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Receptionists' role in new approaches to consultations in primary care:

a focused ethnographic study

Abstract

Background
The receptionist is pivotal to the smooth running of general practice in the UK, communicating with patients and booking appointments.

Aim
The authors aimed to explore the role of the receptionist in the implementation of new approaches to consultations in primary care.

Design and setting
The authors conducted a team-based focused ethnography. Three researchers observed eight general practices across England and Scotland between June 2015 and May 2016.

Method
Interviews were conducted with 39 patients and 45 staff in the practices, all of which had adopted one or more methods (telephone, email, e-consultation, or internet video) for providing an alternative to face-to-face consultation.

Results
Receptionists have a key role in facilitating patient awareness regarding new approaches to consultations in primary care, while at the same time ensuring that patients receive a consultation appropriate to their needs. In this study, receptionists' involvement in implementation and planning for the introduction of alternative approaches to face-to-face consultations was minimal, despite the expectation that they would be involved in delivery.

Conclusion
A shared understanding within practices of the potential difficulties and extra work that might ensue for reception staff was lacking. This might contribute to the low uptake by patients of potentially important innovations in service delivery. Involvement of the wider practice team in planning and piloting changes, supporting team members through service reconfiguration, and providing an opportunity to discuss and contribute to modifications of any new system would ensure that reception staff are suitably prepared to support the introduction of a new approach to consultations.

Keywords
communication; family practice; focused ethnography; general practice; medical receptionists; primary care; qualitative research; remote consultation.

INTRODUCTION

The public are increasingly using communication technologies in everyday life. In the UK, policymakers have suggested that alternatives to face-to-face consultations based on such technologies could transform primary care, alleviating staff workload and improving patient access.[1–3] These alternatives include consultations by telephone, email, internet video (for example, Skype™), or structured electronic forms (e-consultations). The underlying assumptions about benefits relate to increased convenience and accessibility for patients and an efficient use of practitioners' time.[4,5]

Despite the rhetoric associated with the benefits of adopting alternatives to face-to-face consultations, there is still reluctance among primary care providers to adopt such methods,[6] with concerns about their potential impact, particularly on workload and patient safety.[7,8]

The successful implementation of innovations is reported to be reliant on vision, mission, culture, communication, strong leadership, and participation.[9] When these innovations include digital technologies, there is a need to understand and integrate these changes within existing routines, particularly as healthcare provision is dependent on constraints relating to the availability of time, resources, and people.[10] However, this can be complicated by a number of possible barriers including patient, staff, team, business, and financial barriers.[11]

In a conceptual review exploring the current usage of alternatives to face-to-face consultations there was a recognition that introducing new approaches to consulting would need to be attuned to the work patterns and views of frontline staff, with the views of doctors being most influential. However, the authors note there was little consideration of the impact on the reception and administrative staff who are likely to play a crucial, yet under-explored, role in implementing these alternative approaches to the consultation.[12]

Receptionists play a pivotal role within general practice and family practice settings, providing an interface between the practice and the patient,[13] managing both the practitioners' and the patients' expectations.[14–16] Receptionists operate

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How this fits in

The role of the receptionist is pivotal within general practice, providing an essential interface between the patient and the practice, managing demand while maintaining a safe and efficient service. Guided by a conceptual review, the team-based ethnographic approach enabled a unique insight into practice organisation and the implementation of alternatives to face-to-face consultations, with a focus on the role of the receptionist. With general practice constantly evolving, it is important to consider how the introduction of new innovations might affect the whole team. Involving the wider team, including the reception staff, in discussions and planning would ensure that reception staff are suitably prepared to support the introduction of alternatives to face-to-face consultations.

within a complex system, with the ultimate goal of ensuring fair access to services.[17] Although they may have less status than clinical staff, they can be very influential in patients' access to care if they are well supported.[18] However, training and support for reception staff development is reportedly patchy.[19] With the growing complexity of general practice the role of the receptionist is evolving, and often their role is undervalued by patients and GPs.[20]

