cefotaxime or ceftriaxone as the first line of treatment in most patients, with the addition of ampicillin for older patients (to cover the possibility of *Listeria* infection), and vancomycin with or without rifampicin in case of a serious risk of infection due to penicillin resistant pneumococci. Importantly, the society recognises that a good outcome depends on factors other than the choice of antibiotic alone. Awareness of the early clinical signs, and prompt attention to oxygen requirements and circulatory support are rightly stressed.

Algorithms are not intended to cover all circumstances. For example, in some parts of the world pneumococci remain predictably sensitive to penicillin, and this drug can remain a first line agent for presumed pneumococcal meningitis, but we do not know how long this will be true. Patients in special or high risk groups, such as immunocompromised people or small children, present particular problems, and expert advice needs to be sought immediately.

Some will argue with the detail. The authors state that a lumbar puncture should not be done in patients with septicaemic meningococcal disease and take a relatively conservative approach to lumbar puncture and the use of computed tomography scans in general. The evidence base for these assertions is not always clear. It needs to be acknowledged that because of a lack of systematic controlled clinical trials, many of the recommendations of the working party, including those on the use of antibiotics, are based on expert opinion and consensus driven guidelines rather than a secure evidence base. However, in the absence of better evidence most doctors accept that documents such as this generally represent the standard of care for a particular clinical condition. The problem is that despite this guidelines are often not followed. In a revealing study carried out in the Netherlands, van de Beek et al followed up 365 adult patients with bacterial meningitis.[4] A year before the study began, a multiprofessional group of Dutch experts drew up guidelines for the empirical treatment of bacterial meningitis. These were agreed at a national consensus conference and were subsequently widely disseminated throughout the country. During their study, van de Beek et al found that only a third of patients received treatment in compliance with the guidelines. In patients over 60 years and those with other risk factors who were arguably at greater risk of a poor outcome if treatment was suboptimal the compliance rate was as low as 17%.

Although de Beek et al could not show any obvious clinical detriment as a result of failure to comply with the approved regimen there are important lessons here. Clearly, there are many reasons why the uptake of such guidelines may be low. These include poor quality advice (for example, not evidence based or not practical), and poor dissemination of the information (targeting the wrong group of doctors, for example). Guidelines for the use of antibiotics are becoming increasingly popular as a means of improving the quality of care, but if they are to be effective they need careful consideration—not just of their content, but of how they are followed up and implemented.[5]

An additional but less obvious benefit of the publication of such guidelines is that they draw attention to changing practice in a rapidly moving field. At the time of the last leading article in the *BMJ* dealing with acute bacterial meningitis, just three years ago,[6] the management of penicillin-resistant pneumococcal infection was unclear and the role of corticosteroids debated. In the current recommendations from the society a combination of vancomycin and rifampicin is advised if resistance to penicillin is considered likely. Notably the use of adjunctive corticosteroids has changed after the recent publication of the European dexamethasone meningitis study, which showed a significant reduction in mortality in patients who were given dexamethasone 10 mg every six hours for four days and started just before or at the same time as the first dose of antibiotics.[7] However, though bacterial meningitis is a seemingly tractable infection, in this study the mortality from pneumococcal meningitis was still 14%, even in the group treated with steroids. There is still much to do.

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No-fault compensation systems

Experience elsewhere suggests it is time for the UK to introduce a pilot scheme

In 1978 the Pearson Commission in the United Kingdom rejected a no-fault system in dealing with clinical negligence. While declaring the existing tort system as costly, cumbersome, prone to delay, and too capricious in its operation to be defensible, the commission rejected no-fault compensation on grounds of the difficulty in overhauling the tort liability system and the perceived difficulties in causation judgments.[1] A general conservatism in the legal profession and opposition from the insurance industry were other factors. Much has changed in the NHS since then.

