

## Gatekeeping Care: The Medical Secretary as a Cultural and Institutional Core in Dentistry, Nursing, and Radiologic Technology

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### Abstract

Healthcare organizations are often described through the visible authority of clinical professions—dentistry, nursing, and radiologic technology—while administrative roles are framed as supportive infrastructure. This conceptual article challenges that hierarchy by arguing that the medical secretary functions as a cultural and institutional core that materially shapes access, experience, and meaning of care. Synthesizing contemporary evidence on administrative work in primary care, clerical burnout, and administrative burden, the article positions secretarial practice as a form of infrastructural power enacted through (1) information governance, (2) temporal governance, and (3) communication gatekeeping. Recent qualitative studies show that administrative staff routinely conduct patient-facing triage, educate patients, reorganize visits, and coordinate systems under strain—especially during pandemic-era transitions—yet remain under-recognized in policy and professional discourse. The article integrates these findings with institutional and axiological perspectives to propose a relational model of healthcare in which administrative mediation is constitutive of care rather than peripheral to it. Implications are developed for professional identity formation across dentistry, nursing, and radiologic technology, and for ethics of access, fairness, and bureaucratic care. The conclusion outlines research directions for empirically examining secretarial centrality in interprofessional practice, digital workflows, and patient trust.

**Keywords:** medical secretary, administrative staff, gatekeeping, institutional power, professional identity, care ethics, access to care, coordination

### 1. INTRODUCTION

Healthcare institutions are typically imagined as pyramids of expertise: clinicians and clinical technologies occupy the visible center of diagnosis and treatment, while administrative work is classified as “support.” This representation is culturally powerful,

because it assigns legitimacy and value to what is clinically visible and devalues what is organizationally enabling. Yet contemporary evidence increasingly suggests that healthcare is not only delivered through clinical acts but also *produced* through infrastructural organization—records, scheduling, triage rules, communication pathways, and digital interfaces that shape how care is accessed and experienced.

Recent research on administrative staff in primary care illustrates that administrative workers do far more than “clerical tasks.” In pandemic-era restructuring, administrative staff were described as essential to maintaining access, reorganizing visits, applying guidelines, educating patients, and supporting clinical workflow under rapidly changing conditions (Marshall et al., 2024). Administrative work has also been linked to patient-facing burdens that affect care-seeking and equity, with administrative processes functioning as barriers or “hurdles” that structure who can navigate healthcare effectively (Herd & Moynihan, 2021). Meanwhile, evidence on clerical staff burnout highlights the intensity of customer-facing demands and the organizational resources required to sustain administrative roles that are effectively part of care delivery (Medich et al., 2022).

This article argues that the medical secretary (and functionally similar roles such as medical office assistants and front-desk administrative staff) should be theorized as a **cultural and institutional core** within healthcare systems. “Gatekeeping care” is used here in a non-pejorative sense: administrative actors regulate entry, shape the tempo of services, and translate institutional logic to patients, thereby co-producing care as an institutional and cultural experience. The focus on dentistry, nursing, and radiologic technology is deliberate: these domains depend on high levels of coordination, documentation integrity, and time-sensitive flow—exactly where administrative mediation becomes structurally decisive.

**Aims.** The article (1) synthesizes 2018–2024 empirical literature that reveals administrative staff as care-enabling actors; (2) develops a theoretical framework for administrative power as infrastructural authority; (3) analyzes implications for professional identity and hierarchy across dentistry, nursing, and radiologic technology; and (4) proposes a relational model of healthcare institutions that re-centers administrative mediation.

## 2. Contemporary evidence: administration as care infrastructure

### 2.1 Administrative work as coordination under institutional stress

Qualitative evidence describes administrative staff as “integral but often overlooked members” of healthcare teams who coordinate clinic operations and patient access (Marshall et al., 2024). In that study, family physicians’ accounts emphasized administrative staff contributions to reorganizing visits, supporting triage and scheduling, and sustaining patient navigation during rapid workflow shifts—activities that go beyond routine clerical labor and resemble frontline coordination work. Importantly, the authors note that administrative staff are often unrecognized as a regulated profession, despite performing work that materially affects access and continuity (Marshall et al., 2024). This mismatch—high responsibility with low symbolic status—is central to the cultural and axiological tension explored in this article.

