NO-FAULT COMPENSATION FOR MEDICALLY CAUSED INJURY: A COMMENT ON THE CURRENT PROPOSAL

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In 1989 the Task Force on Patients' Rights recommended in its report to the Committee of Health Ministers that "no-fault" schemes should be set up in Australian states to compensate patients who have been injured by medical treatment. The author briefly discusses the issues involved in the choice between no-fault and tort in this field – in particular deterrence, accountability and allocation of costs. She then examines several aspects of the Task Force's proposal, including justifications for a limited scheme, criteria for coverage, and accountability. It is concluded that no-fault schemes should be introduced to help the plight of patients injured by medical treatment if this is shown to be financially feasible by further research into the incidence of this type of injury. An Appendix to the article sets out the stories and opinions of some patients allegedly injured by medical treatment.

I. INTRODUCTION

The shortcomings of the tort system as a means of providing compensation for personal injury have long been recognised. "No-fault" schemes have been advocated as a solution to some of these problems, and various types have been implemented. Workers' compensation and motor vehicle accident schemes in Australia are examples of a cause-based approach to no-fault,[1] whereas in New Zealand, a comprehensive accident scheme operates.[2]

One class of personal injury which has been considered as a candidate for no-fault reform is injury caused by medical treatment. In Australia, the Committee of Health Ministers referred this matter to the South Australian

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1. Motor Accidents Act 1988 (NSW); Motor Accidents (Compensation) Act 1979 (NT); Motor Accidents (Liabilities and Compensation) Act 1979 (Tas); Motor Accidents Act 1973 (Vic).
2. Accident Compensation Act 1982 (NZ).

based Task Force on Patients' Rights ("the Task Force"). In its 1989 report, the Task Force recommended that no-fault schemes should be set up in Australian states to compensate patients who have been injured by health care.[3] Some of their key recommendations which will be discussed in this article are :

* compensation should be payable for any injury or loss arising out of or caused by health treatment or care;
* deterioration through sickness or disease should be excluded;
* the inevitable consequences of treatment should be excluded;
* limits on compensation should be by limits on the amount payable, not by illogical limitations on criteria;
* funding should come from within the health care arena, including health care institutions, government, and registered health professionals;[4]
* the scheme ought to exist in lieu of the common law system of compensation, rather than as a supplement to it;
* quality assurance and disciplinary proceedings would need particular attention; and
* further cost analysis is required in each state.

Loss of earning capacity would be compensated by periodic payments; medical, hospital and rehabilitation expenses met as incurred; and lump sums paid to compensate for non-economic loss in cases of permanent disability. In cases of death, compensation would be paid to the deceased's dependants. The Task Force took the view that the scheme should be administered by a small board composed of people with a range of different backgrounds and expertise. Its recommendations are still being considered and discussed, together with other options, by the Committee of Health Ministers; no definitive decision can be expected for some time.[5]

3. Task Force on Patients' Rights *No-fault Compensation for Medical Misadventure* Adelaide, March 1989. The article's discussion is relevant to all the states, but when it is necessary to be specific, it will focus on Western Australia.
4. Although the proposal is to compensate injuries from care provided by health care institutions or registered health professionals, discussion will largely concentrate on the care provided by medical practitioners, who are usually in overall charge of the care of patients.
5. Personal communication to the author by an employee of the Western Australian Health Department.

This article will briefly discuss the issues which are involved in the choice between no-fault and tort in this field, and then examine some aspects of the Task Force's proposal, namely the justification for a specialised scheme; the criteria for compensability; problems in determining the causation of injuries; retention or exclusion of the common law; quality of care and accountability; and funding and costs. Discussion of such important matters as the level and structure of the compensation to be paid, and the method and principles of administration to be used, is omitted.

The stories of some patients injured by medical treatment appear at the end of this article, setting out their feelings and opinions about how the present system has dealt with them. This brings a more human dimension to the theoretical discussion of the issue in the body of the article.

