Changes in receptionists' attitudes towards involvement in a general practice-based trial of screening and brief alcohol intervention

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SUMMARY

Background. *Primary health care receptionists are increasingly expected to be involved in research. However, little is known about receptionists' attitudes to research or health programmes.*

Aim. *To examine changes in receptionists' attitudes, with different levels of training and support, towards involvement in a general practice-based trial of screening and brief alcohol intervention.*

Method*. Subjects were 84 receptionists, one per practice, who assisted in the implementation of a screening and brief alcohol intervention programme. Receptionists were randomly assigned to one of three conditions: control (no training or support), training alone, and training plus ongoing telephone support. Baseline and follow-up questionnaires were used to assess changes in receptionists' attitudes.*

Results. *Of 40 items that measured receptionists' attitudes to involvement in the programme, 70% had deteriorated after three months, 20% significantly so. There was no effect of training and support condition. Receptionists' and GPs' attitudes to research and health programmes conflicted.*

Conclusion. Receptionists developed more negative views about involvement in research and health programmes over the three-month study period, regardless of level of training and support.

Keywords: *practice receptionist; alcohol, health programmes, research, attitudes.*

Introduction

PRIMARY health care receptionists have, to date, been the subjects of little research. Most of what has been published has focused on patients' attitudes towards receptionists, and tends to depict them in negative terms.[1-3] The receptionist is seen as an impediment or barrier to early consultation,[3-6] particularly for young adults and parents with dependent children.[2,4]

Primary health care receptionists are, however, central to the operation of general practice, since they are the intermediaries through whom virtually all contacts with general practitioners (GPs) are made.[2] The receptionist is an important member of the primary health care team,[1] and is involved in a specialised and essential job under circumstances that are often difficult and sometimes unpleasant.[7]

While primary health care receptionists' duties have traditionally included running the appointment system, dealing with requests for home visits and repeat prescriptions, and other administrative tasks,[1] they are increasingly being asked to expand their workload, learn new skills, and take greater responsibility. For example, receptionists have been involved in the triage of patients,[2,4,8,9] decontamination of instruments,[10] basic nursing auxiliary tasks (urine testing, weighing and measuring patients, applying dressings),[8] and general practice audit.[11] More recently, primary health care receptionists have been asked to be involved in research.[12-15] Murphy *et al* have described the role of the receptionist as that of a 'gatekeeper', with the ability to influence research in a positive or negative way depending on their attitudes, beliefs, and practices.[16]

The aim of this study was to examine changes in receptionists' attitudes towards their involvement in a general practice-based trial of a screening and brief alcohol intervention programme in the United Kingdom (UK) and the influence of training and support on these attitudes. The study also compared receptionists' and GPs' attitudes towards the programme. This study was part of the UK arm of Phase III (Strand 3) of the World Health Organisation (WHO) Collaborative Study on Disseminating and Implementing Brief Alcohol Intervention in Primary Health Care.[17]

Method

Subjects were 84 receptionists, one per practice, from the Northern and Yorkshire region, who assisted GPs in implementing 'Drink-Less', a screening and brief alcohol intervention programme (designed in collaboration with receptionists[18]). Receptionists were recruited from the second stage of an earlier randomised controlled trial of strategies to increase dissemination and implementation of brief alcohol intervention on which sample size calculations were based.[19,20] From the pilot and main study original random sample of 785 GPs, one per practice, who were approached by mail marketing, telemarketing, and personal marketing strategies, 354 GPs requested the brief intervention programme and were asked to implement it, and, of these, 141 agreed that they and their receptionists would use it for the three-month study period. Practices were stratified by marketing condition and were randomly allocated to three training and support conditions that consisted of written guidelines only (control), training alone (training), and training plus ongoing telephone support (training plus support).

*Control condition (*n = *47)*

No training or support was offered to receptionists in this condi-

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tion. The programme, which contained written guidelines, was dropped off at reception without demonstration.