The broader care-coordination literature reinforces that continuity depends on intentional organization of multiple participants and information exchange; care coordination is partly an infrastructural problem, not only a clinical one (Albertson et al., 2022). While many coordination studies focus on “care coordinators” as formal roles, they also clarify the foundational importance of standardized protocols, information sharing, and referral pathways—domains where secretarial and administrative staff frequently maintain the operational reality of coordination (Albertson et al., 2022).

### 2.2 Administrative burden as a hidden architecture of inequality

Administrative processes in healthcare are frequently framed as neutral mechanisms of organization—necessary procedures designed to ensure compliance, documentation accuracy, and resource management. However, the theory of administrative burden reframes these processes as structured experiences that impose measurable costs on individuals (Herd & Moynihan, 2021). Administrative burden consists of three primary dimensions: learning costs, compliance costs, and psychological costs. Together, these dimensions shape how individuals access, interpret, and endure institutional systems.

In healthcare settings, administrative burden becomes particularly consequential because access to care is mediated through bureaucratic procedures. Patients must learn eligibility rules, navigate appointment systems, complete forms, understand referral pathways, and comply with documentation requirements. These tasks are not evenly distributed in their difficulty. Vulnerable populations—those with limited health literacy, language barriers, disabilities, or socioeconomic constraints—experience disproportionately higher learning and compliance costs (Herd & Moynihan, 2021). Thus, administrative systems can unintentionally reproduce inequality.

From the perspective of gatekeeping care, this means that administrative mediation does not simply coordinate internal workflows; it structures patient access externally. Forms, waiting lists, appointment algorithms, referral verification processes, and insurance documentation become filtering mechanisms. These filters operate quietly, often unnoticed in institutional discourse, yet they decisively shape who enters the system smoothly and who encounters friction.

The medical secretary occupies a pivotal position within this architecture. While secretarial work is frequently procedural, it is also interpretive. Secretaries clarify requirements, decide how strictly to enforce rules, prioritize urgent cases, assist patients struggling with documentation, and sometimes adapt processes informally to reduce friction. In this sense, the secretary becomes an actor within what Herd and Moynihan (2021) describe as the moral and distributive consequences of administrative systems.

Administrative burden therefore functions as a hidden architecture of inequality: it embeds normative judgments about deservingness, urgency, and legitimacy within routine procedures. The secretary’s role is embedded within this architecture, simultaneously enacting institutional rules and mediating their impact.

**Conceptual Table: Administrative Burden in Healthcare Gatekeeping**

Before presenting the table, the following matrix illustrates how administrative burden dimensions translate into inequality risks and how secretarial mediation can either mitigate or amplify those effects.

<b>Dimension of Administrative Burden</b>	<b>Typical Healthcare Examples</b>	<b>Inequality Risk</b>	<b>Secretarial Gatekeeping Role</b>	<b>Ethical Implication</b>
Learning Costs	Understanding referral requirements, insurance rules, digital portals	Higher barriers for low literacy or non-native speakers	Explaining procedures, translating requirements, guiding form completion	Promotion of informational equity
Compliance Costs	Completing forms, gathering documents, repeated visits	Financial/time strain on low-income patients	Flexible scheduling, assistance in document verification	Procedural fairness

Psychological Costs	Anxiety about rejection, fear of mistakes, confusion	Reduced care-seeking among vulnerable groups	Reassurance, empathetic communication, reducing intimidation	Preservation of dignity
Temporal Costs	Long waiting times, rigid scheduling	Disproportionate impact on workers with inflexible jobs	Prioritization, triage adjustments	Justice in time allocation

**Administrative Burden and Symbolic Power**

Beyond procedural consequences, administrative burden also produces symbolic effects. When patients encounter repeated bureaucratic obstacles, institutions may appear distant, opaque, or unresponsive. Conversely, when secretarial mediation is empathetic and supportive, institutional legitimacy is strengthened. The secretary thus operates at the intersection of bureaucratic authority and cultural perception.