II. COMPARING TORT AND NO-FAULT

A. Compensation

The problems for plaintiffs in bringing a tort claim to recover compensation are too well known to require detailed recapitulation here. Plaintiffs injured by medical treatment suffer the same problems as other tort plaintiffs. In brief, the drawbacks of tort are:

* the number of injured people who go uncompensated;[6]
* inequality of bargaining power in settlement negotiations;[7]
* delay;[8]

6. H Genn "Who Claims Compensation: Factors Associated with Claiming and Obtaining Damages" in D Harris (ed) *Compensation and Support for Illness and Injury* (Oxford: Clarendon Press, 1984) 45, 46; P Danzon *Medical Malpractice: Theory, Evidence and Public Policy* (Massachusetts: Harvard University Press, 1985) 19-24.
7. P Cane *Atiyah's Accidents, Compensation and the Law* 4th edn (London: Weidenfeld and Nicolson, 1987) 256, 258, 273; Harris supra n 6, 318-9; Royal Commission on Civil Liability and Compensation for Personal Injury *Report* (London March 1978) ("*Pearson Report*") vol 1 para 251; T Ison *The Forensic Lottery: A Critique on Tort Liability as a System of Personal Injury Compensation* (London: Staples Press, 1967) 14; New South Wales Law Reform Commission A Transport Accidents Scheme for New South Wales: Final Report (LRC 43 1984) para 3.25 ("*NSW Report*"); R Carlson "A Conceptualization of a No-Fault Compensation System for Medical Injuries" (1973) 7 Law and Society Review 329, 333; Danzon supra n 6, 43.
8. *NSW Report* supra n 7, para 3.78, 3.80; Ison supra n 7, 16; P Keeton and R Keeton *Compensation Systems: The Search for a Viable Alternative to Negligence Law* (Minnesota: West Publishing, 1971) 2; Harris supra n 6, 319.

* "once and for all" assessment;[9]
* negative emotional effects;[10] and
* compensation neurosis.[11]

Some particular problems with the tort system in the field of medical negligence are :

* the difficulty of choosing a solicitor with the requisite specialist experience and expertise;[12]
* the difficulty of obtaining medical records;[13] and
* the difficulty of finding expert witnesses who will testify against a colleague.[14]

No-fault has the potential to eliminate or reduce many of these problems. However, there would be some negative consequences for plaintiffs if no-fault were introduced:

* general formulae would be used to determine the amount of compensation, rather than individual assessment;[15]
* a bureaucratic process for claiming compensation would replace the opportunity for a trial as of right before a court of law;[16] and
* loss of the independence of lump sum compensation.[17]

9. Ison supra n 7, 15; *NSW Report* supra n 7, para 3.40-3.42; National Committee of Inquiry into Compensation and Rehabilitation in Australia *Compensation and Rehabilitation in Australia: Report of the National Committee of Inquiry* July 1974 ("*Australian Woodhouse Report*") vol 1, para 134.
10. *Pearson Report* supra n 7, vol 1, paras 247, 249-250; C Havighurst "Medical Adversity Insurance - Has its Time Come?" [1975] Duke LJ 1233, 1235; S Lloyd-Bostock "Fault and Liability for Accidents: the Accident Victim's Perspective" in Harris supra n 6, 160-161; C Ham, R Dingwall, P Fenn and D Harris *Medical Negligence, Compensation and Accountability* (Oxford: King's Fund Institute, 1988) 9.
11. *NSW Report* supra n 7, paras 3.72, 3.74; G Mendelson "Not 'Cured by a Verdict': Effect of Legal Settlement on Compensation Claims" (1982) Med J Aust 132; R Culpan and C Taylor "Psychiatric Disorders Following Road Traffic and Industrial Injuries" (1973) 7 Australian and New Zealand Journal of Psychiatry 32, 38.
12. Ham supra n 10, 439.
13. Task Force supra n 3, 29-30.
14. Ham supra n 10, 9; R Keeton "Compensation for Medical Accidents" (1973) 121 U Pa L Rev 590, 594.
15. *NSW Report* supra n 7, para 3.13.
16. Ibid paras 3.13-3.14; K Marks "A First in National No-fault: The Accident Compensation Act 1972 of New Zealand" (1973) 47 ALJ 516, 521; A Hutchinson "Beyond No-fault" (1985) 73 Cal L Rev 755, 764-765.
17. *NSW Report* supra n 7, paras 3.11, 3.12.

However, the benefits to plaintiffs from no-fault would outweigh these disadvantages, especially if the scheme were designed to minimise these effects.

