BEHIND THE IRON AND GOLDEN CURTAINS

Medical care in the U.S.S.R. and the U.S.A.

JOHN FRY, M.D., F.R.C.S., F.R.C.G.P.
Beckenham

ALL over the world medical planners and practising physicians are faced with dilemmas of care consequent upon impossibilities of matching public wants and professional needs with available resources.

Anyone who has had an opportunity to travel abroad and to study medical services of other nations soon realizes that these problems are not related to local and national systems of medical care. We are facing the modern 'doctors' dilemmas' of deciding priorities and equating barriers in order to ease the strain on medical services.

Faced with such common problems it is useful to examine what goes on in other lands to see what can be learnt and applied to our own system. It was therefore of particular interest that I was able to pay visits recently to the U.S.S.R. and the U.S.A. to study medical care and to consider what we in the United Kingdom can learn from the two modern giants.

National characters

Before discussing the patterns of medical care in these two great nations with differing cultures and philosophies it is appropriate to consider some local characteristics which undoubtedly colour the ways in which their medical services are organized.

The U.S.A., with 200 millions, is the land of free-enterprise where individual freedom is coupled with personal responsibilities for the provision of medical services.

Paradoxically, it is the richest country in the world, which at the same time has evidence of profound social misery. It is a young country with sensitive roots. Its real history spans no more than a hundred years with a population explosion and social advancement confined almost to the twentieth century. Being so young and so sensitive it is scarcely surprising to discover that Americans are appreciative of praise, anxious of outside opinions yet resentful of

criticism. Its polyglot society has been welded into a nation and has achieved the image of a lively extrovert country where the criterion of success is wealth and where the accents of progress are on efficiency, science and gadgets.

The U.S.S.R. is an old nation with a new social system that celebrates its fiftieth anniversary only this year. Its 230 millions have developed from a mixing of ancient civilizations and cultures. It is a country with natural resources and potentials and with tremendous scientific achievements, yet with a rather dowdy external image. It prides itself on achieving an egalitarian society based on socialist beliefs and planned economics with a conspicuous absence of poverty and personal wealth.

To the visitor from Britain the first impressions are those of memories of our own post-war utility era with few luxuries and consumer goods and queues outside shops for basic commodities of uniform grade and appearance whenever these are available. Noteworthy national characters for the outsider are those of a dedicated nation plodding slowly yet methodically to achieve a series of planned and agreed targets and prepared to accept and retain old and traditional concepts and methods.

Medical care

Although related and influenced by national characters, the objectives of medical care in the U.S.S.R. and the U.S.A. are the same—namely to improve health and prevent disease.

In the U.S.S.R. there is an almost total state medical service that is monolithic yet flexible. Based on careful and intensive economic and operational planning with due attention to economic laws and resources and national priorities it is undoubtedly the most unified and completely integrated system of medical care in the world today. Decisions on needs such as staffing, professional duties, hours of work and building have been based on calculations of a series of norms and standards and these have been applied, with local modifications, to the whole of the U.S.S.R.

There are five main principles that have guided the development of medical care in the U.S.S.R.—the service is free; it is accessible to all, even those in the remotest areas; care is provided by highly qualified and well-trained personnel who are all 'specialists' (*vide infra*); prevention of disease has been made a prime objective of care; and through widespread health education and the encouragement of voluntary work the public have become very actively involved in disease prevention and health maintenance.

The structure of the system of medical care in the U.S.S.R. is very much akin to the traditional Russian wooden dolls, each a replica of the other. So with the Russian medical system. The

pattern is similar from top to bottom. Thus from the very top, the Ministry of Health of the U.S.S.R., through the Ministries of Health of the various Republics, the oblasts (regions), the rayons (districts) and right down to the uchastoks (neighbourhood areas), there is the same orderly and tidy military-type organizations of care based on local geographical and population units (figure 1). Because of this type of organization there is no free-choice of doctors but this did not appear to lead to any particular difficulties.

