General practitioners and their staff

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SUMMARY. We describe the practices and staff of a random sample of 158 doctors. There has been a significant increase in ancillary staff since the Doctors' Charter of 1966. The study showed that there was no economy in staff as the number of doctors in a practice increased. In the selection of receptionists, doctors preferred married women over 35 with children, and were in favour of good personal qualities rather than good academic attainments. However, a high standard of work is important as well as a good understanding of human behaviour.

Introduction

EVER since the Doctors' Charter of 1966, there has been a steady increase in staff employed by general practitioners. From 1966 to 1975 in England, for example, the number of nurses (expressed as whole-time equivalents) increased from 105 to 723, an increase of 689 per cent. Significant increases were also seen amongst receptionists (302 per cent), secretary/receptionists (151 per cent), dispensers (165 per cent), and secretaries (191 per cent; DHSS, personal communication). Over the same time period the number of unrestricted principals has risen by only nine per cent (DHSS, 1976).

During this time, the numbers of doctors and ancillary staff all working together under the same roof also increased. This can be seen by the 21 per cent decline in single-handed practices during the 1966 to 1975 time period (DHSS, 1976). The average doctor is now in contact with more doctor colleagues and ancillary staff than ever before and the organizational complexities of practice have grown so much since 1966 that it is now more important than ever to examine the ancillary staff who play such an important part in general practices.

Aim

The purpose of this study was to look at the practices and ancillary staff of a random sample of general practitioners. The receptionists were studied in greater detail because they are more vulnerable than their colleagues to criticism by the public with whom they are in day-to-day contact.

The study examined some of the qualities doctors look for when choosing a receptionist and also the doctors' attitudes towards formal training.

Method

A random sample of doctors was taken from family practitioner committee lists. Two areas were selected, one in the north of England and one in the south. The sampling was such that only one doctor was taken from any group practice. A sample of 200 was taken and a mailed questionnaire was sent. A duplicate was sent after three weeks to those who did not respond to the first invitation. The total number of completed schedules returned was 158, a response rate of 79 per cent.

Table 1. Distribution of respondents by practice size and national distribution of practice sizes.

Practice size (number of partners)	Number of respondents	Per cent	National distribution of practice sizes* Per cent in each size
1	34	*21.5*	*39.7*
2	38	*24.1*	*23.8*
3	36	*22.8*	*18.5*
4	30	*19.0*	*10.3*
5	14	*8.9*	*4.6*
6+	6	*3.8*	*3.0*
Totals	158	*100.1*	*99.9*

*Source: Department of Health and Social Security (1975). *Health and Personal Social Services Statistics*. London: HMSO.

Table 2. Distribution of full-time equivalent ancillary staff.

	Number of respondents using ancillary staff							
	Employed by the doctor		Employed by health authority but working with the doctor					
Number of full-time equivalent staff	Nurses		Health visitors		District nurses		Midwives	
	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent
0	84	*53.2*	17	*10.8*	10	*6.3*	39	*24.7*
0.5	28	*17.7*	61	*38.6*	51	*32.3*	59	*37.3*
1	30	*19.0*	48	*30.4*	42	*26.6*	37	*23.4*
1.5	6	*3.8*	13	*8.2*	14	*8.9*	10	*6.3*
2	7	*4.4*	11	*7.0*	21	*13.3*	10	*6.3*
2.5	3	*1.9*	3	*1.9*	4	*2.5*	—	—
3	—	—	4	*2.5*	9	*5.7*	1	*0.6*
3.5	—	—	—	—	4	*2.5*	1	*0.6*
4	—	—	1	*0.6*	3	*1.9*	1	*0.6*
Total full-time equivalent staff	74.5		143.5		193.5		112	

Results

Table 1 gives the distribution of respondents by practice size and also gives the national distribution of practice sizes. The table shows that the sample under-represents single-handed practices and slightly over-represents larger practices.