This symbolic dimension is particularly relevant in dentistry, nursing, and radiologic technology, where access pathways often involve multi-step referrals and time-sensitive scheduling. In radiology, delays in documentation can postpone diagnostic imaging. In dentistry, insurance preauthorization can determine treatment timing. In nursing contexts, admission paperwork shapes continuity of care. Administrative burden influences not only entry but clinical trajectory.

**Reframing Gatekeeping as Ethical Mediation**

The concept of gatekeeping is often associated with restriction. However, when examined through the lens of administrative burden, gatekeeping becomes an ethical mediation practice. Secretarial decisions—how to interpret urgency, whether to offer additional explanation, how strictly to apply rules—carry distributive consequences.

Herd and Moynihan (2021) argue that administrative systems should be evaluated not only for efficiency but also for equity. Extending this insight, the secretary’s role becomes part of the ethical landscape of healthcare institutions. Administrative mediation can reduce inequality by lowering friction or inadvertently amplify disparities through rigid enforcement.

Therefore, administrative burden reveals that the medical secretary’s role is structurally central to the moral ordering of healthcare access. Care is not only delivered clinically; it is filtered administratively.

**2.3 Digitalization increases administrative mediation rather than eliminating it**

Healthcare digitization is frequently promoted as a solution to administrative inefficiency. Electronic health records (EHRs), patient portals, automated scheduling systems, and telehealth platforms are often described as mechanisms that reduce paperwork, streamline communication, and enhance transparency. However, empirical evidence suggests a more complex reality: digitalization does not eliminate administrative mediation—it redistributes and intensifies it.

Qualitative research examining staff perspectives on patient access to electronic records demonstrates that digital transparency generates new interpretive demands (Davidge et al., 2023). Patients who access clinical notes online may misinterpret terminology, become anxious about preliminary findings, or seek clarification before clinicians have had the opportunity to contextualize results. In such cases, administrative and frontline support staff frequently become the first point of contact for explanation and reassurance.

Thus, digital systems shift—not remove—the burden of mediation. Tasks once confined to internal documentation become interactive and relational. Administrative staff must:

- Interpret system outputs for patients

- Manage increased messaging volumes
- Clarify procedural expectations
- Coordinate between digital interfaces and clinical workflows
- Handle emotional responses triggered by online information access

**Redistribution of Tasks and Moral Responsibility**

Digital health systems create new sites of responsibility. When appointment bookings become automated, staff must monitor errors, resolve scheduling conflicts, and address inequities created by algorithmic prioritization. When portals allow direct messaging, administrative staff triage incoming communication streams before they reach clinicians. This redistribution of labor introduces a moral dimension. Administrative staff now mediate:

- The timing of clinician response
- The framing of institutional communication
- The perceived transparency of the organization
- Patient expectations about immediacy and access

**Table: Digitalization and Expanded Administrative Mediation**

Before presenting the table, the following framework clarifies how digital systems generate new forms of administrative responsibility rather than administrative reduction.

Digital Innovation	Intended Benefit	New Administrative Mediation Required	Risk if Mediation Fails
Electronic Health Records	Centralized documentation	Data validation, record reconciliation, correcting patient misunderstandings	Clinical delays, mistrust
Patient Portals	Transparency and autonomy	Explaining notes, managing patient anxiety, responding to digital inquiries	Increased workload, confusion
Automated Scheduling	Efficiency	Conflict resolution, triage override, system troubleshooting	Access inequity
Telehealth Platforms	Accessibility	Coordinating technical setup, managing digital literacy barriers	Missed appointments

Digital systems also introduce algorithmic governance—rules embedded in software determine appointment availability, referral eligibility, and documentation requirements. Yet algorithms require human oversight. Administrative staff frequently intervene when digital systems fail to capture contextual nuances such as patient vulnerability, urgency not visible in coded data, or technical barriers. This creates a hybrid governance structure: Technical rule-based automation and Human interpretive mediation.

