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SOVIET GENERAL PRACTITIONERS AND POLYCLINICS

BY
R. S. SAXTON, M.B., D.T.M.&H.
D.Obst. R.C.O.G.
General Practitioner, Brighton

In my endeavour to find out if there was such a person as a general practitioner in the Soviet Union, and, if so, what it felt like to be one, I located her (70% of doctors in the U.S.S.R. are women) as the section doctor of a polyclinic. "Section" in this context refers to a section of the district served by a polyclinic. The actual work of the section doctor corresponds fairly closely to the work of a British general practitioner, but, like some British G.P.s, she does not do any surgery, midwifery, anaesthetics, or any treatment of a specialist nature. She is described as a physician therapist. I attended her surgery, visited her patients with her, and met her family in her home. Hence I got many valuable impressions as well as more tangible facts and figures. However, lack of time, language difficulties, and errors in notes and memory are my excuses for any inaccuracies and the many omissions in the following account.

Staffing

The institution known as a polyclinic varies in size and scope according to the size and special needs of the population served. Thus in a large urban residential district there might be a number of children's polyclinics staffed with paediatricians, including the local school doctors, and an adults' polyclinic; and in an industrial district there would be factory polyclinics, including on their staff doctors with specific duties in various parts of the factory. Within this comprehensive scheme covering the whole population there is a considerable degree of overlapping which allows for freedom of choice of polyclinic in some cases, and of section doctor in most cases. Thus adults of the family of a worker may attend that worker's factory polyclinic, as is usually the case, for instance, in the Tashkent Textile Combine, where most of the workers live fairly near at hand. This arrangement does not apply, however, in the "High Speed" shoe factory to any extent, as most of the workers live a fair distance away. Although this is the present pattern of polyclinics—that is, geographically isolated from hospitals—it is understood that future building in urban areas will tend more and more to polyclinics in conjunction with district hospitals.

The source of much of my information is polyclinic No. 71, situated in the Leningrad district of Moscow. It serves an adult population of 70,000 people who live within 2 km. (mostly much less) of it, in an area where many new six- to eight-story blocks of flats have replaced old wooden houses. In the same district are various children's polyclinics serving populations of about 20,000 children.

Moscow polyclinic No. 71 has a medical and dental staff of 94. Dentists are called "stomatologists" and rank as specialist doctors. Doctors engaged in public health in the area are also included in this figure. The 94 medically qualified staff are classified as follows:

4 administrative staff
19 section doctors
5 surgeons
4 pathologists
3 ophthalmologists
1 gastro-enterologist
1 haematologist
3 neurologists
1 endocrinologist
5 gynaecologists
11 stomatologists
2 dermatologists
2 oto-laryngologists
1 urologist
3 radiologists
3 medical referees
3 Pasteur Institute doctors
6 sanitary doctors
1 epidemiologist
11 emergency doctors (2 on day duty and 11 on night duty)
5 ward doctors (interchangeable on a rota basis with the section and emergency doctors)

The status of the specialist is that of a registrar, and the scope of his work limited. For instance, no major surgery is undertaken.

I do not profess to know the precise role of each of these categories, and know of their work only to the extent that it impinges on that of the section doctor. They work six hours a day, and their pay varies from the director at 1,700 roubles a month to the specialist at 930 roubles a month and the section doctor at 800 roubles a month. Any attempt to translate these figures into English equivalents is bound to be misleading. 800 roubles a month is about what a skilled worker in industry earns with an 8-hour working day. The higher ranks of the profession—for example, professors of medicine—earn very considerably more. The doctors are expecting a 15% rise in salary very soon. They are also permitted to undertake extra part-time work and private practice, though the latter is, I understand, rare. I have since learned that the section doctor's pay is now 725 to 1,100 roubles a month according to seniority.

Working Arrangements

A typical adults' polyclinic, such as No. 71, is a large three-story building with a semicircular drive having two entrances from the road. The doors to the central entrance hall are flanked by two cloak-rooms, where attendants take charge of overcoats, hats, etc. Opposite the entrance is the reception desk. It has numerous sections labelled alphabetically to indicate where patients' records are kept. The building contains numerous consultation rooms leading off fairly wide passages. Outside each consultation room are a few chairs for the convenience of waiting patients. There

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are also an x-ray department, physiotherapy department, operating theatre, antenatal clinic, a number of small wards totalling 50 beds, and all other offices appropriate to the staff listed.