B. Quality of Care

If the medical malpractice system deters providers of medical care from undesirable accident-causing behaviour, changing to no-fault would increase the number of medical accidents. There is a distinct lack of empirical evidence on the deterrent effects of tort liability,[18] which means that discussions on the subject have been necessarily theoretical in nature. "Economic deterrence", an influential theory, defines optimal deterrence as a minimisation of total accident costs, including both costs resulting from accidents and money spent on accident prevention.[19] This theory seems to lead to the conclusion that tort does optimally deter accident-causing conduct if all the costs of accidents that are economically worth preventing are placed on medical practitioners and hospitals, who are in a position to control expenditure on accident prevention.[20] This model assumes that the relevant behaviour is governed by totally rational economic considerations, and also that all providers have the ability to make accurate judgments about the likelihood of a low probability event (tort liability); but neither assumption is correct.[21] The major flaw in the argument that tort achieves optimal economic deterrence is that contrary to its premise, not all the costs of the relevant accidents are placed on the careless provider of treatment. This is because most injured patients do not recover tort damages,[22] and because most settlements are discounted for uncertainty.[23] Also, the widespread use of liability insurance means that an individual provider has little financial incentive to spend

18. S Sugarman "Doing Away With Tort Law" (1985) 73 Cal L Rev 555, 587; R Bovbjerg "Medical Malpractice on Trial: Quality of Care is the Important Standard" (1986) 49 Law and Contemporary Problems 321, 328.
19. G Calabrasi "Policy Goals of the 'Swedish Alternative'" in C Oldertz and E Tidefelt (eds) *Compensation for Personal Injury in Sweden and other Countries* (Stockholm: Juirsforleget, 1988) 79; Danzon supra n 6, 9-10; W Schwartz and N Komesar "Doctors, Damages and Deterrence: An Economic View of Medical Malpractice" (1978) 298 New England Journal of Medicine 1282, 1283.
20. Danzon supra n 6, 9; Bovbjerg supra n 18, 335.
21. P Bell "Legislative Intrusions into the Common Law of Medical Malpractice: Thoughts About the Deterrent Effect of Tort Liability" (1984) 35 Syracuse Law Review 939, 975.
22. See page 338-339.
23. Bovbjerg supra n 18, 331; Schwartz and Komesar supra n 19, 1284.

money on accident prevention.[24] Thus it seems likely that the economic costs of tort liability have little deterrent effect on providers' accident causing behaviour. However, non-economic costs, such as damage to the provider's professional reputation,[25] embarrassment,[26] time and energy,[27] unpleasantness and the destruction of relationships with patients[28] probably do have some deterrent effect on providers. It must not be forgotten, though, that factors which have nothing to do with tort liability also play an important part in preventing medical accidents. These include genuine concern for the welfare of the patient, fear of adverse publicity, concern for the good opinion of colleagues (especially referring physicians), the need to retain hospital privileges, professional pride, training and codes of conduct.[29] Hospitals which do not hold liability insurance have a strong financial incentive to prevent injuries.[30]

Deterrence, to the extent to which it occurs, is a positive effect of the tort system on provider behaviour. But the tort system can also have negative effects on behaviour. "Defensive medicine" is the name given to medical treatment which is motivated by a desire to avoid tort liability rather than to benefit the patient. It can include unnecessary treatment steps, reluctance to use innovative methods of treatment, disinclination to practise in high-risk specialties, refusal to treat patients seen as "malpractice risks", and the non-performance of valuable but high-risk procedures.[31] There is a lack of empirical evidence about the extent of defensive medicine, and some take the view that it may not happen at all, but to the extent that medicine is being

24. Bell supra n 21, 953; Schwartz and Komesar supra n 19, 1287; M Robinson *Accident Compensation in Australia - No-fault Schemes* (Sydney: Legal Books, 1987) 3; R Bowles and P Jones "Medical Negligence and the Allocation of Health Resources" (1988) Professional Negligence 111, 112.
25. Bowles and Jones supra n 24, 112; Danzon supra n 6, 129; Carlson supra n 7, 362; Law Council of Australia *Submission to the Task Force on Patient Rights: No Fault Compensation for Medical Misadventure* (1988) 19. Of course, damage to professional reputation can also have economic consequences.
26. Schwartz and Komesar supra n 19, 1287; *NSW Report* supra n 7, para 3.8; Danzon supra n 6, 129; Bell supra n 21, 984-985.
27. Bell supra n 21, 985; Danzon supra n 6, 129; Schwartz and Komesar supra n 19, 1287.
28. Bowles and Jones supra n 24, 112; Bell supra n 21, 985.
29. Schwartz and Komesar supra n 19, 1285; Sugarman supra n 18, 563; J O'Connell "Neo-no-fault Remedies for Medical Injuries: Co-ordinated Statutory and Contractual Alternatives" (1986) 49 Law and Contemporary Problems 125, 139.
30. Bell supra n 21, 989.
31. Havighurst supra n 10, 1235; Sugarman supra n 18, 580, 582; Carlson supra n 7, 335; Bovbjerg supra n 18, 324.

practised defensively, the tort system is having a negative effect on the quality of medical care, because the welfare of patients is not being given prime importance.

