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Examining Physicians' Motivations to Volunteer:

An Applied Visual Anthropological Approach

by

Jess Paul Ambiee

A thesis submitted in partial fulfillment
of the requirements for the degree of
Master of Arts
Department of Anthropology
College of Arts & Sciences
University of South Florida

Major Professor: S. Elizabeth Bird, Ph.D.
Michael V. Angrosino, Ph.D.
Nancy Romero-Daza, Ph.D.

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Dedication

To my father and mother for always supporting me in all my endeavors.

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Examining Physicians' Motivations to Volunteer:
An Applied Visual Anthropological Approach

Jess Paul Ambiee

ABSTRACT

In the U.S., the number of persons who cannot afford health care continues to rise. Providing a "safety net" for such persons is becoming increasingly important. Medical professional volunteerism provides access to health care for people who have little or no access to health care otherwise.

At a not-for-profit free health clinic in Tampa, Florida, hundreds of physicians have volunteered their time in an attempt to reduce the health care gap in their community. The clinic sees thousands of persons who have very limited options in regards to their health care. This study investigates the reasons physicians volunteer and the barriers physicians face when providing free medical service. Through a survey, shadowing sessions, and focused in-depth videotaped interviews with volunteer physicians concerning the risks, rewards, experiences, and barriers of professional volunteering, a greater understanding of this important topic was obtained. This applied visual anthropological project was developed in collaboration with the free clinic in order to provide a product which would be of use to the organization at the end of the research process. This research led to an enhanced understanding of this population as well as recommendations in volunteer physician recruitment strategies.

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Chapter One: Scope of the Study

The main research questions in this study, conducted at a free clinic in the Tampa Bay area, are, "Why do physicians volunteer their medical services, and what are the barriers for physicians in volunteering?" The purpose was both academic and applied: first, to show how anthropologically-informed method can be used to better understand the phenomenon of physician volunteerism, and second, to provide tools to help the clinic improve physician recruitment. The products of the research are both a traditional applied anthropology thesis and a brief DVD developed from interviews and images collected in the project, and intended to help the clinic with recruitment efforts. The construction of this research project was developed in collaboration with the clinic, so as to provide a product which would be useful to the organization at the conclusion of the research study.

The Research Setting

The Judeo Christian Health Clinic (JCHC) in Tampa, Florida, is a free clinic that provides health care for medically indigent persons who have no other resources for their health care needs. A free clinic is defined as a volunteer-based clinic that provides free or low-cost healthcare services to medically uninsured or underinsured people (Geller et al. 2004:44). It receives no government or United Way funding but relies solely upon its own fundraising efforts through the private sector to meet expenses. The clinic operates independently and on an annual budget of approximately $500,000.

The Judeo Christian Health Clinic (JCHC) was founded in 1972 by a Presbyterian minister, and is located in an urban setting on Martin Luther King Drive and N. MacDill Avenue. In March 1972, the clinic began in a Sunday School classroom on a one night per week basis with one physician, one nurse, and a few volunteer staff. Due to overwhelming demand, a new building was constructed in 1973 to house the clinic and more medical personnel were recruited to volunteer. George Bush recognized the clinic for its efforts to deliver free health care to the medically indigent with the 1989 President's Volunteer Action Award. In 1999, the clinic raised one million dollars in order to build a new 8000 square foot facility with twelve examining rooms, a laboratory, a licensed pharmacy, three complete dental operatories, and an optician's dispensing lab (Judeo Christian Health Clinic 2006). Today, the clinic is one of the most up-to-date, largest, and comprehensive free clinics in the Southeast United States.

The executive director oversees internal operations, professional recruiting, fundraising, and public relations. Clinic policies are set by the JCHC Board of Directors. The executive director, receptionist, and night clinic coordinator are full time employees and

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there are five part-time positions (pharmacist, administrative assistant, two staff assistants, and a dental assistant) that are paid out of clinic funds. All other JCHC staff are volunteers.

The funding of the clinic is essential in understanding the goals and nature of the clinic. The clinic does not qualify for governmental assistance in part because it serves persons that are not eligible for governmental health assistance, such as undocumented immigrants. However, this lack of governmental oversight allows the JCHC organization to provide care as it best sees fit. This is also in line with its mission to serve people who have very few options in the way of health care.

The clientele (i.e., patients who receive health care) have no insurance, do not qualify for Medicaid, Medicare, or any other public assistance program, and lack the funds to pay a private doctor or to purchase health insurance. Also, it is not mandatory for patients to be U.S. citizens. The JCHC targets people who are "ineligible for government assistance but unable to afford private care"; in other words, the persons that fall between the cracks of our health care system (Judeo Christian Health Clinic 2006). A term heard around the clinic for their clientele is the "working poor" or the persons who do not have access to care through the present health care delivery system in this country. The clinic handles more than 26,000 patient visits annually. In a 2005 study of the JCHC, it was found that 63% of JCHC clients were women, 92% of JCHC clients resided within Hillsborough County, and the greatest number of clients came from the 40 to 49 year age range. Most patients who qualify for the clinic work at low-paying jobs with little or no benefits, such as health insurance; to qualify, patients' incomes must fall between 100% and 250% of federal poverty income guidelines (See Figure 1 in Appendix A).

According to Bea Dreier, the JCHC Director (personal communication, May 2007),

> In Hillsborough County, we have what is called the Hillsborough County Healthcare Program, and that's for people below the poverty level [below 100%, as seen in appendix I], and they will take care of those people, there is also Medicaid that will take care of a lot of those people as well. But our patients don't qualify for those programs.

The JCHC offers many services within its building and provides additional services within JCHC referral/specialist physician offices. Departments within the clinic building include pediatrics, gynecology, asthma & allergy, dental, eye, general medical clinics, podiatry, dietician counseling, Hepatitis C screening, and dermatology (Judeo Christian Health Clinic 2006). The services that are provided within the clinic vary in their hours of operation depending on the type of service. The clinical hours for the medical specialties are less than the hours for general medicine. General medical care is provided Monday through Thursday after 5 pm, and Fridays after 1 pm. Specialty-specific care (such as gynecology, asthma, or dermatology care) is usually provided after 5 pm one day

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per week. Most appointments are set after 5 pm because the vast majority of physicians who volunteer at the clinic also work full-time jobs.

The amount of service provided at the clinic, for both general and specialty-specific care, is established based on both the number of volunteers available and the demand by the JCHC clientele. The JCHC and St Joseph's hospital have a written agreement that the costs associated with all diagnostic tests and procedures for patients referred to by the clinic will be covered by St Joseph's hospital. These are often needed with referral/specialist care.

The doctors involved in providing care to the JCHC clientele were the main participants of this research study. These include both doctors that visit the clinic and referral doctors, who treat JCHC patients in their private offices, free of charge, on a referral basis when a patient's needs exceed JCHC capability. According to the JCHC, there were 106 doctors who volunteered at the JCHC, and 87 referral doctors who volunteered their services in 2005-2006.

When asked to define the difference between in-clinic physicians and the referral physicians, the JCHC Director explained:

> Well, we have hundreds of physicians who volunteer for the JCHC and many of those doctors actually come to the clinic after they've worked all day at their own private office and they work during evening hours here at the clinic and see patients, and help provide free health care to these people who have no other resource for their health care needs. We also have a list of hundreds of doctors for patients who need subspecialty care that's not offered at the clinic. For instance, if a patient needs surgery or needs to see an urologist or a neurologist, we have a referral agent who can pick up a phone who can call that doctor in that specialty and make an appointment for that patient and that doctor sees that patient free-of-charge. They've agreed ahead of time to see X amount of patients per month, or whatever. They follow those patients for whatever their condition is.

My internship supervisor in this research study was the executive director of the JCHC, who played an important role in the research process. To ensure the project would be applicable to the clinic, the director introduced and helped define the research topic. The clinic expects to gain something productive and helpful out of this research project. I will provide recommendations to improve recruitment procedures, as well as a DVD video highlighting both the doctors who volunteer and the clinic itself. The hope is that the DVD may help in recruiting physicians, publicity, and fundraising. The director assisted me in identifying doctors to participate in the project, and has been very helpful throughout the research process.

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The physicians who see JCHC patients come as volunteers, receiving no pay for their services. In this way, physicians and the physician recruitment process are integral to the everyday operations of the clinic. Physicians are always in demand and the clinic can only see as many patients as there are doctors. As Shapiro (2003:54) notes, "Free clinics and similar voluntary efforts are likely to remain an important component of the health care safety net". The executive director of the clinic, when discussing possible research topics, mentioned one of the most important things for the clinic is to recruit more physicians.

Purpose of the Project

Anthropology is concerned with the generation of basic knowledge and the application of knowledge to the solution of human problems (USF, Department of Anthropology:1). Applied anthropology is often commissioned by an organization outside of academia and the purpose is often to give clients concrete recommendations or tools for specific purposes. The topic of research is often *not* selected by the anthropologist and this is the crucial distinction as compared to other types of research within anthropology (Ervin 2005:4).

The goal of this research project is to understand the reasons physicians volunteer their time freely to help patients who cannot afford medical care. The main research question is: "Why do physicians volunteer their medical services?" Included within this is another important question: "What are the barriers for physicians in volunteering their medical services?" Understanding the answers to these questions can possibly improve recruitment procedures. It may help the clinic advertise to prospective volunteer doctors by emphasizing the positive, beneficial reasons and directly addressing the main concerns in volunteering. This project also has a strong applied component, in that if we can understand why physicians do or do not volunteer, strategies can be developed to better recruit them. Recruiting more volunteers is crucial to the functioning of the clinic, as the executive director explains:

> It is important to the clinic to have adequate staffing of physicians here during all of its clinics. We are limited by how many patients we can see, by how many, by the number of doctors we have on duty that night. Most of our physicians work on a rotating basis, and if they are here on a Monday night, and say we have five physicians, we will schedule 8 to 10 patients per doctor, so if we have 5 physicians, we are likely to see 50 patients that night. If we have one physician, we can see 8 to 10 patients, so we are only limited by the number of doctors we have. You are constantly looking for more doctors as the patient load increases all the time. We actually doubled and tripled our patient load just during the past several years.

Currently, physicians are recruited through advertising and word-of-mouth. The clinic advertises through the Hillsborough County Medical Association, and sends a newsletter

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to local physicians in town. Addresses of the physicians are gathered through the yellow pages, and the director believes the clinic reaches 99.9% of local doctors. Word-of-mouth is conducted from doctor to doctor, board of directors to doctors, or lay volunteers to doctors.

The current policy or strategy on deciding the number of hours physicians volunteer at the clinic is quite understated or possibly non-existent. According to the director, physicians usually ask her, "What kind of commitment do you expect?" To which she replies, "Most doctors work about once a month." The physicians then usually agree to volunteer once a month. After a deeper investigation of the physicians which this project will provide, I hope to possibly offer recommendations on how to improve current policies.

In this study, I interviewed volunteer physicians at the Judeo Christian Health Clinic with the goal of understanding their main motivations to volunteering. I interviewed and observed/shadowed doctors who currently volunteer, and videotaped the interviews. The videotaping was done not only for research analysis, but also to create the video that emphasizes the rewards doctors receive when they volunteer and directly addresses the perceived barriers to volunteering, in an effort to attract prospective volunteer doctors. Upon mentioning my previous filmmaking experience, the clinic director was very enthusiastic about creating a video that would somehow highlight the clinic. Refining the topic and purpose of the video came with numerous discussions with the clinic director. The video portion of the study aims to contribute to the applied component of the project. This medium will hopefully serve as one of the tools the clinic can use to encourage more physicians to volunteer, and will also be helpful for the clinic in general because it will communicate to the larger public the type of work that is being done there. Finally, recommendations will be given to clinic staff in order to improve functioning of the clinic, based on the findings of the thesis.

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Chapter Two: Literature Review and Theoretical Framework

Introduction

"The idea that an individual would make significant personal sacrifices for another person, particularly when that person is a stranger, has long fascinated students of social behavior" (Clary et al. 1998: 1516).

Alexander Ervin, in his book on applied anthropology, explains that "given practical problems to solve, applied practicing anthropologists have to be pragmatic. That requirement frequently forces them to draw upon theories from other social science disciplines – social psychology, community medicine, sociology…Often such alternative theory sources are directly informative about the problems at hand…practitioners can blend these sources with insights from anthropological theories or perspectives" (Ervin 2005: 11). Marshall (1992:1) claims a defining characteristic of applied anthropology is a strong commitment to social change through the application of anthropological concepts and skills in collaborative and interdisciplinary research. Ervin (2005) also mentions that applied anthropologists must be flexible in their theoretical framework and most anthropological academic theories were strongly influenced by other intellectual trends. Also, there is relatively little anthropological literature concerning the sociocultural act of volunteerism. Upon reviewing the sociological literature concerning altruism, Piliavin and Charng (1990) stated longitudinal, prospective research studies on volunteers is essentially non-existent. Most of the volunteerism literature comes from the field of psychology.

Psychological Motivations to Volunteer

"Given the increasing demand for volunteers, researchers have begun to explore how volunteerism is instilled in emerging professionals. A better understanding of the motives that underlie professional volunteerism may be useful in recruiting and training professionals to give back to their communities" (Fletcher and Major 2004: 109).

In the field of psychology, the functional approach to understanding altruism is the predominant one. Central to this approach is that people engage in various activities for purposeful, goal-oriented reasons (Fletcher and Major 2004:110). Related to the functional approach is the Volunteer Functions Inventory, created by Clary et al. (1998), which is based on the functional approach to understanding altruism. A functional perspective towards motivations to volunteer is chiefly concerned with the "why" of volunteerism (Whitt 2006:10). Understanding these reasons is important and could give

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us concrete answers as to why members of a specific population (e.g. Tampa physicians) would participate in long-term volunteering. Once this is better understood, the recruitment technique of local doctors by the JCHC may be enhanced.

The doctors that volunteer at the JCHC do not indulge in short-term or spontaneous altruistic behavior. This long-term helping is called “planned helping”, which calls for sorting out priorities and is a very cognitive decision (Clary et al. 1998:1517). What sustains this long-term altruistic behavior? In planned helping, there are common threads: the helper must seek out the opportunity to help, the helper arrives at this decision after a period of deliberation, the helper provides assistance over time, and the helper’s decisions about beginning to help and about continuing to help are influenced by whether the particular activity fits with the helper’s own needs and goals (Clary and Snyder 1999: 156).

There has been much research in the field of psychology to understand the precise motivations that can be fulfilled through participation in volunteer service. Clary et al. (1998) identified and operationalized six personal and social functions served by volunteering, ultimately refining classic theories of volunteerism. The motivations to volunteer have their related counterparts in the functions volunteering serves. The Volunteer Functions Inventory (VFI) has been validated by factor analyses, used with various different volunteer activities, tested by numerous researchers in their own studies, and has ultimately reached a level of acceptance to where it is commonly used in volunteer studies within the field of psychology. Okun, Barr, and Herzog (1998) empirically tested competing measurement models of motivations to volunteer: specifically, a one-factor model (from 1991), two-factor model (from 1990), and the six-factor VFI model (Clary et al. 1998). Their conclusion was that the six-factor model had the best fit of the data and recommended the VFI to ascertain the importance of the various volunteering motives in their population (1998: 620). This survey will be used in this study, but will be a secondary tool to the ethnographic approach common in anthropological investigations. The results from the VFI will be compared to the results from the traditional ethnographic approach to see the level of corroboration. This will allow further triangulation within the study and possibly grant further acceptance to the VFI.

Clary et al. (1998), with assistance from previous psychological research, found and refined six motivational functions served by volunteerism. Each function or factor is measured with five items within the thirty question self-report survey instrument. The six motivational functions are:

Values – This centers on the opportunities that volunteerism provides for individual to express values related to altruistic and humanitarian concerns for others.

Understanding – This involves the opportunity for volunteerism to permit new learning experiences and the chance to exercise knowledge, skills, and abilities that might otherwise go unpracticed.

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Social – This offers opportunities to be with one's friends or to engage in an activity viewed favorably by important others. This reflects motivations primarily concerning relationships with others.
Career – This is concerned primarily with career-related benefits that may be obtained from participation in volunteer work.
Protective – In the case of volunteerism this may serve to reduce guilt over being more fortunate than others and to address one's own personal problems.
Enhancement – This centers on personal development, personal growth, and higher self-esteem

These different motivational areas show that persons doing the same activity, such as treating patients for free, may be doing it to meet different psychological functions. In a study of Italian young adults volunteering (Marta et al. 2006) which incorporated the VFI, it was found that *multiple* motivations underlying the activities are associated with greater satisfaction and good integration in the organization. People who are motivated by more than one factor are less vulnerable to costs related to the activity and are more likely to maintain a longer involvement.

Volunteerism is sometimes seen as doing an act for which one has absolutely nothing to gain and sometimes even something to lose. However, numerous studies have illustrated potential benefits in volunteering. In a study conducted in 1980, volunteer workers over 65 years old were compared to retired elderly who did not engage in volunteer activity. Volunteers had a significantly higher degree of life satisfaction, a stronger will to live, and fewer symptoms of depression, anxiety, and somatization. This study (Hunter and Linn 1980) illustrates the possible intangible benefits of volunteerism.

How satisfaction of motivational functions actually affects motivation is currently being debated. Roy Baumeister, a social psychologist, has recently conducted research on how satisfaction influences motivation. Baumeister's theory states that when we get something we desire, the subsequent feeling of satisfaction reinforces and increases the strength of that desire when it returns. This is contrary to standard theories of motivation which state that satisfaction reduces subsequent motivational drive. Baumeister has conducted three psychological experiments and has recently presented this research at the Association for Psychological Science (Elish 2007).

