Research

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Slaying the dragon myth:
an ethnographic study of receptionists in UK general practice

Abstract

Background
General practice receptionists fulfil an essential role in UK primary care, shaping patient access to health professionals. They are often portrayed as powerful 'gatekeepers'. Existing literature and management initiatives advocate more training to improve their performance and, consequently, the patient experience.

Aim
To explore the complexity of the role of general practice receptionists by considering the wider practice context in which they work.

Design and setting
Ethnographic observation in seven urban general practices in the north-west of England.

Method
Seven researchers conducted 200 hours of ethnographic observation, predominantly in the reception areas of each practice. Forty-five receptionists were involved in the study and were asked about their work as they carried out their activities. Observational notes were taken. Analysis involved ascribing codes to incidents considered relevant to the role and organising these into related clusters.

Results
Receptionists were faced with the difficult task of prioritising patients, despite having little time, information, and training. They felt responsible for protecting those patients who were most vulnerable, however this was sometimes made difficult by protocols set by the GPs and by patients trying to 'play' the system.

Conclusion
Framing the receptionist–patient encounter as one between the 'powerful' and the 'vulnerable' gets in the way of fully understanding the complex tasks receptionists perform and the contradictions that are inherent in their role. Calls for more training, without reflective attention to practice dynamics, risk failing to address systemic problems, portraying them instead as individual failings.

Keywords
ethnography; health services accessibility; primary care; qualitative research; receptionists, medical; role.

INTRODUCTION

Receptionists are important figures in general practice. They provide a primary contact point for patients and shape patient access to health professionals.[1] In addition to administrative and organisational tasks, they are responsible for allocating patient appointments, which frequently involves making decisions about patient need: for which they have minimal time, information, or training.[2] The Medical Receptionists and Secretaries Handbook[3] offers advice on ascertaining the patient's needs, and stresses the importance of receptionists understanding the limits of their position; however, the advice is so broad it is of little practical value, while the limits of the receptionist's position is left undefined. Given the importance of receptionists in influencing patient access to care, their work is the subject of surprisingly little research.[4]

The portrayal of receptionists as 'dragons', fiercely guarding access to healthcare professionals is widely circulated in mainstream media.[5,6] In the research literature, Arber and Sawyer[2] have engaged with this reputation, exploring patients' perceptions of receptionists. Other studies, although acknowledging the potential for tensions and ambiguity in receptionists' work, argue that they would benefit from more training to understand their role more clearly[7] or to improve specific abilities.[8] Initiatives to improve the patient experience in general practice often focus on training receptionists.[5,9] Existing literature has focused on particular dimensions of receptionists' work, such as verbal interactions with patients,[8] emotion management,[1] confidentiality,[10] repeat prescribing,[11] and decision making;[7] some examples are particularly successful in using this approach to illuminate the broader complexities of the role.[1,11] This article pursues this further, exploring the work of receptionists by contextualising actions within wider practice structures and interaction, and considering how these may exacerbate or alleviate the challenges receptionists experience. Greater consideration of such issues may offer insights that can improve wellbeing among staff members as well as practice performance.

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How this fits in

Receptionists are often seen to be 'gatekeepers', who are in a position of power. Literature and management initiatives are in support of more training to improve their performance and, consequently, the patient experience. Attempting to address the issue from a perspective in which receptionists are assumed to be powerful and patients vulnerable is problematic; it prevents a full understanding of the complex and often contradictory nature of the work of GP receptionists and leads to simplistic calls for training to address their skill deficits. Reflecting on the social dynamics and organisation of individual practice may increase an understanding of reception work and help to improve whole-practice functioning for staff and patients.

METHOD

The research was conducted as part of improving Access to Mental health services in Primary care (AMP): a 5-year programme funded by the National Institute for Health Research, which aimed to increase equity of access to primary care services for common mental health problems.[12]

Ethnographic observation, a qualitative research approach, used increasingly in health-services research,[13] was employed. It involves spending time with research participants during their everyday activities, observing and talking to them about their actions and interactions as they unfold. This immersive approach attempts to increase understanding about how people perceive their world.[14] Approximately 200 hours of ethnographic observation were conducted in seven general practices in the north-west of England between 2009 and 2011.

