USSR Letter

Investigations by the People's Control Committee

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The previous two articles in this series have examined arrangements in the USSR for reviewing clinical activity once a complaint about the treatment of patients has been received. Another context in which doctors may be called on to provide expert opinions is the system for supervision of government administration known as the People's Control Committee. Through its department of science, culture, and health, this committee undertakes inquiries into issues of health care delivery and has the power to impose disciplinary measures on medical and other personnel.

The investigations reported in this article look back, in a sense, to a lengthy programme of measures relating to food production which were adopted in May 1982 by the central committee of the communist party of the Soviet Union. In a short paragraph dealing with health services in rural areas, the party issued the following instructions:

"Increase construction of ambulatory—polyclinic institutions and pharmacies. Take measures to staff medical institutions in rural areas with cadres of specialists. Raise the level and quality of medical service and the treatment in sanatoria and health resorts of workers on State farms and collective farms."¹

Staff of the USSR People's Control Committee and its subordinate committee for the Russian republic, together with "a large group of specialists," made detailed assessments of rural health care in the non-black earth—that is, the less fertile—zone of the Russian Soviet Federated Socialist Republic. An account of their findings was brought to public attention a few months ago in *Izvestiya*.²

Shortage of doctors

The account in *Izvestiya* opens by referring to substantial improvements achieved over the years in the supply of modern medical equipment, in staffing levels, and in the number of health service units. Nevertheless, in certain areas and in respect of specific programmes, the "required level" has not been reached. As for qualified staff, an especially acute problem exists in Rayakoski in Murmansk region. This settlement, together with the surrounding countryside, was served for over 20 years by an ambulatory unit, whose personnel consisted of a general physician, dentist, feldsher, nurse, and laboratory assistant. Now the unit has only a single feldsher, and, as a result, many patients have no alternative but to travel 100 km (63 miles) to the district centre.

The same basic problem, presenting in a different mode, emerges from statistics relating to a very wide area, the rural districts of Pskov region. Though 736 doctors had been directed

to units there during the past five years, the flow in the opposite direction was almost as great, as a total of 652 had returned. The investigators also use a far more precise indicator of the maldistribution of medical manpower: the ratio of doctors to population is 51 per 10 000 in urban areas but only four per 10 000 in rural parts of Pskov region. Incidentally, throughout all the regions studied most house calls to rural patients are made by feldshers.

That towns should have a more generous supply of doctors may be explained readily by reference to such factors as the location of medical schools, large hospitals, research institutes, and administrative agencies. Similarly, the rapid turnover of "drafttees" cannot be regarded as a recent and localised phenomenon: arguably it is the Soviet Union's longest standing and most intractable problem in rural health care delivery. Having made these points, however, I must emphasise that the ratio quoted above represents an astonishing imbalance by almost any standards. The degree of underdoctoring certainly justified the report's criticism that a recent resolution of the regional executive committee "strangely" failed to acknowledge the need for "the consolidation of medical cadres in the countryside."

The Pskov region was again singled out in connection with infringement of discipline at work. For their shortcomings in that regard, 167 doctors and other health care workers had received official reprimands during the previous year. (A separate total for doctors alone is not given.) As for the exact nature of their misdemeanours, the report implies that some had shown "a heartless attitude towards patients," a criticism by no means novel in the Soviet central press. Possibly the number of reprimands also reflects in part the drive, initiated by Yuri Andropov, against absenteeism, slackness, drunkenness, and other forms of labour indiscipline that appear to be endemic in almost all sectors of the country's economy.

Failure to respond

Official concern over productivity obviously helps to explain the criticism that a substantial amount of working time continues to be lost when patients make an appointment to see the doctor, have an examination, or receive treatment. Feldsher-midwife posts, the most outlying units of the rural service, should have rescheduled their clinic sessions, but in fact, "they are seeing more patients during the day time" and are usually closed on holidays and workers' days off. Chelyabinsk region is named as an offender in this context; there "a fifth of the pharmacies do not function at all on Saturdays."

In comments on the emergency care service the welfare of patients rather than productivity forms the underlying imperative. Delays in responding to calls (no times are given) occurred widely throughout the non-black earth zone. Shift rosters for emergency care teams bore no relation to the volume of calls and so teams were idle at night but were increasingly late in reaching patients during peak hours. On a more serious level, this service simply did not exist for many remote villages, whose inhabitants consequently had to find vehicles travelling to district hospitals.

In an example of what can happen the report recounts how a farm worker suffered a heart attack in January of this year and was eventually taken to a cottage hospital late at night by his relatives after the emergency care team had "refused to leave the district centre." That incident was reported from Oryol region, but "comparable facts" also came to light in Pskov and Vologda regions.

Local and central

Routine examinations, so large an element in primary care, proved to be another black spot in the rural health service. Not only was the quality of work judged to be defective at times, but many errors had crept into the statistical returns. Thus in several districts of the Komi autonomous republic figures for periodic examinations of state farm workers were so inflated that only a tenth to a twelfth of the number recorded had actually taken place.