Relevant Anthropological Theory – Functionalism, Critical Medical Anthropology, and Altruism

Functionalism, in the anthropological sense, is a paradigm that attempts to explain social customs and institutions through their contributions to maintaining the unity and survival of the society. In a functionalist view, a society is able to continually exist because customs are adaptive and make it possible for people to cope with their environment and one another. This definition is closely related to the psychological definition of functionalism, but the viewpoint is from a larger, more macro perspective. Critics of the

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functionalist school of thought state that functionalists' underlying assumption is that every custom must have some positive social or cultural function, ignoring dysfunctional customs, and an uncritical acceptance of the status quo, being blind to forms of change that can lead to greater stability. According to Crapo (2002:17), however, analyzing the functions of customs is probably the most common single technique used in anthropological discussions of human life, regardless of the specific school of thought. This paradigm fits well with studying the creation and maintenance of a not-for-profit private clinic. A free clinic can be seen as an inherently adaptive institution formed due to larger, possibly dysfunctional health policies. The free clinic can be seen as an institution which is developed so as to protect members of society, serving as a safety net, increasing the social stability of the community as a whole. The creation of free clinics can be seen as increasing stability at the community level. Greater protection of the community and its members serves a role in improving society members' quality of life as a whole. While the psychological and anthropological definitions of functionalism derived separately, they can be seen to mesh, although at different levels (psychology at the level of the individual, anthropology at the level of society).

A discourse is a system of rules regulating the flow of power (both positive and juridicial) which serves a function of promoting interests in a battle of power and desires (Brown 2002: 31). Discourse, according to Foucault, *constructs* the topic. It defines and produces the objects of our knowledge and governs the way that a topic can be meaningfully talked and reasoned about (Fu Jen University 1998: 1 quoted from Hall 1997:44). The limited discourse in this research study is based on people living in the United States without proper access to health care and those who are willing to serve this population. For instance, this study discusses medical malpractice primarily as a potential barrier for prospective volunteer physicians and how policies are being enacted in order to mitigate this barrier. But should patients who receive free health care have less right than a paying patient to sue a medical practitioner if that practitioner exhibits gross negligence? Persons who *must* rely on others' aid instead of having a right to health care, as in this country, must face this issue. If health care was seen as a basic human right, where all persons have a right to proper medical care, at the U.S. policy level and in the general American cultural worldview, would such a stance even make sense? This study does not primarily address the inherent inequality of *why* people, in the first place, do not have proper access to health care, and the need for this population to rely on altruistic medical professionals for this access. This study does not attempt to combat inequality as a larger force, but focuses on the free clinic as a strategy to stopgap current inequalities which are the *result* of larger forces.

The purpose of the free clinic was to mend the gap in health care service in this country between economic classes, but the work of the free clinic and the process of this research study itself can be seen as implicitly accepting and/or further allowing current health care policy to remain as is. In part due to the formative local theory approach and to realistic constraints, this project's scope does not, in itself, actively investigate the larger construction of U.S. health care policy. In other words, the discourse of this project is

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quite limited and the construction of this discourse itself may be seen as supporting health care disparities. This construction of a topic inherently limits its findings.

The function of free clinics can be seen as aiding societal stability, as developed from the anthropological functional perspective. Critical medical anthropology is a theoretical perspective which focuses on how the distribution of wealth and power affects disease patterns and health care access. Joralemon (1999) believes this critical perspective can be incorporated into all medical anthropology research. The creation of the free clinic in itself highlights the poor health care access for the indigent in the local community. The need for certain people in our community to rely on altruistic medical professionals highlights the relatively poor access to health for these individuals. While this, in itself, is not the focus of the research, the nature of the study does incorporate this critical theoretical paradigm.

Ransom (1997) declares "we need to break with the myth of both the State and the Revolution that will overthrow it, decompose the complex reality that in fact constitutes the social world, and substitute a political ethos of critique for one that aims to transform society according to a transcendent vision of fully liberated human nature: [these] are the preconditions for effective oppositional thought in a post – Berlin Wall world. (Ransom 1997:60). Looking at the larger issue of health care and health care as a human right, an ideological shift is perhaps one of the few impetuses that can change an issue as large as the right to health care in this country.

Donald Joralemon (1999), in his text on medical anthropology, asks "If tinkering with the system only serves to maintain its oppressive characteristics, is the only option an unlikely social revolution?" Critical medical anthropologists acknowledge that their analysis of the class interests behind health care systems can lead to, as Nancy Scheper-Hughes describes, a "politics of despair" (1999:95). In response to this, Merrill Singer (1995:91) feels the day-to-day work of critical practitioners must be regarded as a means or as dynamic phases in a progressive struggle and not an end. The research done at the local level must continually highlight, document and connect the disparities prevalent at the larger, more global level.

Investigating altruism and the act of volunteering is essential in a study of physician volunteerism. Sociologist Gerald Marwell emphasizes child rearing and enculturation as significant to adult actions. Marwell proposes that we learn to be happy when others are happy and sad why they are sad because of our inherent dependence on those around us, mainly parents (Piliavin and Charng 1990:42-43). This dependence pushes people to be more oriented towards satisfying the needs of others. This theory attempts to investigate the source of altruism.

Is altruism, defined here as performing acts with no direct benefit to the individual or near kin, distinctly human? Is there a biological or genetic component tied to this behavior? At the Max Planck Institute of Evolutionary Anthropology, researchers

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Warneken and Tomasello (2006) conducted studies with chimpanzees and humans in an effort to find if performing altruistic acts, those which do not benefit the individual or kin, might have developed evolutionarily in primates. Warneken and Tomasello found that chimpanzees and infants both will assist other chimpanzees and infants, respectively, in acts that will have no direct benefit to themselves. The researchers concluded that even young children have a natural tendency to help other people solve their problems and our nearest primate relatives show skills and motivations in this direction, suggesting that human and chimpanzee's common ancestors possessed some altruistic tendencies. Altriusm might have somehow evolved uniquely in primates. Sociobiologists have demonstrated mathematically that under certain conditions, there are three separate selection processes - group selection, kin selection, and reciprocity selection - that can actually lead to the establishment and perpetuation of "altruist" genes in populations (Piliavin and Charng 1990: 45).

Volunteerism in Today's Society

According to the U.S. Bureau of Labor Statistics (2005), about 65.4 million people (28.8% of Americans) volunteered through or for an organization at least once between September 2004 and September 2005. This monthly survey of about 60,000 households, called the Current Population Survey (CPS), also found that women volunteered at a higher rate than men across age groups and educational levels. This survey showed that roughly the same percentage of volunteers became involved with their organization on their own initiative (40%) as were asked to volunteer by someone in the organization (43%). This survey also illustrated a disparity on volunteerism based on education level. While only 21% of high school graduates with no college volunteered, 46% of college graduates volunteered. This shows that health care professionals, in general, may be more likely to volunteer than the general population. This survey found the primary stated reason non-volunteers had for not currently volunteering. 45.6% stated lack of time, 15.2% stated health problems, and only 2% stated burnout and/or the previous volunteer experience was not enjoyable.

Ted Cox (Chester 1990:30), in his practical guide to volunteer management, remarks that volunteers expect:

1) To know where their work fits into the organization's mission
2) To be heard
3) To know how well - or how poorly - they are doing in their job, and to be given the chance to correct weaknesses
4) To be able to use the experience and knowledge that they have acquired over a lifetime
5) To grow in their responsibilities if they choose to do so

Walter Pidgeon Jr, a nationally recognized consultant in volunteer management, believes that not-for-profits have not fully used the marketing advantages that could be presented to prospective volunteers on the personal benefits received from the volunteering process

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(Pidgeon 1998:52). The National College Graduate Study on Volunteering, conducted from 1990 to 1991, concluded that individuals do receive “return value” from volunteering including a number of personal and career skills (1998:44). “Return value” is defined as the overall benefit that an individual can receive from the volunteer experience. Also in the National College Graduate Study on Volunteering, 1094 of 1305 (83.2%) of respondents stated self-satisfaction/helping others was the primary reason why they volunteered (1998:37-38).

Issues in Health Care, Health Care Volunteerism, and Health Care Policy

There are specific problems or issues within health care that must be addressed. Medical malpractice, in general, is a large problem physicians face in practicing medicine. In their examination of medical malpractice, Studdert, Mello, and Brennan claim, “Physicians revile malpractice claims as random events that visit unwarranted expense and emotional pain on competent, hardworking practitioners. Commentators lament the "lawsuit lottery," which provides windfalls for some patients, but no compensation for the vast majority of patients injured by medical care” (2004: 283). There is also a perception among physicians that poor patients are more likely to sue. Rising malpractice insurance costs and fear of litigation are thought to reduce physician availability in poor neighborhoods and create access barriers for the medical indigent (Burstin et al. 1993: 1697). From an economics standpoint, the poor would be less likely to claim than others. This is partly due to the perception that a claim from a poor person is not as economically attractive to a lawyer as that of a wealthy person, and thus one would expect fewer suits by the poor. Also adding to this, legal services lawyers, often the only attorneys available in poor neighborhoods, are prohibited from taking on malpractice cases unless the client has first been turned away by two private attorneys. In addition, Burstin et al. (1993), in their study of socioeconomic status and filed malpractice claims, conclude that the poor, elderly, and uninsured are *less* likely to sue than other groups.

As of 2005, 46.6 million people, or 15.9% of the population, were without health insurance coverage in the United States (DeNavas-Walt 2006:20). 24.3% of households with incomes lower than $25,000 had no health insurance coverage and 43.6% of foreign-born non-citizens of the U.S. had no health insurance coverage in 2005 (2006:22). Also, there are a significant number of people in the United States who are underinsured. Previous research has documented decreased access to health care services and increased burdens of economic hardship, ill health, and mortality that the uninsured and underinsured experience (Donelan et al. 1996: 1347, Burstin et al. 1992). Blumenthal and Rizzo (1991) found that the proportion of the average physician's patients who are uninsured is substantially below estimates of the proportion of the general population that is uninsured.

The expense of health care and the lack of health care coverage are great. According to Emmons (1995), uncompensated care costs in 1994 were estimated to be as high as $11

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billion. According to a previous study (Cunningham et al. 1999), there may be a linkage between physicians' volunteer services and economics. Cunningham and colleagues state the rise in managed care plans imposes greater price discipline on health care practitioners through discounted fees, capitated payments, selective contracting, and other methods, and thus they experience increased financial pressures. This lessens the ability to shift the costs of uncompensated care onto other payers. This study found that regardless of the physician's level of involvement with managed care, those who practice in areas with high managed care penetration provide roughly 25% fewer hours of charity care than physicians who practice in areas with low managed penetration. This shows the economic environment of physicians to be a possible barrier to physician volunteerism. These issues in health care and specifically in health care of the underserved need further study.

There have been policy changes in Florida to protect volunteer workers so as to encourage more people to provide their volunteer services. In an effort to encourage health care volunteerism, the Florida Access to Health Care Act (Fl Statue 766.1115) was passed in 1992. Protection under this act gave participating health care volunteers state-sponsored sovereign immunity (Barnhill et al. 2001: 2178). Sovereign immunity limits the amount of damages that can be awarded. Florida's sovereign immunity laws limit the amount of damages that can be awarded to $100,000 per claim and $200,000 per incident (Barnhill et al. 2001: 2179). This protection is based on the volunteer serving as an agent of the State of Florida. This means that the State of Florida assumes responsibility for the treatment of patients eligible under this program (Volunteer Health Services Program 2007). This law has no current bearing to the JCHC, since the law only protects doctors who sign up as agents with the health department and see patients within the state's income guidelines. Since the clinic sees people who "fall through the cracks" of health care given by the state, the clinic and the state's patient income guidelines are not compatible with each other. JCHC patients' incomes must fall between 100% and 250% of poverty income guidelines.

According to the JCHC director, however, the clinic attorney is looking into the possibility of the health department covering retired doctors who volunteer at the JCHC (letter to author, July 12, 2007). The JCHC requires patients to sign a release form agreeing to some preconditions: "In consideration of said present and future services, treatments, medications and other activities received from the JCHC and without any other representation, promise or agreement, oral or written, I hereby fully and completely release and discharge the said JCHC and any and all other parties in interest from all claims, demands, grievances and causes of action of every kind and nature whatsoever, including, but without limitation of the foregoing, all liability for damages or injuries of every kind, nature or description, known or unknown, permanent, or otherwise, now existing or which may hereafter arise from or out of the above mentioned services, treatments or medications received at the JCHC, state of Florida." Even with the patient's signature, which is required before treatment, this form does not protect the

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clinic's physicians from a lawsuit based on gross negligence. It may, however, make the patients of the JCHC less likely to initiate a claim.
According to Barnhill et al. (2001), since the Florida Access to Health Care Act has passed, the number of health care volunteers has increased from around 4,000 in 1992 to 18,000 in 2000. Barnhill et al. conclude that medical malpractice is a great fear and acts to lessen this fear have resulted in an exponential increase in the medical volunteer work force. Related to this is public policy enacted to protect volunteers serving both nonprofit public and private organizations. The Volunteer Protection Act of 1997 was created in response to the withdrawal of volunteers from service to nonprofit organizations because of concerns about possible liability (Runquist and Zybach 1997:1). This act only provides a defense for the volunteer but does not prohibit lawsuits against volunteers. Runquist and Zybach state that the policy is quite ambiguous and still leaves the volunteer at risk for significant legal fees even if the case is thrown out. According to this Act, a volunteer is not liable for harm if they are not guilty of *gross negligence* or *reckless misconduct*. Gross negligence and reckless misconduct, however, are the most common in medical malpractice lawsuits. A plaintiff needs only plead indifference on the part of the volunteer to the safety of the individual harmed (1997:2). Therefore, this policy act does not provide any real coverage. Runquist and Zybach conclude that the intention of the law is laudable, but the language of the Act is flawed. The Florida Volunteer Protection Act is modeled after the federal act and similarly offers very little protection and does not absolve volunteers from litigation. As can be seen, volunteer-status medical liability protection for JCHC physicians is little to non-existent

Ethnographic Study

This study suits itself to be an ethnographic study. Ethnography is a scientific approach to discovering and investigating social and cultural patterns and meaning in communities, institutions, and other social settings (Schensul et al. 1999: 1). In an ethnographic approach, ethnographers discover what people do and why before they assign meaning to behaviors and beliefs (1999:1).

The naturalistic approach to ethnography implies an inductive analytical strategy - that explanatory theories grow out of the experience as it is observed in real life (Angrosino 2002:2). Ethnography effectively builds local theory - theories that explain events, beliefs, and behavior in the special site an ethnographer is studying which may be adapted for use elsewhere (Schensul et al. 1999:7). Ethnographic research always involves face-to-face contact between the ethnographer and the community of study (1999:7). This project is based on formative local theory in that it starts with a research topic to be addressed in a localized population and the population is involved in identifying it (1999:17). The need for qualitative data for this project is essential. Chester (1999:74) states that it is difficult to get a feel for the effects programs have on people at the level of the individual, and ethnography is well suited to this purpose.

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Ethnographic research that involves video and multimedia representation of visual research to support the dissemination of research products within organizations is identified as within the emergent field of "applied visual anthropology" (Pink 2006:128). There is a direct relationship between the video and written components of this research study. The data, analysis, and conclusions gathered from the research study will be included in a traditional academic-style written format but also will be incorporated into a video format. This will allow the research findings to be more accessible to the community involved in the study and allow for a greater "applied" component of the research study. The video and written components should not be a detriment to each other but enhance the quality of the overall study.

The Applied Component & Video Advocacy

The functional approach to understanding volunteerism allows for a strong applied component, specifically mentioned by Clary et al. (1994) as the matching hypothesis. This is the idea that persuasive messages will succeed in engaging volunteer intentions and actions to the extent that they focus on the relevant motivations underlying volunteerism. In other words, persuasive messages can motivate people to initiate volunteer service to the extent that the messages are tailored to the specific motivations important to individual recipients of the messages.

A recruitment video was developed based on the findings of this project. This video was created after the data, from both the ethnographic research and the VFI, was analyzed. This allowed for the messages to be more tailored to what this specific subgroup, physicians, sees as important in their volunteer service. In the book, "Recruiting and Training Volunteers", Ilsley (1981) suggests that an excellent recruitment tool or recruiter must identify with the target group and have knowledge of the folkways, mores, and history of the group being recruited. The ethnographic data gained from this study greater informed the researcher about the target group and this can only positively influence the production of the recruitment video.

Increasingly in visual anthropology, the video medium has been used in part with the applied component of a research study. Pink (2004: 4) asserts the current demand stems from three key interests: the users of applied anthropology, graduate students seeking to utilize their skills outside the confines of academic visual anthropology, and academic/professional visual and applied anthropologists who seek to share their theoretically informed practices of research and representation with non-anthropologists. There have been numerous recent applied visual anthropology projects. Rich and Chalfen (1999) developed a pediatric research project and used the video medium to educate clinicians on how patients interact with disease on a day-to-day basis. This allowed clinicians to better plan patients' medical management. The Steps to the Future Series (Levine 1999) brought to light the issue of HIV/AIDs in South Africa and challenged societal attitudes and perceptions about the disease. Stadhams (2004) developed a television series based on anthropological tenets concerning poverty and

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tourism research she was conducting in Gambia. With these previous projects in mind, this project will utilize the video medium not only to analyze why physicians volunteer their medical services and the barriers in volunteering, but also to create material which will directly aid and improve the current situation.

As can be seen, a number of social science disciplines have produced research that is relevant to the project at hand. Having an understanding of U.S. health care and policy, volunteerism, topic-related psychology, and appropriate methodological approaches is essential to this study. As an applied anthropologist investigating a practical problem, being aware of relevant research from other disciplines is essential.

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Chapter Three: Methodology

Before starting the research, I was a volunteer at the clinic for about 10 months. Establishing myself as a clinic volunteer allowed me to have a better understanding of the everyday functioning of the clinic, gain a more emic perspective of being a volunteer, and to build trust and rapport with the clinic staff. I assisted the JCHC director with audiovisual materials and also assisted the pharmacy department by sorting out pharmaceuticals. As a volunteer, I produced a photoDVD project to highlight the clinic's current volunteers and their work. The DVD was eventually shown at the annual fundraising dinner and has also been used as background footage in other recruitment activities. I developed the research topic while volunteering at the clinic. The director and I had numerous discussions concerning a possible study topic and we eventually agreed on studying physician volunteerism as this is essential to the everyday functioning of the clinic. Within the research setting, my main role and responsibility was that of a researcher as well as the producer of the video. I was given permission to use archival JCHC materials as well as all areas of the clinic. I feel the previous time spent as a volunteer at the JCHC made the conduction of the research occur more seamlessly. It was important to maintain the collaborative nature during the project as when the original idea for the project was developed. I regularly gave project updates to the JCHC director. Data collection was conducted from January to May 2007.

