Shortcomings of the NHS: a yawning chasm

SIR,—I am an NHS family doctor, one of a group who try to provide a competent 24-hour service to our patients. I am dispirited by the inadequacies of the service. It is not possible to practise adequately without access to x-rays, and acute admissions should certainly be available in emergency. In this area there are normally two radiologists working and they have a very heavy work load. Following the tragic death of one there has been a vacancy for most of this year which it is hoped to fill by the end of the year. Cuts had to be made and general practitioners found that no x-rays could be ordered except for chest films. This meant that patients needing x-rays had either to be referred to hospital clinics which continued to carry their normal work load or go privately 15 miles, which few can afford. Another alternative for the doctor is to order the x-ray to be performed, as there is no shortage of radiographers, and then himself attempt to interpret the films—a job in which he has had no training. Admittedly this shortage will soon be over, but one fears other shortages may not be long in developing. Apparently in some specialties suitably trained hospital staff are not keen to apply for consultant vacancies in NHS areas such as this, away from teaching centres.

Three patients of mine have died in the past three months, all in their fifties, who might have survived had there been adequate hospital facilities available for treatment. The most recent died at home of a coronary thrombosis about an hour after the only local hospital capable of providing treatment refused his admission as all their medical and intensive care beds were occupied. A few days earlier there was another fatal thrombosis in a man awaiting investigation with a view to coronary surgery. The head of the academic department concerned tells me that his waiting list for such cases is about one year. The third death was that of a man awaiting replacement of a heart valve, and his life would certainly have been prolonged had the operation been successfully performed.

It is popularly supposed that the NHS is under some stress but that only non-urgent cases are suffering. This is just not true. My patients express incredulity when the true situation is put to them. Family doctors have a contract with the NHS and it is arguable that they cannot fulfil this under the conditions described above. Resignation would, however, not help. There is likely always to be a gap between what the nation can afford and the latest technical achievements which are possible. At present it is not so much a gap as a yawning chasm and people might do well to look where they are standing lest they fall in.

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Preventing deaths from malaria

SIR,—When I read the article by Dr A P Hall (23 September, p 877) I experienced a feeling of déjà vu. Following the Junior Members Forum of 1974, where the symposium was entitled "Medicine in the supersonic era," four motions were sent to the Annual Representative Meeting at Hull. The first, that legislation should be passed to compel airlines to issue malaria warning cards, was passed

as a reference to Council. The other three, requiring the travel industry to give adequate health information in holiday brochures, urging the DHSS to issue an annual gazetteer and establish a tropical diseases information centre manned 24 hours a day, and recommending the availability of malarial prophylactic drugs on NHS prescription, were passed by very large majorities and so became the policy of the Association.

Since that time the annual figures for cases of malaria in Britain have continued to rise at the same rate as previously and nothing is done to implement simple measures that might cut down on the number of needless deaths and time loss from illness. Dr Hall's article is a valuable reminder that the BMA has allowed the grass to grow under its feet and perhaps we should nudge the sleeping "Elephant" into activity.

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SIR,—With reference to Dr A P Hall's article on the above subject (23 September, p 877), so far as the major British airlines are concerned he is obviously misinformed. Information on malarial risk has been available to our passengers in booklet form over many years. As this method of communication had limited success, since 1977, owing to strong representations from our respective medical services, in-flight announcements have been made concerning malarial risk. These are made before landing in malarious areas or where onward travel can involve such a risk. It should be mentioned that we have been complimented by both the World Health Organisation and the Department of Health and Social Security for taking the lead in this field and it is noted that a number of foreign operators have now followed our example.

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Heat stroke in a "run for fun"

SIR,—Heat stroke is emerging as the principal medical emergency of mass participation community running. In accord with the report of Drs M R Nicholson and K W Somerville (10 June, p 1525) a mass participation 10-km run conducted in the normally temperate climate of Canada resulted in 15 people treated in hospital for heat stroke of varying severity.

The run was conducted in Waterloo, Ontario, at the beginning of the Canadian summer (11 June 1978). The starting time was 1 pm, when the temperature was 24.3°C, humidity 49%, wind velocity 16 knots, and cloud cover minimal. Approximately 1300 people participated in the run. While many people were treated for minor heat problems, the 15 admitted to hospital exceeded the proportion observed in the New Zealand run. Eight of the victims were kept at least overnight and two for four days. The age and ability levels varied considerably. Three were girls aged 14-18 and the 12 males ranged in age from 17 to 38 years. Eight of 12 respondents to a

survey conducted after treatment in hospital considered themselves to be runners and not joggers, although none were the front runners. This differs from the New Zealand run, in which the victims were active in sports other than running.

An attempt to discover whether there was a common cause of the heat stroke resulted in the following conclusions. Firstly, all victims had been able to cover the 10-km distance in training with no problem. However, no individual trained in the hottest part of the day. Secondly, many victims had drunk large volumes of fluid before the run and some had drunk fluid during the run, yet this did not provide adequate protection from the heat. Thirdly and most importantly, most victims had thought they could finish in spite of the relatively hot conditions. They therefore continued to push themselves, ignoring signals from the body concerning heat load. The result of this continued running was that eight people lapsed into a state of unconsciousness. The unconscious state was followed immediately by collapse in some, but at least four of the victims have no recollection of distances varying from 800 m to 2 km. This obviously can have serious life-threatening implications if exercise is continued when the heat-dissipating mechanisms are ineffective.

It is of interest that none of the experienced competitive runners were admitted to hospital and very few suffered even minor heat-related problems. The reason for this is probably twofold: the competitive runners are trained to a greater extent and they have also developed the art of listening to signals of fatigue and stress from the body.¹

It becomes apparent that stricter control must be placed on the organisation of mass participation runs because the participant may not be sufficiently aware of methods of preparation and of warning signs. Recommendations concerning the conduct of distance runs have been published before,²⁻⁵ but now the medical and sports science communities must petition the amateur athletic sanctioning bodies to enact restrictions which prohibit the scheduling of a distance run for potentially hot periods of the day. In addition, regulations governing minimal medical precautions should be established. No longer is it sufficient to count on chance to bring a cool day in the middle of the summer.

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¹ Morgan, W P, and Pollock, M L, *Annals of the New York Academy of Sciences*, 1977, **301**, 382.

² *Medicine and Science in Sports*, 1975, **7**, vii.

³ Sutton, J R, and Harrison, H C, *Medical Journal of Australia*, 1977, **1**, 193.

⁴ Sutton, J R, et al, *Medical Journal of Australia*, 1972, **2**, 127.

⁵ *Medical Journal of Australia*, 1977, **1**, 165.

Natural history and prognosis of recurrent breast cancer

SIR,—Since the publication of our paper on the natural history and prognosis of recurrent breast cancer (9 September, p 730) we have been told by medical statisticians that there is a flaw in that part of the life-table data which we present in graphical form (figures 1, 2, and