The ambulant patient wishing to consult a doctor may phone the reception desk or call in and make an appointment. If the matter is of some urgency the patient may call at the usual hours of the appropriate doctor and have an immediate appointment. If not urgent a specific time is arranged, and there may be a delay of a day or two. So far as is reasonably possible the section doctor sees five patients an hour and the specialist eight patients an hour in their clinics. If the patient thinks the illness is in the domain of a specialist, the receptionist will advise whether this is so, and make an appointment accordingly. Thus many patients will by-pass the section doctor. However, all the medical records are kept together, so that all previous records are available whichever doctor is consulted. Although normally the section doctor is selected for a patient on a geographical basis, the patient is at liberty to change to one of the others on demand, by applying at the reception desk. The patient with an appointment collects a slip of paper appropriately inscribed from the reception desk and proceeds to the corresponding clinic, where the nurse admits him when the doctor is ready. A clerk from the reception desk brings the patient's records to the doctor.

The section doctor's clinic is a comfortable little room where doctor and nurse together interview their patients. It has a desk, chairs, couch, cupboards, etc., and usually several indoor plants for decoration. The consultation and examination are, according to our standards, friendly and orthodox. The doctor may then issue a prescription for medicine, send the patient for laboratory or x-ray investigation, for various forms of special treatment—physical medicine, inhalations, injections, etc.—or for further specialist advice, or admit the patient. The doctor can also issue certificates of incapacity to work, valid up to one week. If the patient is considered to be unfit after that period, certification has to be by the polyclinic medical commission (the medical referees). After six months' incapacity a district medical commission reviews the case, and may make a pension award.

Domiciliary Visits

If the patient is unfit to attend the polyclinic he sends a message which is dealt with by the receptionist. If the matter is not of immediate urgency, and the corresponding section doctor has not yet gone on her round, a visit is booked for that doctor, who usually has five or six visits a working day and three hours to do them in, with car and chauffeur provided. If the matter is too urgent to await the section doctor's normal visiting hours, or if the round has started, one of the emergency doctors is sent. On rest days only a team of specialists is on duty. All patients are visited on the day the request is made.

The section doctor starts her round with a list of visits, including acute cases she is currently visiting or has taken over from the emergency team, and chronic cases which she visits at regular intervals. She has ample time to take off her coat and hat, sit down and talk over the domestic problems, examine the patient, and give such prescriptions or treatment as she thinks fit. The patient usually announces his temperature at the beginning of the consultation. A doctor can admit a patient to the polyclinic wards or call in one of the specialists for a domiciliary visit, which she does fairly frequently (estimated at 10–12% of cases). It is particularly when going on her round with the doctor, seeing her ill patients, or meeting her well patients casually in the street that one realizes that doctors in the U.S.S.R. are respected and esteemed by the people as much as in England.

The drugs and treatment used in the Soviet Union are in the main similar to those used in this country. In addition to chemotherapeutic and antibiotic remedies, however, they still employ drugs and therapeutic methods which we have replaced or do not consider useful. For instance, dry cupping is still practised, and in hypertension leeches are applied to the mastoid region and intramuscular injections of magnesium sulphate are given. In general, the more expensive drugs and all injections are given by doctors or nurses calling at the patient's home, and these are free. Most medicines to be taken by mouth are sold at State pharmacies against prescription, and are fairly cheap. If the patient, however, is considered financially unable to buy such medicines, the polyclinic can authorize free dispensing.

Corresponding to the section doctor there is a section nurse who attends the clinic with the doctor, and visits patients as needed in the same section of the district.

Prevention

There is always a stress on prophylaxis in medical work in the U.S.S.R., as the following random examples which came to my attention indicate. All medically qualified persons are expected to spend four hours per month in health education. At the polyclinic the doctors are on the look-out for those in subnormal health who might benefit from sanatorium or rest-home treatment. The regular observation of cases of hypertension is also considered as a means of prophylaxis. Efforts are made to have a regular annual overhaul of all workers, and this is compulsory for all juveniles under 18. Women workers are invited to attend the gynaecologist three times a year with a view to detecting early cancerous or precancerous conditions (some consider cervical erosions to be precancerous).

The doctors at the polyclinic are also encouraged to keep their professional ideas and skills up to date, and to improve them. There is a weekly conference of doctors at which some of them give a five-minute talk on an interesting case. Every three months the ward doctors are replaced by some of the section doctors, who will thus have three months with greater possibilities to study sick patients and keep in touch with the various departments of the polyclinic. Specialists may go at intervals to hospitals. For instance, surgeons spend four months out of each year at hospitals. The regular and relatively short hours of work allow time for study, for writing, or even for another part-time job, and financial and other incentives are not lacking to encourage these things.