The main method used in this project was in-depth interviewing and qualitative analysis of the interview data. Secondary methods utilized in this project were a psychological and demographic survey (called the "VFI Survey) and observation/shadowing. The "VFI Survey" was sent out to all current volunteer physicians the JCHC had on file, which amounted to 194 possible respondents. At the end of the survey, the final question asked if the participant would like to also participate in a voluntary in-depth videotaped interview and/or shadowing session. Asking for interview participants with this technique allowed everyone in the JCHC current physician pool to have an equal opportunity to participate or be "chosen" for the interview. Due to the voluntary nature of the study, this opportunistic sampling technique was used to obtain the largest number of participants. Thirty volunteer physicians chose to participate in the survey (15.5% response rate). Of the 30 volunteer physicians who participated in the survey, 15 agreed to participate in the in-depth videotaped interview (50% response rate). The first ten physicians to agree to participate were involved in the interviewing phase of the research study.

Multiple methods are used to gain different perspectives of the phenomena and triangulate the data. Also, these forms of data collection (survey, observation, and

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interviews) will help illuminate the emic perspective of the volunteer doctors. It is logical to assume that the best source of information about doctors and their motivations is the doctors themselves. There was diversity within the local JCHC physician population, and I made every effort to represent this in the research products so prospective doctors may see how they best fit at the clinic and which role would serve them best.

As the researcher, I reviewed all responses and determined what statements or ideas were being emphasized by the participants in response to the main research questions. At the completion of data collection, the video footage was transcribed and analyzed, so as to produce conclusions about physician volunteerism and provide recommendations as to how to improve recruitment and better maintain volunteer physicians.

The main goal of the video production was to enhance the applied component of the research study and give back something of value to the participating community. The videotaped interviews were used to create a video that speaks to prospective volunteer doctors and possibly student doctors. This is done to complement the more traditional written format of this research study. A similar procedure was used in an applied visual ethnographic project in which I participated previously, the USF Visual Anthropology Prodigy project. The goal of understanding the "emotions and passions…visions and dreams" of Prodigy (a non-profit institution), and displaying these on video was reached by performing similar open-ended structured interviews with Prodigy participants (Bird n.d.:14).

Methodologically, the applied component of the research process is in many ways the most difficult to perform successfully. This project is a community-based research study. In anthropological community-based studies, one must address the balance between doing objective anthropological research and being a conduit for the agenda of the community partner (Bird et al. 2007: 151). The research process and the production of the video must be constantly discussed and negotiated between the researcher and the community to allow for a beneficial product for the community and a truly applied piece of research to take place.

As an anthropologist, I have moral obligations to members of the research population, the wider society and culture, as well as to the profession. It is necessary to keep data confidential and private to protect the members of the research population. It is also necessary to make sure the population under study understands the research project and gives consent to be a part of this study. I have gone through the IRB process at the University of South Florida and have followed IRB guidelines throughout the project.

In-depth Topical Interviewing

I constructed a list of open-ended interview questions from background research in this area and assistance from key informants which helped answer the main research

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questions. I attempted to ask the questions directly relevant to the research study consistently to all participants, so as to allow for comparison and deeper analysis of the subject at hand. The open-ended interview questions complemented the closed-ended questions that were asked within the survey. I interviewed 10 physicians who currently volunteer at the clinic and two staff members. All interviews took place either at the JCHC or the specific physician's place of employment. All current volunteer physicians were given the opportunity to participate in the interview; a total of 15 agreed, and the first 10 who consented were interviewed.

The interviews were one-on-one and all of them were recorded. During the interview, I guided the discussion to keep on target and obtain answers relevant to the research question. The interviews ranged from 15 to 40 minutes. Eleven were videotaped and one, with a clinic staff member, was audiotaped per the person's request. All of the interviews were later transcribed.

Observation/Shadowing

Also in line with ethnographic methodology, I observed six of the 10 doctors I interviewed during their volunteer work at the clinic to gain another perspective of what it is like to be a volunteer doctor. Shadowing all 10 of the physicians who consented to an interview was not possible due to scheduling/appointment difficulties. We would frequently discuss issues related to the research subject during these sessions. Often physicians would give somewhat deeper responses to the questions asked during the videotaped interview during the shadowing sessions, having more time for further reflection. I gained a deeper understanding of the physicians' volunteer experiences by shadowing them through their service. During the interviews, physicians would explain what it was like to volunteer for the JCHC. These experiences of volunteering were often confirmed during the shadowing sessions.

Upon entering each examining room, the physician I was shadowing would introduce me to the patient and inform the patient about the purpose of my presence. Oral consent was obtained before any recording or observing took place. Initially, I wanted to film the physician-patient interaction to enhance the edited video by showing actual footage of what is done by volunteer doctors at the Judeo Christian Health Clinic. However, the camcorder and tripod were too intrusive in the office rooms where physicians would see patients. The patients, as well as myself, felt uncomfortable with the large equipment and the process of recording what is usually a private interaction. Therefore, with permission from the clinic director, patients, and the physician, I took a small digital camera and took still photos of the interaction to use in the edited video. These photos will complement the communicated responses by the volunteer doctors during the interviews. The photos were taken in such a way as to only identify the physicians. The patient's privacy was secured. No patients will be able to be identified from the video.

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Survey

In numerous studies concerning volunteerism, the Volunteer Functions Inventory (also known as the VFI) has been given to participants to understand what functions the participants gain from volunteering. The VFI is accepted and used particularly in the field of psychology. The VFI was a large subsection of my survey, with 30 of the 38 questions on the survey being drawn from it. The other component of the survey was demographic-type questions. The survey was used to gain a better sense of the physicians volunteering at the clinic (see appendix for the full survey; see chapter two for more information concerning the VFI). The main use of the VFI survey was to help triangulate the data. The results from the VFI were compared with the ethnographic results.

The clinic retains the mailing addresses of all physicians currently volunteering. All current volunteer physicians were notified by mailing of the survey and were given a link to the online survey. I had to adjust the survey distribution method due to the low initial response. A fraction of the physician pool had previously provided email addresses to the JCHC and this group received both a mailed letter and an email. The JCHC director personally gave out surveys to current JCHC physicians whenever possible, and the more direct personal approach in survey distribution turned out to be most effective. The VFI survey was available on zoomerang.com, an online survey website, and a paper form was also available at the JCHC physician lounge area.

This survey asks closed-ended type questions. From previous personal experience, I have found that most participants do not write in great detail in surveys, so a short answer survey was seen as more suitable and productive. The executive director of the clinic supported the idea of an online survey and agreed to help notify JCHC physicians of our study. This is stage one of the research process. There is a statement on the survey asking if the survey participants would be comfortable with participating in an in-depth videotaped interview with questions structured around their work at the Judeo Christian Health Clinic as well as videotaped observation/shadowing sessions. This would make it simpler to recruit participants for this portion of the project as well as give everyone an equal opportunity to further participate in the study. There was also a statement letting the participants know that portions of the videotape may be used in creating an edited video for the clinic.

Methodological Issues and Limitations

One methodological limitation of this study is best related to Erving Goffman's dramaturgical approach concerning interaction analysis. Goffman states the "actor" consciously plays a certain role (predefined by societal norms) and plays this role to meet society's standards. In Goffman's (1959) *Presentation of Self in Everyday Life,* his impression management thesis dictates that individuals constantly exude expressions that impress others who are present. While individuals do not learn scripts that allow them to know in advance what they will do, everyday conduct derives not from a script but from

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enacting the standards of conduct and appearance of their social group and people of this group are implicitly socialized to fill in and manage any part they assume (Smith 2006:42).

According to Goffman, much of our day-to-day social interaction is aimed at promoting and protecting our own face (social standing) and the face of other members of our group (Crapo 2002:131). The physicians who are being interviewed may slip into a role they think is appropriate to the environment – the white coat they are wearing and the social identity they carry. Being interviewed may bring out more of an "expert" commentary. This is not a deceptive interaction but this environment limits or defines the experience. Due to the limitations in time spent with the participants, we are unable to see the person in different settings which might cause the person to act in a different fashion.

This idea is also in line with the looping effect or labeling theory as described by Ian Hacking (1999). This theory denotes, for instance, that the act of classifying someone as a deviant might reinforce deviant behavior. The act of calling a person a Judeo Christian Health Clinic volunteer physician will reinforce the individual to behave in a manner in line with their perception of the meaning of that title. Each participant had to sign the IRB form to participate in the project and one of the stated goals is to recruit more physicians. Therefore, they have an idea of what is expected of them and how they should portray themselves. The surrounding atmosphere always plays a role in the process of conducting an interview. The videocamera, microphone, and general environment involved in the interview may further reinforce the feeling of a physician to take on a role, to follow a familiar script, and evoke responses that seem appropriate to meet the environmental standards and be representative of the social group he or she is a part. This may result in physicians resorting to comfortable "party lines" instead of thinking about the issue at greater depth. This is why it was necessary to probe and ask a question repeatedly in somewhat different ways to possibly get beyond the "party lines". For example, I asked how they (the JCHC physicians) began volunteering, the factors that caused them to volunteer, what caused them to volunteer at the JCHC specifically, and what they would do if they were in charge of recruiting physicians. All these help answer the question, "Why do doctors volunteer their medical services?" one of the main research questions.

A good example is during an interview with Dr. B. When asked what rewards she gets, she initially proclaimed none and this activity is purely to assist others. But after probing further, the response differs. This variation in responses illustrates further information about the topic at hand.

Ambiee: Can you tell me, maybe a specific event, or maybe in general, about rewards in volunteering, or rewards a physician would get in volunteering here?
Dr. B: Well, I mean, I don't look at volunteering here as something that deserves a reward… I don't look for reward in this.
(A few minutes later in the interview)

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Ambiee: Can you tell us more specifically about that - is there a social network that develops here with physicians? Or you have gained any friends through this consortium?
Dr. B: Well, I guess one of the benefits, some of the other internists and family practice physicians that volunteer their time here send me patients because they know they know me from here, they know what kind of physician I am, and they are happy to send me patients, and that might not have occurred otherwise.

While all current volunteer physicians of the JCHC were given a chance to be interviewed, only a small percentage agreed. Therefore, there is most likely a bias in this pool towards the more dedicated volunteer physicians. However, this might help in understanding how these physicians became so involved. While the sampling technique was opportunistic, the ratio of primary care to specialty care physicians who volunteered to take part in the study ended up being fairly representative (1.3 to 1, respectively) of the JCHC physician population at large (roughly 1.2 to 1, respectively). Physicians preferred to do the interview first and then have the observation session. Establishing rapport was more difficult due to issues of time with this population. This is a common problem in studies that involve "studying up." Studying up is when informants have more capital or power in the researcher-informant relationship and often limit or control the researcher's participation. Adding to this problem was the somewhat sporadic volunteer service of the majority of JCHC physicians. Some will volunteer only once or twice a year and most volunteer either once a month or every other month. Due to the difficulty of scheduling appointments, it was necessary to allow for a longer period of data collection.

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Chapter Four: Findings

Introduction

The main research questions for this project were: “Why do physicians volunteer their medical services?” and “What are the barriers for physicians in volunteering their medical services?” In the analysis stage, statements were extracted from the interviews and questionnaires that directly pertain to the investigated phenomenon. Meanings were formulated from the statements. They were arrived at by the researcher reading, rereading, and reflecting upon the pertinent statements in the original transcriptions to get the meaning of the client’s statement in the original context (Creswell 1998: 281). Clusters of themes were organized from the meanings. This will help the clinic in that they will understand why doctors volunteer and create a better advertising campaign. Atlas.ti, a qualitative analysis software program, was used to code and maintain organization of the data.

The format of this chapter reflects the analysis methodology. While I have created and organized the themes that have emerged from the research, the participants of the research project “speak” for themselves. The participants appropriately and eloquently discuss the emergent themes themselves so my subsequent discussion of why a theme is significant would be over-interpretation. I believe this format complements the formative local theory and ethnographic framework on which this project is based. Although not *all* statements by JCHC physicians addressing each research theme are represented within this chapter, the numerous quotations highlight the subtleties and variety within each theme and also display the significance of the theme in itself. In the following section, only the interview results are presented. Why physicians choose to volunteer and the factors that sustain their service will be discussed first, followed by the barriers and perceived barriers physicians face when it comes to providing free medical services. Survey results will be discussed following this section.

Why Physicians Volunteer & Continue to Volunteer

The Need for Access to Health Care

What can be seen in the physician interviews is their strong belief that our society needs better health care and health care should be a basic human right. This belief seems to propel many to volunteer.

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Dr. X previously served on the board of directors for a large Tampa hospital while practicing medicine concurrently, so has seen issues of health care from both an executive and practitioner level.

Dr. X: The plight of health care and access and quality is at such a dismal low in this country and Tampa is just part of the problem. Out in the L.A. area, more recently, it was just horrible, there were a lot of doctors taking care of the indigent there. While I was in Colorado, there was a bunch of doctors taking care of the indigent, it's just, [volunteer work] allows us to do what we are trained to do and those of us who have a volunteering make-up to us, then it feeds that.

Dr. L focuses on internal medicine and geriatrics and also has practiced medicine overseas.

Dr. L: Well, the patients we see here, as I've said before, are the working poor. Most of them had no contact with a medical person for many, many years. If they do have problems, many come here much later than we would really see them in private practice. And often, I feel like I'm working in a 3rd World country where we see classic textbook cases, especially diabetes, I've seen people walk in here with sugars in the 400s, and they have been going like that for a couple of months. You know, people walk in here with extreme chest pain and have a heart attack. And they have chest pain on and off for months, *but they don't have access* so this is their last resort where we hear about it.

When asked about the root causes for people not having access to medical care in this country, Dr. L responded, "Because of the cost, number one, and there is not a national health care here. I mean, that's a huge problem in this country. You know, it should be, as we discussed earlier, it should be basic. Everybody should have access to health care."

Spiritual Value: "Makes me feel good"

All physicians stated that the work makes them feel "good". Some emphasize it more than others, but all, in some fashion, state it as a reason as to why the volunteer. This theme shows that physicians are not just selfless people who do things without getting anything back, but displays that they are receiving some sort of function, or gain, from this service. I have grouped these types of responses under a thematic group called "spiritual value". This is a definite value that is gained by these physicians. Physicians often tie in this internal satisfaction with the gratefulness of the patients.

Dr. N, an obstetrician-gynecologist, has seen patients in the Tampa Bay area for over 33 years. Obstetrician-gynecologists specialize in women's health and primarily deal with complications and problems associated with the reproduction capacity and also deal with a patient's emotional, psychological and psychiatric needs. Dr. N has volunteered at the Judeo Christian Health Clinic for over twenty years.

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Dr. N: The most important reason that I personally volunteer at the JCC is the rewards I get repeatedly. The smile on the faces and the handshake and the "Thank you, Doctor" in several different languages that gives me a good sense of well-being. It makes me feel like there is a purpose for me to existing on this earth. It makes me feel good that these patients know that I spent my time to come down that evening and see them without expecting anything other than their gratification and the hopes that I can improve their quality of health.

Dr. M is an obstetrician-gynecologist with a private office near the free clinic and sees JCHC patients there on a referral basis.

Dr. M: Well, volunteering is very rewarding, the population here at the JCC is very grateful. They're always nice people and they are always happy to see me, and whatever I can offer them, they seem pleased with. I like the feeling of helping out, of giving back to the community. I have always felt rewarded by the patients' gratitude and I have always felt like I have made a difference in somebody's life after I have done the surgery and helped them out.

Dr. L: One of the most important reasons (I volunteer) is I always feel good. It doesn't matter what kind of lousy day I have had, and I have had a lousy day today, and it's been a long day, and I know that when I leave here, I always feel fantastic. It doesn't matter how bad the patients are, how good the patients are, you just get a wonderful feeling that you are doing something, that you are helping somebody else.

Dr. E, a general adult neurologist, has volunteered at the clinic for over ten years. When asked what sustains her volunteer service to the JCHC, she responded, "The patients. The patients sustain me. The patients are very appreciative. They can't believe that they are coming to see a doctor for free. They do what I ask them to do. They are good patients."

The following comment by Dr. B, an otolaryngologist, details how the "spiritual value" gained at the JCHC was lacking at her regular practice - primarily due to the difference of the gratefulness of the patients.

Dr. B: I've had several patients here who have had cancers, who I've operated on, and it's nice to know that I've done something that hopefully will prolong their life, and most of them have been very grateful which is nice. I came from a practice in Ft. Lauderdale where it was extremely rare to have a patient who thanked you for taking care of them. So it is nice to have patients who are truly appreciative of what you do.

This theme that emerged in this study is closely paralleled to what sociologist Rebecca Allahyari found when studying volunteers assisting the homeless in Sacramento. Allahyari (2000) found that volunteers continually pursued self-betterment when performing their actions, aiming to create oneself as a more virtuous, often more spiritual

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person. This pursuit was termed by Allahyari as moral selving, and it involves working or "improving" on the inner emotional self. Interestingly, while the volunteer work itself is focused on the recipients, one of the main rewards of the service perceived by volunteers is improving themselves. Similar findings were obtained in this study. Physicians in this study mostly highlighted the spiritual value gained from the work, while improving oneself economically, socially, or career-wise were scarcely mentioned. While physicians aid patients mostly physically, or tangibly, they themselves seem to be aided by their own service internally.

Volunteer Work Benefits the Community and the Local Emergency Rooms

Volunteer physicians often mentioned in the interviews that one of the key motivators for them to initially volunteer was the want to "give back" to the community. The JCHC director has also heard this often when physicians sign up to volunteer, stating, "A lot of them have told me that the community has been very good to them and they'd like to give back". But in what sense? Is this in a Farmer class ideology sense, as mentioned above, in order to provide more resources for the non-dominant class in order to reduce the inequality inherent in a class-based society? This somewhat vague response by physicians required additional probing to gain an understanding of how they felt they were actually, tangibly, giving back to the local community. Upon analyzing the data, a common trend was that seven of the ten physicians mentioned the emergency room specifically in relation to how they felt they were giving back to the community, and this phrase was mentioned by physicians within the interview transcripts a total of 22 times. There is a definite relationship between physician volunteer service and the state of local emergency rooms.

