I am grateful to have this opportunity of stating publicly the extent to which I am indebted to the Royal Colleges in general, and the Royal College of Physicians in particular, for the help that they gave me during my inquiry into Access to Justice. Before discussing the reforms which I recommended as a result of that inquiry, I would like to stress that in my experience the relationship between the medical profession and the judiciary and the courts has always been of a high order. The courts are very conscious that in many fields of litigation they depend on expert medical advice in order to come to a just decision.

The general approach of the courts is to apply the standards that the medical profession adopts. Thus we judge whether there has been negligence in the treatment of a patient by asking whether or not the medical treatment, which is the subject of complaint, accords with standards which any recognised section of the medical profession regards as acceptable. If the treatment does accord with such a standard, then in general we do not categorise it as negligent. By adopting this standard the courts have managed to hold the balance fairly between the interests of the patient and the interest of the profession. By striking the right balance, the courts reduce the risk of proper medical practice being undermined by the fear of litigation and recognise the need for compensation to be paid where treatment is of an unacceptable standard. In addition, the courts do not impose their ethical standards upon the medical professions. Wisely, they leave the medical profession to determine what is, and what is not, ethical behaviour.

However, members of the medical profession are from time to time uncertain whether a particular course of treatment is or is not lawful. When doctors have problems of this nature, they can rightly expect the courts to provide them with the advice and assistance they need. If the problem needs to be resolved urgently because the health of a patient is at stake, then the courts are under a heavy duty to ensure that it is resolved expeditiously. Here, I believe, the courts can take pride in what they have achieved with the co-operation of the legal profession.

First, the courts have significantly changed their attitude to giving advisory declarations on medical issues. At one time it was the courts' practice not to grant advisory declarations as to whether future conduct would or would not be unlawful. A doctor was then faced with the choice of either not giving treatment or taking the risk of giving treatment and having that treatment later condemned as unlawful. Now it is clearly established that if there is a doubt as to the lawfulness of treatment, the court can rule on this in advance of the treatment being given. As a judge of first instance, I was by chance involved in the three cases upon which the present approach is based. The first case involved the Royal College of Nursing who were concerned as to what part a nurse could properly play in procuring an abortion without being under the direct supervision of a doctor. The second was as to the lawfulness of doctors providing advice on contraception to children below the age at which it was lawful to have sexual intercourse with them. The third case involved what advice and assistance could lawfully be given to an individual who wished to terminate his or her life.

It has been particularly important that the courts should be willing to grant advisory declarations when a patient is unconscious as a result of an accident or illness and is incapable of stating whether or not he or she consents to a particular course of care. The law has laid down that in such circumstances a doctor may lawfully treat a patient as long as he or she acts in the patient's best interest. Indeed, if the patient is already in his or her care the doctor is under a duty to treat the patient. The case which made this clear was only decided in 1989. In that case it was obvious that it would be desirable to sterilise an adult woman of unsound mind and the court held it was lawful for the operation to take place.

However, doctors are not entitled to impose treatment on someone who is of sound mind, however much that treatment might be in the patient's interest, if he or she does not consent to have that treatment. A patient may, if he or she wishes, starve him or herself to death. But should a doctor provide, or continue to provide, treatment or care that would or might prolong the life of a patient if continuing the treatment is futile, since it would not confer any benefit upon the patient? This was the issue that came before the court in relation to Anthony Bland, the young

This article is based on the Samuel Gee lecture given at the Royal College of Physicians of London in May 1997 by THE RT. HON. THE LORD WOOLF, Master of the Rolls, House of Lords.
were the 1000 victims of the Hillsborough football disaster. He was 21 years old when the matter came before the House of Lords and had been in a persistent vegetative state for three years. The House of Lords drew a distinction between two situations. The first is bringing a patient’s life to an end by positive steps, such as administering a drug to bring about his or her death; that would be euthanasia, and unlawful. The second is not prolonging the patient’s life by discontinuing medical treatment, e.g., stopping artificial feeding and the administration of antibiotics, when it is known that the result will be that the patient will die. This is lawful. But it is subject to a proviso which again involves the standards of the profession. The proviso is that responsible and competent medical opinion is of the view that it is not in the patient’s best interest to prolong his life. Two members of the House, Lord Browne-Wilkinson and Lord Mustill, were especially concerned about having to reach a decision, because this is an area where it is particularly important that Parliament should review the law. They also recognised that the solution that was being provided was not ideal. As Lord Browne-Wilkinson said: ‘How can it be lawful to allow a patient to die slowly, though painlessly, over a period of weeks through lack of food, but unlawful to produce the immediate death by a lethal injection, thereby saving his family from yet another ordeal to add to the tragedy that had already struck them? I find it difficult to find a moral answer to that question’. As perhaps could be forecast, Parliament has not provided the legislation which their Lordships thought desirable and so the courts are still having to develop the law on a case by case basis.