In her home life the doctor can get right away from her job. After her six hours the emergency doctors take over all responsibility; she does not do any midwifery. Often husband and wife go out to work, and they may employ a domestic worker in the home. They appear to live in modest comfort. The nature of their work does not require such an elaborate establishment as a British G.P. It is not necessary to have a car or even a telephone, though most of them probably have the latter. Secretarial and nursing assistance, surgery accommodation, instruments and apparatus, transport, stationery—in fact, every conceivable necessity for the job—is provided by the polyclinic.

Conclusion

To sum up. Every family in the Soviet Union has its own general practitioner, called a section doctor, and if there are children in the family there are two G.P.s, one a paediatrician. There is a reasonable freedom of choice of doctor in spite of the State salaried service. The work of the section doctor is unhurried and is facilitated by the constant nursing assistance in the surgery, and the easy access to specialist clinics. The number of consultations is small in proportion to the number on the doctor's list, and is evenly distributed from day to day. This is achieved by an appointments system run by trained receptionists who direct cases obviously requiring specialist advice direct to the appropriate specialist. Domiciliary work is also leisurely and is facilitated by the provision of a car and chauffeur, ease of admission to a bed in the polyclinic, and ease of obtaining specialist advice in the home. The doctor is free to prescribe as she thinks fit what is available. There is a personal and friendly relationship between doctor and patient, and the doctor is a well-respected member of the community. The doctor's

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work for the polyclinic is limited to six hours a day, six days a week. Outside these hours she is free from all responsibility for her patients, and other doctors are standing by for any emergencies.

The polyclinic is a most valuable institution for both prophylaxis and treatment. It is at the same time a valuable centre for education of both the patient and the doctor, and a means of rationalizing and easing the work of the general practitioner.

PUBLIC HEALTH COMMITTEE

The Public Health Committee, at a meeting held at B.M.A. House on August 2, re-elected Dr. J. B. TILLEY as its Chairman. Thanking the members, the CHAIRMAN referred to the recent death of Dr. G. F. Buchan. They all knew what Dr. Buchan had done for the Public Health Service. "He is a great loss to our particular branch of the profession," said Dr. Tilley.

Royal Commission

Dr. H. D. CHALKE reported a good deal of disquiet among those who had read the report of the proceedings at Newcastle upon Tyne, and, more particularly, the following resolution passed by the Representative Meeting there :

That the position of the public health medical officers shall be reviewed after the report of the Royal Commission is received and appropriate steps taken with a view to ensuring their proper status and remuneration *vis-à-vis* their colleagues in other branches of the medical profession.

There had been read into that the implication that nothing was to be done about remuneration in the public health service until the Royal Commission had reported. It should be made quite clear that that resolution did not preclude steps being taken in the interim.

The CHAIRMAN agreed, pointing out that even taking the wording as it stood there was nothing to say that the position could not be reviewed before the event. He himself hoped that something would be done in that direction long before the report of the Commission ; and it might be that further steps would have to be taken after the report was issued.

Dr. S. WAND, Chairman of Council, expressed his concurrence with what the Chairman had said.

Evidence to Royal Commission

The CHAIRMAN reported that he, together with the Chairman of Council and the Secretary, had called on the Chairman of the Royal Commission, who had refused to include the public health medical officers in the Commission's inquiry. He had added, however, that the Commission would be anxious to have evidence on remuneration in the public health service. His view was that it might be helpful if that evidence approached the form that it might have taken had the public health service been considered along with the other branches of the profession, as the appearance of that evidence in the published proceedings of the Commission might be helpful to the public health medical officers later.

Following that meeting, said Dr. Tilley, he and Dr. Wand had seen the Minister of Health. Dr. Wand had pressed the Minister exceedingly hard. Dr. Tilley had had to tell the Minister that the Whitley machinery had not broken down, nor had the Public Health Committee considered a recasting of the scheme of remuneration since the initial claim was made in 1950. He had inferred, from what the Minister said, that his view was that until the Whitley machinery had broken down on the recasting of a whole new scale of salaries he could do nothing about it.

Following a lively discussion, in which the Chairman of Council took a prominent part, it was decided to set up a special evidence subcommittee comprising the Chairman and Drs. Chalke, Harding, Hughes, Kelman, and Pickup.

