PRACTICE OBSERVED

Practice Research

Assessment of receptionists by questions on patient management

D J G BAIN, D DURNO

The development of group practice and health centres is based on the belief that comprehensive care can best be provided by teamwork. The primary health care team has evolved over the past 15 years and the roles of doctors, nurses, and other ancillary staff reviewed.¹ Despite their importance, remarkably little seems to be known about the work of receptionists, and there have been few reports on the tasks of those at the front line of relationships between patients and practices.

Evidence about the work of the receptionist is limited to methods of working,² in-service training,³ and the time taken for various activities.⁴ Quality of care in general practice is frequently discussed now, and audit is being pursued in a number of quarters. Thus there is a need to measure not only the activities of doctors but also the knowledge, skills, and attitudes of those who frequently see the tone of practice/patient relationships—the receptionists.

Method

This study was based on the responses of receptionists to a problem-solving exercise based on patient management questions (PMQ). In the usual PMQ a patient's history and clinical findings are presented in sequence, and at selected points the respondent is asked to answer questions about diagnosis and management. In the PMQ for receptionists the sequence of questions was not concerned with diagnosis and management but related to a series of events occurring in a family that had recently registered with the receptionist's practice. The case history was intentionally presented as that of a "difficult family," with

frequent demands for service and requests for late visits. The questions were set to test (a) the receptionist's knowledge of the method of registering patients in a practice; (b) attitudes to patients' requests for appointments and home visits; (c) skills in handling difficult and emotionally upset patients; and (d) methods of communication with general practitioners in their practice.

Forty practices in the Aberdeen area were asked if one senior and one junior member of their reception staff would each complete a PMQ based on the case history described. Receptionists were asked not to read through the series of questions beforehand but to complete the answers in sequence, and they were asked not to answer questions in collaboration with colleagues. They also recorded their age, number of years in the present post, whether they were a member of the Association of Medical Secretaries, Practice Administrators and Receptionists (AMSPAR), and details of any training they had received in the past two years. A general practitioner member of the practice was also asked to complete the PMQ without discussion with the receptionists.

The PMQ was also completed by three general practitioners and two receptionists with a known interest in receptionist training. From them a consensus of responses was obtained about answers that were appropriate, less appropriate, and inappropriate. Agreement was reached on the answers and their weighting determined, the most appropriate receiving the highest marks and the less appropriate responses being given lower marks. Unacceptable responses either scored no marks or in some instances marks were deducted for highly inappropriate answers.

The completed answers were returned to the organiser of the study for scoring. To test the reliability of the scoring method, a second examiner also scored the answers and a similar method of scoring by the two examiners was used for doctors' responses.

Results

Forty practices were circulated and were asked to return two receptionists' replies and one general practitioner reply for each practice—a potential of 80 replies from receptionists and 40 from GPs. Sixty-eight completed PMQs from receptionists were received, giving a response rate of 85%. Twenty-six replies were received from GPs,

Southampton Medical School, Alderbrook Health Centre, Southampton SO1 5ST

D J G BAIN, MD, FRCP, professor of primary medical care

Foresterhill Health Centre, Aberdeen AB9 2AY

D DURNO, MD, FRCP, regional adviser in general practice

a response rate of 65%, but as these replies included doctors of all age groups and from different practices it was thought reasonable to use these replies for comparison.

The average age of the receptionists was 40 years and they had spent an average of six years in their present post. Seventeen had previous experience in reception work before taking up their present position, and 21 were members of AMSPAR. Only nine receptionists had attended a formal training course during the previous two years, and six of them were AMSPAR members. This meant that there were 24 receptionists who had either recent training or contact with an organisation with an interest in training receptionists.

Table 1 shows that the mean score for receptionists was 14.9, range 7-24; and the mean score for general practitioners was 18, range 14-23. The difference between the means is significant ($p < 0.005$), with general practitioners' scores significantly higher than those of the receptionists.

The comparison between scores of AMSPAR members and recent course attenders (group A) and the remaining receptionists (group B) is shown in table 11. Receptionists in group A had a higher mean score than those in group B, and group A also had a smaller range of scores than group B. The average age in the two groups was similar, 39.5 years in group A and 40.5 years in group B. Although the age range in both groups was also similar, there was a higher percentage

of receptionists aged over 45 years in group B (35%) than in group A (40%).

