Supplementary Materials for: *Patient aggression towards receptionists in general practice: a systematic review* by Willer, Chua and Ball (2023).

Table S1. *Search strategy and terms*

Database/s	Search strategy used
• CINAHL Complete via Ebsco • Scopus • Pubmed • Healthcare Administration Database	Title, abstract and keywords: (reception* OR "front desk" OR clerk) AND ("primary care" OR "general practice" OR ambulatory) AND (stress OR hostility OR aggression OR ptsd OR "post-traumatic stress" OR "workplace stress" OR burnout OR "occupational stress" OR "job stress" OR absenteeism OR presenteeism OR "sick leave" OR "self-harm" OR distress OR “mental health”)
• Google Scholar	*Full search strategy would not fit into the Google Scholar search window. Thus, the final search phrase was split into two, with first 10 pages from each search included:* *Search 1:* (reception* OR "front desk" OR clerk) AND ("primary care" OR "general practice" OR ambulatory) AND (stress OR hostility OR aggression OR ptsd OR "post-traumatic stress" OR "workplace stress" OR burnout OR "occupational stress") *Search 2:* (reception* OR "front desk" OR clerk) AND ("primary care" OR "general practice" OR ambulatory) AND ("job stress" OR absenteeism OR presenteeism OR "sick leave" OR "self-harm" OR distress OR “mental health”)

Table S2. *Abstract screening guide, inclusion and exclusion criteria*

Domain	Screening question	Inclusion/Exclusion criteria
1. LANGUAGE	Is the study published in English language?	• Studies must be published in English language
2. TYPE	Does the abstract refer to original research of any study design?	Any study design includes: • Quantitative or qualitative study designs, instrument testing (eg survey tools) if responses from relevant types of participants Excluded: • Guidebooks, training manuals, advice articles, conference discussion proceedings, study protocols, reviews
3. SETTING	Does the abstract indicate that the research took place in a primary care setting?	Definition of Primary Care Setting: (Derived from AIHW and DoH definitions) • Entry level to the health system, typically first contact an ambulatory individual with a health concern has within the health system • Can include bricks and mortar clinics, mobile/home visiting GP or telehealth services as long as there are reception staff to manage appointment bookings and payments, by phone or electronic means that interact directly with patients and prospective patients • Covers care not related to a hospital visit (ie non-emergency, and any emerging hospital-requiring condition is transferred to a hospital) • Unreferred medical services in Australia, may be shared care arrangements in other nations (eg in UK you are designated your NHS GP, in USA your primary care physician may be determined by your health insurance network) • Care is provided by at least medical practitioners, although often other allied health and nursing staff are available for consultations (if initial care is provided by Indigenous Health Worker, mark as 'maybe') • Care provided includes health promotion, prevention, early intervention, treatment of acute conditions, and management of chronic conditions • Community health centres that allow walk-in consultations (no referral) • (Dentistry is currently excluded from the scope of this review but note any studies that mention primary care dental clinics as we may need to discuss this in text)

		Excluded: • Urgent Care Centres, Hospitals, emergency care, specialist clinics (eg for medical specialists like cardiologists who need referrals to visit), solely allied health clinics, refugee reception centres, military workforce or prison primary care
4. POPULATION	Does the abstract indicate that reception staff were participants or considered as relevant factors of the research?	Definition of reception staff: • The paid front line staff in a primary care setting who may undertake the following duties: greeting patients as they arrive, answering phone/email enquiries relating to appointments and billing, administrative tasks such as filing and coding, receiving payment for consultations from primary care patients • Reception staff may not have received external training for the role • Nurses may sometimes fill reception roles as well as nursing duties at other times, this would be included if the abstract indicated the nurse was engaged in receptionist duties at the time the research related to. Excluded: • Administrative staff not in a frontline role (eg back office only)
5. PHENOMENA	Does the abstract indicate that the research involved investigating the experiences/attitudes/beliefs of reception staff, or conduct/experiences/attitudes/beliefs of patients towards reception staff?	Rationale: although the project is interested specifically in aggression and hostility experienced by reception staff from patients, these factors may be reported as part of other findings and may not appear in the abstracts. The constructs of hostility and aggression should be considered at full text assessment.
DECISION:	Should this article be included?	• Yes, all five screening questions answered Yes or Unclear • No, at least one answers definitely No

