

RUTH UPPERTON

**A TRULY NO-FAULT APPROACH TO TREATMENT
INJURY COVER IN ACCIDENT COMPENSATION**

Faculty of Law

Victoria University of Wellington

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I Introduction

New Zealand’s accident compensation system is ‘no-fault’, meaning that New Zealanders are compensated for their injuries whether or not they can find someone to blame for their misfortune. However, until 2005, claimants injured while receiving medical treatment had to show either that their injuries were caused by negligence, or that their injuries were both rare and severe. The negligence standard was taken from tort law, and required the claimant to show that the injury was a registered health professional’s fault.

This fault requirement created many of the problems that tort law had in the past: it was inefficient, arbitrary, and created a blaming culture that bred hostility between the Accident Compensation Corporation (ACC), the injured, and health professionals. In 2004, ACC published a review of the medical misadventure provisions, calling for them to be replaced by no-fault compensation provisions in line with the spirit and content of the rest of the accident compensation scheme. In 2005, medical misadventure became treatment injury, and both application and acceptance rates rose for claims concerning injuries received during medical treatment. However, the treatment injury provisions still contained fault elements, despite the legislature’s claim that the provisions were no-fault.

In this paper, I will address the role of fault in a compensation scheme for those injured during medical treatment. First, I will define fault in its tort law context and outline some strengths and weaknesses of fault as a legal concept. Then, I will provide a short overview of New Zealand’s accident compensation scheme, the medical misadventure provisions, the push for reform, and the structure of the treatment injury provisions. This will give background to an in-depth discussion of the treatment injury provisions’ incorporation of fault standards. Also relevant to this discussion is the accident compensation scheme’s reporting mechanism, which potentially complicates ACC’s role as purely an injury compensating, preventing and rehabilitating body. Finally, it is necessary to consider whether compensation itself is inherently fault-based, an argument raised by some commentators.

My conclusion is that some aspects of the treatment injury provisions still use fault to determine cover in some situations. The provisions give particular weight to the fault of the claimant in causing her own injury. This use of fault standards can be removed from the treatment injury provisions with some minor amendments, which are set out at the end of this paper.

II Defining Fault

A Introduction

To understand the accident compensation scheme as a no-fault system and analyse the place of fault in treatment injury cover, it is first necessary to define ‘fault’ as a legal concept. ‘Fault’ is defined in the Butterworths New Zealand Law Dictionary as:¹

1. A defect, blemish, flaw or imperfection.
2. A mistake or error in thought or action. In contract, a **fault** is an error which may include some instances of carelessness.
3. Negligence, breach of statutory duty or any other act or omission which gives rise to a liability in tort.

For the purpose of the Contributory Negligence Act 1947, ‘fault’ is defined as “negligence, breach of statutory duty, or other act or omission which gives rise to a liability in tort or would, apart from this Act, give rise to the defence of contributory negligence.”²

The accident compensation scheme’s no-fault principle was created in opposition to previous compensation systems that depended on fault – tort and criminal law – so the concepts of fault found in those two areas of law are relevant to determining what fault is for the purposes of the accident compensation scheme.

It is worth noting that the accident compensation scheme also replaced suing for personal injury in contract,³ but contract law works on strict liability principles, and fault is mostly irrelevant to its application.⁴ The scheme also prevents people from suing in administrative law for breach of the New Zealand Bill of Rights Act 1990 when the damage caused is personal injury.⁵ However, as administrative law damages were created by the courts well after the scheme was introduced, the use of fault in administrative law is not relevant to the use of fault in accident compensation. Therefore, what follows is only a consideration of fault in criminal law and in tort law.

1 Peter Spiller *Butterworths New Zealand Law Dictionary* (7th ed, LexisNexis, Wellington, 2011) at 115.

2 Section 2.

3 Accident Compensation Act 2001, s 317(2)–(3).

4 John Burrows, Jeremy Finn and Stephen Todd *Law of Contract in New Zealand* (4th ed, LexisNexis, Wellington, 2012) at 696–697. Although for a different opinion see Melvin Aron Eisenberg “The Role of Fault in Contract Law: Unconscionability, Unexpected Circumstances, Interpretation, Mistake and Non-Performance” (2009) 107 Mich L Rev 1413.

5 *Simpson v Attorney-General* [1994] NZLR 667 (CA) [*Baigent’s Case*].

B In criminal law

Most criminal offences require mens rea, a state of mind that makes the defendant at fault for what has happened. Mens rea is usually satisfied by showing either that the defendant intended the elements of the crime, or was reckless to whether the elements occurred, meaning that the defendant foresees a likelihood that she will cause the elements of the crime.⁶

Negligence constitutes the mens rea of some crimes, whereby a defendant can be held accountable for failing to take all reasonable steps or failing to act in the way a reasonable person would.⁷ Ordinary negligence is the mens rea of manslaughter in New Zealand,⁸ while most other jurisdictions require a higher standard, for example gross negligence.⁹ In New Zealand, most ‘true crimes’ require intention or recklessness, which justifies their harsher punishments and reflects society’s moral outrage over deliberate wrong-doing.

The criminal concept of fault is mostly irrelevant to a discussion of fault in accident compensation because no one would recommend importing criminal standards into the accident compensation scheme. The criminal law is relevant to accident compensation cover in two ways.

First, the scheme provides cover for mental injuries sustained by victims during the commission of an act that matches the description of a listed offence, but the Accident Compensation Act 2001 (ACA) does not require that the victim prove the injurer had the requisite criminal intent.¹⁰ So a person injured in an assault can still get cover for that injury even if the assaulter had a mental illness and was incapable of forming the requisite intention for the criminal offence.

Secondly, ss 25(1)(b) and (ba) require that the claimant show criminal fault where the cause of her injury was the inhalation or ingestion of any virus, bacterium, protozoan, or fungus. Unlike under s 21, a claimant under s 25(1)(b) or (ba) is required to prove that the inhalation or ingestion was the result of a criminal act, and may therefore need to prove intention.¹¹ This approach uses a criminal fault standard, but in doing so, it allows more victims of crime to receive cover for their injuries.

6 *Laws of New Zealand Criminal* (online ed) at [5.18].

7 See for example the Fisheries Act 1983, s 105(2)(b)(i).

8 *R v Yogasakaran* [1990] 1 NZLR 399 (CA).

9 See for example the Crimes Act 1961, s 150A.

10 Accident Compensation Act, s 21.

11 This would only require that the claimant point to the injurer’s criminal conviction for the act, which may include a breach of the Health and Safety in Employment Act 1992, arguably a

C In tort law

Tort law usually requires fault before assigning liability. Fault usually takes the form of intentional or negligent action, rather than malicious action;¹² so a person is liable in the tort of battery not only if she intended to strike another, but also if she intended a gesture which, by chance, struck another person as he walked by. However, it is important to remember that tort law is not one coherent body of law, and that liability in tort may in some cases be imposed for unintentional or seemingly blameless conduct, while malicious harm does not always constitute a tort.¹³

The main objective of tort law is to shift a loss to the person who should bear it, usually because that person is at fault for that loss.¹⁴ The predominance of fault in tort law is relatively recent, beginning in the 19th century:¹⁵

Fault liability was seen as a moral principle: the courts regarded it as unfair to hold a person responsible for harm that could not have been prevented by taking reasonable care. Nowadays, fault remains predominant.

The defendant’s liability in tort law may be disproportionate to the level of fault. For example, if the plaintiff’s loss is very high, but the defendant’s culpability only just meets the standard of fault required, the defendant is still liable for the total loss.

The accident compensation scheme replaced tort liability by barring civil claims for loss compensated for under the ACA.¹⁶ The main tort affected was negligence (although battery, a less-used tort, now has almost no application in New Zealand because of the ACA bar). In negligence, fault is determined by reference to the ‘reasonable person’ standard, an abstraction that requires the plaintiff to prove to the balance of probabilities standard that the defendant did not act as a reasonable person would in the circumstances.¹⁷ The reasonable person is not the perfect person.¹⁸ If a perfect standard of conduct was required, fault would no longer be relevant to liability in negligence.

criminal statute (see Roger Thornton (ed) *Personal Injury in New Zealand* (online looseleaf ed, Brookers) at [AC25.10]).

12 Stephen Todd (ed) *The Law of Torts in New Zealand* (6th ed, Thompson Reuters, Wellington, 2013) at 8–9.

13 At 9.

14 At 14.

15 At 15.

16 Section 317.

17 The standard was first described in *Blyth v Birmingham Waterworks* (1856) Eng Rep 1047 (Exch), and fleshed out in *Hall v Brooklands Auto Racing Club* [1933] 1 KB 205 at 224, *Arland v Arland and Taylor* [1955] OR 131 (CA) at 142, and *Frost v Chief Constable of the South Yorkshire Police* [1999] 2 AC 455 at 495 (HL).

The reasonable person test does not usually take into account a defendant’s particular weaknesses, although it does take into account the circumstances of the case.¹⁹ This approach allows the test to be applied equally to everyone, but it does not provide for purely fault-based accountability. A defendant may be found legally at fault for negligent conduct, but may not be morally at fault if, for example, she was not capable of providing the level of care expected of a reasonable person.²⁰ The focus is on what should have happened, not on what the particular defendant could have done.

The test sometimes ascribes extra skills or knowledge to a defendant, when that defendant has held herself out as possessing those skills or knowledge. So a doctor must live up to the standard of care reasonably expected of a skilled and informed doctor.²¹

A reasonable person, or a reasonable health professional, can make mistakes. Lord Denning MR has held that a professional person’s ‘error of judgment’ is not negligent, but as Stephen Todd says, relying on statements made by Lord Edmund Davies:²²

to say that a surgeon committed an error of judgment is wholly ambiguous, for while some such errors may be completely consistent with the due exercise of professional skill, others may be so glaringly below proper standards as to make a finding of negligence inevitable. If the epithet “error of judgment” is to be employed in this context at all, it ought to be reserved for use in circumstances where the defendant’s conduct has measured up to proper professional standards, yet the course that he or she took turned out to be mistaken. The point is that a defendant can be expected to take care but not to guarantee that harm will be avoided.

While a defendant must take all care reasonably expected of her, she is not required to avoid all harm to the plaintiff.

D Conclusion

The criminal fault standard is not a prerequisite to cover under the accident compensation scheme, and there is no danger that it will be; although of course, the scheme provides cover for injuries that result from criminal acts where the fault standard is reached. The tort fault standard is the standard most relevant to a discussion of fault in accident compensation cover for injuries caused by medical treatment. In particular, a discussion of fault in treatment injury requires consideration of the negligence standard that takes

18 Todd, above n 12, at 408–409.

19 At 409.

20 At 15.

21 At 410. See also *Bolitho v City and Hackney Health Authority* [1998] AC 232 (HL).

22 At 410. For Lord Edmund Davies’ original statement, see *Whitehouse v Jordan* [1981] 1 All ER 267 (HL) at 277b.

into account the knowledge and skill of a reasonable professional, because it is usually the fault of a registered health professional that is relevant in these cases. As the next two sections of this paper show, it was criticism of tort law, specifically negligence, that spurred the creation of the accident compensation scheme; and it was the negligence standard that was later used to determine cover for medical misadventure.

