Commentary

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The Sovietisation of British medicine

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In this article, I argue that certain developments in contemporary Britain that affect the medical profession have worrying parallels in Soviet history. I write as someone who has worked in the National Health Service (NHS) for 45 years, who served on UK Medical Schools Council for eight years and was president of the British Medical Association but who has also worked for 30 of those years in the countries that emerged from the Soviet Union.

Soviet medicine in the 1920s

In November 1917, five days after the Revolution, the Bolsheviks issued a decree committing to comprehensive health coverage.[1] This was incredibly ambitious, especially given the loss of as many as 10,000 doctors in World War I. A vast increase in medical education was needed but this required a new way of doing things.

Early in the 20th century, Russia had adopted the German model of medical education that would spread throughout Europe.[2] Two years of preclinical training in relevant sciences were followed by several years of clinical training, delivered in the 15 leading universities. This differed from the American model where freestanding medical schools taught little science and, in 1910, the Flexner Report paved the way for reforms that brought the American model much closer to the European one.[3]

In the Soviet Union, things were moving in the opposite direction. In 1930, medical training moved out of universities into freestanding institutes,[2] where their curriculum was tightly prescribed by the Ministry of Health. The course was shortened to between 4 and 4.5 years and the theoretical content was greatly reduced.[4]

The new curriculum abandoned the concept of a broad medical education. There were five streams of undergraduate specialisation: therapeutics (including internal medicine, surgery, and obstetrics/gynaecology), paediatrics, hygiene, dentistry and pharmacology.[2] Knowledge was tested in a national exam but, because it was undertaken orally, there was great scope for manipulation. Those pursuing specialist status completed a further three years of training.[4] Targets for numbers of doctors were set out in five-year plans, containing ambitious, but unrealistic goals that were rarely met. Yet this did not prevent success being claimed, with fabricated data and stretching of definitions.[5]

Yet even expansion in medical students that was achieved was not enough. Much first-line care was delivered by 'feldshers', health workers with even less training, often working alongside midwives. This group predated the revolution but their numbers were greatly increased.[6]

Soon, however, some initial changes, such as shortening the length of study, were reversed and specialist and continuing education were greatly strengthened.[4,7,8] However, the many features persisted and the performance of the Soviet health system fell ever further behind other once comparable countries.[9] The problems were exacerbated as the Soviet Union failed to develop an effective pharmaceutical programme at a time when treatment was being transformed by new medicines elsewhere and, as one detailed analysis concluded, the 'industry limped along and the populace suffered'.[10]

Fortunately, for the politicians, the introduction of 'Stalinist science' in the late 1920s made life easier.[11] It created conditions whereby they could promote interventions, such as light or magnetic therapy, that were easily available and which gave the impression that something was being done, even if they were ineffective.[12] The medical and scientific establishment were complicit in this deceit, promoting these treatments while ensuring that they had access to the small amounts of western medicines available.

By the 1980s, the consequences for health were becoming inescapable, despite strenuous attempts to conceal them. Evgenii Chazov, Gorbachev's health minister, openly admitted that the quality of care was often extremely poor.[13] Our research confirmed

this, with widespread use of treatments with no scientific basis.[14–16]

British medicine in the 2020s

A century later, the United Kingdom (UK) has also undergone a revolution of sorts. While on a much smaller scale, Brexit has given rise to almost a decade of exceptional political instability and, although some changes affecting doctors predate it, shedding the constraints imposed by European law has opened new opportunities for those seeking to introduce changes to the medical workforce.[17]

These changes are, as in the Soviet Union, a response to a severe shortage of doctors. There has been inadequate investment in training, coupled with losses not due to war, but rather to premature retirement, part-time working and emigration.[18] The proposed solutions have some similarities too. Medical education will be expanded rapidly, aiming to double student numbers, but without increasing resources proportionately.

Once again, the obvious solution has been to shorten and simplify the medical degree. The Medical Director of the General Medical Council argues that since the advent of the mobile phone, doctors no longer need a 'huge repository of facts in [their] heads' and sees an opportunity to 'streamline', presumably a euphemism for 'shortening' training.[19] Clearly, online access to information can be invaluable, for example when calculating the correct dose of a potentially toxic drug for a child, but it does not help if you do not know what you are looking for. Nowhere is there any detailed discussion of the skills required for diagnosis and management in ageing populations characterised by multimorbidity.[20] How much of medicine involves experience, recognising clinical patterns, and how much requires knowledge of anatomy and physiological, pharmacological and pathological mechanisms? Of course, advocates of the streamlined approach could base their hopes on artificial intelligence but what we know so far suggests that this is somewhat premature.[21] As Oliver and Vaughan have noted, 'the GMC already seems confident that it knows exactly what the problems are and how to fix them'.[22] Postgraduate training will also be 'streamlined', with similarly vague and untested proposals.

But even this 'streamlining' does not address the severe lack of resources. The Soviet authorities asked the medical schools to do more for less. A 1924 paper described how they had to train three to four times more students with a quarter of the income.[23] Today, many British universities are only surviving by cross-subsidising teaching with fees from overseas students, now threatened by the government's migration policies.[24] Practising doctors will play a much smaller role in clinical teaching, removing the role models that often inspired their students. The autonomy of the universities has also been curtailed, as in 1930, with the introduction of a national licencing examination.[25]

But changing the medical curriculum will take time, so politicians need a quick fix. The answer is to create a new group of workers, physician associates (PAs).[26] Conceived as health workers who can *assist* doctors, in many hospitals and primary care facilities they have become *substitutes* for them.[27] Like-feldshers, they offer a means by which those living in places where it has been impossible to retain doctors can get some basic care. They are trained in what is termed, but left undefined, the 'medical model'. Although required to have a degree to enter training, in reality this can be in anything, including homeopathy or the humanities.[28] There are many examples on social media of job descriptions and other documents that imply that their two-year training is equivalent to a medical degree. Growing concerns about patient safety have been ignored.

