NO FAULT COMPENSATION FOR PERSONAL INJURY IN NEW ZEALAND: SOME IMPLICATIONS FOR ANAESTHETISTS

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New Zealand has a long tradition of legislation designed to reduce the personal impact of illness and accident. A comprehensive government-funded Health Service has functioned since 1935. In 1966, a Royal Commission headed by a Judge of the New Zealand Supreme Court was appointed to examine problems faced by the community in coping with the immediate and more remote consequences of personal injury (Woodhouse, 1967). The Commission's report made recommendations arising from "the inevitability of two fundamental principles":

No satisfactory system of injury insurance can be organized except on a basis of community responsibility.

Wisdom, logic and justice all require that every citizen who is injured must be included and equal losses must be given equal treatment. There must be comprehensive entitlement.

Arising from the report of the Royal Commission, an Accident Compensation Commission (ACC) was established to commence activity in 1974. Until that time, the law in New Zealand related to personal injury was very fragmented. Accident or disease which could be shown to be work-related might be compensated from compulsory insurance held by the employer. Criminally- and motor vehicle-induced injury were also associated with specific compensation schemes. In the medical sphere it was possible to obtain damages if negligence on the part of some other person could be established.

Before looking at the consequences of abolition of these sources of compensation, it is necessary to review principles related to a common law action for negligence as these were applied in New Zealand until 1974. The critical issue was not the outcome of the accident, but whether or not the defendant was at fault. If no fault was proven then the plaintiff was left to bear the burden. Liability was determined "not by the quality of the defendant's conduct, but by its results". In favour of the right to bring a common law action for negligence, it has been stated that the threat of damages gives a financial incentive for care on the part of the person providing it. The Royal Commission considered that this threat loses force against the background of insurance leading to widespread sharing of any risks. It also considered that there were worldwide reports of unfair decisions reached in common law actions.

The special topic of injury arising from medical treatment was not discussed by the Royal Commission in any depth. Such injury was included in the scheme because the victim has suffered personal injury "no matter where or how the injury might occur".

The Royal Commission recommended that the law relating to personal injury in New Zealand should change in a number of ways:

"That the procedures and techniques of private litigation be replaced by non contentious processes of assessment and review with recourse to the courts only on a point of law."

"That if the scheme is to be universal in scope, it must be compulsory in application. Accordingly, there will be no place for special arrangements for contracting out."

The major recommendations of the Royal Commission were embodied in legislation which took effect on April 1, 1974. After that date a person suffering injury by accident had no civil right of action against any other person either at common law or under any statute. The provisions

of the Accident Compensation Act provided the only avenue for recompense. The original act was redrafted in 1982 when the Accident Compensation Corporation replaced the earlier Commission.

Under the definitions of personal injuries by accident "medical, surgical, dental or first aid misadventure" is included, while damage from cardiovascular or cerebrovascular episodes is ordinarily excluded. Many of the consequences of the definitions used in the legislation have been carefully reviewed by Blair (1983). He notes that in New Zealand law the term "misadventure" has not been previously used. He considers it is implicit that legislators intended that "medical accidents" should have the protection of the Act. Importantly, "medical misadventure" has a wider meaning than "medical negligence". In discussion on this issue, Blair cites the case of Roe v. Minister of Health (Cope, 1954) in which permanent neurological damage occurred after the subarachnoid administration of "tainted anaesthetic injections". It was considered likely that there were "invisible" cracks in the ampoules but, because there was no reason to foresee that the ampoules were cracked, there was no negligence. On the same facts, the plaintiffs would have had a valid claim under the New Zealand Accident Compensation Act. There are now no grounds for a common law claim for negligence against a medical practitioner. Any such claim could be dealt with under the broader heading of medical misadventure. If the Corporation accepts a claim it becomes liable for payment in respect of the victim's reasonable medical costs as submitted by registered practitioners and costs for matters associated with that treatment and with the results of the accident. There is also provision for lump-sum payments in the event of permanent bodily impairment, suffering, loss of amenities, disfigurement or neurosis.

When an accident has occurred there must be notification of the fact and circumstances to the Corporation, together with supporting medical and other reports as required. Details of functioning in terms of payment procedures are outside the scope of this paper. However, in outline, the Corporation considers the evidence available to it and then gives a decision in respect of payments to be made and associated administrative matters. If there is dispute as to fact or in respect of the degree to which injury by accident may have contributed to the patient's state, there is provision for review, initially within the Corporation.

