that my references to the "healthy reputation" of our defence bodies in defending "nuisance" cases and to the existence of National Health Service complaints machinery in Britain is "anecdotal stuff" that can come only from someone "immersed in the system." If Dr Turner had taken the trouble to check his facts he would have found that these factors are universally accepted by our colleagues in the United States as largely responsible for the fact that the number of claims against doctors per head of population in Britain is less than 10% of that in the United States. Dr Turner also regards it as complacent of me to refer to our judges as "well aware of the dangers of encouraging defensive medicine" in comparison with judges in the United States. Again, he will find it difficult to get any support from American colleagues, who are fond of quoting Lord Denning's warning in a well known case that "if these medical malpractice awards get too large we are in danger of injuring the body politic just as medical malpractice cases have done in the USA."[1]

The solutions to the problem offered by Dr Turner do not inspire confidence. His reference to "no fault" compensation in the course of his criticisms of the BMA overlooks the fact that we set up a working party over three years ago to examine that system, the report of which was approved by the annual representative meeting this year and is currently being raised with the government. Whatever effect such a system might or might not have on the size of damages in personal injury cases, Dr Turner seems not to have realised that its purpose, as the report itself emphasises, is to obtain speedy compensation for the victims of medical accidents and not to enable negligent doctors to escape the consequences.

Dr Turner claims that differential subscriptions would relieve the National Health Service doctor of responsibility for the excessive claims from the private sector. There is no evidence whatsoever that claims from the private sector are disproportionate. Differential subscriptions would merely place the burden on those at highest risk, such as registrars in obstetrics and gynaecology, anaesthesia, and accident and emergency medicine, who are also least able to pay. They would also restrict doctors in their area of practice and be very difficult to administer in the absence of specialist registration.

Dr Turner complains about the "sheer amateurism" of the medical establishment, as shown by my article. If he means the BMA I hope he has noticed from Dr Richard Smith's article (12 September, p 621) that the BMA council executive has called for an inquiry by a select committee of parliament so that the necessary action may be based on solid facts rather than the mythology that pervades most of Dr Turner's proposals.

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1 Lim Poh Choo v Camden Health Authority [1979] 1 QB 196, 217(CA).

SIR,—Dr John Havard's leading article raises a number of points relevant to medical defence in Britain (15 August, p 399). Although we should be relieved that we do not have the contingency fee system of America, we have a number of problems which seem likely to get worse over the next few years.

Firstly, although public expectation is not so high in Britain as in the United States, undoubtedly people are expecting more and more from their health care. Paradoxically, the very nature of the health service in being free at the point of use means that some people abuse the system to extremes. Patients at times seem to expect that every request should be met without question regardless of its costs, nature, or time of presentation. This has tended to devalue the system in that many people have no conception of the costs of their medical care.

Secondly, it is incorrect to say that the health service complaints machinery in Britain enables patients to find out what went wrong without having to sue. Although this may often be the case, it is not always and patients complain of doctors putting up barriers to protect themselves.

Thirdly, although the defence organisations do a good job on our behalf, many doctors are alarmed at the rapidly escalating costs of medical defence—the annual subscription having just risen to £1080. This is indicated by the number of doctors who opted for the subscription method of paying for medical defence until this was withdrawn recently by the defence organisations, presumably because the flow of funds was insufficient to meet demand. In the not too distant future there will probably be a crisis in the health service as doctors are unable to meet their defence subscriptions.

No fault compensation would, of course, solve this problem for doctors but funding would have to be obtained elsewhere and it seems unlikey that the government would be prepared to fund such a system.

The rising number of complaints against doctors surely also must have relevance to the hours we are expected to perform. A tired doctor is more likely to make a mistake than one who is fresh from a good night's sleep. Defensive medicine is arriving in Britain and will without doubt put pressure on an already underfunded health service.

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Keeping up with orthopaedic epidemics

SIR,—We would challenge Mr Christopher Bulstrode's suggestion (29 August, p 514) that a rising incidence of fractured neck of femur is responsible for the present difficulties experienced in running orthopaedic trauma services.