Each level of care has, and knows, its functions and roles and each level is responsible for the one beneath it and is concerned with organizing total medical care for the public within its range of activities. Thus the first level of care is in the polyclinics at which the uchastok doctors (*vide infra*) are based. The rayon (district) covers 50,000–500,000 persons, depending on the density of the population, and the medical administrator is the chief physician of the local rayon hospital. He is at the same time a practising clinician and a medical organizer and he is responsible for *all* the medical services in his district, including polyclinics (general practice), public health services and hospitals.

At the oblast (region) level the population covered is from 1–5 millions and in such a region the head medical administrator is a full-time medical organizer concerned solely with administering the services in the rayons and in addition the central oblast hospital, which functions as a referral unit of difficult and complex cases from the peripheral rayon hospitals, and other centralized public health services. He, the chief medical officer of the oblast, is responsible to the Ministry of Health of the Republic in which the oblast is situated. As a further illustration of the integration and unity of the service is the fact that the chiefs of the clinical departments in the central oblast hospital, such as medicine, surgery, obstetrics and paediatrics are responsible also for the standards, quality and organization of their respective specialties in the whole region. To achieve this they maintain regular personal contact with, and supervision of, all those working in their specialty in the region. They also arrange for more expert specialists to travel to assist others working in peripheral hospitals in cases of emergency or other clinical difficulties. They are responsible also for arranging and maintaining postgraduate education in their specialty.

In the U.S.A. medical care, in keeping with its national philosophies, is based on free enterprise; freedom of the individual to choose his doctor in hospital (this seems more theory than actual fact); responsibilities of the individual for payment of medical services, which includes his choice and ability to undertake private health insurance; on the acceptance of the 'specialist' as a necessity in modern medical care; in the cult of the regular medical check-up

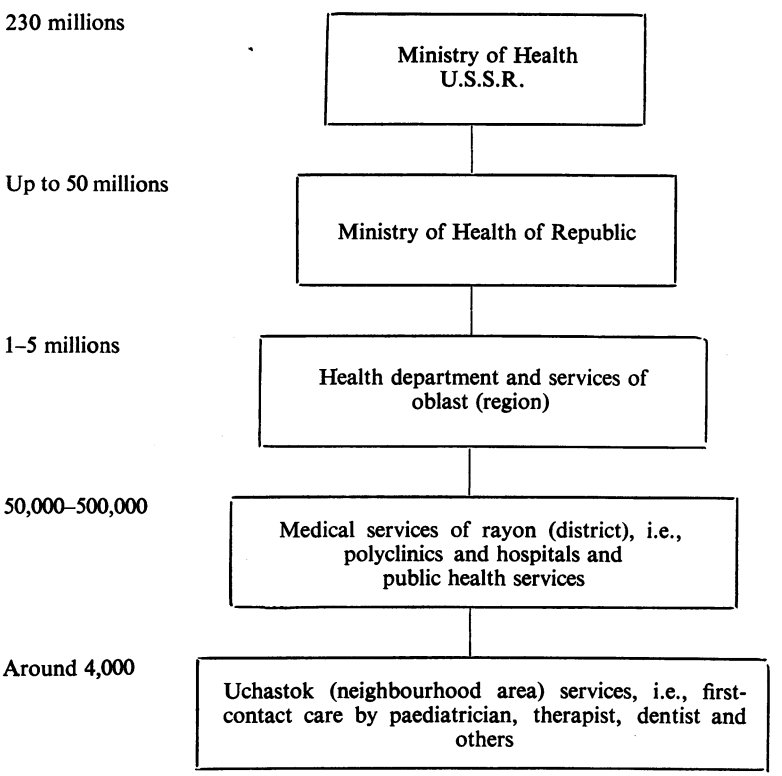

Figure 1
Structure of medical care services in U.S.S.R.

as an important instrument in preventive care; and on voluntary and community self-help and initiative in sponsoring and planning local health services.

For these reasons there is no set and standard structure of medical care in the U.S.A. Whilst the central federal authorities exercise an overseeing role, and have in the past two years been more involved through the Medicare Acts, and the state authorities are involved with safeguarding public health and providing care for the indigent poor, it is left to local community initiative and professional enterprise to organize and develop most of the hospital services and the doctor-of-first-contact care.

