Issues for women in claims for medical misadventure

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I INTRODUCTION

The first Accident Compensation Act (namely the Accident Compensation Act 1972) came into force on 1 April 1974. It was followed by the Accident Compensation Act 1982. Both of these Acts have now been replaced by the Accident Rehabilitation and Compensation Insurance Act 1992. The purpose of this article is to examine whether the original scheme and the substantial changes to the scheme which were enacted in 1992 have served the interests of women who have suffered "medical misadventure". The article will compare the claim for "medical misadventure" with the common law claim for damages and evaluate the benefits and disadvantages of the accident compensation schemes, especially in relation to the impact on women, as compared with the common law. The article will also examine whether since the enactment of the legislation there is an adequate system of accountability and responsibility.

The aim of any modern compensation system,[1] whether it provide damages awards or insurance-based compensation, is surely to provide justice and political fairness. If the system is to be fair then the assessment of compensation should also be fair. While the earner has a recognised need for compensation based on loss of earnings resulting from disability, equally the person whose health is impaired and whose right to freedom of lifestyle choice is restricted by that impairment should also be entitled to compensation. In New Zealand the task of devising an appropriate method of calculating compensation for those physical impairments which do not affect the ability to earn have been placed in the "too-hard basket".

The aim of any health system must be to provide quality care. In an ideal society part of quality care will be ensuring that injuries are reported, so that mistakes will not be repeated. Quality care is inextricably intertwined with ethics. As part of the ethical commitment to patients' health, professionals owe a duty to their patients to help them obtain compensation for preventable errors. Any compensation must be adequate. Therefore, this article will examine the compensation payable to both injured workers and the unemployed to see whether it is adequate. It will also ask whether women, both inside the workforce or outside it, are achieving equitable parity with men.

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1 When mediæval law was developing, its aim was retribution and deterrence; now the law's principal aim is to provide compensation based on the principle of *restitutio in integrum.* See H McGregor *McGregor On Damages* (15 ed, Sweet & Maxwell, London, 1988) paras 9-18, 10.

The original proposals for the changes that occurred in 1974 were based on the belief that "[t]he elderly and the young must be included on a basis which recognises their past or potential contribution to the productive effort of the nation: and the housewife because of her direct and continuing contribution to that effort."[2] In 1974 when the scheme first came into force there was almost full male employment. This was still true in 1982. However, by 1992 the number of unemployed males had increased dramatically (see Table 1). Likewise, the figures of registered unemployed women have increased sharply between 1982 and 1992 (see Table 2). Table 2 shows that in 1974 approximately half of the women in the 15 to 60 year old age group were in the workforce, whereas for men the figures show that almost all men were in the workforce (see Table 3). In 1982 the figure of women in the workforce had increased to slightly over half, and by 1992 the proportion had increased to about two-thirds. The figures for women are not entirely accurate as not all women will register as unemployed. In addition, where a woman is deemed to be dependent she is not eligible to receive the unemployment benefit if her partner is working. Compensation under the schemes has, since inception, been calculated principally on loss of earning capacity. Again this has had a greater impact on women, either the unemployed or those outside the workforce, than on men, because the schemes have not provided any real and significant compensation for physical impairment unless that impairment affects the injured claimant's ability to engage in income earning work.

So, too, the accident compensation scheme, in relation to its cover for "medical misadventure", has impacted in a different way on males than on females. Although there is no supporting statistical evidence (because records are not kept), clearly women are clients of the health services more often than men.[3] Women's reproductive functions have been removed from the home environment and have become institutionalised. Natural functions have sometimes become buried by "high-tech" medical interventions. Thus women are health clients both for natural processes (particularly the birthing process) and for ill-health. Women will also come into contact with the health service, as care givers, be it as a mother, a spouse, or as a daughter of elderly parents. By and large the medical hierarchy is divided into leaders, principally male medical practitioners, and the led, principally female nurses. It is important to bear these factors in mind when looking at the impact of the accident compensation schemes on women. Women are more likely than men to suffer from "medical misadventure". Furthermore, the male dominated medical profession are the "gate-keepers" of the scheme. It is a health professional who first informs a patient that something has gone wrong and that the injury may be covered by the legislation. There may be a reluctance to accept that one's own or a fellow practitioner's actions have caused harm.

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2 *Compensation for Personal Injury in New Zealand: Report of the Royal Commission of Inquiry* ("Woodhouse Report") (Government Printer, Wellington, 1967) para 282.

3 Overseas data supports this proposition. See C Faulder *Whose Body Is it?* (1985) 4; Gadsby "Special Issues Facing Women in Medical Negligence" (1992) 3 AVMA M & LJ 5.

II THE LEGAL POSITION BEFORE 1974

Prior to 1974, the only legal remedy for those who had suffered any personal injury, apart from workplace accidents or motor-vehicle accidents, was a common law action in tort, or more rarely in contract. (In certain circumstances the perpetrator of injury could be prosecuted for a criminal offence or a quasi-criminal offence. Certain professionals were also liable to proceedings for breach of their profession's code of conduct.) Those who suffered personal injury were restricted in their right to bring a claim for damages arising out of that injury. Damages provided compensation principally for economic loss, although in rare circumstances damages would also be available for non-economic loss.[4] The claim was predicated on there being a "tortfeasor" who could be proved to have been in breach of a duty of care.

The right was enforced principally through the tort of negligence, but, where the action of the defendant was "intentional", a claim could be brought in the ancient tort of trespass to the person, which includes assault, battery and false imprisonment. For injured workers compensation was available without proof of fault under the Workers' Compensation Act 1956. This entitled the worker or the dependants of a deceased worker to compensation which was payable during periods of total or partial incapacity for work, provided that the injury arose out of and in the course of his employment or the incapacity resulted from certain industrial diseases. It was not available to the self-employed.

III THE WOODHOUSE REPORT

The accident compensation legislation had its genesis in the Woodhouse Report. Prior to 1966 there had been some dissatisfaction with the workers' compensation legislation, and the government of the day wished to implement the International Labour Convention (No 121) and a recommendation of the International Labour Organisation.[5] Accordingly a Royal Commission of Inquiry was appointed to examine the existing workers' compensation scheme and to make recommendations for legislative change. It was given the additional power to examine any associated matters which it deemed relevant to the objects of the inquiry.[6] When the Royal Commission reported in December 1967[7] its proposals were radical in that it recommended the abolition of the tort action for personal injury. In place of the tort claim and the workers' compensation scheme it recommended a comprehensive compensation scheme for every person in New Zealand (whether or not permanently resident and whether or not the injured person was earning).

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4 McGregor, above n 1, chapter 33.

5 In 1942, in a report for the United Kingdom Government, Lord Beveridge had been highly critical of the UK workers' compensation legislation on which the New Zealand Act had been modelled. Instead he had recommended a unified plan for social security; *Report of the Inter-departmental Committee on Special Insurance & Allied Services* ("Beveridge Report") (1942: Cmd 6404).

6 Above n 2.

7 Above n 2.

The evidence and submissions heard by the Royal Commission indicated dissatisfaction with the tort of negligence, the third-party motor-vehicle insurance scheme and with the workers' compensation scheme. Little, if any, attention was given to defects in the law of torts in general or, perhaps more particularly, to injuries in the course of medical treatment. The thrust of the Woodhouse Report was that the tort of negligence was a lottery. It provided compensation for a small group of the injured who could pin liability on a "tortfeasor". Benefits under the workers' compensation scheme were available for a very limited period. The Royal Commission argued that both of these schemes were expensive to operate and that the funds directed towards them could be more effectively channelled into a comprehensive compensation scheme based on proof of "personal injury by accident" rather than on proof of fault.