The relationship between score, receptionists' age, and number of years in practice is shown in table 111. Because of the high correlation between age and number of years in practice it was necessary to examine the relationship between scores and these two factors by partial correlation. Table IV shows that there was a weak but significant negative correlation between score and age, but no evidence of an association between score and number of years in practice. When, however, the top 10 scores were compared with the bottom 10 scores, the number of years in practice had a notable effect on score irrespective of age.

There was a weak correlation between receptionist and GP scores in the same practice, but none of the correlation coefficients were statistically significant. Nineteen receptionists had scores below the mean of 14.9, and 11 of these came from practices from which no GP reply was received.

TABLE I—Scores for receptionists and general practitioners

	Receptionists	GPs
No. of respondents	68	26
Mean score	14.9	18.0
Range	7-24	14-23
Standard deviation	3.59	2.91

$p < 0.005$, $t = 2.918$.

TABLE II—Scores for receptionists grouped according to whether they were trained and a member of AMSPAR

	No. of respondents	Mean score	Range of scores	Standard deviation
Group A	24	16.1	13-24	2.73
Group B	44	14.3	9-24	3.49

$p < 0.05$.

Group A—With recent training or AMSPAR membership, or both.

Group B—Without recent training or AMSPAR membership, or both.

TABLE III—Receptionists' scores and number of years in practice

Years in practice	No.	Average score	Mean score
0-5	15	13.7	16
6-10	12	12.2	13.9
11-15	21	16.8	14.9
All receptionists	48	14.3	14.9

TABLE IV—Relationship between receptionists' scores, ages, and number of years in practice

	Correlation coefficient
Score and age	0.04
Score and years in practice	0.01
Age and years in practice	0.81
Score and years in practice (partial correlation)	0.26
Score and years in practice (age held constant)	0.26
Score and years in practice (age held constant)	0.26
Score and years in practice (age held constant)	0.26

Examples of receptionist behaviour

With regard to specific items in the PMQ some interesting points emerged. Nineteen receptionists (23%) were unsure of the procedures for registering patients who had previously been registered with a GP in the same catchment area.

When a call was received at 5.00 pm for a visit to a one-year-old child with a 24-hour history of diarrhoea and vomiting five recep-

tionists (65%) did not refer this to the GP and decided to give the family an appointment for the next day. This was scored as highly inappropriate behaviour. All five receptionists were above the average age of receptionists in this study, and all had been in reception work for 10 years or longer. Twenty-three receptionists (34%) informed the mother that requests for calls should be made by 10.00 am if visits were to be made the same day. By comparison, only 23% of the general practitioners said that they would inform the child's mother that the request for a visit should have been made earlier.

The receptionists seemed reluctant to discuss with their doctors problems about communication with patients. When a patient had been seen and sworn at the receptionist 28 (41%) of the receptionists said that they would not discuss the problem with their doctor. When a patient was visibly upset after a consultation and expressed a desire to see another GP in the future only 12 receptionists (18%) considered it necessary to communicate this information to the GP. Twenty-three of the general practitioners (88%) expected their receptionists to inform them about such patients.

When a patient who had been regularly attending one of the doctors in the practice telephoned to complain about the treatment received and requested an appointment with another partner 38 (56%) of the receptionists informed one or both partners of this. Most of the general practitioners (81%) were of the opinion that the receptionist should tell these facts to the general practitioner.

The final question in the PMQ was about a request from relatives of a "difficult family" who wished to be admitted to the practice list; eight (12%) of the receptionists refused this request without further discussion with their general practitioners.

Discussion

What lessons were learned from this study of receptionists' answers to patient management questions? All the receptionists subsequently attended a meeting to discuss the results, and they welcomed the opportunity to review their approaches to the difficult task of handling patients. The difference in scoring between the doctors and receptionists was largely due to the doctors scoring better on matters of communication, and when receptionists apparently failed to transmit information about difficult patients or took inappropriate decisions about late calls this may have been due to a lack of opportunity to meet doctors regularly and discuss practice policies.

Receptionists with recent training or membership of a professional organisation with an interest in education had high scores, thus the results of the study support training of receptionists. It would be wrong to assume that training was the only factor that influenced scores, and a prospective study of receptionists would be required to evaluate the influence of training. There was evidence that the older receptionists scored less well on patient management questions than their younger colleagues, and this has implications for the training of reception staff in general practice. If most training takes place in the practice, the findings in this study suggest that the senior reception staff require help in training new recruits. How many general practitioners supervise and plan the training of newly employed staff?

