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Risk reduction in general practice and the role of the receptionist

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Abstract

Medical receptionists play a crucial and pivotal role in any practice, as they are usually the first points of contact for patients and the intermediaries through whom contacts with the medical practitioners are made. This paper reports the findings of a qualitative study of medical receptionists undertaken to explore their role in general practice, particularly in relation to activities involving direct patient assessment, monitoring, counselling and therapy. The findings highlight a number of significant issues in relation to the potential liability of the receptionists, the medical practitioners, the medical centre owners and their insurers.

Risk reduction in general practice and the role of the receptionist

Introduction

Legal issues are becoming increasingly important to general practitioners (GPs). Hence there is a need to identify and reduce potential risk that may lead to an adverse incident and consequent legal action. Medical receptionists play a crucial and pivotal role in any practice, as they are usually the first points of contact for patients and the intermediaries through whom contacts with the GPs are made. As employers, GPs are vicariously liable for the actions of their employees, like receptionists, so endeavour to provide guidelines and protocols to reduce the likelihood of them undertaking 'risky' activities. However, because of the complexity of most medical receptionists' jobs and the increasing work demands on GPs, there is the likelihood of receptionists undertaking unsupervised activities that may place the GP at risk of litigation.

As part of a larger study about the current and potential roles of general practice nurses, principal GPs in one Division of General Practice in southeast Queensland, Australia were asked about the activities of their receptionists. The findings indicated that some receptionists, while primarily employed for reception and clerical duties, were performing tasks that involved direct patient assessment, monitoring and therapy.¹ Although a small percentage of these receptionists may have had some prior nursing training or experience they were not currently licensed or employed under a nursing award and were therefore not regulated by statute. Interestingly, 29% of the GPs thought that medical receptionists could be taught to perform any 'nursing' work required in general practice. The study also found that 60% of the GPs surveyed did

¹ E Patterson, C Del Mar and J Najman, "Medical receptionists in general practice: Who needs a nurse?" (2000) 6 *International Journal of Nursing Practice* 229-236.

not employ a nurse essentially because of financial constraints and a perceived lack of need. The researchers concluded that these findings could be indicative of the current trend in health care to appropriate the work of nurses to lesser-paid unregulated workers to reduce the costs of running the service.

Based on these findings, a follow-up qualitative study of medical receptionists was undertaken to further explore their role, particularly in relation to clinical activities. This paper presents those findings and discusses the implications for risk management in general practice.

Background

Two decades ago Arber and Sawyer asserted that the power and influence of “lower participants” (medical receptionists) in small organisations, like general practice, had been the subject of little research.² Consequently they surveyed over 1000 adults in the United Kingdom (UK) to ascertain their experiences of the receptionist as ‘gatekeeper’ in determining their access to the GP. They noted that the receptionist frequently makes a medical assessment based only on a brief verbal exchange. These researchers observed that, in general practice, receptionists tend to work under guidelines (rather than formal rules) that they will modify under certain circumstances. Part of the study explored the receptionist’s role in giving health advice to patients. The majority of participants did not view the receptionist as having any role in this area, however, 14% of parents with children under five years claimed to be the recipients of unasked advice. The study did not establish the extent to which receptionists were involved in ‘hands on’ clinical procedures.

² S Arber and L Sawyer, “The role of the receptionist in general practice: A dragon behind the desk?” (1985) 20(9) *Social Science & Medicine* 911-921.

Almost 15 years later, Eisner and Britten observed that, although there had been some published work acknowledging the importance and difficulty of the general practice receptionist role, receptionists' views had rarely been sought.³ They surveyed 150 receptionists in one Health Authority in the UK and followed this with interviews of a sample of 20. Their findings indicated that while receptionists derived satisfaction from various aspects of their job they also experienced stress from difficult patients, the appointment process, and feeling caught between doctors' and patients' demands. The researchers concluded that receptionists' work is complex, demanding and intense.

Recently, the New South Wales Court of Appeal ruled that "a doctor's receptionist has a duty of care to assess a patient's condition, determine the urgency of the case and make an appointment based on the circumstances and urgency of the patient's symptoms".⁴ According to Kubacz, the case rested on the details of a conversation the receptionist had with a patient regarding the booking of an appointment. Kubacz asserts that if the receptionist had been provided with "all of the relevant information" and had not made an appropriate appointment, it is likely she would have been found to have breached her duty of care and the doctor may also have been found liable.

