patients should be avoided. However, anaesthetists should be mindful of the available evidence which shows that, in terms of mortality at 1 yr, young or low-risk patients suffer the greatest detriment as a result of delayed surgery. Mortality benefit should not be touted as a justification for proceeding with urgent surgical fixation for high-risk fractured hip patients.

**Declaration of interest**

None declared.

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**Reply from the authors**

Editor—I thank Dr French for his interest in our paper.¹ There is inconsistent evidence regarding the potential benefit or harm of early surgery in the high-risk patient. Our data are supported by others²–¹⁰ who have found that early surgery appears to be of benefit overall for patients with fragility hip fracture with regard to long-term mortality. In our study, this difference was greatest for younger and fitter patients as defined by Nottingham Hip Fracture Score¹¹ ≤4. We found no significant difference in 1 yr mortality for high-risk patients (NHFS >4) between early and late surgery, but we would caution against over-interpretation of these data. This was not a randomized controlled study, and the high-risk cohort will include patients who were delayed for medical reasons and those who were delayed for administrative reasons. Khan and colleagues’ comprehensive, qualitative review of the literature until 2007 concluded that there were no adequate studies that suggested an increased risk from early operation. There are, however, data suggesting that length of hospital stay and morbidity are adversely affected by delay to surgery.¹² The benefit of operation as the best form of analgesia is well recognized. I agree with Dr French that ‘mortality benefit should not be touted as a justification for proceeding with urgent surgical fixation for high risk fractured hip patients’. However, there are other humanitarian and potential healthcare cost benefits to operating sooner. At the risk of courting controversy, I would suggest that clinicians and healthcare providers should justify why surgery is delayed in any patient with hip fracture.

**Bibliometrics of anaesthesia researchers in the UK**

Editor—I read with interest the article by Moppett and Hardman.¹ The authors are to be commended for their comprehensive approach to measuring bibliometrics of UK anaesthesia researchers. This article provides valuable information for benchmarking research performance of anaesthesia researchers. It also highlights the difficulties of determining citation profiles of researchers using scientific citation databases and which single-number citation indices may best measure the research performance of individual researchers.

Despite the increased use of bibliometrics for measuring the scientific performance of clinician scientists in recent years, there is still no consensus on which bibliometrics should be used for measuring research performance of individual researchers in medicine, and which researchers may be assessed successfully using bibliometrics.

Hirsch² first described the h-index for elite physicists—winners of the Nobel prize in physics and newly elected members of the National Academy of Sciences. However, the h-index—and its variations—may not always be applied with the same success to other scientific populations with

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**Declaration of interest**

I.K.M. is on the editorial board of the *British Journal of Anaesthesia*.

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