Table S3. *Quality assessment results*

Author, year	Design	Score based on appropriate JBI Critical Appraisal Tool											Overall appraisal
		1	2	3	4	5	6	7	8	9	10	% 'yes'	
Ahluwalia, 2005	Qualitative	N	Y	Y	Y	Y	N	N	Y	Y	Y	70	Included
Bowie, 2014	Qualitative	N	Y	Y	Y	Y	N	N	Y	Y	Y	70	Included
Ceramidas, 2010	Qualitative	N	N	Y	N	Y	N	N	Y	N	Y	40	Included
Hammond, 2013	Qualitative	N	Y	Y	Y	Y	N	N	Y	Y	Y	70	Included
Magin, 2009	Qualitative	N	Y	N	Y	Y	N	Y	Y	Y	Y	70	Included
Morrison, 2022	Qualitative	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	100	Included
Naish, 2002	Qualitative	N	Y	Y	Y	Y	N	N	Y	Y	Y	70	Included
Parker 2017	Qualitative element	N	Y	Y	Y	Y	N	N	Y	Y	Y	70	Included
Pina, 2022	Qualitative	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	90	Included
Strathmann, 2009	Qualitative	Y	Y	Y	Y	Y	N	N	Y	N	Y	70	Included
Ward, 2011	Qualitative	N	Y	Y	Y	Y	N	Y	Y	Y	Y	80	Included
Bayman 2007	Cross-sectional	Y	Y	N	Y	Y	Y	Y	Y			88	Included
Herath 2011	Cross-sectional	Y	Y	N	N	Y	Y	Y	Y			75	Included
Hobbs 1991	Cross-sectional	Y	Y	N	N	Y	N	Y	N			50	Included
Lopez-Garcia 2018	Cross-sectional	Y	Y	Y	Y	Y	Y	Y	Y			100	Included
Sampson 2004	Cross-sectional	Y	N	N	N	N	N	Y	N			25	Included
Arber, 1985	Prevalence	Y	Y	Y	N	Y	N	Y	N	Y		67	Included
Chambers 2006	Prevalence	Y	Y	N	N	Y	N	Y	Y	N		56	Included
Dixon 2004	Prevalence	Y	Y	N	Y	Y	N	Y	Y	N		67	Included
White 2008	Quasi-experimental	Y	Y	N	N	N	N	Y	N	N		34	Included

Appropriate JBI Critical Appraisal Tool for qualitative[1], cross-sectional[2], prevalence[3], quasi-experimental[4].
Qualitative: 10 criteria, Cross-Sectional: 8 criteria, Prevalence: 9, Quasi-experimental: 9. Responses: Yes: Y, No: N

References

[1]Lockwood C, Munn Z, Porritt K. Qualitative research synthesis: methodological guidance for systematic reviewers utilizing meta-aggregation. Int J Evid Based Healthc. 2015;13(3):179–187.
[2]Moola S, Munn Z, Tufanaru C, Aromataris E, Sears K, Sfetcu R, Currie M, Qureshi R, Mattis P, Lisy K, Mu P-F. Chapter 7: Systematic reviews of etiology and risk . In: Aromataris E, Munn Z (Editors). JBI Manual for Evidence Synthesis. JBI, 2020.
[3]Munn Z, Moola S, Lisy K, Riitano D, Tufanaru C. Methodological guidance for systematic reviews of observational epidemiological studies reporting prevalence and incidence data. Int J Evid Based Healthc. 2015;13(3):147–153.
[4]Tufanaru C, Munn Z, Aromataris E, Campbell J, Hopp L. Chapter 3: Systematic reviews of effectiveness. In: Aromataris E, Munn Z (Editors). *JBI Manual for Evidence Synthesis.* JBI, 2020.

Table S4. *Characteristics of studies included in 'Patient aggression towards receptionists in general practice: a systematic review'*