The scheme proposed by the Royal Commission was based on five founding principles: comprehensive entitlement, real compensation, complete rehabilitation, community responsibility, and administrative efficiency. The Royal Commission believed that compensation should be real compensation, and should be available not only for those in the workforce but also for those, principally housewives and former members of the workforce, who sustained the workforce through their unpaid endeavours.[8] Thus, as part of the principle of community responsibility, those earning had a duty to support those who were not. For without the support of the non-earner the earner would not be sustained. In other words, since society and all its members benefit from enterprises which are carried out within the framework of our society, then it is just and equitable that the community as a whole should bear the costs of accidents however and wherever they occur.

The scheme which came into force in 1974 was only loosely based on the Woodhouse proposals.[9] Nevertheless it did provide a twenty-four hour system of compensation for all personal injuries in New Zealand and regardless of cause and wherever they occurred. At that time there was no definition of "personal injury by accident" and there was a degree of uncertainty as to what was covered by the term. The scheme was essentially a workers' compensation scheme, but one which covered all accidents, so the uncertainty was not surprising. There was undeniably a lack of awareness of the many different types of "accident" which are compensatable under a scheme wherein "fault" on the part of another person is irrelevant.[10] To remedy this

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8 Above n 2, para 7, p 21.

9 After the Report was received the Government called for a white paper: *Personal Injury: a Commentary on the Report of the Royal Commission of Inquiry into Compensation for Personal Injury in New Zealand* (Government Printer, Wellington, 1969). Subsequently a parliamentary select committee, known as the Gair Committee, submitted a proposal. These latter proposals formed the basis of the legislation enacted in 1972.

10 The submissions made to the Royal Commission related to its principal term of reference (defects in the workers' compensation scheme). Defects in the tort claim in respect of accidents outside the work-place and not on the road were peripheral to the inquiry. If the terms of reference had been wider then it can be assumed that the

defect, amending legislation was passed late in 1974 providing a definition of "personal injury by accident" which remained unchanged until the Accident Rehabilitation and Compensation Insurance Act 1992 was enacted. In relation to medical accidents there had been no particular dissatisfaction with the common law system, but from the inception of the scheme it was quite clear that medical accidents were covered by the scheme as part of the package, which provided a comprehensive system of compensation for "personal injury by accident".[11]

IV COMPENSATION BENEFITS AVAILABLE UNDER THE 1982 ACT

The aim of a common law damages award is to place the injured person in exactly the same position, so far as money can do, as he or she would have been in had the accident not occurred.[12] The only form a damages award can take is a lump sum. This is in contrast to the accident compensation scheme, workers' compensation schemes and the German system of quarterly pensions. Damages are awarded once and for all, for all past, present and future losses.[13] In a personal injury claim damages will include both a pecuniary and a non-pecuniary sum.[14] In addition the common law is able to take account of future losses and, to a limited extent, of the effects of inflation.[15] Section 87 of the Judicature Act 1908 gives the court a discretion to award interest on damages. The common law has, in limited circumstances, awarded damages for mental distress. It is well recognised now that the common law will award damages for nervous shock,[16] even where the injured person is not present when the accident occurs.[17] Nevertheless, the circumstances under which such an award of damage may be made have been severely limited by the House of Lords' decision in *Alcock* v *Chief Constable of South Yorkshire*.[18] It seems that for recovery to be accepted it will be necessary to show that the injury is reasonably foreseeable and that the relationship between the plaintiff and the defendant was sufficiently proximate to warrant the recognition of a duty of care.

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accident insurance industry would have been able to provide statistical information about the incidence and cause of "accident".

11 Accident Compensation Act 1982, s 2(1) provides:
"'Personal injury by accident' -
(a) Includes -
(i) ...
(ii) Medical, surgical, dental, or first aid misadventure: ..."

12 *Liesbosch Dredger* v *Edison SS* [1933] AC 449, 459 (per Lord Wright).

13 *Fitter* v *Veal* (1701) 12 Mod 542, 88 ER 1506.

14 See SMD Todd (ed) *The Law of Torts in New Zealand* (Law Book Co Ltd, Sydney, 1991) 880.

15 *Pennant Hills Restaurants Ltd* v *Barrell Insurances Pty Ltd* (1980) 145 CLR 625; *Todorovic* v *Walker* (1981) 150 CLR 402.

16 *Mt Isa Mines* v *Pusey* (1970) 125 CLR 383.

17 *McLaughlin* v *O'Brian* [1983] 1 AC 410; *Jaensch* v *Coffey* (1984) 155 CLR 549.

18 [1991] 3 WLR 1057.

The purpose of the accident compensation scheme, as explained by the Royal Commission, is quite different.[19] The purpose of the scheme is to cushion losses due to injury largely by a system of periodic payments. For "earners" (employees and the self-employed) whose injury causes them to lose earnings either totally or partially and either temporarily or permanently, the legislation provides for earnings related compensation.[20] The scheme is based on loss of earning capacity, not on where or how the injury occurred. Unless the injury is work-related there is no payment for the first week of incapacity. The rate of payment of earnings related compensation is 80 per cent of the amount of the loss of earning capacity due to injury. In certain limited circumstances there is also provision for compensation to be paid in respect of loss of potential earning capacity.[21] Under the 1992 Act there is provision for any person who has been an earner to elect to purchase from the Corporation the right to receive compensation for loss of potential earning capacity.[22] To qualify to make such an election, the person must have been in continuous full-time employment for at least 12 months, and make the election either while still employed or within a month from the termination of employment. Such election provides cover for a maximum of two years. Where an earner dies as a result of personal injury, earnings related compensation is payable to the dependent spouse, children and other dependants.[23]

In general, there are no earnings related payments for non-earners, apart from those who are qualified to elect to receive compensation for incapacity occurring within two years from the specified date. Those who have made such an election are entitled to receive compensation for a maximum of five years from the date of the accident.[24] The scheme provides for a contribution to the cost of medical treatment and physical rehabilitation for both earners and non-earners.[25] There are also certain rights to

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19 Woodhouse Report, above n 2, para 279, pp 107-108:
- (a) The compensation purpose of the scheme is not to provide merely for need but to shift a fair share of the burden suddenly falling upon individuals as a result of personal injury.
- (b) This is a form of social insurance – not a form of social assistance. Once this general target is recognised and kept in mind apparent difficulties in subsidiary areas will tend to disappear.
- (c) Since the object is compensation for all injuries, irrespective of fault and regardless of cause, the level of compensation must be entirely adequate and it must be assessed fairly as between groups and as between individuals within those groups.
- (d) If economic reasons require preference to be given then the more serious incapacities must always have priority over short-term or minor cases.
- (e) The compensation process must not be allowed to impede rehabilitation: on the contrary it should be developed in ways which will support the important objectives of rehabilitation.

20 Accident Rehabilitation and Compensation Insurance Act 1992, ss 38 and 39.
21 Accident Rehabilitation and Compensation Insurance Act 1992, s 46.
22 Accident Rehabilitation and Compensation Insurance Act 1992, s 45.
23 Accident Rehabilitation and Compensation Insurance Act 1992, ss 58-62.
24 Accident Rehabilitation and Compensation Insurance Act 1992, s 45(8).
25 Accident Rehabilitation and Compensation Insurance Act 1992, ss 27-29.

vocational and social rehabilitation.[26] Under the 1992 legislation the emphasis of rehabilitation is on individual responsibility.

Both the 1972 and the 1982 Acts contained provisions for the payment of two lump sums, both of which were available for earners and non-earners. The first of these was for permanent loss or impairment of bodily function, based on an assessment of permanent partial incapacity, calculated as a percentage of full capacity.[27] The maximum available under this provision was $17,000. The other lump sum was payable in respect of loss of amenities or capacity for enjoying life, including loss from disfigurement, and pain and mental suffering, including nervous shock and neurosis.[28] This provision was comparable with a common law damages award for loss of amenities and loss of expectation of life.[29] For non-earners the two lump sums were the principal compensation payments to which they were entitled.