*Training condition (*n = *47)*

Receptionists received one session of face-to-face training on how to implement the programme at their practices in this condition. Receptionists received no further support.

*Training plus support condition (*n = *47)*

In this condition, receptionists received one session of face-to-face training on how to implement the programme at their practices, and fortnightly telephone calls to provide support in coping with refusals and negative responses from patients, coping with time constraints and workload, and integrating the programme into normal work routine.

Regardless of training and support condition, receptionists were asked to hand out and explain the alcohol use disorders identification test (AUDIT) to all patients aged 16 years and over attending study GPs. Patients took their completed questionnaire into the consultation where they were advised by the GP if appropriate to take part. Receptionists were also directed to keep a tally of patients who did not complete a questionnaire, place a sticker on the notes of patients who had been screened, and collate carbon-copies of patient screening questionnaires. All receptionists were telephoned two days after programme delivery to confirm data collection procedures. Training and support interventions were carried out by a trained researcher with social sciences background.

Each receptionist was asked to complete a baseline questionnaire, contained within the Drink-Less programme, prior to implementation. A reply-paid envelope was supplied for return of the questionnaire. Follow-up questionnaires were mailed to all receptionists three months after implementation of the programme and were collected during a practice visit at which researchers debriefed the receptionists and provided written feedback on the study.

Questionnaires were developed and piloted by the WHO Collaborative Study Group and are available on request from one of the authors (CAL). Baseline questionnaires collected sociodemographic and employment data and follow-up questionnaires collected feedback on the programme. However, both questionnaires contained a multidimensional attitudinal scale consisting of 40 items on a seven-point Likert scale (with neutral at midpoint) to determine changes in receptionists' attitudes during the course of the programme. The attitudes and beliefs measured in the questionnaire were: interest and involvement in health programmes and research, value of alcohol intervention in general practice, receptionists' perception of their role in the practice, and organisational issues including job involvement and dealing with workload and stress.

General practitioners who implemented the programme also completed baseline and follow-up questionnaires. These data are reported in detail elsewhere;[17] however, some findings from GP questionnaires will be reported here, where they provide a direct contrast with receptionists' attitudes.

Data from questionnaires were entered into SPSS for Windows 3.1. Descriptive statistics were used to summarise sociodemographic and employment data. Non-parametric statistics were used to analyse ordinal data from the Likert scales. Wilcoxon signed rank tests were used to analyse changes in attitude over the three-month study period, while Kruskal–Wallis tests were used to analyse differences in changes in attitude between training and support conditions. Statistical significance was set at 0.05.

Results

Response rate

Eighty-four (60%) practices actually used the programme; the distribution from the three training and support conditions was: control, *n* = 23 (27%); training, *n* = 27 (32%); training plus support, *n* = 34 (41%). Of 84 receptionists and GPs involved in the study, 62 (74%) and 69 (84%), respectively, returned a baseline questionnaire; 57 (68%) and 67 (80%), respectively, returned a follow-up questionnaire; and 47 (56%) and 56 (67%), respectively, returned a complete set of both questionnaires. Data are presented from 47 receptionists and corresponding GPs who returned both questionnaires.

Characteristics of receptionists

All receptionists were female with a mean age of 42 years (SD = 9.6). The majority (44%) were educated to 'O' level or equivalent and had previously been employed as a secretary or clerk (38%). Average length of service at the current practice was seven years (SD = 5.7) and most (70%) receptionists worked five days per week; however, 74% reported working part-time (fewer than 37 hours per week). The majority (90%) of receptionists had been trained in service, although 44% had attended a medical receptionists' course. Eighty-one per cent (81%) of receptionists had a written job description and, while the major duties were associated with general secretarial and reception tasks (84%), some had a more varied role including management (8%), medical assistance (4%), finance (2%), and ordering supplies (2%). The majority (90%) of receptionists worked in group practices with an average of four GPs (SD = 1.9). The average practice list size was 7615 patients (SD = 3771.8).