Since the Anthony Bland case, similar assistance has been sought in the courts in a fairly substantial number of other cases. Some of these have been variations of the Anthony Bland case; others have raised different issues. In a recent case, a mother was in danger of inflicting injury upon herself and losing the baby she was about to have because she suffered from a needle phobia; the needle phobia was preventing her making any decision at all. The situation was extremely urgent and the court at first instance sat at 9.25am to 9.55pm so that it could grant a declaration. An appeal was heard on the same day from 11.00pm to 1.00am and a declaration granted by the Court of Appeal with the consequence that later that morning the mother, having learnt of the decision of the court, voluntarily gave her consent and was delivered of a healthy child.

The courts also recognise that cases of this nature need a special form of case management. As the issues were often of a similar nature to those dealt with by the Family Division, the cases were allocated to that Division so that the Family Division judges of the High Court could develop expertise in their disposal. Furthermore, the President of the Family Division laid down procedures that would ensure that these cases received the urgent attention they required. The consequence is a marked improvement in the ability of the courts to assist the medical profession and, in so doing, the interests of justice and the needs of the public.

Medical negligence litigation

Medical negligence was given a high profile during my inquiry and has been the subject of a number of my recommendations. This is because medical negligence was one of the areas of litigation in which it was obvious that the civil justice system was not working satisfactorily and radical change was needed. I am confident that no one who has personal experience of this subject would dispute this diagnosis.

The recommendations I made for the improvement of the handling of medical negligence cases are but an example of my recommendations for the improvement of litigation generally. If the general recommendations are not sound, then my recommendations as to the handling of medical negligence cases must also be flawed.

Because of this, I now refer to a campaign of opposition to my recommendations upon which Professor Michael Zander, Professor of Law at the London School of Economics, has felt it right to embark.

As I understand his thesis, it is that there is nothing very much wrong with the way the civil justice system is working but, insofar as there is anything wrong, it is unlikely that anything can be done about it, because lawyers will not change their ways and, in any event, my recommendations will make the situation worse rather than better.

In making this root and branch attack on the reforms, Professor Zander recognises that he is, as he has said himself, a Cassandra figure. He said in a recent lecture:

‘the Woolf project appears to have almost universal support including, so far as one can tell, that of the senior judiciary, the Bar and The Law Society as well as both the lay and the legal press’.

He adds that

‘one might have expected that of all people, practising lawyers would take exception to Lord Woolf’s caustic view of the way that they operate. But neither the Bar or The Law Society has raised a peep of protest about this calumny. Indeed, Lord Woolf’s view was essentially not different from that of the independent working party set up in 1992 jointly by the General Council of the Bar and The Law Society’.

Here he refers to the report brought out under the chairmanship of Miss Hillary Heilbron QC and Mr Henry Hodge which reflected the views of forty-four highly experienced practitioners. He suggests there has been remarkably little interest in awkward facts and analysis that suggest that this emperor is wearing no clothes.
The tenor of Professor Zander's lecture reminded me very much of the remark attributed to a nineteenth century judge who was reported to have said 'Reform, don't talk to me about reform, things are bad enough already'. Professor Zander concluded his lecture by saying:

'The arguments I have been pressing are very strong ones and they deserve an answer. But they have not been answered - perhaps because they are unanswerable.

I propose that the new Lord Chancellor should say 'I want to be told by someone in detail and addressing the facts and figures why Zander is wrong. And Zander should be given an opportunity to reply to such an assessment of his argument. And let there be a reply to Zander's reply and let this process go on until both sides have said what they have to say. Such exchanges or advice to the Lord Chancellor should be published and then let the Lord Chancellor decide which is the better argument'.

