A broader training for medical receptionists

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SUMMARY. A course for 40 medical receptionists working in general practice was arranged at a local postgraduate centre. The curriculum was divided into two sections. The first dealt with the traditional, factual side of medical reception work and the second was concerned with the human behaviour aspect of a receptionist's work. It seems that there was some benefit to the receptionists from their experience of both aspects of this course.

Introduction

AT the 1978 Symposium held in association with the Annual General Meeting of the Royal College of General Practitioners (*Journal of the Royal College of General Practitioners,* 1979), Mrs Sandra Kilby, a practice manager, drew attention to the poor level of training and support most receptionists receive from their practices. She highlighted the lack of communication between the receptionist and the doctor, lack of knowledge and communication skills by receptionists, and poor pay and conditions of work. In response to these criticisms, it was decided to run a course that would have both a traditional and a human behaviour content. Reports on previous courses for medical receptionists have concentrated on factual curricula (Anderson, 1976), though Cotter's (1978) description of his course emphasized the dual aspect of the receptionist's role.

Aims

The aims of the course were to help each receptionist to appreciate her role as the person of first contact, her place in the primary care team, and the confidential nature of her work. In addition, it was hoped that the course would help her to understand and perhaps cope better with anxious and angry people. An additional aim was to encourage her to communicate not only within the practice but with her local colleagues.

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Method

Details of the course were circulated to all the practices in the Reading area. From over 100 applications, 40 receptionists were invited to attend. It was decided that the course should consist of six two-hour evening sessions. Each was divided into two parts.

The first hour used the traditional, factual approach of a short presentation designed to encourage group discussion and to promote the exchange of useful, factual and practical information. The topics in these sessions were as follows:

1. Receptionist's role and function

General discussion followed a brief outline by a doctor of the variety and scope of a receptionist's job.

2. Medical ethics and confidentiality

The confidential nature of a receptionist's work was defined and emphasized and areas where breaches of confidentiality could occur were explored, using examples drawn from members' own experiences.

3. Appointment systems

This session illustrated different methods for managing appointment systems which included sequential booking, limited block booking, and release block booking. The strengths and weaknesses of each system were discussed.

4. Use of the telephone

The GPO supplied a stimulating film with a speaker who advised on the most effective telephone techniques and the range of equipment currently available.

5. Dealing with requests for visits and advice

Methods for dealing with requests for visits and advice were discussed and emphasis placed on the importance of individual practices defining their own procedures for their reception staff.

6. Primary health care team

A district nurse, health visitor, dispenser, and treatment room nurse each gave a short talk about their role and their needs and expectations of receptionists. In addition, the dispenser advised on the most efficient method for dealing with repeat prescriptions.

7. Contracts of employment and salary scales

This covered the law relating to contracts and the Employment Protection Act of 1975. The Guild of Medical Secretaries' recommended salary scales and a sample contract were circulated as a basis for discussion.

8. Structure of the National Health Service

A simplified guide to the working of the National Health Service was presented, with an explanation of the various tiers of authority and the interrelationship of the different branches of the Health Service.

The second half of each session dealt with the behavioural aspect of the receptionist's work.

1. Transactional analysis

An introduction to the psychological theory of transactional analysis was presented in short lecture form with visual illustrations of the important aspects of the theory as outlined by Harris (1967). The receptionists were then divided into small groups to play a game, designed by a counsellor colleague (S. Turner, personal communication), which gives personal experience and practice in using the concepts outlined in the theory.

2. Conflicts in the role of the receptionist

This session began with a short dramatic presentation of a typical scene at the reception desk in order to highlight some of the difficulties experienced by a receptionist when trying to meet the needs of both patients and doctors. The situation was role-played by trainee counsellors and some audio effects were used to heighten the sense of reality. The scene was then analysed in terms of the concepts of transactional analysis.

This session was planned to show the receptionists that the organizers understood some of the difficulties they experienced in their work and also to encourage a more open discussion of the problems of dealing with patients and other members of staff.

3. Communication skills

This session began with the course participants pairing off and doing trust walk encounter exercises to encourage individual participation and communication (Johnson, 1972). These exercises illustrate how vulnerable and frightened a person becomes when he is sick or disabled. They also show how dependent a patient can become upon the skills of his or her helper, whether this is a doctor, a nurse or a receptionist.

The course members then divided into small groups for a simulated experience of being in various types of working organizations. The different examples of organizational structure included the hierarchical, autocratic, and democratic methods of working. (The experience of being within these varied groups can show how communication can be affected by the organizational structure.)

