DOCTORAL THESIS

Title	Reconstructing the Role of the Medical Receptionist: A Phenomenological Exploration of the Experiences of Women Who Work as Reception Staff in Medical Offices
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Reconstructing the Role of the Medical Receptionist: A Qualitative Exploration of the Experiences of Women Who Work as Reception Staff in Medical Offices

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Chapter 1: Introduction to the Study

Introduction

This chapter summarizes the problem this research is trying to address, the background of this problem, the purpose of this study, the research questions, the current knowledge gap, my previous practice-based research, methodology and methods chosen, and the potential relevance of this research.

Problem Statement

Seeing the doctor is an experience that over 96% of people in the western world have had. Most of us have been deeply conditioned around this, having seen doctors since we were babies. The conditioning comes from diverse and varied origins, from our culture, families, communities and multiple forms of media. Western culture has historically idolized doctors, and to this day, they top every list indicating status and prestige: the most respected profession, the most prestigious profession, the highest status profession, and the highest paid profession (Dolton et al., 2018; The Harris Poll, 2016). Until recently, doctors have been portrayed in books, movies, on TV, in magazines and in other media, as wise, all-knowing, benevolent, male and white. While family cultures vary greatly, most children grew up with admonitions to respect the doctor, to shower, dress, show gratitude for and not interrupt doctors; concurrently, children are often given the message that becoming a doctor is one of the most admirable and prestigious of goals (marrying a doctor, for white women born before 1970, would be close second). In fact, 9 out of 10 adults would encourage their children to become doctors (The Harris Poll). More complex portrayals in the media, and more transparent and honest sharing by physicians in the

last decade, have led to a more nuanced view of physicians and their work, encompassing high prevalence of burnout, lack of empathy as a product of medical school, doctors that seem greedy rather than benevolent, more clueless than wise, and more flawed human beings than god-like. However, wherever the iconic doctor is on the continuum of our cultural perceptions, they are invariably surrounded by a cadre of subordinate helpers: nurses, physician assistants, medical assistants, referral clerks and receptionists. This flock of helpers has been framed at times as "support staff," "relationship extenders," "employees," or often, not framed or referenced at all. The primary job duties of these helpers are to serve the physician; the physician is the 'customer' in the work of support staff, as opposed to the patient being the customer. Even before physicians began seeing patients in offices, they appeared to have had these 'helpers' surrounding them. Earlier in the 1900s, when they most frequently made home visits, or treated patients in their own home, their wives or older daughters would often perform the receptionist role (Neuwelt, 2016).

This group of people surrounding the physician was not, and is not, equal in pay, status, respect or in experience or medical expertise; in fact, the physician is able to complete all of the tasks the support staff engages in when these tasks are seen in purely transactional terms. For example, the doctor has the training and skills to give injections; however, the nurse or medical assistant does this to save the doctor time, presumably, to do what only the physician is able to do. The doctor could ostensibly schedule their own appointments, answer their own phones, and answer patient questions, whether clinical or administrative; however, a receptionist does this in order to save the doctors time for other tasks. This is often called 'practicing to the top of scope' in the health care field. In short, the people surrounding the physician are not working to add

expertise, knowledge, or skills that the doctor does not have; instead, they are there to complete tasks deemed too menial for a physician.

For many decades, those surrounding the physician were invisible; we did not hear their voices, nor were they studied in the literature. In medical sciences research, the great majority of research is by, for, and about physicians. Even within the specific category of health care communications research, this is true. In fact, even after health care communication became a focus of study and exploration starting in the late 1970's, to date, the overwhelming majority of all research in this area is on the physician-patient dyad of communication. This is despite the fact that this dyad represents only a fraction of the total health care interaction between a medical care office and someone who is a patient.

This research on communication between the physician and patient is remarkably consistent. We know unequivocally that the communication between doctors and patients has a significant and incontrovertible influence on the patient's experience of the encounter, adherence to the physician's recommendations, the patient's health outcomes, and the patient's safety. The communication between this dyad also deeply affects physician job satisfaction, their perception of time scarcity, and the level of physicians' burnout and fatigue.

While most of the research on communication in the medical sciences literature is still on the physician-patient encounter, more recently, in the last 10 years, this research on communication in health care contexts has focused in part on nurse-patient communication. These research findings are similar to the research on physician-patient communication–that nurses' communication with patients influences a similar set of outcomes, including the patient's experience, adherence to medical recommendations, safety and clinical outcomes. So too does the research show that the quality of this communication between nurses and patients affects

nurses' job satisfaction. Although still nascent and dwarfed in the amount of research on the physician-patient dyad, the literature on nurse-patient relationships is a hopeful step in looking at people outside of the physician, toward the larger team of health care workers in the provision of care to patients.

What is missing from the literature is any substantive focus on the receptionist role in health care. If 96% of people in the western world have been to a doctor, then all of those people have interacted with the a medical receptionist when they enter the office. In fact, receptionists typically have the most contact with patients, making appointments, taking calls for refills and other matters, checking patients in before appointments and checking them out after the appointment. Compared to medical assistants, nurses, health aids and physicians, receptionists spend the most time with patients during a typical encounter, an average of 40 minutes vs. an average of 5 minutes with a staff with preforms vitals or 15 minutes with a doctor. This 40 minutes typically includes phone calls, making appointments for patients, check-in procedures, verification of insurance and payment, administering forms for the appointment, and overseeing the waiting room experience of patients.

In addition to the tasks undertaken by receptionists when a patient enters the clinic, receptionists also have a significant amount of discretionary decision making around the patient's health, including mediating communication between patients and doctors, deciding how urgently to make appointments and managing refill and paperwork requests from patients. Despite this, there is very little research on the role of receptionists, fewer studies of their relationships with patients. There are some notable exceptions, including Aaron Cicourel's study (2004) of receptionists' phone conversations with patients around appointment making, and there are at least two American studies (Dixon et al., 2004) and one British study (Magin et al., 2009)

around patient verbal abuse of receptionists. There are no known studies exploring receptionists experiences of their work, their perception of their role. There seems to be a gaping hole in the literature on this most pivotal position in health care.

Purpose Statement

The purpose of this study is to do just that–to bring women who are receptionists to the center, by studying them, their experiences of work and the workplace, and their perception of their relationships with patients. I hope to bring attention to the complex and important nature of the receptionist position and the thoughts, feelings, communication and relational patterns that characterize their experiences of work and relationships with patients.

By highlighting and exploring this aspect of health care, one that is so common and consistent yet remains unnamed as part of health care, we may be able to reframe our sense of what we think of as medical care. Currently, the dominant discourse understands medical care to mean what a doctor provides to a patient. In this construct, medical care does not start until the physician walks into an exam room. This study posits human connection itself as the basis of treatment, and in this way, squarely places receptionists as part of the treatment process. In this way, this study aims to open the possibility for a new, broader, and perhaps more useful, interpretation of health care and what we consider treatment. In doing so, this research may encourage the visibility, status, respect and understanding of the role of the reception staff.

Reflexivity on Underlying Theory

As a young adult studying to become a therapist, I was fascinated by Carl Rogers' research on the impact of empathic relationships on treatment outcomes. In the last 15 years, it has been heartening to see that research began to focus on the impact of skillful relationship

building within the medical field, which has been correlated to improving clinical health measures. While Carl Rogers (1963) original research, and the decades of research it has inspired has clearly established the deep importance of an attitude by the therapist of "unconditional positive regard" for the patient, in patient outcomes, this research had been largely siloed from medical sciences literature. The more recent, similar and very robust literature that built on Rogers' work, such as Scott Miller and Barry Duncan's (2010) research around the 'therapeutic alliance,' demonstrating that goodwill and empathic relationships with the patient are fundamental to effective treatment, has remained almost completely siloed from medical sciences research and practice. While the field of psychology, with talk therapy as its main strategy, and the therapist themselves as the tool of the strategy, may have absorbed Rogers, Miller and Duncan's research as belief consistent, the medical sciences field dominant discourse has not. My own experiences as a therapists and as a client of other therapists, have been deeply consistent with this research, and as a result, I've been fascinated by the slow pace of transfer of knowledge to the medical sciences.

Reflexivity on the decision to focus on receptionists

As a customer, I have been intrigued at how much influence a receptionist or other staff at a front desk or front check-out counter has on my perception of the organization or business. A receptionist or cashier that does not make eye contact for several seconds when I walk to a counter, or perhaps not at all, does not smile or engage in any attempts at purposeful connecting by offering pleasantries like "did you find everything you were looking for" or "raining today, isn't it?" deadens the interaction; it relegates it to only a transaction. If these interactions happen over what I might consider low-risk transactions such as the dry-cleaner or the gas station, the

consequences of having many in one day may be that the day will be a forgotten one, of errands, and tasks. If these interactions happen around what I perceive as high risk, high value services, for example a medical appointment for something I am worried about, an appointment at a new school for my anxious son, a lab appointment to assess the level of white blood cells my husband has in this stage of his cancer, these interactions will bring me to my knees in fear. Fear can take many different forms, and mine often takes the form of anger.

Medical appointments are often high risk for us; they are deeply personal, involving our bodies functioning, our beliefs about our bodies, our health, and our wellness. We are often in the care of medical providers due to illness, or injury, when our body is vulnerable. Even when not ill or injured, we are vulnerable. We are weighed, measured and otherwise evaluated for judgment and discernment by another. We are asked questions, often by those we do not know well and often about things those closest to us do not ask or know about. We are asked about our sexual history and habits, our use of substances, our bowels and our sleep. These experiences are within the context of a long and disturbing history of a power imbalance between physicians and patients, and often the de-humanizing process results in abuse, marginalization, dismissal and disinterest.

There is a vulnerability in the dependence inherent in the power imbalance in the relationship–we may rely on medications we can only get from our medical providers, need paperwork only they can sign, rely on their documentation for particular government programs or payments. And ideas and beliefs about what we need to care for ourselves, if delivered through traditional medical care, must have the agreement of our medical provider in order to be received. In this way, the power we have as patients in the relationship is only what we disclose, or don't disclose about our own narration of our health, our bodies, and how we present

ourselves in the relationship. In fact, over 80% of the information used for diagnosis and treatment planning comes from a patient's self-disclosure. There has been significant research in this area of self-disclosure–when do we withhold the truth, when do we lie to medical providers? The research indicates withholding information from our physician is not an isolated experience, but instead something most of us do regularly. We alter and shape our disclosures, depending, largely, on the qualities of the relationship between us and our health care providers. In relationships where we perceive negative judgment from another, we tend to withhold, or lie (Rotor et al., 2014). We may minimize the amount of soda we drink, indicate we want to quit smoking when we don't, deny side effects of medications, withhold that we took our spouses medication for a migraine last weekend. After years of severe punishing insomnia that was immune to my menu of non-medication interventions, I was prescribed a medication that actually allowed me to sleep for a whole night, somewhat regularly. It felt like a miracle; it changed my life; I cried with relief the morning I woke up after the first time I had slept the whole night. I took it every night, traveled with the medication, and feared frequently at some point the doctor would tell me I couldn't take it anymore. When we were moving out of the country, I secured multiple refills from my doctor, in fear I wouldn't be able to obtain the medication outside of the United States. After the move, as the supply dwindled, I became increasingly nervous about my upcoming appointment with my new National Health Services doctor in Scotland. As soon as she saw the medication bottle, she said "we don't prescribe medications for sleep like they do in the US." She leaned back in her chair and crossed her arms; her tone and posture clearly indicated judgement–I felt I could read her mind: the headlines about overmedication in the United States, Americans over-reliance on medications to solve every itch, hurt or imagined illness. She said, "we treat insomnia with cognitive therapy." I felt the blood drain from my face. I'd done

multiple courses of therapy, at least 2 focused only on the insomnia. I knew if I seemed angry or demanding, I'd never get the prescription. I quickly managed my facial expression and tone to mask my feelings. I carefully shared with her the number of interventions, including multiple medications, courses of therapy, natural remedies and environmental changes in our home. I shared the withering impact of lack of sleep on my work, my parenting, my relationship with my husband–I was performing for her, trying to make myself seem sympathetic. I tried to casually let her know I was a licensed mental health therapist in hopes this might sway her. I felt myself exaggerating to convince her; I lied about how long I had been on them–I shaved off a few months to make it seem like a short-term intervention. The more I sensed her judgment, the less truthful I became and the more purposeful in my acting. This is what physicians refer to as manipulation, a pejorative term, once applied to a patient, puts them in a "problem patient" bucket that is hard to get out of. What is missed, in this labeling of patients, is that manipulation rarely occurs in equal relationships, and that instead, it is often the consequence of power imbalances.

Medical care is enormously important in most of our lives and the influence physicians' decisions have on our wellbeing is significant. The presence or absence of an empathic relationship with a physician determines how much we self-disclose and whether or not we adhere to treatment recommendations. Understanding how crucial this relationship is in the context of our health, it seems important to broaden our focus to better understand the influence and impact of the omni-present medical receptionist, beginning with their own experiences.

Purpose of this Study

There is a lack of understanding, knowledge and literature regarding the experience of receptionists and the connection between this and their relationship with patients. This lack of exploration has led to a significant knowledge gap in medical sciences literature and is a primary driver for this study.

The research itself could potentially offer new possibilities for how we think about receptionists in medical settings, their experiences and the impact of their experiences on their relationship with patients. The hope is that the research will provide an alternative construction to the dominant medical model which diminishes the role of relationship in health care and elevates medication or other technical procedures as the only objects of treatment. By ignoring the receptionists in medical literature, we enable the dominant discourse that positions this (mostly female) workforce as little more than a conveyer belt to get patients to the doctor, who will dispense the "real" treatment. Out of this discourse comes the cluster of familiar conditions: low status, low wages and low respect for this position.

Increasing our understanding of the experiences of receptionists might shift not only on how much value we put on these positions, but also the discourse of health care itself, significantly. We might question whether treatment is what we've constructed it to be and whether the almost exclusive focus on the patient/physician dyad is useful. It would facilitate questioning what we traditionally see as valuable in health care and allow us to consider the myriad of variables that go into effective health care and see what has been historically invisible: what is outside of an exam room and a physician's purview. Through eliciting the perspectives of receptionists, we will likely co-construct a different understanding of what is important in health care settings and perhaps *who* is important in health care settings. We might begin exploring, for

example, the name of the "waiting room"; the structure that places a desk between receptionists and patients; what the true function of a receptionist's position is; and what meaning we make of the relationships between receptionists and patients.

Research Questions

This study will look closely and explore deeply receptionists' experiences of their work, their perception of their relationships with patients, the communication that characterizes the relationship, and their role status within their clinic.

Using a phenomenology-informed methodology, and a feminist perspective, I will study six women who are receptionists in two busy primary care practices in central California. The central research question I will explore is: What are the experiences of medical receptionists? Specifically:

1. What meaning brought the subjects to their current work as receptionists?
2. What are their experiences in this role?
3. What are their constructions and experiences of their relationship with patients?
4. What is the toughest aspect of their relationship with patients?
5. What influence or impact, if any, do they feel they have on patients' health?
6. What are their understandings, thoughts and experiences around gender and race? dynamics in this work?
7. What is the receptionists experience and perspectives on their standing within the larger health care team?

Practice-based Research Conducted

I have worked deeply in this area, both in building systems that support and privilege the building of goodwill relationships between patients and the health care team, and in developing specific workshops that increase the resources of those who work in health care to develop these relationships. For a period of 5 years I was working in a traditional medical clinic system, focusing on improving patient satisfaction, measured by patient satisfaction surveys. Satisfaction scores of patients are determined by 'patient experience' surveys, sent by a third party. The results of the patient experience scores are very important to health care entities in the United States, as often reimbursement by insurance companies, both public and private, depend on high scores. As a result, many health care organizations such as hospitals and out-patient systems have directed enormous resources to improving patient experience scores. Most of these resources are spent on improving transactional efficiency, such as decreasing waiting times in the waiting room or increasing access to timely appointments, for example. While some organizations have devoted time and money to efforts to improve patient relationships with health care staff, in the field currently, over 90% of these interventions have focused on the patient-physician relationship.

My motivation to work with receptionists in order to improve patient experience scores was partly based on my own experience of the deep impact receptionists had on my experience in health care, and partly based on what I had heard from both receptionists and patients over many years. When patients had poor experiences, when they were angry, scared or sad about their experiences in the systems I worked in, it was overwhelmingly around the receptionists. Patients often said they felt 'ignored' in the waiting room, that the receptionists were 'rude,' and

that they ‘didn’t care,’ that they never received calls back from them. Over the years, multiple people told me they were changing health care providers, not because of the doctor, but because of the reception staff being unhelpful, discourteous, or disrespectful.

I reasoned that intervening with receptionists would have a greater impact on patient experience scores than intervening with physicians. I was correct in the most simplistic sense: after resourcing receptionists with more autonomy, support and communication tools, patient experience scores went up almost 20 percentage points, more than any other single intervention with physicians.

What was more subtle and interesting was what happened when I started talking to the receptionists about their relationships with patients. I learned that they felt powerless to help patients; they had no autonomy or influence when it came to helping patients get appointments, decreasing their time waiting in the waiting room; they were sure these were the reasons patients were angry with them much of the time. We began an ongoing conversation about the fact that if empathic relationships were established with patients, these factors–waiting, appointment availability–rarely provoke anger. I created a workshop, focused on supporting receptionists in developing and maintaining empathic relationships with patients, called *The Empathy Effect*. It offered 4 hours of protected time, and permission, to privilege their human connection to patients over the transactional tasks they had been assigned. During the course of many workshops over the years, 4 insights became apparent:

1. Women who work as receptionists want to help patients.
2. Women who work as receptionists often feel powerless to help patients, as they have little authority or control over the transactional duties they are assigned.

3. Women who work as receptionists are often verbally abused and threatened by patients, which goes unaddressed by management.
4. Women who work as receptionists describe a somewhat complicated and wounded relationship with many patients, fearing many patients, feeling angry at some, and feeling deep compassion for others.

This practice-based research work that I did with receptionists and the insights that came from it, are the motivation for this study. The previous work described above was in many ways focused on receptionists, but from an employer and patient's perspective, with a focus on improving evaluation scores by the organization and improving patients' experience. This was consistent with my views and perspectives at the time; my interests were not on receptionists as people but on receptionists as objects within a system. My evolution of thought between that research and this study has been deeply influenced by the social construction and social justice fields.

Methods

My research methods are phenomenology-informed. . The methods will include two in-depth interviews over a period of four months with the women who are working as receptionists at these sites. There will be periods of observation, sitting side by side with receptionists, behind the desk. The observations will be conducted to more deeply understand and explore receptionists' experiences, in their relationships with patients and other health care team members, as well as to physically show my respect and care for their perspective. This is an example of the overarching reasoning in my decision to use phenomenologically-informed research methods over ethnographic research methods. The culture is not my focus; the women who are receptionists are. Only in this way am I able to ensure I don't replicate the dominant

discourse, and my previous experience, of seeing receptionists as an object within an environment, or not seeing them at all.

Relevance of the Study

The research is relevant for academia as it would expand the social construction research in the area of health, medical care and treatment by prompting a reconsideration of what we have considered important in health care. By highlighting an aspect of medical care that has been previously invisible, we create the possibility of exploring other previously ignored, dismissed or marginalized areas of health care. For health care practitioners, this research could enhance their understanding of how they can better help their patients in a way they had likely not been considered. It may increase the value of the dominant medical discourse attributes to receptionists if they are recognized as influencing patient care and wellbeing. It may enhance the support, resources and pay that receptionists receive, through the recognition that their experience of work influences their relationship with patients. It may open the door to practitioners considering other areas that may be newly accepted treatment that might influence patient clinical outcomes in areas they had previously not considered. For society in general, health care research that prioritizes relationships, and what is created within relationships, provides a counterbalance to the dominant discourse of treatment as an object, separate from the people who give it and those who receive it. This research may increase openness to the idea of other non-physician members of the health care team to also be seen as integral to the process of care.

Summary

This chapter introduces the subject of the study, receptionists' experiences of their role, and their perceptions of their relationship with patients, contextualizing this subject within the existing health and medical sciences literature, as well as the health-related social construction literature. The introduction stated the problem this research was hoping to address and gave an overview of the methods utilized in this research. I reflected on my dual role as a health care worker, and as a researcher and the considerations around this.

The literature review will give an overview of the literature related to this, including the social construction of health and health care; how our experience and appraisal of health care impacts and influences our health; the relationship with health care providers and as a primary driver of this experience and appraisal; and specifically the importance of the perception of empathy from health care providers in this appraisal. The literature review also addresses the fact that most of the research around this relationship has been on the physician-patient relationship, largely ignoring other members of the health care establishment, particularly receptions. The review will share research that demonstrates the importance of reception staff on patient experience as well as the level of complexity of their work, their potential and actual influence on patient health, and the lack of training or support they receive in their roles. Lastly, the review looks at the research around race and gender within health care workers, and specifically for receptionists in the United States- the pay and status implications that influence their experience of work.

The methods section discussed qualitative research methods, specifically phenomenology-informed methods, as the chosen methodology for this research. A reflexive section discusses my own evolution during the process of this dissertation, which influenced my

decision to forego my initial proposal of including more quantitative methods and measures, and instead only using interviews, with supportive observations. A summary of the decision making between ethnography and phenomenology-informed methodology is shared, as well as a discussion of the specific method used in the research: narrative interviews. Reflections on my own role as a researcher are outlined, including my relationships with the subjects, and with their place of employment.

The findings chapter shares the rationale for organizing findings into themes. Included in this chapter are also reflections on including a short self-defined biography of each of the subjects, in their own words, and what I hoped to mitigate in doing so. Findings are shared by theme, with six themes total, and sub-themes within each theme. Each them is summarized, and extensive quotes that support the theme are included. Other data that was gathered through informal observations were also included.

The discussion chapter is organized into three main sections: (i) Limitations of the research, (ii) implications of the research for different discourse communities, especially those referenced in the introduction and literature review, and (iii) areas for further research. In the discussion chapter I include my own reflections on my role as a researcher.

Chapter 2: Review of the Literature

Introduction

There is a culture shift happening, slowly but steadily, in the medical sciences. The belief that there is a defined and binary dichotomy between mind and body, between subject and object, and between provider and patient, has been successfully challenged from a variety of fields, philosophically (Kristeva et al., 2018), in feminist literature (Kligler, 2009, p. 137), social construction (McNamee, 2011, p. 150) and within the traditional medical sciences field as well. Even within the dominant discourse, there is a deeper understanding of the importance of how we think of the health care we receive, how we experience it, how we appraise it, and the influence this has on our own health outcomes.

Various scholars (Yaribeygi, 2018) agree that communication plays a significant role in determining our behavior, and that the language used is a product of social construction. Moreover, there is increased attention to what we are creating in our relationships with health, health care, and health care providers, and how that influences our experiences and our health. Mehta (2011) refuted the claim of mind and body dichotomy in the medical fields by positing that the framework failed to appreciate the relationship between human beings and their environment. We humans are social beings, and our state of health is determined by numerous factors besides physiological issues. Moyar (2013) further challenged the mind-body dichotomy philosophy by exploring the works of (Yaribeygi, 2018, p. 2990) that established a link between the state of mind the health condition of an individual.

Nonetheless, Mehta (2011) observed that despite the change to the philosophy of mind-body dualism contemporary human construction of this duality in the medical field is still the

dominant construct, especially as it applies to the physicians and patients. According to Mehta, this rigidity is due to the lack of sufficient patient engagement in the treatment process, resulting from and in, a lack of relational processes.

Extant Research

Mindset or Meaning making

One of the fascinating areas of research related to how we think of health and health behaviors is what is usually referred to as mindset research. This research demonstrates how the values and beliefs we co-construct with others influence not just how we think of particular health behaviors but also how our bodies physiologically and biologically respond to those things.

For example, many studies suggest that what meaning we give to certain activities influences the way our bodies respond to those activities or substances. Particularly, Crum and Langer (2007) have shown that how we think of movement impacts how that movement affects our bodies. In their research, movement that is thought of and constructed as exercise shows physiological benefit to the person engaging in the movement; however, the same movement, when it is not construed as exercise (for example in this study, hotel workers cleaning rooms) does not produce the same physiological effect. What constitutes exercise is, of course, a socially constructed phenomenon; his research explores what happens when the meaning of practice is reconstructed to mean something different and that this changes how our bodies respond to exercise.

In related research by Crum et al. (2011), how we think of the food we ingest influences how the food is metabolized in our bodies. The study by Crum et al. demonstrates that when we believe we are ingesting a diet food, our bodies produce ghrelin hunger hormones in a shorter period after eating and ghrelin slows metabolism. The study also showed the converse. When we think we are ingesting a high-calorie indulgence, our hunger hormones ramp up the metabolism and stay at bay longer. It is the social construction of food–what the meaning is of diet food versus what the purpose is of indulgent food that moderates our body's responses, even when those foods have the same physical biochemical makeup (Crum et al., 2011).

Another study that has been conducted in this area was carried out by Rhew et al. (2018), in which the authors examined "The Neuroscience of Growth Mindset and Intrinsic Motivation." In this systematic review, the researchers analyzed 34 articles on the mindset growth and its relationship with intrinsic motivation in human beings. Rhew et al. (2018) found that, in education, when teachers do not assume that the students will develop inherent motivation naturally, but instead, teach students about the importance of their own mindset, or constructs, or their performance, they are able to significantly improve their grades. (Samora et. al., 2019). The study further revealed that the mindset construct determines the level at which the body can stretch to achieve the set objective. According to Maarouf et al. (2019), the body is designed to execute what the mind has perceived, and therefore, a possibility conceived of with the mind is equally attainable by the body; conversely, what cannot be perceived, or constructed, by the mind as a possibility, cannot be achieved by the body regardless of physiological capability.

In another study (Yaribeygi, 2018), explored the relationship between stress and body functions and established that state of mind has both positive and negative effects on the physiological processes in the body. They posited that people tend to give more attention to the

negative repercussions of stress, perhaps due to the fact most of the research on stress has focused on the negative consequences. Their appraisal of stress then, is negative. According to this review, how we appraise the stress we are feeling, whether we consider it positive or negative, actually alters the hormonal response in the body with negative appraisal resulting in over secretion or deficiency thus the malfunction of somatic cells, while positive appraisal does not result in these functions. Another example of how our mindset, our collective construction of a particular thing, informs how the biological body responds is in the healing time of wounds. Research has shown that the healing time of wounds is influenced by how we are relating to the injury, whether we are fearful and anxious about it, or whether we are able to relax in relation to the wound (Broadbent et al., 2006).

Placebo Research

It is well known to most of us that the understanding that beliefs about medications influence how effective the medication is. The placebo effect is the phrase used to describe a beneficial effect produced by a placebo drug or treatment, which cannot be attributed to the properties of the placebo itself, and must, therefore, be due to the patient's belief in that treatment (Enck & Zipfel, 2019; Greenberg, 2018; Rousseau, 2018).

Placebo research of the last 50 years is some of the richest and most robust explorations of how our mindset, our socially constructed beliefs around health, are connected to how our bodies respond. Most agree placebo effect research began with Henry Beecher's article "The Power of Placebo" (1955), which showed a similar healing effect between prescribed medications and painted sticks (Peciña et al., 2015). Current research from (Khan et al., 2018) demonstrated diabetic patients have lowered hemoglobin AIC from placebo medications equal to

or sometimes more than prescribed medications; the same authors show improvements in adult and child ADHD symptoms from placebo medications. Placebo research is varied and complex, with differing hypotheses on the mechanisms of action. What is mostly agreed upon is that it exists and that our beliefs about medical treatments are influenced in a myriad of ways, from the color of the pills we take (Shapiro, 1971), to how we relate to medical authorities, to the nature of the office visit, and the meaning we construct around this.

Benson and Friedman (1996) acknowledged the effectiveness of the placebo effect quoting various studies, including the use of this technique in treating *angina pectoris* as explained by Heberden in 1772. Despite the introduction of different medicine, it was revealed that there was never an intervention superior to the placebo effect in controlling this disease. Benson concluded that the placebo effect could be harnessed for as long as the factors that provoked it were in existence (Benson & Friedman, 1996, p. 193). However, he identified the need to replace the name with better terminology "remembered wellness" arguing that the placebo effect did not adequately describe the role of our cognition, and instead is more associated with the drugs and surgical procedures based on scientific methods.

In another fascinating study, Colagiuri (2010) demonstrated that the placebo effect had a significant influence on outcomes in Randomized Controlled Tests (RCTs) meant to show the efficacy of medical treatment (Colagiuri, 2010, p. 246). He posited that the patient's expectancies on intervention could make the healing possible, thereby hindering the activity of the medicine administered. In a double-blind placebo-controlled RCT, the researchers were not able to determine if failure in blinding was as a result of active treatment administered or it was stimulated by patients' expectancies (Colagiuri, 2010, p. 246). Therefore, the mindset of an individual and the feeling of belief in a particular intervention has the power to produce healing

even if the medication did not exist, so long as the patient is convinced that the treatment works (Dauber, 2018, p. 202). The placebo effect is well known, well researched, and accepted in traditional medical research and practices and has been extensively applied in the health care sector. (Crum et al., 2016).