The legislation enacted in 1992 contained no provisions for lump sum payments. Thus, in effect, the lump sums have been abolished. Instead the legislation provides for the payment of an independence allowance, where the person's personal injury has resulted in a degree of disability of 10 per cent or more.[30] The maximum amount of the independence allowance is $40 per week for persons who have a degree of disability of 100 per cent.[31] For those whose degree of disability is 10 per cent the allowance will be $4 per week.

Since the early 1980s the number of unemployed has increased steadily. New Zealand now has a significant number of unemployed. More women than men are registered as unemployed (see table 3). The figures do not include non-registered unemployed. A significant, but unknown, number of women do not register as unemployed because if a woman is deemed to be dependent on her spouse she does not qualify for an unemployment benefit. While this does not have any direct relevance to the amount of compensation that an injured woman will receive, it may affect the number of reported injuries. There will be little incentive to report an injury if there is no entitlement to compensation.

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26 Accident Rehabilitation and Compensation Insurance Act 1992, ss 18-26.

27 Accident Compensation Act 1982, s 78.

28 Accident Compensation Act 1982, s 79.

29 Such damages, in respect of a death claim, were abolished in New Zealand by the Statutes Amendment Act 1937, s 17. However, the right to claim damages for loss of expectation of life, in a claim under the Deaths by Accidents Compensation Act 1952 and the Law Reform Act 1936, was reinstated by the enactment of the Finance Act 1977, which repealed the Statutes Amendment Act 1937. See M Vennell "The Accident Compensation System and the Mt Erebus Claims" (1982) 8 NZ Recent L 295, 297-298.

30 Accident Rehabilitation and Compensation Insurance Act 1992, s 54.

31 Accident Rehabilitation and Compensation Insurance Act 1992, s 54(5) prescribes the method for assessing degrees of disability.

V MEDICAL CLAIMS BEFORE 1974

Prior to 1974, when the scheme first came into force, common law claims against medical and other health professionals were uncommon.[32] There was little "claims consciousness". Nevertheless, both public and private hospitals carried insurance against liability. The medical profession belonged to one of two of the British medical defence societies, and thus received the same benefits and protections as their colleagues in that country. Most claims were settled out of court so figures about the numbers of claims are not available. Information is not available about the iatrogenic incidence of claims. Claims were available in both contract and tort. The principal available action was in negligence. The standard of care applied was that laid down in the English decision in *Bolam* v *Friern Hospital Management Committee*.[33] In New Zealand the Court of Appeal had recognised, in *Smith* v *Auckland Hospital Board*,[34] that a claim in negligence was available when a patient had asked a specific question about the risks inherent in a particular procedure and there was a failure to inform the patient about those risks. This was an early recognition of the need for consent but it was restricted to those situations where the patient had actually asked a question. As yet no general duty to inform a patient of the risks of any procedure had been recognised.

There had been two earlier reported claims alleging medical negligence. In *Furness* v *Fitchett*[35] there had been a negligent disclosure during the course of judicial proceedings of confidential information about a patient's mental health. Damages, including a punitive sum, were recovered in a subsequent action in negligence. In 1953, in *MacDonald* v *Pottinger*,[36] it was held that although proof that a pair of forceps found in a patient's abdomen after a surgical operation of itself raises an inference of negligence, this is not free from doubt. In North J's view the doctrine of *res ipsa loquitur* did not apply in the circumstances of a complicated surgical operation performed by a team. This is in marked contrast with the approach taken by courts in the United States.[37] Although there was a clear inference of negligence, no member of the team could be singled out.

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32 See G Palmer *Compensation for Incapacity* (Oxford University Press, Christchurch, 1979) 43: "[i]n New Zealand ... in 1970 there were no more than '60 arguably serious medical malpractice claims' and the total payout from insurance companies was $150,000 [footnote omitted]". Palmer's statement is based on Franklin's research discussed in MA Franklin "Personal Injury Accidents in New Zealand and the United States: Some Striking Similarities" (1975) 27 Stan LR 653, 670. Common law claims for medical malpractice have increased markedly in other common law jurisdictions since 1974. This may be due to greater claims consciousness. Here any such developments have been precluded by the legislation.

33 [1957] 1 WLR 582.

34 [1965] NZLR 161. The New Zealand Court of Appeal reversed the decision of Woodhouse J in the Supreme Court, [1964] NZLR 241.

35 [1958] NZLR 306. Now this case would probably be brought as an action for breach of confidence rather than in negligence.

36 [1953] NZLR 196.

37 See, for example, *Ybarra* v *Spanguard* 25 Cal 2d 486; 154 P 2d 687 (1944).

Without a doubt if the accident compensation scheme had not been introduced the law of torts in respect of claims for medical negligence would have followed the same developmental process as has occurred in other common law jurisdictions.[38] Here, claims consciousness has increased in other areas of professional negligence.[39]

VI "MEDICAL MISADVENTURE" UNDER THE ACCIDENT COMPENSATION ACTS 1972 AND 1982

A *Positive Acts*

Under the 1972 and the 1982 Acts there was no requirement to prove fault on the part of a health professional. All that had to be proved was that there was a damaging event (an accident) *and* a consequential and causally connected personal injury. The cases before the courts (and the Accident Compensation Appeal Authority) under those Acts fell into three classes: first, where there had been a positive action by a member of the medical profession, which resulted in injury to the patient (or where the patient's pre-existing condition worsened); secondly, where there was a failure to treat the patient for either injury or sickness; thirdly, where there was a failure to obtain informed consent to treatment, perhaps because there had been a failure to explain the risks fully. The issue was, then, to what extent a situation falling into any of these classes was a "personal injury by accident". It seems that a patient who had not suffered such an injury and did not have cover under the Act might have been able to bring an action in negligence against a doctor, surgeon, hospital or other health professional.[40] Because "fault" was not an issue, health professionals did not feel threatened, and were generally supportive of those patients claiming compensation. Evidence was therefore fairly readily obtainable to show that something had gone wrong. Where "fault" is an issue there may be difficulties in obtaining probative evidence.[41] New Zealand is a small community. The professions are collegial bodies with small numbers.

Three cases came before the High Court which directly raised the issue as to whether "medical misadventure" had occurred.[42] In all three the Court accepted the claim. In *MacDonald* Bisson J appeared to move away from the previous objective approach, that if the risk was one which was known to the medical profession then it was not medical

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38 See the discussion in Brennan *Just Doctoring: Medical Ethics in the Liberal State* (University of California Press, Berkeley, 1991) 128-133.

39 For example, in actions against solicitors and accountants.

40 According to *L* v *M* [1979] 2 NZLR 519, the claimant needed to first ascertain from the Corporation whether he or she has cover under the Act. See Accident Compensation Act 1982, s 27(3)-(5), but compare *Green* v *Matheson* [1989] 3 NZLR 564. Now see, Accident Rehabilitation and Compensation Insurance Act 1992, s 14(5), which requires the Corporation to be a party to any proceedings where cover is in issue.

41 See above n 38, 129.

42 *Accident Compensation Commission* v *Auckland Hospital Board and M* [1980] 2 NZLR 748; *MacDonald* v *Accident Compensation Corporation* (1985) 5 NZAR 276; and *Viggars* v *Accident Compensation Corporation* (1986) 6 NZAR 236.

misadventure. He adopted a subjective approach which involved looking at things from the point of view of the victim (and her medical advisers), so that if as a result of treatment things "turned out badly" for the sufferer of sickness or injury then the Act afforded cover because of the *patient's* misadventure.

It was apparent under the 1982 Act, as interpreted by the courts apparently applying those three cases, that the happening of an injurious event was examined, in relation to each victim, to see whether either the event itself was an unlikely one, or its consequences were unlikely. In some cases where there was no satisfactory reason for an occurrence, and no identifiable cause for an unexplained occurrence, it was classified as an accident.[43]

The Court of Appeal in *Green* v *Matheson*[44] said that once a "personal injury by accident" is found to have occurred, all the resultant emotional and psychological effects will fall within the statutory words "the physical and mental consequences of any such injury or of the accident".[45] Further, this case suggests that operational acts, whether they be negligent or in error, would be covered as medical misadventure under the 1982 Act; so, too, risks *beyond those normal* (that is, rare and unusual) to medical treatment would be covered. No scale of rarity was laid down. It was left to the courts to decide whether it was sufficiently unusual or unexpected as to warrant recovery.

