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The place of receptionists in access to primary care: Challenges in the space between community and consultation

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ABSTRACT

At the point of entry to the health care system sit general practice receptionists (GPRs), a seldom studied employment group. The place of the receptionist involves both a location within the internal geography of the clinic and a position within the primary care team. Receptionists literally 'receive' those who phone or enter the clinic, and are a critical influence in their transformation from a 'person' to a 'patient'. This process occurs in a particular space: the 'waiting room'. We explore the waiting room and its dynamics in terms of 'acceptability', an under-examined aspect of access to primary care. We ask '*How do GPRs see their role with regard to patients with complex health and social needs, in light of the spatio-temporal constraints of their working environments?*' We engaged receptionists as participants to explore perceptions of their roles and their workspaces, deriving narrative data from three focus groups involving 14 GPRs from 11 practices in the Northland region of New Zealand. The study employed an adapted form of grounded theory. Our findings indicate that GPRs are on the edge of the practice team, yet carry a complex role at the frontline, in the waiting space. They are *de facto* managers of this space; however, they have limited agency within general practice settings, due to the constraints imposed upon them by physical and organisational structures. The agency of GPRs is most evident in their ability to shape the social dynamics of the waiting space, and to frame the health care experience as positive for people whose usual experience is marginalisation. We conclude that, if well supported, receptionists have the potential to positively influence health care acceptability, and patients' access to care.

1. Introduction

This paper examines the preclinical phase of primary care from the perspective of those positioned as the first point of contact for patients: general practice receptionists (GPRs). It explores the 'space' between patients and clinicians; both the literal space of the 'waiting room' and the metaphorical social space occupied by GPRs and patients as they interact and engage.

By way of context, the socio-spatial environments of health care are increasingly being conceptualised as spaces that can support or detract from people's wellbeing (Conradson, 2003; Evans et al., 2009). Evidence indicates that aspects of the health care environment have particular and significant implications for populations who experience dismissal, discrimination and social exclusion in both health care contexts and in their everyday lives (Browne et al., 2012). It has been argued that geographic research has tended to overlook the complexities of the daily operation of health care (Andrews and Evans, 2008), something that this research addresses.

Our interest in reception spaces and processes within primary care settings aligns us with a range of other recent work that has critically examined the internal geographies of health care spaces. Ranging from general practices (Conradson and Moon, 2009), through accident and emergency clinics (Barnett and Kearns, 1996), to specialist hospitals (Gesler et al., 2004; Kearns et al., 2003) health geographers have examined how design, marketing, power relations and professional practices can, in combination, generate spaces that variably welcome or deter patients. Specifically, the spaces of primary health care have been examined in terms of access, equity and community (Hanlon, 2009). This paper extends our interest in the socio-spatial dynamics of care sites (Kearns and Neuwelt, 2009). It builds on Arneill and Devlin's (2002) investigation of the influence of the waiting room environment on patient perceptions of quality of care. Further, it complements Strathmann and Hay's (2008) examination of

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patients' treatment of receptionists with a concern for the opposite dynamic: how do receptionists perceive patients and their working environments? Our study also responds to the work of Evans et al. (2009) on the aesthetics of waiting spaces and their call for research involving patient and provider perceptions. Such perceptions are of interest because of the complex but under-recognised internal geographies of community clinics. In the words of Gillespie (2002, p. 211) "… rather than a neutral backdrop to social relations, architecture, materiality and space can uphold dominant cultural discourses, social divisions and inequalities".

We bring to our deliberation a concern for improving equitable healthcare access for people with complex health and social needs, often referred to as disadvantaged or 'hard to reach' (Conradson and Moon, 2009; Hanlon, 2009). Established inequities in access to primary care in New Zealand (NZ) forms a national context for our investigation. NZ primary care is organised around general practices, most of which are privately owned by general medical practitioners (GPs). Practices belong to administrative structures (primary health organisations) and set their own fee levels. With the exception of young children, co-payments for clinical care are required, which has created cost barriers to care (Barnett, 2001). People of Māori and Pacific ethnicities and low income earners have consistently experienced inequitable 'realised access' to primary care, having the lowest primary care utilisation relative to need in NZ (Scott et al., 2003). While cost has been found to be a major explanation, it is not the only factor underlying this trend. For example, there is evidence that Māori have experienced significant (negative) differences in the processes and outcomes of care compared to non-Māori patients (Crengle, 2007). Drawing on Hanlon (2009), we suggest that these differences can be attributed to both material and discursive influences on health care utilisation.