Author/s, year of publication *Title* **Year of data collection**	Location, setting	Design, data collection type	Participant characteristics: n, role, gender, age, represent-tativeness	Patient aggression construct (type/ impact/ strategy)	JBI Score %	Notable Findings
Arber, S and L Sawyer, 1985[26] *The role of the receptionist in general practice: a 'dragon behind the desk'?* **1977**	United Kingdom (London and South East of England). Multiple primary care practices represented.	Quantitative with some open-ended items. Representative sampling. Structured in-person interviews using non-validated survey instrument.	1000+ community dwelling adults, gender not reported but established as representative of population in region surveyed.	Type	67	Patients who have experienced receptionists as an active intermediary were more likely to report interaction difficulties with receptionists. The survey data lend support to two major findings: (1) that as practices become larger and more complex receptionists operate with more rigid rules, leading to greater hostility expressed by patients towards reception staff; and (2) parents with dependent children and young adults express more antagonism, because they are more likely to experience the receptionist as a 'gatekeeper' with whom they need to negotiate to see a doctor for acute care for themselves or for their children.
Hobbs, F, 1991[28] *Violence in general practice: a survey of general practitioners' views* **1989**	United Kingdom (West Midlands). Multiple primary care practices represented.	Quantitative, cross-sectional using written non-validated survey instrument.	1093 medical staff, 82.3% male, age <35- >65 years, broadly representative of workforce.	Type	50	This study investigated violence towards general practitioners but 16% of verbal abuse, 18.7% of verbal abuse with threats and 18.4% of physical aggression occurred in the waiting area which would have been witnessed by or involving PCRs. Of all incidents of violence, 16.4% took place in the waiting area. Frequency of aggression directly towards receptionists and other staff was collected but not reported clearly in the article.
Naish J et al , 2002[29] *Brief encounters of aggression and violence in primary care: a team approach to coping strategies* **~2000**	United Kingdom (inner and outer London). Multiple primary care practices represented.	Qualitative, interviews and focus groups	74 participants in total with 21 receptionists (9 in interviews and 12 in focus groups). Other participants included practice managers and nursing and medical staff.	Type Strategies	70	Patient aggression was identified as a key issue in primary care with receptionists at particular risk, especially of verbal abuse including 'screaming and shouting' which was reported as occurring very frequently. Minimal support was provided to receptionists and they were usually excluded from team meetings. Few practices kept records of incidents. Participants provided recommendations to improve safety including formal record keeping, a practice protocol with regular training, team discussions and improvements to the working environment. Receptionists were also interested in receiving counselling as they felt the practice meetings were not deep enough. Of resolving issues leading to PAH: *"Yes we try and sort it out between ourselves, if we don't get any joy like that we often ask the practice manager to come in or a doctor, someone who's got kind of a bit more authority."*
Sampson F et al, 2004[31] *Why are patients removed from their doctors' lists? A comparison of patients' and doctors' accounts of removal* **2000**	United Kingdom (England). Multiple primary care practices represented.	Quantitative, cross-sectional survey, using a non-validated survey instrument with some open-ended items.	166 participants in total with 89 medical staff (74% male, mean age 46 years) and 77 patients (53% male, mean age 37 years)	Type Strategies	25	Violent, threatening or abusive behaviour was noted as the most common reason for a patient to be removed from a patient list and that it was the medical receptionists who were most often the target of this abuse (81% of incidents). 91% (52 of 57) of incidents of violence included a verbal abuse component. A fifth of patients (15 out of 76, 19.7%) admitted threatening, shouting at, attacking or pushing the doctor, their staff or patients. Violence, threats or abuse were defined as: Threaten or shout at the doctor, practice staff or other patients, Attack or push the doctor, practice staff or other patients, Do any damage to practice property or surgery
Dixon CAJ et al, 2004[27] *Abusive behaviour experienced by primary care*	United Kingdom (Leeds) Multiple primary care	Quantitative, cross-sectional survey, using a non-validated survey	122 receptionists, 98% female, mean age 45 years (range	Type	67	The research centred around whether a national 'zero tolerance' about violence in primary care campaign had made a difference to PAH. Two thirds (68%) of the receptionists surveyed had experienced verbal abuse in the past year (after the campaign), both on the telephone (60%) and face-to-face (55%). In the year prior to the campaign, 61% had received verbal abuse, 51% face to face and 55% telephone. 14% had experienced a threat of physical abuse in the past year, and 10% in the year prior to that. 4% had experienced physical violence in the past 12 months and 1% in the year prior to that.