In the same way that how we appraise our activities, what we ingest, and our medications influences how we are influenced or impacted by them, so too does how we consider our relationship with health care professionals change how we experience the care they provide.

Meaning Making in Health Care Interactions

The meaning we make of the care we receive when we are patients is influenced by many factors, conscious and likely unconscious. One of the most well-researched areas of influence is the relationship between patients and medical doctors (Decety & Fotopoulou, 2014; Derksen et al., 2013; Kim et al., 2004). The increase in research in recent years on the patient-doctor relationship has allowed us to look at different parts of that relationship to explore what factors within the association have the most impact, both on health care outcomes and on the patient and provider experience (Makoul et al., 2007; Montague et al., 2013; Pollak et al., 2011; Pollak et al., 2008; Rakel et al., 2009).

A study conducted by Burroni et al. (2015) to investigate the impact of the dermatologist-patient relationship on patients' adherence to topical therapy as a treatment for psoriasis revealed that most clients did not comply with the intervention, citing lack of information on the treatment and insufficient trust of the clinicians. The absence of good rapport between the physicians and their patients led to a lack of trust from the patient toward the physician, leading the patient to not adhere to the recommendation. (Burroni et al., 2015, p. 9). This poor rapport, relationship, or

connection which results in a lack of confidence in the doctor or the intervention, and the subsequent lack of adherence to the recommendation, and resulting poorer health outcomes, has been found by Lindsay (2017) as well (p. 662). Further studies have shown that a patient's perception of the efficacy of treatment was related to their confidence in the physician, ultimately causing poorer outcomes, by either increasing the duration of healing time needed, or lowering the adherence rate to the recommended therapy (Jiang, 2019, p. 9).

Levy and Signorelli (2014) when investigating the patients' adherence to APS (Hughes' syndrome) treatment recommendations, observed that patient education, frequent monitoring, and proper communication- all related to relational aspects of the physician-patient relationship, had a significance bearing on the outcome of a clinical procedure. The motivation by a patient to strictly follow the instructions given by a practitioner depended on three aspects: the level of knowledge or information the patient has about the treatment (Jackson et al., 2017, p. 47); the rapport existing between the physician and the patient; the notion or attitude of the patient towards the health care provider, moderated by the relationship, and the intervention being offered (Levy & Signorelli, 2014, p. 1265). For example, the use of topical treatment of psoriasis was found to fail due to the patient's notions on the condition, with approximately 60% of the respondents interviewed stating that they did not consider psoriasis to be a disease (Jackson et al., 2017, p. 47). Those who did not believe psoriasis to be a disease were more likely to appraise the relationship with the physician as poor.

How we consider the relationship with those who are providing care for us influences how we appraise the care itself, and subsequently, how we respond to the treatment itself (Levy & Signorelli, 2014, p. 1265). When we feel a doctor is trustworthy, competent, and caring, we are more likely to believe that their diagnosis and recommended treatment is not only accurate

but also in our best interest (Burroni et al., 2015, p. 9); this, in turn, increases adherence to the recommendations (Colagiuri, 2010, p. 246). In addition to the experience of our doctors' increasing adherence, there is also a plethora of research showing that our appraisal of the doctor as caring changes how fast we heal from wounds (Levy & Signorelli, 2014, p. 1265). According to the World Union of Wound Healing Societies (WUWHS), patient-practitioner collaboration and positive relationship is vital in positive treatment outcomes of wound healing (Castaldo, 2013, p. 182). Lindsay (2017) found that the when patients are treated with dignity, shown respect by being invited to be involved in the treatment process, treatment outcomes improve. Patient-centered care does not only improve the outcome of wound healing process but also generates patient satisfaction (Friman et al., 2019, p. 231).

Empathic Relationships

When reviewing the literature on the importance of patient experience of their relationship with the physician, one particular aspect of the relationship stands out as primarily important: the perception of empathy in the relationship. The perception of physician empathy from the patient perspective has one of the biggest influences on our appraisal of the care we receive. The literature clearly demonstrates that one of the most influential characteristics of the patient-provider relationship is how caring it is appraised to be by patients. (Nuemann et al., 2009).

While caring and empathy, like love, compassion, and goodwill, are words that are defined variously and by different people in different fields of study, most agree these terms describe something that happens between people and is attributable to a relationship. There is an ongoing discussion, both in and outside of academia, concerning how to define empathy best. In

the medical sciences research, given that empathy is considered to be essential for the formation, development and continuation of the therapeutic relationship, it has been suggested that compassion in the clinical context involves an ability to (i) understand the patient's situation, perspective, and feelings (and their attached meanings); (ii) to communicate that understanding and check its accuracy; and (iii) to act on that understanding with the patient in a helpful (therapeutic) way (McConvey et al., 2013, p. 617) . The term "relational empathy" has been used to describe such an approach in other contexts (Jaafari et al., 2018; McConvey et al., 2013, p. 617; Tavakol et al., 2011, p. 297). One could question whether feeling care or empathy for another has any connection to what others perceive. One person might feel care or love for another; however limited relational resources may prohibit developing a generative relationship where the attention is experienced by both parties. Limited relational resources, due to trauma or other events that can cause a limited capacity to open-heartedly engage with others, are only one possible barrier or difficulty in co-creating empathic encounters.

The literature often constructs two types of empathy: cognitive empathy and affective empathy. Affective empathy, sometimes called emotional empathy, is when one feels the same feeling another is feeling. This is often caused by emotional contagion and is rarely purposeful; instead it is a reaction to another's feelings. This is usually considered a lower form of empathy, and it often does not result in skillful conveying of care to another. An example of affective empathy is when a child is crying plaintively after being injured; another might respond 'you shouldn't have been running in the driveway!' This is often due to the other overwhelmed with affective empathy and reacting to discharge the emotion they feel.

Cognitive empathy emanates from one's ability to imagine the perceptions, experiences, and feelings of the counterpart. In contrast to affective empathy, cognitive empathy does not

necessarily involve one person actually feeling what another has or is feeling; instead it is cognitive perspective-taking of another. Differences in culture, implicit bias of either person, poor previous experiences with other similar interactions, or differences in how people coordinate meaning can all be barriers. According to McConvey et al. (2013), empathy has a biological origin in which scientists believe that the medial prefrontal cortex part of the brain is responsible for higher-level thoughts and judgments, making a person either develop emotions or not all. Understanding the limits of measuring empathy within relationships, there is abundant research and literature in the area of the patient-provider relationship, which influences meaning so profoundly.

How empathy is Measured in Health Care Settings

The canon of research on empathy of health care providers, and its impact on health outcomes, is primarily measured by the patient's perception, using standardized tools (Hojat et al., 2001; Howick et al., 2017; Montague et al., 2013; Pollak et al., 2011; Pollak et al., 2008). Conversely, lack of empathy is also typically measured by patient perception (Kinsler et al., 2007; Moyers et al., 2013). One common technique for measuring empathy is the Questionnaire for Cognitive and Affective Empathy (QCAE) (Tavakol et al., 2011). The tool focuses on an individual's responses to specific questions gauging the level of emotional strain one undergoes when a friend is found in a painful situation (Webb et al., 2013)

When we look closer at the perception of empathy in health care relationships, we can see that communication, both verbal and non-verbal, seems to be one of the most critical ways empathy is communicated. There is a strong tradition of looking at communication in service provision within traditional medical research, and the research in this area has increased

exponentially over the last 20 years. This is likely driven by the robust findings referenced above. Despite this, traditional medical research tends to focus on communication as an object, handed from the provider to the patient, and less often focuses on the relational processes of communicating, connecting and coordinating meaning.

In contrast, social construction research has explored the relational aspects of health care for many years. For example, there have been explorations of collaborative health care (Gergen, 2015; Gordon et al., 2012), narrative medicine (Charon, 2006; Katz et al., 2000) and multidisciplinary care (Thistlewaite, 2012). These collaboratively oriented approaches have specific commonalities, all related in a sense to empathy: generous listening, connection to those being treated, and a flattening of the typical "expert-patient" dynamic and inviting those being treated to be a part of the process. Social construction research has shown collaboratively oriented approaches in medicine have resulted in improved clinical outcomes, decreased hospitalization, and improvement in both provider and patient experience (Anderson & Gehart, 2006; Asen & Scholz, 2010; Froderman & Mitchum, 2010; Gittel, 2009; Mehi-Medronna, 2007).

These commonalities are all aspects of the relational orientation of social construction where emphasis on what people are constructing together is highlighted. To that end, there is a thread of commonality with what is often described as an empathic connection–what we might refer to as the discourse of empathy. Studies (Jaafari et al., 2018; Tavakol et al., 2011; Valasek, 2017) have revealed that the effectiveness of compassion is when the client can observe or hear it from the clinician, and Jaafari et al. (2018) posited that a feeling must be expressed to be recognized, and it can be done through communication.

The impact of this empathic relationship, signified by communicated empathy, has an enormous influence on our health. The research measuring patient-perceived empathy

demonstrates the effects of medical providers' understanding on patient adherence and outcomes, including lowering hemoglobin levels in diabetics, improving success in weight loss, improving healing time for wounds, lowering depression symptoms, improving pain scores, and even lessening the duration and severity of common cold symptoms (Del Canale et al., 2012; Kelly et al., 2014; Pollak et al., 2011; Pollak et al., 2007; Rakel et al., 2009). Physician empathy has been shown to improve patient quality of life scores, post-cancer treatment (Nuemiller, 2007), and increase patient adherence to physician recommendations (Kim, 2004). Patient perceived empathy has been shown to outweigh race and language concordance in developing therapeutic relationships between physicians and patients (Adams, 2015). Aggarwald (2015), in a meta-analysis of patients with mental health conditions, found that communication that was perceived by patients to be caring resulted in significantly higher treatment retention and improved clinical outcomes. Miller and Johnson (2001) found that a single brief encounter, if sufficiently empathic between treatment provider and patient, is related to significant positive changes in problematic patient drinking. Miller and Johnson attribute this to "unconditional love."

Crandall and Marion (2009) observed that effectively communicated empathy among nursing staff to the patients increased the rate of patient revisit to medical offices. According to their findings, 62.7% of the respondents interviewed stated that 'good' relationships, indicated by signs of care or empathy from the nurses as one of the primary reasons they will adhere to the recommendations for follow-up appointments.

A study by Ward and McMurray (2011) indicated that demonstrated empathy was observed to have a significant impact on the recovery process for a patient with depression. They concluded that creating an empathic connection between the counselor and the client helped in establishing a suitable environment for the patient to open up, freely share about their struggles,

collaboratively problem solve with the counselor, and adhere to recommendations. Communicated empathy thus improves health care outcomes by developing trust between the client and the health provider, facilitating adherence to treatment recommendation. (Ward & McMurray, 2011, p. 1583).

Appraisal of how caring it is the relationship between patients and doctors has been found to have significant influence on perceptions and experiences outside of the clinical interaction. For example, the quality of perceived empathy from patients also effects malpractice claims. Patients often refuse to attribute errors to the physician that enacted the mistake when they felt the physician was caring and trustworthy; instead, patients incorrectly attribute medical errors to physicians who they had poor relationships with, often describing the physician as "cold" or "uncaring" (Crandall & Marion, 2009). Crandall and Marion associated lack of client trust in the clinicians due to the absence of empathic communication skills by the physicians. This pattern continues even when patients are shown evidence of the correct error attribution. This pattern is so consistent that researchers can accurately choose which physicians have had 2 or more malpractice claims against them, and accurately predict which physicians will have two or more in their careers, by merely listening to audiotapes of their tone (in this study, verbalized words are taken out of the recording, so only tone can be recognized) during interactions with patients. Physicians that use an authoritative tone that lacks warmth in their voices and who miss emotional cues from patients are 40% more likely to be the subject of litigation in their careers (Gaspar & Schweitzer, 2013, p. 160).

Research on Empathy's Opposite: Stigma, Judgment, and Bias.

When health care relationships are perceived as non-empathic, and instead as stigmatizing, judgmental, or with negative bias, this has an equally negative influence on our health. Bias, stigma, and judgment can be defined as a set of negative attitudes, beliefs and stereotypes that lead people to avoid, reject or discriminate against others with particular characteristics or conditions. Often these negative beliefs and opinions are unconscious, or implicit, meaning the person who has them is not aware of the ideas and has not purposefully chosen the perspective. Sometimes the opinions and attitudes are conscious, and are agreeable to the person, or explicit. Individual people are not the object of stigma; rather a condition or characteristic they have would be stigmatized. Groups of people can be the object of bias or stigma, such as people of particular ethnicities or races, people who identify with a particular religion, or the Lesbian, Gay, Bisexual, Queer + community. Sometimes it is conditions that are stigmatized, which then is associated with a 'type' of person. Some of the most common examples of stigmatized conditions in health care are chronic pain and addictive disorders; however, any behavior or condition that is deemed 'difficult' by health staff is likely to lead to that patient or their condition being stigmatized. For example, Appukuttan (2016) observed that high levels of anxiety exhibited by some patients with dental problems sometimes make them more difficult to be attended by dental staff and providers; subsequently, dental staff and providers describe these patients as 'difficult' and develop patterns of interacting with them that are harsher than with other patients.

There is an extensive body of research demonstrating the negative impacts of stigma, bias, and judgment, on patient satisfaction, patient adherence to treatment recommendations and clinical treatment outcomes (Kinsler et al., 2007; Link & Phelan, 2001; Moyers et al., 2013).

Many factors contribute to the development of or lack of empathic relationships. How physicians feel about patients influences their communications, and subsequently, patient's health outcomes. Research has shown that physicians "liking" patients or not, impacts how they respond to patients' pain; the pain of the patients who physicians like is taken more seriously and assumed to be essential to treat, while those who physicians dislike are more likely to have their pain minimized or dismissed (Ruddere, 2011). Flickinger (2015) demonstrated that the level of respect physicians had for patients impacted their communications skills, with higher levels of respect resulting in more skillful patient communication and lower levels of respect associated with less skillful, shorter, and more abrupt communication, communication that is rarely associated with caring.

Crandall and Marion (2009), in their study to identify attitudes towards empathy, pointed out five factors that might hinder empathic relationship between patients and physicians to be: overreliance on technology; lack of enough role models in the practice; failure by colleagues to teach cognitive skills in evoking cognitive empathy; time pressure and past negative experiences leading to stigma and bias; and other negative judgments about particular conditions or groups of people. While it is largely agreed upon by those working in health care services that the use of technology in medicine has been a barrier to caring interactions, for example, having doctors looking at a computer and typing while a patient is talking. However. there is ample evidence summarized above that technology itself is not the cause of poor-quality interactions, lack of empathy communication, or the conveyance of negative biases, judgements and stigma.

Problematizing the focus only on "physicians."

Clearly, the breadth and depth of the medical sciences research focusing specifically on the communication between medical providers and patients is substantial. However, the strength

of the medical paradigm, which assumes treatment is an object, unmoderated and unaffected by the person giving it or receiving it and unaffected by the relationship between patient and provider, is substantial and apparent even within this communication-focused research. This is a likely reflection of the patriarchal construct which casts the medical provider as the sole hero in health care provision and all others as supporting actors. The current dominant construction, with its focus on treatment as an object, rendered by an educated male, and received by a passive recipient, ignores not only the well-studied impact of the quality of the relationship on treatment, but also of other members of the health care team, such as medical assistants, health navigators and health educators, and especially receptionists, who are generally not considered part of the care team at all. In the dominant discourse, the terms "treatment provider" or "medical provider" are reserved only for physicians, indicating only they are the provider or medical care, the only purveyors of treatment. The focus remains fairly rigid on what has been considered the traditional point of care: the dyad of the medical provider and the patient.

Even within the social construction research, there is a tendency to consider the medical provider and a medical team (multidisciplinary or not) the only provider of care (O'Mahony et al., 2007). The literature on health care communication, treatment, patient satisfaction, patient experience of care, and patient perception of empathy is seldom focused on reception staff. Twenty-years ago Karen Brodkin Sachs (1988) wrote, "soap operas and scholars seem to agree that hospital workers are doctors and nurses." The same could easily be said about medical out-patient offices. While there is some limited research in anthropology which has focused on staff positions outside of the provider-patient or nurse-patient dyad, that research is still mostly on licensed professionals who are adjunct parts of the traditional clinical care team, such as specialists, or interpreters (Browner, 2003; Davidson, 2001).

Existing Research on Medical Receptionists.

With the exception of Cicourel (1999), researching the medical receptionist's role as gatekeepers on phone interactions, there are very few studies in the United States on receptionists, fewer on their relationships with patients and no known studies on their experiences of work and perception of their relationships with patients. The United Kingdom does slightly better; there is some research on receptionists' invisible and unacknowledged work in three main clinical areas: triaging patients for appointment urgency, passing on prescription refill requests to physicians, and sharing test results with patients (Litchfield, 2017, p. 523). In their study on the future role of receptionists in primary care, Litchfield (2017) spelled out that in addition to acting as gatekeepers in medical facilities, receptionists play three vital roles in primary care. 1. They exercise the discretion to prioritize appointment allocation to patients based on their judgment since they lack professional skill-related directly to health care. 2. They facilitate the acquisition of repeat prescriptions that do not require direct consultation between the patient and the physician. 3. Relaying typical test results to patients from the clinicians is another crucial role played by the receptionist thus necessitating their inclusion in medical outcome studies.

There is relevant, interesting, and experience-congruent research (Litchfield, 2017; Neuwelt et al., 2016), which demonstrates the strength of the medical receptionist impressions, behavior, and interactions with patients, on patient satisfaction and larger patient experience of care. Neuwelt et al. (2016) find that over half of all complaints of health care visits focus on dissatisfaction with the receptionist, an indication that the impact of receptionists is particularly high on patient experience and in need of further exploration. Further, in the study to establish receptionists' opinions on their care role in Auckland, New Zealand, Neuwelt, Kearns, and

Cairns (2016) interviewed 32 receptionists and found that receptionists are engaged in juggling duties between patents and physicians, which creates significant tensions for them, but this is ordinarily invisible to other staff. Neuwelt and his team conclude that receptionists play a crucial role in bridging the health care system to the community and therefore must be considered key to the health care practice (Neuwelt et al., 2016, p. 122).

What is Missing?

Despite many clear indications and a small amount of supporting research that demonstrates the vital role receptionists play in the health care experience of patients, as well as the evidence that their relationships with patients is deeply significant to not only patient experience but also on patient adherence (Russell & Bowles, 2016), research on the personal views of the receptionists themselves, as well as on their experience of, and appraisal of their work, role and their perceptions of relationships with patients, remains very low (Neuwelt et al., 2016, p. 122; Russell & Bowles, 2016, p. 120). This lack of focus on the experiences of medical receptionists is consistent with their low social status, being primarily women, and women of color in the United States who are engaging in low prestige, low wage work (Russell & Bowles, 2016, p. 120). This, too, could perhaps indicate a disinterest, a lack of curiosity about receptionists themselves, likely mirroring the dominant medical discourse, but at odds with the strength of these patients' responses to reception experiences (Neuwelt et al., 2016).

The Demographics of Receptionists.

Reception staff in medical settings are disproportionately women, usually young, and without formal education (Desilver, 2017). Reception is low-wage work, and an overwhelming percentage of receptionists are women of color (National Women's Law Center).

Virtually all medical care facilities have receptionists; in North America and Europe, almost 100% of the population has regular contact with medical receptionists (Amin et al., 2016, p. 2). They are positioned at the point of entry in any medical organization, making them the most accessible member of the health care team. They are also the most accessible member of the team telephonically; the back office rarely answers phones from the outside, only picking up when a caller is transferred to them; instead, receptionists are responsible for both patients coming in-person, as well as people calling in. According to Neuwelt et al. (2016), receptionists are primarily hired for their secretarial skills and their ability to complete the transactional tasks required with patients at the front desk. Rarely are there preset entry requirements of becoming a receptionist. According to Hammond et al. (2013), employers look almost exclusively for relevant work experience to conduct the transactional tasks, making the hiring of receptionists transactional as well. In fact, in many medical organizations, the recruitment of reception staff is called "warm body" recruitment, reflecting the belief that anyone can do it, and who does it is unimportant.

Nonetheless, Burrows et al. (2017) posited that most receptionists are employed without any specific skills set around traditional reception tasks. This is despite the fact that they engage in deeply important and impactful work regarding patient care. According to their survey, Amin et al. (2016) argue that receptionists are almost solely responsible for contacting the patient for care, determining the rate of service flow in hospitals and ambulatory settings, and giving or

withholding medical appointments based on the availability of the doctor. Despite not being considered providers of treatment, receptionists with some medical qualifications may be called upon to provide assistance in the general practice (Ramsaran-Fowdar, 2008). Burrows found that sometimes receptionists are given some training 'on-the-job'; however, this training is mostly based on administrative tasks and knowledge rather than any training around navigating patient-receptionists relationships, or clinical subjects.

The Expected Role of Receptionists in Managing Emotions

Receptionists routinely engaged in encounters with patients are also expected to manage complex, confusing and sometimes conflictual interpersonal interactions, such as when patients are hostile or otherwise escalated. In such cases, receptionists are expected to demonstrate skills that deal with the patient's attitudes (Manser, 2009), even though they are in a semi-public place, with no other clear support. Different difficult situations and stress factors may arise at the reception, and receptionists are expected to devise ways of solving those complex issues. Strathmann and Hay (2009) write that such problems may include intense patient emotions, issues of race and class, and other delicate situations, such as escalation of emotion, and even threats of violence. In such cases, the receptionists typically rely on their history, personal and professional, to understand and deal with these situations. While interacting with patients, receptionists are expected to assess the risk in every situation and make viable decisions unique to each case. According to Alazri et al. (2007), receptionists often feel that their choices are problematic and not feasible, particularly when dealing with patients who are perceived to have a higher social status, or more authority, than the receptionist.

There is, still, an expectation that receptionists should be adept in dealing with angry clients and specific personal crises preventing them from escalating and affecting the continuous provision of care (Hewitt et al., 2009). Receptionists engage in deep and complex interactions with patients all the time, more so than any other member of the health care team (Burrows et al., 2017). They also are the only member of the team to continuously relate to patients, without an office or another area to retreat to–their office is the semi-public space of the waiting room.

Alazri et al. (2007) observed that receptionist' work is not only complicated but is also demanding and intense. They found that individuals in these positions demonstrate a high level of commitment in performing their duties. Staff, non-patient visitors, doctors and other clinic personnel typically require attention and tasking during the day as well, and this, coupled with their highly visible physical position in the waiting room, often leaves little time for rest.

Stressors of Receptionists.

There are many stressors receptionists experience. The position they hold is one of incredible responsibility, with little or no authority, which is the highest stress work situation for most people (Iacobucci, 2016). They are tasked with making appointments for patients who are in sometimes urgent need, although they have no official authority regarding appointment availability. They are responsible for responding to patients who may need medical advice, medication refills or referrals to specialists, while having no authority in meeting these specific demands. They are expected to address patient emotions, including anxiety, grief, anger and fear, with little autonomy, training or support in how to meaningfully address it. They are often tasked with medical decision making that far exceeds their training, such as phone triage and emergency care, and requests for prescriptions by the patients (Strathmann & Hay, 2009). In most cases,

most of the receptionists are expected to determine the most effective solutions, despite having little autonomy and usually no authority in medical decisions (Hewitt et al., 2009).

Another other job stressor is the lack of opportunity for personal and career development. According to Jeffrey (2016), most receptionists are overloaded with work to the extent that they do not have time to pursue academic development unless the employer offers it, which is exceedingly rare. Consequently, studies have revealed that there is a low probability that medical organizations will offer, support or even encourage receptionists to obtain further training or education, since despite evidence to the contrary, such as that cited above, their duties are considered to require less expertise (Jeffrey, 2016, p. 446; Kumar & Talwar, 2017).

Lack of Training or Resources for Receptionists.

Despite receptionists' engagement in numerous clinical decisions on a daily basis, receptionists remain one of the least resourced positions in the medical organization (Duncombe, 2011, p. 164). According to Duncombe, receptionists in medical settings, have a need for a higher level of more specific skills and training than receptionists in other fields. For example, receptionists in medical settings are often talking to people in various stages of acute medical distress, and as a result, receptionists in medical settings need to be equipped with extra training on basic assessment of medical issues, as well as how to assess acuity, in order to match patients to the appropriate service, in the appropriate time. Iacobucci (2016) further emphasizes the importance of training the receptionists on effectively gathering information from patients that is related to their visit with the physician, in order to ensure the physician is prepared to meet the patient's needs. Examples of this include, gathering information from patients on what procedures they are requesting, in order that the physician and medical assistants can prepare the

room and the physician's supplies and equipment, such as breathing machines for treatment for asthma patients, wound care for wound management, and injections for vaccine appointments. Receptionists typically manage all paperwork needs that comes to the practice, including letters to and from patients for schools, employers, insurance companies and lawyers. Additionally, receptionists are expected to interact with, manage, mitigate or otherwise intervene with a broad range of sometimes intense emotional states of patients.

Medical assistants, the most similar in job class to receptionists in pay and status, engage in a 2-year training program, which includes intern experience in medical offices and certification at graduation. They typically have ongoing core competency training in organizations, which consists of both technical skills such as CPR and giving immunizations as well as interviewing skills to elicit information from patients (Li 30). Receptionists, who interact with sometimes hundreds of people a day, compared to medical assistants, nurses, and physicians who interact with between 10-25 people a day, depending on specialty and practice, receive no such training. Rarely do receptionists engage in any formal education or program to become receptionists, and it is very uncommon for receptionists to intern in the position before being hired. After receptionists are employed, they are often excluded from even clinic-wide training (Russell & Bowles, 2016, p. 126), as they are considered non-clinical. Despite the fact that receptionists are the most likely people in medical settings to engage with escalated patients, they rarely receive training in this area (Ward & McMurray, 2011, p. 1583), and, in fact, despite how collective this experience is, it is uncommon for it to be mentioned in job descriptions as a core duty, or in interviews, as part of what the position entails.

Additionally, receptionists are rarely formally trained or supported in any interpersonal or relational development, despite this being the core component of their job. Receptionists are

typically only given instructions on their transactional tasks, such as entering patient details into the computer and calling insurance companies for authorizations (Li, 2018, p. 30). According to Hewitt et al. (2009) receptionists lack any significant authority and can only operate within a strictly defined jurisdiction leading to a lack of autonomy in their work. The available literature shows that lack of adequate training and low autonomy restricts receptionists and offers them little freedom in their responses and relationships with patients.

Receptionists' Realm of Work: The Waiting Room.

Receptionists work in the semi-public place of the waiting room for 8 or more hours a day. The waiting room is in effect their office. Despite this, rarely are receptionists given the autonomy and authority to actually be in charge of the waiting room, for example, making decisions around the flow of patients from and to the waiting room, the design of the room, décor, or defining practice norms of interacting with patients. The waiting room is a shared space between patients and receptionists, and patients with other patients. In contrast with exam rooms, communication between patients, and between receptionists and patients, is semi-public, often overheard by others. Patients spend the majority of their total time in the clinic in the waiting room, with the average of 47 minutes in the waiting room, while the average time with the physician is 12 minutes (Burrows et al., 2017); however, there is little research on receptionists or patients' experience in waiting rooms (Neuwelt et al., 2016, p. 122). This is likely due to the dominant narrative of what constitutes treatment; "waiting room" indicates a place where nothing happens, a holding space before treatment is given to a patient by the physician. One example of a signifier that the waiting room is considered a room where no treatment occurs is the presence of a television. In many medical waiting rooms in the United States and Europe, a

public television is on; usually the patients do not have any control over the content or volume of the television; surprisingly, just as often, the receptionists do not have decision making power around the television either.

In some more modern organization designs, receptionists are secluded from the patients' waiting room, and instead are placed at the entry way of the organization. However, this does not offer an improvement to their working conditions but instead makes it more challenging, as in these design, receptionists are highly visible and exposed, yet do not have the ability to assess the emotional climate of the waiting room. Regardless of physical placement, receptionists are always physically separated from what is considered the medical team–the physician, nurses and medical assistants. Litchfield (2017) observed that receptionists serve as a link between the medical team and the patients and are obliged to pass the information between these two parties, often resulting in miscommunications, with receptionists frequently bearing the blame and consequences of this.

Research on the Influence of Receptionists on Patients' Experience of Care.

