USSR Letter

Aspects of ethics (1)

MICHAEL RYAN

British Medical Journal, 1979, **2**, 585-586

In countries that are economically developed doctors may share a common knowledge base of medical science, but it is evident that they differ widely in respect of such matters as social standing, remuneration, interest-group activity, and relationship with the state. Analyses of these interrelated factors show differences that are most striking between doctors practising in pluralistic Western democracies and their counterparts in the Eastern bloc. This holds true despite the fact that certain Western countries—the United Kingdom, for example—have chosen to make government a near monopoly employer of medical skills and thus are similar in that respect to the Soviet Union and its satellites. The extent of state responsibility for health services should therefore be regarded as a far less influential source of differences than the varying political traditions and sociopolitical climates.

The health services of the United Kingdom and the USSR have much in common so far as basic organisational features are concerned, but British doctors may strive to retain their image as members of "a free and learned profession," whereas their Soviet counterparts have lost this image irretrievably. It is hardly necessary to underline the fact that this loss was one result of the Bolshevik revolution and the subsequent liquidation of independent craft unions in Russia. Doctors in the Soviet Union are the salaried employees of a government that is totalitarian in the basic dictionary sense of tolerating no opposition. Their status, briefly expressed, is that of technicians deprived of any effective power base.

Given that Soviet doctors are unable to maintain their independence by interest-group activity, in what ways are they controlled or influenced by the state when handling issues with an ethical component? This question is simple to pose, but by no means easy to answer. One reason for the difficulty is the existence of a virtual "information blackout" over this topic. As I have pointed out recently,[1] a researcher cannot expect to obtain from Soviet sources even fairly basic data relating to certain health-service institutions, services, and disease categories; this observation applies with even greater force to the obviously sensitive topic of intervention in matters of professional judgment. Information relating to this area is scattered and difficult to locate, but it is nevertheless still possible to assemble an outline picture from Russian-language sources. So the following account draws on original material to focus attention on the main constraints—ideological and institutional—that may inhibit a doctor from acting in the best interests of his or her patient.

Department of Social Policy and Social Work, University College of Swansea, Glamorgan SA2 8PP
MICHAEL RYAN, PHD, lecturer in social policy

A framework of controls

Perhaps the most easily identifiable and powerful influence is the set of doctrines supplied by Marxist-Leninist theory in its officially disseminated form. This conventional wisdom is taught to medical students—and to all other young people receiving higher education—through the medium of compulsory lectures that are an integral part of their course. Although this is not the place to examine in detail the content of such teaching, two summary points are relevant. Firstly, it unequivocally subordinates medical ethics to what the stock phrase terms "the revolutionary world view of Marxist-Leninist philosophy." Consequently the ethical behaviour of a doctor is perceived—in the words of a recent textbook—as "a refraction of the norms, rules, and principles of Communist morality through the prism of professional medical activity."[2] The second and closely related point is that official doctrine constantly assigns heavy emphasis to the authority of the Soviet state and to the leadership function performed in it by the Communist Party of the Soviet Union.

The right of leadership that theory (and force majeure) confers on the party has its corollary in the duty of obedience that is owed by the population being led. It might be supposed that this general statement can have little practical application in the delivery of medical care. But such a view would be totally erroneous, as is indicated by the following quotation from an authoritative source: "The administration of the organs of the health service must have qualified staff who are politically trained and know how to implement the political line of the party in their work."[3] Incidentally, the cosy associations of the phrase "party line" for a British citizen have no place in this context—mainly because we enjoy opportunities of choice that are denied to Soviet citizens.

The "organs" referred to above denote the agencies responsible for planning and managing medical care; at higher levels, these are ministries of health and, at lower levels, the health departments. They operate within the so-called "administrative-territorial" system of local government that exists throughout the USSR. This system comes under the direct influence of the party—which does not focus solely on major policy issues discussed in Moscow, and does not become increasingly attenuated as one approaches the point at which doctor and patient interact. At every level of administration, party officials and party members may make an impact and, indeed, they are expected to keep the operation of field agencies under constant review. During a recent visit to a teaching hospital in Kiev (capital of the Ukraine) I noted that one room was designated for party meetings—a detail that may be taken as symbolising the extent to which keepers of the collective conscience penetrate the day-to-day operation of health-service units.

The influence of the Communist Party of the Soviet Union is one that affects—and is intended to affect—the widest possible range of social and economic activities. A second influence of crucial importance may be identified in specific institutional

features of the health service. This is the authority assigned to the medical bureaucrats who work in the operational units—the hospitals, policlinics, dispensaries, and the like. Although this factor serves to reinforce the first, it is analytically quite separate and the doctor-administrators should not be perceived as party officials wearing a different hat (many of them are not even party members).