**Implications for Professional Identity**

In dentistry, digital imaging records and appointment systems demand precise data flow before procedures can occur. In nursing, electronic documentation and medication administration systems increase reliance on record accuracy. In radiologic technology, digital referral validation determines imaging sequencing.

Digital infrastructures thus make professional autonomy more dependent on administrative information governance. When systems malfunction, clinical roles become visibly dependent on administrative mediation.

Beyond operational implications, digital health alters patient expectations. Patients increasingly expect real-time access, immediate responses, and seamless digital interaction. Administrative staff must translate institutional constraints—limited clinician time, triage protocols, documentation rules—into communicative explanations that preserve trust.

In this sense, digitalization transforms the medical secretary into a cultural translator between algorithmic systems and human experience.

Rather than marking the decline of administrative roles, the digital turn intensifies their centrality. Healthcare institutions become socio-technical systems in which administrative actors ensure coherence between technological infrastructure and clinical practice.

Therefore, digitalization does not diminish the gatekeeping function—it amplifies its scope, complexity, and ethical weight.

#### **2.4 Administrative roles as emotionally demanding, customer-facing gatekeeping**

Administrative staff who are patient-facing experience high demands and risk of burnout when resources and training are insufficient. A study of Veterans Health Administration (VHA) primary care clerical staff reported burnout predictors aligned with customer-facing strain and the need for supportive work environments; the work is explicitly framed as part of team-based primary care even though staff are “not clinicians” (Medich et al., 2022). This evidence supports a key theoretical move: if administrative roles carry workload and emotional labor similar to frontline service roles, then they also carry ethical and cultural responsibilities tied to patient experience—core elements of “care.”

### **3. Theoretical framework: infrastructural authority, cultural mediation, and axiology**

This paper is a conceptual synthesis rather than a single-site empirical study. Its method is to **theorize administrative labor as institutional mediation** by integrating empirical findings (2018–2024) with institutional and moral frameworks.

#### **3.1 Infrastructural authority: power through flow**

Administrative power in healthcare often operates as **infrastructural authority**—authority exercised through control of flows rather than clinical judgment. Contemporary organizational accounts of primary care describe how administrative staff triage and reorganize visits, maintain staffing, apply guidance, and stabilize operations under uncertainty (Marshall et al., 2024). These actions shape the conditions under which clinical decision-making occurs. In this sense, administrative power does not compete with dentistry, nursing, or radiologic technology; it *conditions* the possibility and quality of their work.

Care coordination research provides a vocabulary for this: coordination requires standardized protocols, referral structures, and mechanisms for accountability and information exchange (Albertson et al., 2022). When secretaries manage appointments, confirm referrals, route records, and organize communications, they enact infrastructural authority—power that “governs the conditions” of care rather than the content.

#### **3.2 Cultural mediation: translating institutional logic into lived experience**

Administrative staff are often the first human interface of healthcare institutions. In a cultural sense, they translate institutional rules into patient experience: what counts as urgent, what is “appropriate,” what documents “matter,” and what time is available. This translation work becomes more salient under digital transformation, where staff must support new behaviors and expectations around online records and communications (Davidge et al., 2023). The secretary thereby mediates the symbolic relationship between patient and institution: legitimacy, fairness, trust, and perceived respect.

#### **3.3 Axiology of gatekeeping: fairness, dignity, and bureaucratic care**

Administrative burden research shows that bureaucratic processes can impose learning, compliance, and psychological costs that shape equity and access (Herd & Moynihan, 2021). From an axiological perspective, gatekeeping is not merely logistical; it is inherently moral. Scheduling choices, documentation requirements, and communication styles enact implicit value judgments about who is prioritized and how dignity is preserved. If

administrative burden is a measurable feature of healthcare experience (Herd & Moynihan, 2021), then the secretary's gatekeeping becomes part of healthcare ethics, not outside it.