The majority of receptionists' work is in interacting with patients (Ramsaran-Fowdar, 2008). Often receptionists interact more with patients than the rest of the health care team when measured in accrued minutes of interaction (Kumar & Talwar, 2017, p. 23). Certainly, patients spend more time "with" receptionists in the waiting room than they do with any other health care staff, including physicians (Matusitz & Spear, 2014). Additionally, receptionists engage patients in checking them in, taking payments, authorizing insurance, having the patient fill out forms, interacting with patients on phones, scheduling appointments and checking patients out after the visit with the physician has concluded. This high level of interaction, their constant visibility to

patients, the perception of receptionists as the liaison to the medical team, and the subsequent perception that the receptionist is a 'gatekeeper' to the physician, causes receptionist to draw a disproportionate number comments and reactions from patients. Receptionists elicit substantially more reactions that physicians, nurses, or medical assistants, both positive and negative (Morrison, 2014). This is corroborated by public review internet sites and social media sites that aggregate ratings, such as YELP or Health Grades, which often have 2-3 times more comments about receptionists' interactions than those of the physician (Hewitt et al., 2009). Neuwelt et al. (2016) did a study showing that receptionists draw the majority of complaints when looked at as a whole in the organization (Health and Social Care Information Centre, NHS wrote complaints). The depth and breadth of the responses and reactions to receptionists compared to physicians reflects the core importance of the role that receptionists have.

Receptionists are the first person patients' see when they come in the door of a medical clinic or office and are often the first person patients' talk to when calling the clinic. Their status as the leaders of the first impression, makes them of the most influential communicators of the medical office. Receptionists interactions and relationships with patients are often the determining factor for a patient in returning to the clinic after a first appointment, and whether a patient should put their confidence in the care they receive there, making subsequent decisions to follow recommendations, or even to return (Brant et al., 2018, p. e478). Subsequently, they have a significant impact on patient health and health outcomes: dissatisfaction with reception staff can have severe implications for no-shows, adherence, emergency room use and ultimately, treatment outcomes (Cowling et al., 2016).

Receptionists are necessarily the initiators of the relationship between patients and the medical organization, as well as the moderator. They are one of the most significant variables in

the effectiveness of the ongoing relationship between patients and their care organizations. Litchfield (2017) observed that receptionists serve as a link between the medical team and the patients and are obliged to pass the information between these two parties, often resulting in miscommunications, with receptionists frequently bearing the blame and consequences of this.

Most of us, as patients, have experienced the disproportionate effect receptionists have on our perception of an organization and the care provided. We might not consciously be aware of it, as we, too, may have likely dismissed receptionists as only obstacles or facilitators of our real treatment.

We decide, typically within seconds, how friendly, kind, caring, professional, and competent a doctor's office is simply by the reception environment, experience, and the receptionists themselves (Harrington, 2006). According to Harrington (2006), the judgment of receptionists by the patient in most cases is based on the initial assessment of an individual receptionist's demeaner, specifically whether we interpret it to be professional, helpful, caring and warm, or alternatively, unprofessional, unhelpful or uncaring.

An example of receptionists eliciting disproportionately strong emotional responses from patients is the anger many feel when receptionists ask what the patient is seeing the doctor for. This task, of eliciting what the appointment is for, has been almost universally assigned to receptionists (Brant et al., 2018, p. e478). There is evidence that the question, coming from a receptionist, is angering to many people (Harrington, 2006, p. 15). This is another example of a high level of responsibility with a low level of authority. This may also be an example of the different constructions of receptionists: the physician has constructed the role of the receptionist to be a gatekeeper and organizer of patient appointments, tasking them with finding out what the reason for each visit is. The patient, however, sees the receptionists as separate from the health

care team, and perhaps not qualified or credible to ask the often personal medical questions "what is the appointment for"; furthermore, the question, when not requested on the phone, is requested at the front desk, in front of others waiting in the waiting room, possibly making the question seem more intrusive and inappropriate.

Barriers to Receptionists' Empathic Relationships with Patients.

Despite the numerous expectations on the receptionists and the significance of their role in the medical office, it is evident that they experience a large number of challenges while executing their role, particularly in interacting with the patients. There are many barriers to receptionists developing trusting relationships with patients and their families. Because the initiation and development of relationships with patients are not identified as essential activities in receptionist work, medical practices rarely talk about these aspects in recruitment, interviews, selection, or training, focusing instead on computer or other paperwork related skills (Crandall & Marion, 2009). Receptionists are not hired with relational skills as a focus and are not encouraged to engage with patients relationally. Usually little instruction or development of resources are provided to receptionists to assist them in engaging with patients relationally (Gaspar & Schweitzer, 2013, p. 160); instead, they are often instructed explicitly to engage with patients in a transactional relationship only. Sometimes receptionists are instructed specifically against developing friendly relationships with patients by physicians or managers who fear friendly conversation will be a barrier to receptionists' productivity.

Lack of practical communication skills among receptionists has been identified as one of the significant challenges to the development of a positive and caring relationships with patients. While now more commonly offered in nursing, dental, and medical school, this type of learning

and training is rarely offered for receptionists, leaving the receptionists with a difficult task of practicing a role where the primary task is interpersonal interactions, something they lack formal training in, as well as lacking the autonomy to freely engage in this way. (Burroni et al., 2015, p. 9; Caswell & Long, 2015). Commonly, receptionists are told explicitly not to engage in chit chat or regular, everyday connecting conversational patterns that are the hallmark of friendly places, such as department stores.

Compounding the barriers to goodwill relationships with patients, there is often a culture of 'warning' receptionists about patients, by physicians or managers. Particularly in low-income medical services, receptionists are often warned about patients, told that all patients are potentially dangerous. There is particular stigma around patients who have addictive disorders, or are taking opioids for chronic pain, with clinic leaders singling this group of people out for being of particular danger. Often receptionists are seated behind protective glass partitions, or have panic buttons under their desk, even though these interventions are inconsistent with a welcoming environment, which is thought to reduce escalations. These warnings inhibit receptionists from making eye contact, demonstrating care or concern or engaging in other behaviors that indicate a deliberate effort to engage relationally. The warnings of physical danger, the plexiglass barriers, the panic buttons and the security guards are inconsistent with the actual danger; while violence in some medical settings is worrisome, such as in emergency rooms, violence in outpatient medical clinics has consistently been found to be very low. (Joint Commission on Quality and Patient Safety, 2019).

Abuse of Receptionists

While physical violence is uncommon, yet addressed regularly, if not effectively, through warnings and protective interventions, verbal abuse of receptionists is very common. Verbal abuse of receptionists by patients is incredibly common. Dixon et al. (2004) found that over 60% of medical office receptionists reported being verbally abused on the phone, and 55% reported face to face abuse. Magin et al. (2009) found similar results, between 62% and 68% of receptionists surveyed experienced telephone and face to face verbal abuse. The overwhelming commonality of the receptionists' experience in being the victim of verbal abuse, often including threats from patients, likely significantly contributing to the often poor relationships with receptionists and patients. Verbal abuse is rarely addressed in organizations, and in fact is typically dismissed as 'part of the job.' It is uncommon that medical organizations acknowledge the chronicity of verbal abuse of receptionists, and by not doing so, normalize it, further strengthening the barriers between receptionists and patients.

Abuse of Receptionist by Physicians

Relatedly, medical receptionists are often subject to being disregarded and being addressed in a derogatory manner (Ward & McMurray, 2011) by physicians. In other research, receptionists in outpatient settings are the most likely target of verbal abuse, reprimands, and other actions of a critical nature by physicians (Carnegie et al., 1996, p. 504).

Receptionist Experience and the Relationship to the their interactions with Patients

The connection between how receptionists are treated, the response, and how they often in turn treat patients has emerged as an issue of concern among researchers in fields outside of

the medical sciences. There is much research in the employee satisfaction field, demonstrating that satisfied staff are associated with better customer engagement, higher customer satisfaction, and overall improved customer experience. Available studies on receptionists in other fields have shown that the negative perception in the receptionist empathy is associated with stressful nature of their work (Carnegie et al., 1996, p. 504).

This 'cascade' of stress is further explained by Rajan (2015). He found that organizational stress in large hospitals, which created managerial stress, ultimately impacted hospital receptionists, who reported higher stress. Patients who reported poor treatment by receptionists correlated with those receptionists who reported higher levels of stress. This could also be called a cascade of dehumanization, or a cascade of objectification because receptionists are often thought of in terms of their function, the tasks they are to complete and treated as objects of the medical office. They, in turn, are more apt to treat patients less like people and more like the problems they bring in for treatment.

Theory

Health and Health Care as Socially Constructed.

Social construction places our attention on how health, illness, and treatment are constructed in particular contexts, by specific participants, engaging in particular ways (Coward, 1989; Gergen, 2015; Sontag, 1989; Stein & Stein, 1990). Social construction invites us to consider that meaning is the byproduct of coordinated activities among and between people (Pearce, 2007) and is something that is dynamically created and in a constant state of changing re-creation through relationships. While there is no single definition of social construction,

Gergen (2015) suggests that we can think of a social constructionist approach as one that accepts one or more of the following key assumptions: A critical stance toward taken-for-granted knowledge, especially knowledge that is labeled as truth, as objective, as real-knowledge that claims itself as fact; historical and cultural specificity, meaning learning is constructed differently in different cultures, and experience is fabricated separately through history, depending on who's voice is dominant in naming knowledge, social and economic factors, and innumerable other variables; that knowledge is sustained by social processes, meaning, knowledge is constructed and maintained between people, not as an individual discovering truths about the world; and knowledge and social action go together, describing the deep impact construction and reconstruction of meaning can have on power relations, on what is considered acceptable treatment of others, or what is permissible in society.

A social construction approach, when relating to health, health care, wellness, and the body, would necessarily include all 3 of these assumptions in its exploration.

1. A critical stance toward taken for granted knowledge: Health and health care in the western world has an enormous, dogmatic body of knowledge considered as fact. This is sometimes referred to as "evidence-based practices" when talking about health professionals' clinical practice; it is also referred to as "research-based evidence." Health sciences are considered hard sciences, in and of itself, an expression of what is considered objectively described reality. Medical sciences are deeply rooted in positivism, and as such, are inherently reductionistic. As Kristeva et al. (2018) articulates in her manifesto of sorts "Cultural crossings of care: An appeal to the medical humanities," even in the current medical sciences dominant discourse about considering a patient's beliefs and culture in their care, the assumption is that medical science is a "true" object and finding the "impact" of an individual's beliefs and culture

on preventive care is only considering a subjective perspective on an objective truth. This research aims for a deconstruction of the binary distinction between hard and soft sciences, between medical science and cultural dimensions of health by challenging the assumed knowledge about what constitutes care, who is the care provider, and what are the therapeutic factors in care.

2. Historical and cultural specificity: despite the characterization of medicine as facts and objective truths, medicine has a long history of historical and cultural specificity, including ethnographic and anthropological references to different constructions of sickness, health, treatment, medication, and healing; and historical specificity, recent examples in western culture include the medical establishments characterization of homosexuals as mentally ill, of women who were abused by their husbands as hysterical, of imperfect mothering being responsible for schizophrenia. Similar examples exist in treatment and healing: the consideration of leaches as treatment for endometriosis and of rest as treatment for "female maladies" of a general nature (Yaribeygi, 2018). Even within the dominant medical sciences discourse, this dynamic and ever-changing nature of truths is acknowledged; it is, however, framed as a continual deepening of discovering "more true" facts as opposed to seeing the ever-evolving meaning and understanding within medical science as socially constructed between people, within a particular time and place.

In another example, one of the foundational deconstruction approaches is rooted in the widely recognized conceptual distinction between disease, the biological condition, and illness, the social meaning of the term (Eisenberg, 1977). In contrast to the medical model, which assumes that diseases are universal and do not vary between time, place, or culture, social constructionists emphasize how the meaning and experience of illness are shaped by cultural and

social systems. Freidson (1970) argued that sickness and disease, just like deviance, are social constructions based on what is not acceptable or desirable in a given culture, dominant power structures or point in history.

The repetition of particular performances of patterns and of coordination of meaning creates norms and traditions that in turn develop a definable and describable culture. The overarching culture of health care in the western world, while dynamic, is describable. Patients play a role in this culture and are in relationship with the health care culture. This qualities and patterns of this relationship significantly impacts their health and their relationship to health.

This research is an exploration of women who work as receptionists, their experiences, their role and their relationships with people who are in the role of the patient, within the larger context of the health care delivery system. The constructed role of receptionists, health care delivery, who (and when) is considered a patient, are moderated by the cultural and historical factors of this point in history. As an example, the fact that the vast majority of medical receptionists are women of color in the United States influences how their role is thought of–that it has little status. Culturally, we are in a time where doctors have enormous status and power, while those who work as receptionists have very little.

3. Knowledge and social action go together. How dominant voices construct health care has enormous impact on the experience of patients, their health, traditionally measured clinical outcomes, as well as on health care workers' experience, health, and wellbeing. What is considered as the current knowledge base on medical sciences and health care has defined how medical care is structured, what roles people take in health care encounters, what is considered illness, sickness, treatment, and even what is considered help. In deconstructing what is considered accepted knowledge around the role of receptionists and their relationships with

patients, this will necessarily alter the social action choices available to us in and around this field.

Summary

In summary, there is a plethora of research indicating that how we think of and experience health, health care, medications, health behaviors, and our relationship with health care providers have a profound and significant influence on our experience and subsequently our health. One particular aspect of the experience, the communication between patients and the medical team, has been studied extensively over the last several decades. The research demonstrates that the communication of empathy, or of caring, has a repeated and significant impact on the experience of care, and clinical outcomes. The focus, however, of this research has been primarily around the communication between the narrowly defined medical team– physicians, nurses and patients. Even within social construction's relationally focused health research, there has been a tendency to focus on traditional medical providers only. What is missing from the literature is a broadening lens, which takes in the whole of the medical care visit, and all of the different roles, interactions, and relationships–including receptionists.

There is limited research on the role of receptionists, their experiences and perception of the interaction with patients, their experiences of their role and work and the connection between them. The literature reviewed indicates receptionists play a significant role in medical care, much of it unacknowledged and invisible. Research demonstrates that receptionists also play a significant role in determining patient satisfaction, and this suggests that receptionists subsequently likely influence treatment outcomes. Despite their significance in the medical sector, the limited literature suggests receptionists receive very little training, development, or

support, and are given little autonomy- all impacting their relationships with patients. The demographics of receptionists in the United States was reviewed, revealing the vast majority of receptionists are women, and typically women of color, who are paid low wages for their work. This research aims to explore the experiences of women who work as medical receptionists, their relationships with patients, and their impact on health outcomes.

Chapter 3: Methodology

Introduction

I chose phenomenology-informed data collection strategies as the main methods for this research. This study attempts to explore and describe, from the women who work as receptionists' perspectives, their experiences in their work and their experiences in their relationships with patients. I am studying how they think of their work, their experience as receptionists in medical offices, as a member of the health care staff, and the meaning they make of their experiences. I will strive to capture and understand the essence of how the women who are receptionists think about their role and what meaning they ascribe to their work, especially their connection and relations with patients and other staff members. In this chapter, I will discuss:

1. Reflexivity on myself as the researcher.
2. An overview of qualitative research and the reasons for the decision to employ qualitative methods for this research.
3. Phenomenology-informed methodology and my reasons for choosing this as the methodology in this research.
4. My reasons for not choosing ethnographic methodology.
5. The main methods used.
6. Social construction as an overarching approach.

Reflexivity on my Role as the Researcher

In this research, one of the considerations I had was the fact that I had worked for 4 years in the medical office that the subjects currently worked in. I had worked there from 2014-2018, a year before the research was conducted. I was there one day a week, most weeks, seeing patients who had behavioral health needs. Two of the receptionists who became subjects in this research I had interviewed as part of the hiring process for their current positions. During the time I worked there, these 2 receptionists had come to me separately, tearfully, asking if I would see their family members. The first receptionist, Jessica, had asked if she could talk to me when we were in the break room. She said she knew I wasn't taking any new patients and asked if there was any way I would consider seeing her 11-year-old daughter, even once. I thought it must have taken a lot of courage to approach me, to disclose that her daughter was having difficulties, and I said so. She began crying and agreed; she said she had thought about approaching me multiple times and had backed down, but because she was so worried about her daughter now, she forced herself. I said to her "you must be so worried," and her tears fell freely, telling me about her daughters depressed mood, isolation, and separation from the family.

Marilou came to me just a few weeks after. Jessica and Marilou work together at the reception desk and are also friends outside of work. I imagined that Jessica had indicated to Marilou it was okay to talk with me. Marilou came to me the same way, in the break room. She said her mom was very depressed, and she immediately began crying. She asked if I could see her mom.

I had decisions to make in each interaction. Therapists are bound by an ethical code (mine is the Social Work Code of Ethics) that prohibit dual relationships that could result in

exploitation of the client. Essentially this means if someone is a patient of mine, developing another relationship with that person, as a friend, employee, sponsor, etc. could possibly create a situation where the patient felt beholden to me, where I could pay them less, or ask more of them than I normally would, and because of our relationship, that if I employed someone who was my patient, they may feel obliged to do something they wouldn't normally do. Even when exploitation doesn't seem plausible or possible, as a result of this ethical principle, most therapist err on the side of caution and do not see people who they know in any way as patients. Many other difficulties may occur in these complex relationships, not rising to exploitation, but still tangled. Most of these difficulties, in my experience, are imagined, and never come to bear; however, the fear of them keeps therapists saying no in these situations. Often, we err even farther and do not see family members of people we know. The example I often use when explaining this to someone I know who wants to become a patient is that if they disclosed hitting their child during a session, and I had to report this to Child Protective Services, it would likely alter our relationship at work. This is an example of a concern that has never happened, yet the fear of it has often driven my decisions.

There are many barriers to these women finding help for their family members. In the central valley of California, there is a deep shortage of mental health professionals; most people who have mental health needs go untreated. There are even fewer mental health professionals that take Medicaid, the public insurance in the United States, for those who are poor or disabled, which is what most receptionists have. Receptionists do not have flexible schedules; they must show up and leave at a particular time, so having to take a child to a mental health appointment during the work week is difficult.

In addition to the financial, work and insurance related barriers, many people have never seen a therapist before, due in part to stigma, as well as cultural norms and beliefs about those who see therapists as "crazy." Jessica and Marilou know me, had worked with me for some time, and they trusted me. They trusted me to help their loved ones, one of the most precious trusts we give to others.

All of this was elevated in my mind as they asked me. And I said yes. Yes, I would see their family members.

There is one receptionist that had disclosed to me, in a few short exchanges over a period of months, that she is the sole supporter of her disabled sister, her daughter and her mother. Receptionists typically make just over minimum wage, about $11.00 an hour. This is far below living wage standards. I left her a turkey and other groceries for a thanksgiving meal, just prior to the thanksgiving holiday a few years ago. Although I didn't leave a note, she thanked me later with tears in her eyes.

Three of the receptionists I had never met because they had been hired after I left the practice. Despite not meeting them, I did in a way have a relationship with them: when I introduced myself as a researcher, to inquire about their interest and consent in the project, they both exclaimed that they had "heard so much" about me from the two owner physicians, Drs. Lisa Gil and Silvia Diego, who are both my long term friends, and from the other receptionists and medical assistants, who I had worked with for years. In this sense, there was an existing relationship, a relationship between my construction in the minds of others and their own projections and expectations about who, and how, I might be.

I first considered it might be best to engage my research in a clinic that I didn't know, with receptionists I didn't know and didn't know me. This, I thought, might ensure their

disclosures and responses to me were not colored through the lens of our relationship. I came to the decision to go forward with my research in a clinic I'd worked in, with 3 of the 6 receptionists I'd known, in part because all research is colored by the relationship between the researcher and the subjects; it is only how much we are attuned and aware of this, how able and willing we are to take responsibility for this, and to hold it up and examine it as best we can. I would also have a relationship with those I didn't know–it would be a different type of relationship, a newer relationship, less history, but a relationship, nonetheless.

I reasoned that my relationship with the three receptionists I had worked with previously at Family First Medical Care was one of trust; we had a history of trusting each other in different aspects over the years. They had disclosed details of their personal lives, sometimes traumatic histories, and conflicts and difficulties with their families. At times, as disclosed above, I had agreed to see their family members; other times I had listened, reflected, and empathized. My relationship with them had been somewhere between a professional therapist and a friend, from my perspective. I had a history of them disclosing sensitive things to me, and I felt I had been helpful to them in these interactions. I reasoned that they may be more apt to disclose deeper, genuine feelings and thoughts to me during the interviews, and that I may be able to engage them in such a way that was helpful, healing, validating to them. In short, I wanted to ensure that any research we engaged in together would feel safe, healing and helpful to them, and I thought there was a greater chance of this with the receptionists that I know, in a place I knew.

I accepted that it is possible because we have a longer relationships, some more intimate than others, they may feel more of a need to please me, to say what they think may be the right thing, or to withhold something they feel might result in me thinking less of them. They may feel

it is more important to keep the relationship in the future and have their eye on preservation in a way that receptionists I did not know may not.

I feel some of this; I feel that I may be more invested in how they think of me, in them continuing to see me as a healthy, thriving, confident therapist who has few personal problems and can be of assistance to them as well as the practice's patients.

Literature informing design and methodology:

This section describes the literature relevant to this study's design and methodology in three sections. First, the features of qualitative inquiry and the characteristics of the phenomenological-informed study are presented.

An Overview of Qualitative Research Methods

Denzin and Lincoln (2011) define qualitative research as:

> A situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that make the world visible. The practices transform the world. They turn the world into a series of representations, including field notes, interviews, conversations, photographs, recordings and memos to the self. At this level, qualitative research involves an interpretive, naturalistic approach to the world. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them. (p. 3)

Crewell's (2007) definition focuses more on the design and process of qualitative research:

> Qualitative research begins with assumptions, a worldview, the possible use of a theoretical lens, and the study of research problems inquiring into the meaning individuals or groups ascribe to a social or human problem. To study this problem, qualitative researchers use an emerging qualitative approach to inquiry, the collection of data in a natural setting sensitive to the people and places under study and data analysis that is inductive and establishes patterns or... The final written report or representation includes the voices of participants, the reflectivity of the researcher and a complex description and interpretation of the problem, and it extends the literature or signals a call for action. (p. 37)

Many characteristics of qualitative research make it the necessary methodological lens for this study. The fact that qualitative research most often occurs in natural settings is consistent with the aims and processes of this study, which is to explore the interactions and relationships between receptionists and patients. The medical office, and specifically the waiting room, is the natural setting for receptionists, and is where all interactions with patients occurs, including both in-person interactions, and phone communications. In order to best understand a receptionist's world, it is important to be in that world, physically. Qualitative research poses the researcher as an instrument and consciously explores the researchers influence on the interviewees and those observed, as well as explores through self-reflection, the researchers own conscious biases and ideas, in an effort to bracket these, in order to have more intellectual freedom in hearing and seeing subjects. Relatedly Qualitative research relies on inductive data analysis, in order to preserve the 'beginner's' mind, or the 'alien' mind, and allows for the emergence of meaning and theory from the data. This is particularly important in this study, as the study is placed in the larger context of the medical field, which is heavily influenced and even characterized by

deductive reasoning. Qualitative research focuses on participant attributed meanings, in this case, the meaning generated by receptionists and patients, both of whom are virtually voiceless in traditional medical literature. For the same reasons, one of qualitative research's chief characteristics, interpretive inquiry, is equally important in this study, as what is of primary interest in this research, is the interpretation, purpose, meanings and understanding the subjects have of their own behavior, communication and interpersonal patterns of action, and their own perceptions of their relationships with patients.

These characteristics of qualitative research, as well as the general focus on a more holistic account, are all characteristics consistent with the psychology field, and specifically of psychological therapies. Unlike the traditional medical field, the field of psychology is generally more aligned with qualitative research; qualitative research emphasizes the researcher's impact and influence on the subjects of study; likewise, psychology empathizes the therapist's impact and influence on patients. The therapist is framed as an instrument–in fact, a therapist has no other tools, no stethoscope, no lab results, no thermometer. Therapists themselves are the instruments of therapy, and the relationship created between therapist and patients is both a goal and a process for helping. In order to successfully acknowledge and understand the influence of the therapist on patients, it is necessary for therapists to explore their owns beliefs, biases and judgments, and this process is deeply important in therapists' training. In therapy, inductive reasoning is the only productive reasoning; it is only the meaning a patient makes of their own thoughts, histories, difficulties, conditions, or preferences that defines what is *real*; only problems that are appraised as such by the patient are problems. Where therapy and research part ways is around what is done with the data collection around meaning making. For therapists, this is a point of influence, or intervention or change; by helping patients re-frame, re-narrate, and/or

develop alternative meanings to particular life events, it is often possible for a patient to change their relationship to the difficulty in a way that is often relieving. The example that most illuminates this is one that has crossed over into popular culture: by re-narrating our difficult childhoods, to see our parents as flawed people who were doing the best they could, we are often relieved of resentment, anger, disappointment as well as the feeling that they perhaps were willingly inflicting suffering on us.

In qualitative research, of course, the researchers do not seek to influence, shape, or change any meaning or narration the subject shares. Instead, the researcher delves more deeply into the patient's world, meaning, and the impact this has on the world around them. There is no intervention to change the subject, and no agreement that this is a goal of the research, as there is between patient and therapist when engaging in therapy.

Furthermore, and taking into account the subject studied in this research, it was important to approach with a philosophy that focused on a sense of respect between the researcher and participants. Different authors describe the research interview in qualitative methodologies as an intimate process, and Kvale and Brinkmann (2009, p. 123) consider it "an interpersonal situation, a conversation between two partners about a theme of mutual interest," situating participants and researcher in a more equalitarian position by recognizing knowledge from both parties; they are both experts on their own experience. At the same time, qualitative methodologies also acknowledge the power asymmetry that exists between researcher and participants and are concerned with purposeful reflection and writing on the role of power in the study methods, especially observation and interviewing. This egalitarian aspiration of qualitative methods is particularly important in research done in the health services field, such as this one. Health care, being intensely hierarchical and patriarchal, is built on inequality and imbalanced power

structures. Doctors are considered experts; patients are not–not even considered experts on themselves. Receptionists are at the bottom on the hierarchy, considered unskilled by traditional (masculine) measures, and lacking in any expertise. Engaging in a methodology that explicitly names the default dynamic between researcher and participant as unequal is paralleling an important aspect of the study itself–the power imbalance between receptionists and the rest of the health care team, particularly the physicians.

Reasons for Choosing A Phenomenological Approach

A phenomenology-informed approach was chosen as the orientating methodology for this study. One of the primary reasons for choosing phenomenology-informed methods is the match between phenomenology's chief functions–making the invisible visible–is the same as one of the main goals of this research. Additionally, phenomenology allows the deep immersion into another's world of meaning in order to explore, describe and elevate the perspective to others, which is an end and means congruent with the process and goal of this study. Phenomenology allows the researcher to delve into the perceptions, perspectives, understandings, and feelings of those people who have actually experienced or lived the phenomenon or situation of interest (Creswell, 2007). Phenomenological research has commonality with other qualitative approaches, including ethnography and symbolic interactionalism (Lester, 2009). It has philosophical roots from Heidegger, Sartre, and Merleau-Ponty (Speigelberg, 1982), and it has been used in the social and human sciences, especially in sociology (Polkinghorne, 1989) and in the nursing and health sciences (Nieswiadomy, 1993).

The purpose of this study are congruent with a phenomenological approach- to illuminate the specific, to identify phenomena through how they are perceived by the people in

the situation. This means gathering 'deep' information about perceptions through qualitative methods such as interviews, discussions and participant observation, and representing it from the perspective of the study participants(s). A phenomenology approach is concerned with the study of experience from the perspective of the individual, intentionally bracketing taken-for-granted assumptions and usual ways of perceiving- those which we are conscious of. Epistemologically, phenomenological approaches are based in a paradigm of personal knowledge and subjectivity, and emphasize the importance of personal perspective and interpretation.

Phenomenology seeks to deeply explore and describe, rather than explain or define. Interview procedures are the most common strategy to collect phenomenological data, although participant observation is also often used in conjunction with interviewing (Lester 2009). Phenomenological interviewing explores the experiences and meaning the subjects make of their own experience (Polkinghome,1989; Thomas & Pollio, 2002). Researchers using this methodology search for the essential structure or essence of the primary meaning of the experience and emphasize the "intentionality of consciousness where experiences contain both the outward appearance and inward consciousness based on memory image and meaning" (Creswell, 2007).

Phenomenological researchers do not assume they understand or know what something means to another (Douglas, 1976; Moustakas, 1994; Thomas & Pollio, 2002). In this way, phenomenological inquiry not only provides structure for the method of study, it also provides discipline for the researcher's mind, the discipline of bringing the mind back from assumptions, to "beginners mind," or "know-nothing mind." Knowing, understanding, assuming and other sense-making are the automatic functions of the human mind, the bodies equivalent of breathing. Just as it takes practice and discipline to be aware of breathing, so too does it take practice and

discipline to become aware of knowing. Phenomenology helps us with this awareness and gives us a place to bring our minds back to, to return to not-knowing inquiry. As a researcher, I have been raised in a white, western culture, in a family that "believed" very much in the authority, credibility, and all-knowingness of the medical doctor. I have worked as an adult in medical settings for the last two decades of my career, and before that, I worked in addiction treatment cultures, which were heavily influenced by the traditional medical model. Part of the decision to use a phenomenological-informed methodology was an acknowledgement that I was part of the culture, studying that same culture, and needed the structure and discipline that the methodology provides to undertake the research with a beginner's mind, even an alien mind. This is suspenstion of judgement about what I "know" or what I see as real is also referred to as 'epoch' by Husseri (1960).

