MEDICAL PRACTICE

Hospital Topics

The Hospital Consultant's Secretary

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British Medical Journal, 1972, 3, 456-459

Summary

Analysis of work done by the secretaries attached to one medical unit in a general hospital showed that much was discretionary in character and entailed making decisions. Work in the unit was made easier and more efficient by this intelligent use of initiative by the secretaries. At present the pay given to medical secretaries in hospital is below a level that would be commensurate with their responsibility.

The professional and managerial roles and functions of hospital doctors and nurses are being delineated with greater clarity. Some of the factors influencing ward sisters' attitudes and the effectiveness of their work have been shown by Revans.¹ The Cogwheel report² made doctors and nurses more aware of the managerial functions they must exercise in hospitals. These roles have been examined in a number of papers.³⁻⁶ One study at least has shown that many consultants are willing to take part in the diagnosis and treatment of organizational problems arising in hospital.⁷

The study of roles and attitudes in one group of people in an enterprise usually shows their interdependence on other people in the same institution. Many people besides doctors and nurses make an essential contribution to the team work of patient care and perform functions without which the modern hospital could hardly operate. The importance of client reception, for example, has been confirmed.⁸ In the course of studies undertaken as part of the Hospital Internal Communications Project^{9 10} awareness of the vital function of hospital unit secretaries became manifest. The initiative of two consultants in charge of a joint clinical unit at a large general hospital brought about the present study of the work and responsibilities of their secretaries. It was felt that the study should be made objectively and in depth by an outside agency with the appropriate expertise but not involved in hospital work.

The study was performed in two stages during 1968-70; the first by J.F.R.I. and D.A.W., and the second by J.H.G. and R.A.F.H. The two whole-time consultants, with their secretaries' consent, offered their general medical unit for the study. The unit of 60 beds had an interest in one specialty. During the three-year period an average of 1,408 patients, mostly admitted as emergencies, passed through these beds annually at the rate of 24.0 patients per bed. In the medical department as a whole (three medical units, 180 beds) over the same period an average of 4,353 patients were discharged or died annually and 24.7 patients passed through each bed. The unit concerned ran four weekly outpatient clinics, one general medical and three specialist. Each year during the study period there was an average of 1,106 new medical outpatients and 4,541 reattendances. Two of the specialist clinics were organized by the unit secretaries.

Stage 1

There was an initial discussion between the two consultants, the hospital secretary, J.F.R.I., and D.A.W. It was decided to try to determine the proportions of time spent by the unit secretaries on various categories of activities and that the study should take

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place over a "representative" period in order to take into account variations in the work load.

Discussion with the secretaries, one full-time and two half-time, enabled suitable work categories to be established. In addition, for a sample period of four days the secretaries were asked to record the approximate proportions of their time which they found were devoted to each category. This enabled the calculations necessary for a sampling study to be made. It was decided to use activity sampling¹¹ as a basis for the study. This is a method of recording the activities of several workers simultaneously by making snap observations at random times. It obviates the main disadvantage of continuous observation in that it allows the workers to perform their tasks with as little interference as possible. About 70 observations were made each day at random times and the activities were recorded under eight categories (Appendix 1). The total numbers of observations under each category were found and expressed as percentages of the grand total of observations. Activity sampling is based on the binomial distribution, and from the formula for standard deviation for a binomial distribution it is possible to estimate limits for the error which is inherent in the percentages for the activities. This error is due to the use of statistical sampling.

RESULTS

Secretarial duties for the unit took in a wide variety of work, much of which was found to be of a routine nature. It included those items shown in Appendix 1 and provided a service for the following medical staff: two consultants, one senior registrar, one registrar, and two house physicians. The secretaries were also in contact with the ward sisters, staff nurses, and, particularly on days on which two of the four clinics were held, patients.

The full-time secretary worked mainly with one consultant, and the two half-time secretaries worked mainly for the other consultant. This arrangement was flexible and the three secretaries so arranged their work that they could be and often were interchangeable. All three secretaries (married women) had been in hospital secretarial work for many years and in their present posts for between 8 and 11 years at the time of this part of the study.