Resources

The ultimate factor influencing the scope of medical care is the size of the resources available. Unquestionably the U.S.S.R. has

more hospitals, doctors and auxiliary staff than has the U.S.A. (table I). Credit must be given to the U.S.S.R. in achieving such a situation in a matter of 50 years, which included the interruption of a catastrophic war. The quality and standards of such a rapidly and mass-produced profession may be questioned, but, as will be shown, both standards and quality when examined objectively are as good as anywhere else.

TABLE I

MEDICAL AND HEALTH RESOURCES IN U.S.S.R. AND U.S.A.

	U.S.S.R.	*U.S.A.*
Physicians	23.9 per 10,000 (1:415 persons) (70 per cent are women)	13.7 per 10,000 (1:720 persons) (less than 20 per cent are women)
Medical education: Medical schools	86	88
Medical students in training	200,000 (over six years course)	45,000 (over six years course)
Annual intake of students per medical school ..	388	85
Annual number of medical graduates (physicians)	28,000	7,000
Hospital beds	9.6 per 1,000 (1.0 in mental hospitals)	9.0 per 1,000 (4.1 in mental hospitals)
Budget for health	7.2 per cent of U.S.S.R. budget is for health	5–6 per cent of G.N.P. is for health

First-contact-care

In all systems of medical care there must be a doctor-of-first-contact with similar roles and functions and like needs of training, tools and support.

Recently terminological differences have created difficulties and confusion in examining this branch of care. In Britain he is still the 'general practitioner' who acts as the personal doctor-of-first-contact, to whom the patients have direct access, who works in a static and small community providing long-term and continuing care and whose experience of disease is limited by the size of his population at risk. He becomes expert in dealing with the 'common diseases that

commonly occur' and inexpert at coping with the 'rare diseases that rarely happen'. In the U.S.S.R. it is the 'paediatricians' and 'therapists' who carry out these same roles and functions and in the U.S.A. it is the 'internists', 'paediatricians' or perhaps even the surgeon, obstetrician, dermatologist or other specialist to whom the American patients have direct access. It is important to stress that whatever their titles, these doctors-of-first-contact have identical tasks.

The differing national systems have created differences in details but the essential roles remain the same. In Britain the doctor-of-first-contact is a generalist seeing all his patients irrespective of their age, sex or illness. In the U.S.S.R. and the U.S.A. these same doctors are 'specialoids', restricting their work to persons of distinct age—paediatricians, sex, gynaecologists, or disease—psychiatrists, surgeons, dermatologists. They are certainly not specialists, as is generally understood, but rather front-line doctors who work with the common diseases and restricted to a particular age-group or body-system.

In the U.S.S.R. first-contact care is provided from polyclinics which are large centralized buildings with full diagnostic and therapeutic facilities for urban populations of from 10–50,000. They are designed to cope with daily attendances of from 400–1,600 and the standard staffing quota is 24 doctors per 10,000 persons.

Polyclinics combine British-type general practice and hospital outpatient care. There are no other outpatient services at the local rayon hospitals. Some polyclinics, in small towns, are in the grounds of hospitals and have a common staff, but in the larger cities they are quite separate with their own staff. Hospitals provide inpatient care only and have quite a separate staff of doctors and nurses. Contacts between polyclinics and hospitals are through the usual channels of communication. However, for educational purposes there is an exchange of the less senior staff of hospitals and polyclinics for two months a year.

Family care is not attempted or intended. Not only do children, adults, expectant mothers, mental cases, tuberculosis sufferers and workers in certain industries have different doctors, but these doctors work from separate polyclinics. The single all-purpose polyclinic is found only in small communities, in larger towns there are separate polyclinic buildings for children, adults, 'women's complaints', mental illnesses, attached to some industrial units and others. The same family of four or five members may be under the care of four or five polyclinics at the same time.

The doctors working in polyclinics comprise the doctor-of-first-contact 'specialoids', such as paediatricians and therapists (general

physicians for adults) and specialists such as surgeons, ophthalmologists, E.N.T. surgeons, dermatologists. These specialists work only in the polyclinics and have no access to hospitals. Thus polyclinic surgeons will operate only on those conditions capable of being dealt with in the polyclinic and more complex cases will be sent on to the hospital surgeons.