B Misdiagnoses and Omissions to Treat

Under both the 1972 and the 1982 Acts not all cases of misdiagnosis were "medical misadventure". For example, in *Re Collier*[46] a failure to treat the correct illness because of a misdiagnosis was held not to be covered. Similarly, where there was an omission to treat at all. Thus, in *Application for Review by E*,[47] where a medical practitioner failed to respond to a call for treatment (an omission), the claim was declined by the Commission,[48] The Commission, in issuing its determination to decline the claim, said that whether or not an event was a medical misadventure required a two-pronged test. Thus it was necessary to establish that "(a) a person suffers bodily or mental injury or damage in the course of, and as part of, the administering to that person of medical aid, care or attention, *and* (b) such injury or damage is caused by mischance or accident, unexpected or designed, *in the nature of medical error or medical mishap*".

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43 *Accident Compensation Corporation* v *Mitchell* [1992] 2 NZLR 436.

44 [1989] 3 NZLR 564, which needs to be read together with *Willis* v *Attorney-General* [1989] 3 NZLR 574, (a claim in respect of false imprisonment and malicious prosecution).

45 Accident Compensation Act 1982, s 2(1)(a)(i).

46 (1976) 1 NZAR 130. The judge left it open as to whether a claim in negligence might be available. This case can be distinguished from *Polansky* v *ACC* [1990] NZAR 481 only in relation to the seriousness of the results. Had Collier been treated for the correct illness he might have survived. Had Polansky been treated for the correct illness she would not have required invasive surgery.

47 Unreported ACC Report, July 1978 (77/R1352) 44, referred to in *Accident Compensation Corporation* v *Auckland HB and M,* above n 42.

48 Subsequently, in an unreported jury trial, a court found negligence established.

VII MEDICAL MISADVENTURE UNDER THE ACCIDENT REHABILITATION AND COMPENSATION INSURANCE ACT 1992

"Medical misadventure" is defined in section 5 of the new Accident Rehabilitation and Compensation Insurance Act 1992. The drafters clearly aimed to limit the scope of medical misadventure where it was perceived that the courts had interpreted the 1982 definition too widely. Cover under the new Act is more limited than under the 1982 Act. Nevertheless, in some respects, although not in all, the boundaries are more clearly defined. The scope of section 5 is more restrictive than previously. So, too, under the new Act there may be cover but the entitlement to compensation may be restricted. Where there is cover, but no right to compensation, there will be no right to bring a common law action. This raises the possibility of argument to the effect that, common law rights having been removed and nothing having been put in their place, the courts should provide a remedy.

A "Medical Error"

"Medical misadventure" is now defined as "personal injury resulting from medical error or medical mishap". "Medical error" is "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 achieved better results." "Medical error" will not cover failures to obtain informed consent, or failures to diagnose unless negligence is established.[49] "Medical mishap" is based on a restrictive test of rarity *and* severity. It appears that very few events will fall within its scope. Where a claimant has been treated other than by a "registered health professional"[50] cover will not be available unless the event falls within the general definition of "accident".[51]

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49 Accident Rehabilitation and Compensation Insurance Act 1992, s 5(6) and (7); compare *Barnett* v *Chelsea and Kensington HMC* [1969] 1 QB 428.

50 Accident Rehabilitation and Compensation Insurance Act 1992, s 3. The definition restricts the category of "registered health professional" to doctors, nurses, chiropractors, dentists, dental technicians, occupational therapists, pharmacists and physiotherapists, together with certain laboratory technologists and podiatrists. First aid workers and ambulance attendants are not included; nor gratuitous first aid assistance by a non-registered health professional. (See *Lynch* v *Lynch* (1991) Aust Torts Rep 81-142.)

51 Accident Rehabilitation and Compensation Insurance Act 1992, s 3: "Accident" means

(a) A specific event or series of events that involves the application of a force or resistance external to the human body and that results in personal injury, but does not include any gradual process; and the fact that a personal injury occurred shall not of itself be construed as an indication or presumption that it was caused by any such event or series of events; ... but excludes any of the

Clearly, it is intended that all cases of "medical negligence", measured according to the test in *Bolam* v *Friern Hospital Management Committee*,[52] will amount to "medical error". Thus, it seems, all cases of medical negligence will be covered under the scheme. The *Bolam* test now has to be reconsidered in the light of the recent High Court of Australia decision in *Rogers* v *Whitaker* [53] in which *Bolam* was disapproved. The definition of "medical misadventure" is so complex, and the exclusionary provisions are worded in such a way, that it is far from clear what is covered. This provision has to be read alongside section 5(9), which provides that in making decisions under section 5 the Corporation is to obtain independent advice (in accordance with procedures to be prescribed by regulation).[54] Thus it seems that the decision as to whether "error" which may well be negligence has occurred will be an administrative decision rather than, as it properly should be, a judicial one. Furthermore, section 5(10) requires the Corporation to report the matter to the appropriate health professional disciplinary body when it considers that negligence or inappropriate action on the part of a health professional has taken place.

It is unclear how this provision will work in practice. Certainly it will be tested in the courts. If the Corporation determines that "error" has occurred, it is presumed that the claimant will be compensated. However, the disciplinary tribunal may then decide that the health professional acted in accordance with appropriate procedures. It is assumed that the disciplinary tribunal will not rubber stamp the Corporation's decision. In the event that the professional is exonerated, compensation could not be withdrawn. The practical effect is that health professionals will be wary of the advisory committees. Claimants may well find that the obtaining of sufficient probative evidence to establish "medical error" will not be easy. On the other hand it may be found that the decision making process will be more effective if the disciplinary hearing precedes the advisory committee hearing. If this were so the payment of compensation could be delayed.

B "Medical mishap"

"Medical mishap" is to be determined on the basis of "rarity and severity" of the outcome (section 5(1)). "Medical mishap" requires a two pronged proof:

(a) The likelihood of the adverse consequence of the treatment occurring is rare; and
(b) The adverse consequence of the treatment is severe.

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occurrences specified above that is treatment by or at the direction of a registered health professional.

52 [1957] 1 WLR 582; *Whitehouse* v *Jordan* [1981] 1 All ER 267.

53 (1992) 67 ALJR 47.

54 The Accident Rehabilitation and Compensation Insurance (Medical Misadventure) Regulations 1992 provide for the establishment of medical misadventure advisory committees to which the Corporation must refer medical misadventure cases for independent advice.

In section 5(2) "rarity" is defined as a likelihood of the adverse consequence on a probability basis of one per cent. How easy this percentage will be to apply in practice is far from clear.[55] (Data showing the incidence of iatrogenic injury is not available in New Zealand.) Furthermore, the test is subjective, as it is limited by section 5(3). Thus an injury will not be covered if, although it is generally rare, it is not rare for the injured person, and this fact was known to that person (or that person's parent, legal guardian, or welfare guardian ...).[56] In *Groves* v *AMP*[57] the patient did not know of her particular susceptibility so, provided the condition was itself rare, she would have been covered under section 5(2). If the condition was not rare then it would not be covered. But section 5(5) excludes "personal injury arising from abnormal reaction of a patient or later complication arising from medical treatment unless medical misadventure occurred at the time of the procedure".[58] Mrs Groves' claim may thus be outside the new Act. It is not clear whether a non-negligent failure to advise of the risk of harm will bring the claim within the degree of rarity as defined in section 5(1) and (2).[59] Nor is it clear whether a failure to advise of the risk of harm, thereby increasing the risk of harm, will also bring the event within the degree of rarity as defined in section 5(1) and (2).[60]

Further, section 5(4) provides that adverse consequences are severe only if they result in death or –

(a) Hospitalisation as an inpatient for more than 14 days; or
(b) Significant disability lasting for more than 28 days in total; or
(c) The person qualifying for an independence allowance under section 54 of [the] Act.