Phenomenological approaches are most effective at describing lived experiences of the individuals, from the experiencer's perspective. With its focus on the experiencer's perspective, phenomenology-informed data collection can often cut through the dominant discourse, making it more likely to prompt action, challenge complacency or normative assumptions. This is particularly important in this study as the traditional medical discourse is dogmatic, wide ranging, and deeply accepted in western culture.

A phenomenology-informed approach, with its focus on exploration and meaning making, is well suited to deeply studying relationships and how parties in relationships make meaning out of their interactions with each other. As Barritt (1986) writes, the rationale for qualitative studies:

> Is not the discovery of new elements, as in natural scientific study, but rather the heightening of awareness for experience which has been forgotten and overlooked. By

> heightening awareness and creating dialogue, it is hoped research can lead to better understanding of the way things appear to someone else, and through that insight lead to improvements in practice. (p. 20)

While Barritt here is speaking generally about qualitative methods, his rationale for use can be applied to phenomenology-informed approaches specifically as well.

Phenomenological Inquiry

When phenomenology informed approaches are used in this way, to explore relationships, it is an acknowledgement of the intentionality of consciousness–the idea that consciousness is always directed toward an object–there is no Cartesian duality, then, instead only a creation of a third "thing" between 2 objects.

Studying relationships with phenomenology approaches in mind, can also be referred to as social phenomenology (Schutz, 1970). How individuals consciously develop meaning out of social interactions, interaction patterns and norms that are created out of these patterns seems like a useful way to explore and describe interactions between medical receptionists and the health care team, and medical receptionists and patients. Social phenomenology approaches are particularly well suited to this subject in that I am studying repeated patterns and norms, as opposed to a single event. Receptionists, their co-workers and patients interact sometimes hundreds of times a day, for months or years on end. These interactions are highly scripted, and the roles of each person are somewhat rigidly enforced by the culture and norms of the medical culture. Performances by both parties are typically restricted in range and can seem repetitive to an observer, and often to the participants. In this sense, social phenomenology informed

approaches, in the focus on patterns and norms within particular cultures provide useful constructs in which to understand the subject of this research

Why not Ethnography

Ethnography was carefully considered as a possible qualitative method for this study. Ethnographies have a long history in the health sciences (Creswell 2007). In the health sciences, and specifically in studying the culture of health care, which is widely understood to mean medical care, ethnographic methodologies are the dominant qualitative research lens in which to understand the subject. It is easy to see why this is: medical cultures are deeply complex, perhaps mirroring only religious, educational and military culture for the defined norms, specialized language, clear hierarchies and explicit and implicit governing rules and laws. Ethnography, with its anthropological history in studying different tribes, is in many ways perfectly suited to explore these complex societies. Observation, interviews, studying of texts, artifacts, manuals and historical markers are all methods associated with ethnography that allow profound exploration into another world (Creswell 2007).

In considering ethnography, I acknowledged all of this, as well as the many great works that have been written about medical culture, using ethnographic methods (Creswell 2007). As I considered my subject carefully, the decision to not to use ethnographic methods became clear. My subject is not medical culture, or even the waiting room of primary care clinics in central California. My subjects are the receptionists who work there. Ethnography would have broadened my main focus to the larger culture of receptionist work. My goal is to go as deep as possible with the receptionists as people, to understand how they think about their work and their relationships with patients. I wanted to study their relationship to the culture, their ideas and

perceptions about the culture, not the culture itself. I was concerned that in using ethnographic methodology, that the receptionists would become just another artifact or character in the ethnographic study, the very way they are mostly considered in society and in medical offices. My goal is to have my methods, observation and interviewing be guided by the larger methodology of understanding and exploring meaning, from the receptionist's perspective, not to study the culture of medical offices.

Congruency of Social Construction and Phenomenology

A phenomenology informed approach and social construction framework are natural partners. Social construction can be seen as a philosophical approach, consistent with a phenomenological approach to understanding the world. Social construction acknowledges that all meaning is socially constructed, between people; that 'true' meanings, that are separate from our construction of meaning, do not exist (Gergen, 2016). Phenomenologically informed methods can be used to understand better what meaning has been constructed; how meaning has been constructed, and the process and influences on the construction. Both social construction and phenomenology-informed approaches, acknowledge that meaning is being constructed and in order to best understand phenomena, we need to understand it through another's eyes, mind and language.

Social Construction as an Overarching Approach

While social construction is not a methodology, or a method, it is an overarching approach to both, overlapping in principles, aims and goals. Social construction approaches are consistent with important research tenants of phenomenology informed approaches, including

the centering of relational process, collaborative practices that challenge the assumption of dichotomies between researcher and subject, and research and practice. A consistent, omnipresent, reflexive stance is also a core principle of phenomenology and social construction.

A challenge in considering the differences is that they may be largely incommensurable. Social Construction is a theory of knowledge that all meaning is constructed between people. Phenomenology is a methodology for studying something. A major difference is that Phenomenology is focused on the essence of a phenomena, seen and understood through an individual, or group's perspective, while social construction would see an individual or group's appraisal of the essence of a phenomenon as constructed relationally.

The main research question–"*What are the experiences of medical receptionists?"* is not a study of patient perspectives, physicians and receptionists; rather, the focus is squarely on receptionists' experience of their work, their workplace, their relationship with patients and the factors that impact this. This main question is followed by a series of what might be called sub questions, some of which are more process oriented, and some of which are more content oriented.

Instrumentation

Questions were developed, with the goal that they would facilitate free self-disclosures, to then direct the dialogue. I developed 7 questions for the initial interview with the receptionists:

1. Tell me about your experience as a receptionist.
2. How do you see your current work as a receptionist, in your life?
3. Please share with me your experiences, thoughts and feelings about your role and relationship with patients.

4. What is the toughest part of your relationship with patients?

5. What is like being the patient or family member of a patient at another medical office, when you are in a different role with a receptionist?

6. What impact, if any, do you think you have on patient's health?

7. Receptionists are overwhelmingly women and women of color in California. What do you think of this?

I developed two questions for the follow up interviews:

1. Please share about your relationship with the health care team (prompt around status questions if needed)

2. Please share with me how you might describe yourself; for example, what are your most marked characteristics, and what is most important to you?

Interviews were semi-structured. The questions were developed in the hope that they would guide discussion in particular areas, and elicit disclosures, that I could then flexibly, encourage and follow. Unlike structured interviews, which by design have already decided what is useful and valuable data, I wanted to remain open to what I would not know to ask, what I might miss with a highly structured interview.

Another reason I chose semi-structured interviewing is to avoid replicating the medical model of doctor-patient interviewing, which is characterized by closed questions, and a directive approach, with the physician having already decided what is valuable and what is meaningless data, and asking questions only in the areas that he or she has decided is most likely to yield the answers to the question that are deemed valuable. Most of us have been trained in our role as

patients in this type of interaction, and we know that once a physician starts asking questions, our job is just to answer them, in as short a way as possible, so as not to annoy the physician. We rarely give more information than asked. Research indicates that this directive, structured style of interviewing is ineffective in medical care. In fact, the more closed questions that are asked, the more the chances increase of inaccurate diagnosis (Tongue, Frese 20015) Additionally, the more directly and authoritatively the medical provider conducts the interview, the less patients disclose their own thoughts or experiences, often absenting important health-related disclosures from the conversation. Lastly, this style of interviewing is largely incompatible with developing a caring relationship, which leads patients to avoid disclosing information that they may feel will be judged by the physician. In summary, structured interviews enforce a particular power dynamic; the one who structures the interview is the one with the power–they decide what will be discussed; they decide what is useful and what is not useful information, what is valuable, and what should be dismissed.

For all these reasons, I decided to conduct semi-structured interviews. I wanted to elicit free disclosures, and to develop a caring relationship with the women I was interviewing; my hopes were that not only would the interview process itself be a good experience for them, but also that they would feel free to disclose things that they might be afraid would be judged, in different circumstances. I wanted to ensure as much as I could, that there was not an uneven power dynamic between me and the women I was interviewing, particularly in light of the fact that one of my areas of interest is in the hierarchy in the office, and their experiences of this. The differences between structured and semi-structured interviewing follow form the theoretical premise underlying Interpretive Phenomenological Analysis.

Process oriented sub questions to be explored are:

1. What is the meaning of the receptionist's role, from their perspective?
2. What meaning to receptionists make of their relationship with patients?
3. How to receptionists think of themselves in the context of the larger medical office and health care team?
4. What are the salient issues around gender, socioeconomic status, race, for receptionists?
5. What influence, if any, do receptionists have on patient health behaviors, from receptionists' perspective?

Content oriented sub questions to be explored:

1. What is the job of a receptionists, from a receptionist's perspective?
2. What are the primary performances and patterns in the patient- receptionist relationship?

Procedures for Recruitment, Participation, and Data Collection

Population.

The population studied is women who work as receptionists in medical offices in California. This population is relatively homogenous in the area of gender (over 95% are women); ethnicity (over 80% are women of color); age (the majority of medical receptionists are between the ages of 25-35), of education (less than 2% of women who work as receptionists in California have a college degree of any kind). (U.S. Bureau of Labor Statistics 2018)

Sampling.

My sampling decisions were driven by the research questions and goals and are consistent with Interpretive Phenomenological Analysis (IPA). The process of selection was purposive, meaning I engaged in a deliberate process of selecting respondents based on a number of factors. My goal was not to understand generally what women who work as receptionists experience, instead, I wanted to understand specific phenomenon from the perspective of a few women who work as receptionists. For this reason, I was trying to find a fairly homogenous sample. In California, as discussed earlier, over 95% of receptionists in medical offices are female, an overwhelming majority of women of color. Reception is fairly low wage work, with no formal training or education mandated, making the socio-economic status somewhat homogenous as well. I knew from working for decades in health settings in California that receptionists do tend to be homogenous based on these factors: Gender, ethnicity (with the majority being Latina), and socio economic and educational levels. By this purposive sampling of six women working as receptionists in medical clinics, who are homogenous based on the above factors, the boundaries around any claims to generalizability are clear. The study will likely say quite a bit about the participants in this study; the study will likely say something about the broader group they may represent in the above similarities, and most likely not much about people outside of this group.

The specific 6 people were chosen for a number of reasons. First, as discussed elsewhere, I chose a medical office where I have intermittently worked, not because it was convenient, but because I had just the right distance between myself and the staff. I was known to 4 out of the 6 reception staff and had goodwill relationships with them. I predicted they would not withhold

information for fear of being judged by me; however, I was distant enough so as not to have an impact on their daily work, their hours, their pay or their status–I didn't have any authority over them in title or influence.

The medical office is large and has three separate offices within one business campus. Each office houses different staff, different physicians, and has a different culture. The culture is influenced by different staff and physicians and different patient populations drawn by physician specialty (for example, while all the medical providers are Board Certified in Family Practice, only two of them do pre-natal, delivery, and post-natal work, drawing many young pregnant and post-partum women). There are two receptionists at each office, allowing me to interview 6 receptionists from three different offices. This is typical sampling as the women who work as receptionists in these offices are typical members of this population. They are Mexican-Americans, women, under age 50, with high school educations.

Analysis

Data was analyzed in accordance with the principles of Interpretative Phenomenological Analysis (IPA) (Smith, Flowers & Larkin, 2009). It was specifically developed by Jonathan Smith (Smith, Harr & Van Langehove, 1995) to allow exploration of subjective experiences, especially social constructions. It is widely used within British psychology (Duncan, Hart, Scoular & Brigg, 2001). IPA recognizes that different people perceive the world in very different ways, dependent on their personalities, prior experiences, culture and time period. While it does not explicitly identify meaning as socially constructed, the recognition that meaning is constructed, make it useful and congruent as a method to analyze data in a research study aligned with social construction principles. Additionally, the main methods of research for this study are

phenomenology informed methods consistent with theoretical underpinnings of IPA, and IPA is strongly influenced by phenomenology in its concern with subjective experience. IPA is utilized to understand the world from the perspective on the study's participants. Within the name of IPA is the recognition that this cannot be done with interpretive work by the researcher, and by extension, recognizes that the research is, in a sense, a participant in the research as well. In this way, IPA acknowledges that the researcher's engagement with the participant has an interpretative element.

Discourse analysis was briefly considered, before being discarded as a possible method of data analysis. Its brief consideration was due to the draw of focusing intently on what was said by subjects, the linguistic construction, and the verbal patterns. This in many ways seemed like it could produce interesting insights into the performances, patterns and verbal constructs of women who work as receptionists. The language in medical care is incredibly rich and varied, while concurrently rigid and objectifying; for these reasons alone, diving into the language of women who work as receptionists seemed like it could be fascinating. Discourse analysis was discarded, however, due to the same reasons. As a researcher, my hope was not fascination; it was exploration and understanding. Discourse analysis is understood by most current psychologists as skeptical about looking beyond what people are saying in order to inquire into how they are thinking or feeling about a particular topic (Smith et al., 1999). IPA contrasts with discourse analysis in this way, in that it assumes an epistemological stance whereby, through interpretive methodology it is possible to access a person's inner world. While discourse analysis exemplifies the role of language in describing the person's experience, IPA explores how people ascribe meaning to their experiences in their interactions with the environment (Smith, Jarman & Osborn, 1999). This is the most consistent method of analysis with the goal of my research–to

explore and understand the experience and meaning making of women who work as receptionists.

Transcripts from interviews were reviewed and annotated line-by-line, noting participants' use of language, descriptions, subject matter, as well as the explicit meaning they stated and my own ideas of the meaning. Importantly, the transcripts contained my questions and comments, as well as the participant(s). In addition to the line-by-line annotations, annotations were also made of dialogue between me and the participants in an attempt to explore and better describe aspects of the relational dynamic that we were engaged in. As the subject of the research was the receptionists meaning of their work and relationship with patients, it was important to me to develop a parallel process of attending to, documenting, and analyzing the relationship between myself and the receptionists as well. I then engaged in a systematic searching for sub-themes that arose from the transcripts, and then larger themes that the sub-themes seemed subordinate to. Recurrent patterns in transcripts, both in the content of what receptionists shared, as well as the shape and process of our conversation, were interpreted as emergent themes. Patterns across transcripts were noted as the analysis of transcripts progressed. These were further interpreted and developed through an iterative process, whereby patterns were clustered together and abstracted into broader interpreted themes–these themes were labeled in the language of the participants to further shape my own perspective during the analytic process.

Six receptionists from three medical clinics were interviewed two times each, for total of three hours for each subject, over the course of a three-month period. The number of interviews was chosen for three reasons: First, I wanted to ensure I had established a therapeutic rapport with the receptionists in hopes they would feel comfortable enough to disclose their thoughts and

feelings to me. Having two interviews, just as having more than one therapy session, allows for the relationship to grow, and I predicted that the second interview, if a sufficient therapeutic rapport had been established in the first, may yield more disclosures, particularly those that may be riskier, deeper or more vulnerable. In this sense, the interviews are a parallel process with the relationship health care providers and staff, including receptionists: only within empathic relationships, in which goodwill and non-judgment are established will patients disclose information that they feel makes them more vulnerable. Second, I wanted an opportunity to share any of my own experiences from my observations in the waiting room, where I chose to wait for them before our interview appointments.

There were two additional methods of research that I considered well into the process of this research. The process of deciding to forego the other two methods of research, and instead to focus solely on the semi-structured interviews with receptions, was a process of resolving an internal conflict. The conflict was one that seems particularly common for women, or perhaps for anyone who works deeply in fields associated with feminine qualities, such as psychology, with its focus on the personal, the experiential, and the relational.

Initially, back when I was conceiving of my proposal for this research, I had felt strongly that this research needed to be relevant to the traditional medical sciences literature. I had been deeply interested in studying women who worked as receptionists in medical settings for a number of years, and my insistence that they were important had felt like a long, drawn out argument I was having, in traditional medical systems, to 'prove' the worthiness of reception staff. As a women, a therapist, and a social worker, I may as well have been arguing for my own worthiness. Traditional medical offices, like the medical field, have strict hierarchies placing doctors at the very top, a relentless focus on quantitative research, an endless pursuit of scientific

truths, and rigid subject-object conceptualizations of treatment. I had worked within medical settings for over 15 years when I began this research; I was an early 'vanguard' as they called us, of integrating mental health services in medical settings, and in that role, I had overseen the hiring and integration of mental health therapists in many large ambulatory medical care systems. The work of integration is largely cultural–negotiating the cultural differences between medical offices, described above with attributes that are commonly associated with patriarchy, and mental health and social work cultures, which are more aligned with feminine attributes, with the focus on experiences, relationships, and shared meaning.

I had been fighting, for 15 years, for there to be equal respect and status attributed to mental health therapists and social workers, and the work they do, as to medical providers. In this sense, the integration of mental health and social work disciplines into medical settings has many of the same characteristics as the process of women first entering male dominated fields, or of early de-segregation in the United States. It is common in these early integration processes that those who are among the first wave to integrate often take on characteristics of the culture they are entering, in order to obtain and retain value and worth, as measured by the dominant culture, and also to ensure safety from harm–whether that is harassment, termination, isolation or other consequences of being part of an 'out-group'.

I had developed a manner of obtaining value within medical settings that included focusing on traditional quantitative research. Anytime I wanted to make the case to a new medical organization about why they should integrate mental health and social work professions, I familiarized myself with the medical science's quantitative literature, used terms like 'evidenced-based practice'. I became increasingly adept at speaking both cultures languages and could switch back and forth depending on who I was talking to. When a social worker

approached me with a question about a patient, I would listen intently, ask her/him how they felt when they were in the room with the patient, explore their own reflections on counter transference. We may end without a conclusion–it may have been that the social worker just wanted to share her feelings about the patient or situation. The conversation would likely have included mutual self-disclosures about our feelings and would be 10 minutes, or 30 if we had the time. When a doctor approached me with a question about a patient, mentally, I changed my focus and quickly decided on the shortest answer to the question and the one with the most clarity and value within their culture. I would not ask questions; we would not self-disclose. I developed this manner after multiple interactions where after I spoke for a minute or more, I saw the doctor's eyes wander as they interrupted and repeated the question.

One of the motives for this research had been to 'prove' women who work as receptionists had value, to demonstrate in the traditional medical sciences language and methods that receptionists were important. For this reason, the methods I originally chose were a combination of both medical and social services culture, of both masculine and feminine: semi-structured interviews, structured observations, and collection of a quantitative-like empathy measure tool.

I had proposed to use an empathy measurement tool called 'The CARE Patient Feedback Survey', with twenty-five patients from the medical clinics, during the 4-month research period. The tool in and of itself is likely bi-cultural, in that it measures a traditionally feminine attribute, in a quantitative manner.

Additionally, I had proposed engaging in structured observation of receptionists, from the waiting rooms. There were many factors that went into my initial decision to include observation. First is the sheer richness of data available in observing a medical office waiting

room. The level of activity and interaction in the waiting room is incredibly high. It is a mix of public and private space, where patients are in the public space of the waiting room chairs, or on the waiting room side of the desk, and receptionists are in the private space, behind the desk. Every day there are more interactions in this space than in all patient-provider interactions in the office, combined. Every patient who is seen in the medical office interacts with receptionists in this room, as do patients who do not have appointments but are instead inquiring about making appointments, refills for medications, or requesting paperwork to be filled out. There are also businesspeople, such as pharmaceutical representatives who come to meet with the physicians, medical waste contractors who come to pick up medical waste, drivers who come in to pick up laboratory samples, and sometimes office staff family members who drop off lunches or pass on messages. Staff from the back office, such as medical assistants, nurses, referral clerks or physicians, come to the front office to confer with receptionists at times, and concurrently during all of this, receptionists are answering and interacting on phone calls.

In addition, besides the interactions between receptionists and those who walk in the door, there are also interactions between people who are waiting. Sometimes people are there with family members, friends, care givers or their children and are interacting with them. Sometimes people interact with those they don't know, who are waiting side by side with them. Often very young children are crying, or toddling around the room, or playing if there are toys available.

Medical Assistants and other staff come into the waiting area regularly to call people from the waiting room. Sometimes they enter the waiting room; more often, they open a door and call from the door. In addition to the observable activities and interactions available, there is also the static environment, the temperature, the smells, the non-verbal sounds, the furniture, art,

colors and light of the room and the configuration of the furniture and patients in relation to the front office.

Second, it is the fact that in my past practice-based research with receptionists-patient relationships, there was a disconnect between what receptionists reported they were doing and what they were actually doing. In my past research, I was studying the relationship building behaviors of receptionists, specifically making eye contact with patients when they walked in the door, smiling at people when they approached the desk and greeting people with a salutation. Before I began, I asked the receptionists how often they felt they did these three things with patients who were walking in the door. Invariably, receptionists reported they were doing all 3 with 100% of patients. I then asked if we could observe them, in order to measure this. They agreed, and 4 different medical clinics were observed monthly for 3-hour intervals, for a period of 9 months. Receptionists knew when they were being observed; the observer had a name badge, and would introduce themselves to the receptionists, letting them know they were going to start observing and would sit in sight of the receptionists for the duration of the observation.

For the first month, in 4 medical offices, the percentage of receptionists who made eye contact was less than 40%; those who smiled when a patient approached the desk was less than 20% at all offices, and incidents of when receptionists greeted patients with a salutation was under 11% at all sites. One site had a 98% greeting rate, and because this was so far out of the norm, we interviewed the observer to find out more. The observer had accidentally coded “sign in here” and “do you have an appointment?” as greetings. When another observation took place at this office with the observer only coding greetings if they were salutations of some kind (hi, hello, good morning, etc.), the percentage was only 9%.

The gap between what receptionists indicated they were sure they were doing and what was actually happening was puzzling. When presented with the observational data, many of the women said that they had thought that their initial assessment of themselves had been aspirational, the way they wanted to be. All of them indicated that the level of stress and busyness was a barrier to smiling, eye contact and greeting. Many of them mentioned the fact that they all sat in front of large computer screens, in which they were frequently working, as a barrier as well.

Despite the reasoning above for including observation and the patient surveying as methods in this research, I was ambivalent at the time of my proposal. I felt as though I was trying to straddle both cultures, and in doing so, was in some way betraying the women who worked as receptionists–all of them, not just those in my future research. I attribute this feeling of betrayal to the fact that both observation and surveying are taking a patient perspective. Both methods are a process of evaluating the subjects in some way, from the outside; it more clearly makes them objects of research, as opposed to subjects of research. These were my misgivings as I prepared the letter to the women who worked as receptionists at the clinic, to elicit from them engagement in the study. I felt myself hesitate to share in the letter that I would also be observing them, and that I would also be surveying patients. It was at that point I realized that my 15 years crusade of trying to prove value of the feminine in an overwhelmingly patriarchal system was likely instead a 49 year history of trying to prove my worth to a distant alcoholic father. This realization, coupled with deep reading of social construction, participatory research, and social justice texts over the last year, led to my decision to use interviewing as the sole method in this research, and to exclusively study the world of these women from their own perspective.

While I decided to forgo the CARE survey entirely, finding there was no meaningful way to use it and retain the perspective of my subjects, I did want to ensure I was grounded in the experience of the waiting room environment during the process of interviewing receptionists. I wanted to have in my mind the environment in which the receptionists work for 8 hours a day and the interactions they are engaging in during that time. Unlike physicians who rarely see or enter the waiting room in the United States due to the workflow design of having their medical assistants call patients from the waiting room into the back office, I as a therapist collect my own patients from the waiting room. In considering how many years I have worked in medical settings, and how many patients I have seen over the years, I have likely walked into the waiting room to talk to receptionists or gather my next patient thousands of times. I imagine that this contact with the waiting room, as well as my close contact with receptionists to confer about scheduling during these times, have influenced my deep interest in the women who work as receptionists and their experiences in relationships with patients. It was through my intersections with the waiting room, and my contact with receptionists, that my interest was borne, and it was through what I observed during these times that I developed practice-based research as well as resources and tools for receptionists. I reasoned that I might sit with the receptionists, on their side of the desk, observing their work, from their perspective. I thought receptionists during their work would allow my questions, conversations, and eventual data analysis would be richer and more insightful, even though I wasn't sure exactly the mechanism by which observation would influence this.

After the subjects agreed to be interviewed, I asked each of them what their thoughts were about me sitting behind the desk with them, off to the side as much as possible, to see them work. The response was surprising and overwhelming; all of them said an unequivocal and

enthusiastic yes; they asked if I could observe them all day, on the busiest days, if I could come every day for a week to observe the sheer variability of their tasks and the intense emotional states patients bring with them.

I decided with them that I would sit for one hour, with each of them, at the time and day they wanted. In the next chapter, I will share more in-depth their responses to me sitting with them.

Interviewing receptionists is the primary strategy of gathering data in this research study. I have been practicing interviewing professionally since I became a therapist 25 years ago. Eliciting vulnerable self-disclosures, eliciting someone's true thoughts, opinions, preferences and beliefs is highly skilled work and depends enormously on the nature and characteristics of the relationship created between people. My interest in this proposal, this line of inquiry is born out of my efforts to coordinate meaning (Pearce, 2004), to establish a therapeutic alliance (Miller & Duncan, 2018) to create rapport with another so it is only fitting that I would bring the same strategies and resources to this study.

The other reason I felt interviewing should be a main form of research method used is I wanted the research to provide some benefit to the receptionist. I felt that through the decision to interview was in and of itself a statement about the importance of the receptionists as people. Interviewing demonstrates deep interest in another's thoughts and experiences. Additionally, my hope is that the interviews themselves provide a benefit to the receptionist, and I'm able to sufficiently provide skillful listening and compassionate responses that they feel valued, seen and heard.

Interviews with the women who are working as receptionists were approximately 90 minutes. Gift cards of $30 dollars were given to each receptionist for each interview to honor the

time they gave to this. Additionally, I offered to share with them the final dissertation as well as a shorter summary developed for them, if they wanted.

Ethical Procedures

The women I interviewed were informed of what the project is about. I first wrote a letter, which I emailed to the 6 women who worked at Family First Medical Care (appendix X), explaining that the following main points: 1) I was doing research for a doctoral program; 2) what the research was; 3) why I was doing it; 4) what specifically was I asking for from them; 5) confidentiality; 6) compensation for their time in the form of gift cards.

One person responded to me by email, stating she would be happy to participate. Two people responded to me by email stating they would like to participate. Three people did not respond. I contacted them in person at Family First Medical Clinic, and all three said they do not use email, and had not received my message. I gave them a copy of the letter at that time. All three agreed quickly to be subjects in the study.

Originally I had considered to interview the 6 women each once alone, and for the second interview, as a group (or vice versa). There were three reasons why I did not continue in this direction, of having one interview (as a group interview):

1. I asked each subject when the most convenient time would be for an interview, and where they would prefer to conduct this. I let them know I would do early mornings, late at night, weekends, at their work, at their home, at my home or at a third, quiet location of their choice. All 6 women said conducting the interviews during their work day, on their lunch hour, was the most convenient. Four of them specifically mentioned family responsibilities, children, husbands and parents they cared for,

which made dedicating time outside of the work day difficult and undesirable.

2. I inquired to the practice owners and clinic managers of Family First Medical Care, whether it would be possible to have all 6 receptionists during a lunch hour; the answer was no- receptionists lunches were staggered to allow for at all clinics to be open all day.

3. 3 of the women (those who I had known previous to the study) communicated with me after my query about to them about the possibility of having a group interview for one of the interview sessions, 2 by text and 1 in person, that they would prefer individual interviews as opposed to group. 2 indicated it would be 'easier to talk' alone with me.

Before the each interview I contacted each participant to ask them what I could bring them for lunch, as the interview was taking their entire lunch hour, plus 30 additional minutes which the practice owners and managers allowed.

At the beginning of each of the interviews I gave them their lunch and encouraged them to please feel free to eat as I knew this was their lunch hour. I talked for a few minutes about confidentiality. I explained that any identifying information will be removed from the transcript, and that only a very small number of people will hear the tape itself–just me and the person at the transcription/typing service I use. I let them know that I have worked at Family First in the past, and did know the practice owners, and that in fact, I was friends with one of them. Four of them women knew this, 2 of them did not. I assured them that everything they said to me was confidential in this way too, to re-iterate, and asked them if they had any concerns about this.

I offered to give them their own recordings, either in audio file, or in written form, if they wanted it. I also said that I will be deleting the interview recordings after my dissertation is completed.

I let the participants know that the interview was not planned to cause distress, and in fact my hope was that the interviews would be helpful to them in some way. I also informed them that they could stop the interview at any time, that they could change their mind before, during, or after the first or second interview, on whether they wanted to participate or not.

There were some similarities and patterns in how the women responded to the gift card compensation; to what I shared in the second point the letter, why I was doing the study; an explanation and exploration of these two areas are in the next chapter. It is central to the methods I used that I engage in the concept of "epoch" to bracket my own preconceived knowledge and ideas so as to better hear, see and understand the phenomena through the voices of the subjects (Field & Morse, 1985). In order to do this, I must be aware of those preconceived ideas and beliefs. Understanding what I am not aware of is still unconscious, and unable to be suspended, yet it seems important to list what I am aware of. The following are examples of conditioning I have been subject to, am aware of, and am consciously bracketing.