All practices in this study were in urban areas with high levels of deprivation, but they varied in: size; healthcare team composition; the organisation of administrative roles; and the size and diversity of the patient population. Details of practice staff and observations undertaken in each practice are outlined in Table 1. Relatively few hours of observation were carried out in practice C, as a result of difficulties accessing the practice manager to receive approval for researcher attendance.

Seven researchers carried out observations individually but with multiple researchers alternating in most practices. All were qualified and experienced in conducting qualitative work, but they hailed from a variety of disciplinary backgrounds, including health sciences, sociology, anthropology, and human geography. One of the researchers was also a GP.

Before beginning fieldwork, researchers collaborated on a practical orientation document containing guidance on employing an ethnographic approach.[14] Observations were focused on access issues broadly conceived, and the form and function of the appointment systems. Receptionists were made aware that researchers were part of a team that was working with their practice to gain a better understanding of how things worked, in order to find ways to improve access to mental health services. Researchers spent the majority of their time in the reception desk area making contemporaneous handwritten observational notes, which were subsequently typed up as fieldnotes. Writing was done between conversations and, much of the time, receptionists were interacting with patients, which meant it was unobtrusive to write notes in the background. Researchers would sometimes ask receptionists to clarify what had just happened or to explain their actions as they were carrying out a task. The extent to which receptionists adapted their behaviour on the basis of what they believed was appropriate is difficult to ascertain, however they appeared relaxed, as well as forthcoming and candid with their views. Observational feedback was provided to each practice during training sessions associated with the AMP project.

The data presented in this article relate to those members of staff who spent at least part of their time working on the reception desk interacting with patients. Consequently, members of staff purely undertaking back-office administrative functions were not classified as receptionists for the purposes of this study.

Fieldnotes were imported into a qualitative data-analysis software package (MAXQDA version 10) and observed incidents that were

Table 1. Practice observation data

Practice	Time observed, hours	Researchers visiting practice, *n*	Receptionists at practice during observations, *n*
A	38.00	3	7
B	22.00	2	8
C	7.25	2	5
D	26.00	1	5
E	36.25	3	7
F	37.00	1	7
G	34.50	3	6

considered meaningful to understanding the receptionists' role were coded with descriptors by each researcher individually. These were then organised into clusters of related ideas, using the dataset as a whole by one of the researchers. Three face-to-face meetings attended by all researchers were held during the analysis process to explore their individual interpretations and work towards consensus about the meanings ascribed to experiences.

The results presented here illustrate how aspects of the social, organisational, and physical context in which receptionists work impact on the way that work is carried out. It should be emphasised that the distinction between results categories is made here in the interests of presentational clarity; as will be discussed, they intersect and overlap in a variety of ways.

The names of all practice staff have been changed.

RESULTS
Interacting with patients and managing appointments

A key function of the receptionist's role is to allocate patient appointments. At the time of the study, there was political pressure and financial incentive for practices in the UK to ensure that patients could obtain an appointment with a GP within 48 hours. Appointment systems varied widely from practice to practice, some had a number of drop-in clinics, whereas others had bookable appointments for all clinics. Online appointment booking was not available at any of the practices and no GPs had individual patient lists.

In all practices a common distinction was made between routine and urgent appointments. As such, it was part of the receptionist's role to ascertain the level of urgency of patients' needs in order to prioritise them. Yet, this was not always a straightforward task. Negotiation with patients over the level of urgency was commonly observed, as illustrated here in a typical exchange between a receptionist and a patient:

A woman (white with fluent English) came to the desk wanting to see a specific GP:

Receptionist (R): *'It'll be next week.'*
Woman (W): *'What time?'*
R: *'It may not even be next week...'*
W: *'Oh, eh, come on love ...'* [slightly aggressive]
R: *'Well what's the problem?'*
W: *'My stomach's swollen, really sore.'*
R: *'Oh ... yeah, right, well I have a cancellation at 5.10 but you'll have to wait.'*

W: *'Yeah, fine ... what do you think's wrong?'*
R: *'Oh I don't know, I'm not a doctor.'*

The woman sits down with her friend who also has an appointment.