C Abnormal Reactions

Section 5(5) excludes "personal injury arising from abnormal reaction of a patient or later complication arising from treatment procedures unless medical misadventure occurred at the time of the procedure". This subsection, which was inserted by the select committee, excludes abnormal reactions or complications (whether due to "medical error" or "medical mishap"), no matter how rare or severe, which causally flow from the original procedure. Thus it seems that rare and severe side effects or reactions will not be covered unless either "medical error" or "medical mishap" took place at the time of the original treatment. It is unclear what the effect of this provision will be. Claims on all

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55 *Re Muir* [1981] NZACR 828 (the contraction of serum hepatitis from an unsterile instrument during surgery was held to be outside the normal risk of surgery, and was thus covered under the scheme); *Re Murtagh* [1984] NZACR 801 (knowledge of events and of pain whilst anaesthetised was held not to be rare and unusual in terms of the 1982 Act).

56 In a similar situation to that in *Wilsher* v *Essex AHA* [1988] 1 All ER 871, recovery would depend on the rarity of the outcome.

57 [1990] 2 NZLR 408.

58 Presumably "at the time of the procedure" means at the time of the *initial* treatment.

59 Compare *Green* v *Matheson,* above n 44.

60 Compare *Gold* v *Haringey HA* [1987] 2 All ER 888.

fours with that of Mrs Groves[61] may well be excluded. It seems, too, that cases such as *Re Lloyd: Decision 737*[62] and *Re Kishor Bava: Decision 1022*[63] will not be "medical misadventure" on any interpretation of section 5(5).[64]

What is a "later complication of treatment" will not be easy to decide. *Green* v *Matheson*,[65] one of the cases arising out of the "Unfortunate Experiment" at the National Women's Hospital in Auckland,[66] shows that there may be difficulties in deciding what is treatment and what is merely observation, and what can be regarded as part of the initial treatment and what is part of the subsequent procedures. In *Matheson* some of the so-called "treatment" (ie the initial treatment) had been given before the original accident compensation scheme had been enacted. Thus a common law claim was available, and it was not covered by the Act. The Court of Appeal held that the events subsequent to the scheme's coming into force on 1 April 1974 were all covered by the 1982 Act, and that therefore there was no claim for damages, other than for exemplary damages.[67] But now it would seem that unless, at the time of the initial treatment, there is some event which qualifies as a "medical misadventure", an abnormal reaction or later complication will not be covered. Thus in *Matheson*, because the initial procedure was not medical misadventure (as it pre-dated the scheme) and would therefore not have been covered under section 5(5), and since the abnormal reaction or later complication was not "personal injury covered by [the] Act", any damage could not arise "directly or indirectly out of personal injury covered by the Act". Therefore, in such circumstances, a claim for damages will not be barred by section 14(1).

D Informed Consent

Section 5(6) makes it clear that a failure to obtain informed consent will fall within "medical misadventure" only if the health professional is negligent in failing to obtain informed consent. Whether or not proper informed consent has been obtained, and, if not, whether there was a negligent failure to do so, will not be an easy question to answer in any given fact situation. Outside New Zealand, as was noted in the Cartwright Inquiry Report, the nature of informed consent has caused courts much difficulty.[68] In *F*

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61 Above n 57.

62 [1982] NZACR 259 (dermatitis which developed as a side-effect of treatment was held to be within the normal risks of treatment).

63 [1983] NZACR 690 (side effects from the aggressive treatment of cancer were held not to be "medical misadventure").

64 See also, *Re Wilson* (1985) 5 NZAR 33. It seems that there will be no recovery in respect of wandering or embedded IUDs (correctly inserted).

65 *Green* v *Matheson,* above n 44.

66 See *The Report of the Committee of Inquiry into Allegations Concerning the Treatment of Cervical Cancer at National Women's Hospital and into Other Related Matters* ("Cartwright Inquiry Report") (Committee of Inquiry into Allegations Concerning the Treatment of Cervical Cancer at National Women's Hospital and into Other Related Matters, Auckland, 1988).

67 See *Donselaar* v *Donselaar* [1982] 1 NZLR 97; *Auckland City Council* v *Blundell* [1986] 1 NZLR 732; and Part X below.

68 See the cases referred to at notes 78-80 below.

v *R*[69] it was held that the doctor concerned owed no duty to inform the patient of the extremely remote risk (between a half and one per cent) that the operation would fail and was therefore not negligent. *F* v *R* [70] was approved by the High Court of Australia in *Rogers* v *Whitaker*.[71] In that case it was held that a medical practitioner has a legal duty to warn a patient of a material risk inherent in a proposed treatment. In so deciding the High Court disapproved the principle stated in *Bolam*[72] that the standard of care is a matter of medical judgment. Rather, the High Court said that it is for the court to adjudicate what is the appropriate standard of care after giving weight to the importance of the patient's right to make her or his own decision about her or his life.[73] Further, the High Court held that a material risk is one which a reasonable patient, if warned of the risk, would be likely to attach significance.[74] It seems that *Rogers* v *Whitaker* has gone further than *F* v *R* in spelling out what degree of risks should be explained to the patient so that he or she can make an informed choice.

If the *Rogers* v *Whitaker* test is to be used to decide whether there has been a negligent failure to obtain informed consent difficult questions will arise as to the relationship of section 5(6) to section 5(1) and (3). If the risk is not material then the failure to obtain informed consent will not be negligent. But is "negligence" in section 5(6) the same as "medical error" in section 5(1)? If it is then it may be that "rare" and "severe" risks which were not material will be covered as "medical mishap". Nevertheless this is not free from doubt. Difficult questions may also arise in respect of the defence of necessity. The relationship of informed consent to wider issues of confidentiality, and the existence of a duty to third persons, is not affected by the legislation.[75]

The issue of informed consent was brought into sharp focus in New Zealand in the Cartwright Inquiry Report,[76] which noted that both medical law and in particular the doctrine of informed consent had, as a result of the implementation of the accident compensation scheme, failed to develop as it had in other common law jurisdictions. In some jurisdictions outside New Zealand, if a doctor has failed to give an adequate explanation of the risks of medical treatment an action in negligence may lie. In England[77] this has been limited, whereas in the United States,[78] Canada[79] and Australia[80] a doctor is required to explain to the patient all the "material risks". In New Zealand, since the coming into force of the accident compensation scheme in 1974, it

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69 *F* v *R* (1983) 33 SASR 189.
70 Above n 70.
71 (1992) 67 ALJR 47.
72 [1957] 1 WLR 582.
73 Above n 71, 51.
74 Above n 71, 52.
75 *Gillick* v *West Norfolk and Wisbech AHA* [1985] 3 All ER 402.
76 Above n 67.
77 *Sidaway* v *Governor of the Bethelem Royal Hospital* [1985] AC 871; *Chatterton* v *Gerson* [1980] 3 WLR 1003.
78 *Canterbury* v *Spence* 464 F 2d 772 (1972).
79 *Hopp* v *Lepp* (1980) 112 DLR (3d) 67; *Reibl* v *Hughes* (1981) 114 DLR (3d) 1.
80 *F* v *R*, above n 69; *Rogers* v *Whitaker*, above n 71.

has not been clear how much a doctor should tell a patient and whether there is any doctrine of "informed consent".[81] In *Bonda*[82] the Appeal Authority accepted that, where a patient had made a general inquiry about the necessity for, and the risks of, surgical intervention, which had not been answered, following *Smith* v *Auckland Hospital Board*, medical misadventure had occurred. In *H* v *ACC*[83] the Appeal Authority found that the failure to warn of the risk of an unsuccessful sterilisation operation amounted to medical misadventure. In *Tiddy*[84] (a more difficult decision) the Appeal Authority held that both partners suffered medical misadventure from a failure to warn of the dangers of unprotected intercourse resulting in pregnancy following an unsuccessful vasectomy.