Dr. B, a otolaryngologist (a doctor that specializes in the anatomy, function, and diseases of the ear, nose, and throat), sees patients at the clinic once a month and has volunteered for six years.

Dr. B: Well, I like to think (my volunteer work) helps the community. In fact, I know that it does, because if we can take care of people's medical problems before they become acute, they won't be filling up the emergency rooms and that provides a benefit to all of us.

Dr. M: I think (the clinic) benefits the community because it's less taxing on the emergency rooms and it makes more productive members if they are not at home with pelvic pain they can actually function.

Dr. L: They do go to the ER, and they get these huge bills and they never pay them. Sometimes you will have people that are paying off people that will pay off, that have a conscience, pay off $25 a month for the rest of their life. But here, for most of the people we see here, they go to the ER, nobody sees the money from them ever. First of all, most of them are untraceable.

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Dr. X: The community has these patients and they've got to go somewhere or nowhere, and it has been well shown they go nowhere if they have to pay and they just get sicker and sicker and end up in the emergency room, or worse.

Dr. W practices urgent care at a Tampa walk-in clinic. He has been volunteering for five years.

Dr. W: I do believe this type of clinic fills the niche where people are working, but they don't have insurance, and they need significant medical care and high quality medical care. With this clinic taking up a lot of that need, a lot of that slack there, I think it allows the other areas of our medical care around the country to continue what they are doing too - such as the Emergency Room, a lot of people here are seen and their chronic problems are taken care of and monitored and they basically are stabilized so a lot of times they don't have to go to the Emergency Room, they don't have to show up in the ER because they are here, they have been taken care of here, and therefore our emergency rooms, a lot of the burden that is there is taken off because the people that are in this situation have gotten medical care and don't need to show up in the ER for their routine care.

The positive effect of medical volunteerism and the free clinic is seen by the JCHC director to lessen uninsured people's severity of disease and the much-publicized problem of increasing healthcare costs.

JCHC Director: I think (the clinic) has a tremendous impact on this community. I think it keeps many, many people out of the emergency rooms, which is the most expensive healthcare setting of all. I think it makes for a, I know it makes for a healthier community, because these people come for us, before they reached a critical stage in whatever their problem or illness may be, and we can treat it before it's gotten out of hand and requires hospitalization or some major type of treatment.

As can be seen, there are many reasons as to how physicians explain their work as being helpful to the community in relation to the emergency room. Physicians mainly felt either their service helped improve the status of local emergency rooms, the health and financial status of patients who would otherwise frequent emergency rooms, or both. The emergency rooms will be less taxed, allowing for greater quality of emergency care for all members of the community that truly need it. People whose only recourse is the emergency room will tend to go when their illness is really advanced, resulting in a less healthy population. While supporting local emergency rooms, improving people's health and financial status, and serving the needs of the community as a whole can be seen as a result of free clinic volunteer work, it can also be seen as reasons physicians sustain their service and the motivators for physicians to initially volunteer. This paradigm of thought, improving or "giving back" to the community, is in line with a functionalist perspective or ideology. The physicians see their work as providing a function to allow

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the greater system at large (i.e. the community) to run more seamlessly. The emergency room theme is important for current volunteer physicians, is a force in sustaining their service, and should be mentioned to prospective volunteer physicians.

Spiritual Value: The Relation between Business, Service, and Medicine

A current person of fame, Dr. Hunter "Patch" Adams, discusses the relation to business, service and medicine from a physician's perspective:

"The major voices in American medicine seem to suggest that solutions lie more in taxes or in universal health insurance than in restructuring the provision of care. They seem to say, "Just give us more money and the crisis will blow over." In the rising panic, the very foundation of medicine is being forgotten. There is loud rhetoric about medicine as a right, and silence about medicine as a service to society. I believe that the concept of service has become misplaced in the madness of operating medicine as a business. We cannot really reduce the costs, or lessen the sorrows of patients and caregivers, until medicine is removed from the business sector" (Adams 37: 1998)

The discussion of business, medicine, and service is seen throughout the interview transcripts.

Dr. W: In my private practice, I'm actually in a urgent care facility, the patients are very appreciative, but they are also paying for it so they expect a lot more about, they expect something back, and sometimes they can be a little demanding that way. The patients here are just so appreciative, you just want to do everything for them.

The interwoven nature of business and medicine at this physician's day job displays the somewhat lessened spiritual value of providing medicine for those that are sick. The following quote elucidates a possible strong motivating factor as to why physicians would crave the spiritual value gained at the clinic. Even though physicians treat people during their day jobs, the business climate may not give them the spiritual value they desire.

Dr. N: Well, volunteerism is important to me, it is important to most physicians I think. The majority of us went to medicine with a goal that we ultimately were going to be able to assist individuals who are having problems associated with health care. That they may have diseases or they may need preventive care that we can do for them. Often times in the private practice of medicine, it is difficult to dedicate a full day or a full evening or that sort of thing to individuals with those needs and the JCC, of course, gives us the opportunity to do that…So it's time well spent, it makes one feel good about themselves and what they do and *what their profession can do* for the community.

Dr. Z is a JCHC referral doctor that specializes in asthma, allergy, and immunology.

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Dr. Z: I think the rewards of volunteering outweigh the barriers, it's the same comment I have made through and through the interview, which is to be a doctor, you become a doctor to help people first. Secondly, to make money. In the process of doing that, when you feel like you've been given a gift, and you've been compensated fairly, you have to try to give back to the community. Whether you do that with monies, where you donate to institutions or whether do that with your time, I think doing a little of both is always necessary.

Dr. Z states the relation of business and medicine. While he states that when you become a doctor to help people first and secondly to make money, this is contradicted in the next sentence. He explains that *when* you feel like you have been compensated fairly, you then have to give back to the community. Even so, this statement shows that this population wants to give back to the community, or practice medicine for the sake of helping people without business-world attachments.

Dr. X: I have always been interested in the care of the indigent. I think that's one of the reasons why I went into medicine. So my private practice evidenced that because I was the only neurosurgeon in five counties to take Medicaid except the medical school, and they often made it difficult for Medicaid patients to get in to see them. I just know, I guess I found out about the clinic's existence, and other doctors that have volunteered here, and it just seemed like a good idea, and that's one of my - the purposes of my life, the meanings of my life is access and quality of care, in particular neurosurgery allowed me to work on access and quality, which are my two main driving forces right now.

In the interviews, many physicians state the reason they chose medicine as a profession was to serve people. Therefore, the physician population may have more reason to need this function or value. While in the daily realm of medicine physicians do serve people, the business aspect of medicine can be seen as interfering with that direct service relationship. Physicians commonly work in private practice and may begin to feel like they are merely providing a product or good to their customers. The need to retract to the idealist state of pure "service" without ties to business can be seen as providing a rich value or function to this population in particular.

How Physicians Came to Be (And Can Be) Involved: Person-to-Person Recruitment

The general blanket approach to recruitment versus more personalized contact was an issue throughout this project. Which is more effective? From the physicians we interviewed, eight of ten doctors and both JCHC staff members discussed the importance of personal contact in recruiting. Most physicians felt that personal contact would best aid recruitment far more than general blanket statements via television and the mail. During this project, we experienced a small case study related to this issue. The annual JCHC fundraising dinner is attended by many current volunteer physicians. Bea told the host to make a general announcement that surveys for volunteer physicians were available at the front of the room. Despite this announcement, no physicians decided to

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fill out the survey. We also mailed the survey to all volunteer physicians and had a minimal number of returns. We got the best return when the JCHC director personally contacted physicians. This experience corroborated the feeling that person-to-person contact would be the best way to recruit.

Dr. W knew about the clinic since its inception, but did not choose to volunteer until much later.

Dr. W: I always thought that this clinic would be good because I had heard of other doctors who had gone to the clinic to volunteer and they had a very positive, good experience. It was important for me to know someone who has volunteered before because when I talked to them, I found out it was an enjoyable experience and that they got a lot of satisfaction by doing it, and that my time wasn't going to be wasted in any way doing things that weren't helpful to people.

Dr. E knew both the facility and some members of the JCHC before getting involved.

Dr. E: I found out about the clinic and went over there and saw what a great place it was, and I like to go over there whenever I can, sometimes I take samples there, samples of medicine and that sort of thing. And I knew the medical director, who I had known since I was a little girl, and I guess I talked to him about it initially, and got involved, and then I met the JCHC executive director and tried to find out how best I could serve the people at the clinic.

Dr. M, now a JCHC board member, is greatly involved with the clinic and has had a long-running connection with the institution.

Dr. M: Well, I actually can't remember why I started but I have always known about the JCC. My best friend's father founded it. That was Reverend Jim Holmes and I have known him since I was a teenager, so I have always known that I wanted to be connected with the JCC and I got back in town and somebody asked me, I can't remember who it was, if I would volunteer here, and I thought that's great, that's just what I want to do.

Even with Dr. M's personal knowledge of the clinic as a teenager, Dr. M recalls being asked to participate as the origin of her involvement. This story highlights the significance and influence of the person-to-person recruitment technique.

Dr. F, an obstetrician/gynecologist with specialty training in reproductive endocrinology and infertility, recalls here how he began volunteering at the clinic in 1974.

Dr. F: At that time physicians were regularly providing services back to the community in areas where they were needed. All of the doctors in my specialty participated in the Judeo Christian Clinic, giving in their professional time on a rotating basis. And as I entered the community this was something that my colleagues were already doing which

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I felt was appropriate and I participated along with them… My experience at the JCC is largely been integrated with the remainder of the obstetric and gynecologic community. And until recently, virtually everybody who practiced ob/gyn in this community did volunteer their time…I think individual physicians, if they are approached directly, would probably be willing to volunteer a reasonable period of time…Well, I've always found direct person-to-person communication to be the best way to solve any problem and I think that by going out and sitting down with the physicians and 1) showing them the need 2) giving them some understanding of the process that exists and 3) having them understand they will be part of a large community providing this so that they will not be overburdened, I would find it surprising if most physicians didn't respond.

Peer influence is a stated reason as to why Dr. F began volunteering. Peer influence can be seen as related to having a more personal contact in regards to recruiting. In the following excerpt, the director lays out the clinic's current recruitment techniques.

JCHC Director: The things that are in place to try to recruit additional physicians is, number one, I try to talk to the doctors individually and ask them if they can talk to their friends or if they know any physician friends who might be interested in working at the clinic/ volunteering at the clinic. That, to me, has been the most effective way. We also send out letter periodically to all physicians listed in the phone book, and we have a good rapport with the Hillsborough County Medical Association. And every time they published their bulletin, which I think is 9 or 10 times a year, they always put a little blurb in that bulletin requesting/informing people that we need additional physicians, and I'm always asking the board members if they have asked their doctors if they would consider volunteering here or anybody else I can talk to, and we put out a newsletter three times a year and I always put a little blurb in there asking for healthcare professionals to volunteer.

While several methods are used in the effort to recruit physicians, taking a personal direct communicative approach is seen by the director as most effective. When I asked a long-time JCHC staff member her opinion of the most effective manner in recruiting doctors, the response was quite similar.

JCHC Staff Member: (The best way is) going to their office and talking to them personally and just asking them.
Ambiee: More personal, not like blanket general mailings?
Danielle: Not like the letter like we are mailing out. I really don't think half these doctors get their letters.

Dr. N, a volunteer for over twenty years who has also personally recruited many physicians for the JCHC, also feels person-to-person recruitment is the most effective technique. However, Dr. N feels the technique should be implemented in a more organized approach.

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Dr. N: How to attract more individuals in health care to volunteer at the JCC is a problem that we all deal with - it's not specific to the JCC, it's the volunteerism issue altogether. The approach I think should be a proactive approach. The clinic that needs volunteers needs to get key people in contact with key physicians and ideally key physicians and key groups. What the Judeo Christian Clinic has not done actively in the past is find some way to get spokespeople into the specialty section meetings that occur monthly at private hospitals where all the doctors of a specialty convene and discuss administrative and clinical matters involving the office and are certainly, if not to listen to a 20 or 30 minute powerpoint presentation, certainly to one single individual who wants to talk about and to give out literature on volunteerism for a specific cause. So getting into areas where doctors are meeting is difficult but not impossible. And it works better in my view than mail appeal, if you see the bulk of mail that doctors get every day, and you categorize it into four or five different categories, whether or not they even see that appeal is somewhat questionable at times. Telephone contacts with individuals of the health care profession for that, that is not very worthwhile, but for every time you have a personal contact within a formal setting where doctors are sitting and willing to review and think about things like that, I think it works.

Dr. X and Dr. L both had similar responses that focused on a personal touch when asked what they would do if they were in charge of recruiting physicians to volunteer. This demonstrates in a different manner how influential physicians think the person-to-person recruitment technique is.

Dr. X: Well, if I was in charge, I would be the champion, I'd make sure I spoke to the hospitals where the majority of physicians work, where physicians are, and Hillsborough County Medical Association, talk to them, and knock on doors, and go around and meet physicians, and say "Hey, we need your help, can you help us out?" If I was King, that's what I would do.

Dr. L: If I was in charge, I would actually like them to come in and spend some time with me here. I don't know if that would be possible but I think that would be a great time. Just come and spend half an hour at the clinic here on your way home from work that day and see what it is all about.

When discussing how to utilize the recruitment DVD, the director perceives using it alongside a personal approach.

JCHC Director: I'm very optimistic about this project. I'm hoping it enables us to recruit more physicians. I'm hoping we can show it to various groups. A lot of physicians have their own specialties and they meet on a regular basis and I'd love to have the opportunity to take this video and show it to those groups. I'd also like to pass out the DVDs to doctors to show to their friends in hopes that they'll try to recruit their friends. It's going to be shown in September (2007) at the Hillsborough County Medical Association's Annual Dinner, and so we'll see what kind of impact it has there.

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As can be seen from the data, person-to-person contact is seen by current physician volunteers and JCHC staff members as integral in recruiting potential volunteers.

Identifying Volunteering Barriers and Overcoming Them

Time as a Barrier

As with any volunteer activity, time is a barrier for the participant to volunteer. Volunteering in its nature is a non-essential, or non-required, activity. Physicians are often strapped for time within the current health care environment. All interviewees in this study were non-retired. Time, and lack of it, is mentioned in all interviews and often repeatedly throughout an individual interview.

Dr. N volunteers at the clinic one evening every other month.

Dr. N: (A) restricting factor is time. Doctors in today's world work very hard. They work from dawn to dusk, seeing their patients wherever their primary place of care is, and for them to take their day off, their afternoon off, their evening off, and to come down and spend the rest of that time doing what they've done day in and day out for the entire year, I think it takes a special sort of sacrifice and dedication on the part of the individual.

A hidden time-associated barrier is lack of planning. Also *flexibility*, in particular, is seen as vitally important for physicians to volunteer. If the clinic is too rigid, they might be less likely to volunteer. Dr. O trained in otolaryngology and head/neck surgery and currently practices as a facial plastic surgeon. Dr. O was familiar with the JCHC as he participated as part of the USF College of Medicine curriculum for medical students.

Dr. O: Everyone's time is very valuable, and it does take time, but that's something that I choose to set aside in my schedule, so I guess I would say lack of planning would be a barrier. If I didn't plan, if I didn't make plans to say "I would be there on this day", then I would never get around to it, so you really have to make the commitment and you have to plan to serve, or otherwise it's not going to happen. Other than that, the clinic makes things very easy for physicians to participate. Really, all I have to do is just show up. So I think the clinic does an outstanding job of making it as easy as possible for physicians to come here and be a part of the clinic and serve.

Dr. W: One of the barriers might be that you would think, you think you don't have enough time. I'm sure that this clinic would allow people to, doctors to volunteers their time for any time that they have available, whether it's once a month or once every other month or whether it's one or two hours of availability here or there. This clinic's been very lenient, I don't want to say lenient…this clinic's been very open to my ability to schedule - one month I may schedule for a Monday night and another month a Thursday

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night. It may be early in the month, it may be late in the month but some people who volunteer may be worried that while they've got to be there once every other week, or once a week, or once a month on a certain day, and it doesn't always go along with their schedule. I think with this clinic, there is a lot of variability and availability of different times to volunteer.

The clinic's policy on the scheduling of physicians is that it is strictly up to the physician how many hours or days he or she wants to volunteer. Most doctors volunteer one evening a month, or 12 times a year, but there is definitely a spectrum on the number of days a year different JCHC doctors volunteer. Dr. M volunteers twice a year and has been volunteering for seven years.

Dr. M: I think to recruit other physicians, it is important to tell them it is not that big of a time commitment. If we get enough physicians to volunteer, then it's only you know, once or twice a year possibly.

The clinic currently offers various options for doctors who would like to volunteer and allows a great deal of flexibility. An example of this are the referral doctors who see patients in their own office during their regular working hours. Dr. E, a referral physician, sees about one to two JCHC patients a month.

Dr. E: Well, the barriers I would imagine for doctors to feel that they can't volunteer is that they think they need to go to the clinic, that's one thing. It's a time issue for a lot of people, like for me, that doesn't work for me to go to the clinic, to have a neurology clinic there. Or to go and see two or three patients, so I would encourage doctors to know to be a consultant, like I am, on a referral basis where patients can come to them.

Dr. Z is a JCHC referral doctor that specializes in asthma, allergy, and immunology.

Dr. Z: I think that it is very flexible at the JC clinic, as you can see we're in my office. Doing this in your office versus doing it in their clinic, there are options. I think there are probably a lot more flexibilities in all sorts of areas.

Dr. B, a otolaryngologist, sees patients at the clinic once a month and has volunteered for six years.

Dr. B: I only have so much time and if I'm not seeing patients in my office who are generating income, that is a financial drain for my practice. So I kind of have to balance how much time I devote to seeing the clinic patients.

Time is often a significant barrier. However, the availability of time is often mentioned as the reason why physicians got involved in volunteering. Time in relation to volunteer service is an important relationship.