A prudent approach might, for instance, lead us to stand by implementing the proposal made in 1979 by the Cantley Committee that attention should be directed first and foremost at the small minority of cases that plainly appear to be lagging. If a case has not been set down for trial within X months of issue of the proceeding, a summons should be issued requesting an explanation. The court could then give whatever directions seemed appropriate in the light of what it was told about the reasons for delay. That would be a reform targeted at the right cases, as opposed to Lord Woolf's scatter-gun approach which would apply the reforms mainly to cases that do not need them.\(^3\)

If you heard his lecture you would no doubt be impressed by his eloquence but you should have been very sceptical of the content.

Although I accept this does not mean that my recommendations have any validity, they were produced after an intense two years' consultation process conducted with the assistance of assessors with a wide-ranging experience of the subject with which my report deals. I was also helped by expert working parties of highly experienced legal practitioners and academic consultants of distinction whose findings supported my conclusions.

Those findings were that the civil justice system has become excessively adversarial, slow, complex and expensive. This is especially true of litigation over alleged medical negligence in the delivery of health care, whether by doctors, nurses or other health carers. For example, there are five respects in which medical negligence actions conspicuously fail to meet the needs of litigants:

1. The relationship between the costs of the litigation and the amount involved is particularly disproportionate. The costs are peculiarly excessive, especially in low value cases.
2. The delay before claims are resolved is more often unacceptable in the case of medical negligence claims than other classes of proceedings.
3. Unmeritorious cases are pursued and clear-cut claims defended for longer than happens in other areas of litigation.
4. The success rate is also lower than in other personal injury litigation.
5. The lack of cooperation between the parties to the litigation and the mutual suspicion as to the motives of the opposing party is frequently more intense than in other classes of litigation.

I emphasise that the system is not meeting the needs of patients or professional health carers. They are both being let down by the present civil justice system. It causes pain not only to the potential plaintiffs but also to those who have been responsible for delivering the health care of which complaint is made. All too often they find themselves in a nightmare situation. Their ambition throughout has been to help the patient but instead they find that they are the subject of hurtful allegations of negligent mistreatment. The allegations often only surface after the carers have ceased to have any real recollection of what happened. They frequently feel intense frustration, believe that if only they could have an opportunity to discuss the issues with the patient, they could satisfactorily explain why things turned out as they did. However, outdated conventions make this impossible. The concern is that an apology, or even an explanation, could be used in evidence against them or prejudice their position with medical defence bodies. The result is that patients feel let down. Treatment has gone wrong, sometimes because of unrealistic expectations as to what could be achieved, and carers react defensively to attacks from patients that they regard as unjustified.

I was convinced that a way had to be found to break down the barriers that divided patients from their carers so that, wherever possible, litigation could be avoided. This could only help everyone involved. It would save on costs. Patients who deserve to be compensated would receive proportionate compensation voluntarily and in an atmosphere that did not poison relations between the patients and those who had been treating them. Often, where things have gone wrong, the need for treatment is at its greatest, and the breakdown results in the professional feeling frustrated by not being able to provide that treatment.

Professor Zander is unwilling to accept that the civil justice system has these serious faults from which I and virtually all commentators agree the system suffers, and is unwilling to accept that, if the faults do exist, my recommendations will improve the situation. Let me therefore deal with these points in turn.

The faults

At the outset I should make it clear that all the blame for the problems, which I believe exist, is not to be laid...
at the door of the legal profession. Too often, in individual cases, lawyers are at least partly to blame but a more important cause of the problems is the way the present adversarial system encourages excessive delay, expense and unnecessary complexity. It is the system, not the lawyers, that explains, for example, the hostility and bitterness that distorts medical negligence litigation.

Delay

On the question of delay, Professor Zander relies on two reports that were about personal injury alone; one published almost 30 years ago (Winn)\(^b\) and the other (Cantley) 18 years ago\(^a\). Even 18 years is a long time ago. The Winn report, as Professor Zander accepts, did consider that delay was a problem and, though not coming to identical conclusions, substantially shared my views. Cantley was a limited exercise; there was no consultation and it took a more sanguine view of the position. Professor Zander suggests I may not have considered the evidence provided by those reports; I know not why he makes this suggestion but it is ill founded. However, I prefer to rely on the up-to-date statistics set out in my Interim Report and on what I and my team found to be the position after what was probably the most extensive and thorough examination that has ever taken place into the civil justice system.