Each doctor-of-first-contact cares for his own uchastok (neighbourhood areas), comprising a geographically defined population. There is no free choice of doctor or patient. The therapist will have to care for some 2,000 adults and the paediatrician 750–1,000 children (under 15).

Because of the very adequate numbers of doctors there are no problems of over-work. The norms state that the doctors work a six to seven hour day, comprising a consulting session of three to four hours at which 15–18 persons are seen and visits to some six to eight homes during a further three to four hour spell. A separate staff is on call for emergencies at night and at week-ends.

The annual number of doctor-patient contacts at polyclinics in the U.S.S.R. averages at ten contacts per year. This is probably the highest doctor consultation rate in the world. Even though these contacts represent a combination of general practice and out-patient care they are twice the comparable rates for the U.S.A. and Britain.

All doctors have their own nurse with whom they work. This nurse combines nursing with secretarial and receptionist roles.

In rural areas with widely dispersed populations first-contact care in villages and farms is provided not by a doctor but by a *feldscher*. She is a medical auxiliary who has been well trained for three and a half years and who works in a community of 500–1,000 persons under the supervision of a doctor, who is based at a polyclinic-hospital unit some miles away. There are frequent contacts between feldscher and doctor and it is evident that the former copes very effectively with a great variety of common and less serious illnesses and also carries out most of the routine preventive care and health education.

In the U.S.A. there is no uniform pattern for doctor-of-first-contact care. It all depends very much on where the patient lives, his means and ability to pay and his occupation and trade union.

If he lives in a large city and is well off then he will consult a paediatrician for his children, an internist for his own medical ills, a gynaecologist for his wife, or a surgeon, neurologist, psychiatrist, dermatologist or cardiologist when he, the patient, thinks it appropriate. These doctors-of-first-contact whom the middle (or upper) class American family consult may work on their own from private

offices or in a group or larger clinic. Some of these groups and clinics are organized by trade unions for members and their families and others by prepaid insurance schemes. Referral to more expert specialists is frequent, but often the patient himself decides what level of specialist he should see and when.

A feature of the American system is that many of these doctors-of-first-contact have access to hospital beds in which they are able to treat their patients. (Such facilities do not exist in the U.S.S.R., except in rural areas). In addition to the extra-professional interest and stimulus that such facilities offer there are also financial incentives because of the insurance-cover provided for hospitalization.

If our American family lives in a small town there are often only one or two doctors and these have to act as 'general practitioner' and undertake a wide range of care that includes general surgery, obstetrics, paediatrics and internal medicine.

If he has not the means to pay the doctor and is not covered by any prepaid insurance then our less affluent American and his family turn to the local hospital for first-contact care. This is provided by the junior staff in the emergency room of the hospital.

It is difficult to assess the work-load of the American doctor-of-first-contact because of the variations and scarcity of reliable records, but the Health Insurance Plan of New York has estimated that their doctor-patient contact rate is five to six consultations per year, and that each doctor sees between 20–30 patients a day, including one to three home visits.

Figure 2 provides a diagrammatic representation of the differences of first-contact-care in the U.S.S.R., U.S.A. and Britain (U.K.).

Hospitals

Hospitals form only part of the medical care system. Modern thinking suggests that they act as medical centres involved in the total care of the local population providing leadership and a focus for the medical and nursing professions as well as providing the traditional inpatient care and consultation services.

How far have the U.S.S.R. and the U.S.A. moved in these directions and how are hospital services organized and planned?

In the U.S.S.R., whilst they are well-integrated into the state system of medical care, it seems that, except for the specialized services such as for tuberculosis and mental diseases, they concentrate on inpatient care. In built-up areas the general hospital staff is separate from that of polyclinics and confines itself to care for those patients admitted to hospital. As has been noted, exchange of staff does occur, but this is largely for educational purposes rather than for providing continuing care. They are not required to act