Also, due to the negative consequences of tort actions for providers, the tort system offers them an incentive to conceal or distort any information that they might have about an injury-causing incident.[32] The natural desire of providers to see injured patients compensated is overridden by self-interest.[33] The resulting behaviour of denial that there is a problem and unwillingness to get involved can be very distressing to patients and erode their trust in the medical profession. This is a detraction from quality medical care which could be prevented in a no-fault scheme.[34] Furthermore, the tort system might cause a provider to delay implementation of new safety procedures in response to an accident out of fear that such measures may suggest to a court that he had been negligent.[35]

A no-fault compensation scheme has the potential to aid accident prevention by providing a comprehensive source of statistics on the causes of medical accidents. This would enable hospitals and doctors to identify procedures which involve high risks of medical injury, and would give them the opportunity either to use alternative treatments or to develop safer ways to perform those procedures.[36]

C. Accountability

Besides their need for compensation, injured patients have other needs and motivations for which the tort system may cater. A desire for retribution may be one; but the tort system does not really further this objective,[37] which is of questionable legitimacy anyway.[38] Most victims of medical accidents are more concerned to obtain an explanation of why their injury occurred or

32. Sugarman supra n 18, 582; L Tancredi "Designing a No-Fault Alternative" (1986) 49 no 2 Law and Contemporary Problems 277, 280; Keeton supra n 8, 2; Carlson supra n 7, 338.
33. D McIntosh "A Prescription for Medical Negligence" in R Mann and J Havard (eds) *No-Fault Compensation in Medicine* (London: Royal Society of Medicine Services, 1989) 131, 134.
34. Carlson supra n 7, 362; Mann and Harvard supra n 33, 11; Tancredi supra n 32, 280.
35. Sugarman supra n 18, 5.
36. Ham supra n 10, 31; M Rosenthal *Dealing with Medical Malpractice - The British and Swedish Experience* (London: Tavistock Publications, 1987) 202-203.
37. This is because the defendant usually does not pay the damages himself, and because the plaintiff will suffer at least as much distress and inconvenience from a law suit as the defendant.
38. Cane supra n 7, 484.

an apology from the responsible provider than to obtain compensation.[39] They also place importance on making sure that the provider will not make the same mistake in future.[40] The essence of these issues is accountability. Making someone accountable means bringing home, to him and to others, the connection between his action and its consequences. Patients, and indeed society as a whole, want the medical profession to be held accountable for the quality of care it delivers, and for each provider to accept responsibility for his actions.[41] A tort action does have a limited role as an official and public forum in which the defendant's conduct is examined, although the "real" defendant is usually an insurance company.[42] However, many tort actions (especially those in which the defendant was most at fault) are settled, which means that there is often no official inquiry into the incident nor reprimand of the defendant.[43]

Despite these limitations, it does appear that tort plays a role in holding doctors accountable for their actions, so it becomes relevant to enquire whether a no-fault system would undermine this. Since such a scheme would remove the risk of judicial criticism of individual practitioners, there is a real risk of loss of accountability for the medical profession.[44]

D. Fair Allocation of Accident Costs

The arguments against the "fault principle", which underpins the tort system, have often been canvassed. The main ones are :

* that it is the insurer who pays the compensation, not the defendant;
* that the standard of care is objective;[45] and
* that the amount of compensation payable is not related to the magnitude of the defendant's fault.[46]

39. Mann and Ho supra n 33, 174; Ham supra n 10, 9.
40. Rosenthal supra n 36, 97; A Simanowitz "No Fault Compensation - Short-term Panacea or Long-term Goal?" in Mann supra and Havara n 33, 146.
41. Bovberg supra n 18, 325; Ham supra n 10, 16; Keeton supra n 8, 3.
42. C Yates "Law Commission proposals for accident compensation: What place for personal remedies?" (1989) 19 VUWLR 29, 38; Ham supra n 10, 16; Cane supra n 7, 487-488 *Pearson Report* supra n 7, para 1343.
43. Cane supra n 7, 487; Sugarman supra n 18, 609.
44. Mann and Havard supra n 33, 10; Rosenthal supra n 36, 179.
45. *Austration Woodhouse Report* supra n 9, vol 1, para 95.
46. Ibid; Cane supra n 7, 414; Ison supra n 7, 17.