If that finding illustrates the difficulty of supervising many small and geographically remote units another finding shows the consequences of "serious errors of planning and distribution" at the top of the hierarchical organisation. In this case criticisms were levelled at the pharmaceutical service and concerned the supply not of much sought after *deficit* drugs but of "medicaments produced by this country's industry in adequate quantities and available in pharmaceutical storehouses." Such are the shortages that rural patients have to travel many kilometres searching for glyceryl trinitrate eye drops, mustard plasters, and other widely used substances. Compounding the problem are poor storage conditions that lead to many drugs being written off because of deterioration. In some regions, by contrast, surpluses had built up and a good deal of wastage occurred.

Given the characteristics of those shortcomings, responsibility for them could only be located at a central point, and the People's Control Committee laid the blame at the door of the Russian republic's health ministry. Comrade A N Apazov, director of the ministry's main pharmaceutical directorate, received "a severe reprimand," and his deputy was "punished severely."

Disciplinary action was also taken against a range of other persons down to the level of individual health service units. There is no mention of dismissals. It is perhaps not altogether a

coincidence, however, that the then health minister of the republic, V V Trofimov, embarked on retirement in April of this year, about a month before the report was published. His successor, N T Trubilin, appears to be fulfilling the traditional role of a new broom. Certainly the report closes by recording his statement: "The Ministry will put into effect measures necessary to remove the defects in medical care for the rural population brought to light by the investigation and will improve the style and methods of work of the Ministry's staff."

Comment

It is a truism that identification of organisational shortcomings is one thing and elimination of them quite another. The strategy of "changing the man at the top" may indeed lead to improvements at least on a limited scale and in the short term. Implicit in that comment, however, is the suggestion that thoroughgoing reforms are apt to lose momentum as they run into the bedrock of social, ideological, economic, cultural, and geographical factors that retard progress in so many aspects of Soviet life.

If that view appears unduly pessimistic it is worth recalling that the People's Control Committee was not investigating newly identified defects; references to issues such as the high turnover rate of doctors and the inadequate supply of drugs can be found year after year in the relevant reports. Their root causes frequently lie well beyond the power of a minister of health to remedy, however committed he may be to removing them. In *On Liberty* John Stuart Mill recorded a summary verdict on the systemic inertia of Imperial Russia which, *mutatis mutandis*, remains strikingly apposite today. "The Czar himself," wrote Mill, "is powerless against the bureaucratic body; he can send any one of them to Siberia, but he cannot govern without them, or against their will. On every decree of his they have a tacit veto, by merely refraining from carrying it into effect."

References

- ¹ *Izvestiya* 1982 May 28:3.
- ² Sisnev V, Petrunek V. A "Skoraya" ne speshit. *Izvestiya* 1983 May 24:2.

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Clinical curio: a shock from dry carpet shampoo

A 53 year old woman was admitted to the coronary care unit unconscious with "no pulse." Her son gave a history of longstanding angina and a possible myocardial infarct five years previously. She was taking glyceryl trinitrate and nadolol 160 mg daily. While watching television she had suddenly felt lower abdominal pain and a desire to defecate. She complained of pins and needles in her hands before collapsing in the bathroom. Despite being cold and clammy on arrival, her hands and face were pink. The blood pressure was unrecordable. Electrocardiogram showed a bradycardia at 48 beats/min with lateral T wave inversion. Initially septic shock was suspected, and intravenous fluids, antibiotics, and hydrocortisone were given. Two hours after admission, bladder catheterisation produced only 10 ml urine. Frusemide was then given intravenously. Overnight she passed 4800 ml urine, having received 4900 ml fluids, though her blood pressure remained unrecordable and her pulse rate 50-60/min. After 12 hours she felt normal, and her lower abdominal pain was improving. Blood pressure was 110/70 mm Hg, pulse 60/min. There were no focal neurological signs, and higher function appeared normal. Biochemical, haematological, and electrocardiographic examination showed no abnormality. Low dose nadolol was started after 24 hours of stable observations.

Later she happened to mention that her son had been cleaning a small portion of the carpet with Dry Magic dry carpet shampoo when

she felt strange and collapsed. The National Poisons Information Centre informed us that the solvent component has a narcotic smooth muscle relaxant effect. This had caused her to be vasodilated peripherally and to look pink. The nadolol had prevented a reflex tachycardia in response to the low blood pressure. Dry Magic is sold in large cartons and has been available for at least three years. Ventilation of the room and avoidance of inhalation has only recently been added to the instructions. The company which manufactures the product says that the powder contains two volatile components: highly refined white spirit with a very low percentage of aromatic hydrocarbons, and an essential oil as perfume. Their safety tests suggest that eight cannisters in an unventilated room of 30 cubic metres could produce dangerous levels. The patent, however, allows for 0.01-20% of aromatic chemicals by weight. Petroleum distillates (of which white spirit is one) may cause vasodilation and, because they are fat soluble, depression of the central nervous system with high doses. Most toxic are the aromatic and cyclical rather than the straight chain carbons. The patient may have been extremely susceptible to their effects in view of the beta blockade.

Nadolol is a long acting, non-specific beta blocker excreted by the kidney. This patient could have been treated with atropine, isoprenaline, or adrenaline had the cause of her hypotension been recognised. It is likely that the high urine output promoted her rapid recovery.—H A LUPTON, general practitioner trainee, Solihull.