These few published papers indicate that medical receptionists in general practice play a critical role in that they largely determine who sees the GP and when, they

³ M Eisner and N Britten "What do general practice receptionists think and feel about their work?" (1999) 49(439) *British Journal of General Practice* 103-106.

⁴J Kubacz "Receptionists owe a duty of care" (2002) 10(5) *Australian Health Law Bulletin* 56.

often make medical assessments and give health advice and they sometimes undertake patient monitoring and therapy. As such their role needs further exploration to help ascertain if current guidelines and protocols are sufficient to manage potential risk situations from occurring. To this end this study was designed to better understand the context in which medical receptionists undertake clinical activities.

The Study

The study was conducted within one Division of General Practice in southeast Queensland. Following approval from Griffith University Human Research Ethics Committee and the Executive Board of the Division involved, individual interviews were conducted with seven medical receptionists. Each of the interviews was conducted at the participant's place of work and ranged from 45 to 90 minutes in duration. The interviews were guided by a set of open broad-ranging questions, the aim being exploration of their role. Responses to interview questions were collated question-by-question and analysed for both commonality and uniqueness.

The Findings

All of the medical receptionists were female and had been employed in general medical practices from two to eighteen years. Six of the seven participants had worked with the same GP throughout their general practice employment and of these, four had moved from one practice to another with this particular doctor. Only one worked with a solo practitioner, three were employed in small group practices and three were employed in large group practices. Only one was employed in a practice that also employed registered nurses. None of the receptionists had any prior nursing experience and only two had completed a certified medical receptionist training

course. Two receptionists had entered the field directly from school and the others had come from a variety of work experiences.

In the practices where there were several (four or more) receptionists, each one's role tended to be specific rather than generic. That is, while one of the receptionists in the practice may have been frequently undertaking a range of clinical activities, the others may not have. For example, one of the receptionists explained that she dealt almost exclusively with one of the GPs who did cosmetic surgery. This receptionist was employed in a practice that also employed two nurses and explained that the receptionists only attended to electrocardiograms, spirometries, first aid, wound dressings and sterilisation of equipment when there was no nurse, which was between 4:30 pm and 6:00 pm during the week and on the weekends. She also explained that not all the receptionists worked during these times while some only worked on weekends. Hence there was diversity within one practice in the extent to which receptionists engaged in clinical tasks.

In another practice, the receptionist said that there were usually about five receptionists on at a time and that they were each assigned specific tasks or duties for the day. She commented,

... one of the receptionists is a nursing sister and she does the lasers, about 16 a day, and the dressings.

When asked if this receptionist had current nursing registration, she replied that she had been a nurse a long time ago but was not registered any more.

A receptionist from another practice described a similar situation. She explained that she sometimes put a dressing on a patient after an excision but the receptionist who “*used to be a nurse*” usually did the ulcer dressings. That receptionist was also rostered to assist the doctors with minor procedures and to monitor the patients afterwards.

Three of the receptionists described the clinical aspects of their role in detail. One described how she had initially only been involved in reception, clerical and accounting activities but as the practice expanded she began taking on more and more patient assessment activities and began initiating some interventions.

When I started being a practice manager I spent a little bit of time in here (the office) but I always kept the door open and I listen to what is going on or the girls will call me if a patient's coming in bleeding, or a patient is coming in with chest pains, or someone has carried someone in and I will respond accordingly. I will take them out of the waiting room immediately and then I assess them. Whether it's chest pain, whether they are bleeding, where they are bleeding from, have a look to see how deep the wound is.

When asked what training had prepared her for this she explained that she used to manage an indoor sports centre and swimming pool in the UK before she migrated to Australia. That job gave her both management and accounting experience as well as skills in first aid and resuscitation. In addition she described how she had ‘acquired’ other skills and knowledge.

I have got a fairly extensive medical background in the family. My husband works for the Queensland Ambulance and his father is a GP. Two sisters and mum, they're all nurses. Another sister is a chemist. The medical background was there growing up...I picked up medical books lying around.

When asked if the other receptionists could be trusted to assess patients and initiate treatment like she did she replied,

No, not that they are expected to either, they are not. They are not paid accordingly, they're not trained accordingly and I wouldn't say that I have the training or qualifications to do it either, it's just experience, but it is sometimes a worry that they can't do everything.