Attitudes and involvement in research and health programmes

One-quarter (25%) of receptionists had previously assisted GPs in implementing other health programmes; most commonly relating to cancer, diet and nutrition, and exercise. Prior to programme implementation, 50% of receptionists agreed that it would make their job more interesting and they would obtain satisfaction by participating in health programmes. Between 60% and 70% of receptionists agreed that they would develop new skills, experience more enjoyment in their work, and would like the increased variety of tasks involved in implementing health programmes. Nearly 90% of receptionists agreed that health programmes were important for the health of the community and reported that they enjoyed interacting with patients at their practice.

Changes in receptionists' attitudes during programme use

The 40 items that measure changes in receptionists' attitudes are summarised in Table 1, along with the percentage agreement at baseline and follow-up and level of significance. Overall, of the 40 items that measured receptionists' attitudes to involvement in the programme, 70% had deteriorated after the three-month study period (20% significantly so), 25% had improved, and 5% stayed the same. On average, the deterioration in attitude was characterised by a shift of two points on the seven-point Likert scale; i.e from 'agree' to 'disagree'. However, there were no significant differences in attitude change between training and support conditions.

Interest and involvement in health programmes and research. Of eight questions designed to measure receptionists' interest and involvement in health programmes and research, seven (87.5%) had deteriorated, five (62.5%) significantly so (Figure 1).

Table 1. Changes in receptionists' attitudes following implementation of a health programme.