receptionists: a cross-sectional survey. **2002**	practices represented.	instrument. Representative sampling.	19-65), 74% British/ English; 22% white, 4% country of origin other than the UK.			The perception of the participants was that abuse was higher in the recent past, with the implication that the 'zero tolerance' policy had had no effect on receptionists workplace abuse rates. More economically deprived areas reported experiencing higher rates of abuse.
Strathmann C and M Hay, 2009[16] *Working the Waiting Room: Managing Fear, Hope, and Rage at the Clinic Gate* **2003-2005**	United States (urban setting), 3 non-referral requiring clinics attached to large medical centre.	Qualitative, 204 hour of field observations and unstructured opportunistic interviews	5 receptionists, gender not reported	Type Strategies	70	Receptionists were observed to and reported carrying out continuous emotional labour as an important part of their role to mitigate abuse from patients. Verbal abuse (loud speaking and shouting) towards the receptionists, emotional response minimisation from the receptionists and ad hoc de-escalation strategies to calm agitated patients were experienced often during the periods of observation and reported to the authors by receptionist participants. Receptionists reported specifically engaging patients positively, to reduce the opportunity for patient frustration, for example, making positive conversation while they wait.
Ahluwalia S and M Offredy, 2005[4] *A qualitative study of the impact of the implementation of advanced access in primary healthcare on the working lives of general practice staff.* **~2004**	United Kingdom (South-East England) Six purposively sampled primary care practices represented.	Qualitative, semi-structured interviews	18 in total with 6 reception staff. Other participants included GPs and practice managers.	Type Impact	70	This study explored the impact on workload and wellbeing of primary care staff of a more responsive appointment scheduling system. Findings from reception staff were reported separately. The change in system resulted in reduction in receptionist stress, easier appointment negotiation with patients, less disclosure of clinical details to receptionists from patients (because the patients could get appointments sooner and didn't have to argue on the basis of condition severity) and fewer perceived incidences of patient frustration and confrontation.
Chambers F. 2006[33] *Violence at work: the experience of general practice receptionists.* **2004**	Republic of Ireland (two Health Board Areas). Multiple practices represented.	Quantitative, cross-sectional survey using non-validated survey instrument, randomised recruitment method.	271 reception staff, 98% female, mean age 38years (range 19-65), 57% were the sole PCR in their practice.	Type Impact Strategies	56	Almost all (99%) of participants had experienced verbal abuse, 31% had experienced threats of physical abuse and 6% had experienced actual physical abuse. 18% of participants had experienced greater than 10 incidences of violence during their time as receptionists. In almost all incidents (95%) the perpetrator was a patient. In 34% of episodes of violence no immediate action was taken, in 27% the receptionist received help from other staff, 16% involved police attendance. In 20% of cases, the patient was permanently removed from the patient list and in some cases the patient was reprimanded. Afterwards, 46% reported that no support was provided, 46% indicated that staff had provided emotional support, 5% received in-house de-briefs, managerial support and support from family. 7% took time off work due to workplace violence, 3% received formal counselling. Only 13% had ever received training in managing PAH.
Ward J and R McMurray, 2011[7] *The unspoken work of general practitioner receptionists: A re-examination of emotion management in primary care* **2005-2008**	United Kingdom (England), three general practice services.	Qualitative, ethnographic, 300hrs of field observations, 50 impromptu unstructured interviews during field observations, 4 semi-structured interviews and 1 group interview.	28 receptionists, 100% female, 23-66 yrs age range	Type Impact	80	The role of a GP receptionist was observed to be demanding and involves multiple types of tasks, rituals, regulations and relations. Direct observation of verbal aggression included verbal racial abuse and a patient venting their frustration upon receptionists. In order to perform a caring approach to patients, receptionists sustained their own emotional regulation to one of calm caring (emotional neutrality), despite it being draining to their own underlying emotional state, especially when dealing with hostility from patients. Receptionists report that they felt angry and upset because of the aggression. Receptionists were observed to engage in 'emotion switching' whereby they instantly 'matched' or 'managed' the emotional state of the patient eg expressing empathy or joy depending on patient context. The authors state that *'GP reception work thus emerges as a complex service role in which the tailoring of one's own emotions in the management of patient interactions is key.*'
White C et al, 2008[30] *Awareness of Depression at the Reception Desk: Education for Primary Care Receptionists*	United Kingdom (Lewisham), 22 practices represented.	Quantitative, non-randomised experimental study, using non-validated program evaluation	78 reception staff at initial time point, 32 respondents at 12 months, characteristics not described.	Type Strategies	34	The intervention studied was a depression awareness-raising workshop to assist PCRs to contextualise the signs of depression that they may encounter in their role from patients, such as crying, anger, anxiety, agitation. It was designed to assist PCRs to take a more compassionate view of difficult interactions with patients. Expressions of anger from patients were noted as routine for PCRs. Participants of the training also felt like they were a more respected and integral part of the practice team. Results included: *"[I've learned] to listen more, be more attentive to patients that seem a little distracted or aggressive/rude."*