There is evidence that, contrary to what has been asserted by some, the fault principle does not necessarily accord with community expectations.[47] Cost-spreading is now seen as a better principle to apply in allocating accident costs, as it makes a loss easier to bear and is fairer to victims.[48]

There remains a need to justify imposing the cost of accidents on a certain group of people.[49] One justification may be that the group is the one best able to avoid accidents. Placing the cost on them would help the cause of prevention by creating an incentive for that group to work for accident prevention.[50] In the case of medical malpractice, this argument would point to providers of medical care as the group best suited to bear accident costs. Of course, they would still pass most costs on to the government and patients through higher fees.

Another possible approach would be to spread the cost of accidents over the community as a whole, using the arguments of social solidarity and community responsibility for accidents as justification.[51] The whole community benefits from the results of good medical treatment, so it could be argued that it should also bear the burden of its bad results.[52] It will be very much a matter of personal political view whether one accepts that such considerations justify having society as a whole bear the cost of accidents.

In the case of medical malpractice in Australia, it would make little difference in practical terms whether the cost were placed on providers or on society generally, since if the cost were imposed on providers, the community at large would still bear the majority of it through Medicare. However, placing the cost on providers could be a useful symbol and reminder of their accountability for the quality of care they deliver.

47. Lloyd-Bostock supra n 10, 159.
48. Cane supra n 7, 478-479.
49. Hutchinson supra n 16, 757.
50. G Calabrasi "The Decision for Accidents: An Approach to No-fault Allocation of Costs" (1965) 78 Harv L Rev 713, 726.
51. J Fleming "Is There a Future for Tort?" (1984) 58 ALJ 131, 138; *Australian Woodhouse Report* supra n 9, vol 1, para 254.
52. R Mann "No-fault Compensation: A Discussion Paper" in Mann and Havard supra n 33, 5, 8.

E. Efficiency

There is no doubt that the tort system is expensive to run. Administrative costs constitute nearly half the total cost of the system.[53] This cost is partly due to factors such as heavy spending on brokerage and advertising by insurance companies;[54] the cost of examining in detail the cause of each accident; the cost of separate assessments by each party regarding fault and the quantum of damage; and legal costs.[55] Moreover, the total cost of the tort system for medical malpractice goes beyond mere financial cost : it includes public spending on courts and judges, the negative effects on medical practitioners and availability of care, the impact of delay on patients, the cost of time lost by plaintiffs and defendants, plus damage to doctors' reputations and patients' trust in them.[56] No-fault schemes cost much less to administer than the tort system, allowing more money to be spent on compensation.[57]

F. Malpractice Crisis ?

The term "malpractice crisis" is usually used to describe a situation in which physicians' liability insurance premiums rise, leading to a decline in the availability of insurance and to low recruitment in high-risk specialties. The United States of America experienced such crises in the mid 1970s, and again since 1985.[58] While the exact causes of these crises are unclear, positive measures which would decrease the likelihood of a malpractice crisis occurring in Australia include: improving the quality of health care to lower the number of incidents which could lead to claims; spreading accident costs evenly over the profession, rather than placing a heavy burden on practitioners in high risk areas; and possibly removing the insurance industry from its current role in fixing premiums. These steps could be taken in the context of a no-fault scheme.

53. Ison supra n 7, 28-29; *Pearson Report* supra n 7, vol 1, para 261; Danzon supra n 6, 16.
54. Cane supra n 7, 449.
55. Ibid, 449-450.
56. Bovbjerg supra n 18, 321.
57. Accident Compensation Corporation *Annual Report 1989*, 35; Ham supra n 10, 23. New Zealand's accident compensation scheme spends 6% of its funds on administration, and Sweden's patient compensation scheme about 16%.
58. Rosenthal supra n 36, 11; Danzon supra n 6, 107.

G. The Verdict

It seems clear that the tort system is not the ideal method of providing compensation for injured patients. It can have negative effects on provider behaviour. However, before it can be decided to replace it with a no-fault scheme, the tort system's positive effects in the areas of deterrence and accountability need to be considered.