This article draws on a focused ethnographic study to examine the specific role that reception staff play in the promotion, uptake, and facilitation of the use of alternatives to face-to-face consultations in primary care. Further information on the wider study is described elsewhere.[21,22]

Method

Data were collected from eight case study practices across England and Scotland (from June 2015 to May 2016) that had offered telephone, e-consultations, email, or internet video as an alternative form of consultation, with varying degrees of success. Case study practices were selected to represent diverse location, patient list size, areas of deprivation, and ethnic mix, as well as experience of implementing alternative consultation types (Table 1). The authors used a team-based focused ethnography (described elsewhere),[21] where targeted data is collected within a focused field of enquiry. This is an applied and pragmatic form of ethnography, increasingly used in health services research to explore policy-relevant questions with a balance of depth and timeliness.[21] The fieldwork team consisted of five researchers: a day-to-day lead, a senior lead, and three ethnographers who worked in the field for up to 8 weeks in each case study practice.

Data collection

Data collection was guided by the results of a conceptual review about key considerations in implementation of alternatives to face-to-face consultations.[12] This identified the gap in evidence about the role of the receptionist, which therefore became a key focus for the study. The authors observed reception areas in primary care and talked informally with staff, recording field notes, as well as conducting formal (recorded and transcribed) interviews with members of practice staff, patients, and family carers. Written consent was obtained from all participants.

The ethnographers recorded their observations and informal conversations in written field notes at the practices before transforming them into an electronic format.[23] Interviews were digitally recorded, using an encrypted recorder. The files were transcribed verbatim using a professional transcription service.

Theoretical approach

Guided by the authors' conceptual review,[12] for this analysis of the role of reception staff the authors drew on Halford's focus on how new technologies can disrupt staff roles within organisations,[24] and Weiss's 'theory-based evaluation' approach to examine the mechanisms through which an intervention is implemented.[25] The combination of observational and interview data provided the research team with an insight into the factors that influenced successful adoption, and the role of reception in implementing the new technology.

Data analysis

A coding frame was devised through discussion within the fieldwork team. A summary profile was created for each practice by each ethnographer after reading and coding their own field notes. Each transcript and summary profile was double coded by a second member of the ethnography team, to ensure reliability and comparability, and then entered into NVivo version 10. Thematic reports were then generated, which included observations of reception staff and interview extracts referring to reception roles. Data consisted of what the authors had observed, what they had heard, and what they had been told across the eight practices, taking local

Table 1. Case study practice characteristics

Practice	Number of days spent in observation	Patient list size	Location of practice[a]	Deprivation score	Alternative to face-to-face consultation used
A	25	18 353	Inner city	Deprived 3	*Telephone consultations* — open to all patients, with an *ad-hoc* approach to scheduling. The receptionist would send a message to the clinician asking them to ring the patient. There were no scheduled appointments for telephone consultations. *E-consultation*[b] — guided by a protocol, with an *ad-hoc* approach to scheduling. The practice was actively promoting the use of the e-consult software through advertising on the website, in the practice, and on the answerphone message
B	19	8954	Inner city	Deprived 3	*Telephone consultations* — open to all patients in a semi-structured way, with some appointments ringfenced for telephone consultations. The receptionist would add more if needed. It was actively promoted by the practice to manage demand
C	18	15 000	Inner city	Mixed 4	*Telephone consultations* — open to all patients in a semi-structured way, with some appointments ringfenced for telephone consultations. The receptionist would add more if needed. *E-consultation*[b] — guided by a protocol, with a structured approach to scheduling. The practice was actively promoting the use of the e-consult software through advertising on the website, in the practice, and on the answerphone message. *Email* — a Webform email was dealt with in the same manner as e-consultations. Less obvious on the website and not actively promoted
D	8	1938	Rural	Mixed 5	*Telephone consultations* — the GP had telephone slots (about six a day), and the receptionist would add more at the end of the day if needed. *Video consultation* — used as part of the communication with people living remotely. It was rarely used. *Email* — used occasionally to organise the practical aspects of care. An email address for administrative purposes was on the patient leaflet
E	17	7196	Inner city	Deprived 1	*Telephone consultations* — the practice used a patient callback system. This was as a scheduled 5-minute appointment. *E-consultations*[b] — guided by a protocol, with a structured approach to scheduling. *Email* — a Webform email was dealt with in the same manner as e-consultations
F	25	13 778	Semi-rural	Affluent 10	*Telephone consultations* — open to all patients in a semi-structured way, with some appointments ringfenced for telephone consultations. The receptionist would send a message to the clinician asking them to ring the patient back when these had been filled. Actively promoted by the practice. A message is displayed in the waiting room promoting telephone consultations. Email — used by nurses to organise the practical aspects of care
G	16	13 511	Semi-rural	Mixed 6	*Telephone consultations* — open to all patients in a semi-structured way, with some appointments ringfenced for telephone consultations. Promoted as an alternative to face-to-face consultations
H	11	6597	Inner city	Affluent 10	*Telephone consultations* — open to all patients in an *ad-hoc* way by sending a message to the GP asking them to call the patient. Used once all face-to-face consultations booked. Cannot book in advance. There were no scheduled appointments for telephone consultations