The average number of patients per doctor in the sample was 2,260 (England 1976 = 2,342; DHSS, personal communication).

Table 3. Distribution of full-time equivalent administrative staff by practice size.

Number of full-time equivalent administrative staff	Practice size (number of partners)							Total staff
	1	2	3	4	5	6	8	
0	4	3						7
0.5	7	1						8
1	19	13	4					36
1.5	2	3	4	2				11
2	1	8	11	4	1			25
2.5	1	4	4	5	1			15
3		3	7	6	2			18
3.5		1	4	2	2			9
4		2	2	6	3	1		14
4.5				3		1		4
5					2	2		4
5.5					2	1		3
6				1	1			2
7				1				1
9.5							1	1
Total full-time equivalent administrative staff	30	64.5	85	99	56.5	24	9.5	

There were no practices with 7 partners.

Non-administrative staff

Table 2 shows the distribution of non-administrative staff for the doctors in the sample. District nurses were most common, and were most frequently employed part time (that is, shared with another practice). Nurses employed by the doctor were the least common of the four groups shown.

Administrative staff

Administrative staff are receptionists, secretaries, and receptionist/secretaries.

Table 3 shows the distribution of full-time equivalent administrative staff by size of practice. When calculating the number of full-time equivalent administrative staff it was assumed that part-time staff worked half time; hence:

$$\text{Full-time equivalent staff} = \text{Full-time staff} + \frac{\text{Part-time staff}}{2}$$

Table 3 shows, not surprisingly, that as the number of doctors in a practice increases, so does the total number of administrative staff employed. What is surprising is that the number of administrative staff per doctor remains fairly constant (Table 4). The penultimate row of Table 4 shows that the number of administrative staff per practice steadily increases with practice size. The last row shows that there are approximately 0·8 administrative staff per doctor no matter what the practice size. Thus the larger group practices do not seem to bring any economies of scale for administrative staff.

This finding differs from that of Drury and Kuenssberg (1970), who found that single-handed doctors use significantly more workers per doctor than all other groups. Our figures are consistently lower and a possible cause of this difference is that Drury and Kuenssberg state that the practices in their sample were

Table 4. Distribution of full-time equivalent administrative staff by practice size. Totals.

	Practice size (number of partners)						
	1	2	3	4	5	6	8
Number of practices (= number of respondents)	34	38	36	30	14	5	1
Total number of doctors in each practice size	34	76	108	120	70	30	8
Total full-time equivalent administrative staff	30	64.5	85	99	56.5	24	9.5
Staff per practice	0.88	1.70	2.36	3.30	4.04	4.08	9.5
Staff per doctor	0.88	0.85	0.79	0.83	0.81	0.80	1.19

There were no practices with 7 partners.

not chosen at random but because they were known to be interested in practice organization. These practices may be more likely to employ administrative staff.

The selection and training of receptionists

The 158 doctors were asked, everything else being equal, which of seven age/marital status categories they would prefer when choosing a receptionist.

The most popular category was a married woman over 35 with children: an opinion expressed by 38·7 per cent of doctors. Single women of the same age group were favoured by only 0·8 per cent of doctors. The school leaver was the first choice of only 1·7 per cent of doctors, but women over 40, whatever their marital status, were the first choice of 19·3 per cent of doctors (Table 5).

Selection of receptionists

Each doctor taking part in the survey was asked to give a rating from 'most important' to 'least important', on a five-point scale, to each of 10 qualities which could be used in the selection of a receptionist. The ratings were assigned the values of 1 for 'most important' down to 5 for 'least important'. Table 6 gives the mean rating for these qualities.

The highest degree of consensus (standard deviation (SD) = 0·53) and the least popular mean rating (4·89) was the possession of a university degree. Other academic qualifications, 'O' levels and a recognized diploma in receptionist's training, came low in rank order, eighth and ninth respectively. The qualities in the top four also show a good consensus; "able to keep a secret" (SD = 0·82); "tolerance" (SD = 0·73); "an understanding of people" (SD = 0·87) and "the possession of a good memory" (SD = 0·78).

