Chapter 54
No-Fault Medical Malpractice System in New Zealand

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Conclusion

Policymakers and experts in law and medicine have long pondered alternatives to the medical negligence systems currently in operation in most Anglo-American legal systems. The latest malpractice "crisis"[1] in the United States has seen an increased interest in testing non-negligence-based alternatives. Legislators in several states are pressing forward with plans for experimentation with alternative compensation regimes, urged on in these endeavors by the Institute of Medicine's recommendations to do this.[2]

Administrative "no-fault" models of compensation for medical injury, such as the one operating in New Zealand, offer one such alternative.

In 1974, New Zealand jettisoned a torts-based system for compensating medical injuries in favor of a government-funded compensation system.[3] The system retained some residual fault elements, but it essentially barred medical malpractice litigation. Reforms in 2005 expanded eligibility for compensation to all "treatment injuries," creating a true no-fault compensation system.[4]

In parallel with the no-fault compensation scheme, the New Zealand system also provides flexible and context-sensitive processes for complaint resolution and provider accountability.[5] The system thereby recognises that injured patients and their families have complex motivations for taking medicolegal action, which may include a desire for (1) financial restoration, (2) communication (explanation, apology, or expression of responsibility), (3) correction (action to prevent harm to future patients), and (4) sanction (which may include professional disciplinary action).[6]

The design of medicolegal systems cannot be separated from the broader social context. Although New Zealand and the United States have a good deal in common linguistically, culturally, politically, and to a great extent legally and medically, the differences caution against applying New Zealand's experiences to the United States without careful thought. Nevertheless, the New Zealand experience may be of interest to those concerned with finding alternatives to the morass of malpractice litigation in the United States.

THE TROUBLE WITH TORT

The failings of the United States medical malpractice system have been well described. Most negligently injured patients do not file suit, yet, paradoxically, most lawsuits arise out of appropriate care.[7,8] And while most lawsuits against doctors are dismissed or withdrawn with no monetary award for the plaintiff, these cases still exact a financial and emotional toll on doctors, hospital administrators, and their insurers.[9] There is also little evidence in support of the tort system's deterrence function, and some credible evidence against it.[10] Much of what we now know about quality improvement and risk reduction suggests that the requisites for improving patient safety are largely inconsistent with the major features of the civil litigation process.[11]

NO-FAULT COMPENSATION

In New Zealand, issues of compensation are addressed separately from attention to the quality of care: in no way is it necessary to claim negligence or error as a condition of achieving compensation, as it is in the United States. Injured patients are entitled to government-funded, no-fault compensation provided by a public insurer, the Accident Compensation Corporation (ACC).[12] In exchange, they have no right to sue for damages arising out of any treatment injury covered by the accident compensation legislation. This prohibition applies even where a person chooses not to lodge a claim or is not entitled to compensation.[13] Health professionals (including those working in the private sector) pay modest professional indemnity levies, and are not required to contribute to the cost of the treatment injury compensation scheme.

To achieve compensation in New Zealand, the patient or bereaved family files a claim with ACC's Patient Safety and Treatment Injury Unit (usually without the assistance of a lawyer). Compensation is available for all treatment injuries, which includes both serious and minor injuries caused during treatment by a health professional. Claimants have to establish a causal link between an injury and treatment, but are not required to show any degree of fault, rarity, or severity. Things that are a necessary part of treatment—for example, an incision during surgery—or ordinary consequences of treatment—such as hair loss after chemotherapy—are not covered.

Claims are decided based on information provided by the patient and his or her health care providers, and advice

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Box 54-1. Case Study: Patient Compensated Within 7 Days of Filing a Claim

Following an elective rotator cuff repair under general anesthetic, Fred, a 42-year-old senior paramedic, complained that his voice was hoarse and he was having difficulty speaking properly. His symptoms were initially expected to improve. At routine follow-up it was noted that Fred's voice was still very hoarse and he was unable to speak normally. Although Fred had made a good recovery with respect to the shoulder surgery, his normal duties required that he communicate clearly with both patients and colleagues, especially in emergencies. As a result of the continued voice problems Fred was unable to return to work.

Six weeks following surgery Fred was seen by an otolaryngologist who diagnosed laryngeal nerve palsy. Fred was advised that, while his problem was expected to resolve spontaneously, there was a chance that surgery would be required.

Fred filed a claim for no-fault compensation from ACC. The claim was accepted as a treatment injury within 7 days of filing, and Fred was awarded weekly compensation at 80% of his usual wage.

Four months following the initial rotator cuff surgery, Fred was still unable to speak above a whisper and sometimes inhaled fluid while drinking liquids. ACC paid for further assessment by an otolaryngologist and a speech therapist, which found that Fred was suffering a severe case of organic dysphonia due to neuromuscular damage to his left recurrent laryngeal nerve.