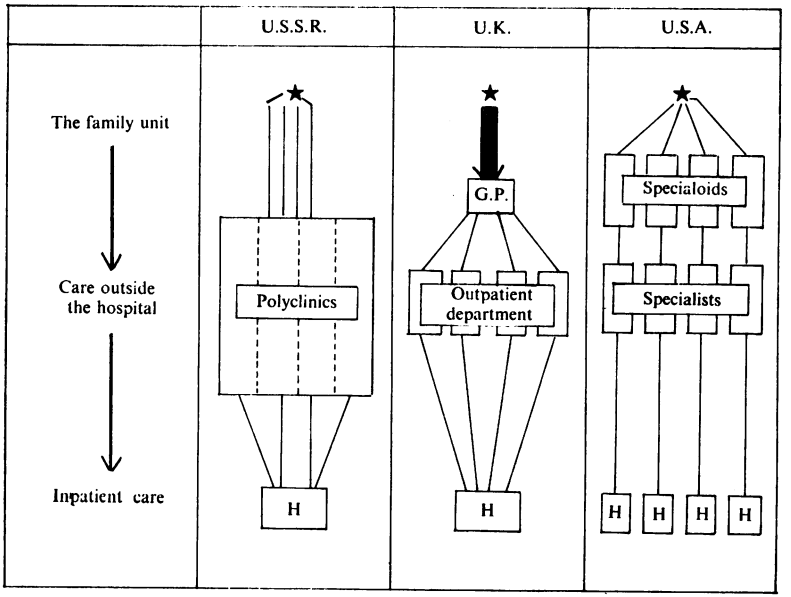

Figure 2
First-contact care in U.S.S.R., U.K. and U.S.A.

as diagnostic centres because full pathological and radiological facilities are provided in polyclinics where, also, are working outpatient specialists who carry out pre-admission assessments, but who do not follow the patient into the hospital.

The real links between hospitals and the community are the head doctor of the rayon, who combines the role of the chief physician at the local rayon hospital with responsibilities for all the health services in the rayon district, and chiefs of the clinical departments at the oblast regional hospital who are responsible also for the organization of their specialties throughout the whole region, in the polyclinics as well as in hospitals.

The hospital system in the U.S.S.R. follows the general national structure (figure 3). From the periphery to the centre there are rural uchastok cottage hospitals providing care for the less complex general medical, surgical, gynaecological and obstetric conditions, rayon district hospitals which care for similar conditions as those in uchastok hospitals but for a larger population, and oblast hospitals which act as regional referral centres with specialized units for heart surgery, neurosurgery, eye, chest, metabolic and other conditions. Each Soviet Republic has its own research and teaching institutes sited at special hospitals which combine functions of specialized

centres with those of community care.

Supporting the hospitals are many sanatoria and prophylactoria (in large industrial units and farms) which have beds for after-care, rehabilitation and preventive care.

Current trends in the Russian hospital service are the building of larger hospitals at all levels and to concentrate where possible on units of around 1,000 beds—it now takes only 18 months to build a hospital of this size in the U.S.S.R. using standard planning and prefabrication techniques; the enlargement of uchastok hospitals to a minimum of 50 beds—it has been found that smaller units are ineffective and uneconomic; and the development in large cities of hospitals for special conditions such as cancer, heart disease and trauma.

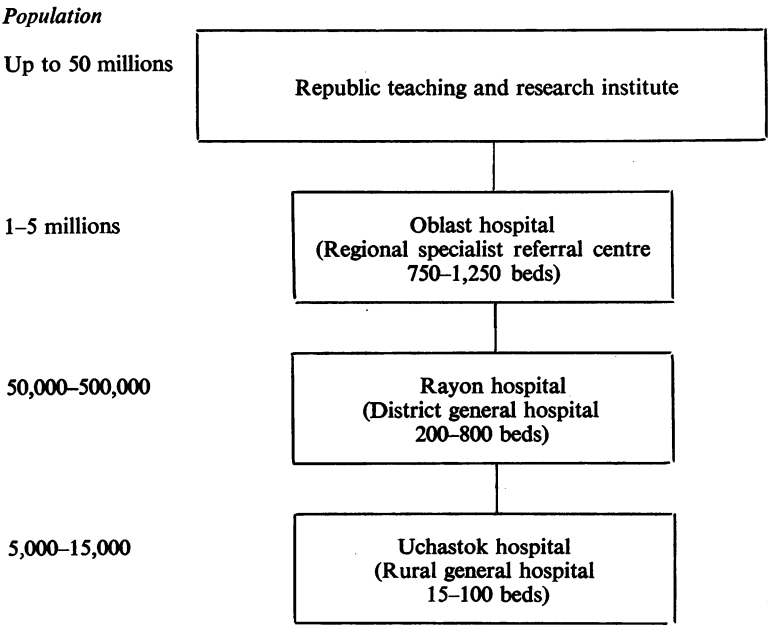

Figure 3
The hospital system in the U.S.S.R.