Statement	% agree at baseline	% agree at three months	Wilcoxon signed rank test
Interest and involvement in health programmes and research			
It would make my job more interesting to help collect data for research (1)[a]	44	36	Not Significant Z = -1.151, P = 0.250
It would make my job more interesting to participate in programmes like this (2)	50	38	Significant Z = -2.202, P = 0.028
I think I would get a lot of satisfaction out of working on programmes like this (3)	46	32	Not Significant Z = -1.914, P = 0.056
Lifestyle programmes are important for the health of the community (4)	86	81	Significant Z = -1.984, P =0.047
I like to get involved in activities at this practice that are different from my clerical tasks as a receptionist (5)	69	55	Significant Z = -2.215, P =0.034
The opportunity to participate in patient education would enhance my enjoyment of my work (6)	64	46	Significant Z = -2.066, P = 0.039
I enjoy interacting with patients at this practice (7)	89	90	Not Significant Z = -0.495, P =0.621
I think being involved with patient education programmes would help me to develop new skills (8)	60	48	Significant Z = -3.295, P = 0.001
Value of alcohol intervention in general practice			
I believe GPs are effective in helping patients to reduce the amount of alcohol that they drink	80	75	Not Significant Z = -1.759, P = 0.079
The effort involved in trying to treat people who have a drinking problem outweighs the positive outcomes	19	16	Not Significant Z = -1.648, P = 0.099
GPs have a responsibility to identify people who have a drinking problem	71	78	Not Significant Z = -1.299, P = 0.194
GPs have a responsibility to help patients overcome drinking problems	78	82	Not Significant Z = -0.098, P = 0.922
It is intrusive to question patients about their drinking habits	21	24	Not Significant Z = -0.411, P = 0.681
Advice on alcohol given to patients by GPs is not likely to be appreciated	17	18	Not Significant Z = -0.346, P = 0.729
GPs cannot help drinkers to cut down on their drinking	3	8	Not Significant Z = -1.546, P = 0.122
It is a waste of time trying to treat people who have a drinking problem	1	4	Not Significant Z = -1.703, P = 0.089
GPs should not ask patients about their drinking habits	2	0	Not Significant Z = -0.480, P = 0.631
Patients would not like to receive advice on their drinking habits from GPs	8	12	Not Significant Z = -1.018, P = 0.309
GPs are not effective in getting patients to change their lifestyle	5	4	Significant Z = -2.056, P = 0.040
Receptionists' perception of their role in the practice			
I would not like to hand out and explain lifestyle questionnaires as part of my work	27	30	Significant Z = -3.002, P = 0.003
It is not part of my role as a receptionist to participate in programmes like this	22	14	Not Significant Z = -0.421, P = 0.673
The tasks I am required to do are always clearly outlined by the GP(s) in this practice	79	77	Not Significant Z = -1.114, P = 0.265
I believe I play an important role in this practice	87	86	Not Significant Z = -0.715, P = 0.475
The GP(s) treat me as if I have an important role in this practice	78	69	Not Significant Z = -1.170, P = 0.242
My role in this practice is to assist the GP(s) to achieve their aims	95	94	Not Significant Z = -0.827, P = 0.408
I see my role as a receptionist as including the administration of education programmes for patients	60	55	Not Significant Z = -0.881, P = 0.378
My role as a receptionist is defined primarily by the GP(s) in this practice	82	88	Not Significant Z = -1.027, P = 0.305
I see my role as a receptionist as including the administration of research activities for the GP(s)	54	60	Not Significant Z = -0.390, P = 0.696
It does not bother me if the GP(s) here ask me to do things that are different from my usual task	92	92	Not Significant Z = -0.589, P = 0.556
My tasks as a receptionist are very clear and well defined	82	75	Not Significant Z = -1.430, P = 0.153
Decision making in this practice should be the exclusive right of the doctors	40	34	Not Significant Z = -1.274, P = 0.203
I feel that receptionists should have a lot of input into how this practice is run	62	62	Not Significant Z = -0.771, P = 0.441
Organisational issues including job involvement and dealing with workload and stress			
I have problems keeping up with the amount of work I have to do	36	34	Not Significant Z = -0.349, P = 0.727
I am happy to take on extra tasks when required	92	81	Not Significant Z = -1.228, P = 0.220
I often feel stressed when I am required to take on extra tasks	26	39	Not Significant Z = -0.995, P = 0.320
I have enough time to do what is expected of me	42	35	Not Significant Z = -0.783, P = 0.434
I am really a perfectionist about my work	77	63	Not Significant Z = -1.615, P = 0.106
I am very much involved personally in my work	88	81	Not Significant Z = -1.897, P = 0.058
I feel a strong sense of identification with this practice	84	75	Not Significant Z = -1.305, P = 0.192
I feel a sense of pride in being a part of this practice	95	88	Significant Z = -2.262, P = 0.024

[a]Numbers in brackets correspond to the numbers in Figure 1.

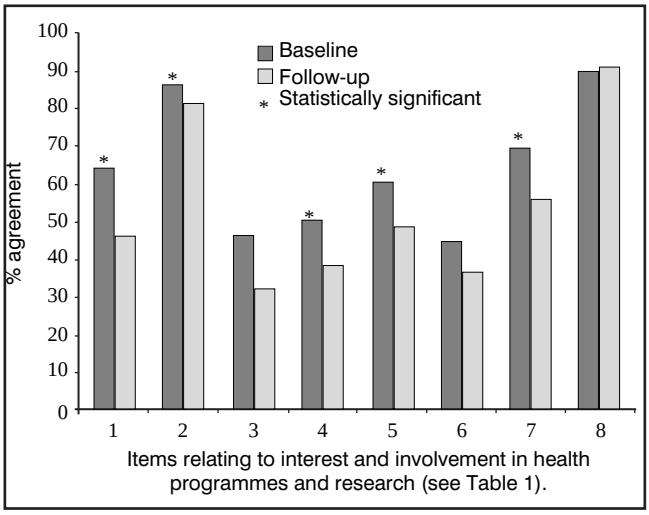

Figure 1. Eight statements relating to interest and involvement and the percentage of receptionists agreeing with that statement.

Value of alcohol intervention in general practice. Of eleven questions designed to measure whether receptionists felt it was worthwhile for the GP to intervene for alcohol, six (54.5%) had deteriorated at three months, one (9%) significantly so.

