should be banned from further contact sports. Murphey and Simmons[18] advised that if head injury was severe enough to produce coma, or if a player has had a craniotomy, then further contact sports should be discouraged.

Inevitably, boxing causes repeated minor head injury, and in this sport much attention has been directed towards minimising the effects. Availability of computed tomography may indicate the extent of damage produced by such injuries.[19] Statutory medical cover and stringent rules regarding further fights after injury have done much to reduce the number of serious head injuries,[7] but the number of participants has also declined. The present study has shown that other sports, in particular horse-riding, are now a more frequent cause of severe head injury. More emphasis should be placed on prevention in these sports. The governing bodies of the individual sports should draw up rules to ensure that sports trainers and supervisors are aware of the correct management of head injuries.

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USSR Letter

Questions of sickness certification

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By virtue of its impact on the workforce, a health service with universal coverage of the population can be viewed as one means of enhancing economic development. For any type of government it may offer the attractive prospect of helping to reduce the number of working days lost owing to accidents and illness among the labour force. In practice, however, democratic governments and totalitarian regimes differ substantially in the extent to which they can oblige health care personnel to put the behests of the state above the health of their patients.

In most pluralist democracies the doctors who practise under a national health service will be required to issue certificates which validate absence from work and enable insured persons to draw sickness benefit, but, generally speaking, their "policing" function is at a minimal level thanks to their retention of an independent power-base. In the USSR, since doctors cannot exercise influence as a pressure group, they have no choice but to accept the role assigned to them in the enforcement of labour discipline. In what follows I draw on a recent article to describe the Soviet regulations governing sickness certification and certain changes that are considered necessary in them.[1]

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Short-term sickness

The front-line doctors in a policlinic or similar unit are limited to issuing initial "certificates of lack of fitness for work" for up to only three days or for five in cases of influenza during an epidemic. They are permitted to extend the duration of sick leave on their own initiative by up to a further three days, or one for influenza. Any absence from work for longer than six days must be validated by superiors in the medical hierarchy. This is done either by a departmental head or by a small committee of the policlinic's staff convened as necessary by the deputy chief doctor, a specialist in what the Russians revealingly term "expertise in fitness for work."

Although the official reasoning behind the adoption of three- and six-day limits is not clearly stated in the article, two considerations appear to have been especially influential. The first is the desirability of a second consultation to confirm or correct the initial diagnosis and the treatment based on it. In this context the authors of the article report a most striking result from their

own research: "According to our data, about 30% of diagnoses established by policlinic doctors at the patient's first visit require refinement or correction, in connection with which the need also arises for a change in the treatment prescribed in the first days of illness."

The second factor that probably helped to determine the choice is that most episodes of illness among workers end within the maximum period of sick leave that one doctor is permitted to grant. This seemingly objective fact becomes blurred on closer inspection, however, as the authors themselves seem to be aware. At any rate, they refer to findings obtained in the 1950s and 1960s by a certain R M Gladstein that a reciprocal cause and effect relationship existed between duration of illness and the maximum period of sick leave which one doctor could allow. When in an experiment sick notes were issued for up to 10 days more than 80% of cases of influenza and acute catarrh of the upper respiratory tract ended within that time. Yet when the maximum duration was reduced to six days the same proportion of cases could be signed off within the six days' limit. Senior policymakers could hardly have overlooked the economic implications of that finding.

Proposals for change

Unlike many general practitioners in Britain, the authors of the article do not argue that certification of short-term illness is a time-wasting task which should be abolished; indeed, such a radical notion would not see the light of day in a prestigious Soviet journal. What the authors advocate are essentially minor adjustments to existing regulations whose interest resides mainly in the background of argument used to support them.

Rather self-evidently, the short duration of sick notes has a direct bearing on the volume of attendances at a policlinic and hence on the work loads borne by the staff. According to a study carried out by one of the authors, 33·0-37·5% of visits to sector *terapevti* and their equivalents in factories were not justified on medical grounds but resulted from the regulations for certification. A broadly similar picture emerged in respect of other types of specialist providing outpatient treatment. To be precise, 32·5-36·5% of visits to surgeons and 34·0-45·0% of visits to neuropathologists and others arose not from medical needs but from the exigences of form-filling. Moreover, out of the referrals sent to heads of various departments after the sixth day to obtain an extension an average of 21% were clinically unnecessary. So the authors could hardly be accused of exaggeration in noting that the present arrangement "leads to the wasteful expenditure of time by both doctors and patients and to the distraction of departmental heads from consultative work relating to observation of more complex and serious cases. . . ."