1. Licensed people in health care, such as doctors, nurses and therapists, are "professionals." I pursued an education, degree and license that puts me in this category. I understand that this separates me from those in health care who do not have higher degrees or licenses.
2. Receptionists are so named because they are the first to 'receive' patients, as they enter through the door of the organization or call into the clinic.

3. There is a hierarchy in health care, with medical doctors at the top, and with receptionists at the bottom. Perhaps only those that clean the office, janitors, etc. would be lower.

The following are assumptions and knowledge I have developed over my career, especially in the last 10 years of doing practice-based research with women who work as receptionists, which I am intentionally bracketing.

1. Receptionists commonly engage in passive and supplicant behavior with medical doctors and others with licenses. This seems to be learned behavior, both from the work environment, as well as in the culture and in the home, as women.

2. Receptionists are the positions typically thought of as not having a separate skill set; in this sense they are rarely thought of as valuable employees, from a provider's perspective. Instead, they are often thought of as replaceable.

3. There is no receptionist certification, like there is in the United States with Medical assistants; although they receive the same pay typically, status is commensurate with the certification.

4. The relationship between receptionists and patients is in general, often wounded, with multiple micro-tears (citation), due to mistreatment by licensed staff during their careers, and by patients.

5. Receptionists often come from the same communities as patients, socio-economically and culturally.

Summary

In this chapter, the methodology of the present study was described. The rationale for the choice of method and design was given. Population and sampling, recruitment, and data

collection procedures were given. The instrumentation was presented, and the data analysis using Interpretive Phenomenological Analysis was explained. Ethical considerations and procedures were explored and discussed.

Chapter 4: Findings

Considerations on Organizing Findings by Themes

As I conceived of this research some years ago, I envisioned organizing the findings from my interviews with the women who work as receptionists by person. I felt that in presenting the data they shared in whole, from each person, without interruption of other organizing structures, would facilitate readers seeing them as whole people, with all of their sentiments, thoughts, ideas and experiences intact and contained within the pages. Dividing data in any other way, even in a qualitative study, I reasoned, is similar enough to the data division process of patients within medical systems and would render similar outcomes–the objectification of people through dividing them up into their diseases. The compartmentalization of people, into pieces and parts, is a defining characteristic of the traditional medical model; we can see this in the specificity of specialists within western medicine–a doctor just for the heart, a doctor for the lungs, a doctor for ears, noses, throats, a doctor for livers, a doctor for blood, for bones, for eyes and for women's genitals. Diseases too are divided up: Specialists for cancer, and within that, specialists for each type of cancer; specialists for blood disorders, and for addictions. Care itself is dis-integrated, following the constructed separation of the mind and body, with our physical body receiving care at one institution, and our minds receiving care at another institution. I reasoned that by dividing experiences of the women who work as receptionists in any way, would in some ways be a replication of this–the compulsion to divide and break down, seemed to be a compulsion to feel competent, to be able to understand, to own this one small part, as a specialist.

My other reasoning for presenting each woman's disclosures together, as an organizing structure, was to avoid the replication of the transactional culture in medical care. As

summarized in the literature review, the traditional medical model in western work does not acknowledge the relationship between people and what is socially constructed; instead treatment is considered an object, handed from one person to another as individuals, and unmoderated by relational processes. Similarly, workers within medical systems are framed as objects, machines, with a function they perform; women who work as receptionists in particular are not constructed as whole people, but instead only as what function they provide for the system. I was concerned that I would unwittingly fall into this; that in interviewing them for this research, I too was using them only for what function they provided me–as 'unreal others' who served to further my own ends.

My decision, however, changed during the course of my research. In the hours I spent with the women who work as receptionists, it became increasingly clear that many of the experiences they shared were in common; particularly their experiences in their relationships with patients, connected to their status as the lowest paid and lowest prestige employee in the medical office. I felt the urge to do something, to advocate on their behalf, to share (with permission) some of my findings with the practice owners, in order to leverage some change in how these women were paid and how their roles were conceived. I realized that it was the culmination of the experiences I was hearing that created the urge; it was the repetition of similar disclosures that had the power. I reflected on social justice movements, and the power of numbers, when people are unified by common experiences. I considered that people often don't know that other people have similar experiences as them, and as a result, they may blame themselves, hide the experience as a secret, or assume it is something to individually struggle with, to figure out on their own, or even to suffer in silence. Victims of domestic violence, sexual abuse and other sexual assaults often describe this. When people begin to talk to each other, to

group their experiences together, there is often a sense of relief–others feel this way! Others have experienced this too! Their strength grows as the blame they took upon themselves begins to shift to its rightful place, on the perpetrator, and/or the system that enabled the abuse.
Out of this, came the decision to group the data gathered from the women who work as receptionists into themes.

There are six themes that came to the forefront clearly in my interviews. In using phenomenology-informed methods, the decision regarding how many themes to include for comprehensiveness, versus what to perhaps set aside in hopes for a clearer narrative of findings, presented itself early on in the data analysis. I made an ethical decision to err on the side of including more themes, although may seem only tangentially related to study's main question. This is because women who work as receptionists are largely seen for the transactional tasks they supply in the system. I was conscious of not wanting to duplicate this, by leaving out themes that were replicated and clear, that did not directly map to the stated research purpose or questions.

The themes and their respective subthemes are:

Theme #1: Coming to be a medical receptionist (motivations/opportunities)

a. Family ties with doctors at the clinic
b. Opportunistic interactions with staff
c. Personal experiences that shaped lifelong desire to help others
d. Desire to work in office/health care setting
e. Financial reasons

Theme #2: Feelings of Achievement, Deeper Purpose in the work

a. The work takes enormous skill, tolerance and fortitude
b. There is significant work/family conflict as a result of demanding schedules; this is tolerable because it is important work
c. Importance and reward of being appreciated by patients supports the deeper purpose and meaning of the work

Theme #3: Experiences, feelings and perceptions that they are treated as unimportant, inferior, or less-than in the hierarchy of the health care team by patients and by other staff

a. Seeing the work as supporting other 'core' health care staff
b. Bottom of the staff and physician hierarchy
c. Perception that patients respect doctors and medical assistants more
d. Considered peripheral to the operations of the clinic by staff and physicians
e. Perception that they are more likely to be blamed if something goes wrong

Theme #4 Patient anger, Emotional labor and other managing of feelings of patients

a. Relating to anger from patients
b. Addressing and comforting patients' fear, sadness, and worry
c. Withholding or masking their own emotions
d. Impact on their own emotional states

Theme #5 Experience and beliefs about their impact on patient's health

a. Support core health care staff

b. Patients respect doctors and medical assistants more
c. Considered peripheral to the operations of the clinic
d. More likely to be blamed if something goes wrong

Theme #6: Subjects' perceptions of racial and gender influences in their job

a. Self-blame for structural racism and sexism
b. Perceptions that whites have better career outcomes, and are promoted more, earn more
c. White staff more likely to complain and leave job; more entitled
d. Minimal identification of racial or gender bias in their current work with Family First Medical Care

Findings from Sitting Alongside Receptionists

The hour I spent before the first interview, sitting with each of the receptionists, was undertaken primarily to ground myself in their perspective, and to demonstrate my genuine interest and care in understanding it. As discussed in the methods chapter, it was not an observation, in any traditional research sense; it was not a formal method to obtain data, and for this reason, I did not engage in any structured noticing or note taking. I did, however, obtain data I felt was relevant to the spirit of this study. This data was in two general areas:

a. Expressions of gratitude that I was sitting with them, as by doing so, I would 'understand' how difficult the work can be
b. Observations that the majority of interactions I witnessed with patients were transactional, business-like, and in general were not reflective of the sentiments all of the women shared in interviews about their connection to the patients

The first category of data I've included in the second theme, the purpose and meaning of the work; the second category of data does not fit naturally into any of the themes and is the only data that did not come from self-disclosures from the subjects. This data is explored at the end of the findings section.

In my efforts to preserve these women as whole people, while grouping their disclosures for more power and impact, I have done two things. First, I transcribed a paragraph or two about each of the 6 women who were subjects of this research, from their own words– the way they define themselves, before the data is presented. I initially started writing the paragraphs myself, from what I knew of the women, but I quickly realized that I too am deeply conditioned in health care settings and have spent over 25 years in the culture that, in chart notes, identified people only by age, ethnicity, gender and diseases. My paragraph started 'X is a 36-year-old Mexican-American women……' before I stopped and realized anything I write about them would be filtered through my own impressions of what I felt was important about them. I decided to go back to each woman and ask them to share about what they feel is most important in who they are. Our identities themselves are socially constructed, and when the women I interviewed answered my question, it was within the context of our relationship, and would likely be different if their husbands, mothers, doctors or co-workers asked them the same question. I wrote their responses word for word, within quotations. In further efforts to name and own the aspect of socially constructed identifies, I added a few sentences of my own, which included information shared in the interviews, which did not fall into any of the larger themes but what I felt was particularly important in terms of their identity.

Additionally, in order to preserve the full humanity of the women I interviewed, where the women disclosed what seemed important information to them, which was not replicated with

other women, not included in my additions below, and could not naturally be elevated into a theme, I noted all of these by the women's names. This was an effort to mitigate the tendency to hear or see people only in what they may be to us.

Jessica:

> I would say I am not the person I was when I was younger. I have been broken down to the fullest. I plan to never go back there. I see myself as a strong, positive woman that knows her focus. Because she knows what she does not want to go back to. I know that I want better for my kids. I plan on being that role model and following what I want them to do, so they can feel like, "Mom does it like that. We should do it as well." Because I don't want them to just hear my words. I want them to get that feeling from me.
>
> I tell them, "Anything negative that happens, we can make it our own way a positive way, anything." Every day when they leave to school, I'll remind them, "What are we gonna have today?" They'll tell me, "A good day," and "If it's not good?" They'll tell me, "We'll make it good," just because it really sucks to be in a prickly spot where you don't love yourself. It feels so liberating, and powerful, and less stressful to not be there anymore, to really love yourself and what you do. For me, I would say just a strong woman that knows where her focus is.

What additional information seems important to me: Jessica was chronically sexually abused as a child and considers her recovery and healing from this as one of the central factors in her life. She articulates frequently that her goal is to turn her own pain into love. She identifies

being a wife, mother and receptionists as roles where she is working to never pass on her own pain or anger to others.

Mari:

> That is a hard question. I guess really it is that I am someone who tries to treat people how I want my mom to be treated. She has a lot of doctors' appointments and I see how upset she get when she isn't treated well by the doctors and especially by the staff. I see what it does to her. I keep this in my mind all the time, that everyone is my mom. I guess the other thing is, um, how do I say this…. I'm willing to do anything I can to help, I just need someone to be patient with me. I will figure out anything, and if I can't, I will find someone who will, I will try as hard as I can to help, but I just really need patience from others. I get flustered, get red, get sort of (makes stressed sound, shakes her hands), I just can't figure things out when people are impatient with me. And I love details, structure… I could never do Alma Laura's (supervisor) job because she gets yelled at by patients, she has to talk to all the angry patients, I would take it home, I wouldn't be able to take it, it would hurt me so much…but I like the detail part of her job, figuring out the best way to do things, stuff like that…

What additional information seems important to me: Mari is the oldest daughter in her family. She is not married and does not have kids; she has always worked 2 jobs and is the sole support of her mother and younger sister. She says when she is sleeping, eating or reading, she is always thinking 'I could be working to give my mom a better life.'

Pao

> I feel, nowadays, we all have this appearance that we're trustworthy and we're trustful, but, in reality, we're not because, now, how this world is becoming, it's all about hatred and jealousy. I think it's being' trustworthy and being you. Being yourself and showing who you really are instead of being someone that you're not. When someone tells you, "Tell me a little bit about yourself," it's, I'm a very respectful person. I respect you as long as you respect me. I'll be worthy of your time. I won't be wasting your time, type of thing, because, unfortunately, that's how it is nowadays.

What additional information seemed important to me: Pao was planning her wedding during this research. She was proud of her work ethic, financial discipline, and ability to earn and save money. She was in the process of hand making all of her own wedding decorations in order to save money. Pao proudly disclosed she had just bought a Gucci purse with money she had earned by collecting recyclable cans. She said she feels her family has never supported her emotionally and that they do not see her good qualities; instead she said she is seen as a 'scapegoat' in her family, the target of perpetual criticism. She sees her marriage to her husband as 'proof' that she makes good decisions. Her husband is undocumented, and she worries he will be deported; she says she hasn't slept a whole night since the election of 2016 out of fear of her then boyfriend and now husband being detained and deported.

Melissa

> I am a caring person. Sometimes, a little too much 'cause I put other people ahead of my needs. I think I'm strong, a hard worker. I'm a good mother. Often times I'm not

perfect, but I know that I'm a good mother, and I mean well. I just think to depend on, because I'm a person that you can depend on. I'm loyal *(crying)*

Because I just feel that people don't see *[crying]* something. I feel that people just judge the outer me, and they don't really take the time to see who I am inside. Even now that I'm not in the marriage or whatever, or going through the divorce, whatever. It's funny–a person might get dressed up, and I go to therapy–how just the world is. They just look at your outer beauty, and not really care about who you really are. Which is sad, it's just sad.

I feel like I'm a good person. I'm genuine, you know? I was raised with morals. I definitely mean well. Because I'm always the type of person that I always think of other people—what they're gonna think, or how they're gonna feel. I want to just make everybody else happy sometimes. Even if I'm not, or even if somethings not—I don't like or what not, just to not deal with that. Having somebody just be a bear or something, I'm just like, "Okay you know what, I can't make you happy, and that makes me feel bad."

What additional information seems important to me: Melissa has four children. She was in the middle of a divorce during the research. Her family had sided with her husband in the stance that she should not leave him. She said she felt alone in her decision and cried 'every day,' but that she feels she deserves to be happy. She shared details about her marriage that indicated she had been, and was, verbally abused for a number of years. Melissa said she gets great comfort from talking to other women at work who have been divorced and who share with her that she will be happy again eventually.

Cynthia:

I'm a straightforward person. That's one thing. What's another thing I can say? I'm bilingual and I feel like that helps a lot with it. I'm hardworking. I'm more like, "I'm sorry if you don't like it but I'm gonna say it," kind of thing I feel like I'm really not criticizing them but I'm like – how do I say it – there's a word and I can't think of it. Not brave but – my self-esteem is high, I guess you can say. I have confidence that I can back it up and say something and not be put down kind of thing. I feel like I've always had that since I was a little girl. Especially because I'm the middle child. Ambitious too. That's one of the things my mom always tells me. She says, "You're so ambitious. You the most ambitious one."

What additional information seems important to me: Cynthia was pursuing her degree during this research. She would be the first person in her family to go to college. She is undocumented, having come here as a child, so fears she will not be able to get the jobs she wants when she finishes school. She says her parents say she should be grateful just to have the job at the clinic, and do not support her going to college. Cynthia said her parents think she is too ambitious, and she needs to 'keep her head down.' She said her father has worked the same job for 25 years, making what Cynthia said is 'pennies' in relation to the work he does.

Alma Laura

Okay, so I think what's most important to me is my kids. Obviously, we have to put that there. I should say God first, obviously. I really think that being focused with my kids and God is my number one thing. You always have to do your prayer. You have to

always depend that God will situate any problem for you. Having my kids on my side gives me the strength. Even on my weakest or hardest points, God and my kids take me through it. That's my number one thing. Having a family is my one thing.

Now, being able to actually continue growing as a person, remember we even talked about creating credit, actually learning and doing what the world does, it's a challenge. It's really hard. Because I am now 35 years old, you start looking at things—well, I'm 34. Being 34 years old, you start looking at what is important to society. You decide what you want to do. Do I really want to build a credit? Do I really want to make a debt with a new card? Am I really gonna buy a house one day? That's when you start learning and making your priorities.

It's really hard because I have actual personal experience—how can I say? My husband is undocumented, and I've been married for almost 16 years, at least. It's like, wow, 16 years have gone by, and I have not been able to actually help him with legalizing him. It's like, "Oh, my God, one day he's gonna be old, and he's not even gonna be able to get Social Security." It's a tough situation, and you start thinking about life and what's gonna work for you in the future. Then, when that stressful moment comes along, and I think about what I do in life, it just goes away. It really helps. I don't know why, but I think that we all are born with our seven—*[foreign language 21:01]*, what are those called? Yeah, we're all born with a mission in life. Let's say that.

We're all given a mission in life. It all comes with something. Whatever your strongest point is as a person, that's what you're supposed to work and give. Even in the medical field, if you become a doctor, what is your strongest? Pediatrician, is it cardiology? Is it working with the elderly in a home? I was just talking to my niece, and

we were trying to figure out where her PhD's gonna go to. I was telling her, "Well, do you want to work with *[foreign language 21:58]* to give them hope for when they die, or do you want to work with the little kids who have been abused?"

Whatever your strongest point, or wherever your heart follows, that's where you have to do. I really think that my heart follows my patients. It doesn't matter if they're small or young. I'll still go home thinking about the patient that just was diagnosed with cancer, or I go home thinking about the mother who delivered last night. I just love that we can work in this office with everybody and everything. You see everything. I don't know. I just love my job, and I thank God every day for my job because it helps me give to the world. I don't know.

What additional information seems important to me: Alma Laura has 3 children and is a very active member of her church. In Spanish she shared with me about The 7 Gifts of the Holy Spirit: Fortitude, Piety, Counsel, Understanding, Wisdom and Knowledge. She attends church every week and records the sermons and sends them to her sister who can't attend. She told me between her church fellowship and her work at Family First, she feels like she knows 'half of Modesto' and can't go anywhere without people calling out to her. She also said she does not have close friends; her relationships are only family, and all the church people and clinic patients and staff. She is fine with this, and feels it allows her to expend more energy in those areas in service.

In the process of using Interpretive Phenomenological Analysis, there were 6 main themes that emerged, with sub themes grouped within them. The themes and sub themes that emerged were as follows:

Theme 1: The How and Why of entering the receptionist job (Motivations/opportunities)

In terms of how the subjects entered the job of receptionist, there were two major sub themes: Having family or other personal ties with existing staff or the physicians at the clinic and having opportunistic interactions with staff or the physicians when they were patients. Out of the 6 subjects, 5 of them had both family and personal ties to the staff at the clinic and had opportunistic interactions with staff when they were patients. As for the reasons for entering the receptionist job, there were three major sub themes: personal experiences that shaped a lifelong desire to help others in the medical field, a desire to work in a medical office setting and financial needs.

Financial motives

Financial motives for becoming receptionists were important to some of the respondents. For example, Mari, wanted to help her mom with the rent and bills for their shared apartment.

> Yeah. It was. Yeah. My mom and I had just moved into an apartment because she's separated from my dad, and all I could think was—the deal I made with my mom, so she wouldn't stress financially, was I was gonna take half the bills, half of everything. Because she was still working at the time. All I could think was I'm not gonna go to work. How am I gonna make my half of the bills? She's just gonna stress. I don't want her to—you know what I mean? That's all I can remember. Now I'm the only one working because of her health and well…thank goodness for the job. (Mari)

Opportunistic interactions with clinic staffers

Mari was introduced to Dr. Diego through her mom. After her mom took her to see Dr. Diego due to a swollen leg, the doctor requested that Mari come and work at the clinic and that is how she got the job. In addition, Mari's experience with her own mother's illness has influenced her relationship with patients, confessing to be more caring towards patient's wellbeing as a result.

Desire to help in health care setting

Jessica had very similar exposure to a front office medical career as Mari. As a child, she accompanied her perennially sick grandma to the hospital, where she helped to translate between her grandma and the nurses. She developed a long-term love for helping in a health care setting out of that experience. Eventually, she was offered a job at her cousin's wife's workplace and reluctantly agreed to work as a receptionist.

> When I was 16. I've always wanted to be in the medical field. [Unintelligible 03:51] I don't care what it is. I don't care if I have to clean the bathrooms. I just want to be in a doctor's office. (Mari)

Some of the respondents such as Cynthia, Melissa and Poa had worked as front desk staff in other industries and later transitioned to the clinic. All 3 of them were also patients of the clinic, and 1 of them, Cynthia, had a familial relationship with a staff member.

> I was working in Del Taco. I was working there for a couple of years. Then I ended up knowing about this clinic because I had severe anxiety attacks. I didn't have a primary care provider or any of that. So, I was a patient first. Alma Laura is 00:25 actually my godmother, she put in a good word for me. (Cynthia)

Theme 2: Feelings of Satisfaction and Achievement of Deeper Purpose in the work

All of the subjects described the job of receptionists as very demanding, needing particular skills, and often being stressful. Besides being constantly busy, the emotional toll created by adverse interactions with patients and other staff make it particularly challenging. In addition, the emotional toll boils over into their personal lives, affecting family interactions, while work demands create conflict with home commitments.

Exhausting Schedule and Work/life conflict

Conflict between work/personal life is one of the challenges identified by the respondents as an important problem that defines their experiences in the front office. Tension between spouses due to conflicting work and home obligations as described by Jessica, Poa and Melissa, sometimes arise from the exhausting nature of the job. The exhausting schedule can lead to disinterest in home chores and exacerbate the emotional state of the individual when engaging with a significant other over such obligations. For example, Alma Laura describes feeling lethargic about preparing dinner for her family after a long day at work.

> There are days that it's just exhausting and tiring. You come home and it's like, "What are we gonna eat for dinner?" How about top Ramen today? You're just tired and exhausted. Like I said, thank the Lord, to me, it's like He gives me the strength, and it doesn't happen as often, but there are days like, hmm, pizza, because I'm tired. Not because they want pizza, right? (Alma Laura)

As a result, meeting family obligations is compromised by work-related demands. In other cases, the receptionist and their spouse's schedules may collide, creating friction at home.

> With my husband, he says I'm never at the house. Just last night, I told him I'm getting off at 5:30. We gotta go to the food store. He goes, "You won't be home then. You'll be home at 6:30 or 7:00.: And when 6:45 hit, and I'm like thinking to myself 'he's right. I'm always late.' We have to stay until the last patient leaves; if the doctors run late, so do we. It is part of the job. It is what we do. (Pao)

Desire for appreciation by patients

The participants felt a deep sense of purpose in their work, around helping patients and 'making them happy.' Appreciation of patients towards the help and work that front office workers provide helps to create a sense of fulfilment in the subjects' contributions and their careers as a whole. Patients may extend tokens of kindness to the receptionist, for example when patients offered fruit to Alma Laura and Jessica. While such experiences are rare, they are bound to help in balancing out the really egregious interactions that drain pleasure from the job.

> Some patients will bring us watermelons or fruit or something, and other patients leave upset with us, but at the end of the day, we all try our hardest to make that person not feel so angry or so upset. They end up apologizing and just saying, "I'm so sorry for everything." Then they end up leaving, and they leave happy. (Jessica)

Mari also intimated that there is a feeling of satisfaction in being able to help a patient and get positive recognition from the patient. She suggests that developing a sense of connection with the patients is a source of pride for the front office team.

> Yeah. I need the—not that attention, nor do I need people to need me. It's more of like, just talking to them, having that connection with a person to where if they come in

tomorrow, they're like, “Hey, Jessica.” Then I know I did something right 'cause they remembered my name. (Mari)

That's where I'm like, “Okay. I need you guys, and you guys need me, so let's do this together.” That's what I like, to have that accomplishment in the front with the patients. (Jessica)

Maintaining a sense of satisfaction with the service among patients is a central part of the job and leads to fulfillment among the receptionists. Cynthia and Jessica allude to this reality in plain terms:

> Then they leave so happy, and I'm just like, okay, this is what I'm here for. This is what makes me happy. (Jessica)
>
> Mm-hmm. Then, I’ll step in. I’ll be like, “I’m sorry. She’s a little busy. Let me help you.” Then, they leave happy. I feel like my priorities are not all straight. Trust me. I’m not a perfect person. I know I have my flaws somewhere. I feel like if a person leaves unhappy, we didn’t do what we’re supposed to do. (Cynthia)

Theme 3: Experiences in the workplace (experiences feeling value or status in the health care team)

Feelings of inferiority

The interviewed receptionists expressed feelings of inferiority as patients and back office staff generally look down on them. Cynthia says that the close working relationship between doctors and medical assistants means that the receptionists can be overlooked, effectively placing them at the bottom of the hierarchy. This means that receptionists are generally viewed as a

peripheral part of the workplace, despite playing a crucial role in patient care as well as the day-to-day operations of the office.

> I feel like doctors have more of a connection with the medical assistants since they're literally working with them. They do everything for them. They forget about the other ones. They always wanna kill the messenger 'cause we're the ones that have to do all of that. Then they go to them, and then they go to the doctor. You know what I mean? It is the hierarchy with 'em. It sucks. They don't let us forget it, that's for sure. (Cynthia)

At the same time, there are perceptions of greater responsibility for mistakes or even sanctions for taking initiative. Some of the respondent's answers reveal that clients tend to project their frustrations with the entire establishment's system on the receptionists. It is common for patients to seek audience with the doctors or medical assistants even for problems that are entirely solvable by the front desk staff. When this happens, it often reflects badly on the receptionists leading to reprimanding and sanctions by back office staff, such as medical assistants.

All interviewees said, in different ways, that patients interact differently with the women in reception than they do with the medical assistants and the providers. They disclosed this happens in two ways. The first is in self-disclosures of thoughts, doubts, opinions and hesitations about the doctor's recommendations, discussed in theme number one. The second major area of difference in terms of how patients act with receptionists is in the expression of anger. All 6 women spoke of this, even without a direct question about this. They indicated that patients who become very angry, who raise their voices, argue or even threaten them, rarely, if ever, do the same with a medical assistant and almost never with a doctor. This common experience of verbal abuse by patients is its own separate theme; however, the difference between members of the

staff, in terms of who is the most frequent target of abuse, is shared here, as part of the larger theme of reception staffs' low status.

> The back office has no idea. Even when we tell them, that patient yelled at me, that patient swore at me, she was rude; but the patients tells the MA and the doctor we were rude, and they believe it. They don't know because once the patient is called back, they are all happy, they change completely. (Pao)

While Jessica says "they see us different. We are not important. They can mistreat us." Jessica is referring to how patients see receptionist staff.

There was a feeling that this is not appreciated by the rest of the team, as they don't see it, or hear it, due to the separation of the waiting room from the rest of the clinic.

> That is what I was telling her the other day. I was like 'they don't realize that every time something goes wrong over here, were the ones that have to hear it. Were the ones that have to try and resolve it and all of that, but they never get to hear any of it. They don't. That door between the waiting room and the back office might as well be made of stone. (Alma Laura)

All women interviewed, at some point in the interview said they were glad I was studying those who worked in reception. Four of them said that even within the medical staff, they felt they were underappreciated, and it wasn't understood how much they do. The way these women described their roles, the lack of acknowledgement or appreciation for the amount of work they did, and the amount of skill it took to manage the unique challenges of the front office position, were similar to feminist perspectives on women who do not work outside the home. For example, writings on housework, childcare, emotional labor, and social labor uses some of the same language as the women I interviewed.

Receptionists as a supporting cast for back office staff

Among the respondents, there is a common perception of the front desk profession as a supporting cast for the core operations of health care. They are cognizant of their roles as a link between patients and doctors, with the aim of smoothing out the interactions for both parties. Mari expresses her belief that receptionists have a role in facilitating the small things in the office so that the back office can function effectively. Jessica expresses a similar opinion, saying that the doctor's role is more important, but she sees the receptionist as a "peacemaker."

> I think our job is mostly just to help each other be a core unit, but definitely I think my place is just to help them help the patient. For now I'm doing just little things, but I think in helping even the tiniest half, making a coffee or something is gonna alleviate something somewhere. (Mari)

Front office as the face of the establishment

Jessica sees the front office team as the face of the establishment and bad interactions with patients are more likely to negatively affect patient retention even if doctors and medical assistants are positively appraised by patients. Some of the subjects feel disempowered from taking even trivial decisions, and thus their contributions may be undervalued. For example, Cynthia even got into trouble for taking the initiative to clean the office, in the belief that it creates a better aura for the patients. Jessica, when talking about the gender and ethnic demographic makeup of women who work as receptionists in California, started crying, sharing how much she was paid. She knew, as is supported by other research (U.S. Bureau of Labor Statistics 2018) that receptionists are typically the lowest paid staff in a medical office, and she directly attributed it to lack of value by the medical team.

Theme 4: Emotional labor of managing patients' feelings; being the target of patient anger

Anger from patients was referenced by all 6 of the receptionists in both interviews. While initially I separated this section into 'Anger in the waiting room,' and 'anger individually,' it became clear that all anger is waiting room anger, meaning even when patients express anger individually to one of the women who work as a receptionist, it is waiting room anger, as the interaction occurs in front of other patients and co-workers, at the desk in the waiting room. All receptionists disclosed they experience anger from patients, and in fact they identified this as the most difficult part of the work.