ACC has since paid for a voice amplifier, and will continue to provide weekly compensation and home speech therapy (including exercises to improve muscle strength and prevent involuntary inhalation of fluid) until Fred is able to return to work. If Fred's voice does not improve sufficiently for him to resume his duties as a paramedic, ACC will fund vocational retraining in a career that can accommodate his disability.

from independent clinical advisors. Straightforward claims can be processed within days or weeks, with a statutory requirement for claims decisions to be made within 9 months (Box 54-1). Patients whose claims are declined have a right of appeal.

No-fault compensation in New Zealand has proven to be stable and affordable over three decades. Four main factors have contributed to the affordability of the system:[3]

1. The compensation scheme is responsible for only a small percentage of the true costs of injury. New Zealand has universal, publicly funded health care and a strong social security system. (Yet, per capita health spending was only U.S.$1886 in 2003, compared with U.S.$5635 in the United States.[14]) All patients, including those who suffer adverse events, are entitled to free hospital care, and heavily subsidized primary care and pharmaceuticals.
2. Fewer than 5% of patients who are eligible for compensation file a claim, despite few apparent financial or institutional barriers. The availability of other forms of accountability may be one factor that contributes to these low claim rates. Of more concern is the fact that in New Zealand, as in the United States, the most vulnerable patients are the least likely to take medicolegal action following an adverse event, with significantly lower rates of claims and complaints among patients who are elderly, of Maori and Pacific ethnicity, and of low socioeconomic status.[15]
3. Awards are modest and predictable: a fixed award schedule means that claimants with similar disabilities receive similar compensation, with an average award of around $30,000. Compensation is available for lost earnings, and other expenses such as home help, childcare, transport, and rehabilitation. Pain and suffering is not compensated, though patients who have suffered a permanent disability are entitled to an additional lump-sum payment of up to $70,000. Full information on entitlements is available to the public through the ACC website.[16]
4. And finally, the system does not incur large legal and administrative costs. The New Zealand system has been very cost-effective, with administrative costs absorbing only 10% of ACC's expenditures compared with 50% to 60% among malpractice systems abroad.[17,18]

While New Zealand's no-fault compensation system has not delivered a perfect solution to the problem of medical injury, it remains popular, and there is no enthusiasm among the public or health care providers for a return to tort law as an alternative.[3] ACC does not deliver the windfalls of a "forensic lottery,"[19] but it offers injured patients reasonable assistance, paid quickly, and without rancor.

NONMONETARY REMEDIES

Following a medical injury, the emotional needs of patients are at least as important as their physical ones. In addition to offering no-fault compensation, the New Zealand system allow for a more nuanced understanding of patients' postinjury needs than occurs within a tort system.

Communication

The open, honest, and timely disclosure of medical error to patients should be a "no brainer."[20] Clinicians have an ethical and professional duty to disclose,[21] and patients frequently say that, when things go wrong, what they need most is information about what happened and how it can be prevented from happening again, and an apology.[22] Over the last decade, programs such as Illinois-based Sorry Works! have made great contributions toward encouraging open disclosure in the United States.[9,23] Yet, for some American patients and families, legal action remains the only way to get the answers they need.[24]

Health professionals in New Zealand have a legal duty of candor following an adverse event,[25] and adverse events are generally acknowledged in the medical record.[26] Apologies can be offered, unconstrained by fears of litigation (though even within New Zealand's no-fault environment, appropriate apologies are not always forthcoming).

Injured patients also have the right to complain to an independent health ombudsman—the Health and Disability Commissioner—if they are unhappy with the standard of care they received from a health professional. In New Zealand's no-fault system, the Health Commissioner plays an important role in meeting patients' nonfinancial needs—for an explanation or assurance that changes have

been made to protect future patients from harm—and also acts as a gatekeeper to disciplinary proceedings. The system may offer "no fault" compensation, but that by no means implies an environment of "no responsibility."

Where appropriate, the Health Commissioner may refer a matter for mediation (Box 54-2). This process allows the health professional and patient to meet, face to face in a safe environment, with a neutral party facilitating communication. It is a conciliatory process that allows for restoration of communication, expression of regret or apology, and an opportunity for both patient and health professional to let go of their stated "positions" in favour of a solution that they can both feel comfortable with. These are things that litigation cannot offer, even to the "winner."[27]

Assurance of Professional Competence

In the most serious cases, the Health Commissioner may conduct an independent investigation in order to meet the patient's need for an explanation of what went wrong and why. At the end of an investigation, the Health Commissioner may recommend, for example, that a health provider undertake further training or review a specific area of practice.