#### **4. Three mechanisms of gatekeeping care: information, time, and communication**

The medical secretary's institutional centrality can be analytically organized around three interdependent mechanisms: **information governance, temporal governance, and communication mediation**. These mechanisms do not function independently; rather, they form a coordinated architecture that structures access, experience, and professional interaction within healthcare institutions.

Gatekeeping care, in this framework, is not merely the act of controlling entry but the structuring of institutional flow. Through these three mechanisms, administrative actors regulate the conditions under which dentistry, nursing, and radiologic technology operate.

##### **4.1 Information governance**

Healthcare institutions are fundamentally information-driven systems. Referral pathways determine access to specialized services; diagnostic results routing determines treatment timing; consent documentation legitimizes intervention; and record integrity safeguards clinical continuity. In this sense, information is not merely supportive to care—it is constitutive of it.

Digital transformation has intensified this informational dependency. Patient portals, electronic health records (EHRs), interdepartmental messaging systems, and automated scheduling platforms have expanded the volume and velocity of data exchange. However, digitization does not eliminate mediation. On the contrary, it often increases the need for interpretive and coordinating roles to manage flows, clarify misunderstandings, and prevent system breakdowns (Davidge et al., 2023).

Administrative staff—particularly medical secretaries—function as coordinators of informational flow. They verify referral completeness, ensure documentation accuracy, route results to appropriate clinicians, reconcile discrepancies, and manage communication between departments. These actions shape:

- Clinical readiness (Is the patient file complete?)
- Diagnostic timing (Were results transmitted promptly?)
- Treatment sequencing (Was documentation verified before intervention?)
- Institutional accountability (Is consent properly recorded?)

When information governance is stable and responsive, clinical professionals in dentistry, nursing, and radiologic technology can act efficiently. When informational mediation fails—through delays, incomplete routing, or miscommunication—clinical authority becomes constrained.

Thus, administrative information governance operates as a form of infrastructural authority: it governs the conditions under which clinical action becomes possible.

##### **Information Governance as Structural Power**

Information governance can be analyzed along three dimensions:

1. Access Control – Who sees what information and when?
2. Flow Regulation – How quickly and accurately does information move?
3. Integrity Assurance – How reliable and complete are records?

##### **Table: Information Governance in Healthcare Gatekeeping**

the following matrix clarifies how information governance translates into operational and ethical outcomes across healthcare disciplines.

Information Governance Function	Secretarial Practices	Impact on Dentistry	Impact on Nursing	Impact on Radiologic Technology	Ethical Dimension
Referral Verification	Checking completeness, eligibility confirmation	Prevents delayed procedures	Ensures accurate care transitions	Confirms imaging eligibility	Equity in access
Results Routing	Forwarding lab/imaging results	Enables treatment planning	Supports medication adjustments	Ensures timely reporting	Continuity of care
Consent Documentation	Verifying signed forms	Legal authorization for procedures	Ethical compliance in treatment	Required before imaging	Institutional legitimacy
Record Integrity	Updating demographic/clinical data	Reduces treatment errors	Prevents miscommunication	Avoids imaging duplication	Patient safety

it becomes clear that information governance is not a neutral background task but a structural determinant of care quality and fairness.