It is unlikely that any of these claims would, in the absence of negligence, be covered under the 1992 Act. Nor will a common law claim lie, unless the courts apply a different test to cases alleging an absence of "informed consent" to that applied generally in negligence claims.

E Pharmaceutical or Clinical Trials

Section 5(8) excludes from cover "personal injury resulting from the carrying out of any drug trial or clinical trial", where the participant has agreed in writing to participate. There are a number of uncertainties of interpretation in this subsection. For example, what is a "drug trial", and what is a "clinical trial"? Under the earlier legislation it had never been determined whether drug or clinical trials were covered, although the issue was canvassed during the course of the Cartwright Inquiry. On the face of it, it would seem that they are not now covered, and that therefore a common law claim will be available, unless perhaps there is negligence on the part of a health professional.[85] Nevertheless, what amounts to a sufficient "agreement in writing", and how or whether it differs from "informed consent", may be in doubt. The uncertainty about the correct interpretation of this subsection is already having an effect on research in New Zealand. Both researchers and pharmaceutical companies are, not unnaturally, reluctant to engage in or support research in a climate of uncertainty about possible liabilities.

VIII DECISION-MAKING

Section 5(9) provides that in making decisions under section 5 the Corporation is to obtain independent advice (in accordance with procedures to be prescribed by regulation). "Where the Corporation considers that medical misadventure may be attributable to negligence or an inappropriate action on the part of a registered health professional" it is required to give that health professional a reasonable opportunity to comment; and, if it concludes that there may have been "negligence or inappropriate action", the Corporation is required to report the circumstances to the appropriate disciplinary

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81 In *Smith* v *Auckland HB*, above n 34, a doctor was held to have a duty to explain the risk if asked.

82 *Bonda* v *ACC* ACAA, 97/90, 27 April 1990.

83 [1990] NZAR 289.

84 *Tiddy* v *ACC* ACAA 111/90, 15 May 1990.

85 Accident Rehabilitation and Compensation Insurance Act 1992, ss 8 and 14(1).

body.[86] This is mandatory. Without a doubt its effect on any health professional whose patient is alleged to have suffered a "medical misadventure" may result in an adversarial stance being taken by the professional.

IX ACCOUNTABILITY AND RESPONSIBILITY

A Experience Rating under 1992 Act

Although the effect of section 5(10) and the introduction of sections 122, 123 and 124, creating a "medical misadventure" account funded by registered health professionals, will together provide some element of accountability for the failures of medical treatment, it seems that in practice these may have unfair results. The experience rating system used to calculate premiums may have to take account not only of "medical error" but also of "medical mishap". A system of no claims bonuses may also be introduced. As claims will arise where there is either medical error or medical mishap, health care providers may be penalised where there has been a medical mishap, even though the provider may not have been at fault. It will not always be possible to draw a line between error and mishap. Nor will it be easy to establish whether the fault is that of a health professional or perhaps a systems failure. Experience rating systems are dependent on accurate data collection. The Corporation has not been noted for its data collection in the past. Undoubtedly the impact on certain specialisations will be greater than on others. Experience rating systems are designed to encourage workplace safety and enterprise responsibility. It is said that they do not operate equitably unless there are a minimum of 1,000 employees in the particular plant. They were certainly not designed, and have never been used in any other jurisdiction, for setting premiums for a health professional insurance scheme. At the most they may hurt the pocket of the health professional but they will not provide adequate accountability.

B Quality Control

In a no-fault society quality control has to be achieved outside the compensation system. Thus the approach to dealing with complaints becomes all-important. The new legislation provides for complaint handling of "medical misadventure" claims through advisory panels. These will exist side by side with the professional disciplinary system, which for medical professionals is prescribed by the Medical Practitioners Act 1968 (which is presently expected to be reformed). At present complaints are dealt with in one of three ways: first, Divisional Disciplinary Committees, which have the power of censure; secondly, the Medical Practitioners Disciplinary Committee, which deals with allegations of professional misconduct, and has the power to fine sums of up to $1000; and thirdly, the Medical Council, which has both an appellate jurisdiction hearing appeals from the MPDC and original jurisdiction in respect of "disgraceful conduct". It can impose fines up to $10,000. All three bodies comprise medical practitioners, who sit with one lay member.

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86 Accident Rehabilitation and Compensation Insurance Act 1992, s 5(10).

Contemporaneously with the coming into force of the accident compensation scheme there has been rising public dissatisfaction with a disciplinary system which is seen as focusing on internal professional issues rather than on responsibility to patients. This was brought into sharp focus by the Cartwright Inquiry into the treatment of Cervical Cancer at National Women's Hospital in 1988. Since then all area health boards and universities have appointed ethics committees to monitor ethical issues within their area of responsibility. There has been a heightened awareness of patient rights. Advocacy services have developed in some areas. Health consumer groups, many of which concentrate on women's health issues, have sprung up. This mirrors developments in other western societies. The major difference between New Zealand and most other western societies is that in other societies a claim in tort is available and there has been a growth in malpractice claims. For example, in 1960 the total expenditure on medical liability insurance in the United States was $60 million. In 1988 it had risen to more than $7 billion. In the same period the ratio of tort claims filed per 100 doctors "rose from 1 per 100 doctors to an estimated high of 17 per 100 doctors in the mid-eighties, falling to 13 per 100 doctors at the end of the eighties".[87] In 1984 the Harvard Medical Practice Study Group reviewed more than 31,000 hospital patient records in New York State. It found that 1 in 27 hospitalisations resulted in patient injury, and that of these injuries 1 in 4 was due to negligence.[88] (Most of the patients were unaware that they had even suffered an injury.) The Accident Compensation Corporation has, up until now, not kept separate figures of medical misadventure claims. As indeed the Harvard study shows, claims are only the tip of the iceberg. It is likely, however, that there would be some similarities between the incidence of medical injury, and negligent injury, in New Zealand as in hospitals in New York State. Figures showing the number of written complaints received by the Medical Practitioners Disciplinary Committee between 1977 show a dramatic increase from under 40 per year in 1977 to 218 in 1990 and to 260 in 1991 (see table 4). Not all these complaints will have resulted in claims under the accident compensation scheme, for the reason that unless there is likely to be worthwhile compensation it is not worth the trouble and expense of making a claim. What is needed is non-threatening quality evaluation and assurance. Brennan discusses the system of quality assurance, through peer review of outcomes, as it functions in the United States.[89] He criticises its lack of openness. Similar systems function here. Here, too, there is a lack of openness, which is exacerbated by the system of discipline. The likelihood of an attribution of fault by the Corporation under the 1992 Act is unlikely to contribute to openness.

X EXEMPLARY DAMAGES

Since the Court of Appeal decision in *Donselaar* v *Donselaar*[90] it is quite clear that claims for exemplary damages are not barred, since these were held not to arise directly or indirectly out of personal injury by accident. However, all the circumstances in which

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87 PC Weiler *Medical Malpractice on Trial* (Harvard University Press, Cambridge, Mass, 1991) 2.

88 Weiler, above n 87; Brennan, above n 38, 126.

89 Above n 38, 1122-1127.

90 Above n 67; see also *Dandoroff* v *Rogozinoff* [1988] 2 NZLR 588.

such claims will be recognised are still uncertain.[91] Courts in New Zealand have now recognised that exemplary damages are available for equitable breaches.[92] The new legislation does not affect the availability of exemplary damages. Indeed, it seems that with the narrowing of cover, and the reduction in compensation benefits, an action to recover exemplary damages may well be an attractive proposition.

