but since the injury she had married a man 40 years her junior. The need to keep up appearances might have accounted for the shallowness of the decline from grade 1 to grade 2.

Discussion

Proximal femoral fractures occur more often with advancing age and especially in very old people. The projected population figures for the rest of this century indicate that the incidence of these injuries will continue to increase for the next three decades because of the increasing numbers of people over 75 years. Not surprisingly, therefore, geriatricians and orthopaedic surgeons take a common interest in this group of fractures which so often presents combined medical and social problems.

Ideally a combined clinical approach is needed when the patient is admitted so that his or her medical state can be completely diagnosed before operation. In this paper we emphasize the importance of pre-existing medical abnormalities. The team should continue to devise the rehabilitation programme to suit and improve the mechanical and medical potential of each individual. By such means some patients may be medically more fit on discharge than before the accident. In this respect we are tempted to go further than Beals's⁸ goal of returning the patient to his prefracture state, though our ideal was not applicable to this series.

Several factors affect the quality of life attainable one year after the injury, some of which can be influenced by treatment or other means and some of which are unalterable. For example, the chances of social deterioration seem to be doubled if the patient is over 75 years. We have shown that the surgical result influences the social outcome, and we hope that improved techniques, particularly directed at displaced subcapital and

very unstable trochanteric fractures, will eventually achieve better results. Perhaps general acceptance of the idea of the orthopaedic-geriatric team would improve recovery rates.

Nevertheless, and despite any marginal improvements that may be obtained by these means, the real need is for adequate resources in hospital and community to deal with the social consequences, especially because pre-existing social handicaps lead to further social breakdown when complicated by femoral fractures. To claim the need for resources is to state the obvious, but a larger prospective study is now being planned to measure these needs and to identify more precisely the possible ways to meet them.

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Around Europe

What Can We Learn From Sweden?

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A recent visit to Sweden on behalf of the British Council yielded some information about the Swedish solution to some of the problems now besetting the medical profession in this country. The way in which the Swedes have tackled, and apparently solved, the problem of overtime for doctors is particularly interesting and may help the present controversy in Great Britain.

Hospital Services

The hospital services are administered on a regional basis but terms of employment are negotiated at the national level between the Swedish Medical Association and the health

authorities. Some 95% of Swedish doctors belong to the Swedish Medical Association which represents all branches of the profession. The competing claims and interests of different branches of the profession, consultants and general practitioners, juniors and seniors, are first reconciled within the profession before any negotiating position is adopted. As far as one can tell there is no question of the Government negotiating separately with different sections of the profession except for administrative posts.

A remarkable feature of the Swedish system is the way in which they have solved the problem of extra work and on-call duties. Their solution, hammered out between the Swedish Medical Association and the Government in two stages—in 1964 and 1970—is based on the idea of a basic working week of 40 hours which applies to all grades of doctor in the hospital service. The salary for any particular job is based on a certain rate for a 40-hour week, which is at present about £12,000 per annum for consultants. The actual number of hours to be worked is, however, fixed by agreement with each individual doctor on his appointment to his particular job and is usually about 46 hours. The extra six hours are paid at the same basic rate as the basic 40

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hours so that the average salary of consultants is about £14,000 per annum. There is no systematic check on the way in which these hours are worked.

These 40-50 hours are worked between 7 a.m. and 7 p.m. from Monday to Friday. Extra time comes into operation between 7 p.m. and 7 a.m. during the week and between 7 p.m. on Saturday and 7 a.m. on Monday. Any doctor working during these on-call hours is entitled to claim compensation in the form of additional time off or additional remuneration at the following rates:

ON-CALL COMPENSATION

- (a) For being on call on hospital premises during overtime hours, a doctor receives compensation in time or money at one-quarter of his basic salary rate.
- (b) For being on call outside the hospital but available soon—that is, within 30 minutes—the rate of compensation in time or money is one-tenth of the basic rate.
- (c) For being on call and available at two hours' notice, he receives compensation at one-sixteenth of his basic rate.
- (d) At weekends all these rates are doubled.

COMPENSATION FOR ACTIVE WORK

When a person on call is summoned to active work he is paid at his normal basic rate for the length of time he is actually working and for travelling time, which also counts as not less than one hour. Every half hour started counts as half an hour and this includes providing advice over the telephone. Nevertheless, several telephone calls about one patient within half an hour count only as half an hour.

"Overtime" in the sense that it operates in industry—that is, remuneration at a higher rate during overtime hours—does not apply to consultants. Nevertheless, true overtime rates do apply to junior staff below a certain salary level. This level covers roughly the first seven years of post-graduate experience. During this time the compensation rates described above are increased by about half. Additional responsibility receives additional remuneration on the basic rate. A head of department receives a supplement over and above his basic salary. Teaching during the agreed working hours does not attract additional remuneration, but teaching outside the agreed working week attracts compensation in money or time off.

There is no private practice on hospital premises but private practice operates on a relatively small scale in consulting rooms and nursing homes. Major surgery is not, however, performed in private nursing homes.

General Practice

General practice as we know it hardly exists, at least in the countryside, though there is an increasing move towards the development of primary care based on health centres. This type of primary care, which has always operated in the rural districts but is now being introduced into towns and cities, is performed by salaried general practitioners whose terms and conditions of service are similar to those of hospital staff. At present it is possible for patients to see a specialist without a

general practitioner referral, but when the primary care service is fully developed this will probably be replaced by the referral arrangement of the type we have in this country.

The same on-call system operates in general practice as in the hospitals. There is the same agreed basic working week of 40-50 hours paid at a standard rate which is comparable to that of consultants. There are the same arrangements for on-call duty and active work out of the ordinary working hours. Nevertheless, because general practice is increasingly centred on health centres only one general practitioner is on call at night for any particular area or whole small town. This one doctor on call may serve a population of 25,000 or more. This is made possible by the virtual elimination of home visits. When there is a night call, the doctor on duty decides over the telephone whether the patient should come to the health centre by car or in an ambulance or go straight to hospital. No night duty is expected of practitioners over the age of 60.

Staffing

Because of the progressive rates of income tax, most doctors do not find it worthwhile to draw their compensation in money but prefer to take it as additional leave. The extra leave accumulated in this way is substantial and is used by some doctors for study and by others for recreation. This, of course, leaves large gaps in the hospital staff at all levels for substantial periods of the year. The authorities recognize this and allow for it in determining the establishment of hospitals and departments. As a result, the ratio of actual medical personnel employed to the theoretical establishment required varies between 1.3 and 1.5 to 1.

Lessons for Britain

There are several lessons which may be relevant to our situation. Firstly, the Swedish medical profession has managed to present a united front to the authorities. Only 5% of doctors do not belong to the Swedish Medical Association, though they forfeit no rights or privileges by remaining outside. Problems between different branches of the profession are resolved within the profession. Secondly, all grades of staff, not just juniors, enjoy the same compensation for on-call and overtime duties. Thirdly, there is a similarity in basic remuneration and conditions of service of consultants and general practitioners. Finally, there is the realistic way in which the authorities have recognized that when medical staff are given agreed additional time off, this has staffing implications, and additional staff are provided. This contrasts strongly with the recent directive of the British Department of Health and Social Security increasing the off-duty hours for junior staff without allowing any increase in the junior staff establishment. Nevertheless, it is only fair to add that hospital staffing at the junior level is enormously facilitated by the fact that junior staff of all grades perform essentially the same duties—admitting, clerking, and examining patients—and share on-call and residential duties equally. This clearly enables emergency cover to be provided in an extremely economical way.

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