III Overview of the Accident Compensation Scheme

A The Woodhouse Report

New Zealand’s accident compensation scheme is based on the Woodhouse Report, written in 1967 by a Royal Commission of Inquiry chaired by Sir Owen Woodhouse.²³ The Commission reviewed the remedies available at the time to victims of injuries, namely suing for common-law damages, compensation for employees injured at work under the Workers Compensation Act 1900, and social security.²⁴ These remedies were found to be lacking. The Workers Compensation Act only provided compensation to employees injured at work, and therefore had limited application.²⁵ It was also inefficient.²⁶ Social security was considered inadequate because it did not compensate an injured person, it was means-tested, and it was provided at a flat rate, without taking into account a person’s prior income.²⁷

Suing for common-law damages was criticised by the Commission for being inefficient, illogical, unpredictable, arbitrary, and presenting a barrier to rehabilitation of the plaintiff.²⁸ Many of the criticisms made by the Commission were criticisms of the fault principle – the rule that, to get damages, the plaintiff must prove that the defendant was at fault for causing the injury. These criticisms were as follows:²⁹

- The fault principle holds those at fault responsible, even if they did not intend their actions.

23 New Zealand Royal Commission of Inquiry into Compensation for Personal Injury *Compensation for Personal Injury in New Zealand: Report of the Royal Commission of Inquiry* (Government Paper, Wellington, December 1967) [Woodhouse Report].

24 See Parts 3, 4 and 5 of the Woodhouse Report respectively.

25 At [185].

26 At [240].

27 At [243]–[245].

28 At [78].

29 At [84]–[89].

- The level of damages extracted from a defendant is not made proportional to his or her level of wrongdoing, but instead is proportional to the severity of the injury inflicted.³⁰
- The injurer is therefore often as innocent as the injured; but the injured is not asked to contribute at all to the cost of the injury.
- Compulsory industrial and highway insurance makes the fault principle a legal fiction; the injurer’s insurer, and by extension the community, carries the loss, not the injurer herself.
- Social progress carries with it increased exposure to some risks. The community benefits from progress, and therefore is responsible when those risks eventuate. The fault principle places the blame on an individual, but it is the system that is at fault, and therefore the community who should bear the loss.

The common-law rule of contributory negligence – that the plaintiff must bear the loss to the extent that he or she caused it – was subject to these same criticisms. The possibility of damages being reduced because of contributory negligence was a risk the plaintiff had to take in the common-law system, making the outcomes of civil suits even less predictable.³¹

As a solution to these problems, the Commission recommended creating a system for providing “immediate compensation without proof of fault for every injured person, regardless of his or her fault, and whether the accident occurred in the factory, on the highway, or in the home”.³² This system would replace the common-law right to sue for personal injury, as well as the Workers Compensation Act.

The Commission outlined five principles against which an accident compensation scheme should be judged, and which it intended to implement through an accident compensation scheme.³³ The first principle was community responsibility. A scheme should ensure the community is responsible for the victims of accidents. As the risk of injury is created by modern society, modern society must provide rehabilitation and compensation for those “statistically necessary victims” for whom the risk eventuates.³⁴ This principle illustrates the relationship between fault theory and accident compensation in the Woodhouse

30 For more on this point, see J Waldron, “Moments of Carelessness and Massive Loss” in DG Owen (ed) *Philosophical Foundations of Tort Law* (Oxford University Press, Oxford, 1995).

31 Woodhouse Report, above n 23, at [93].

32 At [18].

33 At [55].

34 At [55].

Report. While an individual may be directly at fault for a particular injury, the community is the party that should be responsible – although the community is not at fault in the sense that a defendant might be held at fault in a civil suit. The Commission saw an accident as a social issue, not as an event between two or more parties, with legal implications.³⁵

The second principle was comprehensive entitlement. The cover provided by the scheme should allow all injured people to be compensated equally regardless of how their injuries are caused.³⁶ The principle of comprehensive entitlement required the scheme to cover all injured persons “on the same uniform method of assessment, regardless of the causes which gave rise to their injuries.”³⁷

The third principle was of complete rehabilitation: the scheme should encourage workers to return to work where possible.³⁸ It should provide for real compensation, meaning compensation based on real economic and physical losses, not on need.³⁹ The scheme must also be administratively efficient.⁴⁰

These principles were mostly incorporated into the resulting accident compensation legislation.⁴¹ The main way in which that Act departed from the principles was that it did not provide cover for injuries arising from illness, which arguably violates the principle of comprehensive entitlement. This departure was recognised by the Commission in the Report.⁴²

B The scheme today: cover for personal injury caused by accident

The Accident Compensation Act 2001 (ACA) provides cover for:⁴³

- (a) personal injury caused by an accident to the person:
- (b) personal injury that is treatment injury suffered by the person:
- (c) treatment injury in circumstances described in section 32(7):
- (d) personal injury that is a consequence of treatment given to the person for another personal injury for which the person has cover:

35 For more on accidents as social issues, see R Gaskins “Recalling the Future of ACC” (2000) 31 VUWLR 215.

36 Woodhouse Report, above n 23, at [55].

37 At [55].

38 At [58].

39 At [59].

40 At [62].

41 The Accident Compensation Act 1972.

42 Woodhouse Report, above n 23, at [290].

43 Section 20.

- (e) personal injury caused by a work-related gradual process, disease, or infection suffered by the person:
- (f) personal injury caused by a gradual process, disease, or infection that is treatment injury suffered by the person:
- (g) personal injury caused by a gradual process, disease, or infection consequential on personal injury suffered by the person for which the person has cover:
- (h) personal injury caused by a gradual process, disease, or infection consequential on treatment given to the person for personal injury for which the person has cover:
- (i) personal injury that is a cardiovascular or cerebrovascular episode that is treatment injury suffered by the person:
- (j) personal injury that is a cardiovascular or cerebrovascular episode that is personal injury suffered by the person to which section 28(3) applies.

The intricacies of each type of cover are too complex to set out in full. However, to give a contrast to the treatment injury provisions that will be explained shortly, the following paragraphs briefly describe the provisions a claimant must satisfy to claim cover for personal injury caused by accident, the most commonly claimed category of cover.

A claimant seeking cover for her personal injury caused by accident under s 20 of the ACA would need to satisfy the definition of ‘personal injury’. Personal injury is defined as:⁴⁴

- (a) the death of a person; or
- (b) physical injuries suffered by a person, including, for example, a strain or a sprain; or
- (c) mental injury suffered by a person because of physical injuries suffered by the person; or
- (d) mental injury suffered by a person in the circumstances described in section 21; or
- (da) work-related mental injury that is suffered by a person in the circumstances described in section 21B; or
- (e) damage (other than wear and tear) to dentures or prostheses that replace a part of the human body.

The claimant must then show that the cause of the injury was an ‘accident’. There are some exceptions for work-related injuries,⁴⁵ injuries consequential on personal injuries for which the claimant has cover,⁴⁶ and cardiovascular and cerebrovascular episodes.⁴⁷ The definition of ‘accident’ is:⁴⁸

44 Section 26.

45 Section 20(2)(e).

46 Sections 20(2)(d), (g) and (h).

- (a) a specific event or a series of events, other than a gradual process, that—
 - (i) involves the application of a force (including gravity), or resistance, external to the human body; or
 - (ii) involves the sudden movement of the body to avoid a force (including gravity), or resistance, external to the body; or
 - (iii) involves a twisting movement of the body:
- (b) the inhalation of any solid, liquid, gas, or foreign object on a specific occasion, which kind of occurrence does not include the inhalation of a virus, bacterium, protozoan, or fungus, unless that inhalation is the result of the criminal act of a person other than the injured person:
 - (ba) the oral ingestion of any solid, liquid, gas, fungus, or foreign object on a specific occasion, which kind of occurrence does not include the ingestion of a virus, bacterium, or protozoan, unless that ingestion is the result of the criminal act of a person other than the injured person:
- (c) a burn, or exposure to radiation or rays of any kind, on a specific occasion, which kind of occurrence does not include a burn or exposure caused by exposure to the elements:
- (d) the absorption of any chemical through the skin within a defined period of time not exceeding 1 month:
- (e) any exposure to the elements, or to extremes of temperature or environment, within a defined period of time not exceeding 1 month, that,—
 - (i) for a continuous period exceeding 1 month, results in any restriction or lack of ability that prevents the person from performing an activity in the manner or within the range considered normal for the person; or
 - (ii) causes death.

The definition of ‘accident’ is not fault-based, and an accident does not even need to involve a person other than the claimant (with the exception of subss (b) and (ba), discussed at p 6). It is also important to note that the definition of ‘accident’ does not include an occurrence which is treatment given by a registered health professional.⁴⁹ There is therefore no overlap between personal injury caused by accident, and treatment injury.

IV Cover for Injuries Suffered during Medical Treatment

The above section described the cover available to a claimant seeking cover for personal injury by accident. It is now necessary to look more closely at the cover available to the

47 Sections 20(2)(i) and (j).

48 Section 25.

49 Section 25(2)(a).

victims of injuries caused by treatment. This section will begin by describing the previous law, which required claimants to prove fault in some cases, and then discuss the process of reforming those sections, and the outcome of the reform: cover for treatment injury.

A Pre-2005: Medical misadventure

The Accident Compensation Act 1972 and its 1973 amendments⁵⁰ incorporated the Woodhouse principles into legislation by granting all persons cover for personal injury by accident in New Zealand, whether under the earners scheme, the motor vehicle accident scheme, or the supplementary scheme.⁵¹ ‘Personal injury by accident’ was defined as including “the physical and mental consequences of any such injury or of the accident”; “medical, surgical, dental, or first aid misadventure” was added shortly after the Act was passed, as an illustration to aid interpretation.⁵² These phrases were not defined. Thus the statutory cover was defined inexhaustively and left a lot to judicial discretion.

The judiciary created two categories of medical misadventure that would provide cover. Cover would be granted for an adverse consequence of treatment that was either totally unforeseen (medical mishap), or outside the normal range of medical failure for that treatment (medical error or medical negligence).⁵³ This approach was adopted by the Court of Appeal in *Childs v Hillock*, which found that cover would be granted where injury resulted from an “accident-like” event which removed the injury from the category of illness.⁵⁴

In 1992, the legislature codified the definition of ‘medical misadventure’.⁵⁵ Medical error was defined as:⁵⁶

the failure of a registered health professional to observe a standard of care and skill reasonably to be expected in the circumstances. It is not medical error solely because desired results are not achieved or because subsequent events show that different decisions might have produced better results.