Accepting that data produced by the Hospital Activity Analysis have certain limitations,[1] we have used it to examine patients discharged from hospital after treatment for fractured neck of femur between 1975 and 1986 in Leeds Western Health District (table). Office of Population Censuses and Surveys' mid-year population estimates were used to determine yearly discharge rates for patients with this condition. The data show that the incidence of fractured neck of femur and actual numbers of cases in the over 65 age group have not changed noticeably in the past 12 years and suggest that there has been no considerable increase in the incidence of the disorder during this period. Furthermore, the Hospital In-Patient Enquiry for England from 1975 to 1985 shows that the estimated total number of hospital discharges for fractured neck of femur rose from 35 150 to 43 230 during this time (an increase of only 23%) and that the rate of discharge has not changed substantially. The mean duration of stay has fallen, however, from 38·2 days in 1981 to 29·8 days in 1985.

Discharges from hospital among patients aged over 65 with fractured neck of femur 1975-86. Values are rates per 10 000 with numbers in parentheses

Year	Men	Women
1975	16·3 (33)	45·8 (157)
1976	18·0 (37)	46·3 (148)
1977	14·0 (29)	36·6 (127)
1978	15·6 (33)	44·2 (151)
1979	16·6 (35)	50·9 (178)
1980	16·2 (35)	48·6 (172)
1981	16·4 (35)	45·3 (164)
1982	16·6 (36)	46·1 (166)
1983	17·4 (37)	40·1 (144)
1984	16·9 (36)	35·0 (125)
1985	20·3 (44)	53·9 (194)
1986	14·7 (32)	52·4 (191)

We do not deny the burden that patients with femoral neck fractures place on orthopaedic services, but we wonder if it is time to stop blaming an epidemic of this condition for current difficulties. Evidence suggests that differences in surgical and management policies may contribute to the size of the problem.[2] Improved outcome and earlier discharge from hospital might be achieved by a more optimistic therapeutic approach, the development of a dynamic rehabilitation service, closer collaboration between orthopaedic and geriatric staff, and the organisation of a comprehensive hospital and community service for the elderly.

Finally, an analysis of the number of total hip replacement operations performed on residents aged over 65 in the Leeds Western Health District in 1986, in relation to their postal district of residence, shows that operation rates varied by as much as five times among districts. Clearly, care is needed in allocating these scarce resources if equity is to be achieved.

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1 Baker MR. An investigation into secular trends in the incidence of femoral neck fracture using Hospital Activity Analysis. *Public Health* 1980;94:368-74.
2 Gallannaugh SC, Martin A, Millard PH. Regional survey of femoral neck fractures. *Br Med J* 1976;ii:1496-7.

SIR,—It is difficult to think of an operation that has a more successful reputation than total hip replacement; regardless of technique or hardware, the early results are almost always excellent.[1] Often, however, too little is known about the final fate of the replacement, and Mr Christopher Bulstrode is right to emphasise the need for assessment of long term performance (29 August, p 514).

Nevertheless, it is misleading to consider this in terms of the implant alone. Differences in operative technique may be as important as, or more important than, differences in the design of the prosthesis. For example, it has been shown that changes in the cementing technique may result in a 90% reduction in the incidence of loosening of the femoral component, regardless of the type of prosthesis used.[2] These improved cementing techniques are well described[3] yet far from universally applied.

Mr Bulstrode mentions the use of roentgen stereophotogrammetry in the context of implant failure. The validity of this depends on the assumption that migration of the femoral component presages failure. This is by no means established; indeed, Charnley himself reported that slight subsidence could result in a new and final position of stability,[4] and early migration in other prostheses has been found to be compatible with excellent long term results.[5]

Reliable predictors of long term performance are still urgently needed, but these will require a better understanding of the mechanisms of failure. Some of the clues may be found in existing reports, for those who look beyond the glossy advertisements for the latest prostheses.

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