presence in the healthcare and social assistance sectors (29%), as well as manufacturing (15%) and retail (12%). Unlike Northfield, Faribault does not benefit from the financial gains that accompany having two colleges located in their town. Despite their differences, Faribault and Northfield face one common problem, the failure of their healthcare systems in relations to underserved and low-income citizens. The HealthFinders Collaborative and its partners have come together to meet the medical needs of members of both communities through the creation of their two clinics.

Methodology

Our team began by reviewing the applicable literature and research conducted on volunteering narratives, motivations for volunteering, and medical volunteering. To find the most recent and relevant scholarly articles for our literature review, we utilized ProQuest, Ebscohost, Academic Search Premier, JSTOR, and Metapress by searching the combinations of the keywords and phrases “volunteer and narrative,” “volunteer and clinic,” “volunteer experience,” “gender, nonprofit, healthcare workers,” and “volunteer, race, and experience”. A large portion of the material we located was of little practical value owing to focuses outside the

scope of our study. We compiled those studies that did have salience to our research, and have incorporated them.

In addition to our literature review, our group drew on the experience and knowledge of Dr. Christopher Chiappari, Dr. Theodore Johnson, and our partners at HealthFinders to aid in our research by providing guidance and assistance when requested. A central component of our research was meeting the needs of our collaborators, and so our efforts were directed towards those resources that would help us achieve that goal.

Initially, at the request of our partners at HealthFinders, our group developed an online survey through Survey Monkey. The survey was distributed to the HealthFinders mailing list to approximately 55 volunteers. This survey was intended as a first step at gauging the responsiveness of our volunteer population, and basic information collection. The survey did not require the disclosure of any identifiable information unless the respondent elected for a follow-up interview. Questions were developed by reviewing the literature, and analyzing the information requested by HealthFinders. Additionally, this initial survey served as a recruiting tool for in-person interviews. The survey requested respondents to answer whether or not they would be willing to participate in a follow-up interview and for contact information.

Once the survey had been created our group began to develop interview questions that sought to elicit the information that HealthFinders requested. Questions were open ended, and designed specifically to allow respondents to elaborate more or less to their comfort. We attempted to structure our interview questions in a chronological order so that respondents would first narrate their early experiences with the organization, and then move towards their present situation. The questions asked for qualitative assessments and descriptions of these experiences. After drafting our interview questions we shared them with HealthFinders and Dr.

Chiappari in order to confirm that they would meet their needs. Once we received feedback from our collaborators at HealthFinders the questions were revised. During the course of completing interviews, HealthFinders requested an additional section of questions be added to the interview regarding the use of social media and networks. These questions were added to our interviews and all subsequent interviews obtained this data.

The process of recruiting interviewees began with our survey. As will be noted later our survey received a low response rate, yet we were able to begin interviewing those respondents that were willing to be interviewed. We began making contact with volunteers via the method of contact they provided. For additional recruiting we used the directory information provided to us by HealthFinders. Our interviews were conducted between April 5, 2013 to May 8, 2013 in the cities of Northfield and Faribault. Our recruiting allowed interviewees to chose the location so a variety of venues were utilized ranging from participants residences to coffee shops or libraries. As a means of last resort several phone interviews were used when no in-person interview could be coordinated. Interviews generally lasted between 35 minutes to an hour in length. The interviews were recorded through notes, and audio recordings.

Our team visited the Health Finders' Dundas and Faribault clinics while in operation in order to develop a better sense of the space our interviewees had been referencing, and to observe directly the operation of the clinic, and the interactions among clinic volunteers and patients. During our visits the team observed the clinic processes, and interacted with volunteers while they performed their roles. This time was also used to make contact with volunteers previously not approached for interviews.

The Dundas clinic is situated within the basement spaces of the Little Prairie Church in rural Dundas, MN. Although the church was not difficult to locate, it was situated on a fairly

remote stretch of road. When entering the church, one is confronted with a dark and empty chapel. To the left, a stairway leads down to the church's nursery area and the clinical space. The clinic has a waiting area just outside the door where several patients are waiting to be called. The reception desk sits just on the other side of the doorway of the waiting area, accompanied by file storage and workspaces. Finally, there are two patient care rooms in which the providers perform examinations and treatments. Though small, the clinic is well kempt and the volunteers show conscious effort to maintain the space for staff and patients. The clinic operates on Tuesdays and Thursdays from 5:00pm to 8:00pm.

Interviews were planned with the most accommodation possible for our respondents by allowing them to choose the time and location. Our questions proved to be narrow enough to gather detailed responses that met our research goals, yet open enough so that respondents were able to craft responses that allowed their unique narratives to come through. The planning and structuring of our study was based on our research, experience, and collaboration with partners.