XI MENTAL EFFECTS

Under both the 1972 and the 1982 Acts "personal injury by accident" covered the "physical and mental effects of [the] injury or of the accident".[93] The 1992 Act, however, covers mental injury only where it is an outcome of physical injury to the injured person.[94] This means that some criminal injuries resulting only in mental consequences and injuries to third persons which result in mental suffering to a close relative are no longer compensatable.[95] Such claimants will presumably have a claim in tort. So too, claims for inconvenience and mental upset, while no longer compensatable, will clearly be actionable in tort.[96] The effect of this is that where physical injury and mental consequences coincide there may be little or no entitlement to compensation *and* no right to sue; whereas, where there is mental injury without any physical injury to the same person, there may be a right to sue.

XII THE IMPACT OF THE SCHEME ON WOMEN

A *Medical Misadventure*

As noted above, women are clients of the health system both directly as patients and indirectly as caregivers, more frequently than men, meaning that women are more likely to suffer a "medical misadventure" than men. In general women are not as well informed, by the male dominated medical profession, as men about the treatment options available to them. While it is not a-typical the Cartwright Inquiry Report[97] highlighted how women may be powerless and inarticulate in the hands of the health professions. Although section 5(6) could be seen as giving a right to be fully informed, there is no sanction, apart from medical disciplinary procedures, against a failure to inform.

It has been recognised that until the coming into force of the Accident Rehabilitation and Compensation Insurance Act 1992, the accident compensation scheme had provided

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91 *Dehn* v *Attorney-General* [1989] 1 NZLR 320.

92 See, for example, *Aquaculture Corporation* v *New Zealand Green Mussel Co Ltd* [1990] 3 NZLR 299; *Cook* v *Evatt (No 2)* [1992] 1 NZLR 676.

93 Accident Compensation Act 1982, s 2.

94 Accident Compensation Act 1982, s 3.

95 See, for example, *McLaughlin* v *O'Brian* above n 17; *Jaensch* v *Coffey* above n 17.

96 See the discussion in Todd, above n 14, 46-52.

97 Above n 66.

what amounted to insurance against liability for pharmaceutical manufacturers.[98] This is coupled with a health infrastructure which has facilitated the consumption of pharmaceutical products - but the legal and administrative structures provide inadequate consumer protection and have resulted in harm to women.[99] Although the use of pharmaceuticals may also harm many, the ill-effects of their use are likely to cause more harm to women simply because as a group female health clients may be more vulnerable in the hand of a hierarchical health system. It has been argued that women's health treatment is frequently gender discriminatory.[100]

The effect of section 5(8) is to take virtually all claims arising out of pharmaceutical and clinical trials where the injured person has agreed in writing to participate in the trial outside the ambit of the compensation scheme. Where there is no cover a common law claim will lie. Although injured women, particularly those who are unemployed, if successful in a common law claim, are likely to recover more from a damages award than would be available under the compensation scheme, the prosecution of such claims will be expensive and time consuming. The New Zealand courts do not allow class actions or provide for structured settlements. What is a "clinical trial" and what has been "agreed in writing" is not free from doubt. Claims may lie overseas in the country of manufacture but such claims are not without their difficulties.[101]

B Mental Consequences

Some criminally caused injuries are covered by the Act even though the only harm suffered may be mental injury.[102] In all other circumstances there is no recovery for mental injury not consequent on physical injury.[103] Thus, whilst it may appear advantageous to women that at least in some circumstances compensation is available for mental injuries, in practice it will make little difference because of the abolitions of the lump sum for pain and suffering which were formerly available.[104]

C Gender Discrimination in Compensation Payments

The question arises as to whether women are being treated fairly by the compensation system. The female population of New Zealand is slightly larger than the male. Nevertheless the number of males in the workforce is much higher than the number of women (see table 3). Although there are fewer women in the workforce one

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98 See P Bunkle "Withdrawal of the Copper 7: the Regulatory Framework and the Politics of Population Control" in P Davis (ed) *For Health or Profit?* (Oxford University Press, Auckland, 1992) 98.

99 See S Coney "A Living Laboratory: the New Zealand Connection in the Marketing of Depo-Provera", and S Coney "The Exploitation of Fear: Hormone Replacement Therapy and the Menopausal Woman" in Davis, above n 98, 202-203.

100 Gadsby, above n 3, 5.

101 See R Graycar and J Morgan *The Hidden Gender of Law* (Federation Press, Annadale NSW, 1990) 308-327.

102 Accident Rehabilitation and Compensation Insurance Act 1992, s 8.

103 Accident Rehabilitation and Compensation Insurance Act 1992, s 4.

104 Under s 79 of the Accident Compensation Act 1982.

might expect the number of injuries to bear a relationship to the proportion of women and men in the workforce. This is not the case. There is a greater incidence of injured male earners as compared with female (see table 5). (This may be partially explained by the fact that males tend to be employed in more dangerous occupations than females. Nevertheless the figures represent both work and non-work related accidents.) For non-earners the figures are the opposite, with a greater number of female injured than male (see Table 6; the figures for earners and non-earners are compared in table 7).

Since the scheme first came into force compensation for earners has been funded by a levy on employers. Under the new scheme the employers levy will fund the cost of work related accidents; but non-work accidents are now funded by a levy payable by all earners. Accidents to non-earners then and now are funded from general taxation. In addition, health professionals are now levied to fund the cost of medical misadventure. This levy is the only form of enterprise funding in the scheme.

Clearly female earners are not receiving a fair proportion of earners' levy income in compensation. Indeed women may be seen as subsidising men,[105] both through the employers' levy and the non-work accident levy. Under the 1982 Act both earners and non-earners were eligible for one or other of the two lump sum payments.[106] Under the 1992 Act the lump sums have been abolished. They have been replaced to a limited extent by a disability allowance, which will provide a maximum of $40 per week, calculated on a percentage basis with a minimum of 10 per cent disability. It is not clear whether "disability" means inability to work and carry out certain tasks; or whether the disability allowance will provide a small sum to compensate for non-economic losses, such as perhaps the inability to have children. Whatever the correct interpretation, it seems likely that the largely non-earning female victim of "medical misadventure" will not be entitled to any worthwhile sums by way of compensation. The Woodhouse Commission recognised that in our society it is women who, as housewives, are largely responsible for enabling the productive work on which society is dependent to be done.[107] In a time of high unemployment to forget the economic needs of a significant group of the injured is to negate the value of their input into society, and is to place a low value on unpaid work.

The threshold to establish "medical misadventure" under section 5 is a high one. It is questionable how many women will find it worthwhile to pursue a claim for "medical misadventure" when, at the end of the day, there may be no entitlement to compensation. (There may, however, be an entitlement to rehabilitation and further treatment.) Nevertheless, whether or not an injured woman is entitled to compensation of whatever amount, where she is covered she is precluded from bringing a common law claim. The new scheme was launched under the title "*A Fairer Scheme*",[108] but non-

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105 See L Delany "Accident Rehabilitation and Compensation Bill: a Feminist Assessment" (1992) 22 VUWLR 79.

106 Accident Compensation Act 1982, ss 78 and 79.

107 Above n 2, para 7, p 21.

108 *Accident Compensation - a Fairer Scheme* (Dept of Labour, Wellington, 1991).

earning women, especially those who suffer a "medical maloccurrence", may with some justification describe it as "*The Unfair Scheme*".

TABLE 1

Male Employment Figures

Male Work Force in New Zealand					
	1974	**1982**	**1991**		
Employed	828600	854000	814775		
Unemployed	607	26000	99875		
Total Working Age Population(*)	1069340	1157730	1281580		
(*) Civilian non-institutionalised usually New Zealand population aged 15 and over					
Note.					
1. These are Registered umemployed and do not include unregistered unemployed.					
2. All figures are rounded and may not add up.					
3. Information supplied by the Department of Labour.					