In other words, it required negligence on the part of the health professional – codification of the common law’s return to the fault standard. ACC had a duty to report all accepted

50 Accident Compensation Amendment Act (No 2) 1973.

51 Sections 55, 92 and 102B respectively.

52 Todd, above n 12, at 53.

53 *Accident Compensation Corporation v Auckland Hospital Board* [1980] 2 NZLR 748 (HC); *Viggars v Accident Compensation Corporation* [1986] 6 NZAR 235 (HC); *Bridgeman v Accident Compensation Corporation* [1993] NZAR 199 (HC).

54 *Childs v Hillock* [1994] 2 NZLR 65 at 72 (CA). See also Todd, above n 12, at 53–54.

55 Accident Rehabilitation and Compensation Insurance Act 1992, s 5(1).

56 Section 5(1).

instances of medical error to the relevant professional body and to the Health and Disability Commissioner.⁵⁷ The Rt Hon Helen Clark, deputy opposition leader at the time, said that the changes “violate all the original premises [of the scheme]. They bring back notions of fault, they introduce concepts of negligence.”⁵⁸

Medical mishap was defined as an adverse consequence of treatment, which is severe and rare.⁵⁹ A severe consequence was defined as one that resulted in death, hospitalisation for more than 14 days, or the claimant suffering a significant restriction or lack of ability that prevents her from performing an activity in the manner or within the range considered normal for her, and which lasts for more than 28 days in total.⁶⁰ A consequence was rare if it would not occur in more than 1 per cent of cases.⁶¹ If the consequence was usually rare but the person’s circumstances made it a greater risk, there was no medical mishap if the greater risk was known to the person.⁶² This definition was far narrower than the definition at common law, which had simply required the injury to be outside the normal range of failure of treatment.⁶³ ACC had discretion to refer the appropriate authority to cases of medical mishap if it was necessary or desirable to do so in the public interest.⁶⁴

B The push for reform

In 2002, the Hon Ruth Dyson, Minister for ACC, started a review of medical misadventure, in conjunction with the Department of Labour, the Ministry of Health, the Treasury, the Office of the Health and Disability Commissioner, and the Department of Prime Minister and Cabinet.⁶⁵ Following analysis of claims, reports and healthcare literature, as well as consultation with concerned parties, ACC published a consultation document in May 2003, which critiqued the medical misadventure provisions, suggested three options for reform, and asked for submissions from the public.⁶⁶

With regard to fault, the consultation document found that:

57 Section 284(2).

58 (19 March 1992) 522 NZPD 7067. See also (19 March 1992) 522 NZPD 7104.

59 Section 34(1).

60 Section 34(2).

61 Section 34(3).

62 Section 34(5).

63 *Auckland Hospital Board*, above n 53; *Viggars*, above n 53; *Bridgeman*, above n 53.

64 Section 284(1).

65 Accident Compensation Corporation and the Department of Labour *Review of ACC Medical Misadventure: Consultation Document* (May 2003) at 4 [*Consultation Document*].

66 At 4–5.

- The biggest problem with medical error cover was that it required the claimant to show fault. No other category of cover required a showing of fault.⁶⁷
- The requirement to report all instances of medical error led to a blaming culture within the health profession, which undermines professionals’ ability to learn from mistakes, and slowed improvements to patient safety.⁶⁸
- When ACC’s enquiry focused on the fault of health professionals, those professionals were less likely to co-operate with the enquiry, which slowed the claims procedure.⁶⁹
- The focus on fault took time and energy away from focusing on the claimant’s injury and more long-term prevention.⁷⁰
- The requirement to find fault made claimants, health professionals and the public think of ACC as a body that held health professionals to account, or as a disciplinary body.⁷¹

The consultation document then outlined three proposals for reform:

1. Retain the medical error and medical mishap categories, but no longer attribute fault to a particular health professional in cases of medical error, and introduce an endurance rule in cases of medical mishap, whereby claimants would get cover for injuries that were not reasonable for them to endure.⁷²
2. Provide cover for preventable unintended injuries caused by treatment.⁷³
3. Provide cover for unintended injuries caused by treatment.⁷⁴

The public responses to these options were summarised in *Summary of ACC Medical Misadventure Consultation*, published in August 2003.⁷⁵

The first option made medical mishap more individualised: a claimant would be covered for medical mishap which was beyond what the claimant should be expected to endure, given her underlying condition. Medical error would focus on systemic fault, rather than requiring a finding of fault against an individual.⁷⁶ This change would hopefully

⁶⁷ *Consultation Document*, above n 65, at 11.

⁶⁸ At 11.

⁶⁹ At 11.

⁷⁰ At 11.

⁷¹ At 12.

⁷² At 16–17.

⁷³ At 18–19.

⁷⁴ At 20–21.

⁷⁵ Accident Compensation Corporation and the Department of Labour *Summary of ACC Medical Misadventure Consultation* (August 2003) [*Summary of Consultation*].

⁷⁶ *Consultation Document*, above n 65, at 16.

encourage health professionals to co-operate more with ACC, but did not remove the requirement of fault altogether. The first option was rejected by the majority of submitters to the consultation paper.⁷⁷ People thought that the first option, like the status quo, was unfair to claimants and health professionals, was unlikely to speed up the claims process, and did not clarify the role of ACC.⁷⁸

The second option allowed cover for injuries that could have been avoided, had something been done differently, given what was known at the time of treatment.⁷⁹ This approach did not apply a negligence standard, as it would include injuries resulting from errors of judgment that a reasonable health professional could have made, as long as that error was preventable. However, some element of fault would be necessary. Whether the injury was preventable would be assessed in the context of what was known at the time; thus only injuries that should have been prevented, but were not, would be covered, and some objectively preventable injuries would not attract cover.

This option was preferred by 29 per cent of people who submitted on the consultation document.⁸⁰ Those who preferred the third option over the second thought that:

- Preventability implied fault, and therefore has the same problems as the first option and the status quo. It does not fit with the accident compensation scheme’s no-fault principle.
- Preventability is difficult to define, and health professionals might find it easy to argue that an injury was preventable when it was not.
- While preventability is the test used in Scandinavia, New Zealand’s cultural and legal system is different. Thus the test’s success in Scandinavia is no guarantee of its success here.

The third option was the one that Parliament eventually adopted. This option would provide cover for the most claimants, out of the three options and the status quo of medical misadventure.⁸¹ It provided cover for all injuries that were unintended, meaning injuries that were not within the range of expected or likely consequences of treatment. The nature of the illness, the circumstances of treatment, and the underlying health of the claimant are thus all relevant to determining what an expected or likely consequence of treatment is. Consequences that would not attract cover would include deliberate surgical incisions, expected side-effects, and failure of the treatment to work when it is likely that

77 *Summary of Consultation*, above n 75, at 8.

78 *Summary of Consultation*, above n 75, at 8.

79 *Consultation Document*, above n 65, at 18.

80 *Summary of Consultation*, above n 75, at 6.

81 Kate Smith “Reforming the Medical Misadventure System” [2004] ELB 8 at 10.

it will not work. The worse off a claimant’s underlying condition, and the more risky the treatment, the less likely it will be that the claimant can get cover for any adverse consequences of the treatment.

Sixty per cent of submitters preferred the third option.⁸² This option was supported because it provided cover in a similar way to the rest of the accident compensation scheme; it was no-fault, in keeping with the principles of the legislation; and it encourages a learning culture among health professionals. The reasons for preferring a no-fault option were that it would: ⁸³

- improve co-operation between ACC and health professionals, thus speeding up the claims process;
- improve the relationship between health professionals and patients, and within the health profession;
- support a shift from a blaming to a learning culture;
- stop health professionals from being judged by both ACC and other agencies for the same error;
- encourage people to become health professionals, and retain those who are already in the profession;
- avoid the difficulties caused by finding fault in a complex healthcare system;
- clear up confusion about ACC’s role, which would stop claimants expecting ACC to give them damages or to punish health professionals.

In response to the Review, the Injury Prevention, Rehabilitation and Compensation Bill (No 3) was tabled in Parliament on 2 August 2004.⁸⁴ In the government media release in support of the Bill, the Hon Ruth Dyson, Minister for ACC, said that the Bill “removes the requirement to find fault”.⁸⁵ The Explanatory Note to the Bill stated that “The [new] provisions do not require ACC to make any findings of fault and, in this sense, it is consistent with the no-fault nature of the scheme generally”.⁸⁶ An overview of the treatment injury provisions as they currently stand is set out below.

C Treatment injury cover

Cover is granted for:⁸⁷

82 *Summary of Consultation*, above n 75, at 6.

83 At 13.

84 Injury Prevention, Rehabilitation and Compensation Bill (No 3) (165-3).

85 Ruth Dyson “Making ACC fairer and simpler” (media release, 2 August 2004).

86 Injury Prevention, Rehabilitation and Compensation Bill (No 3) (165-3) (explanatory note) at 3.

87 Section 20.

- personal injury that is treatment injury suffered by the person;
- personal injury that is a secondary infection passed on by a victim to a third party or through the victim’s spouse or partner;
- personal injury caused by treatment of a personal injury for which a person has cover;
- personal injury caused by a gradual process, disease or infection that is treatment injury suffered by the person;
- personal injury caused by a gradual process, disease or infection consequential on treatment given to the person for personal injury for which the person has cover; and
- personal injury that is a cardiovascular or cerebrovascular episode that is treatment injury suffered by the person.

A claimant seeking cover for treatment injury must therefore first satisfy the definition of personal injury quoted above.⁸⁸ As with personal injury, the injury cannot just be a mental injury;⁸⁹ nor is chronic pain enough.⁹⁰ Then the claimant must show that the injury is a ‘treatment injury’ under s 32 of the ACA. The claimant must have been:⁹¹

- seeking treatment from 1 or more registered health professionals; or
- receiving treatment from, or at the direction of, 1 or more registered health professionals.

Cover for those who have an infection which is a treatment injury also extends to any third parties to whom they pass on that infection directly, or to whom their spouse or partner passes on that infection directly.⁹²

The claimant must show that her injury is caused by treatment.⁹³ ‘Treatment’ is defined as:⁹⁴

- (a) the giving of treatment:
- (b) a diagnosis of a person's medical condition:
- (c) a decision on the treatment to be provided (including a decision not to provide treatment):
- (d) a failure to provide treatment, or to provide treatment in a timely manner:

88 Section 32(1). See p 12 of this paper.

89 *Lennon v Accident Compensation Corporation* [2013] NZACC 220; *Meneses v Accident Compensation Corporation* [2012] NZACC 328.

90 *Thorburn v Accident Compensation Corporation* [2012] NZACC 187.