Stage 1 of the study was carried out during eight consecutive working days. During this time observations were made at pre-determined intervals between the normal hours of work—9 a.m. to 5.30 p.m. On several occasions work extended beyond "normal" finishing times, and on all eight mornings work had started well before 9 a.m. The secretaries' general attitude to their work was of a high order; Saturday-morning work on the basis of a voluntary rota to help the working of the unit was an indication of this. The application to work of the three secretaries was virtually complete, being over 95%. This compared favourably with utilization figures found for similar types of work in commercial situations, which may amount to only two-thirds of this degree of application.

The analysis of the study, with limits of error on a 95% confidence level, is summarized in the Table. The results showed

that a high proportion, about 85% of the work performed, was of a routine nature; however, a small but significantly essential part (some 15%) of the work was discretionary in character (parts of columns 5, 6, and 8 of the Table), and without this total effectiveness would have been severely reduced. There was also an element of specialization associated with medical knowledge and terminology and an understanding of the general hospital organization and administration acquired over a long period of time without which the secretaries could not have operated so effectively.

In considering generally the fuller social aspects of the type of service which the unit provided one had to consider, in particular, the contact with the patients and local general practitioners. This contact needs to be maintained in as frank and friendly an atmosphere as possible, consistent with the essentially confidential nature of medical work. General practitioners, met casually, attached importance to these aspects of the work.

The study seemed to achieve its original aim in that it enabled more detailed information to become available about the manner in which secretarial work was disposed in terms of its various categories. That the results were acceptably accurate was substantiated statistically by the sampling limits.

DISCUSSION

This first stage of the study indicated that the unit's secretaries were fully extended, performing a wide variety of useful jobs efficiently. It raised several further points of interest—for example, the impact of the secretaries' work on patients and outside doctors, and the question of what proportion of their time spent on work other than that included in columns 5, 6, and 8 of the Table was discretionary in nature. There seemed at times to be a need for initiative, judgement, and decision on the part of the individual secretary without reference to a superior.

The results of this part of the study were discussed with the two consultants concerned. They believed the relationship between unit secretaries and patients and other doctors (inside and especially outside the hospital) to be an immensely important one, and their direct observation led them to believe that it was a good one in respect of these secretaries. To have obtained independent objective evidence of this would have entailed extended questioning of patients and general practitioners, probably by questionnaire, and this form of study was not feasible at that time. It was therefore decided to investigate the degree of discretion entering into the secretaries' work. This study constituted the second stage of the work.

Stage 2

An investigation of the secretaries' roles was carried out by means of a five-column method of job analysis. This particular technique is an amalgamation of two others—management by objectives¹² and the analysis of prescribed and discretionary content evolved in the Glacier Project.^{13 14} These two tech-

Proportion of Time (as a Percentage) spent on Different Tasks*

Secretary	Activity Category										
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8) Telephone			
	Shorthand	Typing Letters	Typing Discharge Summaries	Typing Copy	Liaison Work	Visits to Wards etc.	Clerical Work	Internal	External Short	External Long	External (Doctors etc.)
A	7.1 ± 2.2	25.0 ± 3.8	7.1 ± 2.2	13.0 ± 3.0	8.9 ± 2.5	9.7 ± 2.6	16.0 ± 3.2	9.9 ± 2.6	1.0 ± 0.9	2.3 ± 1.3	0
B and C	8.1 ± 2.3	32.3 ± 4.1	15.6 ± 3.1	10.9 ± 2.8	5.3 ± 1.9	7.1 ± 2.1	13.7 ± 3.0	4.3 ± 1.7	0.4 ± 0.5	1.9 ± 1.2	0.4 ± 0.5
Overall proportion	7.6	28.8	11.4	11.9	7.0	8.4	14.9	7.1	0.6	2.1	0.2
B	11.8 ± 3.9	33.1 ± 5.6	16.4 ± 4.4	7.3 ± 3.1	8.2 ± 3.2	3.6 ± 2.3	8.9 ± 3.4	—	—	—	—
C	4.0 ± 2.4	31.4 ± 5.8	14.7 ± 4.5	15.0 ± 4.5	2.0 ± 1.8	11.1 ± 3.9	19.0 ± 4.9	—	—	—	—
											10.7
											2.8

* See Appendix 1.