Male Work Force in New Zealand

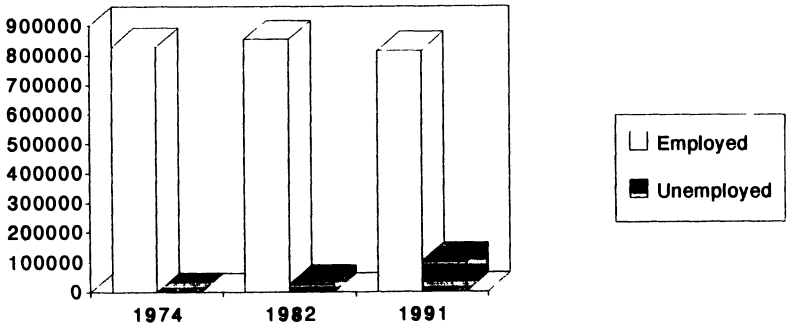


TABLE 2

Female Employment Figures

Female Work Force aged in New Zealand				
	1974	1982	1991	
Employed	358252	439000	636300	
Unemployed	348	21000	66875	
Total Working Age Population(*)	1087130	1196790	1348020	
(*) Civilian non-institutionslised usually resident New Zealand population aged 15 and over.				
Note.				
1. These are Registered umemployed and do not include unregistered unemployed.				
2. All figures are rounded and may not add up.				
3. Information supplied by the Department of Labour.				

Female Work Force in New Zealand

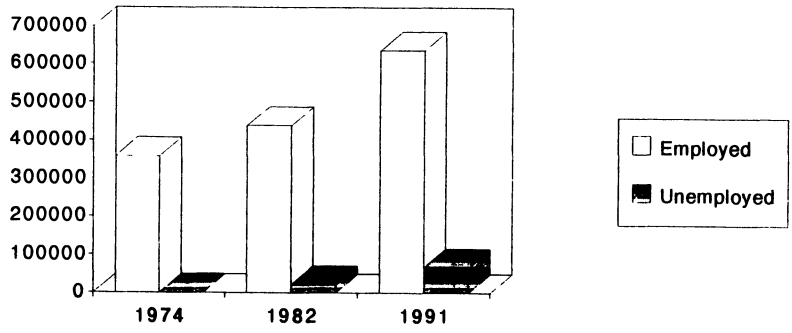
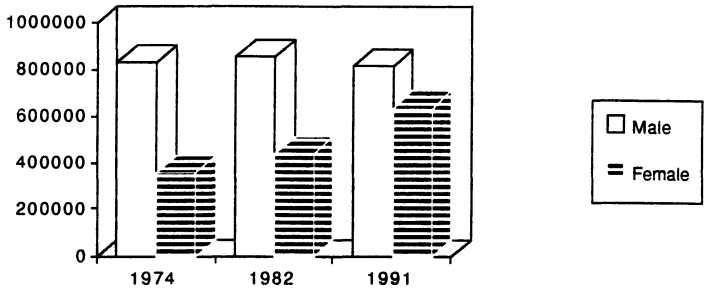


TABLE 3

Figures for Employed Males and Females



Figures for Unemployed Males and Females

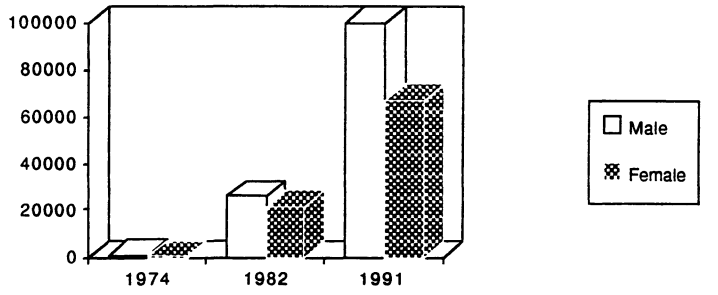


TABLE 4

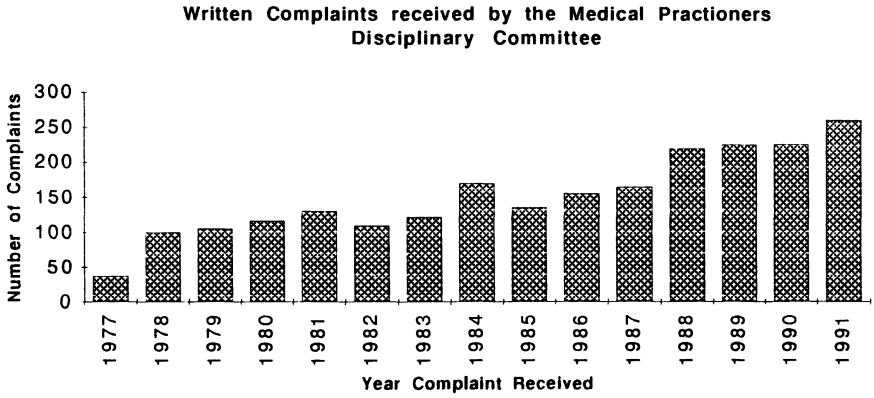
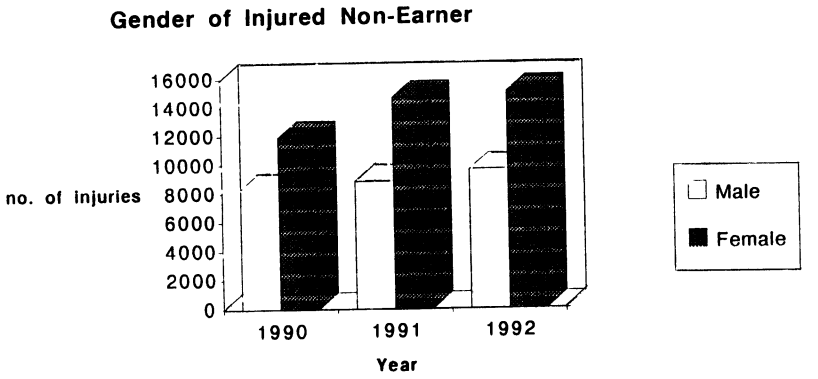

Written Complaints received by the Medical Practioners Disciplinary Committee
Number of Complaints
300
250
200
150
100
50
0
1977
1978
1979
1980
1981
1982
1983
1984
1985
1986
1987
1988
1989
1990
1991
Year Complaint Received

TABLE 5


Gender of Injured Non-Earner
no. of injuries
16000
14000
12000
10000
8000
6000
4000
2000
0
1990
1991
1992
Year
Male
Female

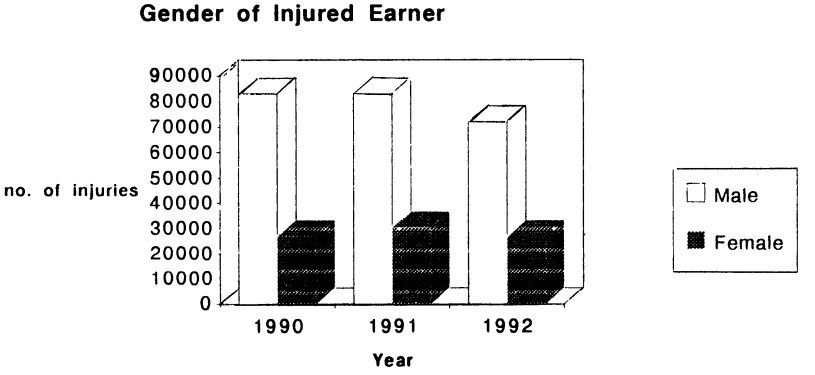

Gender of Injured Earner
no. of injuries
90000
80000
70000
60000
50000
40000
30000
20000
10000
0
1990
1991
1992
Year
Male
Female

TABLE 6

Incidence of Injury

Tables Comparing the Incidence of Injuries in Relation to Gender					
(Figures relate to the last three years)					
Gender of Injured Earner (15 years and over)					
	Male	**Female**	**Total**		
1990	82848	27074	109922		
1991	83146	30389	113535		
1992	72086	26879	98965		
Gender of Injured Non- Earner (15 years and over)					
	Male	**Female**	**Total**		
1990	8338	11907	20245		
1991	8882	14671	23553		
1992	9626	15044	24670		