The secretary in general practice

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IN HOLLAND SINCE 1947 THERE have been courses for the training of 'doctors' assistants'. These are mainly for girls aged 18, and are run by the equivalent of our technical or commerical colleges. The period of training lasts from nine months to two years, and the courses cover three main subjects; first, administration, typing, patient record cards and medical terminology; second, theoretical medicine, which includes the principles of health and disease and a knowledge of medical ethics; and lastly, practical medicine, incorporating at least 26 hours in bandaging and first aid, and a training in urine testing, microscopy, injections and the preparation of instruments. When qualified, this 'doctor's assistant' can be involved in a large part of the Dutch general practitioner's daily work, using this training (Forman 1967, ten Cate 1966).

Britain has lagged behind in this field. Only in 1963 were training courses for medical secretaries first planned at Bromsgrove in Worcestershire and Eastleigh in Hampshire, finally coming to fruition in 1964. This development led to the formation in the same year, of the Association of Medical Secretaries, and was the first attempt in this country to establish formal channels through which a girl could pass to become a medical secretary (Drury, 1966).

When the Review Body on Doctors' and Dentists' Remuneration reported in 1966, it recommended that up to 70 per cent of expenditure on practice ancillary staff be reimbursed to the doctor. This incentive created a demand for medical secretaries, but unfortunately not nearly enough trained medical secretaries were available to meet the demand. The Review Body's Report had come too soon after the formation of the Association of Medical Secretaries to make the work of the Association have any significant effect at that time.

Training in North-east Scotland

"There are many interesting and well-remunerated secretarial posts in the hospital and related medical services for young women of integrity and intelligence. The work is often of a highly-confidential nature, and demands a sympathetic understanding of human nature. Medical secretaries have to exercise a considerable amount of initiative, and must have a high degree of organizing ability, but to the young woman who has these qualities there are few jobs which are more satisfying." This quotation is the preamble to the medical secretaries' course at the Aberdeen College of Commerce, which has run four-term courses for the medial secretary since 1964. For this course to qualify the student for the Association of Medical Secretaries Diploma, three criteria need to be satisfied:

1. A local advisory committee containing representatives of the local medical committee, local hospital authority and local health authority must be set up by the college.
2. Each college must demonstrate a local need for such a course.
3. The college must show that it has the necessary staff (including visiting lecturers) to provide the training.

The last two medical secretaries courses at Aberdeen have enrolled 28 and 39 students. The course run by the local Commercial College does not yet qualify the student for the diploma of the Association, but the reasons for this appear to be only technical, and a solution is on the way.

Apart from its work for the recruit to medical secretary work, the college last winter ran an evening course of 20 sessions for existing medical secretaries, which was well received.

About 20 secretaries attended, and the course covered anatomy, medical terms, audio-typing, shorthand, office procedure and a visit to the local hospital records office.

Early this year an enthusiastic group of medical secretaries in and around Aberdeen drew up an educational programme of lectures for medical secretaries. At the same time they took the first steps to form a North-east Scotland Branch of the Association of Medical Secretaries. Also a questionnaire was sent to all medical secretaries in general practice in the area, i.e. the city of Aberdeen, and the counties of Aberdeen and Kincardine. The analysis of replies suggests that the questionnaire proved to be a worthwhile assessment of the effect of the Review Body's recommendations.

Method

One-hundred and eighty-seven doctors were known to practise in the area, and 73 per cent employed medical secretaries. This did not, of course, include those doctors whose wives acted as secretaries in their practice. Although there were seven fewer doctors in the counties than in the city of Aberdeen, they employed seven more secretaries; it would be unwise to read too much into this, but one possible interpretation is that the rural practitioner is more interested in the organization of his work. From a list of doctors supplied by the respective executive councils, questionnaires were sent to the senior doctor in the practice for distribution to their staff. With each questionnaire went a letter explaining the aims of the survey. It was emphasized that the questionnaire was anonymous, and that the doctors should give their permission before the secretary replied. Of the 137 questionnaires sent out, 79 were returned, i.e. 54 per cent response. With such a response the probability of bias is considerable but at least the response was about evenly divided between town and county.

Results

Only two of the replies showed that medical secretaries' courses had been taken, and only one held the diploma of the Association of Medical Secretaries. The association asks that application for associateship, which would in time lead to membership, only come from those with two year's experience in practice. The questionnaire showed that 55 per cent of the secretaries had been in employment for less than two years.