In the U.S.A. the hospitals play an active part in the community. This is because many hospitals have been planned and built by the local people and because the doctors-of-first-contact have opportunities to treat their patients in hospitals.

The pattern of hospital organization is dependent on the ownership of the hospitals rather than on their functions. Thus there are large university hospitals with medical schools and research units which

act as regional specialist centres as well as providing general care for the local community and first-contact care for the medical indigents. Voluntary non-profit hospitals built and run as a result of local initiatives, drive and monies and aided and supported by state and federal funds and resources. Proprietary hospitals built and designed to make profits for their share-holders. Community hospitals owned by the local state or city and providing care principally for the indigent poor. There are also special federal and state hospitals for mental and infectious diseases and hospitals for veterans.

Planning of hospital services in areas and regions has been difficult because of local freedom of actions. The consequence has been a rather patchy development of hospitals—too many in affluent areas such as California and too few in the poorer south.

Comparing the utilization of hospital services in the U.S.S.R. and the U.S.A., it appears that more Russians enter hospital each year for longer periods. The annual hospitalization rate in the U.S.S.R. is 20 per cent and in the U.S.A. it is 15 per cent, and the average durations of stay, excluding mental cases, is 15–17 days per case in the U.S.S.R., and nine to ten days in the U.S.A.

Public health services

There is no separate public health service in the U.S.S.R. It is a part of the general health system and is involved in working with polyclinics and hospitals as well as providing more traditional public health care.

Public health services are based on a national network of 'sanepid' (sanitary and epidemiological) stations, staffed by specialist hygienists concerned with safeguarding public health, hygiene and sanitation; with food safety and a healthy environment; with control of social factors in the causation of disease; with organizing routine preventive care in polyclinics and hospitals; with the programme of health education; and with forward medical and economic planning through their work as local epidemiological records and statistical units. There is approximately one sanepid station to 50,000 persons but in large cities there is one to 500,000.

In the U.S.A. the public health services tend to be distinct from the clinical and therapeutic sectors of care. Most of their work is the traditional pattern of safeguarding public health through control of the environment and sanitation and infectious diseases. They are involved also in local nursing services and in special programmes relating to maternal and child health, dental care and mental health.

The local services for tuberculosis, mental deficiency, chronic sick and aged are often under the direction of the state public health service.

Recently with the advent of medicare and other trends the public health service has become more involved in organizing general and hospital care for the indigent poor and those entitled to receive state and federal benefits.

Contrary to the situations in the U.S.A. and the U.K., the public health doctor enjoys a high status in the U.S.S.R. This is because he is given a considerable degree of statutory power and independence of action in his work. He has jurisdiction over the polyclinics and hospitals in some respects. He is well trained and practises as a recognized specialist in one of the subdivisions of public health such as epidemiology, environmental hygiene, radio-activity, occupational health, school health, infectious diseases, food hygiene. He is also a key member of the local forward planning committee.

Preventive care

There is growing emphasis everywhere on efforts to prevent disease by early diagnosis and presymptomatic screening and through correcting possible causes and improving health by participation of individuals in healthy living.

Accepted as almost a blind act-of-faith the activities in this field are impressive in the U.S.A. and the U.S.S.R.

In the U.S.A. the routine annual 'medical check-up' has become a cult and a status-symbol amongst the middle and upper classes. It has been encouraged by the medical profession not only as a good principle but also as a ready dollar-earner. It has been supported by industry, trade unions and big business in the belief that it will keep their top workers and executives healthy, happy and reassured. It has been accepted by all who can afford it as a sensible procedure, albeit without very strong positive evidence of true worth.