The statistics show that High Court cases take 163 weeks in London and 189 weeks elsewhere to proceed from issue to trial. In the county courts, dealing with smaller cases, the figure was 80 weeks. These figures were, I emphasise, for the average case. Many would take substantially longer. Research for my inquiry by Professor Genn indicated that in medical negligence cases the average time from issue to conclusion was 6.4 years and in ordinary personal injury actions 4.5 years. To these figures have to be added the substantial period, sometimes years, that is allowed to pass before the action is even begun.

I said in my report that the delays were unacceptable and, as far as I am aware, no one has sought to suggest the figures are inaccurate or, apart from Professor Zander, that my criticism is unwarranted. I was also concerned about the time cases were taking to settle. Here the figures available were for 1993. Of the cases that were set down for trial – that means they had gone through all steps necessary to make them ready for trial – only 13% were determined after trial, and 9% settled at the door of the court or during the trial; that is, after all the expense had been incurred. I also referred to Professor Genn’s research that showed that the majority of cases took as long as 4 to 6 years to settle – larger cases took longer. Again, I regard the figures as unacceptable. In doing so, I have very much in mind the trauma that litigation can cause to those involved and which, especially in medical negligence cases, can leave both sides with a grave sense that the justice system has failed them. In minimising the problem of delay, Professor Zander displays remarkable complacency.

Professor Zander suggests that I am being Canute like and defying reality in suggesting something can and should be done about this, instead of recognising that the enterprise is hopeless. He also categorises the failures of lawyers in this area as minor failures. In expressing these views, he refers to the unfortunate experience of the automatic strike-out provisions. These were introduced into the county court rules in 1990 in an effort to do something about the situation. The device was simple and crude. If a plaintiff allowed 15 months to elapse after the time when the parties had set out their case in writing (documents called pleadings) before taking the steps necessary to enable the court to fix the date for trial, the action would be struck out automatically and they would have to apply for it to be restored. What was not foreseen was that in more than 20,000 cases, the plaintiff’s lawyer would delay for over a year and a quarter to take the elementary step of setting down the case which is a condition precedent to the case coming to trial. I agree with Professor Zander that this provision has been a disaster; there have been appeals galore and actions for negligence and numerous applications for the action to be restored. However, I certainly dissent from his proposed response. Professor Zander suggests we should accept that:

‘there is really nothing that can be done about the problem other than the application of sanctions that are ridiculously out of proportion to the offence, a policy which, sooner or later, has to be abandoned because it is manifestly unjust’.

The error made when the rule was introduced was not to appreciate that there would be anything like this number of cases affected. The error was understandable because the system could not provide the information needed to know otherwise. What then should be done? First, the lesson should be learnt that there will be a substantial number of cases in which, contrary to Professor Zander’s views, if the lawyers for the plaintiffs are left to their own devices, they will delay taking even the most elementary steps in the interests of their clients. Second, in the interests of justice, as no one else can take the responsibility, the court must take the responsibility for ensuring that this delay does not happen. Third, the solution is not to impose Draconian sanctions, except as a last resort, but to make sanctions of this sort unnecessary because (a) the court does not allow the situation to deteriorate to the extent that sanctions become necessary, and (b) the court has the wider range of alternative sanctions I propose. Unfortunately this will only be possible when the technology I have recommended is in place.

The experience with automatic strike-outs is therefore not an argument against case management but
for case management. Ironically, in relation to delay, Professor Zander does make at least two positive proposals which are very similar to my own. They are that dates for trial should be fixed at an early stage in the life of a case and, if it is manifestly lagging behind schedule, it should be called in for directions. Where we differ is that I do not restrict myself to these modest steps, because delay is by no means the only subject to be tackled. There is, in particular, the need to reduce costs, to simplify the system, to remove disproportionate behaviour of differing kinds, and to divert cases from the courts when there is a preferable alternative method for resolving the dispute.