**Digitalization and Interpretive Mediation**

Research on electronic health record access highlights that digital transparency introduces new complexities. Patients may misinterpret clinical notes, require clarification, or contact clinics with concerns about results viewed online (Davidge et al., 2023). Administrative staff often become first responders to these informational disruptions. This introduces a dual burden technical mediation (navigating systems) and Interpretive mediation (explaining meaning)

The secretary thus bridges technological infrastructure and human understanding. In doing so, administrative actors influence patient trust and institutional credibility. In dentistry, high procedural precision depends on accurate records and timely results. In nursing, continuity of care depends on documentation coherence. In radiologic technology, imaging accuracy depends on correct referrals and patient preparation instructions. Administrative governance of information therefore shapes professional identity indirectly. Clinical competence is expressed within informational conditions structured administratively. When information flow is smooth, clinical authority appears autonomous; when it falters, its dependency becomes visible. Traditionally, care is associated with therapeutic intervention. However, if delayed referrals postpone cancer diagnosis or incomplete records lead to duplicated imaging, then information governance becomes ethically significant. Administrative structuring of data flow is therefore part of the moral infrastructure of healthcare.

The medical secretary’s work in managing records and routing information should thus be understood as constitutive of care delivery, not peripheral to it.

**4.2 Temporal governance**

Time is scarce and ethically charged. Gatekeeping care includes deciding how time is allocated and whose needs count as urgent. Evidence from primary care during COVID-19 shows administrative staff participating in reorganizing visits and triaging urgency—a form of temporal governance that reshapes access (Marshall et al., 2024). Temporal governance is thus a mechanism of institutional power and a moral practice.

**4.3 Communication gatekeeping**

Communication is not neutral routing; it frames meaning. Administrative staff often educate patients, explain system changes, and manage questions—especially during periods of rapid change (Marshall et al., 2024). Digital access to records also increases communication tasks, requiring staff to negotiate patient concerns and staff anxieties around transparency, workload, and misunderstanding (Davidge et al., 2023). Communication gatekeeping shapes trust and legitimacy.

**5. A conceptual table: mapping gatekeeping mechanisms to outcomes**

Below is a concise conceptual mapping used to clarify how secretarial gatekeeping becomes care-producing rather than care-adjacent.

this table synthesizes how the three mechanisms discussed above generate **institutional outcomes** and **ethical outcomes** documented in recent literature.

Gatekeeping mechanism	Typical secretarial practices	Institutional outcomes	Ethical/cultural outcomes	Empirical anchors (2018–2024)
Information governance	Routing referrals/results, maintaining records, verifying requirements	Coordination continuity, reduced fragmentation, workflow stability	Perceived reliability and legitimacy of the institution	Albertson et al., 2022; Davidge et al., 2023
Temporal governance	Scheduling, triage-by-urgency, reorganizing visits	Access management, demand control, service throughput	Fairness/priority disputes; dignity in waiting	Marshall et al., 2024; Herd & Moynihan, 2021
Communication gatekeeping	Educating patients, explaining rules, managing patient queries, interface with teams	Reduced confusion, smoother handoffs, fewer failed encounters	Trust, respect, institutional “voice”	Marshall et al., 2024; Davidge et al., 2023

**6. Implications for dentistry, nursing, and radiologic technology**

**6.1 Dentistry: precision work depends on administrative flow integrity**

Dental services are highly structured around appointments, preparation, documentation, and follow-up. Professional identity in dentistry (especially in training contexts) is shaped through sociocultural processes and role modeling, with attention to how learning environments cultivate identity and professional norms (Du et al., 2023). Secretarial gatekeeping intersects with this by shaping patient flow, punctuality, documentation completeness, and the tempo of clinical practice. If identity formation is socioculturally mediated (Du et al., 2023), then administrative mediation is part of the cultural environment in which dental professionalism is performed and recognized.

**6.2 Nursing: relational care is enabled or constrained by bureaucratic conditions**

Nursing often embodies a moral language of care, continuity, and patient advocacy. Yet nursing practice is profoundly shaped by institutional rhythms—handoffs, scheduling, documentation, and interdepartmental coordination. The administrative burden framework clarifies that bureaucratic hurdles are not merely inconveniences but shape lived

experiences, stress, and equity (Herd & Moynihan, 2021). When secretarial work reduces friction, it can protect nursing time for relational care; when administrative systems increase burdens, nurses may inherit the consequences in the form of disruptions, patient frustration, and “administrative spillover.”

