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Short report

The unspoken work of general practitioner receptionists: A re-examination of emotion management in primary care

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ABSTRACT

Dealing with illness, recovery and death require health care workers to manage not only their own emotions, but also the emotions of those around them. While there is evidence to suggest that core occupations such as nursing are well versed in the nature of and need for such work, little is known about the requirements for emotion management on the part of front-line *administrative* staff. In response, findings from a three-year ethnographic study of UK general practice, suggest that as a first-point-of-contact in the English health care system GP receptionists are called upon to perform complex forms of emotion management pursuant to facilitating efficacious care. Two new emotion management techniques are identified: (1) emotional neutrality, and (2) emotion switching, indicating a need to extend emotion management research beyond core health occupations, while at the same time reconsidering the variety and complexity of the techniques used by ancillary workers.

Introduction

Receptionists have become central to the functioning of general medical practices, so much so that Arber and Sawyer (1985) note that it is no longer appropriate to talk of a dyadic relationship between doctor and patient, this having been superseded by the triumviri of doctor–receptionist–patient in primary care. While doctors have been observed to benefit from this change in terms of assistance with service co-ordination and demand moderation (Arber & Sawyer, 1985; Copeman & Van Zwanenberg, 1988; Gallagher, Pearson, Drinkwater, & Guy, 2001) the response from patients has been more ambivalent; with the receptionist as administrative intermediary being stereotyped as an uncaring barrier to much needed health care (Arber & Sawyer, 1985). The above implies that there is little recognition of the place and performance of emotional labour (Mann, 2005) in such front-line health care. This is potentially significant given that receptionists are administrative gatekeepers to General Practitioners (GPs) who, in the English health care system, continue to be the primary medical gatekeepers to NHS care – a position recently strengthened by reform (DH, 2010). This paper considers the extent to which GP receptionists are required to perform emotion management and the implications this has on the patient journey through primary care. We begin with a brief review of the extant literature on emotion management.

In her landmark thesis Hochschild (1983) compares the instrumental use of flight attendants' emotions in the service sector with that of labourers in the secondary sector. She notes that in the former case the 'the emotional style of offering' is part of the service itself as flight attendant's emotions are commodified by the airline in exchange for a wage, just as manual workers are paid for their physical labour power by factory owners (Hochschild, 1983: 5). Emotion management is therefore defined as the ability 'to induce or suppress feeling in order to sustain the outward countenance that produces the proper state of mind in others' (Hochschild, 1983: 7).

This work has been usefully extended by Korczynski's (2003, 2009) distinction between empathetic and antipathetic emotion management (often emotional labour where performed for a wage). Korczynski classifies empathetic emotional labour as that which is intended to produce a positive emotional state in others, such as the sense of happiness, safety or care that may be associated with the work of nurses, cabin crew or hairdressers. By contrast, antipathetic emotional labour is intended to produce a negative emotional state in others, as in the fear and insecurity potentially employed by debt collectors, or prison guards

In 2009, Korczynski developed the empathetic–antipathetic dichotomy to propose that service roles should be differentiated on

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the basis of what he calls the 'substantive nature of the emotional bearing *enacted* by the worker to the customer' (2009:957, *emphasis added*), that is to say the degree to which the worker's private emotions are intertwined with the customer. Similar to Rafaeli & Sutton's (1987) faking in good and bad faith, Korczynski (2009) suggests a 'continuum' of 'emotional bearing', with the two extremes being a 'purely instrumental approach' and a 'caring approach'. The instrumental approach requires workers to have little emotional engagement with the customer beyond the commercial interaction, whilst the 'caring approach' is characterised by a "deep level of humanity enacted by workers towards service-recipients (Bolton & Houlihan, 2005)" (Korczynski, 2009: 958).

Thus, Korczynski's work begins to move us towards the possibility of considering emotion management as a relational process of commission, performance and consumption; the experience of which can be positive or negative. Moreover it serves as a useful backdrop to emergent debates on emotional labour's relationship with health care generally, and our concern with the service role of receptionists specifically.

In spite of some significant contributions to the emotional labour literature stemming from research in health care (notable examples include James (1989); Smith (1992); Bolton (2005); Theodosius (2008)), at present there is no equivalent of this research for those working in health administration. The result is a narrow picture of the place and performance of emotional labour within the health care sector as a whole (Mann, 2005). It is in response to this lack that the present paper considers the emotional labour of GP receptionists.

