a mercury sphygmomanometer alone, 8% an aneroid one, and 29% both. The use of aneroid sphygmomanometers is rising among recently-qualified doctors. Of doctors qualified after 1964 39% used an aneroid one and 43% a mercury one, whereas only 25% of those qualified before 1925 used an aneroid one and 70% used a mercury one ($P<0.001$).

(14) *Are you satisfied with your present equipment for measuring blood pressure?*—Nearly all the doctors (92%) were satisfied with their present equipment.

Notes on the "correct" answers to these questions are given in the Appendix.

Discussion

The findings of this study are based on the reports of the general practitioners who were interested enough to reply to one questionnaire. Space was available in the questionnaire for comment and was used by many of the practitioners. There was much interest in various aspects of high blood pressure, particularly the treatment and aetiology of hypertension.

There were substantial differences between older and younger practitioners, which is important for the design of educational programmes. Differences between doctors working alone and those working in groups may also have been due to age, but were more probably due to the regular contact with colleagues and the greater opportunities to attend courses and meetings of those in group practices.

There were differences between the treatment of patients with and without symptoms in our study. A study of headache and blood pressure in the community[7] showed that most people with headache and migraine have blood pressures similar to those who do not have headaches. A more recent report noted that the responses to questions on headache, epistaxis, and tinnitus showed no relation to systolic or diastolic blood pressure; dizziness was more frequent only in people with very high diastolic pressure.[8]

Methods of measuring the blood pressure and the instruments used varied. Though most general practitioners were satisfied with their equipment some degree of standardization in recording is desirable to ensure compatibility of measurements for treatment and research.

Few doctors reported difficulty in keeping patients on treatment for hypertension, which may indicate the good doctor-patient relationships existing in general practice in the National Health Service. Such relationships are essential for the early diagnosis and continued treatment of high blood pressure and for the community control of this condition.[9]

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Appendix

NOTES ON QUESTIONNAIRE

Q. (1) It would be reasonable to measure and record the blood pressure each year if the patient is seen.

Q. (2) Hypertensive patients do not usually present with symptoms. Symptoms may be reported if the patient is carefully questioned.

Q. (3) Why not tell patients requiring treatment that they have hypertension?

Q. (4) Treatment of hypertension prevents stroke and heart failure.

Q. (5) Most reports to date have indicated considerable difficulty in keeping patients in treatment.

Q. (6) In addition to the usual difficulty of prolonged treatment hypotensive drugs have unpleasant side effects.

Q. (7) and (8) Generally, younger patients were treated at quite low levels. It would be of interest to know levels of treatment for patients over 65 years.

Q. (9) There was general agreement on this difficult question.

Q. (10) This was a difficult question for a yes or no answer. A major difference is the impotence caused by drug treatment.

Q. (11) When recording diastolic blood pressure it should be clearly stated which sound (phase 4 or phase 5) is being used.

Q. (12) Open access to pathology services is now very extensive and many general practitioners take their own E.C.G.s

References

[1] Freis, E., *Journal of the American Medical Association*, 1967, **202**, 1028.
[2] Freis, E., *Journal of the American Medical Association*, 1970, **213**, 1143.
[3] Evans, J. G., and Rose, G., *British Medical Bulletin*, 1971, **27**, 1.
[4] Morris, J. N., *Proceedings of th Royal Society of Medicine*, 1973, **66**, 225.
[5] Moser, C. A., and Kalton, G., *Survey Methods in Social Investigation*. London, Heinemann, 1971.
[6] Cartwright, A., and Ward, A. W. M., *British Journal of Preventive and Social Medicine*, 1968, **2**, 199.
[7] Waters, W. E., *British Medical Journal*, 1971, **1**, 142.
[8] Weiss, N. S., *New England Journal of Medicine*, 1972, **287**, 631.
[9] Hodes, C., *et al.*, in preparation.

Letter from . . . Brisbane

The New Disease—"Administration"?