Problem and Literature Review

The data we sought was centered on if the volunteers had constructive criticisms of their volunteer experiences, ideas for volunteer training, orientation topics, or any other concerns and ideas for improvement. There has been extensive research conducted in the area of volunteering from which our team was able to draw upon.

Volunteering is a distinctive and valued social practice. People are attracted to health-promoting activities in the form of meaningful volunteer work (Hong and Morrow-Howel 2010). For instance, older adults who engage in volunteering may have beneficial health effects such as higher physical function, life satisfaction, less depression and pain, and overall higher enjoyment of life (Hong and Morrow-Howel 2010). One study found how volunteers are more

loyal depending on the positive reputation of an organization and how they personally identify themselves (Grube and Piliavin 2000). According to one study, female volunteers at a breast cancer organization did not consider themselves as activists nor contributing to the public good, but rather as having self-interest in volunteering (Blackstone 2004). Specific volunteer roles experience different perceptions of the organization.

According to one study, women are often marginalized and undervalued in the nonprofit sector (Kosny and MacEachen 2009). Kosny and MacEachen discuss the challenges faced by the nonprofit social services sector and illustrate how it could best solve many of its limitations (2009). They examined the similarities between characteristics of nonprofits and women's social status and work traditionally performed by women. In addition to looking at gender, this study assessed the concept of invisible workers or undervalued and unrecognized work done in the nonprofit sector. The article divides the nonprofit service sector into three categories: invisible labor, empathy labor and emotional labor. All forms of these types of invisible labor often become overwhelming and burdensome on the volunteers because of the lack of breaks, positive feedback and emotional support (Kosny and MacEachen 2009). These workers would often terminate their employment and look for more supportive jobs or volunteer opportunities.

Volunteer work can be an empowering force for people. According to a study done by Gooch, volunteers felt empowered by the friendships they cultivated while volunteering. The volunteers felt a sense of empowerment by being able to work on their interpersonal skills, by learning new information and transferable skills, and while working and completing tasks (Gooch 2004). Also, volunteers felt a sense of accomplishment when able to engage in all of

these ways to strengthen themselves. Over all the volunteer experience reinforced a sense of pride and accomplishment.

Similar to this concept in the journal in their study, Tang and her research colleague's assesses differences in volunteering habits of older black and white retired Americans in relations to social and economic capital(2012). Their research indicated that older white citizens often have more net wealth, income, education and free time; therefore, they are able to volunteer and provide their services at a higher rate than their black counterparts. Researchers also found that older black citizens were just as likely to be involved in service work but it was often performed for their churches, family members or small social network. The overall data suggest that the white retired population is more likely to volunteer than that of their multicultural counterpart because they often have a stronger economic foundation than the non-white retired population.

In her 2008 dissertation, P.A. Duffy researched the motivations for volunteers at a free clinic in rural Iowa. Her ethnographic study of the volunteer experience reveals the common narratives that drive many medical clinic volunteers: empathy and compassion for those in need, and frustration and disappointment with a healthcare system that is failing so many. Duffy's findings cite the intrinsic motivations for volunteering as deriving from a feeling as if one is "making a difference," and compassion for medical patients in general, but especially those marginalized by social and economic factors. The lack of a free clinic to provide for the whole of a patient's needs is also noted to be a typical weight on the volunteer's mind.

Wilson's 1999 study of the effects of volunteering on volunteers makes an effort to catalogue the benefits and costs of volunteering. Wilson uses five categories through which the volunteer act is likely to affect the individual: social capital, democratic or political involvement,

mental health, physical health, and occupational achievement. Through the act of volunteering the individual has the potential to experience a positive or negative impact in these areas. Wilson's research supports our group's consistent finding that the volunteers at HealthFinders experience many direct benefits from their work. Most often these benefits were realized in the form of increased personal satisfaction from helping others, greater social connection through their fellow volunteers, and an additional sense of identity through their role as a volunteer (Wilson 1999). The potential negative effects of volunteering such as role strain and empathy fatigue were highly individualized, but not uncommon.

Based off of how Yeung's 2004 article analyzes the spectrum of motivations that drive volunteerism and are categorized into four intersecting poles: Getting-Giving, Continuity-Newness, Distance-Proximity, and Thought-Action, our own research has yielded comparable motivational sources and axes such as strong narratives focusing on giving back to their communities, continuing a life of service, remaining connected to their communities, and taking action to better the world. This model places volunteer motivation at the heart of understanding the volunteer experience. Our own research takes this position as well. Following Yeung's example we sought to indirectly qualify motivations through personal histories, as well as through direct questioning.

