Soviet Letter

Aspects of primary medical care in Leningrad

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Since the health service of the Soviet Union comes under the direct control of public agencies one might suppose that there is no shortage of factual information about its planning and administration. In fact, however, the scope and detail of organisational data available in Russian language publications suffer from severe limitations.

Ironically, the nearest equivalent to general practice in the Soviet Union is far less open to public gaze than the British system of family doctoring, which operates on an independent contractor basis. On account of the comparative "information blackout," special interest attaches to the recently published findings of a study undertaken in Leningrad during 1976. In what follows the numerical data are derived almost entirely from that study.¹

Policlinics and terapevti

In Soviet towns most diagnosis and treatment of ambulant patients take place in the so-called policlinics. Larger and more complex than British health centres, these units serve populations of 30 000-60 000 and are staffed by doctors from a range of basic specialties. The most numerous single group are the terapevti or general physicians for adults. In theory, one such doctor is attached to each geographical sub-division (sector) of the district served by a policlinic, and he is the closest approximation to a family doctor that can be encountered in the Soviet health service. The Leningrad study based its findings on information about 1302 of these sector terapevti.

One of the most striking findings was that women accounted for 88% of the doctors interviewed. That is well above the level (69%) for doctors and dentists in the Soviet Union as a whole and is probably explained, in part at least, by reference to another finding of the study. This was that most interviewees (70.8%) had first qualified as "intermediate medical personnel," such as nurses or feldshers, before proceeding to obtain their diploma as doctors. The opportunity to transfer from one grade of staff to another has existed for many years and is facilitated by preferential arrangements in medical institutes. It is well known that girls who fail to obtain a place in a medical institute first time round will take nursing courses in the hope of becoming doctors by what might be called the back-door entry.

Medical training

Even in basic medical training there exists a degree of specialisation, and theory states that general physicians should have obtained their diplomas after specialising in "curative medicine." But in fact only 82% of the Leningrad doctors graduated in that broad field. The remainder had backgrounds in environmental health (14%), paediatrics (3.4%), and even stomatology, the Russian term for dental surgery (0.8%). While there must be some overlap between the various courses—especially between curative medicine and paediatrics—the figures quoted apparently emphasise the difficulty of attracting to these posts staff with the most appropriate qualifications.

The research report goes on to point out that the effectiveness of a sector terapevt is closely related to postdiploma training. It transpired, however, that only 61% of interviewees had taken one or other type of postdiploma course in general medicine. In this matter age proved to be a critical factor: 72% of those with less than five years' service had received such instruction compared with 46% of those with over five years' service.

Most policlinics are administered as sections of hospitals, while many of those constructed in recent years are located within the same complex of buildings as the hospitals to which they are subordinated. It might be supposed that this geographical proximity of units affords a golden opportunity for policlinic doctors to work on the wards for a fixed time every few years. Indeed, in the past it was official policy that staff should do so. But this practice has now been largely discontinued, and the survey found that during the previous five years only 4.5% of sector terapevti had treated inpatients under the system of alternating duties.

In addition to formal qualifications knowledge of the socio-economic background of patients probably has a close bearing on a sector doctor's effectiveness. Commonsense suggests that there should be a strong positive correlation between the acquisition of such detailed information and length of service in a single sector. It is therefore truly remarkable that 69.4% of the Leningrad doctors had worked in one and the same sector for less than five years and only 14.4% for longer than ten years.

Effectiveness of primary medical care

Effectiveness in primary medical care, rather obviously, is a concept for which precise measurements cannot easily be derived. Interestingly enough, the one adopted by the survey relates to the number of persons who, to use Russian terminology, are being "dispenserised." In essence this expression denotes long-term follow-up of patients, a practice that originated in the dispensaries for specific diseases such as tuberculosis. According to the survey, the number of dispenserised patients per sector clearly depends on the doctor's length of service in that sector.

Staff may transfer from one sector to another while still remaining in the employment of the same policlinic. Even so, only 20% had worked in the same policlinic for more than ten

years. One of the reasons cited to explain this high turnover-rate is change in place of domicile. The authors of the report maintain that the desire of sector doctors for work near their homes must be taken into account when arranging their duties and assigning living quarters to them.

Cars are used comparatively rarely for home visiting. Most general physicians—65%—walked around their sector, while 32% used public transport and only 3.6% were supplied with official vehicles for this purpose. As is well known, ownership of private cars is at a fairly low level in the Soviet Union, so it is reasonable to assume that few if any of the doctors in the survey possessed his or her own vehicle, and that none used it in connection with work.