The issue which commands most attention is whether the possible (but unproven) deterrent effect of the tort system outweighs its drawbacks as a compensation system. Each side in the debate has tried to cast the "onus" of proving or disproving deterrence onto the other side: those in favour of tort say that advocates of the no-fault system must prove that tort has no significant deterrent effect,[59] while those opposed to tort say that those who want to keep it must show that it does have a deterrent effect.[60] Given the improbability of being able to obtain clear evidence either way, the possible deterrent effect of the tort system should not be allowed to prevent the development of a no-fault scheme. However, any such scheme should be developed with the issue of deterrence and prevention in mind. Quality of care and compensation would be pursued separately, allowing a rational and considered approach to each objective.[61] Likewise, tort's "accountability function" should not be allowed to stand in the way of a no-fault scheme, so long as satisfactory alternative accountability measures can be developed.

The remaining barrier to a no-fault scheme is its cost. Although administrative costs would be much lower than the running costs of the tort system, there would be a large rise in claims, given the small proportion of successful medical malpractice plaintiffs to injured patients. It is impossible to know in advance what number of valid claims there would be, but it seems unlikely that a no-fault scheme would be any less costly than the tort system overall.[62] It then becomes a question of politics whether society is prepared to pay extra to achieve a better and fairer compensation system for medical injury.[63] The possibility that it is not should not prevent a proposal for a better system being put forward for discussion and costing.

59. Bovbjerg supra n 18, 335.
60. D Starr "The No-fault Alternative to Medical Malpractice Litigation: Compensation, Deterrence, and Viability Aspects of a Patient Compensation Scheme" (1989) 20 no 3 Texas Tech Law Review 803, 808; Sugarman supra n 18, 586-590
61. Starr supra n 60, 808; Ham supra n 10, 28.
62. R Keeton supra n 14, 592-593; McIntosh supra n 33,142.
63. Fleming supra n 51, 138.

III. THE TASK FORCE'S PROPOSAL

A. Justifications for a Limited Scheme

There is a general consensus amongst commentators that, in an ideal society, making distinctions in the provision of assistance between injured people whose needs are equally great on the basis of the cause of their injuries cannot be justified. This leads to a rejection of the distinction often made between accident victims and disease sufferers.[64] An illustration of this attitude was New Zealand's plan in 1990 to expand its no-fault accident compensation scheme to cover all incapacity.[65] However, once it is decided that all people suffering physical incapacity should be compensated, the preference of this group over others who have needs (for example, the unemployed and the poor) requires justification.[66] While it may be desirable to help all those in need of financial assistance, the physically incapacitated are a special group because they have health problems and are also open to financial hardship. Those whose need is purely economic can be seen as better off, as they still have unimpaired bodily capacity.

Given limited funds, what should be the priorities between subgroups of the physically incapacitated? Approaches which have been suggested include helping the long-term disabled first,[67] or spreading the available resources equally in the form of low but uniform benefits.[68] A third approach is to have specialised schemes based on the cause of the injury, justified on pragmatic grounds. Australia has already taken steps in this direction, with workers' compensation schemes in all jurisdictions, and no-fault motor vehicle accident schemes in some states. Small reforms have more political chance of being enacted than large reforms,[69] and can sometimes be justified

64. Ison supra n 7, 35; Id *Accident Compensation: A Commentary on the New Zealand Scheme* (London: Croom Helm, 1980) 22; Cane supra n 7, 446; Harris supra n 6, 334-336; J Stapleton *Disease and the Compensation Debate* (Oxford: Clarendon Press, 1986) 115; Havighurst supra n 10, 1241-1242.
65. Accident Compensation Corporation Annual Report 1990, 5. This plan was to come into effect in April 1991, but seems to have been shelved after New Zealand's change of government in October 1990. W Birch (Minister of Labour, New Zealand) *Accident Compensation: A Fairer Scheme* (Wellington, 1991) 14-15.
66. Stapleton supra n 64, 178-183.
67. Harris (ed) supra n 7, 336-337.
68. Stapleton supra n 64, 147.
69. G Palmer *Compensation for Incapacity: A Study of Law and Social Change in New Zealand* (Wellington: Oxford, 1979) 197; Cane supra n 7, 573.