Another receptionist, who worked with a solo practitioner, said that it was essential for her to be able to deal with any type of emergency or crisis because she was the only person available when the doctor was engaged with another patient. She provided examples of this.

I do lots of counselling with people on the phone that ring up upset; people saying that they are about to kill themselves or somebody's died, or you know, just different things, can't cope any more, something wrong with their children. Usually they ring me first and because we are very personal here, they talk to me and say 'oh what should I do?' Then I will try and calm them down and talk to them because I've had kids of my own as well, and been through all the things with kids trying to kill themselves and all that. I've got more life experience than formal, you know, practical rather than theory.

The third receptionist who described her clinical activities had only been in the position for two years and had come straight from school. She said,

It takes you three months to sort of find your way around the clinic, learning a lot of new names, medical terms, until six months and then you think 'Oh I can do this job'. Thereafter you don't even think it; it just happens.

Asked to elaborate on what 'just happens' she replied,

If you've got someone bleeding and no doctor, you're the one holding the pressure and you make a lot of decisions, you know, like how urgent or routine a case is; after awhile you know the patients, you can tell what's serious and what's not...people come in to have a dressing changed; the first time the doctor shows you what he wants, after that you just do it...or taking blood, once you've done it a few times, it's no big deal.

She went on to say that she had learnt to take blood from a pathology collection nurse who worked next door.

It's quite easy you know learning how to jab people, nothing to it really, you don't need to do the full course they run, that's too expensive and takes a couple of days.

Some of the receptionists explained that their practices had written guidelines for triaging patients and performing certain procedures. For example one receptionist said,

We have various questions we ask them. Are they bleeding, have they got any pain, have they got any chest pain. There is a variety of questions that we ask to determine the emergency of their situation, whether we need to get that patient down here or whether they really need to go to hospital straight away.

However, this receptionist then went on to relate how she often made her own judgements about the urgency of a patient's condition "*because I understand their situation after being in the practice for so long time and getting to know them well*".

Another described how the receptionists applied laser treatment and explained that this was "*a simple procedure that doesn't require any skill*". She went on to say,

It takes about 15 to 20 minutes so naturally you are one on one in a room on your own with the patient, so they get very friendly and chatty.

She was then asked how she determined what parts of ‘the chat’ with a patient were important to relate to the doctor. She responded by relating a particular incident that she had been involved in.

We had a young girl and she had been going to another practice and coming here as well. She was a very bad asthmatic, and she was on two lots of different medication. And, because I take asthma medication myself, I said ‘look, I think you should ask the doctor’. ‘Oh no’ she said, ‘I don’t want him to know that I went to the other doctor’. I said, ‘but they don’t mind, you know’. ‘Oh’ she said, ‘well just ask him’. So I did and the doctor said, ‘she’s got to come in, she can’t do that’. So the next time she came I said to her, ‘look, you know I did mention it to the doctor and he is here now so would you like to see him?’ And we fitted her in to see the doctor. He couldn’t believe it, she was on two lots of steroids and she had put on something like a stone and a half in weight. Couldn’t have done her heart a lot of good either I wouldn’t imagine.

This receptionist was then asked if she thought that another receptionist, with no personal experience of asthma medication, would have responded to the situation in the same way. She responded, “*I don’t think so; I guess she was just lucky that she got me that day*”.

Having started her medical receptionist career straight from school, another receptionist said she had essentially “*learnt on the job*”. She explained that out in the country you get all sorts of emergencies turn up at the surgery and you had to deal

with it. She said the doctor had said to her “*there is no one else to do if for me, you've got to do it girl*”. She said that she had been taught how to do dressings from that doctor’s wife who was a theatre sister and usually attended to them herself but sometimes “*was out of town*”. When asked specifically about training for sterilising instruments, she replied that one of the other receptionists had “*been a nurse, been in theatre and that sort of thing, so she knows*”. That receptionist had not had a nursing practising certificate for fifteen years.

Another also described much of her training as “*hands on experience*” built up over time and passed on by the doctors:

It’s mainly verbal we don’t have written guidelines. There are no standard rules, it’s just them (the doctors) saying this is what I want you to do for each different patient.