The key question we address is '*How do general practice receptionists (GPRs) see their role with regard to patients with complex health and social needs, in light of the spatio-temporal constraints of their working environments?*' The notion of 'acceptability' (of patients to receptionists, of reception processes to patients) is a conceptual starting point. We then review previous research on the role of receptionists in health care, and on 'spaces of waiting'. Next, we present the study design and key findings. We close with a discussion of how our research contributes to a deeper understanding of the potential role of GPRs in improving access to primary health care for people who experience marginalisation and high health need. We conclude that the place of receptionists 'under the radar' within primary care teams not only undervalues their complex contributions at the point of entry, but also fails to acknowledge their potential in enhancing the acceptability of health care for patients.

2. Acceptability, reception processes and waiting spaces

Acceptability is an under-examined aspect of access to health care. As the point of entry into primary care and the wider health care system, the acceptability of the waiting space and the actions of GPRs influences access to care. Access is a multi-dimensional concept, which has been described as "the degree of 'fit' between the clients and the system [of healthcare]" (Penchansky and Thomas, 1981, p. 128). In exploring 'fit' the emphasis in research and policy has largely been on geographic access (accessibility) or cost (affordability). Barriers to accessing health care have been categorised as including physical dimensions (e.g., distance) and effective aspects (e.g., cost, opening hours, and cultural acceptability) (Conradson and Moon, 2009; Joseph and Phillips, 1984).

Following the useful distinction proposed by Aday and Andersen (1974), our interest is in 'realised access', or how people actually make use of available health care. Actual use, we argue, is potentially shaped by the degree to which patients receive a positive reception at a primary care setting and is clearly a dimension of effective accessibility. Thus while distributional aspects of primary care, and their equitable availability over space, must remain a fundamental concern (Hanlon, 2009), we maintain that acceptability and, in particular the dynamics of reception spaces and processes, are potentially a potent institutional filter influencing accessibility and utilisation of health care. Acceptability can be defined as "the relationship of clients' attitudes about personal and practice characteristics of providers to the actual characteristics of existing providers, as well as to provider attitudes about acceptable personal characteristics of clients" (Penchansky and Thomas, 1981, p. 129). It incorporates patient satisfaction with characteristics of the 'medical office', such as its appearance (Starfield, 1998). However, acceptability also includes patient or practitioner comfort with personal characteristics, such as age, gender, social status, and ethnicity of the 'others' encountered in that setting (McLaughlin and Wyszewianski, 2002). It is this aspect of acceptability that is often neglected in research and policy (McLaughlin and Wyszewianski, 2002), and which this paper addresses. Whitehead (1991) called for the monitoring of 'acceptability', as a component of healthcare quality and equity, to ensure that services are "user-friendly" for those who most need them (p. 222). Along with patient-centred care, which is currently at the forefront of efforts to improve healthcare quality, acceptability also relates to cultural competence, a component of professional standards for GPs, nurses and other clinicians in countries such as NZ and Canada (Bacal et al., 2006; Brascoupe and Waters, 2009; Wepa, 2005).

The doctor–patient relationship is central to health care acceptability and has been the focus of extensive research, whereas studies have seldom explored receptionist–patient interactions or peoples' experiences of waiting rooms. In the general practice setting, care is initiated in the waiting room through interactions with GPRs, who have been called "the public face of the physician" (Strathmann and Hay, 2009, p. 221). A Canadian study in the non-urgent division of an emergency room found that patients were concerned that their health issues could be potentially dismissed or diminished depending on how they were 'read' by receptionists, healthcare providers, and other staff (Browne et al., 2011). Elsewhere, a UK study highlighted that the structure and organisation of primary medical care gives receptionists a "discretionary role in determining access to the general practitioner" (Arber and Sawyer, 1985, p. 911). Arber and Sawyer (1985) identified that not only is the doctor–patient relationship deserving of attention but so is "the triad of doctor–receptionist–patient" (p. 918). This paper examines one axis of this triad: receptionist–patient dynamics within the specific space of the waiting room.

A discourse analysis of receptionist–patient interactions suggested that GPRs may rely heavily on task-oriented verbal routines and thus be perceived by patients as lacking empathy (Hewitt et al., 2009). A NZ investigation found that some GPRs operate like "invisible clinicians", offering advice to patients and carrying out informal clinical triage (Arroll, 2011). Ethnographic research revealed that GPRs carry out a complex role that they handle by managing their own and patients' feelings, a finding that has been termed 'emotion management' (Ward and McMurray, 2011). GPRs can feel torn between their duty to the practice and their desire to meet patients' needs (Alazri et al., 2007; Gallagher et al., 2001) given their place within hierarchically-structured organisations, where they are often abiding by doctors' implicit and explicit rules (Arber and Sawyer, 1985).

Offredy (2002) has highlighted that GPRs, in her UK study, carried out a 'moral judgement' when prioritising patients. Whether or

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