to work out fair fixed costs for the fast track, unless and until some cases have been conducted under the new procedures. If the fixed costs are set too low, winning litigants could end up paying a slice of their own legal costs out of their damages. This would hurt the very people the report is intended to help.

The changes must be properly resourced, particularly to enable judges to perform effective case management. Lord Woolf makes light of this, arguing that re-deployment of existing resources should suffice. But, as a minimum, all the existing judges and court staff will need intensive training, senior judges will need administrative back up and laptop computers to keep track of their "dockets", and there will need to be a heavy investment in information technology throughout the courts. There may be a need for more judges, especially in the county courts. Putting additional funds into the civil justice system is not viewed as a priority by either major political party. But trying to change the system on the cheap could be the worst of all worlds: if judges do not have the time and the training to read into and think about cases they are trying to manage, quite simply the reforms will not work.

Medical negligence was one of the areas of litigation studied in depth at the second stage of the enquiry. Lord Woolf's proposals are explained in more detail in the next editorial (p 243). One of the most controversial proposals is for rules of professional conduct "to clarify the responsibility of health care professionals to their patients" when they discover a negligent act or omission: solicitors have long had a clear duty to advise their clients to seek independent advice. Why should not health care professionals do likewise?

Doctors will also have a particular interest in the proposals on expert evidence. These too are controversial. In his final report, Lord Woolf has retreated only slightly from the enthusiasm he showed in his first report for court appointed or jointly instructed single experts in many more cases. In my view, this underplays the important role that experts fulfil as advisers to the parties, both early on in the dispute in shaping the elements of a potential claim, and after proceedings have been issued in advising on tactics and sometimes on settlement proposals from a technical view. An expert instructed by the court or jointly by the parties would have to be much more at arms length. In practice, in larger cases the parties would still want their own advisers: if three experts rather than two were instructed, the costs would be increased. Moreover, in many areas of litigation, particularly in medical negligence, there is often a wide range of acceptable practice and professional opinion about a particular type of treatment. Patients will not feel they have been treated fairly, if in future a judge effectively delegates his decision to one health care professional.

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1 Woolf H. *Access to Justice: final report to the Lord Chancellor on the civil justice system in England and Wales*. London: HMSO, 1996.

Managing medical mishaps

Needs greater openness and partnership between doctors, lawyers, judges, and patients

See pp 242, 247

No one likes admitting that things have gone wrong, least of all politicians and doctors. Even if not culpable, they feel vulnerable and tend to react defensively. Medical defence societies used to encourage this attitude, advising their members to behave like motorists involved in an accident and to admit no liability. Fortunately, their policy has changed. Accidents may or may not be avoidable or negligent. A chain of minor errors may cascade into a major mishap. Without a frank and sympathetic explanation accompanied by timely expression of regret or apology, a relationship of trust disintegrates into an adversarial contest between an embattled doctor and bruised families. The time, cost, and turmoil is often out of all proportion to any compensation due or to the extent to which the public interest may be served by the outcome of any legal proceedings. Legal disputes cannot, of course, always be avoided. The task is to find ways of resolving them fairly and swiftly while, at the same time, preserving and protecting that precious thread of trust. One of us (HW) has proposed ways to make settlement of medical misadventure simpler, faster, cheaper, and less painful, while streamlining the civil justice system and making it more accessible.¹

The Woolf proposals were submitted to the Lord Chancellor last week. If they are adopted, legal proceedings in England and Wales will be much more of a last resort for people who are seeking to resolve disputes. A pre-litigation protocol for cases of medical negligence will set out a code of sensible practice that potential claimants and defendants will be expected to follow. Claimants will be encouraged to use internal complaints procedures, mediation, or other informal means of resolution wherever possible. Both parties will be encouraged to make realistic offers to settle at the earliest appropriate stage. The opposing sides in a dispute will have to cooperate

with each other by providing the fullest possible information as to the basis of a claim or defence.

The new system will require a complete change of culture on the part of everyone involved. The challenge is threefold. How can the medical profession be encouraged to adopt a more open and conciliatory approach to misadventure? How can suitable expert witnesses be identified and trained to reach agreement on the limits of medical probability, rather than score points off each other in the ring? How can a small cadre of specialist judges be given sufficient insight into the circumstances and environment of clinical practice to feel at home in bringing together all the medical threads in judgment?

Doctors, the medical defence societies, and NHS trusts have already moved a long way towards greater openness. Medical training should encourage a spirit of candour, humility, and partnership with patients, something which does not always come naturally to medical students or doctors. This should be an integral part of their training in communication skills. The interface of medicine and the law could be explored within the medical undergraduate curriculum, either in special study modules lasting a few weeks or in study for a year leading to an intercalated BSc degree. There is no shortage of topics, ranging from legal and ethical aspects of the new genetics, through clinical risk management, drug licensing, and medical witness skills, to forensic pathology. Enterprising universities might offer a double degree course in law and medicine, a suitable foundation for expert witnesses, solicitors, barristers, coroners, and specialist judges.