In contrast to these receptionists who appeared willing and confident to undertake clinical procedures, another receptionist expressed her unwillingness.

I didn’t want to get involved in that area of it [clinical work] and you have to watch what people consider you to be responsible for if something goes wrong. And I just make it clear; I really don’t want to get involved in that side of it. I make sure someone is comfortable and I will lie them down if I think they need to but when it comes to doing nursing, I just said ‘no I don’t want to do that’ and they were quite happy to accept that.

A few of the receptionists mentioned that they thought a lot of patients believed they had more knowledge and experience than they actually did.

I think they assume that you are a nurse or have nursing background or something to be a medical receptionist. A lot of them have that idea.

The evidence for this she gave as patients ringing to get the doctor's opinion and when told the doctor was busy being asked, "*oh well probably you can help, you're a nurse aren't you?*"

The receptionists were asked if they thought that the medical receptionist role would change at all in the future. The following opinion was very characteristic of the majority of their responses.

I see that being more of a nurse...I mean you could do it in two or three nights, you could learn to take blood and give needles and it only takes two days to get a medical first aid certificate...probably they will do a lot more nursing I think...It's a lot cheaper to employ a receptionist.

Discussion

These data indicate that there is diversity within and between practices in the extent to which medical receptionists undertake clinical procedures. Some describe a role that is difficult to differentiate from that of a practice nurse while others have very limited or no involvement. Some have had prior training through a medical receptionist course and some have been taught 'on the job' by doctors or nurses. There was also diversity expressed in their willingness and confidence to undertake these procedures.

While some appeared to eagerly seek out and take on this role, others just accepted what was delegated to them and some articulated reluctance.

What are clearly highlighted in these receptionists' accounts of their daily work are issues that should raise some concern among GPs and their insurers. A GP who employs an unlicensed nurse as a receptionist to undertake both reception and clinical activities would assume that person has a higher level of knowledge and skill than would an 'untrained' receptionist. Consequently, the level of supervision and guidance for the unlicensed nurse/receptionist may be reduced, opening the possibility of that employee undertaking activities that are beyond their current level of expertise. While GPs cite cost as being a barrier to employing a currently registered nurse ⁵ there may be a much larger unexpected 'cost' in employing an unregulated worker to carry out clinical procedures that require depth of knowledge, critical thinking abilities, and discernment born of professional experience.

As previously pointed out by Patterson, Del Mar and Najman ⁶, it is the capacity for reflective practice that differentiates the skilled, professional practitioner from the worker. According to Schön this requires 'knowledge-in-action', constructed and reconstructed from practice, which is not easily reduced to rules and procedures.⁷ In practices where there are no written guidelines for receptionists but only verbal instructions given, there is the danger that a receptionist will make a decision or initiate an action based on 'customary practice', that is, what the GP usually advises them to do.

⁵ Op cit n 1

⁶ Ibid

⁷ D Schön The Reflective Practitioner: How Professionals Think in Action (Basic Books, New York, 1983).

What is highlighted in the findings is that undertaking clinical tasks is invariably accompanied by communication with patients, which often reveals further clues about their state of health and well-being. It is not unreasonable to assume that the inexperienced person will miss or misinterpret such clues. The case cited by Kubacz⁸ serves as a warning to doctors that they, and their receptionists, may face negligence actions if “relevant information” communicated to the receptionist by the patient is not dealt with in a timely and appropriate manner. The greater the range of clinical activities that receptionists engage in, the more likely it is that information will be divulged to them that they are not competent to assess as clinically important.

Of concern is the belief expressed by some receptionists that clinical activities are easy and require little or no training. Seen only as a ‘task’ that can be taught to anyone in a short period of time, there is the real possibility that assessment for associated side effects or complications may be overlooked. Additionally, it is reasonable to assume that an employee, with this attitude, will not foresee the risks in taking on additional clinical responsibilities, perhaps unknown to the GP. This is exemplified in the receptionist’s perception that counselling a patient over the phone about suicide requires little more than life experience.