4. Coping with aggressive and anxious people

In this session, the course organizers themselves role-played a variety of imaginary situations chosen to illustrate difficult personal interactions between patients and/or staff. It was agreed that the roles taken should be unfamiliar ones and so, for example, a doctor played a receptionist or a patient. It was hoped that this experience of changing professional roles or being in an unusual situation would lead to an increase in insight and understanding of other people's difficulties. After each role-play the participants told the audience how they had felt and explained their attitudes and feelings to the other people involved in the action. The communications were analysed within the concepts of transactional analysis and different ways of coping with the situation were outlined in a general discussion.

In a later session, some of the receptionists felt able to role play some of their own experiences in a similar form.

Course questionnaire

At the beginning of the course, the receptionists completed a questionnaire designed to find out which they felt were the important features of an ideal practice, an ideal employer, an ideal receptionist, and an ideal patient. Of 10 characteristics they were asked to select three and place them in order of importance. They were also asked to select their own best and worst qualities affecting their work as receptionists and to give three examples of the best and the worst characteristics of their working situation.

At the end of the course, the questionnaire was completed again with an additional section asking how long each member had worked as a receptionist, how she assessed the most useful items on the course, and whether she felt there had been any important omissions from the course, and whether any changes were being made in her work as a result of the course. Finally, the questionnaire asked whether or not members would be interested in attending or helping organize future courses or forming a local receptionists' professional association.

It was hoped that the questionnaire would encourage the receptionists to look at themselves and their work environment in a practical, realistic, and constructive way.

Results

The attendance rate of the 40 original course members

Table 1. Ideal characteristics.

	Pre-course rating	Post-course rating	Changes
The ideal practice	*1st: Pleasant atmosphere 2nd: Support by other staff 3rd: Efficiency	1st: Efficiency 2nd: Pleasant atmosphere	Rise in the rating of efficiency
The ideal employer or manager	*1st: Approachability 2nd: Professionally competent 3rd: Reliability	1st: Approachability 2nd: Professionally competent 3rd: Reliability	No change
The ideal receptionist	*1st: Pleasant manner 2nd: Discretion 3rd: Reliability	1st: Discretion 2nd: Pleasant manner 3rd: Efficiency	Rise in the rating of discretion and efficiency
The ideal patient	*1st: Punctual 2nd: Reasonable 3rd: Co-operative	1st: Punctual 2nd: Reasonable 3rd: Co-operative	No change

*Rated most highly.

Table 2. Self-assessment and assessment of own working situation.

Question	Pre-course rating	Post-course rating	Change
Self-assessment of good qualities	1st: Tolerant 2nd: Efficient 3rd: Courteous	1st: Tolerant 2nd: Pleasant manner 3rd: Helpful	Drop in rating of efficiency
Self-assessment of worst qualities	1st: Intolerant 2nd: Exasperation 3rd: Inexperience	1st: Inexperience 2nd: Careless 3rd: Intolerance/panic	Rise in rating of inexperience
Assessment of good aspects of own working situation	1st: Friendly staff/ good atmosphere 2nd: Staff support 3rd: Efficiency	1st: Friendly staff/ good atmosphere 2nd: Efficiency 3rd: Staff support	Slight rise in rating of efficiency
Assessment of worst aspects of own working situation	1st: Poor facilities 2nd: Insufficient appointments 3rd: Poor administration	1st: Poor facilities 2nd: Insufficient appointments 3rd: Abuse/bad language	Appearance of abuse/ bad language

was high: an average of 36 attended each session. It was found that the average number of years of experience of medical reception work was four and a half, within a range of two months to 18 years.

The pre-course questionnaire was completed by 39 receptionists and the post-course questionnaire by 37. The results of the first four questions enquiring about the ideal characteristics of people and their working situations are shown in Table 1. It seems that only efficiency was rated overall more highly in the post-course questionnaire. The ideal characteristics of a receptionist as reported by Williams and Dajda (1979) are comparable to those rated most highly by the receptionists on the course.

Table 2 shows that there were no marked changes in the receptionists' assessment of themselves and their practices between the pre-course and post-course questionnaires. There appears to be a slight drop in their assessment of their own efficiency and a slight rise in their assessment of the efficiency of their own practice.

Table 3. Course assessment (listed in order of preference).

Rating	Most useful sessions	Rating	Omissions
1st	Transactional analysis and role play	1st	First aid
2nd	Primary health care team	2nd	Medical information
3rd	Telephone technique	3rd	Family practitioner committee

Table 3 shows the results of the receptionists' assessment of the content and omissions of the course. They rated the sessions on transactional analysis and role play and the primary health care team as equally valuable. The term 'medical information' was used to cover a wide variety of requests for basic medical knowledge, which ranged from the incubation periods

Table 4. Changes as a result of the course (listed in order of frequency).