The current regulations are also regarded as prejudicial to the principle of sector doctoring. Introduced when both doctors and their patients worked a six-day week, they are still being applied in the changed circumstances of a five-day working week. Apparently this creates difficulties both as regards a patient seeing his own sector (or factory) doctor on a Saturday and as regards the phasing of examinations by these doctors and their heads of departments. In consequence, write the authors, patients "are frequently treated by two or three doctors which, according to our data, prolongs the period of lack of fitness for work."

The authors consider that an appropriate solution to the problems they outline would be to allow doctors to issue sick notes for up to four days at a time and to validate absence from work for a maximum of eight calendar days before referral in any one episode of illness or accident. Reading between the lines, one can infer that the proposed change would have the added advantage of bringing theory into line with actual practice, as imposed by the conditions of a five-day working week. Thus the text states: "It is not always possible for a doctor to observe the 6 day limit . . . since the interval of Friday-Monday makes up 4 days."

Influenza

The proposed periods would also apply in the case of influenza (for which the initial sick note now lasts five days). The authors support their proposal for standardisation by arguing that in a large proportion of cases—"almost 86%"—body temperature will normalise by the fifth day, and if it has not "a doctor ought to assume the presence of complications." The onset of influenzal pneumonia, the most frequent complication, occurs within the first three days of illness. So the issue of sick notes for up to four days "will permit the timely identification of alterations in the course of the illness and will permit a reduction in complications." As a rider, the authors stipulate that patients suffering from influenza should receive home visits from the start of their illness until they are signed off, which implies that at present the final contact occurs in the policlinic and not in the home.

As against the marginal extension of discretion for doctors in the front line, a reduction of two days (from 10 to 8) is proposed in the duration of sick notes issued by the heads of specialist departments. The detailed reasoning here is not easy to follow, but one consideration may be to prevent individual clinicians being unduly generous in granting sick leave. Certainly the statement that "regular consultations between experienced specialists and those less experienced in questions of expertise of temporary lack of fitness for work appear to us as highly essential" may be interpreted along those lines.

Chronic illness

In cases of chronic illness and loss of work capacity due to accidents responsibility for certification passes in due course from the policlinic or similar unit to a form of social security medical board known as the medico-occupational expert commission (VTEK). At present patients must be referred to the local VTEK if they have been on the sick list as a result of one disease for four consecutive months or for five months with interruptions over the previous year. (For tuberculosis the Plimsoll line, so to speak, is 10 months either consecutively or with breaks.) No change is advocated in this compulsory arrangement. But the authors direct attention to a group who occupy a twilight zone that is not recognised in the regulations. These patients present with chronic diseases of various origins (as opposed to a single origin) and often obtain the maximum period of four months' sick leave for each separate disease without being examined by a VTEK. While the authors certainly do not assert that this group consists of inveterate malingerers, they state that except for some 5% these patients "represent a significant part of the work losses from temporary lack of fitness for work: about 15% of all cases and about 30% of all days of lack of fitness for work." With the evident objective of tightening control over these individuals, the authors recommend that such patients should be referred to a VTEK after being on the sick list for a maximum of six months during the preceding year. This measure, they claim, will allow improvement in "the identification and registration of the given contingent of patients and will facilitate the correct resolution of the question of their fitness for work and their treatment."

Comment

Since the article was published in February 1979 no change has occurred in sickness certification procedures, to the best of my knowledge. It is not that the proposals lacked support: their very publication implied that they were considered realistic, and, more significantly, the same journal later printed a much shorter article which unequivocally endorsed all the proposals mentioned.[2] Moreover, it might be thought that the top echelons

of the health service would favour at least updating the regulations to bring them into line with the conditions of a five-day working week.

One explanation for the (assumed) absence of action might be simply that the issue still awaits decision because of bureaucratic lethargy or comparable reasons of an administrative character. Another explanation would take account of the two-way link between duration of illness and the maximum life of a sick note, which was mentioned in the article. The policymakers may thus have decided against a four-day limit on the ground that it might result in more work days lost as a result of certified sickness. Despite the absence of documentary evidence to prove the point, this may well not be too sinister an explanation.

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MATERIA NON MEDICA

A walk to Everest

Having climbed Kilimanjaro, wandered around the edge of the Amazon Basin, and cycled 500 miles across Kenya on a tandem, I applied to join, with two companions, a 200-mile walk to the base camp on Mount Everest. When I added that I was blind, there was a long pause at the end of the telephone. But I was invited to join the expedition and spent a year in preparation—sleeping in the snow, finding the best way to cross logs and stepping stones, and walking in the Peak district.

In November last year we set off from Katmandu with 14 other trekkers and 34 porters. The Newars carry their loads suspended from wooden yokes across their shoulders, while the Sherpas carry 100 lb loads on their backs by a thong over their foreheads. Even with these heavy weights the Sherpas could overtake us and still have enough wind left to sing and play the mouth organ.

