(3) Even with quick transfer arrangements, consultants in acute specialties often still try to effect discharge even if this means retaining patients over 30 days.

(4) Transfer within a few days often benefits both patient and interdepartmental relations.

(5) Acute units will have less anxiety about admitting elderly patients if transfer is relatively easy.

(6) Better support from social welfare and housing departments would facilitate bed availability in both short and longer stay units.

I thank my colleague Dr D N Ropper for allowing me to include his cases in my figures. I also thank my secretary Mrs C M Storie for her invaluable help.

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USSR Letter

Aspects of ethics (2)

MICHAEL RYAN

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In last week's article on medical ethics in the Soviet Union I discussed fairly general topics; here I examine two specific points where the discretion of a Soviet clinician has been severely limited. In any country it is probably inevitable that doctors should act on behalf of the wider society through the issue, or withholding, of sickness certificates to members of the economically active population. Nevertheless, there are stark differences in the extent of supervision exercised over the medical validation of temporary withdrawal from the workforce. In the Soviet Union, unlike Britain, a doctor's opportunity to err on the side of generosity is at an almost irreducible level.

Sickness certification

Drastic curtailment of the individual practitioner's responsibility has been brought about in two main respects. Firstly, he is not permitted to issue a sick-note for a period lasting longer than three days—except during influenza epidemics—and has no authority to excuse a patient from work for over six days at a time for any one episode of illness. Secondly, if he considers that an extension is necessary, he must normally obtain consent for this from a small committee—termed a medical consultative commission—which is convened, as required, at polyclinics and hospitals. Meetings are chaired by the unit's deputy head doctor, whose specific function is to control sickness certification; other members are the patient's own doctor and the head of the relevant department. As "the highest organ" for decision-taking,

the commission enjoys wide-ranging powers, which include transferring a worker to another form of employment or arranging for "easing of conditions of work." Decisions about certification in difficult and complex cases appear to be made primarily on the basis of published case lore—which further reduces the chances of a patient getting the benefit of any doubts. Patients who have no chance of recovery are referred to another type of commission, which assigns them to one of the three categories of invalidity.

From the relevant publications it is clear that great importance attaches to ensuring that the number of work days lost because of illness should be kept as low as possible. This longstanding preoccupation has acquired added urgency in recent years because of labour shortages that affect various sectors of the economy; these threaten to become more serious owing to the low birthrate throughout most of the Soviet Union (the major exception is Soviet Central Asia). Although the costs of "policing" sickness certification are clearly high in terms of time and manpower, the Soviet leadership may well consider them fully justified by the results—at least for the period 1965-74 (more recent data are not available). According to the annual abstract of statistics, the trend was then moving very much in the right direction: in 1965 the average industrial worker had 15.2 certified days absence in connection with illness or childbirth, and by 1974 the figure had declined to 13.5 days.¹ Fairly obviously, several questions can be raised about issues such as the relative impact of improvements in standards of living, housing stock, and conditions at work. It would also be useful to have evidence from longitudinal studies to establish whether chronic illness has resulted from premature return to work. It seems most probable, however, that the Soviet authorities would not publish such evidence if the findings had proved unfavourable.

Unfortunately, no reliable assessment can be made of the impact which the strictness of sickness certification makes on relations between Soviet doctors and their patients. But a useful indication of the bureaucratic pettifoggery which clinicians endure is conveyed in a passage from a short story by Yuri Krelin. One of the surgeons has an encounter with the battleaxe

Department of Social Policy and Social Work, University College of Swansea, Glamorgan SA2 8PP

MICHAEL RYAN, PHD, lecturer in social policy

of a lady doctor responsible for sickness certification; she complains about the documentation for a patient with cancer (who, in fact, is at death's door anyway) and part of their conversation runs as follows:

Your notes should have been made up in your own hand in the history of the illness. But here there's only a record of your ward round and recommendations. . . .

Why should I write it out myself? I don't have the time . . . my signature is there—everything is in order. If it's not, let me sign.

Your signature is there, but Pirogov [another surgeon] must personally come to me with the history of the illness. He must personally present the patient. Why must I delve around in your notes?

Pirogov is busy all day. From morning he has a ward round, discharges patients, writes out all the histories of illness, discharge notes, charts, and other stuff. Then he operates. He was doing aortography. And dressings. How can he be an idler? He simply doesn't have any time left over.²

Professional secrets

There is a second specific area in which a Soviet doctor is obliged to subordinate the interests of his patient to the state's requirements—as set out in legislation, and interpreted by the political and administrative authorities. That is the question of medical confidences, and it is one that repays examination because it so clearly shows a duality of standards and—to use George Orwell's phrase—"double think."