Receptionist (to researcher): *'Her stomach does look swollen. And she really kicks off that one — comes in and wants to be seen immediately.'* Practice B

Within a framework where receptionists are assumed to be powerful and patients vulnerable, it is perhaps tempting to view this exchange as yet another example of a receptionist acting as a powerful gatekeeper. However, this interpretation, although it might mirror the experience of the patient, overlooks the subtleties of the work involved for the receptionist, who had to assess the urgency of the patient's need but had little information to go on aside from her knowledge of the patient and her physical appearance. It also suggests that the woman's past history of aggressive behaviour may have influenced the receptionist's decision making and, therefore, her access to a doctor.

Contrary to the notion of receptionists as obstructive gatekeepers, numerous examples of receptionists altering their position at different times to take on the role of patient advocates were witnessed. Receptionists would often go to great lengths to help certain patients navigate the system, ensuring they obtained urgent appointments even if they had not been requested directly:

'Two people asked about new registrations. Jane [receptionist] *told one of these, a lady who wanted to see a doctor straight away, to phone after 6pm and ask for an emergency appointment.'* Practice E

Furthermore, in some cases, receptionists' concern for the wellbeing of patients extended to feelings of clinical responsibility:

'At the end of the day, I don't want someone leaving the practice without diabetic medication and have that be on my head. Or if it's an asthma attack or something ...'. Practice B

Whether or not a patient was deemed a candidate for advocacy related to receptionists' perceptions of certain groups of patients. Although some were seen as vulnerable, others were regarded as trying to 'play' the system. Receptionists

considered protecting the system, and by extension the vulnerable patients, from those attempting to take advantage of it to be one of their central responsibilities. Patients suspected of being players were those who attempted to gain access to an urgent appointment by exaggerating the severity of their complaint or not turning up for booked appointments that had been arranged at short notice, having claimed their needs to be urgent:

'They know how the system works so they miss one and then phone in the morning and book one for that day/next day. The ones that don't know how the system works are the ones that need to.' Practice F

'Fiona [receptionist] [says] "Doesn't it amaze you that patients that have booked appointments this morning haven't turned up?" Paula [receptionist] and I say that we've just been talking about this. It's always the same ones.' Practice B

Among practice staff, it tended to be non-clinical staff that were most likely to live in the practice area and be familiar with the living environment and individuals within it. This is of relevance to the linkage role that receptionists fulfil between patients and clinicians in the communities they serve. It has the potential to cause anxiety about confidentiality among patients, although the study did not observe this. However, other examples of the implications of living within the community were evident, notably multilingualism, which was a feature of a number of telephone conversations, and other, more unexpected issues:

'There was some discussion about the person who had been shot dead and how he was related to someone they knew, called Tim.' Practice A

'Clare [receptionist] lived in the area and knew a lot of the patients personally, which meant that she didn't have to check many people's addresses as proof of their identity. She told me that she thought it was good for the patients to have someone that they know, but finds that sometimes people ask her about scripts and other work matters on her days off.' Practice G

'... He's twitchy, pacing, seems on edge, and then he leaves. Dawn says something about being glad that they found the script. I get the impression that he's got angry with someone before. Jane says he wouldn't flip out at her because she's known him since before she worked here, since they were kids.' Practice B

Negotiating practice rules and policies
Practice rules and policies had various impacts on the negotiation of urgency and receptionists' relationships with patients. Some policies were helpful for reducing the complexity and made it easier to prioritise patient appointments:

'... I asked more about these "judgments". Fiona [receptionist] gave an example: if a patient said they had chest pain, they would ask them how long they had had it — if they had had it less than 24 hours, they would tell them to phone an ambulance, if they had if for longer, they would give them an emergency appointment.' Practice B

Appealing to certain rules during encounters with patients could be useful because it was a source of legitimacy and helped justify the receptionist's position on a particular issue:

'Paula [receptionist] explained why she couldn't give her a prescription without her seeing a doctor and that there was nothing she could do. The woman was getting visibly worked up and took a somewhat confrontational tone. At this point, Paula looked over to Fiona who was sitting at the mid-desk in order to bring her in to the conversation. Fiona spoke loudly and quite sternly to the woman from halfway across the office. "It's not our decision, it's a government decision," she said. "You'll have to go on the telephone list and then the doctor will give you a call. I'll put you on now." The woman, while still not happy, seemed to accept this and left the reception.' Practice B