### **6.3 Radiologic technology: technical objectivity is framed by administrative organization**

Radiologic workflows require referrals, timing coordination, patient instructions, and results communication. Professional identity research on diagnostic radiographers highlights how identity is shaped by environment influences and organizational institutions, not only by technical skill (Mtombeni et al., 2023). This aligns directly with the present thesis: administrative staff shape the environment and institutional conditions under which radiologic professionalism is enacted. Gatekeeping is therefore not external to radiologic identity but part of its organizational ecology.

### **6.4 Interprofessional dynamics: administrative mediation as the “missing node”**

Studies of interprofessional collaboration identify organizational factors, information systems, and leadership as key levers and barriers (El-Awaisi et al., 2024). While many IPC frameworks foreground clinicians, the day-to-day interprofessional reality often depends on administrative routing and coordination. Re-centering the secretary provides a practical missing node: a role that links services, sequences patient movement, and maintains shared informational order.

## **7. Reconstructing healthcare hierarchy: from pyramid to relational core**

### **7.1 Why the pyramid persists**

The clinical pyramid persists culturally because it maps visibility to value: those who touch the patient in clinically recognized ways are “central.” Secretarial work is often invisible precisely because, when it succeeds, it disappears into smoothness. Yet the pandemic-era literature shows how quickly care access destabilizes when administrative processes are strained or undervalued (Marshall et al., 2024).

### **7.2 A relational-core model**

A more accurate model is a **relational-core** model:

- Clinical roles (dentistry, nursing, radiologic technology) produce content of care.
- Administrative roles (medical secretary) produce the **conditions** of care: flow, time, and communicative meaning.
- Digital systems intensify, rather than erase, the need for mediation (Davidge et al., 2023).
- Administrative burden shapes equity and patient experience (Herd & Moynihan, 2021).
- Administrative roles carry high emotional demand and require resources to prevent burnout (Medich et al., 2022).

## **8. Ethical and cultural implications**

### **8.1 Gatekeeping as moral practice**

Gatekeeping inevitably involves priority decisions. Administrative burden research shows that the design of processes can produce unequal experiences and outcomes (Herd & Moynihan, 2021). Therefore, secretarial work participates in the moral ordering of healthcare: who waits, who is prioritized, who can navigate requirements, and whose confusion is accommodated.

### **8.2 Recognition, training, and institutional justice**

Pandemic-era evidence suggests that administrative staff assumed expanded operational and communicative responsibilities without proportional institutional recognition or formalized professional pathways (Marshall et al., 2024). These responsibilities included triage coordination, patient education regarding rapidly changing protocols, and mediation

of digital transitions. Despite their structural centrality, administrative actors frequently remain excluded from formal workforce planning, professional development frameworks, and policy discourse.

Burnout research further demonstrates that clerical and administrative staff in patient-facing roles experience significant emotional labor and workload strain. Supportive work environments, access to training, role clarity, and organizational resources are associated with reduced burnout risk and improved team integration (Medich et al., 2022). These findings underscore a broader principle: if administrative gatekeeping constitutes care-enabling labor, then institutional justice requires proportional recognition and structural support.

### **Implications in the Saudi Healthcare Context**

The Saudi healthcare system is currently undergoing extensive structural transformation under Vision 2030, particularly through the Health Sector Transformation Program, digital health expansion, and the restructuring of service delivery models. These reforms emphasize efficiency, digital integration, patient-centered care, and governance transparency. However, digital transformation—especially expansion of electronic health records, centralized appointment systems, and telehealth—inevitably increases the informational and communicative mediation required at the administrative interface.

In Saudi Arabia, large-scale implementation of unified digital platforms (such as national health information systems and centralized appointment booking services) has intensified the need for trained administrative personnel capable of managing data accuracy, coordinating referrals across clusters, and assisting patients with system navigation. As healthcare delivery shifts toward integrated health clusters, administrative staff increasingly operate across multiple institutional layers, managing inter-facility coordination and referral pathways.