91 Section 32(1).

92 Section 32(7).

93 Section 32(1)(b).

94 Section 33(1).

(e) obtaining, or failing to obtain, a person's consent to undergo treatment, including any information provided to the person (or other person legally entitled to consent on their behalf if the person does not have legal capacity) to enable the person to make an informed decision on whether to accept treatment:

(f) the provision of prophylaxis:

(g) the failure of any equipment, device, or tool used as part of the treatment process, including the failure of any implant or prosthesis (except where the failure of the implant or prosthesis is caused by an intervening act or by fair wear and tear), whether at the time of giving treatment or subsequently:

(h) the application of any support systems, including policies, processes, practices, and administrative systems, that—

(i) are used by the organisation or person providing the treatment; and

(ii) directly support the treatment.

Treatment injury does not include:

- injury that is a necessary part, or ordinary consequence, of the treatment, taking into account all the circumstances of the treatment, including the person's underlying health condition at the time of the treatment; and the clinical knowledge at the time of the treatment;⁹⁵
- personal injury that is wholly or substantially caused by a person's underlying health condition;⁹⁶
- personal injury that is solely attributable to a resource allocation decision;⁹⁷
- personal injury that is a result of a person unreasonably withholding or delaying their consent to undergo treatment;⁹⁸ and
- personal injury arising out of a claimant's participation in an unapproved clinical trial, when the claimant agreed to participate in the trial in writing.⁹⁹

Furthermore, the fact that the treatment did not achieve a desired result does not, of itself, constitute treatment injury.¹⁰⁰

The positive definition of ‘treatment injury’ and its relationship with the cover provisions in s 20 are not contentious. However, the exceptions to the definition of ‘treatment injury’ create more difficulties, because they are difficult to interpret, and because they

95 Section 32(1)(c).

96 Section 32(2)(a).

97 Section 32(2)(b).

98 Section 32(2)(c).

99 Section 32(4).

100 Section 32(3).

potentially reintroduce a fault element into this category of accident compensation.¹⁰¹ These exceptions are the main focus of this paper’s analysis of treatment injury, and are discussed in turn below.

V Section 32(1)(c): Not a Necessary Part, or Ordinary Consequence, of the Treatment

A The section and its origins

This section outlines an exception to the definition of treatment injury. Treatment injury is:

- (c) not a necessary part, or ordinary consequence, of the treatment, taking into account all the circumstances of the treatment, including—
 - (i) the person’s underlying health condition at the time of the treatment; and
 - (ii) the clinical knowledge at the time of the treatment.

This exception is a reversal of the previous ‘medical mishap’ category: instead of cover only for rare injuries, there is cover for all injuries that are not necessary or ordinary.

The parameters of what is necessary or ordinary is unclear; the Explanatory Note to the Bill lists “a surgical incision during an operation” as an example of a necessary part of treatment.¹⁰² *Holden v Accident Compensation Corporation* describes a ‘necessary part of treatment’ as a deliberate action, while an ‘ordinary consequence’ “encompasses unintended consequences or side effects that are expected to occur in numbers of cases.”¹⁰³

A claimant should not receive cover for the necessary parts of treatment that could be considered a personal injury, because the treatment is necessary to treat the claimant’s condition, and can be seen as a part of the claimant’s underlying condition. To take a surgical incision as an example, it is a physical injury¹⁰⁴ caused by an application of force external to the human body.¹⁰⁵ However, it would not be right to grant cover for it as a personal injury caused by accident, or a treatment injury caused by treatment. Allowing such cover would expand the scope of the accident compensation scheme to cover almost every patient in the New Zealand medical system. This result is avoided by excluding

101 Ken Oliphant “Beyond Misadventure: Compensation for Medical Injuries in New Zealand” (2007) 15 *Med Law Rev* 357 at 382–383.

102 Injury Prevention, Rehabilitation and Compensation Bill (No 3) (165-3) (explanatory note) at 4.

103 [2012] NZACC 170 at [44].

104 Section 26(1)(b).

105 Section 25(1)(a)(i).

injuries caused by treatment from the definition of ‘personal injury by accident’,¹⁰⁶ and by excluding necessary parts and ordinary consequences of treatment from the definition of ‘treatment injury’.¹⁰⁷

B Case law on s 32(1)(c)

The leading case is *McEnteer v Accident Compensation Corporation*.¹⁰⁸ The appellant received surgery to remove an aneurysm. During surgery, unforeseen complications arose which meant that the appellant’s arteries were clipped to control bleeding for a total time of 40 minutes, rather than the more standard 12 to 15 minutes.¹⁰⁹ The appellant suffered cognitive impairment following the surgery, attributed to the longer clipping time.¹¹⁰ Both parties agreed “There was no fault in the surgical or medical treatment that the appellant received. Rather, appropriate levels of skill and care were employed.”¹¹¹

The issue before the court was whether what was necessary or ordinary in treatment should be assessed prospectively, before the treatment began, or whether what was necessary or ordinary could change in the course of treatment. This was relevant because the need to clip the appellant’s arteries for 40 minutes became apparent during the surgery, and was not apparent before. The court found that a prospective approach was artificial, complex, and did not reflect the statutory language.¹¹² For the purposes of s 32(1)(c), in determining whether an injury is a necessary part or ordinary consequence of treatment, ACC should consider what is necessary or ordinary in the context of what actually happened, including aspects of the claimant’s condition that became apparent during the course of treatment.¹¹³ With the legal question answered, the matter was referred back to the District Court to consider whether the 40-minute clipping of the appellant’s arteries was a necessary part or ordinary consequence of treatment.¹¹⁴ The lack of fault on the part of the registered health professional was not considered fatal to the appellant’s case.

However, *Groves v Accident Compensation Corporation* presents an example of a case where fault was relevant to determining whether an injury fell within the exception of

106 Section 25(2)(a).

107 Section 32(1)(c).

108 [2010] NZCA 126.

109 At [3].

110 At [5].

111 At [5].

112 At [16]–[19].

113 At [20]–[21].

114 At [22].

being a necessary part or ordinary consequence of treatment.¹¹⁵ In this case, the appellant had used tricyclic antidepressants and antihistamine medication in the long term, giving him xerostomia (dry mouth). This resulted in dental caries, tooth decay and loss of teeth.¹¹⁶

ACC submitted that tooth loss was an ordinary consequence of the medication he was taking, and therefore his injury was an ordinary consequence of treatment. The appellant’s argument was that part of his treatment should have been for xerostomia, and failure to treat it caused his injury (loss of teeth).¹¹⁷ The injury was not an ordinary consequence of treatment, because the xerostomia should have been treated and injury to the claimant avoided.

The Court focused on the question of whether it was the appellant’s responsibility to maintain his dental hygiene and thus avoid injury, or whether the treating professionals should have prescribed further treatment to avoid injury to the appellant.¹¹⁸ The judge noted that:¹¹⁹

Although the accident compensation scheme is a no fault scheme, defining the scope of treatment also involves examining where responsibility lies for addressing consequences in the nature of side effects.

The judge found in favour of the appellant, surprisingly because of his underlying health condition: the appellant’s anxiety and depression made him an “unreliable agent for his own dental hygiene”.¹²⁰ While the treating professionals and the appellant had a mutual obligation to avoid the injury, the treating professionals ultimately continued to have an obligation to provide treatment, which they failed to do.¹²¹ The judge concluded by saying that the case “involves an enquiry into fault, but only for the purpose of defining the scope of treatment.”¹²²

However, the scope of treatment was determinative in the case, and therefore the Court’s enquiry into fault was what determined whether the claimant got cover. The fault enquiry went towards determining the scope of treatment injury: whether the xerostomia was a necessary part or ordinary consequence of treatment, an exception to the definition of

115 [2012] NZACC 200.

116 At [1].

117 At [22].

118 At [34] and [39].

119 At [40].

120 At [42].

121 At [44].

122 At [45].

treatment injury found in s 32 of the ACA. Treatment injury is the definition that must be satisfied to get cover under the ACA for an injury relating to treatment, and the discussion of fault in the case was more central to the appellant’s likelihood of getting cover than the Court admitted.

C Discussion

Section 32(1)(c) replaced the medical mishap category of medical misadventure, which was concerned with the rarity and severity of injuries, not with fault. Most cases decided under this provision revolve around the likelihood of the injury occurring, given the circumstances and, in particular, the claimant’s underlying health condition at the time of the treatment.¹²³ In excluding necessary and expected injuries from the definition of treatment injury, the provision reduces the scope of cover for treatment injury to an affordable standard and maintains the idea that injuries are only covered if they result from an accident-like event, which normal treatment is not. The provision does not make fault a requirement for claiming cover under the accident compensation scheme. However, *Groves* presents an unfortunate precedent by bringing fault into the discussion of when a consequence of treatment is ordinary and when a consequence can and should be avoided by follow-up treatment.

As has been discussed earlier, there is a difference between negligence and a mere error of judgment. A defendant is only held liable in negligence for conduct that departs from the standard of reasonable care. A person may make an error of judgment, but still discharge her obligation to act with the skill and care reasonably expected of her.¹²⁴ When discussing fault and accident compensation, it is the negligence standard being discussed. So did the Court in *Groves* apply the negligence standard, or were they simply looking for an error of judgment (which is not a fault standard)?

The Court’s discussion of fault in the case was focused on industry standards. Professor Martin Ferguson, who had treated the appellant in the past, said that proper treatment should have involved follow-up, although he noted that there were no guidelines on what should be done to avoid xerostomia.¹²⁵ The Court accepted Professor Ferguson’s advice, noting that there was no evidence of accomplished best practice to contradict him.¹²⁶ The Court also stated that if the health professionals had attempted a programme of treatment

123 See *Accident Compensation Corporation v Porter* [2010] NZACC 104; *Monk v Accident Compensation Corporation* [2012] NZAR 1 (HC); *Holden v Accident Compensation Corporation*, above n 103; *Williams v Accident Compensation Corporation* [2013] NZACC 183.

124 See p 8 of this paper.

125 At [14]–[16].

126 At [42].

for the appellant’s xerostomia, and the appellant had not co-operated, “the treatment obligation might have been discharged”.¹²⁷ In other words, if best practice is followed by health professionals, any resulting side effects are ordinary consequences of treatment, and ACC will not provide cover for those side effects. The standard applied in *Groves* is very similar to the negligence standard: what was relevant to the Court was whether the health professionals discharged their duty to apply the standard of care expected by the industry.

D Recommendation

A fault enquiry is an inappropriate way of applying s 32(1)(c), and could lead to courts finding that an injury caused by a health professional’s error of judgment is an ordinary consequence of treatment. To ensure a no-fault approach is taken, s 32(1)(c) should be amended to clarify that an injury caused by an error of judgment is not an ordinary consequence of treatment.