Total observations made during the study period on secretaries A, B, and C were 517, 280, and 252 respectively.

niques are easily combined into one rather more comprehensive method from which the full benefit of both parent techniques is obtained. The five-column method of job analysis was originally prepared and demonstrated for the Ministry of Technology by J. H. G.¹⁵ and subsequently evaluated with satisfactory results by the Civil Service department.

Information is obtained about the roles under study in five columns (Appendix 2). Columns 1 and 5 are drawn from the management by objectives technique, and columns 2, 3, and 4 from the Glacier Project technique. In column 1 are entered the basic objectives and task requirements in the role, and in column 2 the amount of discretion, judgement, initiative, and authority which the incumbent exercises in pursuit of the objectives and task requirement. Column 3 covers any discretionary limits not already clear from the content of the first two columns. Column 4 is substantially different in kind from the first three columns. Whereas the content of columns 1, 2 and 3 purport to describe reality, column 4 is given entirely to noting the consequences, hopefully hypothetical, of the incumbent's performance being inadequate in the opinion of her immediate superior. By inadequate is meant unsatisfactory performance but not gross incompetence. Column 5 contains notes on how the immediate superior would become aware of inadequate performance should this materialize—for example, the feedback on performance and satisfactory attainment of objectives.

RESULTS

The analysis of the secretaries' day by this method showed a substantial amount of work and responsibility which are normal to many secretarial roles. In addition, however, an appreciable amount of judgement was required, with ensuing responsibility in making decisions which were most untypical of secretarial roles. This came out clearly in the analysis when, for example, the need arose for the secretaries to make specific decisions about what should happen when general practitioners telephoned requesting advice about a patient. Various courses of action could be taken; the secretary concerned was often able to decide which one, there and then on the spot. To do this the secretaries needed a certain amount of clinical knowledge and know-how relevant to the unit's work and confidence and maturity in using this to make such decisions.

Examples of unusual secretarial responsibility were to be found in the tasks of acting as a general centre-point for inquiries of any sort that might arise and in dealing with a wide range of human and administrative problems. In column 2 (Appendix 2) a high degree of responsibility was delegated to and assumed by the secretary in respect of parts of her work. For example, the findings recorded in general were: (column 1) she shall act as a general centre-point for inquiries of any sort that may arise, and (column 2) she decides how to handle each inquiry, call, or situation that arises and how to become aware of situations needing her attention. In marginal cases she decides when a situation needs attention. She decides how to keep well informed about the workings of the hospital and the jargon and terminology used. She decides when to draw the attention of the consultant or one of the unit medical staff to any issue or problem she believes he should know about. She decides how to arrange waiting-list admissions. Taking into account staffing difficulties in other hospital departments and the pressure of work generally, she decides how to get her work done quickly and efficiently. To be specific, for example, she decides what interpretation to put on requests from general practitioners and how to deal with them and what questions to ask and how to maintain a good relationship with all doctors, patients, and relatives.

These examples indicated a rather high level of responsibility for a role designated simply as a secretary. The secretaries performed work which in most organizations would be regarded as executive or professional. Consequently, as was found clearly in the content of column 4 in the analysis, the outcome of in-

adequate performance in either of these roles was of a rather graver nature than one would expect from a usual secretarial role.

DISCUSSION

Is the unit efficient? Is the hospital humane? The answers those outside the institution will give will depend on how the unit behaves when approached. Most inquiries come first to the unit secretary. Kindness is basic but efficiency is essential to it. The secretary is the unit's shop window, and the confidence the unit inspires is in great measure dependent on the secretary's work—what she says over the telephone, how she says it, and how expeditiously, efficiently, and kindly she deals with inquiries.

There is still more to it. The high turnover of patients through wards and outpatient clinics depends not only on the secretary's ability to be an efficient shorthand typist but also on her capacity to organize an appreciable part of the unit's work. Acting as an efficient co-ordinator, she assists the work of the doctors and the sisters to a material degree. Her willingness to take responsibility for some decisions relieves doctors and nurses of work.

Secretaries normally carry communications to and from their bosses, but these secretaries to an extent themselves dealt with the issues that arose, acting at times as general administrative officers.