~2006		survey with some open-ended items. Data collected directly post intervention and at 12 months.				*"[I realised] an angry patient could have been depressed so I did my best to accommodate - very calm and spoke quietly (did not raise voice to match theirs). Later the patient apologised and thanked me for being so caring"* *"The patient was angry but I was very sympathetic and able to help get an appointment to suit her which calmed her down."*
Bayman P and T Hussain, 2007[18] *Receptionists' perceptions of violence in general practice.* **~2007**	United Kingdom (Northwest England), 56 practices represented.	Quantitative, cross-sectional using lightly adapted validated survey instruments for types of workplace crime, workplace stress, personality.	207 reception staff, 100% female, mean age 44yrs (range 20-72), 19% employed full time.	Impact Strategies	88	In the preceding 12 months, 26% of receptionists could recall being threatened by a member of the public while they were at work, and 0.5% had been physically attacked. Staff who felt safe and supported at work (P<0.003) and staff who had lower background sources of stress at work (P,0.001) were less likely to feel they would be threatened or attacked at work. Staff who had received training about violent and abusive incidents felt safer at work [OR 1.27 (1.04,1.55)]. Receptionists who reported having been threatened or attacked in the past 12 months were nearly five times more likely to be worried about being threatened in the future [odds ratio 4.9 (2.0,11.8)] or attacked [OR 4.6 (1.8,11.2)] in the future. 27% were worried about being threatened and 22% were worried about being physically attacked by a member of the public while at work. 37% thought they were likely to be threatened by a member of the public while at work in the next 12 months, but only 7% thought that they were likely to be physically attacked. 29% felt that worrying about being threatened or attacked at work affected their health.
Magin P et al, 2009[32] *Receptionists' experiences of occupational violence in general practice: a qualitative study* and Magin P et al, 2010[25] *General practice as a fortress: Occupational violence and general practice receptionists* **2007-2008**	Australia (Network of Research General Practices), 8 practices	Qualitative, from semi-structured interviews and open-ended items of a non-validated cross-sectional survey	19 interviews and unstructured written responses from 12 additional receptionists and practice managers with past or current receptionist duties, 100% female.	Type Impact Strategies	70	Violence was found to be a common, sometimes pervasive, experience of many receptionists. Verbal abuse, both 'across the counter' and telephone abuse was the most prominent form of violence, although other violence, including assault and threats with guns, was reported. Experiences of violence could have marked emotional and psychological effects and could adversely affect job satisfaction, performance and commitment. *"I find that patients are more aggressive towards admin/reception staff than they are to the GPs and nurses. They are the first point of contact and take a lot of abuse and are still expected to remain happy and smiling people."* *"After abusing staff other than the GP, a patient will go into the consult and be their normal self in front of the GP. Often the doctors don't know about patients' abusive side."* In the 2010 paper which focussed on environmental factors to mitigate PAH from the same data, perspex barriers and physical lockdown processes in three clinics were universally endorsed by participants working there, but staff from other practices had their concerns that it would undermine the ambience in the clinic.
Hammond J et al, 2013[17] *Slaying the dragon myth: an ethnographic study of receptionists in UK general practice* **2009-2011**	United Kingdom (north-west of England), 7 primary care sites	Qualitative, ethnographic, 200hrs field observations	45 reception staff	Type Impact Strategies	70	Verbal abuse of receptionists by patients was a common occurrence, particularly relating to appointment booking and requests to patients to disclose clinical issue. Authors concluded that the role of medical receptionists is complex, with many competing demands and they navigate a complex power hierarchy while also trying to protect vulnerable patients and the primary care providers at the site. Although not tested empirically, procedural policy that clarifies clinic operations for patients and procedures that support familiarity and collegiality between clinical and reception staff appear to be able to de-escalate patient aggression and help reception staff feel supported.
Ceremidas D and R Parker, 2010[21] *A response to patient-initiated aggression in general practice: Australian professional medical*	Australia	Qualitative using semi-structured interviews.	14 CEOs and presidents of associations and organisations involved with medical care, nursing care, practice	Type Impact Strategies	40	Verbal hostility was described as patients being 'demanding' and 'impatient' when speaking with reception. Verbal abuse and aggression was reported to be 'very common'. Verbal abuse of reception staff by patients was characterised as so frequent it should be considered an occupational hazard. *'Respondents generally perceived that front-desk reception staff [especially women] bore the brunt of aggression in the general practice setting.'* (p254). For the organisation, PAH was perceived as leading to problems with workforce retention and led to decreased capacity to provide service to the community. Participants volunteered a number of methods that have been used or are being developed to reduce the impact of patient-initiated aggression. However, robust evaluation of these measures appears to be scarce. Overall, participants reported that responses

