Letter from Latvia: surviving surveillance

Ann-Louise Kinmonth, Juris Lazovskis

"Unfortunately my district is still closed for foreigners, but let us hope it may be open next year. If not, it also should not be an obstacle. I can think of something." So I wrote to Dr Kinmonth inviting her to visit Latvia. Happily, in June 1990 travel restrictions for tourists within Latvia were lifted, and in early July she was able to set off for Riga. She carries on with the story:

During my stay in Riga (one of the oldest cities in Europe¹ and capital of a country about the same size as the Republic of Ireland with a population of 2.5 million) I spoke at the Ministry of Health and at the First Children's Hospital. I was privileged to have Professor I Lazovskis (Juris's father and professor of internal medicine at the Latvian Medical Academy) as my interpreter. As we sat in the park near the opera house discussing the lectures, Professor Lazovskis commented that if he had been speaking English like this a year ago a KGB officer would probably have appeared to ask for an explanation. It is hard to comprehend the effect of this continual surveillance; until recently the *BMJ* arrived in Latvia with articles such as those by Ryan on Soviet health care² removed.

In one talk I presented some data about inequalities of health among children in the United Kingdom, illustrated by death rates by occupational class. The audience were unwilling to believe the data; it was too reminiscent of propaganda of the Breznev era, rejection of which has led to a belief that everyone in the West is very well off.

Comparable data on child health in the Soviet Union are neither readily available nor reliable, at least in part because of the practice of setting "central planning norms" for medical activities, and then applying pressure locally for them to be met. This can result in a divergence between actual and reported activity.

Health surveillance for adults

An example of this is the application of general "dispanserisation" (prophylaxis). In 1985 Latvia became the first and only Soviet republic to attempt to institute general preventive screening of all adults as well as children. A questionnaire was to be administered, mainly by polyclinic nurses, to adults annually from the age of 15 years old until death. It consisted of 69 questions covering every symptom and system. After the questionnaire, every person was to be offered an examination including (besides height, weight, and blood pressure) hearing and vision tests; a search for hernias and lumps in breast and thyroid; rectal examination; cervical smears for women; fluorograms, urinalysis, blood counts, and electrocardiograms, and measurement of ocular pressure each year after the age of 40. The data were to be sent to a computer in each regional town, which sent summaries centrally and returned individual recommendations to the local doctor. These took the form mainly of recommendations to see specialists, and defined intervals for follow up.

I had the opportunity to learn about the application of this system of screening at first hand in Cesvaine, a country village some 125 km from Riga, where Juris has been the polyclinic doctor since qualification five years before. The village reflects its feudal past, the

castle of Baron Von Wulf (now a secondary school) still brooding over its moat and outbuildings. These now form part of the collective farm, which with the squat local Soviet headquarters, cafe-restaurant, public library, factories for bread and cheese, and queues for these commodities in the shops make up the heart of the village. The polyclinic is staffed by Dr Lazovskis, a paediatrician, a gynaecologist, midwife, two nurses, a dentist and dental technician, a laboratory technician, a pharmacist and eight assistants, one notes clerk, washers up, oven lighters, and a chauffeur.

Dr Lazovskis tried initially to meet the planned preventive targets for the 2200 adults of Cesvaine; 80% were to be screened annually and 200 were to be put on the chronic disease registers and seen four times a year. With the nurse he set up an intricate colour coded age-sex and morbidity index with separate registers for chronic disorders. (At risk occupations such as teachers, health workers, library workers, milkmaids, and war veterans are all to be examined two to four times a year.) Every evening the nurse brought the lists up to date.

The nurse wrote 5000 letters in one year to try to get the patients to come. Initially, they did come, but the queues were long and the computer returns took months to come back. When they did, a countrywoman might discover that she must visit the neurologist in the town 15 km away for her headaches, see the narcologist for her smoking habit, and consult the gastroenterologist for her dyspepsia. Gamely, she may have tried to consult, only to find that two doctors

FIG 1—Inita, polyclinic nurse, with her colour coded morbidity index

University of
Southampton, Aldermoor
Health Centre,
Southampton SO1 6ST
Ann-Louise Kinmonth, MD,
senior lecturer in primary
medical care

Polyclinic, Cesvaine,
Latvia
Juris Lazovskis, MD, general
practitioner

Correspondence to:
Dr Kinmonth.

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were unavailable and the third very busy. She might settle for grumbling to her physician at the polyclinic or to her pigs.