In practice B, at the request of a senior GP, receptionists were required to ask every patient their presenting complaint and note it on the booking system. Following this rule put receptionists further into the clinical realm and brought hostility from patients. Tracy, a receptionist, reported a strategy for lessening her discomfort at having to ask and the likelihood of objection from the patient:

'I ask Tracy [receptionist] how she feels about asking people to give a reason for their appointment. She doesn't like doing it. "What's it like?" [to Mary]. Mary [receptionist] doesn't like it — they think that everyone [all receptionists] has a problem with it. Some people [patients] get angry and refuse to tell

them. *Sometimes Tracy gives people a set of very general options (Is it your leg? Back? Chest?). A couple of times she's left it blank and Dr Doepfer* [GP] *has come and shouted at her.'* Practice B

In some situations, rules were effectively unworkable due to language and literacy barriers. In practice D, anyone collecting prescriptions on behalf of someone else had to sign their own name, as well as writing the name of the patient. However, some couldn't write English and most receptionists couldn't read Urdu, which was a common written language among the patient group. Some patients weren't able to write at all and using a thumbprint was not sufficient. Receptionists reported being tempted to break the rules by writing the patient's name themselves.

Staff interactions and practice culture
Practices varied in terms of the interaction level between receptionists and health professionals, the dynamics of these relationships, and attitudes towards roles and responsibilities. An incident in practice B illustrated how it can be particularly undermining for a receptionist if a health professional (in this case a practice nurse) contradicts the receptionists' actions when dealing with a patient:

'... a patient expecting to be fitted in for a blood test that morning — receptionists explained it wasn't possible, but then nurse walked into reception and the patient asked them directly. Receptionists tried to explain to nurse what had been said but nurse cut them short and agreed to see the patient. [Receptionist was visibly upset by this].' Practice C

Other incidents could be a source of pride for receptionists, such as when one doctor publicly demonstrated his faith in their abilities. The following example shows how uncertainties in receptionists' work can create both vulnerabilities and opportunities for positive support:

'Fiona [receptionist] *recounted a story about a female patient coming to the practice and complaining loudly about some kind of appointment mix up. Dr Doepfer* [GP] *had come over to the woman and asked her to explain what the problem was. He listened to her and said, "My girls wouldn't make that kind of mistake," which had appeased the woman.'* Practice B

In practice A, on the basis of receptionists' recommendations, open clinics were introduced once a week, and subsequently increased to four times per week. Receptionists were happier with more open clinics because they could suggest a patient attend the open clinic when no timely appointments were available. More open clinics usually meant that patients could be seen at an earlier date but would usually spend longer in the waiting room. This alleviated pressure on receptionists by giving them more room for manoeuvre with appointment allocation. However, receptionists reported that having four open clinics per week was gruelling for clinicians, who were less satisfied with the arrangement.

Previous research has identified that the practice environment is an important factor when considering communication among practice staff.[11] Practices A and E were comparable in size and in the patient group served. They also had a similar building layout; in both, the reception was on the ground floor and the consulting rooms and common room on the first floor. In practice E, the distance between doctors and reception staff was stark. Doctors were rarely seen at reception and several receptionists reported feeling apathetic towards the practice and underappreciated by the doctors. In practice A, there was a book in the reception area for signing in and out, which all staff used. Doctors were frequently seen at reception and receptionists took advantage of their presence by, for example, asking them to sign scripts. In practice E, receptionists reported that the doctors did not like to be interrupted between patients and had made complaints about receptionists querying their instructions. The contrast between practices A and E illustrates that the practice's built environment was not a primary factor in determining whether the relationships between receptionists and doctors were fraught, and likewise did not shape the culture of the practice.

DISCUSSION
Summary
The data presented above illustrate how various factors act in combination to shape the receptionist's role, creating challenges or making things easier. For example, the system in practice A, which encouraged clinical staff to pass through the reception area, helped to negate physical challenges of the building and provided opportunities for collaboration. This draws links between practice rules and policies, the practice space, and interactions between practice staff. In practice B, a senior GP insisted

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that receptionists ask each patient details of the presenting complaint; this policy had negative implications for receptionists' interactions with patients. All of these issues, and their interactions, are of relevance to shaping the experience of reception work.