The Committee appointed its Chairman and Dr. Hughes to be its representatives on the Evidence Committee of the Association.

Public Health Autonomy

The Committee then gave its attention to a letter from the Society of Medical Officers of Health, dated May 24, which read as follows:

I am desired by the Council of the Society which met to-day to request that the British Medical Association create an autonomous section which will be responsible for negotiations and for public statements on public health matters.

A long and lively discussion ensued, in the course of which the Chairman of Council went into the history of autonomy, being closely questioned on a number of points. At the conclusion of the debate the Committee passed the following resolution:

That it be recommended to the Council [of the B.M.A.] that the Committee on Professional Co-ordination be asked to give full consideration to the position of the Public Health Committee in relation to the autonomous committees of the Association.

It was also resolved that the matter should receive further consideration at the next meeting of the Public Health Committee.

Recognition of Previous Experience in Fixing Commencing Salary

The Committee considered a report that the previous professional experience, other than in the local authority service, of dentists, but not of doctors, was taken into consideration by an authority when fixing the commencing salary. The Committee regarded this as an anomaly which should be referred to Whitley Committee C.

Dr. Kelynack

The Committee heard a report on the illness of Dr. A. V. Kelynack, and resolved to convey to her its sympathy and good wishes.

Scottish News

ASSISTANTS AND YOUNG PRACTITIONERS IN SCOTLAND

CONFERENCE OF REPRESENTATIVES

The General Medical Services Subcommittee (Scotland) has decided to sponsor a conference of representatives of assistants and young practitioners in Scottish House on Tuesday, September 24. The purpose of the conference is to afford the Scottish representatives on the Assistants and Young Practitioners' Subcommittee—Dr. C. Grant (Pitlochry) and Dr. K. Adams (Glasgow)—an opportunity of discussing with representatives of their constituents any problems of common interest. Each local medical committee in Scotland has been invited to send representatives to the conference, and in addition there will be present Dr. W. M. Knox (chairman of the Scottish Committee), Dr. C. J. Swanson (Chairman of the G.M.S. Subcommittee (Scotland)), and Dr. J. T. Baldwin (Chairman of the Scottish Medical Practices Committee), together with Dr. E. R. C. Walker, Scottish Secretary of the B.M.A., and Dr. J. T. McCutcheon, Assistant Scottish Secretary.

If any assistant or unestablished practitioner in Scotland would like any particular matter discussed, he should communicate with the Assistant Scottish Secretary, B.M.A., Scottish House, 7, Drumsheugh Gardens, Edinburgh, 3, by Tuesday, September 10.

Scottish House Telephone Number Changed

The telephone number of B.M.A. Scottish House, Edinburgh, will be changed, as from August 31, to Caledonian 7184.

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Correspondence

Consultants' Contracts

SIR,—I have just received a copy of *The Times* of July 12 and would like to comment on the remarks made by Dr. H. G. Dowler, of Gloucestershire, at the A.R.M. He is quoted as saying, "I think it came as a shock to many people that our agreement regarding remuneration could not be enforced in courts of law," amid a chorus of approving "Hear, hears."

At the time when "contracts" were being negotiated I was a member of the N.W. Metropolitan Regional Hospital Board Consultants Committee. Having listened, almost *ad nauseam*, to endless discussion on the subject of our so-called "contracts," I felt bound to intervene. Having first explained that I had taken my B.A. in the Honours School of Jurisprudence at Oxford, and been subsequently called to the Bar, I then pointed out that the document which everybody was referring to as a contract bore little resemblance to a legal contract at all. Even to a non-practising lawyer it was obviously a unilateral agreement, variable at will by one side—the Ministry of Health.

This produced, I remember, considerable astonishment and dismay at the time. I suggested that legal advice should be taken before the next meeting, and this, apparently, was done, as the Chairman announced that my contention was legally correct and that the agreement we were being urged to sign was not in any way a legally enforceable contract. It is perfectly certain to me, at any rate, that this fact was well known by the negotiators long before anybody signed an agreement with the Ministry. I find it very difficult to understand how so many have apparently remained in ignorance until as late in the day as the B.M.A. Annual Representative Meeting at Newcastle upon Tyne on July 11, 1957.—I am, etc.,

Bagur, Spain. D. G. WILSON CLYNE.

Medical Booklets

SIR,—I do not remember over a long period of years having read in your correspondence columns in one issue three such abysmal letters as appeared in the *Supplement* of August 10 (p. 91).