organisations face a challenge. **2009-2010**			managers and healthcare research. Receptionists not interviewed.			varied in an ad hoc manner depending on the patient and circumstances. Recognition that protections should include harm minimisation strategies (prior and during incidents) and post-incident support.
Parker R et al, 2017[24] *Patient initiated aggression and violence in the Australian general practice setting* [Research institute report] **2009-2010**	Australia, 55 primary care practices	Mixed methods. Qualitative focus groups and affinity groups included in this entry as not published elsewhere. *Cross-sectional survey of practice managers is represented in Herath et al (2010) below. Stakeholder interviews represented in Ceremidas et al (2010) above.*	78 participants in total, 90% female, 28 receptionists.	Type Impact Strategies	70	Verbal aggression was reported by many practice staff to be an almost daily occurrence but was not considered as 'violence'. Less experienced staff, receptionists and administrative workers were more likely to be exposed to aggression compared with more experienced staff such as practice managers and GPs. 'Frontline' staff (reception area staff) were far more likely to be exposed to patient aggression on a regular basis than were GPs and more experienced staff. Many general practice staff claimed that they had never been subject to patient-initiated violence, and then proceeded to relate serious experiences of verbal aggression, intimidation and standover tactics from patients visiting their practice. In addition to raised voices, intimidation and abusive language, a small number of practice staff (typically reception staff) reported that the threatening manner or stance of some patients had caused distress, even though these patients had not become physically violent or abusive, "*He came in and he was frightening ... I have never seen such an evil look.*" Reception staff reported that the ability to remain calm and not aggravate or escalate a tense situation was vital. Some reception staff reported having an innate ability to diffuse or otherwise de- escalate an aggressive patient. Other staff seemed to lack this ability and were therefore deemed unsuitable for work in general practice. Practice staff commonly reported delayed effects of exposure to patient aggression. Some staff reported "going to pieces" shortly after dealing with patient aggression, while other staff did not recognise the impact of the aggressive incident until some months later. Strategies suggested including employing only reception staff who were experienced in dealing with PAH, dedicated training, physical barriers and alarms, regular staff debriefs and signage.
Herath P et al , 2011[8] *Patient initiated aggression: prevalence and impact for general practice staff* **2010**	Australia, multiple general practices represented across urban, rural and remote settings.	Quantitative, cross-sectional, clustered sampling to represent urban, rural and remote areas. Non-validated cross-sectional survey.	217 practice managers. No receptionists.	Type Impact	75	Verbal aggression towards receptionists was reported as common, physical aggression was infrequent. Staff in larger practices experienced more verbal aggression, property damage and theft. Verbal aggression had a greater negative impact on staff wellbeing than physical aggression. Physical and verbal hostility against receptionists, practice nurses and allied health professionals reported by practice managers. Physical acts of hostility included property damage, theft, physical assault or stalking. There were also reports of sexual harassment. 57% of respondents (practice managers) recognised that verbal aggression against staff caused distress, with 11% reporting counselling was needed and 37% said procedural changes in the practice were required. 14% respondents recognised physical aggression caused staff distress and 3% reporting counselling was needed and 11% said procedural changes in the practice were required. For respondents who have actually experienced physical aggression, 39% reported staff distress, 10% reported requiring staff counselling and 29% said there was a need for procedural change.
Bowie P et al, 2014[22] *Laboratory test ordering and results management systems: a qualitative study of safety risks identified by administrators in general practice* **2012**	United Kingdom (Scotland)	Qualitative, using 5 focus groups	40 in total (97.5% female) including 30 reception staff.	Type Impact Strategies	70	'Doctor to administrator communication' and 'Informing patients of test results' were identified as two of four safety risk themes. Receptionists reported struggling to communicate results to patients when they had limited background knowledge or familiarity with the terms the doctor had used to communicate the test findings. This then led to frustrating communication difficulties for patients. Emotional reactions towards receptionists from patients included when receptionists delivered 'bad news' (unwanted blood test results) for example results that confirmed a new diagnosis, or results that found no abnormalities despite symptoms being experienced by the patient. The authors called for a standardised process to mitigate the safety risks which would include protocols for receptionists providing results.
López-García C et al, 2018[19] *User Violence and Psychological Well-being in Primary*	Spain (Region of Murcia), representing 39 primary care clinics	Quantitative, cross-sectional, using validated survey instruments	574 in total (68% female, mean age 49.6yrs, range <35->65yrs) including 148	Type Impact Strategies	100	Non-clinical staff in primary care settings carried the highest risk of exposure to violence and were routinely exposed to non-physical violence and occasionally exposed to physical violence. 'Physical violence' collected in the validated survey included 'the users have even grasped me or touched me in a hostile way', 'users have shoved me, shaken me, or spit at me', 'users show their anger at me by breaking doors, windows, walls', 'users have attacked me when I was trying to prevent their self-aggression'. 'Non-physical violence' collected in this validated survey included 'users question my decisions', 'users blame me for any trifle', 'users accuse me unfairly of not fulfilling my obligations,