The limitations of this study are significant. The results can only be applied to the volunteer population of the HealthFinders clinic, and only then with some caveats. The small sample size makes generalizing our results difficult; however, we feel that there are some noticeable trends in our data. Self-selection was an unavoidable limitation of our study. The implications of this are that the respondents may not be a representative sample of the volunteer population. Additionally respondents may be more prone to exhibiting stronger than

representative opinions. A key component of our research is the qualitative nature of our questions, and the volunteers' responses. This poses its own issues as all data collected is influenced by a respondent's interpretation of our questions, and subjectivity.

Our study initially contended with what would be a major difficulty for any study: low response rates. This challenge was identified when our online survey yielded 13 total responses from a sample of 56 (response rate of 22%). Our study had planned for at least 30 interviews. Our efforts then focused on contacting as many of the volunteers in the directory as possible to invite them to participate in interviews. Unfortunately the low response rate continued into the interview portion of our study.

An additional limitation that we encountered was the scheduling difficulties between HealthFinders staff and our research team. By working with an organization off campus we encountered difficulties with outlining goals and accomplishment dates that worked for both parties, communication with Healthfinder and scheduling with potential interviewees due to issues with the academic schedule, such as breaks and other academic obligations. These scheduling differences hindered our ability to fully collaborate with an off campus group and made reaching our target number of interviewees virtually impossible. Also, we, as a qualitative research team, sought to pursue a more holistic understanding of the overall volunteer narrative, which includes the motivations behind volunteering, the emotional, spiritual, and intellectual. We were interested in Macro level analysis of volunteering, meanwhile HealthFinders was more interested in a micro level analysis. Overall HealthFinders sought to find ways to improve their organization. The biggest limitation that this research project faced was the lack to time that we had to complete the entire research project. As a semester long course the project was forced to

be conducted in short amount of time with scarce resources. The project would have been much more successful if the project was conducted over the course of six months to a year.

Findings and Analysis

Our time with the volunteers of HealthFinders Collaborative produced a varied and useful data set from which our team was able to create an analysis of free clinic volunteers.

Bourdieu, theorizes about forms of capital such as social, cultural, economic, and symbolic capital. These forms of capital will be discussed further below.

Social Capital

Engaging in humanitarian volunteer work enables one to increase forms of capital. For example, a volunteer may increase their social capital by interacting with other volunteers and networking with people in the organization. Many volunteers cited their initial involvement with HealthFinders as emerging from friendships and professional acquaintances. For example, one volunteer stated that her husband was golfing with a HealthFinders volunteer and he mentioned that she [the interviewed volunteer] was looking for an opportunity to get involved in volunteer. This social encounter led to her learning about HealthFinders, and ultimately becoming part of the HealthFinders volunteer network. This is an example of how volunteering facilitates the maintenance and creation of social networks. Previous research has found that volunteers enjoy the benefits of strengthening their social network through volunteering and the contacts they have made through volunteering.

As many of the HealthFinders volunteers are retirees our team had also theorized that the volunteer act served to re-establish or strengthen social capital through creation or maintenance of social and professional networks. Our interviews and clinical observations did confirm a strong sense of community, and camaraderie among volunteers, however this appeared to

manifest itself in a very general and limited fashion. Though volunteers were quick to offer up their peers as exemplary professionals and compassionate individuals, most denied any significant contact with each other outside the clinical setting. Although some volunteers are present frequently at the clinic, this appears to be the exception with most volunteering a few times per month or every several months. This results in fairly limited interactions between the same volunteers. Additionally, the clinical environment, from our observations and informant statements, prevents significant socialization as the work pace is usually prohibitive. Though the volunteers did express positive feelings toward their peers this was never cited as a significant source of their initial and continued rationale for volunteering.

Cultural Capital

Bourdieu states, “Cultural capital can exist in three forms: in the embodied state...the objectified state, ...and the institutionalized state...” (1983). Here our team focused on the accumulation of embodied capital. Embodied capital refers to “the form of long-lasting dispositions of the mind and body...” (Bourdieu,1983). In the setting of a free medical clinic this type of capital can be related to the interactions among peoples from different socioeconomic, cultural, ethnic and racial backgrounds, and the effects of such exposures on the volunteer’s worldview. The direct benefit of these interactions is to increase the awareness of the volunteer in regards to mores, norms, and values of cultures that different from their own. In addition the potential for self-reflection is also increased in these instances (Wilson and Musick 1999).