In sharp contrast to contemporary Britain, all Soviet clinicians are subject to the authority of a medically qualified administrator who holds the post of "chief doctor" in hospitals and elsewhere. Concentrated in the hands of this one individual is such a broad array of powers that he occupies a truly dominant position vis-à-vis his staff. Thus he is responsible for appointing clinicians and has the legal right to impose on them disciplinary penalties for "the infringement of work discipline." (These penalties vary from a reproof to the extreme measure of dismissal.) The chief doctor has a responsibility not only for the professional competence of his staff, but also for their ideological correctness; his list of duties includes: "improving the qualifications and ideopolitical level of medical personnel, in particular of the doctors working in the policlinic and the hospital."[4]

Not surprisingly, there is little published information from which to assess the nature of interrelations between the chief doctor and his or her practising clinicians (most Soviet doctors are women). The evidence that I have managed to find occurs in creative writing, where critical commentary on contemporary institutions is largely submerged in the narrative. One example of such comment is provided in a recently published short story by Yuli Krelin, who is himself a leading surgeon at a Moscow hospital. The main characters in the story are surgeons who work at what may be a thinly disguised version of Krelin's own unit. At an early point, one of them remarks, while reflecting about their medical administrator: "Having been in administration for so long now, he has forgotten that a surgeon—and most likely a physician also—works only as he knows how. No orders, instructions, or recommendations from the administrator, neither a pleasant manner nor—on the contrary—an unpleasant manner, and no moral or material stimulus can make the surgeon's work worse or better. The results do not turn out worse than his skills permit and he will never succeed in performing better than his skills permit."[5]

If practising clinicians do experience the sense of alienation from their hierarchical superiors that is implied by the quotation, they must also recognise the futility of open conflict in conditions where authority is so strongly entrenched. Their perceptions are also likely to be conditioned by the fact of having "internalised" attitudes of deference not only through the general process of socialisation and indoctrination with Marxism-Leninism, but also by undertaking to fulfil a specific set of obligations at the outset of their careers.

The doctor's oath

Unlike Britain, the Soviet Union has made taking a professional oath compulsory for every citizen who receives his or her diploma on the successful completion of medical studies. Interestingly enough, this requirement is of comparatively recent origin, dating back only to 1961, when it was taken first by students at one of the Moscow institutes. By the late '60s, it was considered an expedient means "of raising the moral responsibility and the duty of a doctor to Soviet society," and consequently was made compulsory by article 13 of the 1969 Health Service legislation. In March 1971 an order of the Praesidium of the Supreme Soviet established the definitive text. It runs as follows:

> "THE OATH OF A DOCTOR OF THE SOVIET UNION—Having received the lofty title of doctor and having taken up a doctor's occupation, I solemnly swear:
>
> to devote all my knowledge and powers to the protection and improvement of man's health and the cure and prevention of illness; to work conscientiously in the place demanded by the interests of society;
>
> to be prepared always to provide medical care, to treat patients with attention and solicitude; to keep medical secrets;
>
> to improve continuously my medical knowledge and skills as a doctor; to assist through my work the development of the science and practice of medicine;
>
> to turn for advice, if the interests of the patient demand this, to professional colleagues, and never to refuse them advice and assistance;
>
> to preserve and develop the noble traditions of our country's medicine; in all my actions to be guided by the principles of communist morality; to remember always a Soviet doctor's lofty calling and responsibility to the people and the Soviet State.
>
> I swear to remain faithful to this oath throughout the whole of my life.[6]

Most of the foregoing text is consistent with the high ideals enshrined in the Hippocratic oath. Even so, the laudable dedication to improving man's health and so on is heavily qualified by sinister sounding references to the guidance provided by "the principles of communist morality," and a doctor's "responsibility to the people and the Soviet State." This overriding commitment—significantly positioned near the end of the oath—leads one to infer that when faced with a choice between acting in the interests of his patient and the interests of the State, a doctor is, so to speak, "honour bound" to resolve this dilemma in favour of the State. As I have already indicated, the interests of the latter are articulated by individuals and agencies that may persuade and coerce to a degree that is hard to imagine if one lives in a pluralistic liberal democracy.

References

1 Ryan, M, *The Organization of Soviet Medical Care*, Oxford, Basil Blackwell and Martin Robertson, 1978.
2 *Problemi vrachebnoi etiki i meditsinskoi deontologii*, Rostovski gosudarstvenni meditsinski institut, Rostov-na-Donu, 1977, p 8.
3 *Rukovodstvo po sotsialnoi gigiene i organizatsii zdravookhraneniya*, vol 2, ed N A, Vinogradov, p 30. Moskva, Meditsina, 1974,
4 Barkman, E M, Rodov, Ya I, *Upravlenie bolnitsei*, p 231, Moskva, Meditsina, 1972.
5 Krelin, Y, *Novi Mir*, 1979, **1**, 143.
6 Gromov, A P, *Prava, obyazannosti i otvetstvennost meditsinskikh rabotnikov*, pp 59-60. Moskva, Meditsina, 1976.

What is the cause and treatment of persistent subconjunctival haemorrhage in the elderly?

Even in the absence of specific vascular, haematological, or systemic disease, subconjunctival haemorrhages occur with increasing frequency and tend to become larger as old age advances. This is because the conjunctival blood vessels become more fragile and are more susceptible to rupture as a result of minor trauma or transient raising of intravascular pressure. The subconjunctival connective tissue also becomes less resistant to the spread of small haemorrhages. Very minor trauma such as dust in the eye, or simple stress such as coughing can precipitate a haemorrhage. Apart from simple measures, such as avoiding straining at stool and minimising the stimuli to coughing, there is little the patient can do to prevent their recurrence. Apart from their sometimes alarming appearance they do not usually produce symptoms. There is no effective treatment, although when a large haemorrhage causes such bulging of the conjunctiva that the lids will not close over it, evacuation through a conjunctival incision may be worth while.