In some industries and in some insurance schemes attempts have been made to organize the procedure on a regular basis but in practice it is usually left to the individual to remember to make the effort to have a check-up. At the Kaiser Permanante Group in California the procedure has been streamlined to fit automatic laboratories and other procedures and it is a very impressive exercise. Overall only a minority of Americans are able to take advantage of such highly evolved expertise in the assessment of health and the early diagnosis of disease.

In the U.S.S.R. there has been the same rush into the field of preventive care, again without any conclusive proof of the efficacy of the various procedures. In keeping with the Russian system the whole process has been highly planned and set in motion in a grand manner.

The whole process is termed 'dispenserization'. It comprises a

series of steps including screening, definition of vulnerable groups, correction of underlying social, environmental or medical causes and application of necessary treatment, follow-up at regular intervals of specified vulnerable individuals and general health building by special food supplements, physical culture, rehabilitation, re-employment in more suitable occupations, rehousing and group therapy sessions which relatives as well as patients attend.

At present one-third (80 millions) of all Russians are screened every year. The eventual aim is to screen everyone annually. This is not such a major exercise as it sounds because of the large numbers of doctors in the U.S.S.R. Thus the doctors-of-first-contact who carry out most of the screening procedures may each expect to examine seven to ten persons each week. Also involved in this process is the local sanepid station which not only assists in the selection and follow-up arrangements but also has the power to authorize re-housing and re-employment of vulnerable families and individuals.

It is estimated that a therapist in a polyclinic will have between 100–130 of his 2,000 patients (five to seven per cent) under continuing follow-up. These include persons with chest and heart diseases, diabetes, peptic ulcers and other specified conditions.

As examples of the success of the scheme are quoted figures such as the annual pick-up rate of 0.86 per 1,000 for tuberculosis and one to three per 1,000 for cervical cancer. In Leningrad it has been found that 13 per cent of all new cases of cancer have been discovered through screening procedures.

Quality and service

How can the respective medical services of the U.S.S.R. and the U.S.A. be compared? It is useless to rely on personal impressions and yet there are no reliable measures of quality.

When standard criteria and indices of health are compared we find that they are very similar. Infant mortality rates are 27 per 1,000 in the U.S.S.R., and 25 per 1,000 in the U.S.A. Life expectancy is now 65 years for males and 72 for females in the U.S.S.R., and 67 and 75 years respectively in the U.S.A. In both nations the major killers are now cardiovascular diseases, strokes, chest diseases and cancer.

Assessment and comparison of consumer satisfaction are not easy. In the U.S.S.R. the people have accepted the hardships associated with the development of a new nation in 50 years and a disastrous war, and have become accustomed to restrictions of consumer goods and material comforts and do not grumble very much to a foreign observer. All are proud of a health service that is free and accessible to everyone.

Americans on the other hand, living in a consumer society that is very conscious of service and quality, seem highly critical of their medical services. Amongst the criticisms most frequently expressed were the image of the medical profession currently being more interested in income than in medical care, refusals by doctors to pay home visits, over-hospitalization and over-investigation, of the high costs of care and the disappearance of the old-type personal and family doctor.

Whilst it was not possible for me to study in any detail the various fashionable therapeutic methods and techniques I was struck by one major difference. This was the approaches to the management of the mass of border-line disorders. By these I mean the psychosomatic and functional disorders and those chronic disorders of ageing and degeneration for which no specific cures are possible and for which a certain amount of quackery is required in addition to the general management of the individual.

In the U.S.A., in line with their national characteristics, these unfortunates are attacked with all the latest and the newest drugs and therapies, many of which are unproven. In the U.S.S.R., the accent is on the old and traditional forms of therapy—also largely unproven. Thus hydrotherapy with douchings and baths of various forms are popular, as are other types of physiotherapy, and techniques based on Pavlovian principles.

The most marked differences are in premises and equipment. In both nations there has been a great amount of building of new hospitals and clinics. In the U.S.A. the new hospitals look very new and shine with the latest equipment and the not so new buildings are well maintained. In the U.S.S.R. it is often impossible to gauge the age of a medical building. Most have been cast in the same mould and look alike—curious 'instant-old' appearance. This is due to an almost intentional lack of attention to maintenance of paint-work, furnishings and floor coverings. Yet, paradoxically, there is almost obsessional attention paid to cleanness, with no dust or dirt to be seen.