VI Section 32(2)(a): Wholly or Substantially Caused by a Person’s Underlying Health Condition

A The section and its origins

There is no cover for personal injury that is wholly or substantially caused by a person’s underlying health condition.¹²⁸ This exception seeks to stop claimants receiving cover for incapacities caused by illness. The accident compensation scheme does not provide cover for incapacities arising out of illnesses, except for work-related gradual processes, diseases or infections,¹²⁹ which were covered by the preceding Workers’ Compensation Act 1956 and thus were included from the start of the scheme.¹³⁰ Originally, Sir Owen Woodhouse intended that the scheme would cover the victims of both injury and illness.¹³¹ However, the Report and subsequent statutes only provided cover for the victims of injury.

The accident compensation scheme did not cover illnesses because it was intended to replace the inefficient, arbitrary system that had preceded it – tort law, as well as statutory workers’ compensation – neither of which provided cover for illnesses generally.¹³² The

127 At [43].

128 Section 32(2)(a).

129 Section 30.

130 Woodhouse Report, above n 23, at [290].

131 At [17].

132 At [290].

cost of the levies that would fund an accident compensation scheme replaced the compulsory insurance that people already had to pay as road users or employers. There were no similar payments already being made to compensate the victims of illness. It was difficult to work out how much it would cost to cover illness, but it was likely to be much more expensive than cover for injuries.¹³³

In 1988, the Law Commission published a report recommending that the accident compensation scheme be expanded to include compensation for illnesses.¹³⁴ The Labour Government of the time introduced a Bill to implement the recommendation,¹³⁵ but it could not be passed before the change in government in 1990.¹³⁶

Some judges have applied the ACA cover provisions so broadly that claimants have received cover for injuries that are arguably more in the way of illnesses.¹³⁷ These decisions have rested on the argument that the accident compensation scheme should be interpreted broadly, given Woodhouse’s aim of comprehensive entitlement.¹³⁸ The legislature’s refusal to extend cover to the victims of illness undermines to some extent the relevance of the Woodhouse principles as valid interpretative tools of the current statutory scheme.¹³⁹ At the very least, the principle of comprehensive entitlement cannot overrule a statutory scheme that explicitly denies cover for illnesses that are not work-related.¹⁴⁰

It is especially difficult to exclude illness from cover in treatment injury claims, where many claimants will have a pre-existing condition that cannot be covered because it is an illness. Any injury that occurs during or following treatment could well be caused by the underlying condition, and not the treatment itself, and therefore the cover provisions for treatment injury must find a way to distinguish between the two. The way to exclude illness is to require an accident-like event that causes the injury, which is the purpose of s 32(2)(a).

133 Woodhouse Report, above n 23, at [290].

134 Law Commission *Personal Injury: Prevention and Recovery* (NZLC R4, 1988) at [6] and [176].

135 Rehabilitation and Incapacity Bill 1990 (45-1).

136 Geoffrey Palmer “New Zealand’s Accident Compensation Scheme: Twenty Years On” (1994) 44 UTLJ 223 at 236.

137 *Accident Compensation Corporation v Mitchell* [1992] 2 NZLR 436 (CA) at 438–439; Geoff McLay “Accident Compensation – What’s the Common Law Got to Do with It?” [2008] NZ L Rev 55 at 72–79.

138 *Mitchell*, above n 137, at 438–439; *Harrild v Director of Proceedings* [2003] 3 NZLR 289 (CA).

139 Maria Hook “New Zealand’s Accident Compensation Scheme and Man-Made Diseases” (2008) 39 VUWLR 289 at 293–294.

140 Section 26(2).

B Application of the provision

Stephen Todd has pointed out that this exception may retain the element of fault that characterised the prior cover for medical error.¹⁴¹ Todd considers the case of a person with an underlying health condition, who receives treatment but then whose condition worsens. Did the person’s underlying health condition or the treatment cause the worsening of the condition? One way to answer this question would be to apply legal causation: was there an unbroken chain of causation between the underlying condition and the claimed injury?¹⁴² However, this approach would narrow the scope of treatment injury cover to the point of excluding some injuries that were covered by medical misadventure or that were explicitly intended to be covered by the drafters, such as a stroke caused by an allergic reaction to an anaesthetic.¹⁴³ A person’s underlying health condition could be a legal cause of an injury without being wholly or substantially causative.

Another approach is to consider the ‘potency’ of the underlying condition compared to that of the treatment (a test borrowed from tort concepts of contribution and contributory negligence).¹⁴⁴ There must be a regularity of the connection between cause and consequence,¹⁴⁵ or to put it another way:¹⁴⁶

The underlying notion, no doubt a very rough one, in the selection of one cause as more “important”, “effective”, or “potent” than another is its greater tendency in normal circumstances, and not merely in the particular case, to be followed by harmful (or beneficial) consequences.

This test fits better with the wording of the statute, which only excludes claims where the underlying condition is a substantial cause.¹⁴⁷ The statute requires ACC, in difficult cases, to balance different possible causes. The fact that a person’s underlying condition is simply *a* cause of injury is not determinative. Therefore, the potency test is more appropriate than a test of legal causation. Todd suggested using the potency test, saying that:¹⁴⁸

141 Todd, above n 12, at 54–55.

142 Oliphant, above n 101, at 383–384.

143 This injury was used as an illustration of what would be covered by the new provisions by the Minister for ACC herself (See Oliphant, above n 101, at n 136).

144 Oliphant, above n 101, at 384.

145 At 384.

146 HLA Hart and T Honoré *Causation in the Law* (2nd ed, OUP, Oxford, 1985) at 233.

147 Section 32(2)(a).

148 Todd, above n 12, at 54.

Seemingly in each case a claimant must establish on the balance of probabilities that treatment, or different treatment, would have improved the patient's condition or prevented it from getting worse. The Corporation is no longer required to find fault, but the requirement that the claimant show that the health professional should have treated or should have treated differently is likely to involve the claimant needing to show that the health professional was negligent in making his or her decisions about treatment.

The accuracy of Todd's prediction can be assessed by looking at the case law that has arisen under s 32(2)(a). In *Estate of Ian Sheppard v Accident Compensation Corporation*, the appellant claimed that a failure to adequately treat the deceased's melanoma resulted in death.¹⁴⁹ At issue was whether the earlier death of Mr Sheppard was caused by the failure to treat, or caused wholly or substantially by cancer, an underlying condition.¹⁵⁰ The judge used practice guidelines¹⁵¹ and expert opinions to determine what steps a registered health professional would usually take in treating a patient like Mr Sheppard, and whether these steps would have had a different effect to the result obtained by the health professional in the particular case.¹⁵² The judge concluded that the deceased's condition would not have progressed any other way if the health professional had applied a different course of treatment.¹⁵³ The deceased may have suffered a loss of a chance of recovery, but loss of a chance is not sufficient proof of causation in accident compensation.¹⁵⁴ The focus in the case was on whether “the outcome would have been different if the accepted standard of care had been provided”.¹⁵⁵

Earlier cases decided on s 32(2)(a) had taken a similar approach. In *Derrick v Accident Compensation Corporation*, the appellant's leg had been amputated below the knee after an alleged failure to diagnose a melanoma.¹⁵⁶ The issue was whether the melanoma (the underlying health condition) wholly or substantially caused the injury. The judge found that “most GPs would have arranged a biopsy for the appellant”,¹⁵⁷ and stated, “I do not wish to be blaming a dedicated medical practitioner, but it seems to me that Dr X should

149 [2013] NZACC 117 at [1].

150 At [3].

151 Specifically, the Clinical Practice Guidelines for the Management of Melanoma in Australia and New Zealand.

152 At [11]–[26].

153 At [47].

154 At [51]. See *Accident Compensation Corporation v Ambros* [2007] NZCA 204.

155 At [40]–[41].

156 [2010] NZACC 181 at [1].

157 At [54].

have sought specialist diagnosis and treatment long before he did.”¹⁵⁸ The judge concluded that the injury was not inevitable, but could have been prevented by correct treatment. The appellant won the case.

These cases confirm Stephen Todd’s prediction that ACC and the appeal authority will consider what other treatment options could have been taken in determining the causal potency of the particular treatment option taken.¹⁵⁹ Part of that analysis involves determining what a registered health professional should have done in the circumstances of the case, and comparing that to what actually happened. ACC and the ACC appeal authority are applying a fault standard in determining whether to grant cover when the claimant’s injury may have been caused by an underlying condition.

C Discussion

Section 32(2)(a) makes fault of a health professional the de facto test for some treatment injury cases, specifically those where the treatment that allegedly caused the injury is “a failure to provide treatment, or to provide treatment in a timely manner”.¹⁶⁰ When treatment has been provided, and an adverse and unexpected outcome occurs, there is no need to find fault. If the outcome is not something usually caused by the underlying condition the patient suffers from, it should be relatively easy to prove that the injury was caused by the treatment, and ACC would not need to resort to any kind of reasoning based on fault. Normal causation law would apply.¹⁶¹

However, when treatment has not been provided, it is necessary for ACC to consider whether treatment should have been provided, and whether it would have stopped the injury from occurring. When considering whether treatment should have been provided, ACC and the appeal courts have looked at whether the “accepted standard of care” was provided,¹⁶² a standard that sounds very similar to the “standard of care and skill reasonably to be expected in the circumstances” that was applied under medical error.¹⁶³

It is less clear how the courts would treat a situation where a health professional makes an error of judgment without her conduct departing from the standard of care reasonably expected of her. As has been discussed above,¹⁶⁴ a health professional is not at fault in tort law for an error of judgment that is not negligent. Ideally, ACC would provide cover

158 At [65].

159 Todd, above n 12, at 54–55.

160 Section 33(1)(d).

161 *Ambros*, above n 154.

162 *Estate of Ian Sheppard*, above n 149, at [40]–[41].

163 Accident Rehabilitation and Compensation Insurance Act, s 5(1).

164 At p 8.

for those injured by non-negligent errors of judgment, as well as those injured by negligent errors. In the above cases, the courts have looked to industry standards and what a doctor would be likely to do, which does not give guidance on whether a non-negligent error that resulted in injury would fit the definition of ‘treatment injury’. Would a claimant receive cover from ACC if she were misdiagnosed, even though her condition was very rare and most doctors would have misdiagnosed her despite following good practice? This question is unanswered as of yet.

D Recommendation

This exception is a necessary part of the definition of ‘treatment injury’. It preserves the distinction between injuries caused by treatment and incapacities caused by a person’s underlying medical condition, where that medical condition does not attract cover itself. Where the underlying condition does attract cover (for example, it is caused by an accident), the claimant can receive cover under s 20(2)(d) or (h).

However, to ensure that ACC provides cover for injuries caused by non-negligent errors, this provision should be clarified in the same way as s 32(1)(c), to clarify that an injury caused by a non-negligent error is a treatment injury.