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Dr. W: I've always known about the JC clinic even at the time that I did my residency and internship. I think the clinic was just getting started at that time and I never felt I had enough time to do that, to volunteer at that point, because I was just getting my practice started and working a lot of hours, and seeing/working in the emergency room part-time, seeing patients, and try to build my practice for many years, but I always had it in the back of my mind that I wanted to do some kind of volunteer work…(Now) I got a little bit more time, my kids are grown up, they are out of college, I don't have to push as hard, you know, in my practice. In fact, I have taken a job where I don't work as many hours as I did when I was in private practice and I felt that it was my time to go ahead and do some volunteer work. So basically it was a matter of timing, it was good for me at that point and I'm glad that I'm able to do it at this point.

Dr. L has been volunteering at the clinic for roughly seven years.

Dr. L: Nothing really makes it more difficult for me to spend time here. If I want to spend time here, I can make the time to spend here. It's just a matter of juggling your work hours and what you have to do…I actually always thought of volunteering after my kids left home, because when you go home at night, there are lots of other things to do, so that is a big barrier.

Malpractice as a Barrier

The possibility of being charged with a malpractice claim is something all physicians dread with the current medical-legal environment in this country. Also, the perception that the poorer socioeconomic population is more litigious is seen by current volunteer physicians as a barrier for non-volunteers.

Dr. N: The biggest barrier particularly in the recruitment of physicians to work at the JCC is that the medical-legal climate in this country and in particular in the state of Florida makes it difficult at times for doctors to feel comfortable giving extra time to volunteer in a clinic.

One physician relays a story of a malpractice claim unrelated to the clinic. However, this shows the disapproving viewpoint of malpractice from the perspective of a physician.

Dr. O: And, let's see, during my experience with indigent care, I have not had any malpractice lawsuits. I had a patient we took care of him in my training that was a taxi driver and two kids ran and skipped the fare, and when he went after them, they shot him. He came to the hospital, and he was in the hospital for quite some time and then he ended up dying before he left the hospital. He was, you know, he died in the hospital, and then I was kind of involved as a witness because they tried to blame his death on malpractice with the hospital rather than the children, the kids that shot him, so that was a case I was peripherally involved in, but was not named in.

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The following remarks highlight the perspective of current volunteer physicians that liability risk cannot be totally eliminated but it can be put in a more realistic perspective.

Dr. O: I think the biggest barrier is the constraint on a physician's time, and their, you know, cautiousness about the types of liability they may take on, would be the two biggest concerns. But they are easy to overcome. And overall, as long as you are documenting well, and considering this is a free clinic I think the liability is relatively low.

Dr. B: Well, for those who are in practice, and are carrying medical liability insurance, there's a perception that this population of patients is more likely to sue. That has not been my experience. And I think the fear of being sued because you are taking care of someone gratis is probably not valid, and I know that is one concern…I think that in general, the patients that I have had here have been appreciative of the care that's been provided to them. It's rare to see somebody who has a sense of entitlement that comes to this clinic. There are some, but they are rare. And those are the people who I am a little more weary of, in terms of, would this person be likely sue me if things didn't go well in their care. And like I said, I just don't see that many people like that here. There is always a concern about liability. I don't really think about it much because it hasn't been an issue, and I don't think it will be, but it's always in the back of your mind if you are practicing in Florida.

Dr. N: The concerns about the medical-legal climate, I can only reassure individuals that the average patient, at least, the patient I see at the JCC will be the least litigious patient that I could ever see. You can see the gratefulness and appreciation in their eyes when you've seen them, the fact that they leave that clinic with a sense of satisfaction that this doctor has taken his or her time to come down and spend time with me and the likelihood that that can result in litigation, of course it is not impossible, but in my view, is very unlikely.

Level of Liability Related to Specialty

Dr. W: I think it's probably, most malpractice carriers would want to encourage people to volunteer, and they wouldn't make it too difficult for them to get coverage for this type of clinic. If you were doing some high-risk clinic work, volunteer work, then that might be a different thing, but I don't consider this clinic a high risk for malpractice.

Dr. O: Considering this is a free clinic, I think the liability is relatively low.

Dr. O and Dr. W believe liability is relatively low for medical professional volunteer work. However, as can be seen in the statements below, it is not the same for every specialty. Liability, just like malpractice insurance rates, varies depending on the specialty. The JCHC referral specialist states the most needed volunteers are surgeons. Surgeons carry the highest level of liability. As mentioned above, liability is a major

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barrier in recruiting volunteers which could be the reason why surgeons are the scarcest in the volunteer population.

JCHC Staff Member: Whatever doctors are there, I use completely, and it's the same ones over and over again. Because we don't have that many doctors in each specialty, or have such a great variety. We only have three surgeons for twenty people. We only have two or three for each specialty, sometimes only one…There is usually not a wait for anything, unless its surgery or gynecology, or gastroenterology. There are just so many people that need those three specialties that it gets backed up and we only have so many doctors that do each thing…We don't have certain specialists, for instance, neurosurgeons or orthopedics, if a patient needs them, we don't have it.

Dr. X's statement below shows the relatively high risk of liability in a field like neurosurgery:

Dr. X: The issue of physicians taking care of patients that don't pay and putting themselves at risk for taking care of those patients because they can be sued for whatever reason, forget if something is going wrong, even if nothing went wrong, particularly in neurosurgery. There is not much room in the brain for tumors and blood vessel problems and other things while operating on them, so doctors can be at great risk financially by doing good, you know. They put themselves at risk, that's another barrier.

Dr. Z confirms Dr. X's sentiment that the inherent dangers of surgery are often high, both physically and financially.

Dr. Z: The concerns for volunteering…is the potential infringement affecting my malpractice. I see it more, not in my field, but my colleagues in surgery, they'll often find themselves between a rock and a hard place. They'll have someone, not related to JC Clinic, with a thorn by a fish in the carotid artery, after removing it, they don't make any problems except a secondary infection, an abscess occurs, and with poor follow-up there is a complication, all of a sudden there is a extenuating circumstance and an older patient, and when you are doing that, you are doing anesthesia, they come out with something else. They are the risks that are involved, as I said more so in the surgical field that occur a percentage of the time, not due to neglect or a mistake, it is one of the risks factors. You might not make it to the end of the day, it is a risk factor.

The lack of physicians in these specific areas is most likely not random or by chance. The issue of medical-legal liability is significant for all physicians, more so for physicians that are at higher risk due to their specialty. The lack of volunteer physicians for surgery is likely directly related to malpractice.

Physicians Unsure about Malpractice Coverage

Many physicians seem to be uncertain about if and how their malpractice coverage

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covers their work at the free clinic. This uncertainty can be a barrier for prospective doctors and cause extra concern or worry for current doctors. The following quote exemplifies the often unsure replies physicians give when asked about their malpractice insurance covering their volunteer service.

Dr. O: I do not know if this type of medical practice falls within the (pause) what's it called, the….because the clinic is affiliated with the university there may be an exemption from liability affiliated with the university institution, I'm not sure, but obviously my malpractice insurance would be a fall-back if there were (pause) a claim. Usually it does not require any change in malpractice as long as it's in the same county as your current malpractice coverage.

The physicians that are assured their malpractice insurance covers their volunteer work only needed to ask their employer or insurance company. The following quote exemplifies this. In addition, in all the interviews I conducted, no physician stated their insurance coverage has directly told him or her they will not cover their medical volunteer work.

Dr. W: I know some doctors have said that they might have medical malpractice problems with this type of clinic, but to my knowledge, there haven't been any concerns with that here. I know with my job, I am lucky enough that my employers made sure that any coverage that I might need is available when I work at the clinic here. Not only am I covered in my job, I am covered in any volunteer work that I do.
Ambiee: Is that common for your coverage to cover work done here?
Dr. W: Well, I think it is common if you let your malpractice carrier know what you are doing. In my experience, if you were to just volunteer anywhere and not tell your malpractice carrier, then there might be a concern there that you would not be covered it would depend on your policy.

Prevalence of Spanish-Speaking Patients as a Barrier

Current volunteer physicians believe that due to the majority of their patient clientele being solely Spanish-speaking, this hinders a significant number of physicians to volunteer. This fact is mentioned extensively in current physician volunteer interviews.

Dr. F, who has volunteered for the clinic for over thirty two years, has seen the changes in the patient population through decades at the clinic.

Dr. F: Another barrier, I think in recent times, has been a language barrier. We see more Hispanic patients who don't speak English, and if you are not a Spanish speaking physician, then that does not only make it harder to do a good job but it takes longer to do the job. So, more Spanish-speaking physicians would be useful and more Spanish speaking help.

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For physicians, losing the one-on-one patient-physician relationship due to the need of a translator somewhat diminishes the satisfaction of volunteering. During my observation sessions with physicians, I found that when a translator was necessary, the patient history and communication could still be done but it was not as effortless and it definitely complicated matters. This is seen in the following quote.

Dr. L: The only thing I'd like to talk about is the big language barrier and I think we should try and reach out to some of the Spanish-speaking doctors…because they would be a big plus here, because that is my biggest problem working with. You don't get, you know, all the nuances when you are dealing with a translator, it's very hard to get…you can get an accurate history, but there are certain things that I'm sure you miss out on.

The JCHC staff also feel having a large Spanish-speaking clientele as being a barrier in recruiting physicians.

JCHC Staff Member: I've had people waiting six or eight months because there is such a shortage of surgeons and then some surgeons don't want to take Spanish-speaking patients because they don't want to work through a translator, so it becomes more difficult… The thing is when you tell them most of our patients are Spanish-speaking, that's the reason a lot of doctors don't want to volunteer.

Continuum of Medical Care

The want of physicians to have continuity of care is mentioned in several interviews. Obviously, this is an important issue in treating patients and within the field of medicine in general. Continuity of care is clearly defined by Dr. F.

Dr. F: Well, my personal belief is that the best medical care is one which has continuity and that's best conducted between one patient and one doctor. As society and medicine gets increasingly complex, that's harder and harder to do, and one has to often work as part of a group or part of a team to effectively provide medical care to more people…It certainly isn't possible for any one physician to be there at all times, that would be better, but we don't live in an ideal world and given the circumstances we face, physicians contributing a reasonable amount of their time for the public good is appropriate, and I think this is the best way we can handle that continuum of care given the state of things in 2007…The principal issue that I have is one that I am not sure is solvable. And that is the continuity of patient care. I see that as the biggest problem for a physician because you go there and you know that the next week someone else is going to have to pick up what you have done and so the patient doesn't have the advantage of seeing the same doctor time after time after time. In an environment like this, short of some mechanism of employing a small core of physicians who are there regularly with supplement from volunteer physicians, I'm not sure that I see any solution to that.

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Volunteering a relatively small amount of time to a free clinic exposes the lack of continuity of care to a greater degree. As will be seen later, this continuum of care relates to other risks or barriers to volunteering, namely compliance and medical-legal liability. As Dr. L outlines below, the irregular frequency of the patients visiting the clinic, on a non-routine basis, exacerbates the issue more so.

Dr. L: Sometimes it is very frustrating that you do see these patients and you try to help them the best you can, and the follow up is a huge problem because a lot of them don't come back, some of them are migrant workers, who are working here for a while, and then they are moving somewhere else. And you don't know what happens to them. And today was a typical example. That lady has just come in here, clearly very ill, probably a drug addict, tells me she has got hepatitis C and has got pain all over and is probably wanting pain pills. But I won't do it, and because I won't give her pain pills, just ordered blood work and some tests, the chances of her coming back are very low.

Dr. O outlines similar problems in working with patients that have irregular health visits.

Dr. O: Working with the indigent population is a little more challenging because the follow up is a little more difficult. You don't always get the whole story and you always worry about if you order a test, is it going to get followed up, will the patient show up, because they don't always have the means or resources to follow through to what we recommend to them. So it is a little more challenging, they may not be as compliant, so that's a challenge you face with the indigent population…It's up to the patient to make due with their resources and try to follow through with the compliance at that point…so it is important to take a thorough history, because they are at risk for low compliance. You do have to be very alert for getting a complete history and little signs or symptoms that may seem small, I do try to be very careful about the history I take here, because I don't, because if this is the patient that isn't going to be seen by a doctor for another three to six months, I want to make sure I don't leave anything out.

The above excerpts display the negative components of not having continuity of care. The excerpts below demonstrate how having a continuity of care with a patient is positive and rewarding for the physician. JCHC referral doctors in particular can have greater continuity of care and see patients in their own private practices.

Dr. M: One thing that I find helps is if I see a patient with a definitive problem, I'll have them follow up in my office, and that's way the patient knows she is going to get taken care of instead of just pushed in the system and lost.

If JCHC patients need surgery or follow-up specialty care, JCHC referral physicians in particular can continue to see that patient and follow them through. This is also seen through a particularly memorable experience expressed by Dr. N.

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Dr. N: I think one of the greatest remembrances I have is a patient I saw one evening at the JCC who needed rather urgent gynecological surgery for some pretty serious problems. And she needed a pre-op and a work-up, she could go right straight to the hospital for this sort of thing. I remember seeing her in the clinic and saying I need to get you referred to a doctor's office for a workup and then get you for surgery. And she said in another language with an interpreter, "Could you please do all of this for me?" And under the JCC guidelines, I was able to self-refer that patient to my office, where I worked her up extensively in the office. And then I admitted her to St Joseph's hospital, St Joseph's Women Hospital and performed urgent surgery for her and she made a full recovery and she came and saw me for a 6 week checkup. And I think it was by far this was the most grateful patient that I had ever seen where we had total and complete continuity of care. And that was not only because I was volunteering of my time, but so was my office, office personnel, the hospital, and the hospital personnel.

The excerpt below demonstrates how the medical personnel at the JCHC assist physicians and patients in scheduling follow up appointments, even if they are with different medical professional than the patient saw originally. This is necessary when continuity of care from one physician is not possible.

Dr. W: My biggest concern for volunteering in a clinic such as this is I'm only here once a month or so, and I don't have the follow-up sometimes that I would like with some of the patients I see. There may be someone who I am concerned about regarding tests I have ordered and so forth, and because I don't have the ability to follow up on every patient, sometimes you worry about them, you don't know what's going on with them, but knowing the system here, and knowing the clinic, I really feel that they are getting good follow up and they are getting help. I haven't had any cases that I'm aware of that have fallen through the cracks and you know, tests were ordered and studies were ordered and they either weren't done or the patient wasn't taking care of properly.

Perceived Lack of Resources/Stereotypes of Free Clinic Facilities

Current volunteer physicians often mention their belief in the *perception* among non-JCHC volunteer physicians that working at a free clinic will be problematic or not satisfying because of the lack of resources. The JCHC director has seen this firsthand, " I think a couple of fears that I've seen among the doctors that I've talked to is first of all, when they come to the clinic they are very impressed with the building that we have, and all the equipment that we have. They may have a picture in their mind of what a free clinic is going to look like, and feel like, and when they get here, they like it and they feel comfortable, and they know we have all the equipment that they need, they don't have to bring anything with them." Lack of resources available is particularly untrue for referral physicians because they see JCHC patients in their own offices. The negative perception of the quality of free clinics itself, however, can deter potential volunteer physicians. Often physicians during the interview will attempt to debunk that stereotype.

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Dr. N: One other barrier that I didn't mention is that I hear when I'm out recruiting doctors, "Well, the clinic doesn't have the same type of equipment that I have in my office and because of that I feel encumbered when I get down to the clinic and I just don't have what I need when I need it". And I answer that in two ways: Volunteers who really work hard find the equipment to go to the JCC or there are more than one option for volunteerism at the JCC and the other is you can see patients in your office with your own equipment all on your time, so you don't necessarily have to come and pack up and come to the clinic and not have what is appropriate for you to do, or for you to have.

When discussing the production of the recruitment video with Dr. W, the theme of general negative perceptions of free clinics emerged once again.
Dr. W: (Prospective physicians) would be able to visualize what they would be doing there, and what kind of clinic it is, instead of, "thinking oh, it's a free clinic, it's probably dirty, it's probably not well run (laughs) I'm just going to be wasting my time there", they can actually see the clinic and visualize what's going on and make a better decision that way and not have so many negative thoughts to begin with.

Dr. E emphasizes in the following quote not only the efficiency of the clinic, but its ability to cover even expensive tests.

Dr. E: I have found that the clinic is really very resourceful and being able to get tests that I need done, even expensive tests, like MRIs, even lumbar punctures or echocardiograms, or things that I might need, they can figure out a way to do it, so I don't really have to jump through hoops to get those things done. I send the report back to the (JCHC) doctors who sent the patient here and they find a way to get them done.

Dr. M: Definitely when you volunteer here you have to be more conscious of the expense of all the tests you are ordering. When somebody has insurance, you just order whatever you want, but without insurance you have to be more careful. (Pause) But I haven't had any problems, I can always get the tests that I need, I just write a prescription, I know St. Joseph's hospital has been wonderful about helping out and donating their services.

This quote is especially telling. Dr. M quickly responds that you have to be more conscious of the expense of tests. But after thinking about her experience and getting beyond the "party line" or what seems to be the appropriate response, she realizes she has not had any problems with any of the tests that she has wanted to run. Upon observing Dr. M at her specialty office, the support staff seems to be more aware of who is a JCHC patient than the physician. Upon seeing me in her office waiting room, she had a surprised look and stated, "Oh, am I seeing a JCHC patient?" This denotes that treatment of a JCHC patient must be quite similar to that of a regular paying patient of the physician's private office.

In sum, physicians that currently volunteer at the JCHC perceive the clinic's resources as high-quality and repeatedly voice this throughout the interviews.

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Linkage between "Good Patients", Continuity of Care, and Malpractice

In many of the interviews, doctors would allude to the patients at the Judeo Christian Health Clinic being "good patients", "responsible", or "compliant". Physicians often mention the "goodness" of patients when they are trying to recruit other doctors. This is prevalent in many of the physicians' interviews, so patients being "good" may play a significant role as to why the volunteer or why they continue to volunteer. Another significant issue mentioned by all physicians was malpractice. In a few of the interviews, a linkage can be seen between these two prevalent themes, and this may be the reason why physicians emphasize the "goodness" of the patients.

Ambiee: What do you think are barriers for you in volunteering your time here?
Dr. O: Patients, there is a concern, that if patients aren't compliant, or don't follow what you do, that they can have a delay in diagnosis or a bad outcome, and then, as in today's world, there is the reality of medical-legal liability, so that is something that, you know, it's a risk that we all take.