Receptionists' perception of their role in the practice. Of 13 questions that measured receptionists perception of their role in the practice, eight (61.5%) had deteriorated at three months, one (7.7%) significantly so.

Organisational issues including job involvement and dealing with workload and stress. Of eight questions that measured receptionists' attitudes to their job, seven (88%) had deteriorated at three months, one (12.5%) significantly so.

Experiences with the Drink-Less programme by receptionists

During the three-month study period, receptionists from the 84 participating practices screened 12 814 patients: an average of 153 (SD = 116) patients per practice. Only 2% of receptionists reported that they felt uncomfortable about asking patients to complete questionnaires, 2% reported that it was difficult to get patients to complete the questionnaire, and 74% reported that their role in the programme was important.

Fifty-seven per cent of receptionists reported that the Drink-Less programme was suitable for use in general practice compared with 62% of GPs. Fifty-two per cent of receptionists reported that the programme was demanding compared with only 38% of GPs. Over half of the receptionists (56%) reported that they should be paid extra for this type of work, but only 29% of GPs reported being prepared to pay to run such a programme. Only 11% of GPs reported that their experiences with the Drink-Less programme were negative, and all of the GPs who participated in this study concluded that they and their receptionists would be willing to participate in this type of programme evaluation again.

Discussion

Receptionists represent the interface between patients and other members of the primary health care team and, as such, can be vital to successful implementation of research programmes involving patients. Clearly, receptionists were unhappy with their involvement in the Drink-Less programme and developed more negative attitudes, particularly with regard to interest and involvement in health programmes and research. Development of negative views were not related to level of training or support provided in the study.

The findings from this study were based on responses from 47 receptionists, who completed both baseline and follow-up questionnaires, out of 84 practices who used the Drink-Less programme: a response rate of 56%. Although these 47 receptionists represented only 13% of the 354 practices approached to use the programme, they were highly motivated having screened 12 814 patients, yet they developed negative attitudes.

Interestingly, the results of this study are inconsistent with the findings from the Australian arm of the WHO study.[22] Carnegie *et al* found that, when no training and support was given, receptionists developed negative views about being involved in implementing research programmes. When training and support was provided, these negative effects were abolished. Perhaps this contradiction in findings is partly because of our sample size, which may have been too small to detect any significant difference between level of training and support provided. Another reason for these inconsistent findings is that most of the receptionists in the UK study worked part-time or in job-share situations, which made it particularly difficult to train them all in the intervention procedure.

Development of negative attitudes could be explained by the fact that many receptionists were not involved in the decision-making process. All research in primary care involves the important step of negotiating access to research settings or subjects, and getting this step wrong can lead to projects failing or being compromised.[16]

If research involves a general practice team, it is important to secure the support of all its members. It has been reported that, when GPs involve their staff in a decision about participation in research, receptionists gain greater satisfaction from their contribution to the study.[13]

Another reason for the development of negative attitudes may have been because of the subject matter of the intervention programme. Alcohol is a difficult subject to tackle, and perhaps a better response may have been elicited from receptionists involved in an alternative lifestyle area. Israel *et al* found prescreening for trauma was much more acceptable to receptionists than asking patients about their alcohol consumption.[23]

General practitioners and receptionists in this study held contrasting views regarding the appropriateness of the health programme and their willingness to be involved again. While over half of the receptionists felt they should be paid extra for this type of work, all of the GPs who participated in this study concluded that they and their receptionists would be willing to participate in this type of programme evaluation again.

Previously, most research in health programmes has been delivered under 'ideal' conditions to motivated individuals and resulting in large effect sizes. However, it is more realistic to evaluate programmes in the more challenging setting of everyday clinical practice.[13] In addition, most research has focused on GPs.[24] If health programmes are to be successfully implemented in the future, then there is a need to focus on other members of the primary health care team.[25,26]

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