VII Section 32(2)(b): Personal Injury That Is Solely Attributable to a Resource Allocation Decision

A claimant will not receive cover for an injury caused solely by a resource allocation decision.¹⁶⁵ This provision was carried over from the previous medical error provision,¹⁶⁶ and stops cover being granted for a claimant whose condition deteriorates because they have been placed on a waiting list.¹⁶⁷ Another example of where this provision may work to exclude a claimant from cover is where the claimant should have been treated with a drug, but the drug is not funded in New Zealand. The resource allocation exception stops the accident compensation scheme from influencing policy decisions about who is treated and what treatments are available in our public health system. ACC should not be responsible for the health funding and treatment priorities of the government of the day.¹⁶⁸

165 Section 32(2)(b).

166 Injury Prevention, Rehabilitation, and Compensation Act 2001, s 32(4)(c).

167 Oliphant, above n 101, at 381.

168 (4 May 2005) 625 NZPD 20268.

Ken Oliphant has contended that, as the provision includes the word ‘solely’, a claimant could get cover for an injury caused by a resource allocation decision,¹⁶⁹

in conjunction with a clinical action that is not a necessary part of treatment, *e.g.* where the patient is given the wrong priority for treatment as a result of an error or where the treatment fails to meet the required standard because RHPs¹⁷⁰ are being made to work outside their practice areas in a staff shortage.

He concluded, “Some scope therefore remains for fault to influence the application of the new statutory criteria.”¹⁷¹ However, it is equally possible for those collateral causes not to be anyone’s fault. For example, it may be no one’s fault if a person is put further down the waiting list than she should be because of a computer error. Some errors of judgement can lead to injury without anyone’s conduct departing from the standard of reasonable care to be expected.¹⁷² Litigation could arise over whether a resource allocation is solely responsible for an injury, for example where a resource allocation decision is 90 per cent responsible for an injury.¹⁷³

This exception could be criticised for being inconsistent with the accident compensation scheme as a whole. Some road accidents could be attributed to resource allocation decisions; for example, accidents that would have been prevented had a lane divider been built.¹⁷⁴ A person injured in a road accident of this kind could still recover under the ‘personal injury by accident’ category of cover. It is unclear why only treatment injury should have a resource allocation exception. However, what is clear is that this exception does not make fault a requirement of cover for treatment injury.

VIII Section 32(3): The Fact that the Treatment Did Not Achieve a Desired Result Does Not, of Itself, Constitute Treatment Injury

The fact that the treatment did not achieve a desired result is not in itself enough to attract cover.¹⁷⁵ This exception was present in the prior definition of medical error.¹⁷⁶ The effect of this section is to require something beyond mere failure of treatment to meet the

169 Oliphant, above n 101, at 381.

170 Registered health professionals.

171 At 381.

172 Todd, above n 12, at 371.

173 (5 August 2004) 619 NZPD 14705.

174 Sam Boyer “Further calls for safety barrier to be extended” (11 September 2013) Stuff <www.stuff.co.nz>.

175 Section 32(3).

176 Injury Prevention, Rehabilitation and Compensation Act, s 32(4)(a).

definition of treatment injury. In many situations, this section would stop claimants from getting cover through the treatment injury provisions for illnesses that they would otherwise not have cover for. For example, a person who contracts pneumonia would not usually get cover for that illness. That person should not start getting cover after being prescribed antibiotics that do not cure the infection. There must be some new injury arising from the treatment, which can be termed ‘treatment injury’ and granted cover.

But what counts as a new injury? Todd has this to say on s 32(3):¹⁷⁷

... the scheme is not intended to underwrite a lack of success in medical treatment. But when might there be treatment injury when desired results are not obtained? An obvious answer is when the wrong treatment is given. In addition, “treatment” is defined as including, inter alia, a decision not to provide treatment; a failure to provide treatment, or to provide treatment in a timely manner; failing to obtain a person's consent to undergo treatment; and the failure of any equipment, device or tool used as part of the treatment process. So once again the concepts of medical mishap or medical negligence return in different guises. We may conclude from all this at least that both mishap and error implicitly remain highly relevant, and it may be that they do in fact cover the ground.

Much like the exception for injuries caused wholly or substantially by an underlying condition, this exception seeks to exclude injuries caused by illness, but in doing so imports a fault element into the analysis of whether a claimant has cover for treatment injury. This provision is probably unnecessary, given the exception for injuries caused wholly or substantially by an underlying condition,¹⁷⁸ and the requirement that a treatment injury be caused by treatment.¹⁷⁹ Section 32(3) should be repealed.

IX Relevance of the Claimant’s Fault

A Introduction

There are two aspects of the definition of ‘treatment injury’ that make the fault of the claimant, not a health professional, relevant to a claim for cover under the ACA.

First, there is no cover for personal injury that is a result of a person unreasonably withholding or delaying their consent to undergo treatment.¹⁸⁰

177 Todd, above n 12, at 54–55.

178 Section 32(2)(a).

179 Section 32(1)(b).

180 Section 32(2)(c).

Secondly, the ACA defines treatment injury as including personal injury suffered by a person as a result of treatment given as part of a clinical trial, if either: ¹⁸¹

- the claimant did not agree to the trial in writing; or
- an ethics committee approved the trial, and was satisfied that the trial was not to be conducted principally for the benefit of the manufacturer or distributor of the medicine or item being trialled. The main criterion for approval is that the trial-runners provide adequate compensation in the event of injury. The ethics committee must have been approved by the Health Research Council of New Zealand or the Director-General of Health at the time the committee approved the trial.

Thus a claimant would not get cover if she agrees to a trial in writing, where the trial is unapproved or for the benefit of the manufacturer or distributor of the product.

B The approach in tort law

The plaintiff in a tort action may be partly at fault for her loss. The defendant can use the plaintiff's fault as a defence, either to reduce the level of damages, or avoid liability altogether. The three main defences that require some fault on the part of the plaintiff are discussed below.

1 Contributory negligence

A failure by the plaintiff to take reasonable care to protect her interests is a defence to a charge of negligence, where the plaintiff's lack of care contributed to her loss.¹⁸² This position is codified in New Zealand in the Contributory Negligence Act 1947, which states that where a person suffers damage partly due to her own fault, and partly due to the fault of another, a claim in respect of that damage is not defeated, but the damages recoverable will be reduced, having regard to the plaintiff's level of fault.¹⁸³

'Fault' is defined as “negligence, breach of statutory duty or other act or omission which gives rise to a liability in tort or would, apart from this Act, give rise to the defence of contributory negligence.”¹⁸⁴ The plaintiff's fault must be a proximate cause of the damage, much like the defendant's.¹⁸⁵ The standard of care the plaintiff is held to is supposed to be equal to the defendant's. However, greater allowance is made for

181 Sections 32(4)–(6).

182 Todd, above n 12, at 1095.

183 Section 3.

184 Section 2.

185 *Griffin v F T Wimble & Co* [1950] NZLR 774 (SC).

plaintiffs, because their conduct put only themselves at risk, and they are thus less blameworthy than the defendant. Furthermore, defendants can usually rely on insurance to pay their damages, while plaintiffs are unlikely to have cover for loss that was their own fault.¹⁸⁶

2 *Consent*

A defendant has a defence where the plaintiff consented to the action that constitutes the tort.¹⁸⁷ The defence of consent only applies to intentional torts: battery, assault, false imprisonment and trespass.¹⁸⁸ It also has limited application in defamation.¹⁸⁹ Consent to medical treatment is particularly important, as most medical treatments, for example an incision during surgery, would otherwise constitute battery.¹⁹⁰ Consent in this case means informed consent: a patient must be informed of all material risks of the treatment.¹⁹¹

3 *Assumption of risk*

This defence is also known as *volenti non fit injuria*, meaning “no harm is done to one who consents”.¹⁹² Unlike the defence of consent, this defence applies to plaintiffs who consent to a risk of harm. To use this defence, a defendant must show that the plaintiff was fully aware of what was happening and of the risk of harm, and that the plaintiff freely decided to run that risk anyway.¹⁹³ A key aspect of the defence is that the plaintiff chose freely to run the risk, and was under no constraint or interference.¹⁹⁴ Thus an employee who continues to work despite having full knowledge of a danger at the workplace can still recover if that risk eventuates; the employee cannot be said to have a free choice to stay at the workplace or leave, because of economic pressure.¹⁹⁵

C *The Woodhouse Report*

In the Woodhouse Report, the possibility of damages being reduced because of the defence of contributory negligence was listed as one of the risks of litigation, and thus a

186 Todd, above n 12, at 1011.

187 At 1109.

188 At 1109.

189 At 1111.

190 At 1114.

191 See *Rogers v Whitaker* (1992) 175 CLR 479 at 490 (HCA). For a more in-depth discussion of this point, see Todd, above n 12, at 1116–1119.

192 Todd, above n 12, at 1119.

193 At 1119.

194 Todd, above n 12, at 1122–1123.

195 *Smith v Baker* [1891] AC 325 (HL); accepted in New Zealand in *Harris v Ford* (1909) 28 NZLR 426 (CA).

reason to introduce an accident compensation scheme.¹⁹⁶ The Report also noted that criticisms of the fault principle were directed at the Contributory Negligence Act 1947 when it was passed.¹⁹⁷ This criticism led to a suggestion in the House that all people injured in accidents should be fully compensated regardless of fault, a suggestion that was taken up by the Woodhouse Report. However, the Report did not recommend compensating those whose injuries are deliberately self-inflicted,¹⁹⁸ probably intending that to cover those who self-harm or commit suicide.

D Medical misadventure and the fault of the claimant

The medical misadventure provisions contained the same exclusion for those injured during clinical trials as the current treatment injury provisions.¹⁹⁹ This exclusion built on the common law that preceded it: in *Green v Matheson*, a woman who was subjected to experimental treatment without her consent was found to have cover under the accident compensation scheme that was in place at the time.²⁰⁰

E Fault of the claimant and the accident compensation scheme generally

There are some accident compensation provisions that expressly consider the fault of the claimant:

- A person cannot get compensation for deliberately self-inflicted injury or suicide, but can get cover for treatment of self-inflicted injuries or suicide attempts.²⁰¹
- A claimant convicted of the murder of a person who was a financial provider is not entitled to any support he or she would otherwise receive for the death of that person.²⁰²
- ACC does not have to pay any compensation for economic losses to a claimant who is imprisoned,²⁰³ and may apply for a court ruling to avoid paying specified entitlements where a claimant has suffered injury in the course of committing a criminal offence if paying those entitlements would be repugnant to justice.²⁰⁴

196 Woodhouse Report, above n 23, at [93].

197 At [146].

198 At [289].

199 Accident Rehabilitation and Compensation Insurance Act, s 32(3).

200 [1989] 3 NZLR 564 (CA).