In this physician's thought process, if patients aren't compliant or don't follow directions, there is an elevated risk of malpractice or liability. A lack of compliance is a possible barrier because it relates to malpractice insurance.

Dr. L: I think the negative consequences that we always have in the back of our head is litigation. That is always my biggest fear about working in this country as against in working in South Africa where I initially trained. There was not a lot of litigation. You never felt that the lawyers were on your back. I feel which, especially working in the clinic here, it's very hard to get some of the tests you would do in private practice, and you don't have the same follow up, that's the only concern I have, but at the same time I feel that these patients are so grateful to be seen by doctors, nurse practitioners, whatever, for nothing, that I just hope they would never think of suing if there was a big mistake.

There is a linkage between good, grateful patients, continuity of care, and malpractice. This physician believes the lack of continuity of care may directly increase the chance of being charged with malpractice. However, the patients being grateful can offset this chance. The increased chance of being sued is communicated in the quotes below.

Dr. M: I think some physicians are afraid of the medical-legal issues for volunteering. They don't want to get involved with any more possible lawsuits. And each patient equals a possible lawsuit, so I think some doctors will stay away from that. Also, these are patients that don't have good histories of health care. They don't go to the doctor every year, like our private patients, so that's more risky.

Dr. N: Some professional liability insurance carriers are somewhat nervous if a doctor spends a great deal of his or her time in a volunteer situation. But it's not so much the

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financial part of the professional liability part of the situation, it's just fear of lawsuits, and seeing patients, for instance, in which you haven't had the opportunity to establish a doctor-patient relationship with over time. Some doctors and health care givers feel increase their liability or risk, and this level of concern, it does restrict our ability to recruit at times.

The lack of follow-up in a free clinic setting is a perceived risk to physicians. This lack of continuity of care, mentioned several times, is more so important due to its relationship with perceived litigation or malpractice. Physicians seem to feel that emphasizing the "goodness" of patients will mitigate the fear of malpractice to prospective physicians. In order to significantly alleviate the fear of malpractice charges being filed against volunteer physicians, policy changes at the state or national level would be needed.

Secondary Themes

The themes within this section did not emerge as frequently and were not discussed as intensely within the in-depth interviews as the primary themes above. However, this may be due to the primary focus of the research study and/or the nature of the methodology.

Lack of Publicity for the Clinic as a Barrier

A secondary barrier, one that was not mentioned as often, was the lack of publicity or knowledge of the clinic. However, greater publicity in order to improve recruitment and funding is a common need with volunteer non-profit organizations.

Dr. L: One of the barriers is I think a lot of people don't know about the clinic. I think you've got to get the word out. The only place I have really seen the clinic advertised is in the Hillsborough County Medical Association magazine and I'm sure it is advertised elsewhere. I am not aware of it, but I think a lot of doctors don't know about it.

Dr. W: Well, in order to get doctors to volunteer for a free clinic like this, first of all, they need to know about it. I know a lot of physicians that I talk to are vaguely aware or slightly aware that there might be some free clinics in the area, but they don't even know where they are, the names of them, what's available for volunteer work. I think that just getting out the message that there is a clinic available where you can go and volunteer on a regular basis on your own schedule and it's done with high quality and it's available to anyone, to anyone who would like to come…I don't know if they are aware of the JC clinic.

"Judeo Christian Health Clinic" – Is the Name a Disadvantage in Recruitment?

Due to the methodology, this subject could not be fully explored. The physicians that offered to be interviewed were already current volunteer physicians. If the name's religious connotation is a significant barrier for a subpopulation of physicians, they

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would not be current volunteers. Due to the size of the study, we were not able to recruit non-volunteers. However, current physicians may know non-volunteer physicians affected or have experience and knowledge about this situation. "What advantages and disadvantages does the name itself, 'Judeo Christian', have on recruiting physicians in particular?" was asked to current volunteer physicians during the interviews. Overwhelmingly, the current JCHC physicians felt the name was not a disadvantage in recruiting or otherwise.

The origin and development of the clinic name is explained by the JCHC director.

JCHC Director: I think the disadvantages that some people think we are a religious organization, and it is a faith-based organization, you know, it was started by St John Presbyterian Church by Rev. Jim Holmes. But Judeo Christian Health Clinic, it's named JCHC because of the connotation of the Judeo Christian ethic from the Old Testament, of man helping his fellow man and that's as much as it has to do with religion. I get asked that question so many times, "Why is it named JCHC?" Well, it started out being named "St. John's Clinic" because St. John's started it, but as more churches joined, they changed it to the Christian Coalition Clinic, is what it is, and then synagogues and Jewish groups, and they decided to name it, "Judeo Christian Coalition Clinic" and they stuck with that coalition for the longest time, and people used to ask me weird questions about it like, "What do you do down there? Build bombs or something? What kind of coalition are you?" So finally the board decided they would drop the coalition, insert health, so people would at least know we are a health clinic (laughs). It is an altruistic name, it's a solid beautiful name, but it's not always very apparent as to what we do here. So people have questions about it.

Dr. M: Well, the disadvantage is it makes it seem like it is a religious facility, and it is in a church, and it could be a disadvantage mixing that religion with medicine. But the advantage is that it really is a Judeo Christian value to help other people. That is I think the basic value of religion in general, any religion.

Dr. L: In terms of the name Judeo Christian clinic, I have never had anybody say anything negative about it. I think it is a wonderful name. It's attached to a church, I'm very comfortable with that. I think it encompasses everybody, and I don't think it is a problem.

Dr. N: I do not think the name Judeo Christian would be a barrier at all. I haven't seen it be such. I have never seen it or heard of a suggestion that for the fact is a Judeo Christian effort, appropriately named, for what it stands for, or what its mission is, that anyone has taken offense to that or suggested otherwise.

Dr. X: No, it has a reputation, I don't think so you need to ask one of my colleagues, I suppose if I was a Muslim, I would be a little concerned, so maybe they ought to, I never thought about that, maybe they ought to think about changing their name, "Judeo

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Christian Muslim"….wouldn't bring more doctors, but it might make the Muslim patients feel a little better, course it might make the Judeo Christians feel worse, it's a crazy world we live in.

Dr. W: No, I don't think there is any disadvantage to the name. I think that if the name actually tells why the clinic is here, and how it was originated in many ways, but with regard to the name, I really can't see where there would be a problem with regard to prejudice against the name per se. When you are talking to a free clinic, I mean there may be some people that maybe feel they are left out because they are not Judeo or Christian, but that's not the case, in this clinic, so I don't think that comes to a - I don't think that would be a valid problem.

The Young and Retired Physician Populations

Out of the 30 surveys given back from the clinic, no physicians chose "retired", even though the age range was from 32 years old through 70 years old with the median age being 54 years old. In interviews, the issue of retired physicians was not addressed because they are not themselves retired, although this is a significant issue in volunteer health policy in Florida. This might be a significant segment of the population that JCHC is missing and could actively recruit. In regards to this issue, the director of the clinic stated that most JCHC physicians are in private-practice, but "Our attorney, however, is looking in to the possibility of the health dept covering retired doctors who might be covered under sovereign immunity while working at JCHC" (personal communication). Due to the scope and methodology of the study, however, this issue was not actively investigated. There are not a significant number of retired physicians at the JCHC. Further study in the general retired volunteer physician population is needed.

Below, Dr. N and Dr. B both discuss the extra work retired physicians must do in order to volunteer as a physician at a free clinic such as JCHC.

Dr. N: For instance, retired physicians have to get certain waivers in order to volunteer their time without carrying professional liability insurance.

Dr. B: Malpractice insurance is a big barrier, because there isn't any protection offered to retired physicians who volunteer here. And that's unfortunately kept a lot of people who would like to work here, because they're retired from their active practices, away.

A few physicians feel there is a lack of young volunteer physicians, defined as physicians who have recently completed their residency. Many current volunteer physicians explained they felt too busy trying to get their practice started or providing for themselves and/or their family when they were younger to volunteer. However, Dr. F and Dr. B both mention that improving skills and gaining experience is beneficial for young physicians and this function could be served by volunteering at the clinic even though they are not getting paid. Dr. F said, "I am 66 and I don't have that much to learn from it, but

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younger doctors do". Dr. F explained that while medical students are more of a hindrance than an asset in a clinical setting, residents should come to volunteer at the JCHC because they know enough to be productive members and they can gain experience.

Dr. B: Well, I think that, you know, the university does a great thing by having the medical students come and spend time here. And I think it would be difficult to get residents out of the hospital and volunteer at a clinic but I think that because of the clinic's relationship with the university, if they could figure out which residents will be sticking around after their training they might ask them to consider coming here, you know, as they get started in their practices.

The Need to Further Engage Volunteer Physicians with the Clinic

When I conducted in-depth interviews with specialists, I asked basic questions about how they receive a patient, who pays the costs, etc. Most physicians were quite unaware of how the referral system works. This can be seen as a positive because they do not need to be aware of how the system works and they only have to focus on the patient that has come in to see them. Specialists that see patients in their own office know significantly less about the running of the clinic then doctors who treat within the clinic building. Many specialists showed interest in learning more about the details of the referral system and more about the clinic in general.

This commonly came up among specialists, but Dr. Z best summed this up:

"I don't know that any of us that participate have the whole picture as to how many physicians are participating as we sit right here today and the group of patients that are taken care of, what that population, what group do you extend this care to, you know. We pretty much allow, as physicians, for the JC clinic to determine that… But to have a fuller picture of this would also benefit in the recruitment and the keeping of those physicians that are still participating. Kind of an end-of-the-year video of what you have seen that you are doing this video, the opposite way, to say this is some of the patients we saw, some of the clinics, first time at the end of one year where they are at, that I think acts both ways, to help educate those of us that are participating, those of us that want to participate, those that haven't participated but want to in the future, and to show the patients that are there."

Related to this is that since physicians only volunteer a relatively small amount of time and specialists are not tightly connected to the clinic, this combination can have volunteer physicians gradually participating less with the clinic. The JCHC referral specialist does not refer JCHC patients to all of the doctors currently within the JCHC physician referral binder. The referral specialist explained that "all of these doctors (pointing to the referral binder) are not current volunteers, you know?" The referral specialist claims physicians can be lost gradually because the physicians' staff will not set up appointments for the

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JCHC patients. The executive director of JCHC explains sometimes the doctor does not even know the staff is not referring or scheduling JCHC patients and directly contacting the physician is usually the solution. Someone in the staff serves in the "gatekeeper" role, and is an important unseen figure. When talking to another anthropologist who has previously been affiliated with physician offices, she said this gatekeeper often feels that he or she is doing a favor for the doctor, limiting the number of patients to lessen his or her burden, even while sometimes not telling them.

Ambiee: Do you have any recommendations on how to improve recruitment of these specialties that are needed?
JCHC Staff Member: Just getting our name out to doctors. It's almost like having somebody going to their office in person. Not sending the letter, because does the letter really get to them is the question. There are so many people in a doctor's office, there is so much staff. You know, the office managers filter the mail, they don't give them everything, they (physicians) probably don't read half of it.

This is an issue because physicians may be lost due to this interaction. This is a hidden loss, presumably, because the doctor fades away. However, the referral specialist maintained that gradually losing doctors in this manner is not typical.

Survey Findings

VFI Survey Results

Although the most significant data was gathered through the qualitative interviews, the results of the survey also served to confirm some of the most important themes developed in the interviews, as well as providing some limited demographic data. The categories listed below are clearly defined in the Literature Review chapter above.

Table 1. Motivational Functions Served by Volunteer Service – According to JCHC Physicians

Benefit category	Mean[1]
Understanding	4.14
Enhancement	3.55
Values	6.27
Protective	2.59
Career	1.92
Social	3.30

[1]Means from 7-point Likert Scale,
1 = strongly disagree, 7 = strongly agree.

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Survey Descriptive Statistics:

Table 2. Survey Response Rate			
VFI Survey	Total Number of Possible Respondents	Actual Number of Respondents	Survey Response Rate (%)
Volunteer Physicians at JCHC	194	30	15.5%

Table 3. Demographics of Survey Respondents		
Respondents	Males – 18	Primary Care (Family Practice, Internal Medicine, Pediatrics, OB/GYN) - 17
Total # of Survey Respondents- 30 Physicians Total Possible Respondents – 194 (Total JCHC Physician Population)	Females – 12	Non-Primary Care – 13

Table 4. General Descriptive Data of Volunteer Physicians			
# of Respondents	Average length of volunteer service	Average Age of Volunteer Physician	Average Number of Hours at Day Job
30	9.8 years	53.1 Years	53.38 Hours

Table 5. Retired and Non-Retired Physicians			
# of Respondents	# of Retired Volunteer Physicians	# of Non-retired Volunteer Physicians	Did Not Respond
30	0	28	2

Table 6. Median Amount of Volunteer Service by Physicians	
Number of Respondents	# of Hours Volunteered a Month at JCHC Median Value
21 9 – Did Not Respond	3 Hours a Month

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Due to the low response rate, I was not able to compare subgroups (i.e. young physicians' VFI scores versus older physicians' VFI scores) within the physician volunteer population. This was originally wanted so as to compare subgroups in their motivations to volunteering.

Discussion of Survey Results

As seen by the data, the typical physician volunteers for the clinic about three hours a month. This is affirmed by the JCHC director of the clinic. With time being a large barrier for volunteer physicians, this data shows the flexibility in scheduling. This also confirms the need for a large pool of volunteer physicians so as the responsibility does not fall on a few volunteer physicians.

Due to the low response rate, I was not able to compare subgroups (i.e. young physicians' VFI scores versus older physicians' VFI scores) within the physician volunteer population. This would possibly show different motivations among different subgroups of the volunteer physician population. However, the survey was used primarily to allow all JCHC volunteer physicians an equal opportunity to participate in the in-depth interview (the primary research instrument) and to have a simple method to recruit participants for the in-depth interview and observation process. In this regard, the survey was a success as more physicians volunteered to take part in the interview and observation process than was needed. The survey also helped to triangulate the data from the research study.

Social Benefits to Volunteering

One category of the VFI is the social category. This is defined as offering opportunities to be with one's friends or *to engage in an activity viewed favorably by important others* (Phillips et al. 2001: 49). This reflects motivations primarily concerning relationships with others. Volunteer literature maintains that a successful volunteer organization will recognize and reward their volunteer base (Ilsley 1981). Previously, the JCHC held a volunteer recognition dinner but this was cancelled for two reasons:

1) Lack of attendance at the dinner. Volunteers stated they were too busy to attend.
2) Volunteers did not want the clinic to spend money on "them". They wanted the clinic to spend their money on the patients and the clinic itself. This is affirmed by the results of the VFI – the strongest motivating factor was values which centers on altruistic and humanitarian concerns of the volunteer.

Dr. N mentioned off-camera that he knows doctors who go on these "medical missions" for two or three days out of the year and feel they have volunteered enough and have little interest in volunteering local at the JCHC. He strongly believes this subgroup of physicians feel volunteering internationally is more glamorous than volunteering locally and thus, more beneficial or satisfying to those physicians. Receiving awe and attention

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is definitely a positive beneficial function in regards to volunteering and this is certainly fulfilled in these international missions. The degree to which this motive is received at the JCHC is unknown. The VFI survey results show the "social" score among the thirty current volunteer physicians to be the fourth ranked volunteering function (3.30 on a 7 point Likert scale). This shows that the "glamour" function or receiving attention by important others is not a strongly influential motivation or *significantly* important to current volunteer physicians.

Connection between the Results from the Survey and Interviews

The Values category was ranked the highest (6.27 out of a 7 point Likert scale) by volunteer physicians. No other value was close to this score. Average scores of 4.5 or higher reflect a strong influence of a particular motivation to volunteer (Phillips et al. 2001: 49). Within the in-depth interviews, physicians often cited their intrinsic belief that the value of the service, to give heath care in those in need, was the most important and primary reason they volunteer. The Volunteer Functions Inventory results support this. According to Clary et al. (1998), this is often characteristic of those who volunteer and distinguishes volunteers from non-volunteers. It may be difficult to recruit persons that are not intrinsically motivated by the values function. However, the values function should still be highlighted in recruitment materials as it may motivate those who are likely to be volunteers.

Although no other category had a score of 4.5 or higher, the Understanding and Enhancement functions were the next highest values (4.14 and 3.55 out of a 7 point Likert scale, respectively). The understanding value involves the opportunity for volunteerism to permit new learning experiences and the chance to exercise knowledge, skills, and abilities that might otherwise go unpracticed. This value, ranking second out of six functions, does not fit exactly in line with the results of the open-ended interviews. Physicians very rarely mentioned that their service allowed them to exercise skills and knowledge they otherwise would not use. On the contrary, they primarily discussed positive aspects of volunteering that balanced the somewhat repetitive experience of volunteering in the same capacity as they work within their day job.

The enhancement value centers on personal development, personal growth, and higher self-esteem. This is the third ranked category and is in accordance with the results from the qualitative research. The "spiritual value" of the service was a consistent theme throughout the interviews. As seen in the section "Why Physicians Volunteer," the primary emergent themes are the need in this community for access to health care, benefits to the community and specifically the emergency rooms, and the spiritual value of the volunteer work. These three specific motives garnered from the qualitative research correspond with the first and third highest ranking motivational functions in the VFI – Values and Enhancement.

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The lowest motivational function rated by volunteer physicians was the career function, scoring 1.92 out of a 7 point Likert scale. This is also in complete accordance with the open-ended interviews as physicians, as a whole, rarely mentioned any career-related benefits obtained from participation in volunteer work. This may be due to the average age of a JCHC physician being 53.1 years old, according to the survey, and this population may have little to gain career-wise from volunteering their professional services. The career motive is often highly rated in groups where the population is in the beginning stages of their careers. The survey result may display the lack of young physicians within the survey and the clinic in general. Overall, the in-depth interviews and the VFI survey generally confirmed the results of the other.

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Chapter 5: Conclusions and Recommendations

This section will discuss the video component of the study and draw conclusions based on the findings of the study and in relation to the literature. Recommendations gained from both the literature and the research study will be presented in this section and to the clinic. The contribution of the study to the community will be discussed as well as the anthropological contribution to the research study itself.