Managing patient emotions, specifically anger

All the receptionists have portrayed the waiting room as a space where emotional dispositions are heightened, and anger is the predominant emotion that the receptionists have to deal with. The front office staff have to deal with patients' frustrations expressed in heated anger towards the receptionists. Unable to control what happens in the backroom, where most of the delays arise, receptionists have to shoulder the backlash from patients who want to be attended to by a doctor within a short time of checking into the waiting room. This is visible from the receptionists' descriptions of these interactions:

> She just got really upset. She started cussing me out. I was just like, 'I'm so sorry. (Pao)
>
> The not so good is the wait of 30, 40 minutes and the eyes staring at you, 'When am I gonna get called back? Why am I not in the room already? The doctor doesn't even care about me. (Melissa)

Then it's a domino effect because one patient will come up mad, and then another and another, and it just causes more chaos. (Jessica)

There have been times when I have to get escalated patients out, and that sucks, especially when I have a roomful of patients because I hate them to experience that. (Alma Laura)

I'd say the toughest, toughest, toughest for me has been patients yelling and accusing of this practice and everyone in the practice not trying to help them. (Cynthia)

Then I went out after that, and I had some books in the little room, and I took it out. I was just playing with the little girl, and she wasn't so frustrated anymore, so the mom kind of took a moment to just be by herself and calm down a little. When she went in with Dr. Diego, Dr. Diego said she didn't even explain anything to her. I was like, there you go. It got taken care of without the doctor being there. (Mari)

I always say that the medical assistants will never understand the front office because we get the angriness of, "Why am I waiting so long? Why am I doing this?" When they see them, they're happy because they know that it's a step closer to seeing the actual doctor and why they're there. (Cynthia)

Perception that their low status causes them to be the target of more patient anger

When asked more about this, over half of the women interviewed indicated they believe this is in part related to what they believed was patients' perception of their lack of importance in the office, with Mari stating, "We don't have name tags, or cards. We don't introduce ourselves by name like the other staff and providers do–we aren't real people to patients." Cynthia said

"they don't think we are that important. They save their best behavior for when they get called back to the exam room, not for us in the waiting room."

Responsibility to manage patient emotions:

All felt it was their responsibility to manage patient anger when they are in the waiting room. All 6 of them said that anger in the waiting room is common, and in fact, they state it is a daily occurrence. Five of them described anger as 'contagious' in the waiting room and talked about what lengths they go to manage individual patients' feelings to avoid contagion. Mari and Jessica both said that they consider this a main part of their work and the single biggest area of difference between their jobs and the other health care team member's jobs. All six of the women had been yelled at, and all of them had been insulted. Mari said,

> When they get mad, I can take them being mad and being like 'Oh my god this is unbelievable the way you guys don't care. You say you are going to send my referral and you don't send it. Then they start saying this practice is dumb, this practice shouldn't even be standing. We're all just not ever here for the patient, they start insulting us, it gets hard because you get mad. If someone has kids and has been waiting for a long time and they keep coming up and being rude and loud about it, sometimes I, well this week I took some kids books out to her, for her kids. She sort of calmed down. When she went in with the doctor, she didn't even tell the doctor she was made, I was like 'there you go' I fixed it before the anger got to the doctor. (Mari)

Managing other emotions of patients: the need for compassion

Besides anger, the health care environment is generally a highly emotive and tense environment characterized by a plethora of emotions, often related to the illness. Grief, discomfort and fear are common emotions that patients and their loved ones go through. As with anger, receptionists are often the ones who patients express these emotions to and therefore have to help in dissipating or coping with these feelings. This involves showing compassion and empathy towards patients' feelings on account of their illness and experiences in the treatment process. Poa describes having to listen to emotional clients express their disease-related feelings like abandonment, loneliness and discomfort, and recognizes compassion and patience as a necessary part of her job.

Mari commented about building relationships and showing that she cares:

> It is easier with returning patients that you see regularly. New patients give you that standoffish vibe, regardless of how much you try. That is a little difficult, but I do see a different in how we are treated up there once you throw in a name. Once you learn their names, and you use it, or if you use your name, if you introduce yourself, it helps a lot. They soften to you. (Mari)

In cases of troubling prognosis or even death, the receptionists, in their interactions with patients and their family, need to show sympathy and offer comfort regardless of their own sadness.

> We can call the family and let them know our condolences and if they need anything from us, and then you hear them crying, and it's kind of like, oh, man. This is real. Then sometimes, they'll invite us to the viewings and the funerals, but I can't. (Jessica)

Jessica goes on to describe her experiences and conflicting emotions interacting with the family of a patient, Rosalia, who had died from cancer.

> She'd come in here and cry with us when she wasn't feeling good or just come and sit. She'd be like, "Could you just hold my hand?" I'd just sit there and hold her hand for a good ten minutes, and then I'd go back to work. She used to tell me, "I have nobody. My family's there, but they're not there. (Jessica)

Cynthia frames this further, adding that the unpredictability of patient temperament adds complications to their interactions with patients.

> It's hard because, with some patients, you don't know how to interact with them. You don't know if they're gonna be in a good mood, in a bad mood. Sometimes, you don't know how to even talk to them because, either they're very aggressive sometimes, or when they're super nice but you wanna say "darling," or "honey," or anything like that, you're scared that they're gonna react in a different way. Not only that, but, sometimes when you act nicely with them, they go to the back and they tell the doctor something else, which is very annoying sometimes 'cause you don't know how to react to that…" (Cynthia)

> At the end of the day, everybody just wants you to hear them out. I think, here, it's how you deliver it, whereas at the store, you can take blame. 'I do apologize for this. I'm sorry we don't have this.' (Mari)

> But they're still gonna leave upset. Here, there's plenty of opportunity to diffuse the situation, to understand them and listen. I think that's my biggest—I think that's what I've noticed the most is just the delivery.

What I've learned here, though, the difference from a fast-food place to here is, medical-wise, I feel like they need more empathy. They need more of than to be right. They need empathy for us to understand what they're going through. Restaurant-wise, they just want what they want. Here, no. They just want us to understand the struggle that they went through. Like when they're waiting forever in the lines. It's, like, "I'm so sorry. I understand you've been waiting so long. Let me help you. Let me give you what you want," kind of thing. In the restaurant-wise, no. It's now. "I don't need an apology. I don't need anything. I just want it now." It's more empathetic here. I feel that.

When I came here I felt like it was a little bit more interacting with patients. There is some patients that break down right in front of you and it's like, "Oh God. I don't even know this patient." This patient is really opening up about themselves because no one wants to help them. They have kids. The kids just left them. There's no care for them. [Unintelligible 00:07:47] help them. They only speak English and they don't speak English. You've got to be that [unintelligible 00:07:56] that they want them to be. You sometimes step in either as their daughter, their kids, their wife or the husband, because someone's probably not there caring for them. They sometimes probably come to us for that caring. (Poa)

Interpersonal skills in managing patient emotions

Poa delineates the volatility that comes with dealing with patients. Patients' temperaments are unpredictable, meaning that misunderstandings can occur out of a seemingly unthreatening interaction. Heightened emotions due to discomfort of illness can escalate interactions with both the patient and their loved ones. In order to diffuse such situations, Jessica

suggests that the receptionist has to suppress their own feelings of frustration and maintain an outwardly receptive demeanor.

> It feels bad to see someone mad at you, and you just have them sit there and stare you down. It's like, you don't want to hide behind the counter either. I was like, you want to let them know that they're seen and that they can see you. Even though sometimes, we don't want to hear it, but you just have to put a happy face on it and pretend you do want to hear it. [Laughter] Even just offering them a little cup of water or something, it makes them feel more like, okay, she cares. She's trying, but there's not much she can do. (Jessica)

> It is hard, you get mad. You forget you are at work. You are like 'why are you insulting me for no reason? You don't say that, but you want to. You want to yell back but you can't. (Mari)

> You just do whatever you can to make them feel better. You tell them you'll check on their meds, or when they are supposed to be seen, you ask them if they want to reschedule. But it doesn't work, once they are mad, they are just yelling, calling you dumb, or lazy; I had one mad say to me 'do you not speak English?!' even though we were speaking English. (Mari)

Developing and maintaining these caring relationships with clients is seen by respondents to yield positive outcomes. Jessica gives an example of a typical problematic relationship with patients, emphasizing on accommodative attitude to help ease tensions. This takes a great deal of interpersonal skills. Extending small courtesies to patients helps to deescalate frustrations caused by unavoidable delays as shown by her anecdote about a mother of two who had to wait for two

hours to see the doctor. By extending a profuse and sincere apology, and offering snacks and water, Jessica was able to mitigate a testy situation.

> I can either apologize and take the blame, for being upfront. I'm sorry that it's taking so long, but I can only do so much. I can help make your way a little more pleasurable. I can offer you water. I can tell you— I can accommodate you. If you want to wait outside in your car, I'm willing to give you a call. (Jessica)

In a similar case narrated by Alma Laura, she advised a mother with three kids to move them to a nearby park where she comforted them and was called in when her allotted timeslot came up. Such a small but innovative solution deescalated an otherwise animated interaction. This raises the testy issue of wait times, which is one of the most frustrating factors in customers' interactions with health care staff. She points out the irony that long wait times indicate comprehensive attention from the doctors and nurses.

> The not so good is the wait of 30, 40 minutes and the eyes staring at you, 'When am I gonna get called back? Why am I not in the room already? The doctor doesn't even care about me.' It's like, 'No, you got it all wrong. We care about you. That's why the wait is so long because every patient is taking up their time but with the time needed.' (Alma Laura)

Alma Laura suggests another solution involving placing the decision in the patient's hands in order to give them a feeling of being in control. Asking a frustrated patient to suggest an action plan that makes them happy, in the realization of all the mitigating factors, can help to bring them around to understanding the receptionist's point of view.

> Yeah, they're gonna fight back. When you give them a set of options—it's like when do you want to schedule an appointment, you're like, 'Okay. Do you want to come in at

8:00?' 'No, I can't.' 'Do you want to come in at 2:00?' 'No, I can't.' I am full. Okay. 'What works for you?' (Alma Laura)

Yeah, don't take it out on me. Better now to shake off and on to the next. You cannot go home crying over the fact that a patient left. It just happens and unfortunate. You can't be just all rude about it, like, 'Well, if you want to go, go.' You can't. You can't just be cold about it. You have to still acknowledge, no matter what, they're always right. You can't let it get to you or else the next day won't be as strong. (Jessica)

It's hard at times though when you get those ones that are very impatient or mean, but you can't take it personal. It's just part of the job. (Alma Laura)

It's hard and it's draining because when I get home, I will not answer my phone sometimes. (Melissa)

Theme 5: Experience and beliefs about their impact on patients' health:

Being a conduit between the patient and the doctor, the receptionist has a secondary or indirect influence on the way that the patient approaches their health care decision making. Five of the 6 women interviewed felt they impacted patients' health choices significantly.

Receptionist influence patients' health

While I expected this to draw agreement, their understanding, examples, and explanations of why they had an influence on patient health, was largely different than what I expected. They indicated five main areas where they felt they influenced patient health: 1. being the mediator between insurance companies and patients; 2. making the reception environment friendly and warm, encouraging patients to return; 3. squeezing patients into the doctors' schedules when

there were no appointments available; 4. encouraging patients to follow the doctors' recommendations; and 5. intervening to keep patients from leaving the practice before they are seen.

Vetting and advising on insurance information

One of their main duties is to verify patients' insurance information for coverage of various therapeutic procedures the patients may need. When receptionists vet insurance, they are indirectly injected into the patient's decision to proceed with or abandon certain procedures due to affordability. Melissa gives an example of her and her daughter receiving preferential treatment at a dentist's office because they had private insurance whereas the other waiting patients were on Medicaid. As a receptionist, she says that such dilemmas arise a lot at the front office. According to Mari receptionists often take the role of following up with health insurance companies on behalf of patients. By acting as the middleman in these scenarios, front office personnel facilitate treatments that may otherwise be out of reach.

> When I took my daughter last year to the dentist, obviously, her dad works, we have private insurance. That place is known for they take Medical as well so I'm known. It was weird because the receptionist is sitting there and she goes, 'Oh, she's private.' She told the other girl sitting next to her….Then they put my daughter up first. She was the very first one. (Melissa)

Receptionists discretion in access to the doctor

All of them mentioned if patients did not feel they were 'nice' or cared about, the patients would not want to return for follow up appointments. Each had examples of when they had been told this, by patients. Poa said,

> This mother, she was like 16, and had 2 kids, and she said, this is the only place I can come where they don't judge me, don't look at me like I'm trash for having kids young' …and she said it was me, it was how I treated her, that I was so friendly and called her kids by name and told her they were cute, she said I treated her like a 'normal' mom and that is why she keeps coming here'. Jessica said 'they tell us, they tell us that we are the reason they come back, because we welcome them, we smile at them, we comfort them. (Poa)

Mari said,

> At the end of the day, we see them going in and out, and when we smile and pat them on the back and give their kids stickers, they feel good about coming here, they don't dread it, don't procrastinate coming in. (Mari)

Five of the 6 subjects indicated they take initiative to get patients who do not have appointment into see the doctor even when there are no appointment slots available. Poa, Cynthia, Melissa and Alma Laura all said they frequently get a call or have a patient walk in who wants to be seen or wants a family member to be seen that day. When there are no appointment slots available, these women disclosed they go to the doctors themselves and advocate for the patients to be squeezed in. All the subjects shared that they are generally successful in advocating, eliciting agreement from the doctors to see the patient that day. Alma Laura recalled one time where a woman came in with her 10-year-old daughter who had been vomiting all day

and had stomach pains. She said she went to the doctor to ask that the doctor see the girl. The doctor refused. It was the end of the day and she was already an hour behind schedule. Alma Laura recalled

> And I just said, Dr. Diego, if this was my daughter, if this was Julissa (Dr. Diego's daughter) you'd feel the same as I do. This girl is in so much pain. She will end up in the emergency room for hours and they might not get the right help there, I will stay and lock the doors. (Alma Laura)

She went on to say the doctor agreed to see the girl, who was hospitalized immediately. Alma Laura shared this as a success, that she helped the family avoid hours at the emergency room, and her assessment that it was serious was accurate. "I know the doctor's gonna be mad, but at the same time, they have to be seen, so we somehow squeeze them in."

Jessica shared a similar story:

> Like today I had seven patients waiting in the lobby, and a patient came in with a form from school. Then, they're like, "Oh, my God, I have to turn it in by Monday. I need to see the doctor. I'm like, "Oh, my God, the girls have seven patients waiting." I'm like, yeah, and I pulled it, and I'm like, "Drs going to be mad" but I begged the doctor and got her in. (Jessica)

This dynamic of advocating for the patient to be seen was consistent; more importantly, when I asked these woman a follow up question about how they decided who to advocate for, and who not to, they said they can 'just tell' when someone is really in need. They all acknowledged they turn people away for same day appointments 'all day long, on the phone, walking in, it's no, no, no, no appointment open,' said Melissa. Cynthia shared once when a

patient came in 30 minutes before the office was closing and said she 'really needed to see Silvia'. Cynthia went on,

> Silvia?! She called Dr. Diego Silvia?! No way was I going to squeeze her in. It is so disrespectful to come into the office and call Dr. Diego Silvia. No way. I just said, no there are no appointment. And there wasn't. (Cynthia)

Importantly, there is no guidance for this kind of decision making or support for these seemingly arbitrary distinctions.

Clarifying and supporting the doctor's instructions

Three of the interviewees specifically mentioned that patients who felt uncomfortable, ambivalent, or hesitant about taking the doctors recommendations (which had been given to the patients just minutes earlier), stopped at reception and mentioned their hesitation. Jessica said patients often disclosed to her that they did not want to take the medication the doctor prescribed; Jessica said it wasn't uncommon that someone in her family was taking the same diabetic medication, and she would tell the patients that her mom/uncle/cousin takes the same medication and finds it very helpful. She said she estimated this happened 2 times a week, and that patients frequently told her they would go ahead and try it, because of what she said. 2 of the women interviewed said they had many patients share that they didn't feel confident in the doctor's recommendations, as they felt the doctor had not listened well or had not spent enough time with them. Both women said they shared with these patients that they are patients of the doctors, as well as their children, in order to increase patient's confidence in the doctor's recommendations. Poa, Alma Laura and Jessica said they can remember 'many times' when patients told them during the conversation that this disclosure helped them decide to follow the recommendations.

A patient came in yesterday. She was like, ‘The doctor gave me Trazadone. That is a sleeping pill. I don't want to take it.’ I was like, ‘Why not?’ She goes, ‘One, it costs too much, and two, it's insulin.’ I'm just like, ‘I know, but my dad had that problem, and my dad is taking Trazadone. It'll make you feel better.’ He really is taking it, and he feels so much better. I'm not lying this time. [Laughter] She was just like, ‘Oh, okay.’ I was like, ‘If it's too expensive, let me get you a prior auth going, and then we could give you some samples while you get your prior auth, and then that will give you an idea of how it's gonna make you feel. At that point, if it's not working, come back.’ (Poa)

Sometimes, just telling them, ‘You know what? My dad had the same symptoms, and he's taking that medication. He feels so much better.’ They're like, ‘Okay. I'll try it.’ I was like, ‘But Doctor gave it to you. You should try it.’ When you tell them like that, ‘If Doctor gave it to you, you should try it.’ they're kind of like—they still leave with that lingering, but if you tell them, ‘I took that, or my parents took that.’ they're like, okay. I'll take it now. (Alma Laura)

‘Well, your diabetes is still abnormal, and [unintelligible 24:50] is still in the red.’ They're like, ‘Well, what's abnormal?’ Then, I'm like, Oh, shoot. They're not gonna understand me telling them abnormal. I go back to three or six months. Well, before it was 6.9, but now it's 6.7, so it's still abnormal, but it's better. If you're walking 10 minutes, go walk 15. Right? If you give them a comparison, [unintelligible 25:13] receptionist you learn how to do that. (Jessica)

Patient -receptions staff relationships

Four of the receptionists said they have actively intervened to keep patients from leaving before they saw the doctor. They said that due to long wait times, up to an hour in some cases, sometimes patients get angry and want to leave. Jessica and Pao both stated they immediately try and intervene to get them to stay. Pao said, "I know if they leave, they won't get another appointment for a week or two, or maybe they are made enough they won't come back at all, which means they won't get the care they need." All 4 women said they go to great lengths to keep patients there, including comforting them verbally, going into the back office to ask the Medical Assistants how much longer it will be, and sometimes asking Medical assistants to see the patient earlier. Mari said if the patient needs to leave because they have other commitments, such as picking up children at school, then Mari tells them to go pick up their children and come back, and she will save their place in the schedule. Mari said, "I just say, go pick them up, go get something to eat, I'll text you when it is time; don't just leave, you need to be seen, you made an appointment for a reason, we will make it work." Melissa said she tells patients,

> The only reason they are running late is because they spend time caring and listening to each patient. When you get in there finally, it will be you, and you will be glad you stayed, because it is you know they are listening to. (Melissa)

Pao said she offers water to patients who are agitated and indicate they want to leave; Alma Laura encourages them to wait in their cars, or outside, if they are feeling too anxious to continue to wait in the waiting room:

> I tell them, I just say, yes, yes go outside if you need to smoke, you can just wait outside, I will come get you… or I tell them you are too anxious in here and want to leave? Don't do that, you can wait in your car, I will call you, I will text you when it is time….You

know, whatever it takes for them to be more comfortable, to stay, because they probably end up at urgent care if they leave. (Alma Laura)

Theme 6: Subjects' experience of racial and gender discrimination in the workplace

When I formulated the last question of the first interviews "Over 90% of medical receptionists are women; in California, the majority are women of color. What do you think of this?" my intention was to understand how the women themselves interpret this information and how they relate to it. I wanted to bring this piece of macro information down to an individual and listen to what it means to her. I also had hoped that the question would signal my willingness to hear and listen to whatever they might want to share about their experience with racism; I was concerned that if I didn't signal this, my being white might be a barrier to them sharing about it. There is support for this in the research; for example Hall and colleagues in a systemic overview of bias in health care, (2017) demonstrates that those who are in 'out groups' or minorities, look for subtle cues of others to see if they are 'open' to hearing their experience. This is consistent with my own experience as a therapist. In my early years as a therapist, while I considered myself a feminist, and a liberal, someone who understood the impact of racism, I did not understand the concept of implicit bias, or institutional racism. When I had clients who were people of color, I don't remember ever explicitly letting them know that I would be open and curious to hear their experience of being a person of color. And as a result, I don't remember any client every volunteering any disclosures about this. In contrast, since the 2016 elections in the US, which has brought implicit and explicit bias, racism, including institutional racism, to the forefront of conversation, I have made purposeful signaling and disclosures to people of color that I am an ally, and that I can listen and would like to hear about their experience of being a

person of color in the United States. As a result, I have had numerous disclosures about racism from patients. I've had an African American patient share with me that they believe the women who work at the front office, who are Mexican American, are 'racist' toward her and other African Americans; I've had numerous Mexican American (born in Mexico, and those born here) talk at length about the subtle and overt racism they face, throughout their lives, and the increased frequency and intensity of racist comments toward them and their children since 2016.

Because of my experience in the last few years, experimenting with signaling my interest and openness to hearing this, and because my perspective as a feminist is that reception work being low paid is not an anomaly but is part of a larger system that devalues women and the work they do, and more so for women of color, I had predicted that the women who I studied would welcome the opportunity to talk frankly about this issue, and would share their thoughts, experiences and feelings with me about the negative consequences they have experienced. While all the participants did speak in some way about the gender and race dynamics impact their lives, only half spoke about any negative consequence, disconfirming my prediction.

Preferential treatment of white receptionists

Half of the subjects expressed feelings of conviction that their race affected their ability to move up in organizations. The three ways they identified are:

1. 'White' Americans American girls received higher salaries and were more likely to receive raises frequently.
2. White Americans were more likely to be dissatisfied with the receptionist job and ask to move up or be paid more. Pao said,

> Every job I've worked at with an American, they feel they are entitled, that they deserve better. They tell the boss they want to move up, that they should get more

money. And they do. At one job, this American girls' parents came in, demanding to the manager that their daughter get more hours. Her parents! And she did, they gave her more hours. They get more because they ask for more. Like I said, in my family, everyone is like, you have a job, just be grateful and keep your head down. (Pao)

3. White Americans were more likely to move up in the organization, to positions with higher salaries.

This girl, this girl was at the job for 2 weeks. 2 weeks! Then she was moved up to referrals. She was the only one, and she was the only white one in our group. We'd been there for years. It made me so mad. (Cynthia)

Hmm-mm. I started off at 13. Mm-hmm. That's better now because it's a dollar more, but I'm gonna have to work hours to take my kids to eat [unintelligible 51:09] one sitting. I was like, that's sad. Yeah. (Pao)

We were all Hispanics, but the owners were American. The workers comp doctor was an American and his wife was an American. Then from the receptionist from the medical records and referrals and all of that, we were all Hispanic. So yeah, we are always the lowest job. (Cynthia)

I guess one of the coworkers that I used to work with, she said that there's been about five American girls at work and where are they now? They're nowhere here? The reason being because according to her the moment they worked more than six months they want a raise. Then after the six months they want another raise. Then keep going and keeping going. (Pao)

> Obviously, as Mexicans, we're like, 'Thank you for the job and keep it coming,' because we just need to pay our bills. Then if we get a raise, we're like, Oh my God. Thank you. I wasn't expecting this. (Mari)
>
> I feel like that's why sometimes Hispanics get left in the shadow, because we don't complain. At the end of the day we know that our parents—for me, I was born here, but my parents came from Mexico. You can say I never really known the struggle; you can see the pain in our parent's eyes that you need to get ahead. You can't be complaining about every little thing because nothing is handed to you. You just got to go and get it. (Jessica)

About their ethnicity being a target of insults from patients, Pao said,

People don't know I'm straight up Mexican unless I tell them. They don't know. They tell me stuff about Mexicans, like this patient she said 'why do they speak Spanish here? They are in America,' about the girls speaking Spanish behind the desk. She thought I was white. I told her in Spanish 'soy Mexicano Tambien.' She just gave me a dirty look and sat down.

Melissa said,

Once a patient is mad, everything is on the table; they will say we shouldn't be in this country, that we don't belong here. I've had a patient say he was going to report me to ICE. I was born here. What is he going to say?

Preferential attitudes towards men

The same 3 women also talked about their perception that Men also receive preferential treatment in terms of job progression as expressed by Alma Laura's example of a white male

nurse who was promoted to director of nursing within a year, overlooking similarly experienced women for the post.

> It is so sad. I saw it happen at Golden Valley. I saw them hire a male nurse, a white boy, and the next year, he was the director of nursing. There were all these women nurses with more education, more experience, more skills. I was so mad and I really— "… Everyone's always looking the white guy like he's the smartest guy in the room. It just makes me so mad. (Alma Laura)

The issue of misogyny comes up with Melissa's anecdote about being asked by a prospective job in a practice owned by a male physician to send pictures of herself after she'd sent in her resume. In this respect, her appearance, rather than job-relevant skills of were being assessed.

> I remember a few months back, I sent a resume to a practice in town; and he offered me a job right away by email. When I emailed him, just to kinda see what it was about, he then started asking me for a picture. Which I thought was really wrong. I was thinking [unintelligible 05:10]. Are you even interested in what I can do, what I can bring to your company, or are you just looking at me physically? (Melissa)

Expression of anti-Mexican sentiments

Among the respondents there was an expressed feeling that their racial identity was important in defining their work experiences as well as group dynamics. The respondents expressed the feeling that Pao had expressed, that being of Mexican ethnicity was looked down upon, in their previous workplaces.

> The last clinic I worked at, the doctor straight up told us we couldn't speak Spanish. Even when a Spanish speaking patient came in. We had to speak English to them. He said the white patients would get mad if we spoke any Spanish. I'd still talk Spanish to the patients, and I tell the doctor 'if you are gonna get mad at me, then fire me because I talk their language. I'm not just going to sit and stare at someone when patients greet me in Spanish.' (Poa)

Poa also felt that working in an office where she was the only one of Hispanic origin was difficult, and the people of other races looked down on her.

> Honestly, I can tell you when I was on my second job at the therapist's place, it was a mixed racial. It was myself and I was Hispanic. There was a Filipino. There was an American. There was a Middle Eastern. I felt there was no connection. There was no nothing. I felt like we all were like, 'I'm better. I'm better. I'm better.' Then we had the Middle Eastern gentleman, who was a physical therapist, bashing the ladies. (Poa)

The other three women, Alma Laura, Jessica and Marilou, stated they had not had experiences of race or gender bias or conflict at Family First. Marilou says that the issue of racism is more perceptible in other companies, but she does not perceive it as a problem at her current place of work. Jessica concurs with this position, saying that she has rarely had to deal with cases where confrontation was tied to the color of skin, and instead, that it has been a positive connecting experience at work with the other receptionists.

Researcher reflexivity: Alma Laura's response stayed with me long after the interview was over. It was the single interview in which I felt I had objectified her, and in doing so, had hurt her. It was the opposite of what I had hoped for in carrying out qualitative research in the social construction field, as a feminist researcher. When I asked her the question, she looked

blankly at me for just a moment. I originally thought I had imagined it and dismissed it from the outside of my consciousness. She commented that the pay, yes, was poor; however, the only people who would say it wasn't enough, were those who didn't understand "the spiritual nature of the work, the higher purpose of what we do." I projected that mu talking about how little the pay was, had seemed as if it put her in a category she did not want to be in- a 'low wage/low status' category. I had diminished the authority, power and dignity she felt in the position, which she had confirmed in my prior question, about how much she herself and others who had worked as receptionists impacted patients. She brushed off my wondering about the women domination of the field "of course women are more receiving, we receive children." She returned to my question about people of color and began talking about progress in society, as "they were picking cotton as slaves 100 years ago. " I realized at this point she did not consider herself a person of color; that although she was born in Mexico, her husband was not documented and did not speak Spanish. Her children were bilingual, she thought 'women of color' meant African Americans.

While Alma Laura's comments may have been the clearest articulation of not owning, or identifying with being oppressed, or undervalued, or being a gender, or race, that was the object of racism, Jessica and Mari also in their own way, disavowed any recognition of themselves in the larger statistic. Two of the initial interviewees were quick to agree that the great majority of low paid occupations in the US are filled by people of color; they both felt this was the fault of their own culture. Marilou said that white people,

> Might feel like they are entitled, but that isn't bad. Everyone can ask for what they want. If I don't ask, that is on me. That is how I was raised, be grateful to have a job, just keep your eyes down and work. (Marilou)

Jessica said Poa shared something similar when she shared,

> Our culture tells you just to take whatever work you can get, and hold onto it, just settle, no matter the pay or the conditions. My dad has worked for 20 years for a white man. He does so much work and makes so little money, but he will never leave…. I was raised to settle. I'm the black sheep of the family. They think I am ambitious, and that is an insult. They say I won't succeed; I won't get a degree; I won't get more…especially because I'm undocumented. They think it is crazy to want more than just a stable job.

