Risk reduction in general practice and the role of the receptionist

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Medical receptionists play a crucial role in any practice as they are usually the first points of contact for patients and the intermediaries through whom contacts with medical practitioners are made. This article 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 receptionists, medical practitioners, medical centre owners and insurers.

INTRODUCTION

Legal issues are becoming increasingly important to general practitioners. 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 role in any practice, as they are usually the first points of contact for patients and the intermediaries through whom contacts with the general practitioners are made. As employers, general practitioners are vicariously liable for the actions of employees, such as receptionists, so endeavour to provide guidelines and protocols to reduce the likelihood of their undertaking "risky" activities. However, because of the complexity of most medical receptionists' jobs and the increasing work demands on general practitioners, receptionists may undertake unsupervised activities that place the general practitioner at risk of litigation.

As part of a larger study about the current and potential roles of general practice nurses, principal general practitioners 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 general practitioners thought that medical receptionists could be taught to perform any "nursing" work required in general practice. The study also found that 60% of the general practitioners surveyed did 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 in order 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 article presents those findings and discusses the implications for risk management in general practice.

BACKGROUND
Two decades ago Acber 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. Consequently they surveyed over 1,000 adults in the United Kingdom to ascertain their experiences of the receptionist as "gatekeeper" in determining their access to the general practitioner. 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 unsolicited advice. The study did not establish the extent to which receptionists were involved in "hands-on" clinical procedures.

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. They surveyed 150 receptionists in one Health Authority in the United Kingdom 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". 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 articles indicate that medical receptionists in general practice play a critical role in that they largely determine who sees the general practitioner and when, they often

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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 prevent 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 18 years. Six of the seven participants had worked with the same
general practitioner 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
sole 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 general practitioners 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
4:30pm and 6pm 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:

[O]ne 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 United Kingdom 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 sole 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 ears 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 a while 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 urgency 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 judgments about the urgency of a patient's condition "because I understand their situation after being in the practice for so long 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 in which she had been involved:

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 it 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 15 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 eagerly to seek out and take on this role, others just accepted what was delegated to them and some expressed reluctance to be involved.

What are clearly highlighted in these receptionists' accounts of their daily work are issues that should raise some concern among general practitioners and their insurers. A general practitioner 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 an "untrained" receptionist would have. 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 her or his current level of expertise. While general practitioners cite cost as being a barrier to employing a currently registered nurse, 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.

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

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5 See Patterson, Del Mar and Najman, n 1.
6 Patterson, Del Mar and Najman, N 1.
procedures. 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 general practitioner usually advises the receptionist to do.

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 wellbeing. It is not unreasonable to assume that the inexperienced person will miss or misinterpret such clues. The case cited by Kubacz 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 general practitioner. 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 qualifications. If the employee involved does not have a name badge that clearly identifies the employee 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 receptionists, medical practitioners, medical centre owners and insurers. Where a patient is injured in the course of being treated by the staff of a general practitioner 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

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8 Kubacz, n 4.
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. Section 9 of the Civil Liability Act 2003 (Qld) states the general principles in relation to the standard of care as:

(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 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 her or his duty of care.

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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 he or she is 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 wore 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 general practitioner) may take two forms. In the first instance, the employer may be held vicariously liable for the negligence of 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 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 her or his employment, was beyond the receptionist's 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 general practitioner 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 general practitioner 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 its 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 patient\textsuperscript{10} and being so placed in relation to that patient as to have assumed a particular responsibility for her or his safety. In addition, the case of \textit{Elliott v Bickerstaff}(1999) 48 NSWLR 214 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 \textit{Ren v Mukerjee} (unreported, ACT Sup Ct, No SC 440 of 1989) 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 of 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 \textit{Rooty Hill Medical Centre v Gunter} [2002] NSWCA 60 held that 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 patients that the staff working within the practice are qualified health professionals. This creates the false perception by patients that staff attending to activities considered as medical practices will in fact be medical practitioners, and that staff assigned to provide nursing care will be qualified registered nurses. In a situation where a general practitioner 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 \textit{Nettleship v Weston} [1971] 2 QB 691 the court found that where an individual held herself or himself 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 general practitioner practice has clothed the receptionist in such a way that it would be reasonable for 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, and no generalisations can be made from this study to other general practices, it has identified possible areas of concern for risk management in relation to the role of medical receptionists. In an era of escalating litigation and insurance costs, it is timely for

\textsuperscript{10} \textit{Kondis v State Transport Authority} (1984) 154 CLR 672 at 686.
employing general practitioners to examine more closely the activities carried out by their receptionists in order to identify potential risk. In addition, it may be prudent for general practitioners to investigate alternative practice models that incorporate 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.