Dr. H. G. Howitt, writing on medical booklets, makes some statements which I venture to suggest he would find difficult to substantiate. On what grounds does Dr. Howitt base his suggestions that (1) the N.H.S. has fostered neuroses; (2) the publication of medical booklets has aggravated that "incidence of neuroses"; (3) the "majority of members deplore publication" of medical booklets? If Dr. Howitt wishes to enter the field of controversy in this subject it would be as well to arm himself, and your readers, with more precise evidence and more detailed information. Dr. Howitt states that "the B.M.A. embarked on an unfortunate unethical adventure" in deciding to publish medical booklets: such a statement is as pernicious as it is unfounded. May it be that Dr. Howitt finds it difficult to deal with the intelligent questions which intelligent people, having read the booklets, are now disposed to put to him?

Dr. L. E. Lucas in his letter "B.M.A. Negotiator" makes a fundamental error in not appreciating that it is the strength of our case which matters. Special pleading by however distinguished an advocate, industrial or otherwise, will not make a weak case a strong one. This surely is the "crucial point." Dr. Lucas's contention is shown to be what it is worth in the law courts every day.

Dr. M. B. Griffith writes under "Position of Public Health M.O.s" that "the B.M.A. ought to hang its head in shame" for reasons which he sets out. Might not Dr. Griffith himself adopt that unbecoming attitude in repentance for exposing his profound ignorance of B.M.A. policy in such unpleasant terms?—I am, etc.,

Tunbridge Wells. R. PROSPER LISTON.

Reform of Health Service

SIR,—We have been so busy recently arguing our case for better pay in your columns that some of the other more obvious clouds on the horizon of that oft-quoted fellow "the average G.P." have been billowing out to cover half his sky. It has little to do with money that he is now less happy, less interested, less respected, less concientious, and less informed than we like to think he should be. He has allowed himself to be caught in an administrative net, his technical and intellectual wings clipped, his prestige plucked, and he will soon be cooked—for good. At our local hospital, at which G.P.s are not allowed to work, there are on the resident staff at the moment doctors from Bolivia, Pakistan, India, and Italy, not to mention a succession of Australians. In spite of some of them having difficulty in speaking English, they are, I am sure, doing a very good job, and many Bolivians, Indians, etc., are going to benefit in the future from the practice they have had on our patients. We are grateful to them for filling this gap. But why does a gap exist? Why did we bother to do this full range of hospital residents' jobs if we are not given facilities to do our own minor operations or our own medical investigations? If a patient of mine has a Colles fracture, or an ischiorectal abscess, or requires a paracentesis in aseptic conditions, he must be transferred to a hospital, where he may nominally be under a consultant but in fact is under the care and judgment of a less experienced doctor or one trained in a foreign land. No wonder patients don't look on us as proper doctors.

In a hospital doctors meet as colleagues, not rivals. They learn together and help each other. They become friends. But G.P.s with no common meeting-ground too soon become involved in the worst sort of competition. But much the worst aspect is the effect on the consultants. More and more patients are sent to consultants when the diagnosis and course of action are obvious, because the G.P. himself cannot order treatment or investigations only available at the hospital. The out-patient departments become hopelessly crowded and each patient waits weeks for an appointment. Weeks go by before a patient can start the treatment he needs simply because he is waiting for a few minutes of the overworked consultant's time. The diabetic becomes more ill and the torn shoulder becomes stiff. This all leads to an excessive number of domiciliary visits to ambulant patients. This "jumping the queue" costs this country at least four guineas a time.

Is it not obvious that if we are going to prevent medicine in this country from being the worst in the world, and if we are to attract once again the right sort of man to this great calling, we must have more G.P. hospitals, encourage clinical assistantships, and limit G.P. lists? The present system of running the N.H.S. under three authorities, hospital boards, executive councils, and local health authorities, is the root cause of all these evils and, incidentally, the cause of the appalling cost of the Service. It may seem tidy to the administrator, but it is ruining the doctor—and the country.—I am, etc.,

Briss, Lincs. JOHN WILLIS.

Association Notices

Diary of Central Meetings

AUGUST

21 Wed. **Special Meeting of Council,** 10 a.m.
29 Thurs. Journal Committee, 2 p.m.

SEPTEMBER

18 Wed. Film Committee, 2 p.m.
19 Thurs. G.M.S. Committee, 10.30 a.m.

Branch and Division Meetings to be Held

COVENTRY DIVISION.—At Holly Lodge, Meriden, Saturday, August 24, 6 to 8 p.m., sherry party.

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