Our observations and interviews indicated that it is demonstrable that most HealthFinders volunteers accrue some degree of embodied cultural capital through their work in the clinic. For instance, many of the volunteers who interpret for HealthFinders enjoy improving

their Spanish through their work. These volunteers stated a desire to be able to smoothly translate medical specific terminology from English to Spanish and vice versa. Interpreting for HealthFinders improves these language skills, and those filling roles such as receptionist, nurse, and provider expressed an increased awareness of the Spanish language and their own skill level. By internalizing the volunteer experience through increased language and cultural proficiency these volunteer are bolstering their embodied cultural capital.

Economic Capital

Although, economic capital is not acquired directly through volunteering, many volunteers are not in need of economic resources due to the previous wealth gained at their primary or former employment or their retirement status. The potential for economic benefits through networking with other volunteers is a reality, however, our research did not find any examples of volunteers exploiting this possibility.

Symbolic Capital

Lastly, symbolic capital represents the appropriation of signifiers of prestige, status, and reputation. Being a volunteer strengthens symbolic capital as volunteer work is culturally valued by society as a whole, and it is seen as a positive and morally valued activity. When one becomes a volunteer, they receive a special status in society. They are seen as economically stable as they are able to donate time to provide free labor. Volunteers are also seen as people who possess a specific skill set that can be utilized for the benefit of others. They are honored in many ways and gain more prestige because of their willingness to provide labor for a significant cause in society. Volunteers are also seen as ethical persons in society (Williams 1997). Their motives for volunteering are usually regulated by moral incentives rather than extrinsic incentives of economic capital gains (Williams 1997).

The concept symbolic capital was referenced and acknowledged by HealthFinders' volunteers, but not as a source of external motivation. Repeatedly terms such as "mission," "duty," and "lifestyle," was used by respondents. Often this was explicitly situated in religious terminology and at others in more humanistic terms. The major theme that this reveals is that our volunteers generally conceptualize their volunteering through altruism. No volunteers mentioned a sense of increased status or prestige from their work. When speaking about their activities with HealthFinders, our volunteers were generally patient centric, focusing on the impact the clinic and the volunteers have on the community of those uninsured in their area. They often used statements of empathy such as, "I don't know what they (the clinic patients) would do if we weren't here," or "they have nothing." This emphasis on the needs and vulnerabilities of HealthFinders' patients lead to our respondents discussing the importance of their work, and the positive impact such clinics have on their communities. They did not see their work resulting from a desire to be socially recognized as, one respondent stated, "a do-gooder," but instead they conceptualized their volunteerism as a manifestation of their intrinsic moral ideals.

Overall Analysis

As our partners at HealthFinders had requested information regarding the motivations, and challenges of volunteering, our team had designed the survey, and interview questions with the intent of detecting trends in both positive, and negative data. The initial survey produced several responses that displayed significant dissatisfaction with the experience of volunteering with HealthFinders. Our research team was eager to find such narratives as we felt that they had the potential to produce actionable criticism. However, these respondents declined to be interviewed. Our team anticipated that those with negative responses would potentially be less

inclined to be interviewed or answer our survey, and this was borne out during our research. Despite the majority of our respondents expressing predominately positive experiences with HealthFinders several trends were identified as challenges volunteers face.

“I have enjoyed every moment of it.”

The overwhelming majority of our interviewees described their time and experience with HealthFinders as unambiguously positive. The bulk of our interviewees conveyed that a significant source of satisfaction with their work was the result of their interaction with peers, patients, and HealthFinders staff. “They’re all amazing people,” stated one respondent. Also, numerous volunteers cited the HealthFinders mission statement as an ethos which they fully embraced, and represents their fundamental worldview. As stated by one interviewee, “Their mission lined up so well with my personal ethics that my commitment to HealthFinders has only grown stronger every year.” The volunteer culture at HealthFinders is an inherently supportive and affirmative one. Every interviewee mentioned other volunteers and their actions as examples of excellence in their fields.

“Chaos and Confusion”

Although respondents remained consistently positive in their appraisal of volunteering with HealthFinders, several notable trends of criticism developed. A frequent description of the clinical environment during operation involved the terms “chaos,” “confusion,” “disorganized,” and “hectic.” “Whenever anyone asks me if they can volunteer with HealthFinders, I warn them beforehand that they need to be flexible, you need to be flexible because it’s chaos and confusion,” stated an interviewee when asked to describe the Dundas clinic. The pace and process of the clinic were cited regularly as major contributors to the level of disorder that respondents depicted.

“We have tight margins.”