[a]Practices A–C and F–H measured by the Index of Multiple Deprivation score. Practices D and E measured by percentage of practice patients living in data zones defined as the 15% most deprived (population weighted). [b]All those using e-consults in the study were piloting the use of the software for free. Email was used unofficially in all the case study sites, with GPs using email consultations for selected patients. The use of email by GPs did not involve the reception staff, except when the receptionist was expected to action a clinical response — that is, book appointments, communicate with patients, and so on.

context into account. This enabled the research team to see what people did, as well as what they said they did.

Three of the authors used a 'one sheet of paper' (OSOP) mind-mapping method where they identified each line of argument per thematic report and identified outliers or negative cases, which was then condensed onto one sheet of paper as a summary.[26] Findings were then discussed and refined within the wider research team. All data were anonymised.

RESULTS

The authors spent 139 days in observation across the eight case study practices (Table 1). They interviewed 39 patients and family carers, alongside 45 members of staff. These comprised 19 GPs, eight practice managers, two deputy practice managers, one practice coordinator, two senior practice nurses, three practice nurses and one nurse practitioner, one rural health worker, four senior receptionists, one receptionist, one patient service manager, one practice administrator, and an IT manager.

Practices used a multitude of approaches to inform their patients about new methods of consultation, usually related to the type of alternative to face-to-face consultation introduced, alongside the rationale for its introduction. Those practices using e-consultation or Skype™ as a way to reduce demand or to provide a service for hard-to-reach patients invested in posters and flyers in the waiting room, messages on the practice telephone system, and information on the practice website. Practices using email mainly informed patients by personal invitation. Despite being widely used to address demand, telephone consultations were not well publicised.

In all eight practices it was observed that reception staff were central to implementing alternatives to the face-to-face consultation. However, they reported that they had experienced some changes in their workload as a result of the introduction, but were minimally involved in establishing either the need for these alternative approaches, or how they were expected to operate.

The reception role in patient awareness and uptake of alternatives to face-to-face consultations

In the case study practices, the authors observed at first hand the pivotal role of reception staff in determining whether patients were alert to the different consultation methods.

Field notes demonstrated that uptake of the new service depended on their provision of information:

'During an observation of the reception desk, a receptionist was heard to ask a caller if they had considered using the e-consult service and explained to them how this is done.' (Observation of a receptionist, Practice A)

'Receptionists were observed handing flyers about the new e-consult service to patients during registration.' (Observation of receptionists, Practice C)

This observation was supported by the interviews with patients. For example:

'It would have been just the receptionist at the medical centre who told me about that. I think they've only recently got the software to be able to do video calling, so it's quite a new thing.' (Interview with a patient, Practice D)

As the authors have shown in a linked study, overall uptake of the alternatives to face-to-face consultations in all eight practices was lower than had been anticipated when the new systems were introduced.[22]

Clinical and management staff in some practices suggested they were unsure how much the receptionists were promoting the new initiatives, especially the e-consultations:

'I'm not sure how actively the reception are promoting it [the e-consult]. *I think my hope was that it would be reception-led quite a lot.'* (Interview with a GP, Practice F)

'Well, the receptionists need to push it, so there are more telephone consultations because we encourage it more.' (Interview with practice manager, Practice D)

However, one GP recognised the challenges receptionists faced:

'Receptionists ask people when they first phone in for an appointment, saying: "Why don't you go on the electronic consultation?" And they get mixed response to that. Some people say: "No." And some people say: "Oh, OK then." But they do get a bit of flak ... you then get a message saying, "I tried to get them to do an electronic consultation, but they refused."' (Interview with GP, Practice A)

The authors' observations suggest that, despite the intentions of practice managers and doctors, alternatives to the face-to-face consultation were not routinely offered to patients, except when there were few face-to-face appointment slots available. This reinforced the perception of the alternatives as a 'second best' option:

'They're [telephone consultations] *often offered. Personally, I offer them if there isn't a routine face-to-face appointment, so it's always offered as a kind of secondary option.'*

(Interview with receptionist, Practice G)

Adequate training, support, and acceptability of the new approach for reception staff

In case study practices, the authors witnessed variable enthusiasm among reception staff, typically linked to willingness to adapt, familiarity with the new system, and personal preferences. Though it had been hoped that telephone consultations might be more convenient for the patient and more cost-effective for the practice, interviews suggested a lack of alignment within the practices. For example, a receptionist, asked what they thought about telephone consultations, replied:

'It's not the best way, I don't think, not really. Face-to-face is always better.' (Interview with a receptionist, Practice B)

Some reception staff held opinions about the merits of alternatives to the face-to-face consultation, which could have implications for how these are offered to patients:

'The receptionist then says that some people ask for a telephone consultation, but it is not appropriate for everybody, like elderly people.' (Notes of an informal conversation with a receptionist, Practice G)

Guidance about when and to whom to offer an alternative to a face-to-face consultation was not always in evidence, and practice varied between and within the organisation.

Reception staff were observed using protocols, but also explained that they used experience and personal judgement to offer a range of appointment modes. As a practice nurse (Practice F) said during observation:

'It's about what is an appropriate appointment for the patient and for the GP. The receptionist usually gets it right.'

In Practice A, a memo indicating a list of presenting symptoms that were suitable for e-consultation was on the reception wall, and also in a room where incoming calls were received. In contrast, during an informal conversation with a GP (Practice B), it became clear that reception staff were relied upon to 'use their initiative' to decide in which situations to offer a telephone consultation:

'It's just the comfort of the receptionist to know when they can ... suggest to the patient: "Is this appropriate for a telephone consultation or not?" I think it's just a ... change of thinking really.' (Interview with GP, Practice F)

One of the more challenging aspects of the receptionist's role is the requirement to determine whether or not a patient needs to talk to a doctor urgently. Receptionists did not always feel comfortable about making the decision about whether a face-to-face consultation was necessary, and were often aware of the interactional difficulties that could be caused if patients thought they were trying to discourage or delay appointments:

'You have to ask them what they want to talk to their GP about, and many don't want to share it with the receptionist. It is hard to extract information from people; you have to ask the right questions in order to get the information. You have to go in-depth, and listen more.' (Notes of an informal conversation with a receptionist, Practice F)

Receptionists sometimes used telephone consultations as a way to address patient demand rather than using them for the purpose they were intended by the practice. This could be for patients who had requested a same-day appointment when no appointments were available so if the GP felt the patient required an appointment then the GP might 'squeeze them in'. One receptionist (Practice A), who was observed offering a telephone consultation when there were no same-day appointments, commented:

'Now the GP can make a decision whether the patient needs seeing today.'