Method

Design and approach

A qualitative ethnographic study was undertaken between 2005–2008. The approach was multi-method, with a view to militating against the socially desirable response bias that has been observed in emotional labour research, particularly where there is an over reliance on interviews (Czarniawska, 2004). To this end non-participant observations ($N \sim 300$ h) and impromptu interviews undertaken during observations-($N \sim 50$), semi-structured-($n = 4$) and group interviews ($n = 1$) were all employed.

Participants & place

Three English general practice surgeries agreed to participate in the study. One served a largely middle class ageing population (site A), the second, an area of high social and economic deprivation (site B), and the third an inner-city population of mixed economic and social status (site C). All 28 staff involved in reception work across the three sites took part in the study. All were women, aged between 23 and 66 years. Local NHS ethics and research governance approvals were sought and obtained prior to the initiation of the research.

Procedure

Non-participant observations began with six continuous days at each of the practices. The lead author observed and documented the nature of the work, allowing for the direct identification of emotion management. In total, a further 30 days of observation were undertaken at different points of the study (by both researchers), across all sites, to assess the extent to which the nature of reception work may have altered over time. Because observer interpretations may differ from those of participants, in-situ interviews were used during observations to ask receptionists to comment on their experiences, feelings and motivations. These impromptu interviews (Fox, 2004) lasted anywhere between 2 and 20 min.

Four of the receptionists (1 from site A; 2 from site B; 1 from site C) who had been observed, volunteered to take part in in-depth interviews which lasted for up to 90 min and centred on participant's reflections on: recently observed events, how they negotiate patient interactions, what makes for a good receptionist, and the role of emotional performances.

The final part of the multiple method strategy involved the facilitation of a group interview, in which both researchers encouraged reception staff to share experiences so as to compare perceptions of related phenomenon (Murphy, Dingwall, Greatbatch, Parker, & Watson, 1998). Seventeen receptionists from across all sites volunteered their time to be involved in the group interview facilitated at site C.

Analysis

Handwritten notes of observations and in-situ interviews were transcribed, whilst all other data was digitally recorded and transcribed in the same way. In this sense the in-depth interview data and that elicited from the group interview were verbatim written accounts. Both researchers employed a process of intuitive comparative analysis collaboratively. Building on the work of Glaser and Strauss (1967) a constant comparative method was employed with a view to examining and comparing the actions, processes and interpretations of those engaged in reception work, in such a way that would allow the analysis to construct an account of emotional labour and any competing logics operating through such work. Our aim was to identify the range of processes engaged with and experienced by receptionists, and not their prevalence. There are therefore no 'counts of frequency' or attempts to generalise probabilistically.

A thematic analysis was used to analyse and compare the interview accounts with observations made by the researchers (observations having been rendered as textual data following transcription). To ensure methodological rigour, the researchers' interpretations and analyses were re-presented to a small number of volunteer participants ($n = 6$) during further reflexive interviews (not included in the data set), in which views were exchanged on researcher interpretations of events. Any factual inaccuracies identified during this process were corrected.

No details of patient identity were used or recorded during the study. While age and length of tenure are indicated for receptionists, pseudonyms are employed to designate data extracts. Emergent themes of empathy, neutrality and switching are considered in turn following a brief comment on the nature of receptionists' work.

Results

The role of the GP receptionist in England is to be the first point of contact for users, determining appropriate access to health staff (as administrative gatekeeper), while maintaining records and related documentation. Observation revealed that much of the reception work undertaken at the three practices was similar in kind to that witnessed in other GP contexts (Hewitt, 2006). We watched as the GP receptionists dealt with an almost continual flow of patients, requiring them to carry out routine tasks such as checking-in, booking appointments, filing, coding and directing. Supplementing these were more complexly 'relational-focused' processes (Hewitt, 2006) such as attending to individual patient needs and problems stemming from osteoporosis, language barriers, psychological and mental health problems, emergencies, death and common colds. Mornings were often frenetic, filled with phone calls for appointments and patient arrivals, trailing off at lunch times (where receptionists would catch up on administrative tasks), before