It may be asked justifiably what is the comparable quality of the medical personnel in the U.S.A. and the U.S.S.R. It has been noted that there are almost twice as many physicians in the U.S.S.R. as in the U.S.A., and four times as many medical students graduating. Can individual quality be maintained in the production of such large numbers of doctors? All that I can say is that the doctors and students whom I met in the U.S.S.R. were very similar in knowledge and ideologies to those in the U.S.A. and the U.K.

Lessons for us all

What lessons can we learn from a comparison of these two modern

giants? I would select the following topics that seem of importance to us all.

The complexity of modern medical care makes it imperative that we have some national and local planning policies in order to make the most effective use of our resources. A balance has to be struck between too much and too little state interference in medical care which is at once highly personal and individual and also very much a concern of the state because of the high costs required to achieve high quality. The U.S.A. and the U.S.S.R. show the two extremes of planning and state involvement. Each nation has to decide what balance is to be struck and into which part of the spectrum it seeks to fit. Obviously some state involvement is essential in the provision of national resources such as hospitals, medical schools and personnel and in the payment for medical services.

Whatever system we have there is a need for constant critical evaluation of what we are doing and striving to do. In all countries, including the U.S.A. and the U.S.S.R., there is an insufficient extent of such evaluation going on, largely because it is difficult to carry out and to apply the findings.

In both nations, as elsewhere, the problems of the doctor-of-first-contact are apparent. Neither the U.S.A. nor the U.S.S.R. have solved them satisfactorily. It is still not clear what the roles and functions of such a doctor ought to be and what training, tools and staff he requires. Should he be a generalist or a specialoid? What should be his relations with the local hospitals? Should he have access to beds? Should he work alone, in a group or in a team? If in a team or group how large should they be?

We can see that both the U.S.A. and the U.S.S.R. have decided that specialoids should be their first-contact-doctors, but it cannot be said that this system is any better or worse than the British pattern of generalists as first-line doctors. In both the U.S.A. and the U.S.S.R. some of these doctors work from large and centralized purpose-built premises providing care for up to 50,000 persons and housing over 100 doctors.

In the U.S.A. the doctors-of-first-contact have access to hospital beds and are encouraged to treat their own patients. This raises serious questions of their experience and competence to deal alone with some of the less common conditions. In the U.S.S.R. no such access exists and in fact there is a division between inpatient and outpatient care with different staffs. Should hospitals continue to provide their own outpatient consultation services? In both the U.S.S.R. and the U.S.A. there has been a swing away from this pattern and in both these special outpatient services are being based on polyclinics and groups which combine doctor-of-first-contact and

specialist services. A key question to decide is to what size of population it is justifiable to provide specialist consultation services?

A lesson to us all is the successful integration of public health services into hospitals and polyclinic work in the U.S.S.R. and to note the higher professional status achieved by the medical officer of health when he becomes more of a specialist.

Tempering admiration with British cynicism, it is pertinent to enquire how worthwhile have been the massive efforts of presymptomatic diagnosis and screening? Before further resources are put to this use more proof of the success of such efforts is necessary.

Finally, I make a plea for further and wider exchanges and visits between us all. This is necessary particularly for doctors of the U.S.S.R. who have worked for too long out of touch and out of contact with their colleagues in the West.

Acknowledgements

My gratitude goes to the Milbank Memorial Fund of New York and the World Health Organization for making my visits possible and to the many kind and new-found friends in the U.S.S.R. and the U.S.A., who welcomed and tolerated me in their midst.

Extended use of nursing services in general practice. J. WESTON SMITH, M.B., CH.B., D.R.C.O.G., D.A. and E. M. MOTTRAM, S.R.N.

A partnership of two doctors with a list of 5,500 patients employed a nurse to help in the clinical work of the practice. In addition to immunization and attendance at antenatal clinics in the surgery, her duties also included both new and routine visits to patients' homes. Most new visits were to children with minor infective conditions. This innovation was well received by the patients. The various legal and administrative problems arising from this departure from conventional practice are discussed in detail.