In research and the mainstream media, receptionists are often presented as powerful characters[5,7,15] but the study's observations showed that they are often required to make judgements in uncertain conditions. At times, the receptionist must attempt to reconcile competing demands, and this can expose them to social friction. Being in a position of relative illegitimacy (in both knowledge and status), in terms of making decisions about patients' clinical need, added to this friction in some cases. Receptionists are also susceptible to social pressures exerted by patients that can influence their decision making. Considered in this way, with a greater appreciation of the social dynamics at play, the image of the 'powerful' receptionist appears partial and unhelpful. It relies on a simplification of a varied and challenging role; a reductive process that treats aspects of receptionists' work in isolation from the wider context of the practice.

Increasing training for receptionists is a common suggestion for improving their abilities.[7,9] The study found that many of the difficulties that receptionists face are compounded or alleviated by the actions of other members of the practice team, as well as the organisation, structure, and context of the practice. Although rules and training can be useful when tailored appropriately, the danger is that socially constructed and mediated problems are individualised and mapped onto receptionists, which exacerbates some of the inherent difficulties with which they have to contend. Alternatively, it may be that training only prepares receptionists for what is supposed to happen, rather than what actually happens in an unpredictable and potentially chaotic series of encounters.[11]

Strengths and limitations

A particular strength of the study was the methodological approach; ethnographic observation allowed for an illustration of how a combination of contextual factors within general practice can impact on the work of receptionists. However, the factors considered here by no means represent an exhaustive list of issues relevant for consideration. These practices were all in urban areas of deprivation; it is likely that the experience of receptionists differs in other settings (for example, rural, single-handed practices or private healthcare systems), both nationally and internationally. Further research would be required to explore this.

Comparison with existing literature

This research supports several conclusions made by Swinglehurst *et al*,[11] including receptionists' feelings of responsibility for the wellbeing of their practice's patients and the importance of the 'bridging' work that receptionists do, for example finding ways to link up uncertain territory between how the practice should operate in theory and how it works in reality, that often goes undetected or unacknowledged by GPs. Ward and McMurray[1] identified that the intensity of the emotional spectrum with which receptionists are faced daily, necessitates coping strategies; what they term 'emotion switching'. They suggest that this protective mechanism could partially account for receptionists' reputation as overly bureaucratic and lacking in empathy. In the study, this characterisation was found to be superficial and misleading.

The potential for receptionists to exert power beyond that which is anticipated for 'lower-level workers' in organisations has been noted in a range of settings, as receptionists are gatekeepers to the organisation they serve and are often able to exercise considerable discretion.[16,17] Although the study observed such discretionary decision making by receptionists, it was considered in relation to the evolving web of social norms, staff dynamics, protocols, and patient needs within the practice. This offered opportunities to see aspects of the contextual and the contingent in such occurrences.

This research adds to the existing literature by emphasising the fact that describing receptionists simply as powerful is counterproductive unless what constitutes such a label is also open for consideration.

Implications for practice

The study suggests that greater recognition and understanding from the whole practice team of the challenges and complexities that receptionists must negotiate could enhance the patient experience and, hence, quality of care. Fostering an environment in which receptionists have opportunities to provide valued feedback about how policies affect them could contribute to better practice-systems design and encourage more harmonious interactions that could, ultimately, benefit both patients and staff.

Future research might focus on a

broader set of contextual factors than those considered here. Comparisons of receptionists' work between countries with different primary care models might prove insightful, particularly if attention is paid to the influence of economic factors on the appointment demand–supply dynamic. In other healthcare settings the role of receptionist and nurse may be more blurred.[18]

The study's observations suggest that the ethnic and cultural make-up of the patient group and practice staff is of relevance but this is not explored in this article. Some of the observation practices were in areas that have a high level of ethnic diversity; language barriers and culturally-mediated expectations of primary care presented challenges that absorbed both time and resources of practice staff. Closer attention to this may be a valuable focus for future research.

The historical perception of the receptionist as a 'dragon behind the desk'[2] has been getting in the way of understanding the role of receptionists and thus improving patient care; to slay it entirely will require a concerted approach to understanding and supporting receptionists so that they can better facilitate patient access to health professionals and other sources of help. Receptionists should be enabled to consistently fulfil their potential as the key link between the community and their primary care NHS services.

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