Issues and Recommendations in Constructing a Recruitment Video and Subsequent Recruitment Material

The results of this study were used to help develop the recruitment video. In other words, the themes and ideas that emerged from the interviews and observation shaped the style, content, and format of the video. Throughout the course of the research, physicians often mentioned the lack of time they would have to watch a lengthy video about physician recruitment, and many recommended producing a short video, from about 5 to 10 minutes. Since running time is so important, I feel it is necessary to stamp the running time of the video on the DVD disc so physicians will know how much time to allot to watch the video. These time constraints played a factor in what can be shown; only the most significant themes were mentioned.

Through the survey and interview data, the values motivating function (specifically, the need for access to health care and the benefits to the community) seemed to be essential in motivating current physicians to volunteer. What can be seen in the physician interviews is their strong belief that our society needs better health care and health care should be a basic human right. This belief seems to propel many to volunteer. Therefore, this theme is highlighted in the video and should be in any other recruitment materials. Also, the spiritual value gained from the volunteer work was important to current volunteer physicians and is discussed. Current volunteer physicians constantly mentioned that prospective physicians may not be aware of the flexibility JCHC offers. This flexibility comes both in regards to time and to place – that doctors can see patients in their own office practice. This information should be developed in future brochures and is mentioned in the recruitment video.

Also, if written brochures are produced, direct quotes from physicians should be reproduced. These can be derived from transcripts, with permission from the doctors. This ties in to the personal touch that is essential in recruiting effectively. An example would be addressing litigation and using this quote by Dr. N:

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Dr. N: The concerns about the medical-legal climate, I can only reassure individuals that the average patient, at least, the patient I see at the JCHC will be the least litigious patient that you could ever see. You can see the gratefulness and appreciation in their eyes when you've seen them, the fact that they leave that clinic with a sense of satisfaction that this doctor has taken his or her time to come down and spend time with me and the likelihood that that can result in litigation, of course it is not impossible, but in my view, is very unlikely.

Continuity of care is of great importance to physicians. All recruitment materials should emphasize that a referral physician for the JCHC can have greater continuity of care with a patient. Supported by interviews in this study and by the literature review, it is seen that the poorer population is less likely to sue. Prospective doctors should be informed of this finding. It is necessary to include on recruitment materials that Spanish translators are accessible at clinic. It is also essential to show the facility itself and details its connections with St. Joseph's hospital in recruitment materials to debunk the stereotype of a poor free clinic. This method of creating the video is in line with the Clary et al. (1994) matching hypothesis. This is the idea that persuasive messages will succeed in engaging volunteer intentions and actions to the extent that they focus on the *relevant* motivations of the specific population.

It is necessary to discuss possible barriers or limitations so the video will be believable to prospective physicians as well as directly address possible concerns in volunteering. Time, malpractice, and perceived lack of resources were the most important volunteering barriers or issues with current physicians, so these issues are also discussed. Again, due to the need to shorten the length of the video, *all* themes cannot be effectively included in the video. It is integral to highlight the physical features of the clinic for informational purposes as well as to help debunk the stereotype of a free clinic without appropriate resources. It is important to show what a prospective volunteer will do, so shots of current volunteers at work in the clinic were presented throughout the video. This also created movement in the video and a diversity of visual images. This is important because within the last two decades researchers have found that the simple formal features of television, such as cuts and edits, activate the orienting response (the instinctive visual or auditory reaction to any novel stimulus) which improves a person's memory recognition and focus on the stimulus at hand (Kubey and Csikszentmihalyi 2002:76).

Originally the video was created to attract physicians watching in a general audience via television or large meetings, such as the Hillsborough County Medical Association. This would be a general blanket approach which attempts to reach a large number of people. This was just an initial assumption which arose from how videos are generally distributed. However, another method of delivery was strongly recommended by previous recruitment literature (Ilsley 1981) and current JCHC physicians within the study - a direct hand-to-hand delivery approach of the DVDs in an attempt to recruit physicians with a more personal approach. Having current JCHC physicians help

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distribute the DVDs and recruit prospective volunteer physicians is necessary in this recruitment strategy. I see that it is essential to give current volunteer physicians multiple copies of the video and other recruitment materials to give to other physicians in their day-to-day network. The physician could personally communicate what it is like to volunteer at the JCHC and give the video as supplemental information. Personal contact and person-to-person recruitment was a significant theme across the interviews. The medium would add a separating layer to the person-to-person contact but it would still be a more personal construction since physicians will be discussing issues related to the topic at hand. The prospective physicians could watch the video given to them by someone they trust and still keep that personal feel:

JCHC Director: We've interviewed so many of the physicians that volunteer here. It's not the personal 1-on-1, but it almost is, in a way, because the doctors are talking about their story and their experience here and asking others to join us.

Originally, the video was solely to be used for physician recruitment. The JCHC already has a general video that is used for fundraising and publicity purposes. However, the physician recruitment video effectively displays the clinic, the efficiency of the non-physician staff, and the contribution the clinic has on the local community. Therefore, this video may also be used for fundraising, publicity, and recruitment of non-physician volunteers. In addition, the comments of the physicians as to why they volunteer can be generalized to physicians elsewhere, not just the JCHC. I will soon develop a more general video that will highlight physician volunteerism in general and this will be given to the National Association of Free Clinics (NAFC), so they can distribute the video to other free clinics to aid their recruitment of volunteer physicians.

Relating Selected Literature to Current Findings

In the field of social psychology, there is a schism in theories relating satisfaction and motivation. Historically, it is believed that satisfaction reduces subsequent motivational drive. Roy Baumeister, a social psychologist, has recently presented a theory explaining that once we get something we want or desire, the subsequent feeling of satisfaction reinforces the strength of that desire (Elish 2007). In this study, the average number of years spent volunteering at the clinic by a current volunteer physician is 9.8 years. Throughout the interviews of this qualitative research study, physicians often cite their satisfaction and "feeling good" about their service at the JCHC. They also state that this "feel good" feeling is what motivates them or causes them to volunteer. The findings of this study are in line with Baumeister's theory since volunteer physicians surveyed at the clinic seem satisfied with their work and are still eager to serve.

Barnhill et al. (2001) concluded in part that medical malpractice is a great fear for potential medical volunteers and documented that a change at a state-level increased medical volunteerism. This study affirms that medical malpractice is a barrier to recruit volunteer physicians, but unlike Barnhill's results, this study demonstrates that it

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continues to be a great fear. According to Burstin et al. (1993:1697), rising malpractice insurance costs and fear of litigation are thought to reduce physician availability in poor neighborhoods and create access barriers for the medical indigent. Current volunteer physicians also see this fear of litigation as a problem. Runquist and Zybach (1997) demonstrated that the Florida Volunteer Protection Act offers very little protection and does not absolve volunteers from litigation. The repeated concerns and statements concerning malpractice during this study support this conclusion. Current JCHC physicians feel stronger protection would make it easier to recruit more physicians to volunteer. This is a change needed at the state or federal policy level. A policy change regarding universal health coverage for persons within the U.S. would also solve the problem and lessen the need for volunteer physicians. Isaacs and Jellinek (2007) conclude from their study focusing on volunteer health care programs across the nation that national health insurance would solve the problem of the uninsured more productively given the multiple limits of volunteerism.

Clary and Snyder (1999: 156) explain that in planned helping, the helper's decisions about beginning to help and about continuing to help are influenced by whether the particular activity fits with the helper's own needs and goals. Through the in-depth interviews, the values of the physicians were the key motivating factor and it was certain that they felt that volunteering at the JCHC fit with their needs and goals. From the interview data, it was seen that many of the long-standing physicians volunteered for both the values function and the enhancement function (the benefit to the community, the intrinsic belief in access to health care as a human right, and the spiritual value gained through volunteer service). This corroborates the Marta et al. (2006) finding that people motivated by more than one motivation may be less vulnerable to costs related to the activity.

Recommendations for the Clinic

1. Specialists need to know more about the details of the referral system and the clinic in general.

The JCHC referral specialist, aware of this, agreed that it would be beneficial to create a brochure or informational piece of paper, updated each year, so the referral physicians will know more about the clinic and possibly further engage them with the clinic.

2. As a policy suggestion, each volunteer physician should be given a yearly personal update about the clinic, clinic events, and a form stating their intent to continue their volunteer service.

While physicians are short on time, they would likely be more engaged with the clinic if they knew more about how it runs and their importance within the organization. Currently, the clinic provides a mass-mailing newsletter to inform their participants, but physicians often complain about how much mail they receive and in their offices, they

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might not even get all of it. A more personal contact is recommended to update the physicians. This would also be a good opportunity to ask physicians for suggestions and their level of satisfaction with the JCHC.

3. Further recognize current JCHC volunteers.

I recommend an inexpensive project that will recognize or reward the current health professional volunteer base. Previous volunteer recognition activities were not successful because volunteers stated they were too busy to attend an actual function and volunteers did not want the clinic to spend money on "them." They wanted the clinic to spend their money on the patients and the clinic itself. This is affirmed by the results of the VFI – the strongest motivating factor was values which centers on altruistic and humanitarian concerns of the volunteer. I recommend taking photos of current volunteers and placing them together on a hallway wall of the JCHC. This process is inexpensive but the volunteer may feel more physically linked to the clinic and also feel their work is being recognized. I recommend "in-clinic" volunteers have their photos put up first followed by referral volunteers. This also may attract or satisfy physicians that are primarily motivated by social factors – receiving attention by important others.

4. Person-to-person physician recruitment is most effective.

As can be seen from the data analysis, person-to-person contact is seen by current physician volunteers and JCHC staff members as integral to recruit potential volunteers. A larger proportion of time and energies in relation to physician recruitment should be allocated in the form of personal contact. Mass mailing is not effective. Spokespersons are needed and they can be equipped with effective DVD and recruitment brochures tailored specifically to recruiting health care professionals.

4.2 The current volunteer physician base must help recruit other physicians to the JCHC.

Often current physicians are unaware the importance of recruiting other physicians to volunteer at the JCHC. The current volunteer physician base must be informed of how important recruiting more physicians is to the clinic and take on the task of being a recruiter. Paul Ilsley (1981) suggests that an excellent recruiter must identify with the target group and have knowledge of the mores and history of the group being recruited. The physician lifestyle would be very familiar to a physician recruiter. Often in this study, physicians stated how important it was to know someone who was already volunteering and receiving satisfaction from their time at the clinic before they themselves got involved. This could be practically done by making a clinic brochure informing current health care professionals of the need to have them recruit other health care professionals. As seen in the study, current JCHC physicians personally and directly communicating with other physicians is likely to be the most effective method in recruiting physicians.

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5. Place a suggestion box in the physician lounge area of the JCHC so the JCHC administration may continually be linked to an essential important segment of the clinic.

A suggestion box may make current physicians more involved with the clinic. Ted Cox (Chester 1990:30), in his practical guide to volunteer management, remarks that volunteers expect to be heard.

6. Maintain flexibility in regards to scheduling physicians.

The clinic's current lenient policy in regards to scheduling is supported by the findings within this study. When initiating volunteer service at the JCHC, the physician should make the choice based on what is most suitable and realistic for him or her. Also, the amount of volunteer service should be continually refined so as to best suit the physician involved. The study findings show that one of the most positive aspects of the JCHC clinic, according to current volunteer physicians, is the flexibility they allow in time commitment and service of the physicians. Lack of planning is also seen as a barrier to volunteering. Having a JCHC member help remind and plan schedules with doctors that work personally best for them is recommended.

7. Enlist a few "emergency" translators on call on a weekly or specific weekday basis.

Some days there are no translators volunteering at the clinic and some days there is a surplus of translators. Translators should schedule their shifts 24 hours in advance, so as if there is a gap in translators, the emergency translator can be reached to help translate at the JCHC. While flexibility is important in volunteering, a fail-safe is needed.

8. Target groups that are in need or lacking at the JCHC and create direct messages that will be of interest to the particular group.

Spanish-speaking physicians, physicians of specific medical subspecialties (surgery and orthopedics), young physicians, and retired physicians are in need or are currently lacking at the clinic. The clinic must find current volunteers that are within the needed population and utilize them as spokespersons. Dr. B recommends contacting the medical school to recruit young physicians: "…if they (the University of South Florida College of Medicine) could figure out which residents will be sticking around after their training they might ask them to consider coming here (the JCHC) as they get started in their practices." Current JCHC physicians that have close ties or are part of the medical school would be best suited as recruiters.

9. Concrete information is needed about individual physicians' malpractice coverage.

Through the study, a common theme to emerge was that current volunteer physicians are unsure if their malpractice coverage will protect them from a claim at the JCHC. A brochure detailing malpractice coverage issues and helping physicians out how they are

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covered would comfort some of the physicians that have this uncertainty. Or a JCHC volunteer could work with physicians' malpractice insurance providers to determine the type of coverage the physician would receive if a claim took place at the JCHC. This grounded knowledge would ease the physicians concerns much more. Although most physicians *believe* they are covered, this measure would put them further at ease.

The Anthropological Contribution and Contribution to the Community

This study used a standard psychological assessment, the Volunteer Functions Inventory (VFI) and compared this data with traditional ethnographic methodology. Thus, this study helped triangulate and compare the two methodologies. While the qualitative data was the main part of the research, the quantitative data also helped contextualize the qualitative results.

The applied framework allowed the researcher to gain access for the study as well as give back to the participating community. The process of the in-depth interviews itself contributed to the research goal, by shedding light on the need to recruit physicians. The rigor of the research, performing numerous in-depth interviews on the specific topic of volunteerism was essential in clarifying the themes associated with medical volunteerism. Qualitative research is essential to address the "why" and "how" questions for a study of this sort.

Performing the research study itself highlighted the need for more volunteer physicians. Often physicians, after the interviews, stated they did not think previously of the importance in recruiting but they know physicians that might be interested and would now actively recruit people for the JCHC. Dr. C, after the interview explained, "I work with 18-20 physicians that don't volunteer at this clinic, and I didn't really bring it up, I never thought, I just never brought it up with them, but I think that I should and I think that I will, pretty soon I will." So the act of performing the study alone may have aided in physician recruitment at the JCHC.

The audiovisual tools used for both research purposes and for the applied component were essential to the study. At the end of the project, I am giving the JCHC an edited video that will help recruit volunteer doctors. All decisions about any further distribution of the video will be left to the JCHC administrators. The JCHC executive director has already allotted a time to show the video at the Hillsborough County Medical Association annual meeting in September 2007 in an attempt to recruit more local physicians to volunteer at the clinic. Isaacs and Jellinek (2007:875), in their study of volunteer health care programs across the U.S., claim that clinic leaders have little interaction with directors of volunteer programs in other communities and are often unaware of the ways in which other programs have addressed similar problems. The video may be shared with the National Association of Free Clinics (NAFC) so other free clinics can access and use the video in a similar fashion.

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The anthropological methodology attempts to analyze an issue from a wide range of vantage points. Incorporating audiovisual equipment, medical anthropological, visual anthropological, ethnography, psychological literature and methodology, and volunteerism literature allowed me to do so. This project can highlight the diversity of tools one can use in the field of anthropology in analyzing a single issue. This project is also able to show a segment of the range of possibilities of what can be done in the growing field of applied visual anthropology.

Closing Remarks

This purpose of this study was to further understand why physicians volunteer their medical services and the main barriers to their volunteering, as well as to provide recommendations and a product that would be directly applicable in assisting the free clinic in physician recruitment. I found physicians' schedules, malpractice, language barriers, the lack of continuity of care in the free health care setting, and perceived lack of resources at a free health clinic were themes physicians felt were significant as barriers to their volunteering. The value or belief-system of physicians was significant in why they volunteer, specifically their belief in the need for access to health care for all, as well as their belief that their work at the free clinic will benefit the community and the local emergency rooms. The spiritual value that physicians gained when offering free medical service was also integral to their volunteering. The stated purpose of this study was achieved in that recommendations and a video were developed in order to assist the organization in recruiting, and a greater understanding of physician volunteerism was obtained.

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www.manaraa.com

References Cited

Allahyari, Rebecca
2000 Visions of Charity: Volunteer Workers and Moral Community. Berkeley, CA: University of California Press.

Allen, Natalie and J. Philippe Rushton
1983 Personality Characteristics of Community Mental Health Volunteers: A Review. Nonprofit and Voluntary Sector Quarterly 12(1): 36-49.

Angrosino, Michael
2002 Doing Cultural Anthropology: Projects for Ethnographic Data Collection. Long Grove, IL: Waveland Press.

Barnhill, Kim, Leslie Beitsch, and Robert Brooks
2001 Improving Access to Care for the Underserved: State-Supported Volunteerism as a Successful Component. Archives of Internal Medicine 161(18):2177-2181.

Bird, Elizabeth
N.d. Anthropologists View Prodigy: A Report to the Prodigy Community Arts Program. Unpublished.

Bird, Elizabeth, Jess Ambiee, and James Kuzin
2007 Action Research in a Visual Anthropology Class: Lessons, Frustrations, and Achievements. *In* Pedagogies of Praxis: Course-based Action Research in the Social Sciences. Nila Hofman and Howard Rosing, eds. Pp. 111-132. Boston, MA: Anker Publishing.

Blumenthal, D, J Rizzo.
1991 Who Cares for Uninsured Persons?: A Study of Physicians and Their Patients Who Lack Health Insurance. Medical Care 29(6): 502-520.

Brown, Alison L.
2000 On Foucault: A Critical Introduction. Belmont: Wadsworth/Thomas Learning.

www.manaraa.com

Burstin, H, W Johnson, S Lipsitz, and T Brennan
1993 Do the Poor Sue More?: A Case-control Study of Malpractice Claims and Socioeconomic Status. Journal of the American Medical Association 270(14): 1697-1701.

Burstin H, R Lipsitz, and T. Brennan
1992 Socioeconomic Status and Risk for Substandard Medical Care. Journal of the American Medical Association 268(17): 2383- 2387.

Chester, David
1999 Applied Anthropology and the Volunteer Program at a Science Center. M.A. Thesis, Department of Applied Anthropology, University of South Florida.

Crapo, Richley
2002 Cultural Anthropology: Understanding Ourselves & Others. 5th edition. New York: McGraw-Hill.

Creswell, John
1998 Qualitative Inquiry and Research Design: Choosing Among Five Traditions. Thousand Oaks, CA: Sage Publications.