When people did not come for their check ups the doctors were ordered to visit them at home. At the height of his early efforts Juris was spending over half his time filling in forms and making home visits. "The home visits were interesting in showing me," said Juris, "the social situation in the district—squalor and misery; behind one door drunkards, behind another a quarrelling couple, who stopped quarrelling while I politely explained the importance of preventive medicine to them, and then immediately began again; behind most doors—and some doors were only curtains—overcrowding with up to 10 people in two narrow rooms—nowhere is there affluence, and seldom is there tidiness."

By 1988 it was clear to many that all this counting was adding up to a deterioration in relationships between doctors and patients and was swallowing up health workers' scarce time.

Juris and his nurse discussed the targets for the year. If they did not meet them, the chief doctor of the polyclinic would reprimand them. For example, Juris says of a visit from a health ministry official, "She checked many ambulatory diaries of the patients and to her great surprise and indignation found out that the inscriptions there made by me are too scanty. As I said, as in fact is also true, my notes in comparison with those made by English doctors are like a novel to an aphorism. She said that the only cause is that I lack enthusiasm in handling my patients." Juris decided to make the required returns without seeing the required patients. He was congratulated for his "paper" success in preventive medicine. In 1989, the general screening scheme was dropped.

Real primary care

So what of the real primary care offered by this young doctor, who is said to "lack enthusiasm"? We did a surgery together one Monday morning and saw 18 patients. Among them was a 40 year old builder from the collective farm, who had had pain in his neck for the past five years, worse after a hard day's work. I asked him if there was any particular reason for him consulting with the pain that day—anything causing him stress? He roared with laughter and replied that everyone was stressed in the Soviet Union.

We also saw a 58 year old brewer, an obese ex-smoker previously treated for angina and returning with the same complaint. On close questioning, he had stopped his treatment—a common occurrence as all repeat prescriptions require a doctor's consultation and the drugs must be paid for at full price.

Next came a young man with "trouble with his liver." He was indeed jaundiced. He had been drinking heavily after his mother's death but had also had recent dental treatment. Hepatitis A and B and alcohol related hepatitis are all common here. We referred him to the infectious diseases centre for diagnosis. He was followed by a tall young Latvian man exuding health and waving a paper for Juris to stamp. This had two names on it and was an example of the regular medical examinations required by professional horse riders. The papers were stamped and an evening ride arranged for me. (The ride was one I will never forget. "English women are born in the saddle," declared this horseman in the face of my protestations and provided me with a prancing stallion that soon proved his theory untenable.)

The surgery continued. A cheerful fat woman of 64 complained of shortness of breath in order to get a special letter to the military so that her grandson could come home and help with the harvest. Juris was

FIG 2—Dr Lazovskis ready for one of the thousand or so home visits he makes each year, with chauffeur and military ambulance

dubious. With a flourish, the woman produced her husband's war veteran certificate. This would probably help.

Eventually there were no more patients and we discussed the morning's work, which was representative of the 4000 or so consultations Juris carries out annually. Many of the patients were obese, perhaps not surprisingly in view of their high fat diet, often made more palatable by alcohol. Dietary advice is a challenge where food and alcohol are among the few diversions. Twenty six of Juris's 2200 patients are being treated for diabetes, of 16 with gastric ulcers, six were habitually drunk and failed to come for preventive advice. Ischaemic heart disease and hypertension are common.

The polyclinic nurse, Inita, had been invaluable—but as a medical secretary, telephoning to see what medicine was available and filling in the interminable forms, rather than as a nurse. I asked her how she felt she could best use her time with her patients. After a silence she said, "We are not used to thinking what might be good for our people—we are used simply to being told what to do and doing it."

We discussed the demands of the Ministry of Health for a definite underlying pathological diagnosis in every case, no matter how vague the presenting symptoms. This is the basis of their "novel" as compared with our "aphorisms." While Juris must write "atherosclerotic cardiosclerosis leading to ischaemic heart disease with ventricular failure, grade IIB, and atrial fibrillation resulting in shortness of breath" (and write this on eight different forms in some cases), we might write: "LVF, AF, IHD."

Home visits

Then we were called out on a home visit, one of the 1000 Juris carries out each year, covering many miles on unmade roads, to see a man injured in a drunken quarrel with a soldier. The chauffeur gallantly opened the doors of the military ambulance car for me and we set off smartly along the dusty gravel road.