Costs

The research conducted on behalf of the inquiry established clearly that costs are disproportionate to the issues involved in litigation. They are substantially higher than those in some other jurisdictions, particularly Germany, with which comparisons were drawn as a result of the research conducted on behalf of the inquiry by Adrian Zuckerman of Oxford. There is incontrovertible evidence that cases frequently involve costs of one party alone in excess of the amount in dispute. Unless they are assisted, large sections of the community cannot afford to go to court. This is especially true of medical negligence litigation. Over 90% of the cases that reach the stage of litigation, and 92% of successful litigants, are legally aided. Yet the legally aided section of the community is no more vulnerable to medical negligence than other sections of the community. These figures must suggest that if those other sections of the community were entitled to legal aid, more actions would be brought that would succeed. Even as things are, the April 1997 edition of Health Law estimates that for 1996 the costs to the Health Service are £170 million, and the outstanding contingent liability is £1 billion (these figures include the awards of damages, but costs represent a substantial part of the sum). The author goes on to say: ‘Legal aid does not secure access to justice or ensure compensation for deserving cases. Instead it impoverishes the health service’.

Professor Zander ignores this situation. I do not believe he would do so if he had the opportunity I had of learning what the experience is like at first hand from the litigants, patients as well as doctors and health carers, who are embroiled in this class of litigation. It is horrendous. The reason why lawyers and judges agree with the diagnosis of the inquiry is that, as practitioners, they are all too well aware of what is happening on the ground. Consumer bodies are also adamant that radical action is necessary and support my programme of reform.

There are many other diseases to which the system is prone, including the lack of certainty as to what will be the consequences of becoming involved in litigation, the fact that it fails to allow for the inequalities in resources of the parties, and that it is excessively adversarial. There are problems as to discovery and experts. I will turn now to the reforms or, should I say, the medicine that I have recommended.

The medicine

Professor Zander’s criticism concerns only two important elements of the package of reforms. They are the related subjects of the fast track and case management. The merits of those two recommendations can only be appreciated in the context of the recommendations as a whole. Among the most important are the reorganisation of the civil courts, the creation of a single Rule Committee for the civil justice system as a whole and the creation of the Civil Justice Council and the greater involvement of litigants in their own litigation. These recommendations are intended to provide the structure in which a radically reformed system can operate and to enable that system to be kept under review. In the case of protocols and expert evidence my recommendations are designed to establish an agreed best practice. The protocols are a wholly novel concept designed

- to focus the attention of litigants on the desirability of resolving disputes without litigation
- to enable them to obtain the information they need to settle the action or to make an offer to settle
- if settlement is not possible, to enable the ground to be prepared for the action to proceed expeditiously.

The protocols will receive the support of the court and will be published in practice guides issued by the court. It is intended that they should be taken into account by the court, if litigation results, on the question of costs. They will in effect be a guide as to how to resolve disputes both before and during litigation. It is essential, if they are to have credibility, that they should be drawn up by a working group with unquestionable extensive practical experience of the problem areas of litigation to which they relate.

In the case of medical negligence the working party is known as the Clinical Disputes Forum. Its members are doctors, health carers, lawyers who act for plaintiffs and defendants and insurers. It enables representatives of the different interests for the first time to work together to find the right way forward. They are now reasonably close to agreeing a protocol which accords with my recommendations. Let me quote from a report they have prepared:

‘At present there is often mistrust by both sides. This can mean that patients fail to raise their concerns with the healthcare provider at an early stage, and pursue a complaint or claim which has no or a weak foundation due to a lack of sufficient information and understanding. It can also mean that patients become reluctant,
once advice has been taken on a potential claim, to disclose sufficient information to enable the provider to investigate that claim efficiently and, where appropriate, to resolve it. On the side of the healthcare provider this mistrust can be shown in a reluctance to be honest with patients, a failure to provide prompt clear explanations, especially of adverse outcomes (whether or not there may have been negligence) and a tendency to close ranks once a potential claim is signalled?.

If this mistrust is to be removed and a more co-operative culture to develop, healthcare professionals and providers need to adopt a constructive approach to complaints and claims. They should accept that concerned patients (or their representatives) are entitled to an explanation and an apology, if warranted, and injured ones to appropriate redress, and that an overly defensive approach is not in the long-term interest of their main goal: patient care.