Summary of Findings:

This chapter discussed the factors I considered in decisions around the organizing of data, including my decision to include a short summary in the women's own words, of what was important to them, along with my additions of what additional information I had gleaned from previous knowledge or during interviews, that seemed important.

The 6 themes that surfaced in the research process were identified:

Theme #1: Entering the front office profession (motivations/opportunities)

Theme #2: Feelings of achievement, deeper purpose in the work

Theme #3: Experiences, feelings and perceptions of being treated as unimportant or inferior.

Theme #4 Patient anger, Emotional labor and other managing of feelings of patients

Theme #5 Experience and beliefs about their impact on patient's health

Theme #6: Subjects' perceptions of racial and gender influences in their job

This chapter then shared in detail the data from each subject by name, using their own words, within these 6 themes and related sub-themes.

Chapter 5: Discussion

Limitations of the research

This research has some significant limitations. The nature of the methodology chosen, which was phenomenology-informed, is to go deep with smaller numbers of subjects in order to deeply understand their meaning making and the social construction of their unique perspectives. The sampling method, for this reason, was chosen to ensure the participants were a fairly homogenous group. In this study, the subjects were all women of Mexican heritage, working as receptionists in medical offices in central California. All the women were between the ages of 23-38. Because of the small sample size, and the homogeneity of the participants, extrapolating the research findings into larger groups with more diversity is likely not possible.

Another layer of homogeneity that is a limiting factor regarding extrapolating findings is that all of the subjects worked in the same organization. While the organization itself has three separate and discrete clinic sites, each with their own particular culture, and the subjects of this research have similar demographic characteristics to medical receptionists in the US, organizations have their own cultures, and all of these women worked with that. As discussed in the methodology chapter, Family First Medical Care is owned by two women of Mexican heritage and are both bilingual English and Spanish speakers. This is rare in the medical field, with only 5.8 percent of doctors identifying as Latino or Hispanic, and only 20% percent of doctors speaking Spanish (American Academy of Medical Colleges, 2018; Latino Physicians of California 2017). While the education level, socio economic status, societal status, and citizenship status is very different, the race, ethnicity, and language similarities between the owners of the practice and the women who work as receptionists likely influenced the research participants experience of their work, and thus, the findings of this study.

Another area that is important in considering what might limit this research from being extrapolated to other medical clinic reception staff is the uniqueness of the practice owners and lead doctors at the organization where the research subjects worked. Family First Medical Care is owned by Silvia Diego and Lisa Gil, both family practice doctors. They are both of Mexican descent. Silvia was born in Mexico and brought over as a child to reunite with her mother who was a field worker. Lisa was born in the US. both of her parents were born in Mexico and immigrated as teenagers/young adults. Both women are bilingual, Spanish and English, both as first languages. Silvia's mother only speaks Spanish, so she grew up speaking only Spanish in the home; Lisa's parents spoke both English and Spanish. The uniqueness of two women owning a medical practice is significant. The American Medical Association states that in 2018, only 47% of doctors owned their own practices, and of that percentage, only 30% were owned by women doctors (Henry, 2019).

The numbers become even smaller when ethnicity is factored in. Less than 15% of all physicians are bilingual, Spanish speaking Latina or Hispanic (Moreno, Walker & Grumbach, 2010). While there are no known statistics for how many Spanish speaking women doctors own their own practices, the research that we do have would indicate it was a very small number. In this sense, Family First Medical Care is an anomaly as an employer for the women interviewed. This may in part explain some of the discordant findings discussed further in the section on race and gender, where most reception staff stated that they had not experienced racism at Family First Medical Care; however some endorsed experiencing racism at previous reception jobs, at different practices owned by presumably by non-Spanish speaking men.

Implications for Health Care Entities

Patient Experience

The literature is clear indicating that the experience of patients is primarily influenced by their interpersonal interactions with employees at the place they receive their care. In fact, patient experience of doctors in particular, which is the most well researched, is influenced primarily by the communication between doctors and patients, specifically, whether patients feel cared about or not. When this research expanded to include nurses and medical assistants, specialists and behavioral health providers, the same thing was found. Feeling cared about appears to be the biggest driver of positive patient experience (Howick, J., Steinkopf, L., Ulyte, A., Roberts, N., & Meissner, K. 2017). While the research is still emerging, current research supports that receptionists in particular seemed to have a significant influence on patient experience. As discussed in the introduction and the literature review, when patient complaints are disaggregated on social media, receptionists account for over 80% of complaints, demonstrating the great power receptionists have to influence experience.

This research, exploring receptionist experiences in their work, their perceptions of their relationships with patients and with the health care team, has implications for health care providing organizations as it demonstrates the deep purpose receptionists feel in caring for patients, as well as the sometimes difficult relationships they have with patients. This research demonstrates that women who work as receptionists are almost constantly managing and moderating patient experience in the waiting room, including managing emotional states around wait times. In this research, for example, the women studied frequently reported interacting with

patients who were expressing anger about the wait and sharing that the reason the wait was so long was because the doctor cared so much about each patient they spent significant time with each patient. This is an example of the specific and direct interventions receptionists engage in to influence the social construction of the meaning of the wait for patients in the medical setting.

Further, we know unequivocally that employee experience impacts how the employee treats customers- this is true in health care settings and in non-healthcare settings. The findings point to many areas of poor employee experience for the women in this study, including feeling disrespected and feeling ignored unappreciated. This has important implications for how these women, and other receptionists with likely similar experiences, interact with patients.

Patient Clinical Outcomes

Clinical outcomes are so closely related to experience; they are often used as proxy measures for each other. There are many mechanisms documented which inform this. First, when patients feel cared about, listened to, and empathized with, they are more apt to trust the recommendations given, and adhere to them (Decety, J., & Fotopoulou, 2014). Second, when patients feel cared about, they are more likely to speak up, ask questions, share hesitations, or otherwise engage actively in their care, allowing the care team an opportunity to alter or negotiate recommendations, ensuring that the patient will more likely adhere to these (Del Canale, S., Louis, D. Z., Maio, V. S., Wang, X., Rossi, G., Hojat, M., & Gonnella, J. 2012)

Understanding that women who work as receptionists have such a deep and lasting impact on patient experience means they have a deep and lasting impact patient clinical outcomes. Essentially, how well (or poorly) receptionists are treated at work by the organization, managers and health care providers directly impacts the health of patients.

Additionally, one of the main themes from this research was around how much receptionists directly engage with patients around their care. First, they engage with patients when patients leave the discussion with the doctor, and they stop at the counter on their way out. Often during these interactions, if there is sufficient trust/care built in the relationship, patients disclose their hesitations about the recommendations, which they did not share with the doctor. Women who work as receptionists disclosed repeatedly that they encourage, affirm and comfort patients who are unsure about the providers recommended treatment plan; they shared that often these patients did indeed end up accepting the recommendation. Second, these women describe the decisions they make to either squeeze patients in to see the doctors, or in fact, turn them away, both in person and on the phone. These decisions were completely within the realm of control and authority of the women who as receptionists; there were, in fact, no decision supports or guidance offered for the women in this study on making these decisions. This has enormous consequences on patient's health as the difference between being seen at an urgent care or emergency room, as opposed to someone's own primary care physician, is stark. Research indicates that those seen by primary care providers received more accurate diagnosis, and that patients are more likely to adhere to recommendations from their primary care physician. Additionally, all the study participants indicated they felt they made an impact on whether patients returned for follow up appointments in a timely manner. The study participants identified multiple factors within their realm of influence such as the comfort of the waiting room, their own friendliness and a general welcoming atmosphere, all of which lowered barriers to patients returning for follow up appointments their doctor had advised.

The impact of patient clinical outcomes has implications for patients, health care providers, and insurance companies.

People Obtaining Health Care

This research has several implications for all who obtain medical care in medical offices, in our role as patients. First, understanding that receptionists who work in medical offices have an impact and influence on our health outcomes in the myriad of ways described above may change how we consider the (typically) women who work in that role when we are patients.

If we appraise the waiting room, waiting experience, and relationship with the receptionists as distant, cold, uncaring or otherwise negative, this study indicates that this might negatively impact our health. If we leave the exam room with remaining reservations about the recommendations we received, we are likely to feel uncomfortable sharing these reservations with the receptionist, leaving us to wrestle with our ambivalence on our own once we leave the office.

We may wait longer to make an appointment when we are sick or otherwise in need of care, or we may not go at all, when the unpleasantness of the office comes to mind. If and when we need to see our doctor urgently, this research would indicate that the person who is working as a receptionist has the discretionary power to share this message with the doctor, or not, and to 'squeeze' us into the schedule, or not to. This research indicates that receptionists make these decisions on their own and there is little guidelines or standardized decision making supports that provide guidance in making these decisions. Understanding that this is where bias is likely a big part of the decision-making process, we may assess whether the receptionist is interested with us and evaluate whether we feel any indications that there is negative bias towards us. This research indicates that if we do feel the relationship is cold, uncaring, or judgmental, if it is lacking in eye contact, if we are frequently interrupted by reception staff when speaking, these are all negative

bias signals that we may want to take into consideration, as this may directly influence our access to the doctor. Similarly, our requests to the medical office around filling out paperwork, requesting refills for medications, clinical questions, such as those around test results, or side effects of medications are largely moderated by the receptionist, as the messenger to the doctor. This research suggests there are some patient messages and requests that those who work in reception feel strongly about, and will remember to pass on, and even go farther to advocate for particular patients in getting what they want from the doctor. This research implies that then there are perhaps others, we as patients, who do not receive this focus and advocacy.

The implications for us may be to take our relationships with those who work in reception seriously, and to perhaps make decisions about which doctor and practices we frequent (if we have a choice) based at least in part on how we appraise the relationship with the reception staff at the practice. While traditionally most of us have been conditioned to make decisions about who our primary care provider is just based on the individual care provider themselves, this study gives weight to the idea that it may be wise to make decisions about who are primary care providers is, with a wider lens, one that includes our experience and relationship with the reception staff.

Health Care Delivery Organization Leadership

The influences of women who work as receptionists on patient outcomes has implications for health care organization leadership, such as CEOs of hospitals and community clinics, and owners of private medical offices and physician practice owners. Despite extensive training, experience and expertise, any physician diagnosis or recommendations for patients are worthless if the patient does not agree or does not follow the recommendations or does not return for

continued treatment. While the drivers behind adherence to recommendations or lack of adherence are varied and complex, this study indicates that a patient's relationship with receptionists plays a role. For doctors who own their own practices and who make hiring decisions, this research would support the importance of careful consideration in hiring, training, and ongoing support for reception positions. While the dominant discourse around receptionists is that are not clinical staff, and in fact not part of the health care team, this research indicates they are very much a part of how patients make health decisions, and that they very likely influence patient decision making about adherence to treatment recommendations, making them an important contributor to patient health outcomes. Understanding this, physicians who are practice owners or their clinic managers who make hiring decisions would likely want to carefully screen, interview and select receptionists who are highly skilled communicators, who see connecting with patients as part of their work, and who understand the impact they have on patients' health. Providing support for those who work as receptionist to engage in this interpersonal engagement with patients would be indicated as well. This might include overtly giving permission and encouragement for staff to engage in supportive conversations with patients, including engaging with patients in job descriptions, so as to ensure it is considered part of the work; it would likely entail including reception staff in clinical team meetings, huddles, and other communications normally reserved for the 'back office.' Supporting reception staff in this interpersonal work would also likely include acknowledging that this is the core of the work they do, essentially naming it to make it visible.

Another way in which this research influences practice owners and health care delivery organization leaders is around the high incidence of conflict between reception staff and patients, and specifically, the verbal abuse suffered by reception staff. While other research has

established that reception staff in medical offices are routinely verbally abused, with most research indicating over two thirds of receptionists have been abused over the phone or in person, this research provides more detail on reception staff's perceptions, experiences, and meaning-making of this phenomena. It is clear from this research that all of the reception staff regularly experienced patient's anger, expressed through yelling and insults, and have considered it 'normal' and expected. Medical care organization leadership has largely ignored this problem in the US and the UK and as a result to have created a culture within care organizations where their employees are routinely verbally abused and consider it 'part of the job.' Due to the demographic make-up of reception staff, being over 90% female, and in the US, overwhelmingly women of color, it is difficult not to draw the conclusion that the reason the abuse is so omnipresent and ignored is because the women and especially women of color are not as valued as others. It is difficult to imagine a group of Caucasian men being routinely verbally abused while their employer ignored this. By ignoring this abuse, health care delivery leaders have inadvertently become negligent parents, allowing abuse to occur to those most vulnerable in their homes.

Health care delivery organizations' leadership and practice owners can take action on this by first naming the occurrence as verbal abuse and defining what it is. They can then begin to identify the processes and practices what will best 1) lower the incidence of this type of behavior (prevention) 2) document and track these incidences to better understand the trends and patterns of where, when and how this occurs, and 3) address the patient who engaged in this through standardized stepped interventions 4) provide support for reception staff before, during and after incidences.

Number 1, lowering the incidence of this type of behavior is more complex than it may at first seem. While many health organizations have made efforts to address this problem, the great majority have opted to instead post warnings for patients as the only strategy. Many hospitals, pharmacies and clinics have a posted sign that says something to the effect of 'abuse of staff will not be tolerated.' While this practice has at least the benefit of acknowledging the problem just by nature of the posted sign, it does not, in fact, lower the incidence of escalations and verbal abuse (Joint Commission, 2018). Other organizations have opted for prevention interventions that are more protective in their intent, such as installing glass partitions between receptionists and patients, often seen in emergency rooms in the United States. Interventions in the same vein include hiring private security guards (who in the United States have visible firearms) to stand in the waiting rooms and installing metal detectors patients must walk through. Despite the fact that all of these common efforts in health settings have proven in ineffective, (Southard et al., 2012), and in many cases, cause an increase in escalations (Koivisto et al., 2004; Southarrd et al., 2012).

While we have some research to demonstrate what does not work to prevent verbal abuse of staff, we do not have any known research that is specific to receptionist positions. Instead the above existing research is on nursing staff. There is some research summarizing what interventions have been shown to work in reducing verbal abuse and other violence in health care settings, particularly by the Centers for Disease Control and Prevention, which includes receptionists in their research and recommendations Centers for Disease Control and Prevention. National Institute for Occupational Safety and Health report of 2014.

One strategy that is clearly indicated in the research is to ensure adequate staffing to effectively serve patient needs. This is particularly important in reception positions, as receptionists' desks quickly become bottle necks in patient flow, at times in many organizations

with lines of people waiting to check in. Low responsiveness and quality of service, which can result from inadequate staffing can produce frustration and agitation in patients.

A related secondary strategy includes providing resources, support and training to those in reception position to increase their interpersonal and communication skills, recognize behavioral cues proceeding verbal abuse or other violence and preventative de-escalation strategies.

In my practice-based research, the second strategy was implemented with reception staff at one of the clinics I oversaw in a leadership position. There were 4 women who worked as receptionists, with varying interpersonal skill levels. We met monthly for 4 months, collaboratively developing a plan to lower the incidence of verbal abuse they endured at the clinic and implementing the plan. The plan the women themselves devised was aligned with the researched strategies above: ensure adequate staffing at all times to lower wait times to check in for patients and improve interpersonal engagement with patients early on in the reception experience and increase knowledge and comfort in gauging behavioral cues that proceed escalation and the de-escalation techniques to address. Within 4 months, the incidences of escalation had decreased over 70%. The receptionist themselves identified 2 areas that they believed had the biggest influence on the decrease: Greeting patients with eye contact, a salutation, and a smile, when they first walked in the door, and engaging patients skillfully in the early stages of escalations. This practice-based research adds credibility to the recommendations of a large research entity like the Centers for Disease Control. The social-interpersonal nature of the interventions recommended, and implemented in my experience, are at odds with the most commonly introduced strategies, such as security guards and glass partitions. The former seems

to indicate that more connection between patients and receptionists is effective while further widening the connection between them is ineffective.

Insurance companies or governments that deliver health care services

Insurance companies or governments that deliver health care services, such as the National Health Service in the United Kingdom, pay for their members or their citizens health care. All health costs are born by the company or government, and its members or citizens health are, in part, the insurer's responsibility. This research has particular implications for this sector, as it speaks to both their members' health, and relatedly, for the companies' finances. Because better member health costs less, insurance companies are typically deeply invested in their members adhering to physicians' treatment recommendations. Indeed, lack of adherence to recommendations is fairly low (research here), in some research, and in some conditions, it is as low as 30% (Dunbar-Jacob et. al. 2000). This lack of adherence costs insurance companies an enormous amount of money, (Coughlin 2009) Additionally, the most expensive members for any health insurance company are those that utilize the emergency room at hospitals frequently for non-emergent conditions. Emergency room visits in the United States that do not result in hospitalization which consist of seeing a medical provider then being sent home are called 'avoidable' as they could have been treated or resolved in regular outpatient medical visit. These avoidable visits are the most expensive visits for any insurance company, costing up to $150,000 for a single visit (Wodchis, 2016). Additionally, emergency departments of hospitals are not set up to provide care provided for non-emergent conditions, and this coupled with the fact that the physician who sees members does not know them, the care is often substandard and ineffective, increasing the chances that the reason for the visit is not resolved. In the US and the UK (Wodchis 2016), the top 10% of people in any given insurance coverage cost over 50% of total

costs. Typically, these costs are in part driven up by frequent avoidable emergency room visits for non-emergent conditions. In the United States, there are multiple initiatives, interventions, research, discussions and writings about how to address this issue. Health insurance companies in particular are frequently engaged in trying to solve this issue, developing programs, pilots and projects to attempt to address it. Two of the most common interventions health insurance companies engage in, are 1) to leveraging physicians–paying an incentive if physicians are able to provide particular preventative screenings, see patients for regular checkups, and other interventions based on patients regularly making appointments at their assigned primary care physicians office; and 2) providing care managers to medical offices, which are staff that are assigned to reach out to patients who use the emergency room for regular care, to try persuade the member to utilize other more appropriate resources, and provide support to utilize these. While there are other, less common interventions developed by health insurance companies in order to address this issue, the great majority of those known and written about are related to these two areas–incentivizing physicians to behave differently, and/or providing additional staff to work directly with patients in order to problem solve what is driving them to frequent, avoidable emergency room visits.

In my own experience of working in the health care field in the US, both with health care providers and with health insurance companies, I have not seen any focus on the position of reception at outpatient medical clinics as a possible point of intervention for this issue. There is no known research around avoidable emergency room usage focusing on receptionists.

This research may indicate that insurance companies may have an interest in the reception staff at their providing organizations in addressing this issue. This research demonstrated 2 different ways that receptionists currently do impact emergency room usage, and

could potentially impact it more, with more resources and focus directed toward the position of reception. First, this research indicated the daily decision-making receptionists engage in, around which patients who do not have an appointment, but present on the phone or in person with a need for an appointment. In this research, the subjects repeatedly discussed patients they would 'squeeze' into a doctors' schedule, or which patients they will advocate for, directly to the doctors in the office, to be seen that day. Second, the subjects all discussed the influence they felt they had on the patients' perception of the friendliness and emotional warmth of the office, and subsequently the decisions patients make to return for recommended appointments.

Health insurance companies could consider leveraging incentives toward processes that support the hiring of skillful staff, lowering turnover of reception staff, including reception staff in health team meetings and processes, or other practices that indicate an understanding of the importance of receptionists in patient outcomes, and a willingness to support receptionists in this work.

Employee Experience Discourse Community

The field of employee experience is broad, including what used to be more commonly called 'employee satisfaction,' and what is sometimes called 'employee engagement.' Employee experience has been shown to be related to customer experience, meaning, to state it simply, that if a business' employees are happy in their jobs, customers are also happy with the business. Likewise, if employee experience is poor, if they dislike their job, often the customers are also dissatisfied with the business. While the field is deep and broad, with enormous amount of research, particularly in the last 15 years, it is possible to summarize what is a generally agreed upon explanation for this connection. When employees of a company are happy, when they like their work and the company they work for, they treat customers much better, which translates to

happier customers. Engaged or satisfied employees also tend to spend discretionary time on work-related matters, both thinking about work and acting on work-related tasks, leading to higher employee productivity and better-quality work from employees.

In the health care field in the United States, there has been an intense focus on employee experience for over 10 years. There is one main reason for this: as stated above, patient experience is related to patient health outcomes. This means that employee experience has an impact on patient outcomes. Health care organizations such as insurance companies, hospitals, community clinics, private medical offices and others invariably measure patient experience because of this. In fact, hospitals in the United States are paid in part according to their patient experience scores, measured by a standardized patient experience survey. Many other medical care organizations are incentivized financially by insurance companies to achieve positive patient experience scores. Relatedly, while pay and other financial incentives are rarely tied to employee experience scores, increasingly health care entities are measuring this as well. Almost all insurance companies, hospitals, and governmental or private community clinic systems measure employee experience.

This study found that women who work as receptionists have mixed experiences as an employee. On one hand, in one of the major themes found, they do feel a deep sense of purpose in their work. A sense of purpose has been shown to be an important part of positive employee experience. On the other hand, the participants in this research also experienced their role as having the lowest status of any role in the office, often feeling unrecognized for the work they do. Similarly, while the women in this study did all report feeling a sense of caring and empathy for patients, they also all discussed their very common experiences with being yelled at, insulted, threatened, or otherwise verbally abused by patients. For health care organizations invested in

improving the experience of their employees, either for its own sake or in order to improve their patient experience scores or patient clinical outcomes, addressing the issues of receptionists' experience is deeply important. Receptionists typically make up about 15% of the staffing of any particular health care delivery entity, a large enough percentage of employees to significantly impact overall employee experience. This research indicates that the two areas that would be most fruitful to address are the issues of low status amongst the health care team and verbal abuse by patients.

The Social Construction Field

As discussed in the introduction, while there is rich writing and research within the social construction field on health care, health care teams and particular health treatments, there is no known research specifically on women who work as receptionists. In fact, the social construction research within medical sciences, while quite varied and deep, largely focuses on the traditional provider-patient dyad and exploring de-constructions of the dyad, and reconstruction of a more holistic definition and understanding of health and health care.

This research stakes out new ground within the social construction research, in two different ways. First, it points to the influence that those who work as receptionists have on patients' health. It explores from the reception staff perspective, the many ways they act as arbiters, messengers, advocates and gatekeepers of patients that may not have been known before or may not have been deeply considered previously. In this way, it may expand what is thought of as the medical 'provider,' the medical team, or treatment, in social construction literature.

Social Justice Implications: Feminism

This research has implications for social justice discourse communities, including the social justice research and discourse communities. For the social justice communities engaged in advocacy and political movements, this study also has implications.

This study can inform social justice work, especially groups and organizations that advocate for women's equality. There are three main areas where this study intersects with historically feminist areas of advocacy and focus: First, low pay and low prestige work for women, and relatedly, invisible labor; second, emotional labor and the unpaid and unacknowledged work related to this; and third, women experiencing repeated verbal abuse.

Regarding low pay and low prestige work:

The women who participated in this research are part of a larger demographic that has some of the lowest pay of any group. While women continue to make 70 cents to the dollar for men, women of color make only 60 cents (Sanchez-Hucles & Davis, 2010). Over half of the women interviewed in this research talked about the hardship of the low wages they receive for their work. Tellingly, the women who talked about this were those who had children, while those who did not mention low pay did not have children. It is likely that low wages may be sufficient for living for those without children to support; however, with children to support, the low wages are starkly insufficient, causing deep stress to these women. They all indicated that the role of a receptionist was the lowest prestige position in a medical office, and two of the women studied connected the low pay with the low status. This is consistent with research and with feminists who have long proposed that fields, jobs and positions where the majority of workers are women, are the lowest paid, and have lower societal status. This is also true for the positions that

are held by a majority of women of color; those positions and fields earn even less. Relatedly, the labor of a receptionist is largely invisible and unpaid.

Unpaid and unacknowledged emotional management work

The unpaid and unacknowledged labor of managing the emotions of patients in the waiting room constitutes the majority of work the women in this study talked about. Reception staff, including the women in this study, do engage in various tasks. For example, they are in charge of 'checking patients in,' which entails putting all of the patients' information into the computer system so the medical assistants and doctors know the patient has arrived; they are in charge of insurance verifications (in the United States), which entails calling or visiting a website to confirm the patient does indeed have active insurance and what the co-pay is; they are in charge of answering the phones in most practices in the United States, and specifically at Family First Medical Care, and they are in charge of greeting everyone who arrives, and directing them to where they should go, to sit in the waiting room, to go back to talk to the doctors (in the case of pharmacy representatives), to pick up the bio hazard material, or urine samples, etc. These tasks make up what is considered the acknowledged job of reception staff; these are the tasks that are written into job descriptions, that are explained to receptionists when they are hired, as their main tasks, and the areas that receptionists typically receive training and instruction in. However, this research and supporting research referenced in the literature review, indicate that one of the primary jobs of reception staff, interacting and managing the emotions of patients, is rarely one that is acknowledged, indicated in job descriptions, discussed during interviews, or that they receive training or support on. This work is the unacknowledged work of reception staff. Additionally, receptionists unpaid and unacknowledged work includes managing their own

emotions at all times. This is sometimes called emotional labor, a term that was first coined by the sociologist Arlie Hochschild in her 1983 book on the topic, The Managed Heart. Emotional labor refers to the work of managing one's own emotions that is required by certain professions. All the women interviewed discussed this factor–the day in and day our work of managing their own emotions in order to smile and continue to treat patients kindly, regardless of how they felt. All the women described doing this repeatedly, even when patients are rude to them, raising their voices, or even insulting them. While men too, in public-facing positions, likely engage in this as well, women have a higher societal burden of expectations on them to be 'nice,' regardless of how they feel. In addition to emotional labor, all of the receptionists describe engaging in invisible and unpaid labor, including thinking about patients after they went home at night, writing lists of things they needed to do the next day to follow up on patient issues, texting one another or other office staff about patient concerns, and staying on the phone with patients who are upset, sad, or scared, which is both emotional labor and invisible and unpaid labor. For feminists who research, write and advocate in this area of women's unacknowledged and unpaid labor, this research would indicate that this area, receptionists in medial settings, bears focused attention to intervene on its invisibility.

Women as victims of abuse

The third area with social justice implications is the frequency in which women who work as receptionists are yelled at or insulted. As stated in earlier chapters, other research has found that over two thirds of receptionists in medical offices have been yelled at, threatened or otherwise verbally abused, both on the phone and in person. While I use the term verbal abuse, and in a marital or romantic partner relationship this type of behavior would be called verbal

abuse even in the dominant discourse, the behavior was not described with this term by the participants in this research. This is in fact consistent in health care settings, in my own experience. In my 20 years of experience in large primary care settings, the routine verbal abuse of receptionists is considered a normal part of work and is largely unnamed and unaddressed. This is consistent with how the subjects in this study described it, often stating that it was 'part of the job.' None of the receptionists described these incidences as verbal abuse, or by any other phrase or word that would indicate its seriousness. The verbal abuse is so routinized and normalized in the system, often there is no tracking of incidences, follow up with those who perpetrated the abuse, de-briefing protocols with the victims, or training on how to safely disengage and get help when it is happening. This lack of naming, tendency of the system to ignore or downplay its damage, and common refrain from the victims that it is 'part of the job,' has similarities with domestic violence before 1980.

This way of relating to verbal abuse within health care settings has similarities with violence against women in other workplaces, especially those where the jobs are poorly paid and the job status is considered very low, such as domestic workers and hotel maids. Often women in these positions do not have agency to quit their jobs, due to poverty, immigration status, or other fears. It is uncommon that women in these fields report complaints of abuse to those above them for the same reasons–in this sense, the 'part of job' refrain that the research participants espouse, can be seen as a rationalization for the lack of response, acknowledgement, action or protection provided by the employer. The verbalized acceptance of this abusive behavior as 'part of the job' could be seen as the reception staff taking on the employer's perspective, in the same way that women who are the victims of domestic violence sometimes take the abusers perspective that it was their fault, or that they could have done something different to prevent the abuse episode

from happening. As the focus and subsequently the dominant discourse around the abused women who work as hotel maids has increased in recent years, so too perhaps can this research help in elevating the abused women who work as receptionists experience further into the dominant discourse.

Social Justice Implications: Race and Ethnicity

This study has many interesting learnings for social justice discourse communities, specifically around race and ethnicity. While I began this research sure that race would be a significant theme, in the process of interviewing the women, and interpreting the data, it has become clear that the implications are far different than what I had expected.