Background to employment

Table I shows the age distribution of the secretaries, and it can be seen that most are aged between 30 and 50.

TABLE I

AGE DISTRIBUTION

AGE	<20	21—30	31—40	41—50	51—60	60+
Numbers	8	14	24	22	7	7

Forty-six were married, six are widows and 27 single.

Mature women aged 30–50, possibly with families of their own, seem to be preferred by the doctors in the area. The doctor may see in her an extension of his own image who would be sympathetic to the anxious caller? Perhaps such women were the main applicants for this work. Only more detailed study could answer such questions.

Thirty seven were selected in response to advertisements, 42 by personal contact, for two the method of selection was unspecified. This suggests that the doctor has looked for a particular type of personality. Many of the secretaries were probably patients of the employing doctor.

Table II shows the secretaries' previous employment experience (only two had completed medical secretaries' courses).

TABLE II
PREVIOUS EXPERIENCE

Previous experience	Secretarial (incl. typing)	Receptionist	Nursing	Other	Nil
Number	53	19	9	23	3

Few doctors seemed to be aware of the association's existence. This will change with time. Will reimbursement of secretaries ever be related to qualifications and experience?

There were 67 per cent with previous secretarial experience, but it is not certain that this was of value to them in general practice. Although nine had previous nursing experience, only three were using these professional skills. Of those who had 'other experience', this ranged from clerk to shop assistant, telephonist to hotel manageress and from teacher to rent collector: 29 per cent of women fell into this category, suggesting that some doctors were looking for something other than secretarial skills. Perhaps this only reflects the small number of people properly trained for the job. Until the rôle of the secretary in general practice is more clearly defined, and until the effect of the work of the Association of Medical Secretaries is more widely felt, this pattern is likely to continue.

Source of training. Thirty three (42 per cent) of the secretaries had come to the job as the first secretary in the practice, and had developed their own routine and organization methods. Twenty one had been helped by the doctor and 35 by another secretary in the group. In other words, training in the practice was informal. Had the fact that the secretary spent most of her time in contact with the patient been taken into account during her training in the practice?

Years of experience. The effect of Review Body's Report in 1966 is shown by the fact that 44 (55 per cent) had less than 2 years' experience (17 less than one year). If by 1970 the association will accept for membership only those with the diploma, some of the 55 per cent may find it difficult to become associates of the Association before the end of the year (if 2 years' experience is the minimum qualification).

Attendance at and interest in courses. Most of the 35 (44 per cent) who had attended courses probably referred to attendance at courses run by the Executive Councils of the City of Aberdeen and Counties of Aberdeen and Kincardine. These two courses were held in the executive council offices on a Sunday and the subjects discussed were executive council administration and how it affected general practice. Had the question "Would you attend courses?" been more explicit and perhaps read "Would you attend a day course evening lecture or a series of lectures?", more than 46 (56 per cent) might have responded "yes".

TABLE III
HOURS WORKED

Hours worked	< 10	11—20	21—30	31—40	> 40	No return
Number	4	13	27	31	2	2

Hours worked. Table III shows that most worked between 20 and 40 hours per week. Four worked for less than ten hours per week. Do these figures suggest that perhaps some doctors are not sure how to employ their secretaries in their practice?

Main secretarial duties. How did the secretary spend her time in the practice? Five main activities were looked at: (1) handling records (2) answering 'phone (3) typing (4) handling prescriptions and (5) reception of patients.

The secretary was asked to try and estimate how many hours per week she spent on these duties. The activity which took up most time was reception of patients and the least time was spent on typing.

The following diagrams represent a breakdown of the figures:

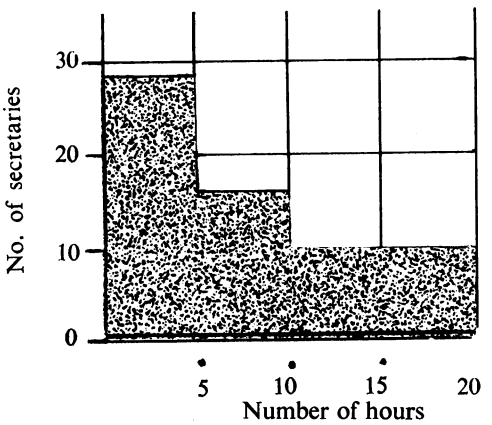

Figure 1 Handling Records

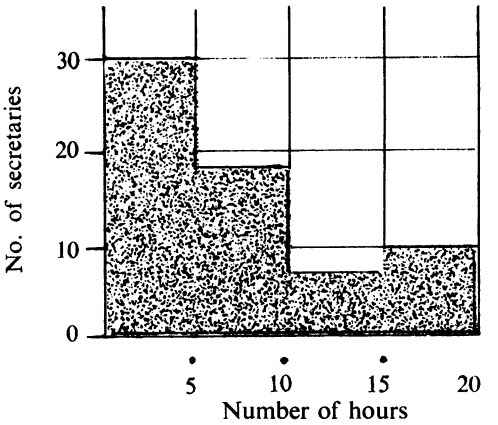

Figure 2 Answering Telephone

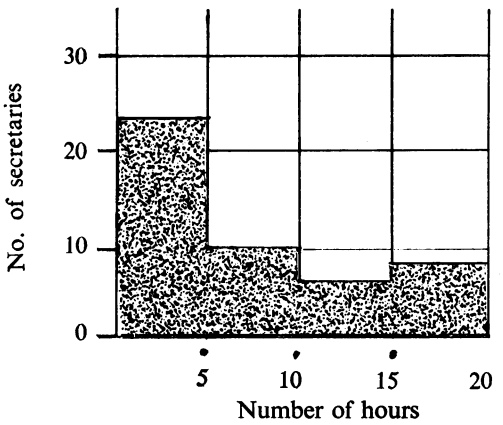

Figure 3 Typing

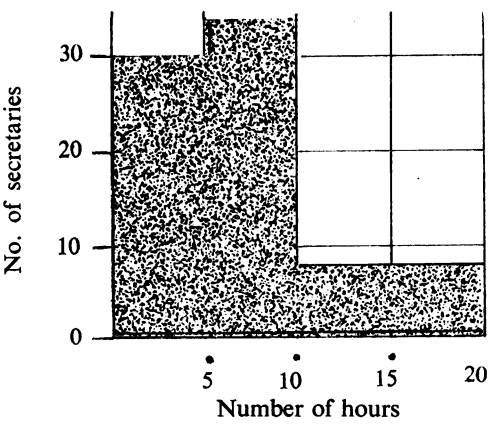

Figure 4 Reception of patients

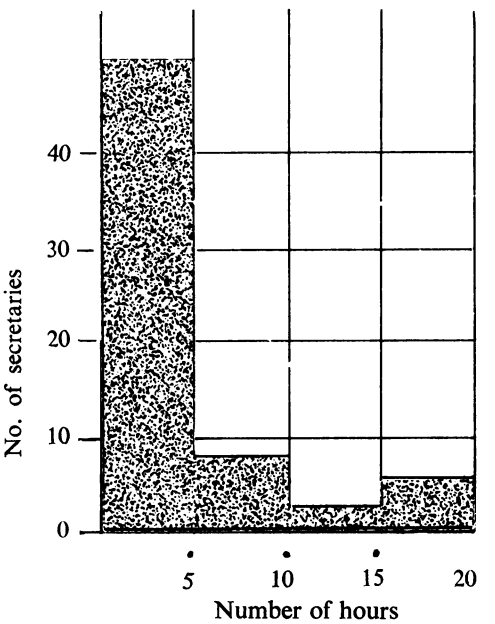

Figure 5 Handling Prescriptions

Of the answers to this question, 13 per cent were incomplete, and invariably the comment made was "impossible to estimate". Of the questionnaires returned only two were typed.

Have we as employers spent enough time with our secretaries explaining how to deal with the anxious patient, the angry patient or the awkward patient? Many secretaries expressed anxiety about these situations. Patient contact gave the secretary high work-satisfaction, but

also gave rise to frustration. We must clearly define the aims and objectives of our practices to our secretaries, enabling them to express these ideals to the patient, thus showing her rôle in the practice to be constructive.