Patients and their representatives should recognise that some degree of risk is inherent in most medical treatment (even the best practitioners make mistakes), and that misdiagnosis or unintended consequences of treatment can be rectified only if they are quickly brought to the attention of the healthcare provider.

The openness on the part of both parties that the protocols will encourage will provide the necessary information for disputes to be resolved, wherever possible, by recourse to the now justifiably fashionable Alternative Dispute Resolution (ADR). This could be dealt with in-house by hospitals. There is everything to be gained by the hospital using its resources to make available mediators and neutral claim evaluators at their own expense.

Both sides of the legal profession are now providing lawyers who are highly skilled in this activity. A pilot mediation scheme of this nature has already been set up. While it may be premature for the courts to insist on it, ADR is sufficiently established to justify the court taking into account an unreasonable refusal to resort to it when determining what costs should be awarded.

The courts have to offer more specialisation than they have done hitherto. Judges in this country have always prided themselves on being generalists. However, society has become so complex and the issues so sophisticated that they must have the necessary expertise to deal with the work effectively. It takes time to instruct a judge who has no background knowledge of the intricacies of this area of negligence, and time in court is expensive.

A Master of the Supreme Court has already been earmarked to deal with the interlocutory stages of these cases in the High Court and the same thing should happen at major centres in other parts of the country. To try the case it is necessary to have a judge who understands the medical issues to which this litigation can give rise. For this reason I recommended, and still do, that there should be a special list for cases of this nature in the High Court so that they can come before a judge with the appropriate experience. The judge must be on equal terms with the lawyer for the parties.

### Expert evidence

I sense that the medical profession is not at all comfortable with the present situation. Here again there is an unhealthy polarisation. There is a tendency for medical experts to be categorised as plaintiffs' or defendants' experts. They are looked upon by the side which has instructed them, and sometimes by themselves, as hired guns, brought in to fight for the best of their ability on behalf of the side that is employing them. It is especially unfortunate that this should be the situation in medical cases because the court is dependent on medical advice for resolving the three issues – liability, quantum and causation – that are often particularly difficult in this area of litigation.

While there has been some improvement, it can still be difficult to find an expert if you are a plaintiff. This is because of the understandable reluctance, on the part of healthcare professionals, to criticise colleagues. As a result, those experts who are prepared to give reports on behalf of plaintiffs are diverted from their practice and become over-dependent upon medicolegal reporting for their livelihood, which can further undermine their independence. My report seeks to improve the situation by making it clear that the experts' first responsibility is to the court and not to the side that instructs them. For this reason, reports are to be made to the court.

While there are some issues near the cutting edge of medical science where there are two schools of thought, there are many areas where what is proper medical practice is not a matter of controversy: the issue is whether that practice has been adhered to. In many issues as to quantum, one opinion is likely to be similar to another opinion. I believe there is scope for the joint instructing of a single expert, at least in the first place, in cases where no controversial medical issue is involved. A breakthrough is needed because at present each side contends that it cannot trust the expert instructed by the other side and so instructs its own experts. This tends to make agreement of medical issues more, rather than less, difficult. We need a more co-operative approach but that only arise if the expert's independence is clear. This really should not be a problem where those who are consulted are asked to advise because of their professional expertise and standing. At the present time one has the ludicrous position that because experts and those who instruct them are not trusted, the parties will not even agree to sequential, as opposed to simultaneous, disclosure of experts' reports. There should also be more frequent meetings between experts to resolve issues. Lack of communication between experts often explains their failure to reach agreement.

Changes of this nature represent a change of
culture. They are suitable subjects for protocols. They will bring about significant changes to the cost and speed with which disputes can be disposed of. More importantly, they will help eradicate the suspicion that has been so destructive to the relationship between patient and carer.

Case management

I now turn to the two areas of the recommendations with which Professor Zander strongly disagreed. Case management is central to my recommendations because it is the means by which cases are handled in the court system. There is nothing new about it. It is an essential part of any system and is used to differing degrees in every developed system of civil justice. My recommendations are criticised because they call for more management by the court. This is exactly what is happening in Canada, New Zealand and Australia and has been happening in the USA for a great many years. It is also part of civil systems. It is practical today to exert greater case management than in the past because of the advances in technology that make it possible for courts to monitor the progress of cases. It is this change that explains in part why, in my report, I attach such importance to technology. The other reason is the savings to the system that it will achieve. As in medicine, technology opens new horizons for the law.