What is alluded to in these receptionists’ accounts of their work is the misperception, held by some patients, that receptionists have nursing qualifications. It would be a reasonable expectation for a patient that a person giving health related advice or undertaking a clinical procedure, like a wound dressing, has professional

⁸ Op cit n 4

qualifications. If the employee involved does not have a name badge that clearly identifies their role as a receptionist rather than a nurse, then the patient may be giving an uninformed implied consent to treatment. An observation made by one of the researchers undertaking the interviews for this study adds substance to this assertion. It was noted in one general practice that receptionists and nurses wore the same corporate uniform and name badge with no designation of role. However, the nurses did wear a nurse's graduation badge, not always visible to others.

As indicated by the foregoing, a number of significant issues arise in relation to the potential liability of the receptionists, the medical practitioners, the medical centre owners and their insurers. Where a patient is injured in the course of being treated by the staff of a GP practice, the level of skill, knowledge and competency of those involved in the patient's care will be of direct relevance to determinations of legal liability. In circumstances where the medical receptionist has undertaken the patient care, the focus of any inquiry into liability would include an assessment of the competency of that receptionist to undertake the particular task, and the process by which the task was delegated. That is, was this receptionist competent to undertake the activity, and did the person who delegated the activity do so on the basis of knowing that the receptionist was competent to carry out the task? Was the receptionist in breach of the duty of care owed to the patient as a user of the health care service? Was the person responsible for the delegation of the task in breach of their duty of care?

In line with other Australian jurisdictions, Queensland has enacted legislation consistent with the recommendations of the IPP Committee. This Committee was

established by the Federal Government to examine the law of negligence in relation to both liability and damages.⁹ Section 9 of the *Civil Liability Act 2003* (Qld) states the general principles in relation to the standard of care as:

9. General principles

(1) A person does not breach a duty to take precautions against a risk of harm unless-

- (a) the risk was foreseeable (that is, it is a risk of which the person knew or ought reasonably to have known); and
- (b) the risk was not insignificant; and
- (c) in the circumstances, a reasonable person in the position of the person would have taken the precautions.

(2) In deciding whether a reasonable person would have taken precautions against a risk of harm, the court is to consider the following (among other relevant things) –

- (a) the probability that the harm would occur if care were not taken;
- (b) the likely seriousness of the harm;
- (c) the burden of taking precautions to avoid the risk of harm;
- (d) the social utility that creates the risk of harm.

The issue for determination is, therefore, whether the level of skill of the receptionist was such that the risk of injury to the patient was foreseeable and significant such that any reasonable person would have taken precautions against the occurrence of such a risk. The legislation stipulates that, in making a determination as to whether a ‘reasonable person’ would have taken precautions, the court will consider the

⁹ .“The *Review of the Law of Negligence*” 2002. www.revofneg.treasury.gov.au/content/reports.asp

probability of the harm occurring as a result of a receptionist, as opposed to another health professional, undertaking the care, the seriousness of the harm caused by the receptionist undertaking that care, and the social utility of the receptionist having undertaken the care. The same process could be anticipated in making an assessment as to whether the person who delegated the task was also in breach of their duty of care.

In addition, there is the question of the validity of the consent and the potential for allegations of “holding out” the receptionist (who may have previously been registered) as a nurse currently registered with the regulatory authority in the relevant jurisdiction. Has the patient been informed that they are to be triaged, counselled, assessed, and in some cases treated, by a medical receptionist rather than a registered nurse? As evident in the data the medical receptionists were frequently involved in a wide range of clinical activities and in one of the medical practices wearing uniforms and name badges identical to those of the registered nursing staff.

As a general proposition, where a patient is injured and succeeds in an action in medical negligence, the liability of the employer (being either the owners of the medical centre or the GP themselves) may take two forms. In the first instance the employer may be held vicariously liable for the negligence of their employees. In this case the financial liability to pay compensation shifts from the employee to the employer provided the task resulting in the injury was within the ‘course and scope’ of the employment. The issue of what work is within the ‘course and scope’ of the receptionist’s employment, is very relevant to the circumstances described above where the activities change from one employer to the next and the level of skill and

knowledge of each employee is so diverse. On the one hand there may be allegations that the receptionist was negligent in carrying out a task which, while condoned by the employer and within the 'course and scope' of their employment, was beyond their level of competency. The circumstances described in the data also highlight the potential for the negligence to be found in the 'unreasonable' delegation of a task to a person who has no skill or expertise in relation to patient care. In this latter instance the inquiry is directed to an examination as to whether it was reasonable for the person delegating the task to have considered the receptionist as competent to carry out the activity. For example, is it reasonable to delegate to the medical receptionist the tasks of assessing levels of pain, degrees of mental illness and rates of blood loss in patients who present to the GP practice? Has the receptionist the level of skill and knowledge necessary to competently undertake a wide range of clinical activities in an environment where there is no direct supervision?