Other duties. Table IV shows the part played by the secretary in other duties. It is surprising that more did not play a part in executive council work, as the questionnaire clearly gave examples, such as immunization and other claim forms. In group practice perhaps a particular secretary is earmarked for this duty. Thirty per cent of secretaries were allowed to calculate salaries. Fifteen per cent of secretaries were used to check urines and read haemoglobins. In small practices this may be reasonable, but in larger groups, the rôle of practice nurse and practice secretary must be clearly defined. Eleven per cent of the secretaries said they were involved in research. Although not more clearly defined, perhaps there are a few secretaries who might be willing to take part in a more intensive study of the rôle of secretary in general practice.

TABLE IV
OTHER DUTIES

Other duties	Executive council	Salaries	P.A.Y.E.	Nursing duties	Lab. procedures	Antenatal clinics	Research
Number	49	24	22	3	12	26	9

Secretaries' likes and dislikes

The opportunity for free expression gave rise to some interesting comments from the secretaries.

Likes (in order of frequency)
1. Contact with patient
2. "Everything about the work"
3. Answering telephone

Dislikes (in order of frequency)
1. Awkward patients
2. Filing
3. Answering telephone and coping with patient at reception simultaneously.

It can be seen that five out of the six answers involve patient contact. With this in mind, the secretary must clearly understand the aims and attitudes of the doctor to his patients. He, in turn, must clearly define these, and at the same time listen to the information his secretary has about his patients. Could it be that the secretaries who did not enjoy filing failed to appreciate the value of this work in the quality of care given to the patients in the practice?

A high level of work satisfaction ran through the answers to this section. Some secretaries expressed rather unusual likes, for example, "dealing with emergencies", "getting to know medical terms", and "making up visiting lists". Most of the dislikes centred round the awkward patient, for example, "trying to fit patients in when no appointments available". This might be an avoidable situation if six hours of appointments per week are available for every 1,000 patients on the doctor's list. Some of the dislikes expressed seemed to have caught the secretary on a bad day, for example, "being stopped in the street by patients, and being asked about other patients, and having to tell deliberate lies".

Future

Two bodies hold the key to changes for the future. First, the Association of Medical Secretaries and, secondly, the local technical or commercial colleges. Before either of these can function effectively, more work needs to be done on defining the rôle of the medical secretary, a rôle which, like everything in medicine, will continue to change in the future.

As far as the recruit to medical secretary work is concerned, apart from her educational qualifications, her personality must clearly be taken into account, especially if she is likely to work in general practice. The syllabus for her training will stem mainly from the criteria laid down by the association. Those criteria will be implemented by the local commercial or technical colleges, who must have the support of their medical colleagues. At present most of the

girls who finish a medical secretary's course find their way into hospital. Perhaps a better career structure in general practice and a clearer image of the importance and satisfaction of the job will attract more into that branch of the service.

The continuing education of the established medical secretary also requires planning. At local level the establishment of branches of the Association of Medical Secretaries can act as a stimulus. Their educational programmes will go far to meet the need, if only to bring the secretaries together as a group. Again, co-operation with local colleges is necessary to establish evening courses, day-release lectures or planned courses extending over longer periods.

Much remains to be learned about this rapidly emerging new profession—it is hoped that this paper will act as a spur to others to research into its needs and how they can be met.

Summary

The background to the medical secretary is discussed. The results of a questionnaire sent to medical secretaries in general practice in North-east Scotland are described. Hopes for the future are expressed.

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PERSONAL POINTS OF VIEW

A good diagnosis

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THE ADVENT OF THE COMPUTER into medicine has resulted in a growing number of people re-examining the nature of medicine, and the nature of the terms used by its practitioners, especially the term diagnosis. Until the word diagnosis is defined one cannot examine logically the paths used to reach it, and this is an area where the computer might help us. Unfortunately diagnosis is a word used rather differently in the context of different clinical situations. A dictionary definition (Chambers) is "the identification of a disease by its symptoms; a formal determining description". Clearly we mean by diagnosis the identification of a disease and, as Scadding points out, the first of our difficulties has now been identified, that of defining a disease. A second difficulty lies in labelling the disease so defined.

The concept of health varies with culture and time, and so *pari passu* does the concept of disease. Even in a defined setting there may be no universality of opinion as to whether a disease is present.

Scadding's formal definition of 'disease' runs: "A disease is the sum of the abnormal phenomena displayed by a group of living organisms in association with a specified common characteristic, or set of characteristics by which they differ from the norm of their species in such a way as to place them at a biological disadvantage". Particularly in the absence of signs