This gives the Corporation a quasi-judicial function. It has the power to summon witnesses, administer oaths and hear evidence in the manner of a Commission of enquiry established by the Crown. However, the adversary system used in courts of law is not a part of review hearings by the Corporation. Claimants have the right of appeal from decisions of the Corporation or a Review Officer to the Appeal Authority (established under the ACC Act) and from thence to the High Court on a question of law or of general or public importance. Cases may ultimately reach the Court of Appeal on a point of law.

Medico-legal aspects

Medical Misadventure is frequently the subject of review proceedings. This has led to a more detailed interpretation of the meaning of the term for the purposes of the Corporation (ACC Report, 1978, 1985). There are areas here of considerable relevance to anaesthetists.

Medical Misadventure occurs when:

(a) A person suffers bodily or mental injury or damage in the course of and as part of, the administering to that person of medical aid, care or attention.

(b) Such injury or damage is caused by mischance or accident, unexpected and undesigned, in the nature of Medical Error or Medical Mishap.

These latter terms require a measure of amplification.

Medical Error. The failure of a person involved in the administering of medical aid, care or attention to observe a standard of care and skill reasonably to be expected in the circumstances. There cannot be a claim for medical error just because hoped for results are not achieved. Thus if a patient suffered a hypersensitivity reaction to an anaesthetic drug, the anaesthetist would not ordinarily have erred (although the event may allow for a valid claim as a Medical Mishap). If the patient had been previously identified as reacting adversely to that drug, then there would be a case for a finding of Medical Error.

Medical Mishap. This covers the situation where an unexpected and undesigned incident, event or circumstance of a medical nature having harmful consequence to the patient intrudes upon the administering of medical aid, care or attention. It might be felt that the anaesthetist's damaging a tooth during laryngoscopy constitutes such an event. However, in recent years the Corporation
NO FAULT COMPENSATION

has rejected claims on the grounds that such damage is not "beyond the range of adverse circumstances normally and reasonably contemplated as within the risks attaching to the administration of such aid, care or attention...".

To gain an indication of the number and effect of rulings by the Corporation which have been directed at anaesthetists, an approach was made to a senior medical officer in the Corporation who is an anaesthetist. The Corporation does not classify its files by specialty, so that national figures were not obtainable. However, the office surveyed handles some 20% of all claims. The period surveyed covers from 1979 to the present. Claims (10) in respect of hypersensitivity reactions to anaesthetic drugs were all accepted as medical mishaps. The same was true of claims for halothane-associated hepatitis (three), malignant hyperpyrexia, neostigmine-induced bradycardia with fatal cardiac arrest, renal failure after repeated methoxyflurane inhalation and severe bronchospasm in a known asthmatic after tracheal tube placement. Claims such as these resulted in financial recompense to the patients or dependents, but it must be stressed that even if there was blame attached to the anaesthetist, this was not considered relevant to the compensation given.

A few cases involving anaesthetists have come to appeal hearings (ACC Appeal Authority, 1984). For example, in an operative procedure to remove skin and redundant tissue from the region of the elbows, anaesthesia was administered with neuromuscular blockade, nitrous oxide and oxygen (2:1 mixture), together with increments of droperidol, fentanyl and diazepam. It subsequently transpired that the patient was aware of events during the procedure, including pain in the area of operation. A claim for compensation on the grounds of medical misadventure was declined at initial hearing and an application made for review. The review officer cited the definitions of medical misadventure given earlier in this paper and then went on to note the concern of the plaintiff that members of the operating team and her family would not accept her story. Evidence as to the occurrence of awareness was produced, convincing the review officer of the reality of the plaintiff’s experience. However, because of that literature evidence, the Appeal Authority held that:

"In order that a claim for medical misadventure can be established on grounds other than medical negligence or error, it must be shown that the consequences were rare or of an adverse nature. In view of the articles referred to which are very extensive, I am satisfied that the awareness suffered by the plaintiff was not a rare or adverse consequence of the proper medical treatment she was undertaking and accordingly I must agree with the decision reached by the review officer."

Perhaps surprisingly, this decision was not appealed. It emphasizes that, even with a change in the nature of the legal process, there is potential for differences of opinion as to whether or not all plaintiffs are fairly treated. It could be realistically compared with a recent British decision in respect of awareness during anaesthesia (Brahams, 1986) when a similar claim was successful.