Formal training

In only six per cent of the practices had the receptionists had training on a formal extended course; another 11 per cent of the receptionists had been trained on a day release basis.

However, 61 per cent of the doctors expressed a desire to give their receptionists an opportunity for formal training, 52 per cent on day release and nine per cent on a more formal extended course.

Table 5. Age and marital status preferred as a first choice.

Category	Number of respondents	Per cent
Over 35, married with children	46	*38.7*
40+, any status	23	*19.3*
18 to 35, married with children	16	*13.4*
Over 35, married without children	16	*13.4*
18 to 35, married without children	15	*12.6*
School leaver	2	*1.7*
Over 35, single	1	*0.8*
Total	119	*99.9*

Table 6. Doctors' rating of a given list of qualities in the selection of a receptionist.

Rank order of qualities		Mean rating	Standard deviation
1	Able to keep a secret	1.34	0.82
2	Tolerance	1.49	0.73
3	An understanding of people	1.52	0.87
4	A good memory	1.79	0.78
5	Able to protect the doctor from the patient	3.49	1.16
6	Strictness	3.75	1.23
7	Good-looking	3.81	1.27
8	Possession of 'O' or 'A' levels	4.11	1.40
9	Recognized diploma in receptionists' training	4.32	1.03
10	University degree	4.89	0.53

Topics of courses

The doctors were asked what subjects from a list of nine they considered most important to be included in a syllabus for receptionists' training (Table 7).

Table 7. Subjects which could be included on a receptionists' course.

Subject	Number of respondents	Per cent
Record keeping	139	*88.0*
Filing	128	*81.0*
Human behaviour	118	*74.7*
Elementary information on drugs	102	*64.6*
Structure of local medical services	98	*62.0*
Typing	94	*59.5*
Instruction in writing prescriptions	85	*53.8*
First aid	79	*50.0*
Accountancy	62	*39.2*

Record keeping and filing came highest on the list (88 per cent and 81 per cent of participating doctors, respectively) and teaching about human behaviour also came high (118 doctors; 75 per cent). Instruction on prescription writing was chosen by only 85 (54 per cent) doctors, and teaching elementary information about drugs by 102 (65 per cent).

Discussion

In our introduction we showed how the number of staff employed by general practitioners has increased rapidly since 1966, the year of the Doctors' Charter, and also that there has been a tendency towards group practices. This study discovered that, with an increase in size of a partnership, there is a corresponding increase in administrative staff (receptionists, receptionist/secretaries, and secretaries), and surprisingly, that there is no economy of scale in terms of numbers of staff.

As an efficiently run industry increases in size the number of employees does not necessarily increase in proportion. A factory which has doubled in size may increase its staff by, say, only 60 per cent, because of automation, deployment of staff, and improvement in organization. This was not found to be the case in this survey when applied to general practice. Why should this be so?

When an extra doctor is added to the practice he may find new work to do, especially in an aspect in which he

is particularly interested, and which has not been previously exploited by the other partners. He may have recently completed a vocational traineeship and be anxious to introduce new ideas and methods which he learnt as a trainee, for example, an appointment system, a new clinic or an age/sex register, each of which may require an increase in staff.

Although only 11 of the practices had trainees in the formal three-year vocational training schemes, these teaching practices would be expected to supply a steady stream of trained young general practitioners to become principals in other practices. A young doctor who has been trained in a good practice will be anxious to implement the improvements he has seen during his training. As the numbers of vocationally trained doctors increase there will be greater pressures on the ancillary staff, making it more likely for them to increase rather than decrease in number. There is also a financial encouragement to employ extra staff. When an additional partner is added to the practice he may qualify for the basic practice allowance, and also, as a result of the Doctors' Charter of 1966, the salaries of additional staff are reimbursed by 70 per cent, a bonus not available to industry.