Despite this, there was a level of expectation that reception staff would be fully able to establish priorities:

'When they get through, the receptionist will determine whether it's urgent or if they sometimes can answer the question. (Interview with a practice manager, Practice E)

However, from a GP's viewpoint, this attempt to prioritise did not always work well:

'I've seen my screen kind of expanding and expanding, and I have had to send a message to reception saying: "I can't do any more telephone consultations today." So, it's educating reception what to put

through to where, really.' (Interview with a GP2, Practice B)

For some reception staff, the change was too great to accept:

'It affected the receptionist team ... because they had to be retrained to work in a completely different way, and some of the staff, well, some are no longer with us 'cos ... they didn't enjoy it.' (Interview with a practice manager, Practice F)

Involvement of reception staff in planning and implementation

None of the practices reported having involved any reception staff in deciding what method of alternative consultation to introduce, nor had they discussed what it was hoped might be achieved. There was little evidence that receptionists had been consulted about implementation or consideration, given that such a change would impact on the receptionists' workload.

One exception to this was a practice manager who was asked about receptionists' involvement in the introduction of telephone consultations. They explained how the team were informed once the decision had been made:

'I went down to reception and there was a team meeting, so I sat down with them and said: "Look, here it is, this is what it is going to do, how would you manage it? So, it is ultimately going to come to you to ring the patient back or to do whatever, what is the simplest way to do that for you?"' (Interview with a practice manager, Practice A)

As the authors have discussed elsewhere,[22] in some of the practices the main reason for introducing an alternative to the face-to-face consultation was to reduce pressure on the telephone system. Patients and staff maintained that a potential benefit of email and e-consultations was that the pressure on reception should be reduced, although in some cases the electronic messages were still received and processed by the reception or administrative staff.

Only one GP stated explicitly that the practice could save money by employing fewer reception staff if the new system helped to reduce demand on the reception desk. However, there was little evidence that there were fewer demands on reception staff — and, in some respects, there were more. For example, receptionists who had requested a phone consultation felt responsible for checking that the GP called back within a reasonable time frame:

'"Somebody's missed that telephone call." And, by that time, usually, the patient's rung in saying: "The doctor hasn't rung me." And then we have to react by getting to the doctor and saying: "Did you not ring that patient?" So there, there can be some extra work.' (Interview with a receptionist, Practice F)

Some respondents indicated that the introduction had resulted in additional work. For instance, receptionists were expected to record a reason given by the patient for a telephone consultation, though this was not requested from the patient when booking a face-to-face consultation. Other additions to the workload were more subtle:

'Obviously, when we book in these telephone consultations, we always make sure that we are checking their contact details as well. Patients do sometimes say: "Well, I know this is my telephone number, but my phone's not working, so I will give you my friend's number."' (Interview with a receptionist, Practice C)

Reception staff were aware that different doctors had different consultation preferences and said that they tried to accommodate these, alongside patients' preferences, when booking appointments.

One form of e-consultation involved a manual step whereby the reception staff allocated the patient to a virtual appointment using a protocol. Although this additional work was not generally recognised, one practice manager (Practice E) acknowledged:

'The biggest change is for the reception staff, yes.'

In contrast, a GP from a different practice felt:

'It is a small role, just sending it to me, so it is not a huge amount of work.' (Interview with a GP, Practice A)

The onus appeared to be on reception staff to make the right decisions. It was notable that, though there was some recognition from the GPs and practice managers that introducing new approaches to consultations might lead to difficulties for receptionists, this was minimal and was not associated with any solutions.

DISCUSSION

Summary

The role of the receptionist in managing

alternatives to the face-to-face consultation was key, due to their patient-facing role. The authors found that receptionists were central in promoting and facilitating the use of such alternatives, managing demand, and ensuring patient safety. However, their contribution and role was not always adequately considered when organising new approaches to consultations in the practice. Reception staff were generally not involved in the decision about which alternatives might benefit the practice, or in discussions about how best to implement such approaches. Receptionists who saw telephone consultations as a 'second best' option were unlikely to routinely offer this option, unless no face-to-face appointments were available. Uptake of alternatives was low in all practices. A contributory factor was the lack of alignment between the practice rationale for introducing the innovation, and any perceived potential benefits that receptionists associated with the new approach. The authors' observations suggest that this mismatch had consequences for the successful uptake of the system.