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A new disease has arisen in this part of the world. It attacks not the human body but the bodies of institutions, is a low-grade malignancy, may have effects varying from irritant to crippling, and might possibly even be fatal. The name of this disease is "administration"—with inverted commas to distinguish it from administration of benevolent type.

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The onset of this disease may be marked by the appearance of a herald spot—a management consultant. After a latent period he produces aberrant mitoses in the administrative staff, so that they begin to proliferate in an uncontrolled fashion, leading to the appearance of committees of various types. Just as malignant cells invade the tissues of the host, to the latter's detriment, so these committees invade the body of the institution, making all sorts of plans which have little bearing on its normal function.

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One looks back a generation. The Royal Air Force used to bring out a magazine, written in the style of the old *Lilliput*, which contained all sorts of helpful hints of use to flying men. On the whole, the theme was how to stay alive in the air, and how more effectively to wage war against the enemy. As time passed and the enemy was clearly beaten (though the cease-fire was yet some months away), the nature of the magazine changed. A new series of feature articles appeared, under the heading "This is Bumph Speaking," the emphasis now being on how to win the war at the desk, and how correctly to fill in forms and to direct them to the proper channels. So in hospitals it seems that the most important part of one's work is not the old style stuff of accurate diagnosis and prompt treatment, but endless discussions with all and sundry, and the completion of returns of useless data to a central authority, whose contact with the patient is at best tangential.

One might think about the purpose of administration in general. Industrial and commercial enterprises are usually run on a pyramidal system, with the chief executive at the top, such functionaries as company secretaries and chief engineers at a second level, spreading outwards through branch managers, branch secretaries and the like, down to the ordinary workers. Hospitals necessarily are different, as Lord Taylor has pointed out.[1] Each medical consultant—be he physician, surgeon, or what you will—has gone through a period of training to the point where he can take final responsibility for a patient's care, and thus each consultant is equal with every other one, and even in hospitals the size of mine there are about 100 clinicians of this rank, with equal legal, professional, and personal responsibility for the work they do.

A business run badly may end in liquidation, or be taken over by a more successful rival. The annual report and balance sheet will usually make clear how well the business is being run. It is less easy to say how well a hospital is run, nor can hospitals be compared with one another, as their functions are not always strictly comparable—one cannot compare a teaching with a non-teaching hospital, a base with a peripheral hospital, a fully developed general hospital with a special hospital, and so on.

Sharing the Role

It follows that the administration of a hospital has a different role from the administration of a business. There are problems which are rightly those of an administrator—catering, maintenance of buildings and grounds, industrial relations, including pay and leave arrangements, are properly administrative functions. In regard to the clinical practice of the hospital, which after all is the reason for its existence, the administration ought to play a different part. On the one hand, it should take to its financier all justifiable requests for future growth, development of facilities, and staff requirements, and should advocate those claims as strongly as it can. On the other, it should support the clinical staff, helping them to do their work.

Some years ago several people were injured in an aircraft accident on a Queensland beach. As the casualties were brought to the local hospital, a senior surgeon, who happened to be on holiday nearby, presented himself to the superintendent saying, "Here I am. What do you want me to do?" A good hospital administration ought to take this attitude towards the clinical staff—how can we help you do your work?

It may be of interest to compare the quality of service provided in the public and private sectors of health care. A patient can leave my rooms, visit a private pathologist and a private radiologist in the same building, and return to me in an hour or so with dry films and a typed report. Pathology results can be telephoned in a couple of hours, or delivered on the same or next day. This standard of service is by no means remarkable but is the normal routine—a pathologist or radiologist who could not provide this would not last long in private practice.