Specific gaps in knowledge were noted with regard to the regulations on the registration of new patients. The complex mass of National Health Service regulations is difficult to remember, but regular contact with local primary care administrators is an essential part of the receptionists' continuing education.

All the receptionists in this study said that they found the PMQ a valuable means of surveying their skills, and were unanimous in agreeing that regular review and in-service training should be encouraged. Only 10% of the respondents had attended a training course—a finding similar to that of others.⁵ An editorial in the *Journal of the Royal College of General Practitioners* drew attention to a new regulation, SAFA 38 (NHS 2978), that for the first time fees and expenses for courses run specifically for secretaries and receptionists will be reimbursed through family practitioner committees. Williams and Dajda⁶ found that only 61% of general practitioners ex-

pressed a desire to give their receptionists an opportunity for further training, and in a report of an in-service course for receptionists Anderson et al⁷ hinted that receptionists did not always find general practitioners receptive to new ideas and requests for training. Alexander⁸ has also emphasised the importance of recognising receptionists' views and attitudes towards their training and their job. Press reports and surveys by consumer associations⁹ are often critical of the attitudes of receptionists, and a recent review of access to general practitioners highlighted the problems faced by receptionists in their role as intermediaries.¹⁰

The findings in this study are not just a measurement of receptionists' abilities but mirror the attitudes of the GPs who employ them. An improvement in the quality of reception work will only come about if general practitioners recognise the need to include the receptionist as a full member of the practice team. The state of reception training can be compared to that of vocational training about 20 years ago. The apprenticeship model may not always be appropriate, and if quality of care begins at the reception desk, then the selection of reception staff and their initial and further training require more critical review.

Conclusions

Patient management questions (PMQs) were used to test and compare the way that receptionists and general practitioners handled patients' requests for appointments and home visits. General practitioners scored much better than receptionists, and this was largely due to higher scores on items related to communication. When receptionists apparently failed to transmit information it may have been due to insufficient opportunities to meet doctors and discuss practice policies, or to a lack of appreciation by general practitioners of the difficulties faced by reception staff. There was evidence that older receptionists scored less well on PMQs than their younger colleagues, yet the more senior receptionists were often responsible for the training of the junior staff. Higher scores were found for receptionists who had recently attended a training course or who were members of a professional organisation. This result supported the belief that the standards achieved by receptionists are dependent on both attendance at formal courses and regular in-service training and review.

Our thanks are due to Dr P. Martin of Laindon, Essex, who provided the initial stimulus for this study, and to the receptionists and general practitioners who co-operated during the study.

References

1. Barber JH, Kratz CR. *Towards team care*. Edinburgh: Churchill Livingstone, 1980.
2. Pritchard P. *Manual of primary health care*, 2nd ed. London: Oxford University Press, 1981.
3. Durno D. The secretary in general practice. *J R Coll Gen Pract* 1970;19:406-11.
4. Drury WVM, Kuensberg EV. Inquiry into reception activities in general practice. *Br Med J* 1970;ii:94-6.
5. Mulroy R. Ancillary staff in general practice. *J R Coll Gen Pract* 1974;24:178-81.
6. Anderson WV. An extended course for medical receptionists. *J R Coll Gen Pract* 1976;26:378-81.
7. Burdick IC, Richardson PM. Receptionists at work. *J R Coll Gen Pract* 1972;22:131-4.
8. Alexander DC. Training staff in general practice. *J R Coll Gen Pract* 1979;29:113-3.
9. Williams WO, Dajda R. General practitioners and their staff. *J R Coll Gen Pract* 1979;29:145-9.
10. Anderson PMO, Anderson S, Lander DA. A broader training for medical receptionists. *J R Coll Gen Pract* 1980;30:400-3.
11. Alexander DA. The medical secretary: her views and attitudes. *J R Coll Gen Pract* 1981;31:308-11.
12. *Issue of consumer concern*. Occasional Paper. National Consumer Council, December 1981.
13. Aches S, Sawyer L. Changes in general practice: do patients benefit? *Br Med J* 1981;283:1367-70.