Because all of the women are what I had termed 'Latina'–meaning, they had been born in Mexico, or their parents had been born in Mexico, I had predicted that the question I asked about race over 90 percent of medical receptionists in the US are women. Of this figure 80% of the receptionists are women of color in California; reception is typically low wage work–what do you think about this? I predicted that themes would emerge about the connection between status, pay, race and gender, with general agreement that implicit and structural racism play a part in ensuring that the majority of low wage work is done by women of color in the US. Instead, what emerged was a fundamental lack of agreement about the terms of my question. For example, Alma Laura, who was born in Mexico and came to the US when she was 12, responded at length about how unjust this was, how it was rooted in the history of oppression and racism of people of color, then continued to talk about slavery. I clarified with her what she understood when I said people of color; she stated this meant 'black people, African Americans.' She went on to talk about the sadness and anger she feels about how they are treated in the US. I asked her who she

considered ‘white.’ She said she considers herself white, because her skin is very pale; she considers her husband Mexican, because he only speaks Spanish and does not have citizenship. She said her son, whose skin is darker than hers, might be considered Mexican too. It seemed to me that her social construct around race differences were about skin tone. She asked me at one point: ‘Do you consider Dr. Gil white?’ Lisa Gil is one of the physicians at the office, with very light skin; both her parents were born in Mexico; she grew up speaking Spanish and English in the home. Her skin is light. When I returned the question to her, she said Dr. Gil was white, but Dr. Diego was Mexican. Silvia Diego was born in Mexico and came over as a teen; she is darker in skin tone that Dr. Gil. Pao, used the term ‘American’ for those who in the dominant discourse are considered ‘white,’ despite the fact that she was born in the US, she did not refer to herself as ‘American.’ She said multiple times ‘I’m straight-up Mexican,’ because her parents spoke only Spanish and were ‘traditional Mexican’ in values and parenting styles. She spoke at length about ‘American’ women who she worked with in fast food organizations, were ‘entitled’ and ‘their parents were entitled’ for them. Her definitive distinctions around race and/or ethnicity seemed to be around cultural norms and attitudes. Cynthia was born in Mexico, and disclosed in the interview that she was undocumented, without legal rights to be in the United States, as she was brought over to the US when she was a child. She talked about Alma Laura being ‘Mexican’ because she was ‘traditional,’ and her parents and siblings being Mexican, while she identified herself as ‘American,’ and shared that she didn’t relate to her family’s norms and values around jobs, which she summed up as ‘get a job, don’t ask for more, be grateful and keep your head down’ while she felt she was achievement oriented and ambitious, attending college with her sights set on working professionally with autistic children. She said her family thought she was entitled, sometimes selfish, and risk-taking. Similar to Cynthia, she seemed to define race around

cultural norms and behaviors. Melissa, who has the darkest skin of any of the women studied, also responded to my question about women of color as if I was talking about African Americans only. I clarified with the term 'Latina' and 'Hispanic' (Those from Latin American countries and Spanish Speaking counties, respectively, which Mexico is both), and she waved the race part of the question away, focusing on women in lower wage jobs, and talking about her estranged husband and his lack of respect for her 'little job' at the clinic. Jessica was born and raised in Mexico, migrating to the United States as a teenager. She said she and her husband are Mexican, but her kids are American, due to being born here. Her definitions of 'women of color' were women who had been born in non-United States Countries. Mari's mom and dad were both born in Mexico; she was born here. She grew up speaking English and is the only women interviewed who does not speak Spanish, although her mom and dad are bilingual. She has very light skin and considers herself 'white.'

Because of the lack of agreement on the definition of race, my question asking these women to reflect on the role race might play in the low status and low pay of their positions was not effective in the sense it was intended to be; I assumed the question would be received as if I was talking about them; instead, they assumed I was talking about other women of color.

Although the question wasn't effective in the sense it was intended, it did provide rich data, with detailed disclosures of how these women thought of race, ethnicity, culture and the labels that accompany those things in the dominant discourse. There responses gave weight to the framing of race as a social construct, that there is no biological, physical or other objective marker to define race. Instead, race and ethnicity are constructed within the context of relationships. It is difficult to define white, even within the dominant discourse. It is easier to talk about what the dominant discourses define as 'not white,' Having skin darker than a particular

tone is ‘not white’ (suntans not withstanding); being born outside of the US or North Western Europe is ‘not white,’ unless you were born to ‘white’ families in British and French settler colonies in Africa, for example. If your parents were born in another country, you might not be ‘white,’ unless those parents were born in north or western Europe. It becomes increasingly untenable to try and define race in these terms, with all the exceptions, conditions and changing divisions.

Reflexivity: During the same period, I was interviewing these women, talking about race and ethnicity, my 10-year-old son was writing a report about the Tlingit Indians from Alaska. He was reading the last paragraph to my husband and I, and a sentence that read ‘my family is Alaskan, that is why I chose the Tlingit to report on….’. My husband said, ‘I’m not Alaskan. I wasn’t born there.’ I mentioned to my son that my daughter was born there, but only lived there for 3 months, so I wasn’t sure if that made her Alaskan. I was born and raised there. I left when I was 35. My parents went to Alaska before it was a state and raised all their kids there. They moved after 40 years. My husband was adamant that my daughter and I were born there, so we were Alaskan. I said I wasn’t sure just being born someplace made you able to own it as your heritage. My husband had moved there in his early twenties and lived there for 20 years; he felt deeply a part of Alaska and loved it like a person. My parents had migrated as homesteaders and built a life there; my dad helped build the pipeline, bringing us pieces of the scrap steel when he came back into to town for breaks. My parents obtained their pilots license, bought a float plane, and spent time in the ‘bush’ frequently. They raised 3 children there. I said I felt like my husband and parents were as Alaskan as my daughter, or more so. My daughter chimed in that likely only the native peoples were really Alaskan–when we asked her why, she said because they had been there the longest, migrating over from Russia, and were a different ethnicity, although she

struggled with circular definitions in trying to define ethnicity. The conversation finally came around to the fact that we've been in California for 15 years, and do not identify as Alaskan at all anymore–too many years since we'd lived there. I realized that we were going through all of the changeable, ambiguous, socially constructed, permutations of what is considered citizenship, race, ethnicity and national identity: where was one born, how long has one been there, where one's parents were born, does one embody the constructed cultural identity of the place sufficiently, what someone's physical features look like, and if one chooses to leave, and live elsewhere. My son was left with no agreement from us on the construct of 'Alaskan,' just as there was no agreement on 'women of color' from my research subjects.

This implication seems potentially very significant for researchers in the area of race, and race identify, those who work in advocacy and social justice work, and those who work in public policy and politics. The findings of this study suggest that the language that is used in these fields to describe people of color may have significant impact on how the very people the field is describing may not relate, may not see themselves, in the work. For example, many social justice organizations in the United States have the word 'color' in their title. 'The Color of Change' is a social justice organization devoted to advocating for people of color; 'The coalition of Communities of Color' is another. It seems plausible, given this research, that some of the subjects I interviewed would not perceive that these organizations were advocating for them, despite the fact that the women would be explicitly included by the organization's advocacy efforts. Similarly, public policy and legislation in the United States often uses the term 'person of color' when defining specific policy or legislation that effects this population. The findings of this study suggest that it shouldn't be assumed that these people or communities think they are part of the legislation or specific policy.

Social Construction Discourse Community

The dominant discourse around medical care has defined treatment as something a physician hands to a patient. It is a medication, a diagnosis, a procedure, recommendations or even a referral. It is a concrete action taken by the physician and acted upon the patient. The social construction field has a large body of research, writing and thinking around de-constructing, and re-constructing aspects of this. For example, there is robust research and other writing on the social construction of diagnosis in general, and particularly mental health diagnosis. There are other bodies of research and writing on the social construction of health, weight, body shape and disabilities. There are many researchers, authors and thinkers who have delved into the social construction of the patient as a passive object, and the doctor as an expert. The literature within social construction on narrative inquiry and collaborative care within the health care settings is rich and robust, representing a significant counterbalance to traditional medical sciences constructs. There is virtually no previous focus within these areas on the ubiquitous reception staff in all medical services. This research may have implications for the social construction discourse community, in broadening the focus of the social construction writings and research around health, to include all people involved health care interactions–to essentially step outside of the (likely patriarchal) dominant discourse that places doctors at the center of all constructions and deconstructions around health. This research may influence the social construction community in considering those who have been invisible in health discourses, or have been considered at best, supporting cast member, to be worthy and important areas of study in and of themselves. There are also implications for the social construction research and discourse specifically around narrative inquiry, collaborate care, and other non-traditional

practices in health care, in that this research may indicate a need to broaden the focus of who might be considered part of the 'treatment team' to include everyone that people as patients interact with in the health care delivery system.

The Bias Discourse Community

Bias can be defined as a cluster of negative attitudes and beliefs about particular populations, conditions or characteristics. The field of research around bias is quite large; there has been a substantial amount of research on racial bias in particular in the last 60 years. One of the most famous early studies on bias in the Unites States gained national attention during Brown v. Board of Education, the landmark 1954 case that eventually overturned "separate-but-equal" segregation in the United States, where the supreme court Justices contemplated oral arguments and pored over case transcripts. They also considered black and white baby dolls.

The dolls were part of a group of groundbreaking psychological experiments performed by Mamie and Kenneth Clark, a husband-and-wife team of African American psychologists who devoted their life's work to understanding and helping heal children's racial biases. During the "doll tests," as they're now known, a majority of African American children showed a preference for dolls with white skin instead of black ones—a consequence, the Clarks argued, of the pernicious effects of segregation. The dolls and related research are largely credited with the ultimate prevalence of Brown in the court case, paving the way for de-segregation of schools in the US. Since then, there have been thousands of studies on racial bias, which has resulted in an increasing understanding that implicit and explicit bias exist and have significant negative implications for people of color. Specifically, bias research in the medical sciences has found that people of color suffer worse health outcomes for most health care conditions, and much of it

can be traced to physician bias. Recently, there has been much publicity about the research showing that African American women had (Dominguez, 2011) worse maternal and child health outcomes. When controlling for other variables, bias has been shown to be the causation of this.

Other areas of study within the bias field relevant to this research is the study of bias towards particular health conditions, such as chronic pain, addiction and mental illness. Sometimes called 'stigma' in the research, it has demonstrated that people with these conditions suffer worse health care outcomes, due to bias toward these conditions, and those who have them (research here). When both areas of common bias are combined and a person of color has chronic pain, addiction or a mental illness, health outcomes are deeply negatively affected, with research showing gaining access to care is worse, the quality of care received is worse, and health outcomes are worse.

Bias is typically conceived in the research in two areas, implicit and explicit. Implicit can be defined as beliefs and attitudes that may be unconscious, or even sub conscious. They deeply influence our decision making, yet we are not aware of them. Explicit bias is negative beliefs and attitudes that are conscious; we are in fact, aware of them. We can identify our biases, talk about our biases, and also choose to attempt to alter, counter, negate or otherwise mitigate them, or if we agree wholeheartedly with them, we can choose to keep them, support the attitudes and beliefs with evidence we see.

Explicit and implicit bias thrive where there is high autonomy, and low guidance in decision making, making it particularly relevant to this research.

This research supports existing research on receptionist discretionary decision making in the area of access (research here, from lit review); it found that receptionists made decisions about which patients to refer to urgent care or the emergency department, and which patients to

attempt to work into the doctors' schedule. Receptionists are gatekeepers for the practice and this role is both implied and explicitly given at the direction of the physicians, in most practices. While some training or decision making supports are typically provided to those who work as receptionists, the training or decision making supports rarely cover all possible inquiries and situations, and this gap between decisions that are already made through given instruction, and those that are not, is where this discretion lies. In this research, receptionists repeatedly talked about making decisions on the phone and in-person, about whether to deny the patient an appointment when there was none open, or instead, to advocate for the patients to be 'squeezed in' the doctor's schedules, going so far as to plead with the doctors, efforts which they described as generally successful. In this research, there was no articulated structure in which these decisions are made, no mention of decision-making supports, and no indication that there was agreement between the women who worked as receptionists on how these decisions were made.

In this atmosphere of autonomous decision making, with little to no decision making supports from the practice owners, the women in this research described making decisions in a variety of ways, for example, denying a patient an appointment because the patient referred to one of the doctors by her first name 'Silvia.' The participant expressed irritation and judgment that a patient would do this, and explicitly made a decision to turn the patient away, rather than advocate for her to be seen. Another example of how seemingly random the decision making can be was described by one of the women who said she related to the women as a mother, as a mother who was concerned about her child; the participant described thinking about the woman and the child having to wait in an emergency room for hours and opted instead to advocate to the doctor to see the child, in fact insisting that it was important, and the doctor relented.

This atmosphere is one where implicit and explicit bias thrive. In the examples above, it is easy to see that the women who work as receptionist were making important medical decisions based on their feelings about the patients. This research found that almost all decisions that were made by receptionists around access to the doctors were made from emotional responses to the patients themselves. The receptionist's biases, then, are a substantial part of their decision-making process, both explicitly and implicitly. In the examples from the research, Cynthia has a negative view of someone who would use the first name of a doctor; this she was conscious of. The patient may also have been a race that Cynthia had implicit negative bias towards, resulting in her being angrier about the perceived transgression. Similarly, Alma Laura's advocacy for the child to be seen was explicitly about her empathy with the mother; it is possible the woman was also of a race or ethnicity that Alma Laura had positive implicit bias towards, adding motivation for her to ensure the child was seen. Gaining a detailed understanding of the role of bias in the role of reception in medical offices will likely provide a deeper understanding of the many micro-interactions and decision that contribute to poorer health outcomes for those who are historically stigmatized, such as non-white ethnicities, those with addiction or severe mental health conditions.

The placebo and related mindset research and discourse community

This research has meaning for the placebo discourse community, including those working in placebo-related research. The placebo related research is largely research about how we think about things, how our mental constructions of any object or person influences how our bodies emotionally and biologically respond to that particular object, person or service. This is sometimes called 'mindset' research as well. As discussed in the introduction and the literature review chapters, it is clear from the current research in these areas, that how 'treatment' is

thought of, how it is socially constructed, directly influences how we respond to that treatment in many different areas. There is existing research on how patients' relationships with doctors influences how they consider the treatment recommendations, as well as the treatment itself, including medications and procedures. This research, in its findings that reception staff engages with patients directly and routinely around how they are thinking about their confidence in the doctor, the doctor's recommendations, their experience in the office, including whether the patients are 'cared' about or not, likely indicates that the reception staff is also an integral part in the social construction of the meaning of the treatment. In this sense, this research broadens the lens of how this discourse community has considered what influences mindset in health care settings.

Areas of Further Research

There are many findings in this research that bring to mind research that could further explore the themes surfaced in this research.

Further research on the perceived status of reception staff

The finding that receptionists experience their role in the medical office as one of low status and low respect**,** both from patients as well as from doctors and other members of the health care team, such as medical assistants and nurses. Further areas to research in this area that may be fruitful and enlightening would be around how the other health care staff do, in fact, perceive of the reception staff. Is the reception staff correct in their perspective of how they are thought of? Similarly, research from patients' perspective, in how they too, in fact perceive of receptionist's status, and whether this is concordant or discordant with what the participants in this research experience. Another area related to this that would be of interest might be what

aspects or variables contribute to this perception of low status–for example, what influence does the geographic separation from the 'back office' have on the construction of receptionists as low status?

Further research on the verbal abuse so commonly experienced by receptionists. The findings in this research were concordant with my expectations that all receptionists had been verbally abused, and that, in fact, this was a fairly common occurrence. The existing research indicates that two-thirds of medical receptionists have been verbally and sometimes physically abused or assaulted; however, in my experience working in medical settings for the last 15 years, I have not met a single reception staff who has not experienced being yelled at, insulted, and threatened. I suspect that at least a portion of the one third of receptionist in that research (Dixon et al., 2004; Magin et al., 2009) who did not endorse being the recipient of verbal abuse may have had a level of tolerance to this type of treatment, which led to them not classifying it has abusive. None of the receptionist staff in my research used the word 'abuse,' and in fact, the majority of them characterized the abuse as 'part of the job,' attributed many sympathetic reasons for the patient behavior (for example, that the patient is scared, they have a lot of stress, they had to wait so long), and at least two of the subjects seemed to indicate that verbal abuse was their burden to manage–that they felt as if it was their responsibility to 'let it go' or 'let it roll off your back,' and not 'take it on.' Because of my experience in working in medical health care settings and my familiarity with the frequency of patient yelling, insulting and threatening staff, I was able to describe what I meant by 'patient anger' and 'verbal abuse' specifically, and in this way I think all of the women I interviewed were able to recognize this

and endorse it. I imagine that another researcher might have labeled the angry behavior in such a way that the reception staff did not recognize it.

Further exploration into reception staff's experience of this angry behavior of patients is warranted to better understand the problem, the nuances, and the possible solutions to this. The research on the problem is minimal; only the research cited in this paper was found. Further research could explore in depth the frequency and depth of the problem; the differences found in different settings, or different types of practices; the nature of the problem, understanding what proportion of angry behaviors are yelling, which are insults directed at the practice and insults directed at the receptionists; what proportion of the angry behaviors are threats, and what the nature of the threats are. Additionally, research could look deeply at the patterns of abuse, including particular cultural norms of the office, or specifically, norms in the waiting room. All of these questions could be explored from multiple perceptions–the reception staff, the patients, and the practice owners or leaders.

Another area of interest and possible exploration is around the physical setting. For example, what are the differences in this behavior between different settings? Different types of health practices, small ones, very large clinics, rural versus urban located offices, those with low wait times or high wait time; social justice questions such as: do male receptionists experience similar levels of verbal abuse as women? Do different races and ethnicities experience different levels or frequency of verbal abuse?

Other research questions that could be explored would be: What ameliorates or decreases the frequency and level of this behavior? Do changes in the physical environment make a difference? Does wait time or other practice factors make a difference? Can receptionists make a

difference by initiating and mitigating different types of relationships with patients, responding to angry patients in particular ways, or engaging in dialoged differently?

Research on the role of conscious and unconscious bias

This research finds that receptionists make autonomous decisions about which patients to provide access to the doctor. These decisions are typically unguided, made without decisional supports. Receptionist staff decide who not to advocate for, which patients they do not 'squeeze in,' or those that they do not bend the schedule for. Bias, both implicit and explicit, likely play a role in these decisions. Further research to explore specifically this area, engaging people who work as receptionists in qualitative exploration of their own known biases, and cross referencing those with patients given, and denied, access to the doctor. Implicit bias of reception staff could be studied through the use of implicit bias detection testing and referenced with patterns of giving and withholding access to care. There is currently robust research on bias adversely affecting treatment outcomes of historically marginalized populations, such as people of color in the United States; there is less understanding of the exact mechanism by which bias is expressed, and of when bias alters particular treatment trajectories. Further research in this area of reception staff's role in increasing or decreasing access to timely care could add significantly to our understanding of the intersection between bias and poor health outcomes.

For those invested in a more compassionate, humanistic world

It is understandable if perhaps our motivation for having positive relationships with those who work in reception positions is because we understand they are more likely to pass on our messages to physicians, return our phone calls and squeeze us in for appointments; health

concerns bring up fear in most of us, and self-centered and self-protective behaviors are often an outgrowth of fear.

There are other, more humanistic reasons for developing positive relationships with those who work in receptionists' positions in medical offices. This research indicates that the work of reception staff, specifically the relational work of engaging with others' sometimes intense emotional states, can be heavy, difficult, and sometimes even abusive; it can also be rewarding. This research indicates that reception staff largely takes their cues from us, as patients, about how to interact with us. As compassionate humans, we can make efforts to 'see' those behind the desks in our medical clinics as real humans, and engage with them human to human, as opposed to objects. This is easier than it sounds; most of us have been conditioned to see those we love as real humans, and everyone else as 'unreal others', as Tara Brach (2016), the Buddhist psychologist writes. This construct is particularly strong when the others are in roles that constrict their humanity–wearing uniforms, having no name tags (literally no name), sitting behind a desk, etc. This construct is strengthened when people are in roles that are unequal in terms of societal hierarchy; for some, receptionists may be 'below' them, someone who is there to serve the doctor, and them. For some, the receptionists might be 'above' them, someone who has the power to control access to the doctor, the uniform and desk signally authority over.

For us when we are patients, engaging with those who work in reception human to human might look like making conscious efforts to make eye contact, to greet them with a salutation, to smile, and to engage in 'connecting talk,' which is sometimes referred to dismissively as 'small talk.' When the term 'small talk' is used, it is often framed as a shallow social requirement. When we engage with others who are in service positions in brief conversations about typically culturally neutral subjects, such as the weather, one of the more common examples, it often has

the effect of momentarily breaking us both out of the social roles associated with that social positioning. The transactional, task focused nature of most service interactions strengthens unspoken power imbalances and social roles; it decreases our ability to see others as real people, and others ability to engage with us as real people. Engaging others in connecting talk frequently alters these power imbalances and can momentarily lift the rigid social roles, setting a foundation of sorts for a moment of connection between two people. To use one of the more common examples of connecting talk content, we could walk into a physician's office, a café, the post office, or the grocery store, and instead of exchanging solely information specific to the business transacted: 'Can I have an Americano?' or 'I have an appointment today,' we could purposefully add in connecting talk: 'It is so cold today!' even a question 'so busy today–how is that for you?' This may not spark a moment where hierarchies and roles disappear for a moment, where we 'see' someone else as our daughter, our father or our niece–but it may. Another, similar practice is engaging in 'purposeful compliments,' which is the practice of looking closely at someone for something we like, admire, respect or enjoy, and sharing this with them, to demonstrate goodwill, empathy and a desire to interact on a humanistic level. This practice, like connecting talk, can take a bit of repetition to feel comfortable; often it involves the presence to notice the other person, a quickness about identifying something we like, and an ability to translate this into words, and verbalize fairly rapidly. Some examples of purposeful compliments I engaged in this morning: to a women working at the cash register of a café 'I like your nails!' which triggered a short exchange about how excited she gets for holidays, as she has her nails done in holiday themes and colors; to the man at the grocery store register today 'you are really fast at this,' which led to an exchange about how long he has been working in his position, a job he said he took to provide health insurance for his children.

I have imperfectly engaged in these practices regularly when I am interacting with those who are in service positions in my daily life. Sometimes I forget, I fall into the trance of unreal others, and revert to performing in my conditioned role, and almost invariably, the other person does the same. When I am consciously practicing though, and I smile at someone behind a desk, and let them know I like their necklace, it is as if the glass partition, literal or figurative, has disappeared. It is a few moments in time when we see each other as human. Multiple interactions like this a day feel like it warms the world, the whole community I live in. My 14-year-old daughter told me her goal is to compliment every single service worker she interacts with. She says the goal forces her to look for what she likes, and ensures she always finds it.

The social construction of doctors as the important people in any given health care interaction, conversation about health care, or health care writing dominates us all; it has been the dominant discourse and narrative of books were read as children, movies we grew up on, and reinforced in most of our families, school, society and culture, almost invariably. In research replicated year after year, 'doctor' is the profession with the most respect and status associated with it. In fact, 8 of the 10 most respected professions are different types of doctors (Dolton et al., 2018; The Harris Poll, 2016). It is understandable why we may have hierarchies of importance in our minds when we go to a medical visit; it makes sense that we may reserve our best behavior, or friendliest self for the doctor, and that we may mask unpleasant feelings, such as our irritation at the wait, in front of the doctor. This research may serve as encouragement for all of us to become increasingly conscious of the hierarchy of importance in our mind when we are in health care organizations and increase our willingness to really see and engage with all of the staff we come into contact with, including those who work as receptionists.

Conclusion

Overview of the Dissertation:

This research introduces the subject of the study, receptionists' experiences of their role, and their experience of their relationships with patients, contextualizing this subject within the existing health and medical sciences literature, as well as the health related social construction literature. The introduction stated the problem this research was hoping to address and gave an overview of the methods utilized in this research. I reflected on my dual role as a health care worker, and as a researcher, and the considerations around this.

The literature review gave an overview of the literature related to this, including the social construction of health and health care; how our experience and appraisal of health care impacts and influences our health; the relationship with health care providers as a primary driver of this experience and appraisal; and specifically the importance of the perception of empathy from health care providers in this appraisal. The literature review also addressed the fact that most of the research around this relationship has been on the physician-patient relationship, largely ignoring other members of the health care establishment, particularly receptions. The review went on to share research that demonstrates the importance of reception staff on patient experience as well as the level of complexity of their work, their potential and actual influence on patient health, and the lack of training or support they receive in their roles. Lastly, the review looked at the research around race and gender within health care workers, and specifically for receptionists in the United States, and the pay and status implications.

The methods section discussed qualitative research methods, specifically phenomenology informed methods, as the chosen approach for this research. A reflexive section discusses my own evolution during the process of this dissertation, which influenced my decision to forego my

initial proposal of including more quantitative methods and measures, and instead decide to only use interviewing. A summary of the decision making between ethnography and phenomenology informed methods was shared, as well as a discussion of the specific method used in the research: narrative interviews. Reflections on my own role as a researcher are outlined, including my relationships with the subjects, and with their place of employment.

The findings chapter shares the rationale for organizing findings into themes. Included in this chapter are also reflections on including a short self-defined biography of each of the subjects, in their own words, and what I hoped to mitigate in doing so. Findings are shared by theme, with six themes total, and sub-themes within each theme. Each theme is summarized, and extensive quotes that support the theme are included. Other data that was gathered through informal and observations were also included.

The discussion chapter is organized into three main sections: Limitations of the research, implications of the research for different discourse communities, especially those referenced in the introduction and literature review, and areas for further research. In the discussion chapter are my own reflections on my role as a researcher.

Reflections

This dissertation has been in some ways a record of my own intellectual, academic, professional journey for the last three years. When I began at the Taos Institute in 2016, I had not heard of social construction. When I started classes and began reading the leading and most influential social construction texts, I felt as if in some ways I was seeing the academic and intellectual validation of what I have always felt, that knowledge is a product of a particular time, a particular place, and particular groups who are the dominant voice, who declare what is 'true.'

While this felt like a breath of fresh air, I was still heavily conditioned in the dominant culture, as well as the medical model, and this was apparent in my original proposal, in which I suggested pairing narrative interviewing and other social-construction consistent methods, with more quantitative measures. When she questioned it, I argued to my Taos advisor that this was necessary in order for the research to have any relevance in the traditional medical sciences literature, which I felt strongly aligned, having been steeped in it, and the worship of it by those of high status around me in my professional life for over 25 years.

I came to her initial perspective myself, over a period of 2 years, between reading, writing and studying social construction and related literature for the first 2 chapters of the dissertation. My decision to let go of the quantitative methods of this dissertation came to a head when I began constructing my research protocols; I just couldn't seem to resolve my interest and curiosity in women who work as receptionists as people, and the quantitative methods that consistently placed them as objects, as being evaluated by another's perspective. I realized that I could not do both; that only by letting go of all other perspectives could I become agenda-less, in order to free my mind to listen and see who they are and what they were telling me.

In concluding this dissertation, I feel my decision yielded a deeper and more meaningful research process, as well as more meaningful findings; I continue to have residual feelings of sadness of some sort, in letting go of the perspective of the dominant discourse. I suspect this is likely due the ease of status and respect that tends to accompany dominant discourse perspectives.

I'm deeply grateful to all the receptionists I partnered with in this study, to the Taos Institute and the work they do, and to Blanquerna for their genuine interest in my proposal, and their consistent support of my academic work.

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APPENDIX I Research Materials

Questions for Interview #1

1. Tell me about your experience as a receptionist.
2. How do you see your current work as a receptionist, in your life?
3. Please share with me your experiences, thoughts and feelings about your role and relationship with patients.
4. What is the toughest part of your relationship with patients?
5. What is like being the patient or family member of a patient at another medical office, when you are in a different role with a receptionist?
6. What impact, if any, do you think you have on patient's health?
7. Receptionists are overwhelmingly women and women of color in California. What do you think of this?

Questions for Interview #2

8. Please share about your relationship with the health care team (prompt around status questions if needed)
9. Please share with me how you might describe yourself; for example, what are your most marked characteristics, and what is most important to you?

June 1, 2019

Dear FFMC Receptionist:

I'm writing to you today to ask if you would be willing to be part of a research study I am conducting.

I am a doctoral student (obtaining my PhD) at the University of Blanquerna, in Barcelona, Spain. My research is on medical receptionists' experiences. The title of my dissertation is: 'Re-constructing the Receptionists Role in Health care'.

I'm interested in this because during my experience working as a therapist in primary care settings for many years, I've come to believe that receptionists are likely the most important member of the health care team, in terms of patient care. However, it is very uncommon to see any research focused on receptionists, and there is even less research from a receptionists' perspective.

For my research, I want to interview receptionists who work at Family First Medical Care (all of the receptionists who agree) 2 times between August and October. The interviews will be taped so I can transcribe them for analysis. The interviews are totally confidential, only me and the person who transcribes the tapes (a hired typist) will hear the interviews.

The interviews will not be included in my dissertation, only the analysis of the interviews will be. Your real name will not be in the dissertation, nor will any identifying information.

If you agree to be interviewed, I would like to offer a $30-dollar gift card to someplace of your choice for each interview, to compensate and thank you for your time.

The interviews can be done anywhere that is convenient for you. They can be done at Family First before or after your work, or during the lunch hour. I can also come to your home, or we can meet at another location, whichever you prefer.

Please let me know whether this is something you would like to do, as soon as you can. If you have any questions, you can email me at ecm_milo@me.com, or call me at (209) 769-3923.

Thank you!

Elizabeth Morrison