The New Zealand system draws a clear distinction between the concepts of competence review and professional discipline. Professional registration bodies, such as the New Zealand Medical Council and the Nursing Council, are authorized to carry out competence reviews to ensure that practitioners have the requisite skills, knowledge, and attitudes to practice safely.[28] Competence reviews have an educative, rehabilitative focus and, while rarely welcomed by practitioners, they are not intended to be a punitive measure. Providers who are impaired by illness or addiction come within the jurisdiction of the Medical Council's Health Committee, and are offered appropriate support and treatment until they are able to resume safe practice. Professional disciplinary proceedings are rarely required, as the focus throughout is on support of health professionals to get back into safe practice rather than punishing them.

Box 54-2. Mediation Assists Parties to Resolve Dispute Following Patient's Death

Mr. White, an elderly man with chronic airways disease and recurrent pneumonia, developed respiratory failure and was admitted to hospital. During his admission he was often uncomfortable and distressed. Mr. White was unaware that he could ask for morphine to alleviate his symptoms. During the discharge planning stage, Mr. White's family thought that hospice care would be appropriate but the hospital did not facilitate a referral to the hospice. Mr. White was discharged to a rest home where he received inadequate palliative care in the weeks before his death. His daughter later commented: "The charge nurse was an intimidating person. I felt that I could not pursue the fact that I wanted to speak to a doctor about my father and his discharge."

Mr. White's family complained to the Health Commissioner, who referred the matter for mediation. The mediation was attended by Mr. White's son and daughter, his doctor, and a hospital representative. An independent mediator helped the family and health professionals to discuss Mr. White's care, and agree on an acceptable outcome.

During the mediation the hospital apologized and acknowledged that aspects of Mr. White's care had been inadequate, that the timing of discharge was inappropriate, and that the family had not been appropriately involved in discussions about his ongoing care. The hospital agreed to revise its discharge planning policies and procedures, and to improve liaison with families and caregivers. The family agreed to allow Mr. White's story to be used as a case study in providing hospital staff with additional palliative care training.

System Learning

While money is the only way in which the United States medical malpractice system can approximate the value of a lost life, it does not satisfy a plaintiff's interest in knowing what is being done to prevent a recurrence.[29] A desire to prevent future incidents can be seen both as a genuine desire to protect others, and as an attempt to find some meaning in the loss that happened to them. Physicians, who seek to "do no harm," also benefit from a medicolegal system that supports improvements in patient safety in the aftermath of injury.[30] Medical malpractice litigation essentially fails to address the question "How can we improve the probability that this dispute will not occur again?"[31] Once inside the courtroom, even patients who were initially motivated by a collective good (a desire for improved patient safety) are required to transform that motive into a demand for individual enrichment (monetary damages).[32]

As an independent statutory agency separate from the political and policy decision-making process, New Zealand's Commissioner is well placed to use patients' desires for safer systems as a positive force for change. The actions of organizations, as well as individuals, are considered, and the Commissioner uses individual complaints as "a window of opportunity"[33] to improve health services generally. Lessons learned through complaint investigations are disseminated back to provider groups through regular meetings and presentations, and through published articles relating to specific areas of practice.[25,34,35]

CONCLUSION

The New Zealand experience with no-fault injury compensation has long been of interest to torts scholars, health care policy analysts, and others in the United States, where a flirtation with no-fault has been persistent if episodic. While the New Zealand system has not delivered a perfect solution to the problem of medical injury, it remains popular, and there is no enthusiasm among the public or health care providers for a return to tort law as an alternative. It seems that most New Zealanders would agree with Richards and McLean that "even an imperfect administrative compensation system [is] an improvement over the . . . medical malpractice system."[36]

The New Zealand experience also offers important support for the hypothesis that money is not the only thing

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that patients are seeking in the aftermath of an injury,[37] nor is it the most important thing that physicians can offer to patients. The remedial narrowness of the United States tort system allows almost no outlet for meeting patients' nonmonetary interests, and a demand for money often serves merely as an instrument by which some other motivation can be satisfied.[11] In contrast, the New Zealand system has the capacity to offer patients different forms of "accountability" including, but not limited to, financial compensation for their injuries. By providing compensation where compensation is called for, and addressing other intangible needs appropriately, the interests of patients, physicians, and the public may be better served.

Contextual differences in health funding, social security, and community values limit generalization of the New Zealand experience to other countries. Nevertheless, this system merits close consideration for its efforts to compensate injured patients quickly and equitably, while simultaneously offering accountability mechanisms focused on ensuring safer care, rather than assigning individual blame.

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