The long overdue white paper on the reform of the clinical negligence compensation system is much awaited. Reforms to be considered include fixed tariffs

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for specific injuries, no-fault compensation, alternative dispute resolution, structured payouts instead of large one-off lump sums, and alternative non-cash methods of compensation such as home nursing care.[2] The current system is based on the law of tort, which requires the claimant to prove harm caused by a breech of the duty of care. The adversarial and blame orientated nature of this system is not conducive to the culture of openness required by clinical governance and the NHS Plan. Supporters of the current system point to the threat of litigation as a deterrent to substandard care, although the evidence does not support this. Levels of medical litigation are five times as high in the United States than Canada, but no evidence exists that doctors in the United States deliver superior care. Any deterrent role is becoming increasingly redundant in the face of more effective risk management, clinical governance, peer review, and monitoring by hospital authorities and the General Medical Council.

In no-fault liability the claimant must show that the medical error was a causative factor in the resultant injury, irrespective of who is to blame (proof of causation rather than proof of fault). Medical accidents are an expected social phenomenon, and losses are calculated through an inquisitorial tribunal, which has access to all relevant documents and independent expert advice. The reduction in legal and administrative costs and a lower level of payouts offset the costs of greater numbers of claimants. The advantage is that claims can be investigated promptly, without the restriction of communication typical of the adversarial process.[3] The system is deemed more equitable and efficient by the BMA and the royal colleges.

The royal colleges, cognisant that a no-fault system may seem to protect offending doctors, emphasise that negligent professionals would face disciplinary procedures.[4] The colleges advocate a twin track system similar to that in Canada**,** where avoidable healthcare injuries are "designated compensable events" and subject to no-fault liability.

The BMA regards the present system as harmful, unpredictable, and unjust for both patients and medical staff. In the BMA model a no-fault compensation fund would handle compensation after causation is proved at a local level. The fund panel would work out compensation according to predetermined criteria. Smaller claims would be settled by individual trusts through the complaints procedure. Drug errors would be excluded as too complicated and expensive.[5] A no-fault system in clinical negligence care would not be unique in the United Kingdom—similar systems exist in workmen's compensation schemes and police injury cases.

In reforming the system, lessons can be learned from experience in other countries. A Canadian task force recommended the introduction of limited no-fault compensation.[6] Interestingly, many of the recommendations mirror the changes advocated by the NHS Plan and the Woolf reforms—such as contingency fees, case management, procedural measures to expedite the litigation process, methods of alternative dispute resolution, effective quality assurance, and risk management. In the United States capping malpractice awards and limiting contingency fees—lawyers often take a third of the compensation—have been introduced successfully in some states. Selective no-fault schemes are in place in Virginia and Florida, covering birth related neurological injury and vaccine injury. Another concept on trial in the United States is that of accelerated compensable events or designated compensable events. Certain defined medical injuries are compensated without proof of fault. The events tend to be avoidable and the system is being used in obstetrics.[7] Some regard it as an incremental move towards a no-fault approach in the United States.

New Zealand is the greatest exponent of the no-fault system since it replaced the tort system in 1972 after the report of the Woodhouse Commission.[8 9] Initial teething problems led to criticisms of compensation shortfalls, lack of accountability of doctors, and the definition of medical misadventure (used in place of medical negligence). In 1992 a reformed act was passed to address some of these criticisms and laid heavy emphasis on disciplining doctors at fault. The administrative costs are 10% of income, and the scheme seems to work well in the field of medical litigation.[10] However, the minimal cover provided by the act and complete bar on the right to sue remain unique to New Zealand. The socialist legal ideology of Scandinavia also favours a no-fault principle in dealing with medical harm, relying on insurance rather than litigation. Sweden created an insurance system for patients in 1975, based on voluntary agreement, and Norway introduced a similar scheme in 1988. Denmark adopted a mandatory patients' insurance scheme similar to Finland.

In France medical negligence claims against the state are handled under an administrative law scheme, separate from the civil justice system and compensation for hospital mistakes is automatic.

In the United Kingdom a no-fault system would increase compliance with the mandatory reporting of adverse clinical events and would facilitate the culture of openness demanded by clinical governance, the NHS Plan, and the modern approach to look for errors in the organisations instead of blaming individuals.[11 12] It should be introduced on a limited pilot basis and monitored closely for some years.

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