Frequency	Changes	Projected changes
1st	Insight and understanding	Staff meetings
	Staff meetings with doctors and health visitors	Better salaries
3rd	Prescription writing	Better facilities

of infectious diseases to understanding the results of pathological tests. Table 4 shows the responses to the questions about the possible changes in the receptionist's own work or that of her practice occurring as a result of the course. The development of insight and understanding was the most frequently mentioned change.

The majority (27) of the receptionists were interested in attending future courses and half (18) expressed interest in establishing a local receptionists' group. A few (5) were willing to help in the running of subsequent courses.

Discussion

It was encouraging to see that, despite the fact that the course was held in the evening, the attendance rate was high. The organizers were impressed by the receptionists' willingness to learn, their intense pride in their job, and their loyalty to their own practices. There was lively and intelligent participation in the open discussions.

It emerged from the session on the role of the receptionist that there was a wide diversity of tasks required of a receptionist by individual practices. Confidentiality was a topic that evoked much interest. There seemed to be marked variation between practices in the attitude to confidential information. Some receptionists were permitted to give clinical information directly to patients, while others had to refer all enquiries to a doctor. In many practices there seemed to be a shortage of appointment time. This was not helped by an inflexible response from the doctors.

The session on telephone technique was instructive and several receptionists arranged for a GPO representative to come to their own practice to advise on improvements in the practice telephone system.

The discussion on dealing with requests for home visits and advice exposed the dilemma for the receptionist, who may be caught between a doctor's reluctance to visit a patient at home and her inability to make an accurate assessment of the clinical needs of the patient.

A few practices had a reference system to help the receptionist to deal with requests for factual advice or basic medical information, and these were appreciated by those who used them.

It was surprising how little the receptionist knew about the work of other members of the primary health care team. This session may have stimulated the receptionists' interest in general staff meetings in their own practices.

The session on contracts and salary scales was approached with some trepidation by the organizers, who had been warned of an instant growth of militancy and feared a fierce reaction from the receptionists' employers! The scales recommended by the Guild of Medical Secretaries aroused great interest. These scales may answer Mulroy's request for a standard rate of pay (Mulroy, 1974). It was apparent that in this group the majority of the receptionists were being paid less than the recommended rate and none were paid above it. It seems that, with the growth of unionism within health centres, poor pay could be a fertile focus for discontent.

Many of the receptionists were quickly able to understand the basic concepts of transactional analysis and to use them to analyse human behaviour. Their ability was at least equal to other groups of professionals, such as nurses and teachers, who had had a similar teaching programme.

It was interesting to note that respondents to Williams' (1979) questionnaire on the subjects which could be included in a receptionists' course thought human behaviour to be an important topic.

The receptionists were at first shy of taking part in the role plays but when they did, showed both ability and insight. With encouragement, they were able to talk about their feelings and ideas. It seemed that the receptionist is a facilitator: her tolerance, good humour, and commonsense often help her through difficult situations with anxious, angry, or disturbed human beings. However, she may be upset by these experiences and need the support of other members of the practice team. This need is often overlooked. It emerged repeatedly from the discussion that the receptionist is seen as, and feels that she is, a buffer between two groups—the patients and the doctors or other medical professionals. She has to cope with the needs and the demands of both and yet has very little power to influence or change the organization. The receptionist is sometimes considered a safe focus for aggression or anxiety by the patients and the medical staff and it is therefore a position that demands maturity and tolerance and can induce feelings of anxiety and isolation. The receptionists said they had enjoyed meeting others working in a similar situation and that the contact had helped them to put their own work into a better perspective.

The organizers hoped that, as a result of this course, a local receptionists' association would be established. Despite considerable interest at the time, this has not occurred so far.

From the results of the questionnaire, it seems that the course may have increased the receptionists' appreciation of the value of efficiency in their work, in the work of their employer, and in the running of a

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practice. A sad footnote that appeared on several questionnaires, in reply to the question asking for details of projected changes, was "all changes blocked by the doctors". However, it was encouraging to learn that some of the receptionists felt they had developed insight and understanding, and some practical changes such as staff meetings and improved techniques for prescription writing seemed to have begun as a result of the course.

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Minor psychiatric disorders

Recent studies have suggested that psychosocial factors play an important part in the prediction of the course of minor psychiatric disorders. Fifty-nine new psychiatric outpatients suffering from minor disorders were assessed, using standardized clinical and social interviews, and 52 were followed up after one year and the clinical assessment repeated. Social and clinical factors were equally important predictors of the number of months of illness in the survey year, but social and constitutional variables were superior in the prediction of percentage change in symptoms over the year.

The results of correlation, factor and multiple regression analyses suggest that the course of minor psychiatric disorder is best predicted by three sets of variables which are, in order of importance, the patient's material social circumstances, his clinical symptoms, and his 'genetic risk' scores.

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