Health-Care Professionals and Ruiz-Hernández J et al, 2016 *Evaluation of the users violence in primary health care: Adaptation of an instrument* **~2015**			'non-health staff' which would have included receptionists and administrative staff.			committing errors or complications', 'users make ironic comments to me', 'users get angry with me because of assistential delay', 'users give me dirty or contemptuous looks'. 90.1% of participants experienced this kind of violence. The average frequency of exposure to one of these acts was quarterly and higher than medical and nursing staff. The most frequent events were 'anger for healthcare delay' (~ monthly), 'raise their voice or complain' (~ monthly), 'rude interruptions' (monthly to quarterly). Exposures to non-physical and physical violence was significantly related to negative psychological variables. Frequency of exposure to non-physical violence was moderately related to emotional exhaustion, somatisation and anxiety and insomnia in the instrument validation study. Physical violence was most related to emotional exhaustion and personalisation. General health score of non-clinical staff was higher than medical and nursing staff but this was not tested directly in relation to frequency of exposure to violent acts.
Morrison E, 2022[15] *Reconstructing the Role of the Medical Receptionist: A Phenomenological Exploration of the Experiences of Women Who Work as Reception Staff in Medical Offices* [PhD Thesis] **2019**	United States of America (California), three medical practices	Qualitative, phenomenology, using semi-structured interviews	6 receptionists, 100% female, under 50 years old and Mexican American	Type Impact	100	The participants in this study all recounted frequent experiences of verbal abuse from patients, including the expression of anger, cursing, racial abuse, devaluation and described it as 'part of the job'. The author concluded that receptionists, and particularly those who hold multiple marginalised identities that signal low social status (women, people of colour) are predictable victims of abuse at work. In this study, receptionists 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 most of the time' They reported suppressing their feelings in order to retain an 'open demeanor'. Clinical staff were characterised as reinforcing hierarchy by ignoring the efforts and risk encountered by receptionists *("That door between the waiting room and the back office might as well be made of stone").* Feelings of inferiority, on a background of already feeling like the lowest power people in the primary care hierarchy. Feeling peripheral despite having a central role in the patient experience.
Pina D et al, 2022[23] *Sources of Conflict and Prevention Proposals in User Violence Toward Primary Care Staff: A Qualitative Study of the Perception of Professionals* **2019-2020**	Spain (Health District of Murcia), multiple sites	Qualitative, using focus groups	44 in total (68.2% female, mean age 50.3yrs, range 38-64), up to 8 medical receptionists represented.	Type Impact Strategies	90	Three thematic blocks were identified as relevant for mitigating the harms of, or reducing, violence from patients to primary care staff: deficits in training or education, the need to strengthen multidisciplinary teams and the patient professional relationship. Actions suggested by participants included training and working to increase the quantity and quality of communication between professionals and the service users. While data specifically relating to reception staff is not clear due to the reporting being in aggregate with other primary care informants, overall findings indicate that patient-initiated aggression is a common problem. Further, there was confusion over what is considered aggression. Feelings in response to PAH: 'burned out', 'I had no strength there', feeling 'not psychologically prepared' for patient violence, 'unprotected', 'went home feeling awful'.

PAH: Patient-initiated aggression and/or hostility