Of the two major pathology practices in Brisbane, one covers centres as far afield as Mt. Isa, 1100 miles to the north-west, Gladstone to the north, and the New South Wales border to the south—while the other has 16 offices in the greater Brisbane area. Both collect specimens from patients at home, in private hospitals and nursing homes, and both provide round the clock specialist services at all times. Both have staffs of over 100 technicians, nursing sisters and clerk-typists, but neither feels the need of a medical administrator—the principals conduct this work along with their normal practice of pathology. Similarly, my radiological colleagues provide a round-the-clock service, take portables in hospital, never deliver a poor quality film, do not lose their records, are readily available for personal discussion, and again function without any medical administrator.

Routine Work Has to Wait

While at public hospitals it is possible to get rapid pathological services, it is far from routine, is usually the result of a special request, and the doctor has the feeling that the time taken by the clerk or technician to facilitate this will delay someone else's results further. The same applies to radiology: though it is possible to get urgent work done quickly, routine work is slow, with waiting times at some hospitals up to days for inpatients, and weeks for outpatients where non-urgent contrast radiology is required.

To give another example, Brisbane is favoured with several excellent private hospitals, the biggest of which has 250 beds, and functions under the control of a matron and a manager, with a board of management to whom they are responsible. Its services extend to neurosurgery. In spite of recent inflation, this hospital is still growing and putting up new buildings. The standard of nursing varies from good to excellent, and, so far as the attending clinician is concerned, the hospital appears to run very smoothly without the need for full-time or even part-time medical administrators, though several doctors serve on the board.

What accounts for the difference? One thing is quite obvious: the large "administrative" hierarchy of the hospitals and their parent departments or commissions cannot move with anything like the speed or efficiency of private practitioners whose administrative tasks—and they must be considerable in view of the volume of work done—are carried out as a side-line while they get on with their normal professional activities.

I draw the conclusion that first-class people who take a pride in their work, and to whom the provision of a first-class service is a personal challenge, always do better than "administrators," who are removed from what they call the work face, and whose responsibility to their patients and colleagues is diluted by passage up and down "administrative" paths. Thus making "administration" even more complex, and providing ever-growing numbers of staff to carry out purely "administrative" functions is likely to increase rather than decrease the difficulties of clinicians doing the work for which the hospitals are designed.

All this is not intended to cast a slur on the excellent work done by many friends and colleagues in hospital pathology and radiology departments. But while these people have great professional skill, they do not enjoy any administrative autonomy, and cannot run their departments as they would like to, because of the "administrative" structure into which they must fit. The dissatisfaction which they obviously feel is shown in the frequent passage of radiologists from public to private practice. Pathology does not have the same high turnover, probably because in this specialty much more of the work can be done by technicians than in radiology, and hence the existing private pathologists can expand their services considerably while adding only one or two doctors to their staff.

Size No Obstacle

Public hospital "administrators" may offer the defence that big organizations are much harder to run than small ones. This is

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just not so. The most efficient store with which I have ever dealt is not only much the biggest in Australia, but one of the biggest in the world. On the other hand, a public servant once told me that in his experience a reason for many delays and inefficiencies was that many of his "administrative" colleagues would not make a decision, in case their decision later proved to be wrong, and as a result, their promotion prospects declined.

There is a cynical statement among public servants that "we look after our own." To the outsider, this appears to be the case. As the number of senior public service appointments multiplies, so titles have become more grandiose, to allow for the creation of new grades at a senior level. Thus in some departments the chief doctor, formerly known as the principal medical officer, is now called the chief director of medical services, allowing for the appointment of various assistant directors subordinate to him, but who are still very senior staff. Whether at the extreme end of the line, in the wards and outpatient clinics, patients are treated any better as a result of this Parkinsonian growth, is another question.