The man was little injured but had a loose tooth and feared a military reprisal. He sat in a room with broken glass at the window and sacking hung at the door, in what had once been a fine farmhouse. As happened with many such buildings, the owners had been sent to

Siberia and the house divided into flats for workers on the collective farm.

We made another house call to the widow of Saulietis, a writer of Latvian folk history. She is 99 years old now and has survived both Siberia, where she was sent on account of her husband's writing, and his death and that of her son in his 80th year. She received us in her decaying but still elegant summer house, Sauliesi. When the Latvians fought off the Russians in 1919 she was already 28, and she was 49 years old when on 21 July 1940 Soviet rule was installed and the deportations to Siberia began.³

We returned tired to the flat where Juris lives with his wife, Solveiga, and baby son, Peter, on a wage lower than that of his chauffeur. It consists of a living room in which the family sleeps (Peter holding court from his cot), a small kitchen, a tiny bathroom festooned with nappies and offering a leaking supply of cold water, a hall used as a general store, and a balcony also used for drying clothes. Here I was hospitably entertained.

During my stay, I saw an exhibition by the Latvian artist Vitolds Kucins, who paints the Latvian countryside and predicament. In one picture a shockhaired man stares at us, one blue eye concealed by his greatcoat collar. Behind him Latvian countryside stretches away—except for one piece of it, which is half thrust into the man's pocket. The picture is entitled

"Thief." It could be a political statement or a green statement, or both. (We were advised against bathing in Riga Bay because of the chemical pollution brought down by the great river Daugava, and on our trips through the countryside we saw little or no wildlife.)

I left Latvia with images of rolling countryside and the great storks that patrol it mixed with impressions of the health care system: the courage and dedication of a few, the demoralisation of the many. When I explained that we had a new general practice contract in which we too must now meet targets—for example, cervical smears from women irrespective of their risk or even of their dissent—I was offered this Latvian solution: "Take two smears from each consenting woman, and name one for a woman who has decided against the test; this will satisfy the demands of the state and the desires of the individual." It is odd that as the Latvian health service moves away from bureaucratic, rigid, preventive medicine towards family physicians of the kind recommended by the general practice charter of the 1960s, so we move towards the kind of system the Latvians have abandoned. I hope we have the resources to support it as they so clearly had not.

1 Van Der Post L. *Journey into Russia*. Harmondsworth: Penguin, 1964.

2 Ryan M. Mother care for children in hospital. *BMJ* 1984;288:381-2.

3 Hart-Davis R, ed. *The autobiography of Arthur Ransome*. London: Central Publishing, 1976.

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Style Matters

Statements from the Vancouver Group

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The following statements were agreed by the International Committee of Medical Journal Editors at its meeting in San Francisco in February 1991.

Order of authors

The order of authorship is determined by the authors. All authors should meet the basic criteria for authorship (as stated elsewhere¹). Because order of authorship is assigned in different ways its meaning cannot be inferred accurately unless it is stated by the authors. Authors may wish to add an explanation of the order of authorship in a footnote. In deciding on order authors should be aware that many journals limit the number of authors listed in the table of contents and that the National Library of Medicine lists in Medline only the first 10 authors.

Protection of patient anonymity

(1) Detailed descriptions or photographs of individual patients, whether of their whole bodies or of body sections (including physiognomies), are sometimes central documentation in medical journal articles. Use of such material may lead to disclosure of patients' identity, sometimes even indirectly by a combination of seemingly innocent information.

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might identify patients should be avoided unless essential for scientific purposes. Masking of the eye region in photographs of patients may be inadequate protection of anonymity.

(3) If identification of patients is unavoidable, informed consent should be obtained.

(4) Changing data on patients should not be used as a way of securing anonymity.

(5) Medical journals ought to publish their editorial rules for accepting publication of detailed description of individual patients and photographs. When informed consent has been obtained by authors this should be clearly stated in the article.

1 International Committee of Medical Journal Editors. Uniform requirements for manuscripts submitted to biomedical journals. *BMJ* 1991;302:338-41.

Correction

Medical research in Australia: Top of the pile: the institutes

We apologise for a catastrophic error that occurred in this article by Dr Richard Smith (27 April, p 1006) because of an editorial oversight. In the map on p 1006 Melbourne and Canberra were placed in New South Wales and Canberra was shown on the coast. We reassure our Australian readers that the *BMJ* has no insight into impending political or geographical upheavals and that this is simply an error. For readers unaware of local sensitivities the mistake is equivalent to showing Glasgow in England, Canada as part of the US, or Paris as a suburb of Berlin.