(Accepted 1 March 1982)

Organising a Practice

Ten years in a health centre: concept and reality

E T ROBINSON, F A BODDY

The term "health centre" is said to date back to 1920 when it was used in the *Inter-Regional Committee for the Study of the Health and Allied Services* (the Dawson Report). A system of small hospitals (or primary health centres) was proposed; these would be staffed by general practitioners and include maternity units, and secondary health centres would provide more specialist care. Both would emphasise prevention and combine it with the curative approach to medical practice. The present concept of a health centre—that is, a building designed for general practitioners, district nurses, and health visitors—can be attributed to a joint planning commission of the BMA and the royal colleges, which reported in 1942. Again, the proposal emphasised preventive medicine.

The authority for building health centres was granted to local authorities (in Scotland, central Government) in the Acts that established the National Health Service in 1948. But largely because of the administrative structure of the Health Service and the disincentives for practising in health centres imposed by the terms of the general practitioner's contract, progress was very slow. By 1963 there were only 26 health centres in Britain and most of these were built where more traditional services were lacking.

The major impetus for providing health centres came in the late 1960s in the wake of the "Family Doctor's Charter" of 1965 and the consequent change in the general practitioner's contract. These changes included arrangements for the reimbursement of part of the costs of practice accommodation and of clerical staff and had the effect of removing barriers to change in general practice; they also encouraged a more holistic approach to medical care in the community. Other changes in attitude encouraged this process: the benefits of the practice team were appreciated; the rising costs of hospital care were being questioned; and the integration of different aspects of Health Service was being explored. The consequences of these changes in policy have been impressive. By 1979 there were 948 health centres in England and Wales and a further 74 in the planning stages. In Scotland 137 centres are now open and a further 30 at various stages of development.

A health centre is a building that contains facilities for at least two of the three main components of community health care—general practice, nursing, and social work. An attraction of the developments since 1970 is the way in which the essential concept of a health centre has proved adaptable to different styles of practice. It has also generated a good deal of argument about, for example, the facilities that are desirable or necessary, the optimal size of a health centre, and the way it should be organised. It is difficult to write about health centres in general terms while dealing at the same time with those pragmatic aspects of practice that give meaning to the idea. An individual's

experience of health centre practice is so closely bound up with both the circumstances of his practice and the character of the health centre from which he works that it is difficult to be sure that one's own experience is comparable to that in other places. There seem to be some general conclusions, however, which we shall return to at the end of this review.

Practice in a health centre

More than 10 years ago we were both concerned in the planning and commissioning of the first large urban health centre in Scotland.¹ Woodside Health Centre is located in a socially deprived area of inner Glasgow, provides services for about 35 000 people, and contains six general practices, which had been located in less than ideal premises in the same area. To accommodate the shape of the site, the building is a long, rather narrow structure on two floors but with the ground floor planned in the shape of the letter E. Thus the shared services of the health centre—such as the record system—are located in the main stem of the building and the general practitioners' consulting rooms are in corridors leading off the main waiting area. This design is less than satisfactory (a square would probably have been preferable), but it has the advantage that patients quickly identify particular corridors as the "premises" of their doctor, so that to some extent the design protects the characteristics of the different practices.

The health centre has an x-ray room, provides physiotherapy and chiropody, and has its own pharmacy. The second floor provides accommodation for two general dental practitioners, offices for the nurses, health visitors, and social workers, and also contains the university department of general practice. There are two treatment rooms staffed by nurses, in which a wide range of minor procedures and dressings are carried out, and full laboratory services are provided by a van service to the local hospitals twice daily.

The changes in the material circumstances of practice that came about with the move to the health centre provided opportunities for improved patient care. Moreover, there were three other important changes that occurred at the same time: the attachment of health visitors and district nurses to the general practices; the inclusion of social work services in the centre; and the provision of a broad range of specialist clinics in the centre. These provided the opportunity for closer relations with services and thus changes in the approach to general practice. A fourth change was the opportunity to employ economies of scale in, for example, the organisation of records, the use of radiological systems, and arrangements for out-of-hours cover.

Quite apart from the organisation and administration, however, the period of planning the health centre was one of enthusiasm and idealism; the handicaps and frustrations we had felt in the old premises were to be replaced by a more conscious approach to providing primary health care, though we do not mean to imply that much of the present work of the practice is different from that of practices in many other settings. The

Woodside Health Centre, Glasgow G20 7LR

E T ROBINSON, MD, FRCP, general practitioner

F A BODDY, FRCPD, FFPM, epidemiologist