Training in witness skills, however, calls for a professional certificate rather than an academic diploma. Expert witnesses are likely to be doctors first and witnesses afterwards. All specialties would be needed, although some, such as obstetrics,

are by their nature more accident prone than others. How about the Academy of Medical Royal Colleges, the Law Society, and the Bar Council jointly sponsoring an appropriate course? Courts would gradually build up a panel of holders of this certificate, from whom experts might be instructed by the court in agreement with the parties. Different experts might perhaps be specifically responsible for researching different sides of the argument, but their joint task would be to agree the parameters of the medical facts.

Finally, how might specialist judges acquire suitable insight into both the circumstances of clinical practice and the hopes and fears of patients? One of us (PR) would be pleased to arrange for such judges to spend a day with a general practitioner, to shadow a junior doctor in a casualty department, and to live in overnight with an admitting team. But the judge should also see medical practice through the

patient's eyes (something that would also be good training for doctors)—waiting with a patient waiting in a hospital clinic or a casualty department, sitting on the patient's side of the desk.

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1 Woolf, Lord. *Access to justice: the final report*. London: HMSO, 1996.

Motor neurone disease

Some hope at last for respiratory complications

In patients with motor neurone disease, progressively worsening breathlessness often coincides with deteriorating bulbar function, and this combination may lead to difficulties in swallowing and coughing and a risk of aspiration. Occasionally, chest infections cause life threatening respiratory failure. The progressive nature of motor neurone disease acts as a deterrent to active management, but since its time course varies so much, should patients be denied the treatments that would be considered if they had a different diagnostic label?

There is no simple answer to these difficulties. The essential starting point is a detailed analysis of the distribution of the affected respiratory muscles and of the patient's symptoms. The most common way in which the chest wall muscles are affected is weakness of the expiratory muscles leading to a weak cough.¹ If there is no bulbar weakness a poor cough does not require any specific treatment unless it is severe enough to cause retention of sputum, at which stage a tracheostomy should be considered.

A few patients develop bilateral diaphragmatic paralysis out of proportion to any weakness of the other respiratory muscles. They usually present with breathlessness on exertion and on lying flat at night, and they complain of excessive daytime sleepiness. They have a relatively good prognosis.² The most effective treatment for relieving nocturnal respiratory failure and sleep related symptoms is non-invasive ventilation either in the form of a nasal positive pressure ventilator or a negative pressure system such as a cuirass.^{1,3} These treatments need to be used only at night, and because they do not require an artificial airway they do not impair coughing, swallowing, or speech during the day.

Similar techniques are effective if there is global weakness of the inspiratory and expiratory muscles, but this pattern usually develops in patients who are considerably disabled. These are the patients most likely to develop ventilatory failure during chest infections. Whether or not to proceed to intubation and ventilation can be a difficult decision if the issue has not been previously addressed. Often patients are ventilated in the hope that weaning will be possible and that a decision can then be made about how to respond to any further infections. Most patients, however, prefer to discuss what will be done in an emergency before it arises for the first time,^{4,5} and this is helped by greater openness in the initial consultations.

Another underrecognised but distressing complication is intermittent adduction of the vocal cords.⁶ During wakefulness this may lead to episodic stridor, which is often precipitated by the presence of food or fluid in the pharynx. At night it may lead to noises like snoring and to obstructive sleep apnoea. No treatment

is needed if the stridor is mild or infrequent, but if it worsens a tracheostomy should be considered. If there is no other bulbar impairment a silver tube is sufficient and enables speech to be retained. A tracheostomy may also be needed if the main symptom of adduction of the cords is sleep apnoeas, but in these circumstances (as with sleep apnoeas in general) nasal continuous positive airway pressure (CPAP) should be tried first. Like non-invasive ventilation, it needs to be used only at night, and the patient remains totally independent during the day.

Widespread bulbar impairment producing dysarthria, dysphagia, and an impaired cough is more common, and it may lead to aspiration and major airway obstruction.⁷ The first line of management should direct attention to swallowing techniques and the texture of the food. Next a gastrostomy should be considered, as this will allow avoidance of all oral feeding. If aspiration remains a problem, however, the alternatives are a tracheostomy with a cuffed tube or a laryngeal diversion procedure.⁸ Unfortunately, both of these deprive the patient of speech. In practice the outlook for most people with severe bulbar problems is poor, and these procedures are probably best reserved for the few patients with mild extrabulbar weakness.

An assessment of the respiratory symptoms and the extent of respiratory muscle weakness, though important, is by itself insufficient for planning management. Any benefits to the patient from, for example, non-invasive ventilation will be lessened if the other disabilities from the motor neurone disease are extensive and if it is rapidly progressing. The attitude of the patient and carers is equally important. The implications of choosing whether or not to provide treatment should be discussed openly at an early stage. All the forms of non-invasive ventilation, continuous positive airway pressure, and surgery have their drawbacks, but all can bring considerable benefits if used selectively. They should not be seen as the first step in an inexorable escalation of high technology interventions but as one of a series of adaptations to the evolving disabilities that inevitably arise in the course of the disorder. Clinical experience (and the small amount of published data^{9,10}) shows that if all these components are taken into account when considering home ventilation the patient's quality of life can be considerably enhanced.

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