Moreover, workforce nationalization policies (Saudization) have expanded local participation in administrative healthcare roles. This creates both opportunity and responsibility: professional development frameworks must align with the growing complexity of administrative functions. Without structured training in digital systems, communication ethics, and coordination protocols, administrative staff may face expanded expectations without commensurate preparation.

From an institutional justice perspective, three areas are particularly relevant in the Saudi context:

#### **1. Formal Recognition of Administrative Competence**

Administrative healthcare roles should be embedded within professional competency frameworks aligned with digital governance standards.

#### **2. Structured Training in Digital Health Mediation**

As patient portals and electronic records become standard, administrative staff require advanced training in digital literacy, data governance, and patient communication.

#### **3. Clear Responsibility Boundaries within Cluster Models**

Integrated healthcare clusters necessitate explicit delineation of administrative authority to prevent overload, ambiguity, and systemic fragmentation.

Failure to integrate administrative roles into transformation planning risks reinforcing symbolic marginalization while expanding operational dependence. Conversely, recognizing administrative mediation as part of care delivery aligns with national goals of efficiency, transparency, and patient-centeredness.

### **Institutional Justice as Cultural Reform**

Institutional justice is not merely a matter of compensation or workload distribution; it is also symbolic. Recognition affects professional identity, motivation, and institutional culture. In rapidly modernizing systems such as Saudi Arabia's, where governance reforms

emphasize accountability and service quality, acknowledging the ethical weight of administrative mediation becomes culturally significant.

If secretarial gatekeeping structures access, shapes patient trust, and sustains interprofessional coordination, then institutional justice requires:

- Professional development pathways
- Inclusion in interprofessional training programs
- Ethical recognition within healthcare discourse
- Organizational safeguards against burnout

Such measures align not only with empirical findings on administrative strain (Medich et al., 2022) but also with broader systemic reform goals.

In sum, recognizing the medical secretary as a central institutional actor is not a symbolic gesture—it is a structural necessity in digitally transforming healthcare systems, including Saudi Arabia’s evolving healthcare landscape.

### 9. Limitations and future research directions

This is a conceptual synthesis rather than an ethnography of secretarial work inside a single institution. It draws on recent empirical studies that are often focused on primary care and pandemic-era transformations; evidence specifically on dental and radiology administrative mediation is less developed in the 2018–2024 literature compared to broader administrative-staff research.

Future research should:

1. Conduct **multi-site qualitative studies** of medical secretaries across dentistry, nursing units, and radiology departments to observe real-time gatekeeping decisions and their ethical framing.
2. Measure relationships between administrative staffing, administrative burden, and patient experience—extending the administrative burden framework into facility-level analyses (Herd & Moynihan, 2021).
3. Examine how digital transformations (online records access, messaging, scheduling automation) redistribute mediation work and shape interprofessional trust (Davidge et al., 2023).
4. Investigate secretarial work as a site of **professional identity and recognition**, aligning with broader calls to theorize identity in health professions more robustly (Cornett et al., 2023).

## 10. CONCLUSION

This article has argued that the medical secretary functions as a cultural and institutional core in healthcare. Contemporary evidence demonstrates that administrative staff are essential to care coordination, patient-facing navigation, and institutional resilience, especially under conditions of crisis and digital transformation (Marshall et al., 2024; Davidge et al., 2023). The administrative burden framework reveals that these processes are not neutral; they shape equity, stress, and legitimacy in healthcare experience (Herd & Moynihan, 2021). Burnout research further underscores that secretarial gatekeeping is emotionally demanding frontline work that requires organizational resources (Medich et al., 2022). By centering information governance, temporal governance, and communication gatekeeping, the article reframes administration as constitutive of care. In doing so, it reconstructs the cultural hierarchy of healthcare and expands the axiological boundaries of what counts as “care work” in dentistry, nursing, and radiologic technology.

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