While I favour greater case management, it does involve the parties in more expense and so can only be justified if the savings and other benefits that can be achieved justify that expense. Therefore, hands-on case management is to be limited to those cases where it is likely to produce real dividends. Just because a medicine can be effective does not mean it should be used unless it is justified.

In medical negligence cases, for example, case management has a clear role to play that will undoubtedly be beneficial. It will weed out the hopeless cases that create unnecessary dislocation and expense to hospitals; it will ensure that discovery is controlled; it will confine the parties to the real issues and control expense by limiting hearings; it will be used to encourage settlement and restrict the issues. Administrative arrangements have already been made to deal with the fear that it will result in inconsistency of treatment, by having the same procedural judge or Master to deal with all the cases in London; similar arrangements will be needed outside London.

The court provides a forum in which the lawyers and the judge can work out the most satisfactory way a case can be dealt with; the judge then supervises the progress to trial in accordance with that programme. The judge will prevent parties not fulfilling their responsibilities, acting unfairly to a weaker party or acting unreasonably. Other types of litigation where case management is unnecessary will move directly to a hearing.

I would not wish litigation in the field of medical negligence or in any other field to be handled in this country as it is in the USA. However, the Rand report on judicial case management in the USA indicates that early case management reduces time to disposition. It also found that my approach to early settling of a trial date and reduced discovery cut both delay and costs. While early case management had an upward effect on costs, its overall effect was to reduce delay without having any significant effect on costs or the perception of fairness. Moreover, as Professor Resnick has pointed out, the increase in cost from early case management may be the consequence of Congress applying to small cases rules that are only appropriate to the large cases for which they were designed. I am not recommending that case management shall apply to all cases where a defence is entered. In particular, hands-on case management, in the sense that term is used by Rand, is not intended to apply to cases on the fast track.

The fast track in its strict form will not be suitable for medical negligence cases. Its virtues are that it provides a restricted procedure and a no frills form of litigation on a fixed timetable at a fixed cost. It provides a litigant with certainty as to what he is letting himself in for. A working group of volunteers are conducting an experiment in Birmingham to test whether a modified fast track could work in small cases.

I know the fast track is unpopular with the Association of Personal Injury Lawyers, as they see it as a threat to their livelihood and I would wish to take their concerns into account insofar as it is in the public interest to do so. It is right that what my reforms seek to achieve should be subject to fair and balanced criticism. It is no part of my argument that the new Lord Chancellor should not conduct the review, as he indicated prior to the election would happen. It would, however, be unfortunate indeed if, as Professor Zander suggests, the Lord Chancellor were to call a halt to all the work that is in progress at the present time.

I do not suggest the process of implementing my report is going to be easy. There are bound to be teething troubles. Modifications of detail will need to be made. My proposals are not written in stone. However, they do offer a practical programme to achieve a dramatic improvement in the way we handle civil litigation and in access to justice. The implementation of these improvements is important to the public as a whole. It is particularly important to doctors and all whose work is the provision of health care and those who receive that care. A great many lawyers and doctors have worked and are working hard in their valuable spare time to ensure that these improvements come about.

Editor’s note: Professor Zander’s response to this lecture may be found in: Zander M. Woolf on Zander. New Law Journal 1997;147:768–70.
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Limitations of Expert Evidence

Edited by Stephen Leadbeatter

Doctors, when asked to give expert evidence, may find the strength of their contribution diminished by their lack of experience of court procedures; while lawyers may become frustrated in the conduct of the case through failing to appreciate the ethical and practical constraints that limit a doctor’s freedom to divulge information about a person’s medical condition. At the conference, organised jointly by the Royal Colleges of Physicians and Pathologists, doctors and lawyers were able to listen to each other’s problems and proffer clear practical advice. This book, based on the conference, will provide a helpful source of information to medical practitioners from a wide range of disciplines and to those in the professions supplementary to medicine as well as to members of the legal profession. Anyone involved in medicolegal matters, particularly those who give and receive expert evidence would do well to consult this book.

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