Strengths and limitations

A strength of the authors' approach to the ethnographic fieldwork was that it drew on their conceptual literature review,[12] which guided them to focus on areas including practice organisation and the unintended consequences of new technologies. The review identified that reception staff have been little discussed in the literature, so they were a key focus for the study.

Using a focused ethnographic method enabled the research team to see what people do, as well as what they say they do. The authors' team-focused ethnography was an applied and pragmatic form of ethnography, enabling exploration of a specific social phenomenon as it occurs in everyday life within a relatively short time span. As a result, there is the risk that some of the more nuanced features of the practices were overlooked. However, through regular meetings of the research team, possible areas of interest were highlighted and added to the researchers' focus.

Using ethnographic observation and interviewing can lead to a researcher effect. Because three researchers were employed to collect data, a shared understanding of the phenomenon under investigation must be developed, along with a level of trust required to share reflexively. To address this, the authors instigated a careful process for gathering comparable data across the team, including regular telephone conferences and analysis meetings.[21] In analysing the data, the authors prioritised what they saw and heard during the observations over what they were told (in interviews), reporting the source of the data.

The case studies included in this study were selected because of their direct experience of adoption of alternatives to face-to-face consultations. The authors did not select practices on the basis of whether or not their introduction of alternatives appeared successful. Some of the technology (for example, e-consultations) was new, therefore, the authors accept that if repeated at a later date the level of uptake may differ. It is also possible that other practices may have different experiences of reception staff involvement.

Comparison with existing literature

When introducing a new initiative to an organisation, there is a need to ensure communication, clear vision, and strong leadership,[9] while integrating changes within existing routines.[11,27] Therefore, it is important to recognise the potential of all primary care team members,[20] and receptionists are crucial to the introduction of any new appointments system. Although this might seem an obvious move, the study practices, on the whole, did not do this. The prominent views of the doctors in considerations of new innovations, as reported in the conceptual review,[12] were repeated in these findings, and it appears that the effect on other members of staff was not much considered. This omission was material in the failure to sustain the change, or in its subversion, leading to unintended consequences.

As earlier studies have indicated, the role of the receptionist is to provide an interface between the patient and the practice,[13] and therefore receptionists are central to introducing new approaches to consultations. The decision about when to offer an alternative to a face-to-face consultation is linked to providing a safe, efficient, and equitable service,[14,15] as well as helping to assess need and manage demand.[17,28]

In a recent paper on the introduction of online consultations, the authors reported that work was redistributed from the GPs to the patients and the administrative staff.[29] The authors' findings support the view that the introduction of alternatives to face-to-face consultations could have unforeseen implications for other primary care staff, which may increase their workload. There is little evidence that the introduction of

alternatives to face-to-face consultations are associated with any reduction in GP workload.[30,31] This study has begun to address the limited acknowledgement in the literature of the role of the receptionist in the introduction of alternatives to face-to-face consultations.[12]

Implications for practice

The operational role of the receptionist in alerting patients to face-to-face consultations, and facilitating the use of alternatives, was underpinned by assumptions that reception staff understood its purpose and would offer the new service as expected by clinicians and management, and that the new initiative would have little (or only beneficial) effects on reception workload. The authors' findings suggest that this was not always the case. The lack of consideration of the impact on receptionists, combined with the lack of training, meant that receptionists used their own initiative about when and how to offer (or not to offer) different forms of consultation. Such issues may have hindered the success of the service innovation, and led to unintended consequences, such as increased workload.

Therefore, the authors would recommend that general practices, and wider providers of primary care, should consider the role of the receptionist as key when considering the introduction of new systems for how patients access care. This should lead to involvement of receptionists in planning the implementation of these initiatives, supporting team members through service reconfiguration, and providing an opportunity to discuss and contribute to modifications of any new system. This should be accompanied by adequate training for receptionists' new roles, along with clarity about expectations of them. Although the focus of this study was the introduction of alternatives to face-to-face consultations, these insights may be applied to wider issues of practice changes. Clarity about the rationale for any changes needs to be discussed throughout the team, otherwise there is a risk that the planned changes will be less successful than expected.

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