A similar type of progress of uncontrolled growth of dubious benefit is beginning to affect the Royal Australasian College of Physicians. This body has rightly noted the need to enter the field of postgraduate medical education, and has some tentative proposals to create an organization for the purpose. It is clear that the first necessity would be a director of postgraduate education, whose salary would have to equal that of a professor or at least associate professor; he or she will require at least one stenotypist, an audiovisual aids technician, possibly a part-time librarian; would have to travel extensively throughout the length and breadth of Australia; and would spend a great deal on postage and stationery. On presentday costs this would scarcely be done for under $80 000 a year (doubtless more in future years), and I can only hope that the Fellows and Members of the College are not called upon to find this sum, in addition to their present considerable annual subscription. Again, to look at the person at the far end of the line, the greatest need of the doctor in practice trying to keep himself up to date is time in which to read—and, if some way could be found of providing this, most doctors would have the wit to know what their needs were in relation to the work they are called on to do, and where to look for help—in the form of books, journals, meetings, and the many other postgraduate activities already available.

Formalizing, codifying, "structuring," assessing, collating, auditing, and talk of recertifying sounds very fine; keeps people in undemanding highly remunerative occupations; and occasionally provides the basis for a Ph.D. in education or psychology. But who conducts a cost-benefit analysis of this sort of work, and who is to say there are not alternative methods of getting better value for less money?

"Illusion of Progress"

"We tend to meet any new situation by reorganizing—and a wonderful method it may be for creating the illusion of progress, while producing confusion, inefficiency, and demoralization." So said Petronius Arbiter 2000 years ago—and the only difference now is that reorganization usually involves additional committees and "administrative" posts and pathways—or so it seems in the public hospital sphere. By contrast, the school board on which I serve consists of seven members, as it did 100 years ago, and, while the school roll has risen to 1000 and the annual budget to a million dollars, the office staff has increased by only one.

Alvin Toffler speaks in *Future Shock* of the need for constant review of administrative frameworks to meet change. This is probably applicable to big business, but the pattern of sickness and the basic forms of medical and surgical treatment change only slowly. While a comprehensive new health service, such as was introduced into Britain in 1948, requires far-reaching administrative reorganization, the same is not true of year-to-year developments within hospitals, where the administration is not so much a major framework as a support service for clinical practice, teaching, and research.

Good administrators can give a lead. Crawford, Ritchie, and Herriott[2] were able to improve bed usage at Sydney Hospital as a result of administrative changes aimed at improving patient care—but it is notable that Frank Ritchie was not only the President of the hospital, but also senior visiting physician. When "administration" becomes a major end in itself, when "administrators" find unreal management problems in the ward or operating theatre, and set up elaborate organizational machinery without prior discussion with the clinical staff involved, it has got out of hand. There is a risk that, cancer-like, it may proliferate, feeding on the host's tissues and interfering with their proper function.

Cancer-like Growth

In this part of the world, the disease of "administration" is not confined to hospitals and royal colleges. A few months ago the Chief and Deputy Chief of Staff of the Royal Australian Air Force resigned their commissions, the reason being, so far as one can ascertain, their lack of confidence in "administrative" reforms affecting the Service. That the process is active in Britain too is apparent from Professor Calne's comment about "new committees or subcommittees that are proliferating like cancer cells, to the detriment of the National Health Service."[3]

"Administrators" have time to get together, draw up plans, rule up pieces of paper, compose forms to be filled in—this presumably being the way some of them see their duties. The busy doctors and nurses who look after patients have not the same opportunities to get together to discuss the implications of such proposals, and, when necessary, decide on a line of action to modify them or offer alternatives. By drawing attention to this disease, I hope to alert colleagues so that they can be on their guard against it, and by constant vigilance, vigorous individual action, and collective action when the opportunity arises, deal with this insidious process.

There is a right and proper place for administration in hospitals. Even so, these institutions should develop their own surveillance systems and immune processes so that, like a healthy body, they can keep their various components working in harmony.

References

[1] Lord Taylor, *British Medical Journal*, 1974, 3, 250.
[2] Crawford, L. E., Ritchie, F. L., and Herriott, B. A., *Medical Journal of Australia*, 1971, 2, 1291.
[3] Calne, R. Y., *Lancet*, 1974, 2, 1308.

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