There is an apparent need, given the diversity of the activities performed by receptionists, to consider the development and implementation of competency standards similar to those applicable to registered and enrolled nurses. The development of assessment models, to determine levels of competency (similar to those developed in relation to making determinations about the levels of supervision for endorsed enrolled nurses in the administration of medications) would at least provide both the receptionist and the GP with a benchmark upon which to both undertake or delegate a task.

In addition to being found vicariously liable for the negligence of an employee the incorporated health facility may be found to be in breach of their non-delegable duty

to the patients who attend the practice. The existence of a non-delegable duty is founded in the legal relationship between a patient and an incorporated health facility where the existence of a ‘special relationship’ is found to exist. Such a relationship, which is found most frequently to pertain to the hospital-patient context, is characterised by the hospital undertaking care, supervision and control of a particular patient¹⁰ and being so placed in relation to that patient so as to have assumed a particular responsibility for their safety. In addition, the case of *Elliott v Bickerstaff*¹¹ identified the requirement of vulnerability and dependency. As stated by Giles JA at 242:

“[no] doubt the patient is usually specially dependent or vulnerable in that the patient has no relevant expertise and, rather like an employee, must put up with whatever the hospital subjects him to in fulfilling its undertaking, and perhaps it is thought that, by its arrangements, the hospital has ultimate control over what the patient is subjected to even though it does not control how the medical officers do their work”.

In *Ren v Mukerjee & Anor*¹² the plaintiff successfully recovered in negligence where he was able to establish that the Canberra Hospital failed to provide adequate services. The particular obstetrician was absolved from liability and the Court held that the hospital, not the employee, determined the levels and qualifications of the staff and was required to have sufficient staff available, “to ensure the patients can be treated...”. Though the case law most frequently involves health care institutions, the New South Wales Court of Appeal in *Rooty Hill Medical Centre v Gunter*¹³ held that

¹⁰ *Kondis v State Transport Authority* (1984) 154 CLR 672 at 686.

¹¹ *Elliott v Bickerstaff*¹¹ 1999) 48 NSWLR 214.

¹² *Ren v Mukerjee & Anor* (ACT Supreme Court, No. SC 440 of 1989)

¹³ *Ren v Mukerjee & Anor* (ACT Supreme Court, No. SC 440 of 1989).

a medical centre had undertaken to provide medical services to the respondent patient that were non-delegable and for which the centre was liable.

There are also the significant issues associated with engendering or facilitating a false belief by the patients that the staff working within the practice are qualified health professionals. That is, creating the false perception by the patients that the staff attending to activities considered as medical practices will in fact be medical practitioners, and the staff assigned to provide nursing care will be qualified registered nurses. In a situation where a GP practice is, with knowledge, “holding out” a receptionist as a registered nurse it may not only generate proceedings from the professional registering authority but also impact on the determination as to what standard of conduct amounted to a breach of the duty of care. In the case of *Nettleship v Weston*¹⁴ the court found that where an individual held themselves out as being competent to undertake an activity it was reasonable for those who were involved in, or relied upon the representation, to assume the individual in fact had the requisite skill and competence necessary to safely undertake the task. In the present context therefore, if the GP practice has clothed the receptionist in such a way that it would be reasonable for the patients and clients to believe that the person is a registered nurse then it will also be reasonable to assume that the person has the knowledge and skill consistent with that qualification.

While this study was limited to one Division of General Practice in Queensland, Australia and no generalisations can be made from this study to other general practices, it begins to identify possible areas of concern for risk management in relation to the role of medical receptionists. In an era of escalating litigation and

¹⁴ *Nettleship v Weston* (1971) 2 QB 691 (CA)

insurance costs, it is timely for employing GPs to more closely examine the activities carried out by their receptionists to identify potential risk. In addition, it may be prudent for GPs to investigate alternative practice models incorporating a skill mix of employees – receptionists, registered nurses and enrolled nurses to undertake activities within their scope of practice. Preventing a negligence claim may be more cost effective than employing unregulated, cheaper employees.