Work load

The number of adults per sector has a direct implication for the work load and amount of time spent on home visits and, more generally, for the quality of the service provided. From time to time reductions in the ideal number or norm have been made at the highest levels of government—the Central Committee of the Communist Party of the Soviet Union and the Council of Ministers. In 1977, for example, these bodies adopted a joint resolution concerning measures to improve health care, and one requirement was that general medical sectors should be subdivided into smaller units so that there will be one sector therapist per 2000 adults by 1982 and one for every 1700 adults by 1985.

At the time of the survey, Leningrad was already close to achieving the first target: for the city as a whole the ratio stood at one therapist per 2020 persons. This average, however, concealed appreciable variations, ranging from 1500 to 5000 in districts of new housing. The heavier case loads in the latter presumably act as an incentive to transfer to another sector, especially if that one is situated closer to the base polyclinic. The survey reported that 27% of sectors were considered by the doctors to be "inconvenient" on one ground or another.

In the Soviet health service, as elsewhere, official statistics can convey a misleading impression of the real staffing position. Thus the posts for sector therapists had been reported as being filled virtually to capacity. Nevertheless, in response to detailed inquiry a more accurate picture emerged. Firstly, the permanently assigned therapist would not necessarily be available when needed. The basic reasons for her absence ranged over leave, illness, pregnancy and childbirth, postdiploma training, and looking after sick members of the family. Predictably enough, the frequency and causes of absence varied with the age and sex of the doctors.

Secondly, only 72% of sectors were served by their "own" doctors while 24% had doctors who had taken the post as their second or supplementary job. The residual sectors had no staff specifically assigned to them, which, according to the survey's careful wording, "makes the work of the polyclinic more difficult and evokes dissatisfaction among both doctors and the population."

Second posts

Holding second posts in no sense constitutes moonlighting: official advertisements for vacancies often refer to the opportunity for undertaking additional duties, and the short working hours make this perfectly feasible. Sizeable numbers of doctors probably regard this as a convenient way of increasing their total income above the comparatively low basic level of pay. However that may be, in the Leningrad study almost 47% of interviewees held second posts, the vast majority as sector therapists.

Doctors' attitudes

Given that the Soviet system has a strong tendency to inhibit direct and open criticism of social institutions, it is most interesting that the survey concludes by referring to the doctors' attitudes towards their work. A fairly substantial proportion—41%—expressed dissatisfaction with organisational issues in the polyclinic or their own sector. The reasons given for dissatisfaction included overlarge caseloads, absence of a practice nurse, lack of opportunity for professional development, difficulty of following up patients in hospital, and shortage of time for performing obligatory functions. So it could be scarcely surprising that the authors came to the conclusion that "Analysis of the reasons for dissatisfaction of sector doctors with the work they undertake has revealed the influence of organisational questions on the psychological condition of sector doctors which, without question, also reflects on the quality of their work and on the stability of cadres." Whether the administration is now taking action on the basis of this exposé must remain a matter for conjecture.

Reference

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What is the cause of high altitude pulmonary oedema? Is there an inverse relation between altitude and duration of exposure in initiating the condition? How do age and physical exertion at altitude affect the likelihood of this complication occurring?

High altitude pulmonary oedema is caused by a too rapid descent. Hypoxia and hyperventilation lead to a complex series of changes including a shift of blood from the systemic to the pulmonary circulation and pulmonary artery hypertension. Vasoactive substances in the pulmonary circulation may be implicated in the development of oedema. Acetazolamide and spironolactone have been recommended as prophylactics, but hard data on the efficacy are lacking, and it is widely held that they are no substitute for a slow rate of ascent. Physical exertion probably contributes to the occurrence of high altitude pulmonary oedema, the old may be less susceptible than the young, while children, who are inclined to run about, may have an additional susceptibility. Physical fitness is no bar to its occurrence, but there is wide person-to-person variation and no reliable method of predicting who is likely to be at special risk—thus while one person may be affected at 10 000 feet, another may be unaffected at 15 000

feet. The condition is uncommon in the Alps as many who go there sleep at about 6000 feet, making day trips to higher altitudes. In the Himalayas and the Andes, where trekkers remain at medium to high altitudes for longer periods, the condition is much more common, especially in those who go by road or air transport to points from 9 to 16 000 feet. A visitor to Mt Etna should have no trouble—if he feels unwell he should walk back to his car and go down to a lower altitude—symptoms abate with remarkable rapidity on descent.

A woman of 32 whose husband has a first and a second cousin with Friedreich's ataxia asks what is the possibility of her having a child with the disease.

Classical Friedreich's ataxia is autosomal recessive. Accordingly, if this is the correct diagnosis in the husband's first and second cousins the risk to the children of the marriage will be low, provided that the husband and wife are not cousins. If the exact form of spinocerebellar ataxia is in doubt or if the husband and wife are cousins then the couple should be referred to a genetic clinic.