The operation of a free clinic in rural Minnesota runs into the same challenges as do free clinics across the United States. The most frequently cited issues fall under the topic of resources. In terms of capital and human resources HealthFinders Collaborative one volunteer with several years of experience responded, “More money,” when asked about what would really help improve HealthFinders. Later the same volunteer stated that one of the biggest issues facing the clinic in the future would be the small number of physicians in the organization. However, the single most cited issue by volunteers was the “bug problem.” During the spring boxelder bugs inundate the rural church where the Dundas clinic operates. The majority of these insects find their way into the clinic area where they expire. Volunteers typically recognized the difficulty of combating such seasonal infestations, and their main complaint was that the bugs created the perception of an unclean space for delivering the quality healthcare. Resources for the organization and the volunteers at the clinic are tight, and this was beyond all others the most consistent challenge mentioned to us during our research.

“To be honest communication is still an issue.”

Difficulties with communication were also brought out routinely in our interviews. “I feel totally disengaged from the conversations that HealthFinders staff are having,” remarked a long-time volunteer. Difficulties were noted in regards to vertical communication, but not so with horizontal communication. Multiple volunteers discussed how they work effectively with their peers to arrange for vacations or other absences from their normal clinical schedules. Though the majority of volunteers stated that they felt HealthFinders staff was responsive to their questions, ideas, and concerns, there were volunteers who expressed frustration with certain specific instances where repeated requests for changes had gone unaddressed. Other

communication issues revolved around management level activities at HealthFinders, and the perception by some volunteers that decisions that shape and affect their volunteering were being made without their input. Our team had some difficulty analyzing the issue of communication at HealthFinders due to a wide range of views from the respondents, with some of those views being contradictory. From this we gauged that the individual volunteer's role, level of experience, and seniority may have significant effects on how they perceive organizational communication.

Training and Cultural Competency

HealthFinders initially charged our research team with providing a qualitative assessment of the level and type of interest within the volunteer population in regards to training and cultural competency. Both the survey and interviews sought volunteer perspectives on these issues. What became clear over the course of our research was that the volunteers' unique backgrounds and experiences shape how they understood their roles in the clinical setting. Many of our respondents expressed a willingness to participate in classes or training in addition to their clinical volunteering. Which we did not find surprising as many of the volunteers have some experience in the healthcare field, and are familiar with continuing education and license maintenance.

What we found most notable were those respondents who expressed reluctance to implement classes for clinical volunteers. Though time constraints and other commitments surely played a part in this resistance, they most often expressed that such additional training was "unnecessary," and that classes would not accomplish anything that couldn't be done during their evenings at the clinic. For our team this resistance to implementing more formal methods of training and education presented as problematic. More research is needed on the nature of these

dynamics and their foundations, however we can say that should HealthFinders Collaborative seek to enact more rigorous training and education standards they will likely receive push back from a vocal minority of their volunteers.

Our interviews were rich with personal narratives that aided our team in understanding how HealthFinders volunteers conceptualize their identities, and their motivations for volunteering. Though exact wording differed, our respondents consistently described their experiences in narratives with shared conceptual frameworks of altruism, community, and need. The literature provided several avenues for analyzing the motivations that inspire volunteerism, and we attempted to use them with the most effect. Throughout our interviews we developed a strong sense of the community of volunteers who make HealthFinders possible. Their work often goes unnoticed by the larger communities in which they reside, but the importance of their personal and organizational missions drive them forward.

Conclusion

Our team spent significant effort culling the literature for methods of analysis that would meet the dual purpose of the research. The decision to use Bourdieu's theory of capital proved useful, yet challenging. Most notable was that respondents typically conceptualized their motivations and experiences in terms of benefits provided, not received. This proved to be challenging when attempting to frame their motivations and experiences in terms of capital. In those instances where respondents cited positive effects on themselves directly resulting from their volunteering they did not attach notable significance to them.

The clearest benefit of compiling this research is that we as a qualitative research group have started to fully conceptualize the motives and aspirations behind medical volunteering. Some of our most significant findings were related to forms of capital, work environment and

training. Volunteers did not cite, or for that matter recognize, the benefits derived from their volunteering as significant factors in their decision to volunteer.

Although, the volunteer experience is highly individualized with unique narratives shaping the conceptualization of motivations and identities, our respondents shared an internalized sense of altruism as the primary source and guide for their volunteer activities.

As our research was directly based on collaboration with community partners it is our sincerest belief that the findings we have discussed will prove useful in informing the HealthFinders Collaborative. It may prove beneficial if researchers analyze best ways to improve cultural competency whether via discussion, lectures, educational videos, or other methods of teaching and learning. Also, future research that looks to illuminate the highly individualized volunteer experience identity. Finally, A comparative analysis between similarly situated volunteer staffed clinics and employee based clinics.

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