This situation may now be changing following growing awareness among both doctors and the public of problems, mostly about patient safety[29] but also illegal prescribing,[30] unclear accountability[31] and damage to specialist training.[32] However, the contractual and funding arrangements that have been established to promote the expansion of PA numbers, including salaries much higher than newly graduated doctors, reflect a powerful ideological pressure to expand their roles.[33]

As in the Soviet Union, the UK ambition is set out in a series of plans. Unfortunately, the similarity continues. These plans overclaim but underdeliver. Apparent success depends on highly imaginative use of data, such as reporting a refurbishment of a department as building one of 40 promised new hospitals.[34] In the Soviet Union, 'any cabin or barn where it was possible to put beds was declared a hospital'.[35] Often it appears that the assumptions in these plans have little attachment to reality, exemplified by the highly critical National Audit Office report on the NHS Long Term Workforce Plan.[36] Indeed, an exercise we conducted that assembled key stakeholders for one element of this plan, medical school expansion, raised far more questions than it answered.[37]

Unlike in the Soviet Union, there is still a thriving and vocal civil society in the UK. The medical profession is represented by the Royal Colleges, the British Medical Association and many specialist societies. Some have spoken out loudly about these

measures.[38] But not all. The power of patronage is important everywhere. In the Soviet Union it was the ability to ascend to the ranks of the nomenklatura, with the benefits that brought.[39] In the UK, it is more subtle, such as the honours system or access to ministers. As a consequence, there will always be those who prioritise the wishes of those in power over the interests of the medical profession and the country.

The bigger picture

I am not the first to draw comparisons between the UK today and the Soviet Union. Innes's 2023 book *Late Soviet Britain: Why Materialist Utopias Fail* argues that both have suffered from many of the same problems, even if coming from very different ideologies, Leninism and neoliberalism.[40] She writes that both regimes have used their ideology to 'justify a near identical methodology of quantification, forecasting, target setting and output-planning' and continues 'These techniques will tend to fail around any task characterised by uncertainty, intricacy, interdependence and evolution'.

There are other parallels in the area of health. Life expectancy is an important measure of national progress and, outside of wars and other or pandemics, has steadily improved over time. When, very rarely, it stagnates or declines, it should be a warning, as in the 1980s Soviet Union prior to regime collapse.[41] Yet this has also been happening in the UK since the early 2010s.[42] Another parallel is the rising numbers of waterborne infections in the UK,[43] recalling those afflicting visitors to the Soviet Union.[44]

Looking beyond health, one might argue that extension of the concept of 'extremism' to include those opposed to 'British values' invites inevitable comparison with 'anti-Soviet activities'[45] or to see the power to remove citizenship as a form of exile.[46] Similarly, we see a raft of measures seemingly designed to limit the ability to vote raise concerns. Yet it is important not to stretch any analogy too far. The UK remains a democracy and it would be preposterous to suggest that it would build a gulag, although the Rishi Sunak's refusal to rule out joining Russia and Belarus outside the European Convention on Human Rights is obviously concerning.[47] Nor should it be forgotten that the UK has been willing to disregard international law[48] and a recent Prime Minister unlawfully prorogued Parliament.[49]

What is to be done?

This commentary is an argument against complacency. Inevitably, many readers will reject its arguments, but some may pause to reflect.

If they do, they might first demand much greater transparency. The General Medical Council has said that it was 'working in the background' on its proposals to transform medical training, yet their content elicited widespread surprise. A recent extraordinary general meeting at the Royal College of Physicians of London was a model of how not to conduct an open discussion.[50]

Second, they may also call for improved governance arrangements. The General Medical Council is a key player in these developments but it remains unclear who, in practice, it is accountable to.[51] Similar questions arise concerning some Royal Colleges.

Finally, they may ask for analyses, such as ours of medical school expansion,[37] that confront policies developed in Whitehall with reality on the ground. Crucially, these can identify unintended consequences before they happen. King and Crewe, in *The blunders of our governments*, provide many examples of mistakes that could have been avoided.[52] The current proposals to change the nature of the medical profession should not become another avoidable mistake.

Declarations

Competing Interests: MM was a member of UK Medical Schools Council and a board member of UCL Partners between 2015 and 2023. He is an honorary consultant at UCLH NHS Trust. In 2022–2023, he was president of the British Medical Association. He is a former chair of the Global Health Advisory Committee of the Open Societies Foundation. He has conducted numerous research projects in the countries of the former Soviet Union, funded by the Wellcome Trust, UK Department for International Development, European Commission and the World Bank. He is Research Director of the European Observatory on Health Systems and Policies and is a former member of the International Advisory Committee of the Moscow Medical Academy. He accepted the award of a CBE for services to health in Europe in 2005 and is a Fellow of the Royal Colleges of Physicians of London and Edinburgh and the UK Academy of Medical Sciences, and an Honorary Fellow of the Faculty of Public Health and the Royal College of General Practitioners. He declares no other interests.

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