Clary, E. Gil, Mark Snyder, and Robert Ridge
1992 Volunteers' Motivations: A Functional Strategy for the Recruitment, Placement, and Retention of Volunteers. Nonprofit Management & Leadership 2(4):333-350.

Clary, E. Gil, Mark Snyder, Robert Ridge, Peter Miene, and Julie Haugen.
1994 Matching Messages to Motives in Persuasion: A Functional Approach to Promoting Volunteerism. Journal of Applied Social Psychology 24:1129-1149.

Clary, E. Gil, with Mark Snyder, Robert Ridge, John Copeland, Arthur Stukas, Julie Haugen, and Peter Miene
1998 Understanding and Assessing the Motivations of Volunteers: A Functional Approach. Journal of Personality and Social Psychology 74(6): 1516-1530.

DeNavas-Walt, Carmen, Bernadette Proctor, and Cheryl Lee
1996 Income, Poverty, and Health Insurance Coverage in the United States: 2005. Electronic document, http://dspace.nitle.org/bitstream/10090/469/1/p60-231.pdf, accessed July 28, 2007.

Donelan, Karen, Robert Blendon, Craig Hill, Catherine Hoffman, Diane Rowland, Martin Frankel, and Drew Altman
1996 Whatever Happened to the Health Insurance Crisis in the United States?: Voices from a National Survey. Journal of the American Medical Association 276(16): 1346-1350.

المنارة للاستشارات
www.manaraa.com

Elish, Jill
2007 FSU News: No satisfaction zaps motivation, FSU psychologist says. Electronic document, http://www.fsu.edu/news/2007/05/24/no.satisfaction, accessed July 15, 2007.

Ervin, Alexander
2005 Applied Anthropology: Tools and Perspectives for Contemporary Practice, 2nd edition. Boston: Pearson Education, Inc.

Farmer, Paul
2005 Pathologies of Power: Health, Human Rights, and the New War on the Poor. Berkeley: University of California Press.

Fletcher, Thomas, and Debra Major
2004 Medical Students' Motivations to Volunteer: An Examination of the Nature of Gender Differences. Sex Roles 51(12): 109-114.

Foucault, Michel
1980 Power/Knowledge: Selected Interviews and Other Writings 1972-1977. Colin Gordon, ed. Colin Gordon, Leo Marshall, John Mepham, Kate Soper, trans. New York: Pantheon Books.

1988 Technologies of the Self: A Seminar with Michel Foucault. Luther H. Martin, Huck Gutman, Patrick H. Hutton, eds. Amherst: The University of Massachusetts Press.

Fu Jen University
1998 Michel Foucault. Electronic document, http://www.eng.fju.edu.tw/crit.97/Foucault/Foucault.htm, accessed July 21, 2007.

Geller, Stephanie, Buck Taylor, and Denman Scott
2004 Free Clinics Helping to Patch the Safety Net. Journal of Health Care for the Poor and Underserved 15: 42-51.

Goffman, Erving
1959 The Presentation of Self in Everyday Life. Garden City, New York:Doubleday.

Hacking, Ian
1999 The Social Construction of What? Cambridge, MA: Harvard University Press.

Hall, Stuart, ed.
1997 Representations: Cultural representations and signifying practices. London: Sage Publications.

المنارة للاستشارات
www.manaraa.com

Hattis, Paul
2004 Overcoming Barriers to Physician Volunteerism: Summary of State Laws Providing Reduced Malpractice Liability Exposure for Clinician Volunteers. University of Illinois Law Review 1:167-181.

Hunter, K., and Margaret Linn
1980 Psychosocial Differences between Elderly Volunteers and Non-Volunteers. International Journal of Aging and Human Development 12(3): 205-213.

Isaacs, Stephen and Paul Jellinek
2007 Is There A (Volunteer) Doctor in the House? Free Clinics and Volunteer Physician Referral Networks in the United States. Health Affairs 26(3):871-876.

Ilsley, Paul
1981 Recruiting and Training Volunteers. New York: McGraw Hill, Inc.

Joralemon, Donald
1999 Exploring Medical Anthropology. Needham Heights, MA: Allyn & Bacon.

Judeo Christian Health Clinic
2006 Judeo Christian Health Clinic. Electronic document, http://www.judeochristianhealthclinic.org/english/index.htm, accessed July 20, 2006.

Kubey, Robert and Mihaly Csikszentmihalyi
2002 Television addiction is no mere metaphor. Scientific American 286:74-80.

Levine, Susan
2003 Documentary Film and HIV/AIDS: New Directions for Applied Visual Anthropology in Southern Africa. Visual Anthropology Review 19(1,2): 57-72.

Lundberg, Mark
2007 Volunteer Health Services Program. Electronic document, http://www.doh.state.fl.us/Tobacco/VHS/archive/Volunteer/default.html, accessed July 12, 2007.

Marshall, Patricia
1992 Research Ethics in Applied Anthropology. IRB: Ethics and Human Research 14(6):1-5.

Okun, Morris, Alicia Barr, and A. Regula Herzog
1998 Motivation to Volunteer by Older Adults: A Test of Competing Measurement Models. Psychology and Aging 13(4):608-621.

المنارة للاستشارات
www.manaraa.com

Phillips, Margaret, Emily Mark, and Laurie Chandler
2001 Master Volunteer Resource Guide. Electronic document, http://www.oznet.ksu.edu/library/famlf2/ep72.pdf, accessed August 1, 2007.

Pidgeon Jr, Walter P
1998 The Universal Benefits of Volunteering: A Practical Workbook for Nonprofit Organizations, Volunteers, and Corporations. New York: John Wiley & Sons, Inc.

Pink, Sarah
2004 Applied Visual Anthropology Social Intervention, Visual Methodologies and Anthropology Theory. Visual Anthropology Review 20(1):3-16.

2006 The Practice of Anthropology in Great Britain. National Association for the Practice of Anthropology Bulletin 25(1):123-133.

Piliavin, Jane and Hong-Wen Charng
1990 Altriusm: A Review of Recent Theory and Research. Annual Review of Sociology 16:27-65.

Ransom, John S.
1997 Foucault's Discipline: The Politics of Subjectivity. Durham and London: Duke University Press.

Rich, Michael and Richard Chalfen
1999 Showing and Telling Asthma: Children teaching physicians with visual narrative. Visual Sociology 14:51-71.

Runquist, Lisa and Judy Zybach
1997 Volunteer Protection Act of 1997 – An Imperfect Solution. Electronic document, http://www.runquist.com/article_vol_protect.htm, accessed July 12, 2007.

Schensul, Stephen, Jean Schensul, and Margaret LeCompte
1999 Essential Ethnographic Methods: Observations, Interviews, and Questionnaires. Walnut Creek, CA: AltaMira Press.

Shapiro, Howard
2003 Providing Charity Care: A Primer on Liability Risk. Family Practice Management 10(1):52-54.

Singer, Merrill
1995 Beyond the Ivorty Tower: Critical Praxis in Medical Anthropology. Medical Anthropology Quarterly 9(1):80-106.

المنارة للاستشارات
www.manaraa.com

Smith, Gregory
2006 Erving Goffman. New York: Routledge.

Stadhams, Dianne
2004 Look to Learn a Role for Visual Ethnography in the Elimination of Poverty. Visual Anthropology Review 20(1): 45-58.

Studdert, David, Michelle Mello, and Troyen Brennen
2004 Medical Malpractice: Health Policy Report. New England Journal of Medicine 350(3): 283-292.

The Florida Senate
2007 The 2006 Florida Statutes. Electronic document, http://www.flsenate.gov/Statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=Ch0768/SEC1355.HTM&Title=->2006->Ch0768->Section%201355#0768.1355, accessed July 28, 2007.

U.S. Bureau of Labor Statistics
2005 Volunteering in the United States. Electronic document, http://www.bls.gov/news.release/archives/volun_12092005.pdf, accessed July 25, 2007.

U.S. Department of Health and Human Services
2006 Poverty Level Guidelines. Electronic document, http://www.cms.hhs.gov/MedicaidEligibility/downloads/POV06ALL.pdf, accessed July 20, 2007.

USF, Department of Anthropology
2006 USF, Department of Anthropology. Electronic document, http://web3.cas.usf.edu/main/depts/ANT/, accessed October 15, 2006.

Volunteer Health Services Program
2007 Volunteer Health Services Program. Electronic document, http://www.doh.state.fl.us/Tobacco/VHS/archive/Volunteer/default.html, accessed July 28, 2007.

Warneken, Felix and Michael Tomasello
2006 Altruistic Helping in Human Infants and Young Chimpanzees. Science 311: 1301-1303.

Whitt, William
2006 Age-Related Differences in Public Library Volunteers' Motivations for Volunteering. M.S. Thesis, University of North Carolina.

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Appendices

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Appendix A: Poverty Level Guidelines

2006 POVERTY LEVEL GUIDELINES
ALL STATES (EXCEPT ALASKA AND HAWAII) AND DC

Income Guidelines as Published in the Federal Register on January 24, 2006
Federal Register Vol. 71, Number 15, Page 3848-3849

ANNUAL GUIDELINES

FAMILY SIZE	100% POVERTY*	120%	133%	150%	170%	175%	185%	190%	200%	250%	300%	400%	450%
1	9,800.00	11,760.00	13,034.00	14,700.00	16,660.00	17,150.00	18,130.00	18,620.00	19,600.00	24,500.00	29,400.00	39,200.00	44,100.00
2	13,200.00	15,840.00	17,556.00	19,800.00	22,440.00	23,100.00	24,420.00	25,080.00	26,400.00	33,000.00	39,600.00	52,800.00	59,400.00
3	16,600.00	19,920.00	22,078.00	24,900.00	28,220.00	29,050.00	30,710.00	31,540.00	33,200.00	41,500.00	49,800.00	66,400.00	74,700.00
4	20,000.00	24,000.00	26,600.00	30,000.00	34,000.00	35,000.00	37,000.00	38,000.00	40,000.00	50,000.00	60,000.00	80,000.00	90,000.00
5	23,400.00	28,080.00	31,122.00	35,100.00	39,780.00	40,950.00	43,290.00	44,460.00	46,800.00	58,500.00	70,200.00	93,600.00	105,300.00
6	26,800.00	32,160.00	35,644.00	40,200.00	45,560.00	46,900.00	49,580.00	50,920.00	53,600.00	67,000.00	80,400.00	107,200.00	120,600.00
7	30,200.00	36,240.00	40,166.00	45,300.00	51,340.00	52,850.00	55,870.00	57,380.00	60,400.00	75,500.00	90,600.00	120,800.00	135,900.00
8	33,600.00	40,320.00	44,688.00	50,400.00	57,120.00	58,800.00	62,160.00	63,840.00	67,200.00	84,000.00	100,800.00	134,400.00	151,200.00

*For family units of more than 8 members, add $3,400 for each additional member

MONTHLY GUIDELINES

FAMILY SIZE	100% POVERTY	120%	133%	150%	170%	175%	185%	190%	200%	250%	300%	400%	450%
1	816.67	980.00	1,086.17	1,225.00	1,388.33	1,429.17	1,510.83	1,551.67	1,633.33	2,041.67	2,450.00	3,266.67	3,675.00
2	1,100.00	1,320.00	1,463.00	1,650.00	1,870.00	1,925.00	2,035.00	2,090.00	2,200.00	2,750.00	3,300.00	4,400.00	4,950.00
3	1,383.33	1,660.00	1,839.83	2,075.00	2,351.67	2,420.83	2,559.17	2,628.33	2,766.67	3,458.33	4,150.00	5,533.33	6,225.00
4	1,666.67	2,000.00	2,216.67	2,500.00	2,833.33	2,916.67	3,083.33	3,166.67	3,333.33	4,166.67	5,000.00	6,666.67	7,500.00
5	1,950.00	2,340.00	2,593.50	2,925.00	3,315.00	3,412.50	3,607.50	3,705.00	3,900.00	4,875.00	5,850.00	7,800.00	8,775.00
6	2,233.33	2,680.00	2,970.33	3,350.00	3,796.67	3,908.33	4,131.67	4,243.33	4,466.67	5,583.33	6,700.00	8,933.33	10,050.00
7	2,516.67	3,020.00	3,347.17	3,775.00	4,278.33	4,404.17	4,655.83	4,781.67	5,033.33	6,291.67	7,550.00	10,066.67	11,325.00
8	2,800.00	3,360.00	3,724.00	4,200.00	4,760.00	4,900.00	5,180.00	5,320.00	5,600.00	7,000.00	8,400.00	11,200.00	12,600.00

Ref: Federal Register: January 24, 2006 Volume 71, Number 15, Page 3848-3849

Figure 1. 2006 Poverty Level Guidelines. (U.S. Department of Health and Human Services 2006)

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Appendix B: Physician Interview Guide

Question Sets:

Descriptive:

Tell me your name and your specialty.
Tell me your length of volunteer service.
Can you tell me what kind of patients you see when you volunteer as a (insert specialty) and what it is like to be a volunteer (insert specialty).

Antecedents to volunteering.

1) How did you begin volunteering? Tell us about the impetus (the factors that initially caused you) to your volunteering.
2) Have any previous events in your life influenced you to volunteer?
3) What caused you to specifically choose to volunteer here, at the Judeo Christian Health Clinic?

Experiences in volunteering:

4) Why do you volunteer your time as a doctor? Why is this important to you? What sustains your volunteering here? Why do you continue to volunteer?
5) If you could only give me one reason, the most important reason, as to why you volunteer, what would it be?
6) Tell me what it is like volunteering here at the JCHC.
7) What is it like to see patients as a volunteer physician?
8) To give me a specific, real example, one we can visualize, tell me of a specific interaction or event as a volunteer in which you think encapsulates what it is like to be a volunteer physician. Or a rewarding experience as a volunteer physician.
9) How do your efforts, as a volunteer health care provider, benefit the clients of the clinic?
10) How do they (your efforts) affect our community/society?

Consequences in Volunteering:

11) What do you think are barriers for you to volunteer your time? Tell me of a specific event in which you experienced a barrier to volunteering.
12) What is your biggest concern about volunteering as a physician?
13) Are there any negative consequences or risks to volunteering as a doctor? What are they?
14) What do you think are barriers for doctors generally in volunteering?

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Appendix B (Continued)

14.2) Do you have any recommendations to reduce these barriers?

15) What do you think are the greatest *perceived* barriers for doctors that do not volunteer?

16) What would you do, or say, to assuage these fears of fellow physicians?

17) Tell me about any rewards/benefits (personal or otherwise) to volunteering as a doctor.

18) How do the rewards compare to the negative consequences, in your opinion?

18-2 As a current volunteer, why do the benefits of volunteering outweigh the risks/concerns in your specific situation?

19) Would you recommend volunteering at this clinic to other physicians? If so, How would you influence other physicians to volunteer here? What are the specific reasons you would expand upon?

20) If you were in charge of recruiting doctors to volunteer their time, how would you do so? What procedures would be most effective?

21) In your opinion, what are the advantages & disadvantages in the name “Judeo Christian” in recruiting physicians? Do you know any colleagues of yours that do not feel comfortable due to the name of the clinic?

21.2) How does the name affect you, if at all? How do you think it affects the clients?

22) Is there anything that you would like to mention that we have left out?

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Appendix C: Survey for Free Clinic Volunteer Physicians

Part 1: Descriptive Statistical Information (7 Questions)
All data will be aggregated.

1. How many hours a week do you work at your regular job?
2. How many hours a week do you volunteer at the free clinic?
3. How long have you been volunteering at the free clinic?
4. Are you currently retired or not retired?
5. Please list your age.
6. Please list your gender.
7. What is your medical specialty/medical field?

Part 2: Volunteer Functions Inventory
This is a quick-to-answer 30 question assessment. This should take no more than 5-6 minutes. Please answer all of the questions. No individual identifiable information will be used. All data will be aggregated.

Indicate how important or accurate each of the following reasons for volunteering are for you in doing volunteer work. Please list on a sliding scale from 1 to 7 (1 – Not at all important/accurate 7 – Extremely important/accurate) how important each of these reasons are to you

1. Volunteering can help me to get my foot in the door at a place where I would like to work.
2. My friends volunteer.
3. I am concerned about those less fortunate than myself.
4. People I am close to want me to volunteer.
5. Volunteering makes me feel important.
6. People I know share an interest in community service.
7. No matter how bad I have been feeling, volunteering helps me to forget about it.
8. I am genuinely concerned about the particular group I am serving.
9. By volunteering I feel less lonely
10. I can make new contacts that might help my business or career.
11. Doing volunteer work relieves me of some of the guilt over being more fortunate than others.
12. I can learn more about the cause for which I am working.
13. Volunteering increases my self-esteem.
14. Volunteering allows me to gain a new perspective on things.
15. Volunteering allows me to explore different career options.

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Appendix C (Continued)

16. I feel compassion towards people in need.
17. Others with whom I am close place a high value on community service.
18. Volunteering lets me learn things through direct, hands-on experience.
19. I feel it is important to help others.
20. Volunteering helps me work through my own personal problems.
21. Volunteering will help me to succeed in my chosen profession.
22. I can do something for a cause that is important to me.
23. Volunteering is an important activity to the people I know best.
24. Volunteering is a good escape from my own troubles.
25. I can learn how to deal with a variety of people.
26. Volunteering makes me feel needed.
27. Volunteering makes me feel better about myself.
28. Volunteering experience will look good on my resume.
29. Volunteering is a way to make new friends.
30. I can explore my own strengths.

Would you like to participate in an in-depth videotaped interview (15-20 minutes) regarding your work at the Judeo Christian Health Clinic?

This would be helpful for this research study and for the clinic. An edited video will be created to help the JCHC communicate the work being done at the clinic and recruit prospective volunteer physicians.

If you answer yes, please provide contact information below. The executive director of the clinic will contact you when we begin this phase of the project. Most interviews will be performed at the clinic and will be arranged to best fit your schedule.

We will also be conducting videotaped shadowing sessions after the interviews. This will be used to add "B-roll" or "action" footage to the video. Participants may choose to participate in the videotaped interview but not the shadowing session. Both the interview and shadowing session are completely voluntary.

End of Survey

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