To take first the positive aspect—the importance accorded to preserving the confidences of the consulting room. Thus, as readers of my last article will know, all newly qualified doctors pledge themselves in their oath "to keep medical secrets." Moreover, the basic legislation governing the provision of health care—passed in 1969—stipulated in Article 16 that: "Doctors and other medical personnel have no right to divulge information about a patient's illness, or about the intimate or family aspects of a patient's life that have become known to them in the course of their professional duties."³

As it happens, there is evidence to prove that in the last few years action has been taken to tighten up on fairly widespread laxity. This action may reflect—at least in part—the criticisms made by a better educated and generally less subservient population, which is now demanding higher standards in public services. Whatever the truth of that, some two years ago the USSR Minister of Health issued a circular letter which announced a decision "to restrict to a maximum extent the circle of persons who are permitted access to sickness certificates and to enhance their responsibility for the preservation of confidence in respect of the diagnosis shown on the sickness certificate." Reference was made to the failure of several units to observe rules for storing documents, which meant that patients and others could obtain case histories. Medical staff were also criticised for discussing the condition of patients when within earshot of relatives and other visitors.⁴

Genuine efforts are undoubtedly being made to improve matters—even if much remains to be done (it is not unusual to have two patients in a consulting room at once). But, at the same time—and this is where the duality of approach is evident—doctors are still required to ignore the concept of confidentiality with patients who are deemed to have departed from the approved norms of behaviour. For such people the law affords no protection. The second part of Article 16 of the 1969 legislation states that: "The directors of health service institutions are obliged to report information about a citizen's illness to health-service organisations when it is in the interests of the population's health to do so, or when requested by investigatory or judicial organs."

Reference to public-health considerations may sound innocuous, but this can entail bringing to court a patient who has presented with a venereal disease. Certainly, the health-service authorities have been allowed some latitude to take account of family circumstances. Nevertheless, a recent report stated that out of 83 patients suffering from gonorrhoea or syphilis 18% showed "clear signs of immoral behaviour" which rendered impossible the preservation of their confidences.⁵ (The text gives no indication as to how "immoral behaviour" is defined.)

In law, it is true that the responsibility for divulging information lies with directors of health-service institutions. But, so far as I can discover, this is no more than a quibble and there can be no ambiguity about the position of the patient's own doctor in court proceedings. One source has put the point this way: "The requirement to respect a professional confidence does not mean, of course, that a medical worker can refuse to provide evidence as a witness in the judicial process. Doctors, in accordance with the criminal-procedure code, must give evidence concerning all circumstances of the criminal matter; that means the intimate or family aspects of a patient's life connected with an illness also."⁶

It is hardly necessary to add that the circumstances described are likely to be viewed with abhorrence by most doctors in Western countries.

Conclusion

So far, I have not mentioned the ethical issues raised by the abuse of psychiatric categories for the forcible detention of dissenters in special prison hospitals. This is a subject that has been scrupulously documented in a recent study by Bloch and Reddaway⁷ and there is no justification for any substantive analysis in this short article. Nevertheless, I should say that the psychiatric abuses perpetrated by Soviet doctors may be viewed—but not excused—as an extreme example of conformity to the requirements of the state. In other words, clinicians responsible for these abuses were, in a sense, loyal servants interpreting the dictates of their political masters.

That observation leads straight back to considering the USSR's form of government—which I described earlier as totalitarian. Some might object that a milder term, such as authoritarian, should be applied to the USSR of today. Certainly, the years of Stalin's ruthless dictatorship are unlikely to recur, and the state apparatus is now regarded as less arbitrary in its dealings with the average citizen. It may even be true that, in general, respect for the rights of the individual is more highly developed in the 1970s than at any time since the revolution.

Nevertheless, these gains have not altered the ideological impossibility of encompassing the concept of opposition within the constitutional framework. (Leading figures of the human rights group have been silenced not by firing squad but, almost as effectively, by imprisonment and exile to the West.) So long as the Soviet state remains monolithic, its rulers will continue to confirm their own judgments about what constitute the interests of the community. By the same token, they will continue to ensure that doctors act as agents of labour discipline and of social control, working within a purpose-designed ethical framework.

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