Comment

Brucellosis in Britain is usually caused by *Brucella abortus* and mainly affects those in direct contact with cattle or their unpasteurised milk products.^{1 2} Bone and joint brucellosis constitutes about 9% of brucellosis infections and the spine is the commonest site of skeletal infection.^{1 3} Brucellar spondylitis most often presents with back pain and leg pain, resembling an intervertebral disc protrusion. Girdle pain has been reported.^{1 2 4} Paravertebral abscesses are uncommon in brucellosis.⁴ It is most unusual for brucellar spondylitis to present as right upper quadrant pain. A paravertebral abscess could produce nerve root and diaphragmatic irritation, resulting in right hypochondrial pain with radiation to the right shoulder tip. In skeletal brucellosis the cultures are frequently negative in keeping with the late stage of the disease.^{3 4} Early serological studies may be crucial to the diagnosis. Treatment with tetracyclines and streptomycin is

successful in most cases.¹⁻⁴ Surgery is indicated for spinal brucellosis only if there is instability, vertebral collapse with cord compression, or failure of a thick walled paravertebral abscess to respond to medical treatment.⁴

References

- ¹ Spink WW. Brucellosis. In: Isselbacher KJ, ed. *Harrison's principles of internal medicine*. 9th ed. New York: McGraw Hill, 1982:658-60.
- ² Glasgow MMS. Brucellosis of the spine. *Br J Surg* 1976;**63**:283-8.
- ³ Ganado W, Craig AJ. Brucellosis myelopathy. *J Bone Joint Surg* 1958; **40A**:1380-7.
- ⁴ Kelly PJ, Martin WJ, Schirger A, Weed LA. Brucellosis of the bones and joints. *JAMA* 1960;**174**:347-53.

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USSR Letter

Commissions for complaints

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Two separate but closely related topics that receive scant attention in the Soviet medical press are the evaluation of treatment and the investigation of complaints from patients or their relatives. Whether this neglect can reflect a true lack of interest among practising clinicians seems most doubtful, if only because the matters bear so directly on their professional activity. However that may be, this article draws on three sources that go some way towards filling the information gap and indicating what the relevant administrative machinery entails for Soviet doctors.

Since there appears to be no published account of the complaints system's origins, only a brief conjectural explanation can be offered. One catalyst that suggests itself readily enough is demand from patients whose increasingly high educational standards give them a greater critical awareness of and access to the database of medical science. But the demystification of medicine, though a reality, does not imply acceptance by the government of consumerism and individualistic concepts such as the "right to know." A more cogent explanation is the long established power of laymen (which was legitimated by the Revolution) to control and scrutinise medical activity far more pervasively than they can in Western democracies. The latter reading certainly helps to explain why the investigation of complaints is linked so closely to the hierarchical monitoring of standards and imposition of disciplinary sanctions.

Quality control

For many years, and at least since the late 1940s, health

service units have been required to investigate each fatal outcome of treatment occurring in their catchment area. The interrogation of evidence, so to speak, is carried out at "clinical-anatomical conferences" which make detailed comparisons of clinical diagnosis and the results of postmortem ("pathological-anatomical") examinations. In cases where the findings differ the basic reasons for diagnostic error must be reconstructed. If, as a consequence of this initial investigation, gross errors of commission or omission are discovered the matter will be referred to either the hospital's "treatment committee" or to a "treatment control commission." As one source makes clear, the functions of this commission include consideration of written statements by patients or their relatives that "treatment has been carried out incorrectly."

Investigation of complaints by this machinery occurs not only at the local hospital level; to handle more complex and contentious cases variants on the basic pattern can be set up by district, city, or regional health departments and even by republican ministries or the all-Union Ministry of Health. Presumably it would be normal for complaints against the most senior doctors to be heard at a higher level than the unit in which they work. There is evidence to suggest that government has accepted the principle of composing commissions from experienced specialists to ensure that the inquiry is objective and well informed.

As would be expected, considerable weight attaches to written evidence in the form of hospital case notes ("the history of the illness"), records of outpatient treatment, pathology reports, and so on. But the investigation also extends to interviewing the responsible doctor and other staff concerned in the case under review. More than that, the commission is expected to examine the broad organisational context: to be specific, it may implicate such factors as poor accommodation, excessive numbers of patients, shortages of staff, low qualifications of staff, and shortages of diagnostic equipment.

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Disciplinary action

Regulations require a commission to issue a written determination for every case that it has examined. This document should cover a range of subjects, perhaps the most significant of which from the complainant's viewpoint is: "reasoned answers to questions asked about correctness of diagnosis, treatment, and organisation of the curative-diagnostic process." It must also refer to such matters as "the basic particularities of the patient's organism and state of health." In the light of its findings the commission may recommend specific measures, which may include judicial proceedings, to prevent similar outcomes in future.

Unfortunately, there appear to be no published data for the total number of cases examined or for the percentage of cases in which doctors were found to be at fault. All that can be recorded here is that when breaches of duty have been established, as a rule they attract only administrative sanctions—so the matter does not go forward for judicial investigation. One source specifies the following as among the most frequent types of disciplinary offence: carelessness in the completion of medical documents, infringement of rules for writing prescriptions, infringement of the procedure for investigating patients and admitting them to hospital, failure to carry out instructions issued by the administration, and late arrival at work.