New Zealand has not been immune to the increases in consumerism which have greatly influenced patterns of life in developed countries. Thus we have been faced with a community which no longer accepts the advice and actions of the medical (or any other) profession without question. In parallel with scientific and technological advances in medicine, there have been demands for the delivery of a product which fulfils the expectations held of it. In anaesthesia a patient may have concerns about certain aspects of his or her anaesthetic, but expects to come through the experience with no adverse consequences relevant directly or indirectly to the conduct of anaesthesia. If there is some adverse experience, then all too often there will be questions raised as to the blame which may be attached to the anaesthetist in respect of those events. In New Zealand, no longer can an action be brought under common law—with all its punitive connotations. Many senior legal and medical practitioners consider that this change in the law, notwithstanding the financial protection (modest in amount) available through the Accident Compensation Corporation, has led to the significant increase in complaints to the Medical Council of New Zealand and to the Medical Practitioners Disciplinary Committee (MPDC) of the New Zealand Medical Association.

The Secretary of the MPDC noted that, in 1970–74, the Committee received an average of 10 written complaints each year. From 1980 to 1985 the number had reached 130 each year. During this latter period, one complaint against an anaesthetist was considered sufficiently serious to warrant a finding of professional misconduct. This was the case involving suxamethonium adminis-
Criminal proceedings can still, under the Crimes Act (1961), be brought against medical practitioners "who fail without reasonable excuse to discharge their duty to use reasonable knowledge, care and skill in carrying out treatment, the doing of which may be dangerous to health". Such a charge would not be laid unless the negligence or conduct alleged is of a gross nature. The author is aware of several cases involving anaesthetists in which police enquiry has led to a soliciting of opinion from senior anaesthetists as to their views in respect of an anaesthetic-associated death. In one of these, charges of manslaughter were laid. The case involved a 10-year-old boy with acute appendicitis. A senior locum anaesthetist who had not previously used the anaesthetic machine in question inadvertently gave a gas mixture containing carbon dioxide and nitrous oxide, by confusing the position of the rotameter control knobs. The mistake was first detected when the surgeon reported dark blood in the surgical incision. It seems likely that a nurse drew attention to the bobbins of the rotameters. There was much medical and other evidence on the responsibility of the hospital to have instructed the anaesthetist as to the presence of carbon dioxide and about the equipment to be used. There was conflict on responsibility for the management of the patient after the cardiac arrest had been corrected. The patient died as a result of cerebral hypoxia 30 h after the accident. A verdict of guilty was returned and the anaesthetist fined the sum of $4000. The author was not involved with the testimony, but did sit through much of the proceedings. In my view it is doubtful that the events of seconds or minutes can retrospectively be reconstructed after many months in a way which allows the actions of the individuals concerned to be placed in proper perspective. The fact that gross mistakes were made cannot be in question, but many have been profoundly troubled as to whether these rendered the anaesthetist—acting in profound error but in good faith—guilty of criminal behaviour. It should again be pointed out that the patient's relatives had no right to sue for negligence in a civil action. It must be further noted that because of the nature of their work, the mistakes made by anaesthetists tend to be obvious in a "cause and effect" manner, whereas those of other doctors—for example, mistakes related to inappropriate drug therapy—may be less apparent because of delays in the appearance of an adverse consequence. This makes anaesthetists a vulnerable group, as reflected in the incidents reported in this paper or in the generally high medical malpractice insurance premiums for anaesthetists in the United States.

For the majority of patients, the workings of the "no fault" accident compensation scheme in New Zealand have given an immediacy and certainty to earnings-related protection, so the scheme has worked to their considerable advantage. For anaesthetists, as for other medical practitioners, the scheme, together with increased questioning of their actions, has increased responsibility for careful practice along accepted lines. A corollary to this must include the need for proper records and for very full documentation of any adverse circumstances.

**SUMMARY**

In recent years, there has been an increase in medico-legal and disciplinary actions against doctors, some involving anaesthetists. While this has occurred at a time of increasing questioning of doctors' decisions, in New Zealand there has been the added dimension of a major change in the law related to personal injury. Under the provisions of the Accident Compensation Act there are no grounds for a civil action against a doctor in respect of a medical misadventure. The only provision for recompense is through the Accident Compensation Corporation. With the removal of the punitive aspect of civil actions against doctors, there has been an increase in complaints through other channels. The anaesthetist is particularly vulnerable because of the immediacy with which an adverse event is likely to cause obvious harm to a patient. This can only be countered by high standards of practice, together with careful record keeping.

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REFERENCES

ACC Appeal Authority (1984). Decision Number 33/84.