201 Section 119.

202 Section 120.

203 Section 121.

204 Section 122.

Sections 120 and 122 intend to prevent criminals from profiting from their crimes through accident compensation. Section 121 helps ACC avoid paying lump-sum amounts to prisoners. These sections deal with highly specific situations and are not relevant to the case of claimant who has unreasonably withheld or delayed their consent to undergo treatment.

Section 119, which disentitles claimants whose injuries are self-inflicted, seems more similar to the unreasonable withholding of consent exception under treatment injury. However, the rationale of s 119 is twofold: that suicide and self-harm are health issues, not accidents, and that if a person understands the consequences of what they are doing, and intends those consequences, they should not be compensated for the harm of those consequences. The same reasoning applies to the victims of suicide, although in the case of suicide it is of course the families or dependents that are disentitled.²⁰⁵

F Other relevant law

Under the New Zealand Bill of Rights Act 1990, every person has the right to refuse medical treatment.²⁰⁶

Under the Code of Health and Disability Services Consumers’ Rights, patients have “the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive”,²⁰⁷ the right to information a reasonable consumer would expect before making an informed choice,²⁰⁸ and the right to honest answers to questions.²⁰⁹ Most importantly, medical services can only be provided to a consumer with that consumer’s informed consent.²¹⁰ A health professional who breaches the Code could face disciplinary charges or civil proceedings at the Human Rights Review Tribunal.²¹¹ The Tribunal can award damages for any loss not already provided for by the accident compensation scheme.²¹²

205 Marty Sharpe “ACC’s suicide snub adds to family pain” (18 September 2012) Stuff <www.stuff.co.nz>.

206 Section 11.

207 Health and Disability Commissioner (Code of Health and Disability Services Consumers’ Rights) Regulations 1996, reg 6(1).

208 Reg 6(2).

209 Reg 6(3).

210 Reg 7.

211 Health and Disability Commissioner Act 1994, ss 45(f) and 49(1)(a).

212 Sections 52–57.

G Unreasonable withholding or delay of consent

This exception to the definition of treatment injury incorporates elements of the defence of contributory negligence into the accident compensation scheme. A patient who unreasonably withholds or delays consenting to treatment is failing to reasonably look after her own interests; therefore she is at fault for her loss to some degree, and cannot be compensated. The exception is very much out of line with the rest of the scheme, where fault of the claimant in causing the injury is generally not relevant to cover.

Self-harm is one category of injury where ACC can consider the fault of the claimant in causing the injury.²¹³ However, unreasonable refusal or delay in consenting to treatment cannot be considered a health problem in the same way that self-harm might be. Furthermore, a person who unreasonably refuses or delays to consent to treatment does not necessarily intend the consequences of their refusal or delay (which would likely be a worsening of his or her condition). There are many possible reasons a person may refuse to or delay in consenting to treatment. For example, a person may have a religious conviction that forbids certain forms of treatment, or may be too frightened of the treatment to undergo it. It is difficult to know whether these reasons would be considered ‘unreasonable’ by ACC or a court. There have been no cases on this point.

It is possible that a person with an injury that does not meet the criteria of ‘personal injury’ under the ACA may refuse treatment, and then claim cover for treatment injury when their condition worsens. The exception could be seen as a way to avoid compensating people for injuries that are strictly caused by their underlying health condition; although the ACA already provides that there is no cover for personal injury that is wholly or substantially caused by a person’s underlying health condition.²¹⁴

A more important question is whether the provision is necessary at all. In what circumstances would an injury be held to be caused by treatment, where the claimant refused to consent to treatment? If the sole cause of the injury were the claimant’s refusal to consent to treatment, there would be no cover even without the specific exception provision.²¹⁵ This is because a treatment injury is a personal injury caused by treatment.²¹⁶ If a claimant refused to consent to treatment, and suffered an injury as a result, that claimant would need to establish that they underwent treatment for the purposes of ss 32 and 33. Per s 33, a failure to treat is ‘treatment’, but a registered health professional cannot be said to have failed to treat a patient if that patient did not consent

213 Accident Compensation Act, s 119.

214 Section 32(2)(a).

215 Oliphant, above n 101, at 381.

216 Accident Compensation Act, s 32(1)(b).

to treatment. A registered health professional can only give treatment with a patient’s consent.²¹⁷ This is a very important principle enshrined in the Code of Health and Disability Services Consumers’ Rights and the New Zealand Bill of Rights Act.

If a claimant delayed giving consent, that claimant might argue that the registered health professional failed “to provide treatment in a timely manner”.²¹⁸ However, the health professional could not have acted any earlier than the consent was given; thus the injury still had only one cause – the claimant’s delay in consenting – which is not part of the definition of treatment under s 33.

Following this line of argument, even a reasonable refusal or delay in consent to treatment which resulted in injury would not attract cover, because there is no ‘treatment’, under any of the definitions in s 33.

However, the argument could be made that the legislature intended ‘failure to treat’ to include a failure to treat caused by the reasonable refusal of a patient to consent to treatment. The legislature’s intention is illustrated by the fact that it thought it was necessary to explicitly exclude injuries resulting from an unreasonable refusal to consent to treatment. If a failure to treat because of a reasonable refusal to consent were not included in the definition of ‘treatment’, it would not be necessary to exclude injuries resulting from an unreasonable refusal to consent to treatment.

The best interpretation, however, is that s 32(2)(c) is unnecessary. It is impossible to fit a failure to treat following a claimant’s refusal to consent to treatment into the definition of treatment under s 33. Any injury resulting from a claimant’s refusal or delay in consenting to treatment, whether reasonable or not, would not get cover under the treatment injury provisions.

H Where a claimant agreed in writing to participate in an unapproved clinical trial

This exception draws on the same reasoning as the common law defence of assumption of risk, or *volenti non fit injuria*. Where a claimant has agreed in writing to participate in a trial, we assume she has understood the risks of the trial and been fully informed, and has accepted that risk. Therefore, she cannot claim any cover arising from taking that risk.

However, unlike the assumption of risk defence, the agreement in writing exception does not include a test of informed consent or adequate information. A person could agree in

217 Code of Health and Disability Services Consumers’ Rights, above n 207, reg 6(1); New Zealand Bill of Rights Act 1990, s 11.

218 Accident Compensation Act, s 33(1)(d).

writing to participate in a clinical trial without being informed of the risks of the trial; a person could even agree in writing to participate in a clinical trial and be incapable of understanding the risks of the trial.

Furthermore, the assumption of risk defence only applies to people who freely agree to risk harm, without the pressure of economic or other constraints. A person who agrees to participate in an unapproved clinical trial may be very poor, or very sick and hoping to be cured. In neither situation is a person free of constraints on whether or not to participate. The situation of a poor person agreeing to participate in a clinical trial is analogous to that of an employee who continues to work in a dangerous workplace; both have agreed to a risk of harm, but out of economic necessity, not free choice.

This exception is also inconsistent with the accident compensation scheme as a whole, which generally does not refuse cover to those who consent to a risk of harm, even if their decision is made freely. A person who gets into a car with a drunk driver will be covered if injured during an accident caused by the driver’s drunkenness, even if the accident was a risk the person knowingly took – even if the accident was very likely, given the driver’s condition. A person who uses unapproved equipment to build a shed, and is injured when the equipment malfunctions, would still get cover despite knowingly taking a risk with unapproved equipment. In the same way, a person who takes part in an unapproved clinical trial should get cover for any injuries that result.

The second exception to cover for injuries arising from a clinical trial is where the trial is unapproved. The origin of this exception is less clear than that of consenting in writing to the trial. Potentially, the drafters thought that those who participate in approved trials are taking on a risk that nevertheless benefits society. Approved trials (that are not funded by those who seek to profit from that trialled product) lead to usable results and potentially to better medicine. Unapproved trials only add to misinformation.

The same analogies can be made as before – drunk driving is not useful to society, and nor is using unapproved equipment to build a shed. Going back to the Woodhouse Report, one of the original aims of the accident compensation scheme was to compensate people whose injuries were “statistically inevitable” disadvantages of social progress. The modern world is a dangerous place, but to lose the dangers would be to also lose the benefits; thus the community as a whole has a responsibility to compensate those for whom the dangers eventuate.²¹⁹

However, the best interpretation of that aim is that the disadvantages of modern society include those in which the claimant’s fault plays a part. To return to the drunken driving

219 Woodhouse Report, above n 23, at [89].

example, the intention of the accident compensation scheme is not to cover those who drive safely, but still suffer injury (as some, statistically speaking, must, given the number of cars on our roads). The intention is to cover everyone who is injured on the road, regardless of their fault or standard of driving, because bad driving is part of the consequence of allowing driving in the first place. In the same way, the pharmaceutical industry and the methods of drug testing mean that some companies may use unapproved trials. This is an unfortunate side-effect of the drug industry as a whole. To eradicate it completely, we would need to eradicate the drug industry. Thus ACC should provide compensation for those who are injured in the course of unapproved clinical trials, regardless of their consent to the risk of harm.

The parliamentary materials surrounding the 2005 amendment do not explain the reasoning behind this provision. New Zealand First MP Barbara Stewart said that “notice has to be taken of people who willingly undergo trials so that the rest of our people can be cured of some disease by some new medicine or treatment that has been developed. Quite often people innocently go along to these trials ... sometimes the outcome is not exactly what they wanted.”²²⁰ However, many people who willingly trial medicines may not be covered by the provision, if for example the trial is not approved by an ethics committee.

The rationale may be that a person who consents in writing to a non-approved clinical trial understands the risks of the trial and consents to being exposed to those risks.²²¹ However, this rationale is not applied throughout the accident compensation scheme; a person who consents to a risk of injury by playing a highly physical sport, or by agreeing to be driven by a drunk driver, does not miss out on cover because she has consented to that risk and it eventuated.

I Recommendation

As discussed above, the exception to cover where the claimant withheld or delayed her consent to treatment is unnecessary and should be removed from the section.

The provisions concerning clinical trials are more complicated. A provision that allows ACC to provide cover to those injured during a clinical trial is useful, because it clarifies that treatment given during a clinical trial does satisfy the definition of ‘treatment’ in the ACA. However, it is unnecessary and inappropriate to exclude from cover those who agree in writing to an unapproved clinical trial. For these reasons, it is recommended that ss 32(4)–(6) be repealed and replaced with:

220 (4 May 2005) 625 NZPD 20265.

221 Todd, above n 12, at 60.

(4) **Treatment injury** includes personal injury suffered by a person as a result of treatment given as part of a clinical trial.