The path was so rough and narrow that I had to follow directly behind my guide for all but a few miles, holding on to straps attached to the back of his haversack. We crossed deep ravines on narrow tree trunks, which I crawled over. We crossed rivers on rickety suspension bridges with no sides or used rocks as stepping stones. Here my guide placed the end of my long cane on the right side of the rock; then I, standing on one leg, slid my boot down the cane so that it landed on the right spot. A spiked metal tip to my cane gave great help in crossing glacial moraines and ice-covered rocks. In some places avalanches had obstructed the trail and as I clung to the rock face and heard the river several thousand feet below the feeling of exposure was very real.

At first there was no ice on the Khumbu Glacier, only a heap of rocky rubble laid on top of the ice. As we clambered across the rocks, one of my companions saw some blue ice in the middle, where the glacier was a thousand yards wide. As he looked a crack suddenly developed 12 feet from where he was standing and then snapped shut. The cracking of the glacier became ominous as the day became warmer. I would hear a crack close by which would then spread to right and left and made me realise just how large this enormous heaving amphitheatre in front of Everest was. Avalanches were frequent and sounded like distant thunder.

The local Sherpas thought I was drunk, holding on behind my friend and occasionally stumbling. They were astonished when they discovered I was blind and even more so when they found out that I worked as a physiotherapist. The local blind seldom leave their huts and their lives are ones of inactivity and loss of self respect, which makes me realise how lucky I am, being blind, to live in England, where I can work and finance such expeditions as climbing Everest. This is thanks to the doctors and physiotherapists for allowing the training of blind people and the blind organisations for providing it.—M R TETLEY (physiotherapist, St Albans).

Arma virumque cano

I well remember with what enthusiasm I bartered a large bag of marbles in exchange for a heavy pile of old copies of *War Illustrated*. This journal was started by Sir John Hammerton in 1914 and continued to come out weekly until after the Armistice. Each number was well illustrated with photographs and maps and conscientiously covered all theatres and aspects of the 1914-8 war. Only 20 years later Sir John brought his magazine out of retirement and again completed his exciting narrative of war as it happened.

These faded pages from the Great War fascinated me at the age of 13 in 1938. It may not have shown in the classroom, but I became a bit of an expert on Central Europe and the Baltic. I used to study in detail the maps of the Austrian campaign in Galicia and, for example, knew all about the strategic importance of Przemysl, even if I only learnt how to pronounce the name of this garrison town from a Polish immigrant doctor in London some four years ago. So it was not surprising that when Solzhenitsyn brought out his novel *August 1914* I devoured it with interest, for I knew about the Huguenot Von François, who had won the battle of Tannenberg, even if Hindenburg and Ludendorff gained the credit.

Since I moved to a small town in Alberta, the old people who live in our "Manor House" have given me endless fascination. Here were many of the men and women, now well into their 80s, who emigrated in the 1920s from a war-shattered Europe. They are not the original homesteaders in these parts but the second or third wave of immigrants to Alberta. Many were driven to a new land by sheer desperation. All in their time have worked the Albertan earth as their forefathers had done in Europe.

Now, in their retirement, the life they led before crossing the Atlantic has captured my imagination. The predominant ethnic group is Finn; next come the Estonians. Did this widow's husband support Marshal Mannerheim, or the Reds, in 1919? Does this old Polish gentleman recall the Battle of Tannenberg? Faced with a snapshot of a handsome young subaltern in the Russian Army, seated with his dog at his side, I do not find it difficult to recognise an Estonian of 89 years. Another Estonian, charming and cultured, with a degree in forestry from Talinin University, told me how in 1919 he was a cadet and part of the crew of an armoured train whose howitzers could command a range of 15 miles on either side of the railway, and how proud he was to have helped the White Russians in their campaign of liberation of the Baltic States.

An old Ukrainian was in the Russian cavalry force that attempted to envelop Warsaw in 1919 under General Tuchechewsky. The latter was badly beaten by Pilsudski's cavalry in what must have been an extraordinary campaign. The Russian marshal, of course, fell victim to the Stalin purges of 1936.

As these old people near the end of their days, their human experiences go sadly unrecorded. And when we talk they little know how much pleasure they give to their physician in reminding him of the felicitous barterings of a callow youth.—ALLAN GRAY (Eckville, Alberta).

Correction

Printed information for the lay public on cardiovascular disease

We regret than an error occurred in this article by Mr M O'Hanrahan and others (30 August, p 597). The last three columns of the table in section (*d*) of the Appendix should have read as follows:

	No	
Name and strength	am	pm
Pressure × 10 mg	1	1