Conclusions

We have shown that an appreciable proportion of the work of the secretaries we investigated was discretionary in character and involved responsibilities and decision making of an order beyond the grading allowed for their posts.

We found in addition that the secretaries exercised degrees of initiative, judgement, and decision without reference to a superior in respect of an appreciable part of their work. This role greatly facilitated the work of a busy general and specialist medical unit.

The method of work of the secretaries and the responsibilities they undertook made an important contribution to an efficient and humane service.

This study was made at the West Middlesex Hospital, Isleworth, Middlesex. We are grateful to the secretaries and staff for their help and co-operation, and we are conscious too of the interest displayed throughout by the consultants concerned. It was largely their initiative that enabled this work to be presented as one paper.

Appendix 1

The following is an explanation of the activities included in each of the eight categories into which the total work during the study period was divided.

(1) *Shorthand*.—In the main this was work for either of the two consultants and it took place in the consultant's room. It does include, however, shorthand taken down by the secretaries in the general office from the senior registrar, registrar, and house physicians.

(2) *Typing Letters*.—This was from shorthand, tapes, or written material.

(3) *Typing Summaries*.—Almost all was from tape, but sometimes summaries would be taken down in shorthand for subsequent typing.

(4) *Typing Copy*.—This included stencil preparation from drafts, the preparation of research papers and lecture material, and typing reference cards for research indexing etc.

(5) *Liaison work*.—All work calling for some degree of co-ordination was included here. It involved contact with all doctors

* In many respects these categories might well be combined.

and sisters, particularly over admissions and patients' records. On clinic days there was direct contact with outpatients and there were occasional queries which necessitated the secretaries giving joint attention to the problem in question.

(6) Visits to Wards etc.—These included occasions spent on trips to wards (occasionally on other floors of the building) and additional contacts with medical staff, the duplicating service department, photographic department, medical records department, and the clinic and x-ray rooms in the basement.

(7) General Clerical Work.—This included filing (summaries, letters, etc.), cataloguing research information, noting the movement of records, etc.

(8.) Telephone Calls.—The use of the telephone was noted under four headings: (a) Internal, contact with doctors and records, transport, x-ray, and other internal hospital departments; (b) External (short) and (c) External (longer), included sending telegrams concerning admission to the wards; and (d) External (doctors and clinics).

Appendix 2: Role Analysis

Date:
Title of Role:
Occupant:
Organization:
Notes on Position of Role in Organization

Column 1	Column 2	Column 3	Column 4	Column 5
Objectives	Responsibilities	Limits	Weight of Responsibility	
Work to be done, duties, tasks, etc., with objectives stated in terms of results required, standards achieved, situations maintained, etc.	Decision making, exercise of choice, discretion, judgement, assessment, evaluation, initiative, authority	To decision making, etc., not already clear from Columns 1 and 2.	Consequences of marginally poor decision making	Review mechanisms

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Clinical Problems

Results of Closure of Loop Transverse Colostomies

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British Medical Journal, 1972, 3, 459-462

Summary

The postoperative course of 139 patients who underwent closure of a loop transverse colostomy at St. Mark's Hospital between 1961 and 1970 after distal resection and anastomosis of the large intestine for neoplastic or diverticular disease has been reviewed in detail. There were no deaths and the incidence of breakdown at the site of the colostomy closure was 2.9%. The procedure can be straightforward and safe.

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Introduction

The operation of colostomy closure has a notorious reputation for subsequent breakdown and leakage of faeces.¹ This view was recently substantiated by Knox, Birkett, and Collins,² who showed in a review of 179 patients that there was a morbidity from faecal fistula of 23% and a mortality of 2.2% after closure of a temporary colostomy. A recent editorial in the *British Medical Journal*³ further emphasized these hazards.

Some authors have shown, however, that closure of colostomies may be achieved with fewer complications. Barron and Fallis⁴ reported only one faecal fistula in 200 patients who underwent intraperitoneal colostomy closure by excision and anastomosis. They also reported that only a few patients developed a subcutaneous wound infection and that incisional hernia was a problem of minimal importance. Green⁵ reported four serious colonic complications in a series of 86 patients, of whom three required reoperation. Hubbard, Norico, and Harris⁶ reported five cases of wound infection and two cases of