X ACC’s Reporting Function

A Pre-2005

Under the Injury Prevention, Rehabilitation and Compensation Act 2001, ACC had a discretion to “bring to the attention of or refer to any appropriate person or authority any matters concerning medical error or medical mishap if the Corporation considers it necessary or desirable to do so in the public interest (whether for reasons of public health or public safety)”.²²² It also had a mandatory duty to report *all* accepted instances of medical error to the relevant professional body and to the Health and Disability Commissioner.²²³ A report of this kind would include the name of the claimant, the date and circumstances of the medical misadventure occurred, and the name of the registered health professional or organisation to whom the medical misadventure is attributed.²²⁴

Non-individualised data on injuries and their causes were generally welcomed, but the mandatory duty to report data on individuals was a contentious issue, and a major aspect of the 2003 review of the medical misadventure provisions.²²⁵ There were concerns that mandatory reporting of medical errors encouraged ‘defensive medicine’ in the same way that tort law had.²²⁶ When adverse events did occur, the threat of reporting discouraged health professionals from co-operating with medical misadventure claims and also discouraged an open learning environment where problems were discussed.²²⁷

B Reform

During the 2003 review of the medical misadventure provisions, the Department of Labour and ACC polled affected parties on their views of the reporting mechanism. There was a general view that ACC has a public safety role in informing people on medical misadventure. Unsurprisingly, the majority of claimants and their families thought that mandatory reporting of accepted medical errors would ensure adequate

222 Section 284(1).

223 Section 284(2).

224 Section 284(6).

225 Oliphant, above n 101, at 377.

226 At 377. For information on defensive medicine and tort law see Andrew Brine “Medical Malpractice and the Goals of the Tort Law” (2003) 11 Health LJ 241 at 251–253.

227 Oliphant, above n 101, at 377.

accountability on the part of registered health professionals and organisations.²²⁸ Most health professionals, District Health Boards and health associations preferred no reporting at all. They thought this approach would ensure open disclosure on injuries by health professionals, and enable both timely patient recovery and improvements to healthcare.²²⁹

There was also an option to allow discretionary reporting, which was favoured by some health professionals and claimants. This option would allow ACC to act as a safety net, picking up on gross negligence and repeat errors, but not routinely reporting every case where there was an element of fault. This option was implemented in the 2005 reform.

C Current law

Section 284 places a duty on ACC to report information to the relevant authority where there is a “risk of harm to the public”. This duty only applies to information ACC gains through claims related to treatment injury, or historic medical misadventure claims. The statutory wording allows for reporting regardless of fault, as a risk of harm could be posed by many things, for example an individual, an organisation, a technique, or a piece of equipment.²³⁰

The provision gives ACC broad discretion over whether to report incidents, and thus its policy on this matter is determinative. ACC’s policy is to report all ‘sentinel events’ under s 284, meaning events during treatment that result in unanticipated death or major permanent loss of function. ACC also reports all ‘serious events’, meaning those with a potential for causing death or major permanent loss of function, where there is a high or moderate likelihood of recurrence.²³¹ The person notified is the Director-General of Health. It is then up to the Director-General to decide whether to tell the treating facility, and whether a response is required that can improve safety. ACC may notify a registration authority “if it has expert clinical advice that there are serious competence concerns.”²³²

The 2005 reform was intended as a shift away from fault-based cover and a culture of blame. The reformed reporting mechanism ultimately favoured public safety over co-operation with health professionals, by allowing reporting in some cases. However, the new provision is a much softer approach than before, and ACC’s implementation of the provision is sensible, reporting only where there is a chance of avoiding future death or

228 *Summary of Consultation*, above n 75, at 14.

229 At 14.

230 Oliphant, above n 101, at 378.

231 Stephen Todd “Treatment Injury in New Zealand” (2011) 86 *Chi Kent L Rev* 1169 at 1205.

232 At 1205.

major permanent loss of function. The reporting mechanism provides an effective way for ACC to fulfil its aim of preventing injuries.²³³

One of the problems with the original reporting provision, as well as with the medical error category generally, was that it created confusion about ACC’s role, suggesting that ACC could hold health professionals to account. This frustrated patients looking for something more from ACC than it could provide, and potentially confused health professionals as well.²³⁴ This confusion may remain despite the 2005 reforms. ACC’s role in preventing injuries, as well as compensating for injuries, necessarily overlaps with the role of the Health and Disability Commissioner, as well as other agencies, who work to improve healthcare and bring negligent health professionals to account.

XI Is Compensation Inherently Fault-Based?

Before concluding on the treatment injury provisions, it is worth considering the argument raised by Dr Brian Easton that compensation is inherently fault-based. Easton has argued that the idea of compensation is a “living fossil in the New Zealand no fault system”.²³⁵ Compensation is justified in a fault system because it removes the inequity of the victim losing out while the person who caused the damage is unaffected, and because it acts as a market deterrent, thereby reducing the number of accidents and injuries. The accident compensation scheme takes the injurer out of the picture, by providing no-fault compensation from public funds. The purposes of compensation – equity and deterrence – no longer apply.

Easton traces the development of compensation-based remedies in tort law to the unavailability of rehabilitation-based remedies in the nineteenth century.²³⁶ By the time the Woodhouse Report was written, effective rehabilitation had become a possibility, and the Commission prioritised it over compensation for that reason.²³⁷ Easton suggests that ACC should gradually phase out compensation and emphasise rehabilitation and prevention.²³⁸ Rehabilitation provided by ACC should converge with rehabilitation provided by other agencies. These changes would provide better remedies for claimants, and reduce inequities between those with injuries and those with illnesses. Easton noted that rehabilitation can still involve cash payments, but the focus is on improving the

233 Brian Easton “Ending Fault in Accident Compensation: Issues and Lessons from Medical Misadventure” (2004) 35 VUWLR 821 at 824.

234 Oliphant, above n 101, at 370.

235 Easton, above n 233, at 825.

236 At 825–826.

237 At 826.

238 At 826–827.

claimant’s wellbeing, not on compensating the claimant for loss. Compensation might still have a place in the scheme where rehabilitation is inadequate, for example where the injury creates a permanent disability.²³⁹

However, Easton fails to recognise that the accident compensation scheme works on the principle of community responsibility. The community as a whole takes on the role of injurer for the purposes of compensation under ACC. While ACC does not require that the community be at fault for a particular injury, the community is held responsible for each injury, because accidents are a social problem. The ACC form of compensation does not require fault. It just requires loss. Rather than making the claimant bear the full loss of her injury, the loss is spread around the community by compensating the claimant through funds collected from the public.

Thomas Douglas has this to say on compensation, specifically accident compensation that he thought should be paid to the victims of illness and genetic conditions:²⁴⁰

...it is natural, at least in legal contexts, to think that compensation is necessarily a response to some harm previously inflicted by the compensator. I will, however, understand compensation more broadly so as to include any attempt to restore a person to some better situation that she previously enjoyed, or that she is imagined to have enjoyed prior to the natural and social lottery of birth. (Those who find this definition implausible may simply read ‘compensation-like benefit’ whenever I use the word compensation.)

Douglas went on to argue that expansion of the scheme would require less generous entitlements, and eventually, merging the scheme with the pre-existing healthcare system and social security.²⁴¹ However, Douglas reached this conclusion because of the prohibitive cost of covering incapacities arising from illness, not because compensation cannot be paid out to those incapacitated by disease.²⁴² Compensation can be paid where there is loss, not only where there is fault.

Therefore, while compensation has evolved from fault principles, it is consistent with the no-fault basis of accident compensation to continue to provide compensation to eligible claimants.

239 At 826.

240 Thomas Douglas “Medical Injury Compensation: Beyond ‘No Fault’” (2009) 17 Med L Rev 30 at 36.

241 At 39 and 50–51.

242 At 38.

XII Recommendations

I recommend some minor amendments to s 32 of the ACA, to remove the elements of fault still present in the treatment injury provisions. These amendments are marked on the copied provision below. Section 33, which defines ‘treatment’, does not require amendment.

32 Treatment injury

- (1) Treatment injury means personal injury that is—
- (a) suffered by a person—
 - (i) seeking treatment from 1 or more registered health professionals; or
 - (ii) receiving treatment from, or at the direction of, 1 or more registered health professionals; or
 - (iii) referred to in subsection (7); and
 - (b) caused by treatment; and
 - (c) not a necessary part, or ordinary consequence, of the treatment, taking into account all the circumstances of the treatment, including—
 - (i) the person's underlying health condition at the time of the treatment; and
 - (ii) the clinical knowledge at the time of the treatment.
- (2) Treatment injury does not include the following kinds of personal injury:
- (a) personal injury that is wholly or substantially caused by a person's underlying health condition;
 - (b) personal injury that is solely attributable to a resource allocation decision;
 - ~~(c) personal injury that is a result of a person unreasonably withholding or delaying their consent to undergo treatment.~~
- ~~(3) The fact that the treatment did not achieve a desired result does not, of itself, constitute treatment injury.~~
- (3) Despite subsections (1) and (2), an injury caused by an error that occurs during treatment is a treatment injury, whether the error is negligent or not.
- (4) Treatment injury includes personal injury suffered by a person as a result of treatment given as part of a clinical trial, ~~in the circumstances described in subsection (5) or subsection (6).~~
- ~~(5) One of the circumstances referred to in subsection (4) is where the claimant did not agree, in writing, to participate in the trial.~~
- ~~(6) The other circumstance referred to in subsection (4) is where—~~

- ~~(a) an ethics committee—~~
- ~~(i) approved the trial; and~~
 - ~~(ii) was satisfied that the trial was not to be conducted principally for the benefit of the manufacturer or distributor of the medicine or item being trialled; and~~
- ~~(b) the ethics committee was approved by the Health Research Council of New Zealand or the Director General of Health at the time it gave its approval.~~
- (8) If a person (person A) suffers an infection that is a treatment injury, cover for that personal injury extends to—
- (a) person A's spouse or partner, if person A has passed the infection on directly to the spouse or partner:
 - (b) person A's child, if person A has passed the infection on directly to the child:
 - (c) any other third party, if person A has passed the infection on directly to that third party:
 - (d) person A's child or any other third party, if—
 - (i) person A has passed the infection directly to his or her spouse or partner; and
 - (ii) person A's spouse or partner has then passed the infection directly to the child or third party.

XIII Conclusion

In this paper, I have analysed the ACA provisions that relate to treatment injury, to show that fault is still a factor in ACC's decisions to provide cover for claimants injured during medical treatment. By putting these provisions into the context of the accident compensation scheme as a whole, and by drawing comparisons with the tort law approach and the medical misadventure provisions that preceded treatment injury cover, I have shown that it is inappropriate for these fault elements to remain in the legislation. They can be removed with relatively minor amendments to s 32 of the ACA. I recommend making these changes and bringing the treatment injury provisions into line with the no-fault foundation of accident compensation in New Zealand.

Word count

The text of this paper (excluding table of contents, footnotes, and bibliography) comprises approximately 14,705 words.

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