As for sanctions imposed by appropriate office holders within the health service, the main ones are covered by the tariff whose severity increases from official reproof through reprimand and severe reprimand to transfer to a lower position. Perhaps it should be added that doctors and other health care workers have the opportunity to offer a written explanation of their offence before disciplinary action is taken.

A commission at work

Thus far the sources for this article have been official publications, in effect, and as such they could not be expected to convey any sense of the experience of appearing before a commission.^{1 2} Given the absence of authenticated experiential accounts, it seems justifiable to fall back on realistic fiction in the form of a section from the novel *Surgeon* written in the early 1970s by Yuli Krel'in, who is himself a senior Moscow surgeon.³ The episodes in this book almost certainly draw heavily on everyday life, and the account of proceedings at a commission has a highly convincing verisimilitude. Any suggestion that Krel'in intended to produce a satirical fantasy is belied by the novel's essentially literal tone.

The account opens with the main character, Yevgeni Lvovich Mishkin, being summoned to the city's health department in connection with a complaint of which he has no prior knowledge. He has to appear before the department's surgical commission, which meets there weekly "in order to investigate the complaints of working people about some or other actions by the city's surgeons which, in the view of these working people, were incorrect." Nicknamed the "black tribunal" by those likely to come before it, the commission consisted of about ten people, all surgeons and all unknown to Mishkin.

It transpires that since the inspector who prepared the papers is absent due to illness, an "impromptu" procedure has been decided on, with the consequence that no one has examined the substance of the complaint or the case notes. Mishkin himself is asked to read out the letter of complaint from the workmates of a patient who was admitted to hospital with a cardiac infarct. "He had been cured by the physicians," they wrote, "and should have been discharged already and imagine our surprise on arriving at the hospital one time to learn that although our worker was in a general medical ward he had been operated on at night by surgeons without even a preliminary discussion with his relatives. . . ." At this point an interruption occurs and the session degenerates into a procedural shambles in which members come out with anecdotes and many comments of doubtful relevance to the case under discussion.

Stereotype views

Nevertheless, in the record of small group interaction it is possible to identify expressions of what are probably typical attitudes and preoccupations. For example, one doctor advocates a well defined strategy of defensive medicine. "All these complaints," he tells his colleagues, "don't worry me personally. Write up the case notes as you should—that's all and there's nothing to fear. . . . If you have done everything correctly, nothing terrible can happen. The main thing is to write up the notes. And it's well known—if there's the possibility of a complaint, better not to get involved."

Another conversational exchange that rings true is evoked when the letter writers cite clinical details relating to methods of reanimation. One surgeon refers to patients' erudition as the reason for many complaints; he is corrected by a colleague who regards them as semieducated. In a remarkable outburst of irritation the latter advances the following view: "Health education work really has become absolutely pernicious. We should be taken and taught to control the work of watchmakers and TV repair men. What a joke! They know everything when in fact they know nothing." A third surgeon quotes from the ancient Hindu Vedas: "It is easier to treat a fool."

At least the existence of hearings by a group of one's peers is regarded as preferable to judicial investigation by the procurator, with the possibility of a subsequent appearance in court. A hint of professional solidarity (perhaps complicity) emerges when one member reminds another of an investigation that occurred years ago. "We saved you from the court," said the first, only to receive the riposte: "From the court! We always save people from the court. . . ."

Eventually Mishkin has a chance to explain that his patient did not die and is congratulated on the successful outcome of a difficult operation to remove a blood clot. Moreover, the letter, which had been addressed to a newspaper and forwarded without adequate scrutiny, proves to contain the words: "We are not making a complaint." What the patient's workmates had wanted was an authoritative statement from the newspaper about the correctness of the operation performed—or a warning against it. As a final point, it can be added that subsequently and in connection with a separate case Mishkin becomes subject to investigation for the "incorrect" issue of a sickness certificate. But that is another, if equally revealing, episode.

References

- 1 Gromov AP. *Prava, obyazannosti i otvetstvennost meditsinskikh rabotnikov*. Moskva: Meditsina, 1974:155-6.
- 2 Severova E Ya. i drugie. O professionalnoi otvetstvennosti vracha. *Sovetskaya Meditsina* 1983;4:60-2.
- 3 Krel'in Y. *Ot mira sevo. Khirurg: povest i roman*. Moskva: Sovetski pisatel, 1976:199-212.

What is the aetiology and treatment of granuloma annulare?

The cause of granuloma annulare has still to be elucidated. A few cases have been reported to have followed minor trauma, but usually no such history is present. Even the much discussed relation with diabetes is still a matter for debate; and such an association, if it exists at all, probably applies only to the atypical generalised form of the disease. This lack of knowledge of the cause of the disease is reflected in a lack of specific treatments. Intralesional steroid injections are painful but may be effective. Cryotherapy can also help some patients. Fortunately the disease tends to resolve itself (in more than half of affected patients it can be expected to clear up within two years¹), and often no treatment need be attempted.—J A SAVIN, consultant dermatologist, Edinburgh.

¹ Wells RS, Smith RA. The national history of granuloma annulare. *Br J Dermatol* 1963;75:199-205.