The introduction of an appointment system, for example, would certainly require staff, but brings with it many problems. It is well known that if the system is not run properly and efficiently a barrier is created between the doctor and patient (Williams, 1977). The patients see the practice as a fortress guarded by receptionists, preventing them from seeing their doctor of choice at a time suitable to them. In this survey, 78 per cent of the practices had either full or partial appointment systems. From 1967 to 1972 in England the numbers of appointment systems had increased from 32 per cent to 70 per cent (Royal College of General Practitioners, 1973). In a large practice, although there may be several doctors to choose from, the patients usually prefer to see their favourite doctor, but he may not be immediately available. Any alternative time or a different doctor suggested to them may seem unacceptable.

The outcome then depends on the personality and skill of the receptionist in taking the heat out of a difficult situation. Her attitude may also reflect the attitude of the practice team behind the scenes and in particular the attitude of the doctors. However well academically qualified she may be, unless she has a good understanding of human behaviour, she may be incapable of handling such delicate situations as may occur several times a day in a doctor's surgery. It is not surprising that this study has shown that the most favoured candidate for the post of receptionist was a 35-year-old married woman with children. Mulroy (1974) found that 60 per cent of the receptionists he interviewed were over 35. Such women would probably be more understanding about the problems of families because of their experiences with their own families at home. In contrast, an unmarried woman aged 35 or more was the least favoured candidate, expressed as a first choice by only 0·8 per cent of the doctors. The next lowest in preference was a girl who had just left school.

The reasons for giving such a low priority for school leavers is that they are likely to get married and have children, and are thus lost to the practice, perhaps shortly after being trained. However, this view is short-sighted. The period of training will serve them well should they wish to return as receptionists when their family commitments allow. If general practitioners were encouraged to take school leavers and train them well within the practice, arranging attendances at recognized courses, a pool of trained receptionists would be created who could return to general practice later, more mature and experienced in family life.

Although academic qualification was not thought important by the doctors who completed the questionnaire, a badly trained and unintelligent individual, however pleasant, would be of little value in a busy practice.

It is encouraging to see that 61 per cent of the doctors wanted their receptionists to have formal training. Mulroy (1974) also found that the receptionists are willing to be trained. The lack of training stems from a lack of opportunity.

Although ancillary staff tend to write a considerable number of prescriptions (Madeley, 1974; Manasse, 1974; Austin and Parish, 1976) only 54 per cent of doctors in the present survey thought that teaching about prescription writing should be included in a teaching programme. However, 65 per cent thought that an elementary knowledge about drugs was important.

As larger practices are becoming more common and the number of staff are correspondingly increasing, it is becoming more important to ensure proper selection and training of the practice team.

References

Austin, R. & Parish, P. (1976). Prescriptions written by ancillary staff. *Journal of the Royal College of General Practitioners,* **26,** Suppl. No. 1. 44-49.

Department of Health and Social Security (1976). *Health and Personal Social Services Statistics for England.* London: HMSO.

Drury, M. & Kuenssberg, E. V. (1970). Inquiry into administrative activities in general practice. *British Medical Journal,* **4,** 42-44.

Madeley, J. (1974). Repeat prescribing via the receptionist in a group practice. *Journal of the Royal College of General Practitioners,* **24,** 425-431.

Manasse, A. P. (1974). Repeat prescriptions in general practice. *Journal of the Royal College of General Practitioners,* **24,** 203-207.

Mulroy, R. (1974). Ancillary staff in general practice. *Journal of the Royal College of General Practitioners,* **24,** 358-361.

Royal College of General Practitioners (1973). *Present State and Future Needs of General Practice. Report from General Practice 16.* 3rd edition. London: *Journal of the Royal College of General Practitioners.*

Williams, W. O. (1977). The receptionist—barrier or link? *Medical Secretary,* No. 30, 25-28.