on the ground that they more effectively use existing resources.[70] The philosophy here is that rather than doing nothing because the ideal solution is not currently achievable, it is better to do something beneficial. Also, limited no-fault schemes might pave the way for comprehensive reform by getting the public accustomed to the no-fault idea and creating pressure for anomalies to be removed.[71] The example of this effect in New Zealand (the previously planned expansion of the accident compensation scheme to sickness) has largely disarmed the contrary argument that such an approach will impede reform.[72] However, a problem with the limited scheme's approach is that each system will have borderline cases, which take up an inordinate amount of resources to adjudicate. The greater the number of schemes, the more borderline cases there will be. The extra cost generated is a waste of resources which could otherwise be used for compensation.[73]

Two special factors in the area of medically caused injuries justify a specialised scheme for injured patients. The first is that patients place themselves under the care of medical experts, having no practical choice but to accept their advice. Patients are not in this position by choice, but through necessity.[74] All cases of professional negligence involve the element of a layman relying on the judgment of an expert, but, in contrast to other potential professional negligence plaintiffs, patients put not only their financial security but their health and their lives in the hands of doctors.[75] These special circumstances which apply in cases of medically caused injury set injured patients aside from other disabled people, making it especially fitting that they should be appropriately compensated. The second factor justifying such a specialised scheme is the particular difficulty of establishing a case in this area, which renders the tort system incapable of adequately compensating injured patients.[76]

70. Havighurst supra n 10, 1242; Cane supra n 7, 575-576.
71. Fleming supra n 51, 139; Starr supra n 60, 827; Ison supra n 64, 22; Cane supra n 7, 573, 576.
72. For examples of such arguments see Sugarman supra n 18, 623-627; Stapleton supra n 64, 110.
73. Cane supra n 7, 393.
74. *Pearson Report* supra n 7, vol 1, para 1352; J Hellner "The Swedish Alternative in an International Perspective" in Oldertz supra n 19, 34.
75. An exception to this proposition is occupants of a building designed by an architect.
76. Stapleton supra n 64, 93.

B. Criteria for Coverage

* Compensation should be payable for any injury or loss arising out of or caused by health treatment or care;
* deterioration through sickness or disease should be excluded;
* the inevitable consequences of treatment should be excluded;
* limits on compensation should be by limits on the amount payable, not by illogical limitations on criteria.[77]

By excluding disease, the Task Force embraced the principle that a compensation scheme should not guarantee the success of medical treatment, but they did want to include known risks of treatment in the scheme.[78] It is the view of the author that a middle way must be found between a scheme that ensures the success of medical treatment and one that requires fault (or something similar) before compensation will be granted. This section will propose such a middle path and discuss the principles underlying the choice of criteria.

As the Task Force pointed out, the criteria for compensation should be as clear and simple as possible, so as to keep adjudication and uncertainty costs to a minimum.[79] It has been suggested by many commentators that the best approach would be to list specifically in medical terms the events that would be compensable.[80] However, such a system would have the disadvantage of limiting compensation to the types of medical injuries which are known beforehand to be possible. It would exclude, for no particular reason of principle, those who suffer from a new and totally unexpected type of injury. For example, a haemophiliac may have contracted AIDS from contaminated blood products before this possibility was realised. Given an exhaustive list of compensable events, his injury would not be covered, even though it was caused by medical treatment. A more general outline of the sorts of injuries covered would be of greater use and more widely applicable. An approach which specifies various different categories of medical injury seems to be more able to clearly convey what is included and what is excluded than a single brief phrase such as "medical misadventure", while remaining applicable to new situations.[81]

77. Task Force supra n 3, 57-61.
78. Ibid, 60.
79. Ibid, 59; Starr supra n 60, 821.
80. Starr supra n 60, 830; Havighurst supra n 10, 1254; Tancredi supra n 32, 277.
81. Sweden's Patient Compensation Scheme has successfully employed such an approach, while New Zealand has had many problems in applying its "medical misadventure" test.

What should be the principles governing the coverage of the scheme? In the absence of a scheme for compensating all sickness and disease, a scheme which pays compensation for every ailment or symptom not cured by, or remaining after, medical treatment is not appropriate.[82] This entails making a distinction between a failure to alleviate or cure the original condition, and a new injury caused by medical treatment. However, to cover the situations currently encompassed by the tort system, a no-fault scheme would have to compensate at least those whose condition has been made worse by the negligent failure of a provider of medical care either to diagnose correctly the condition, or to take the right steps to treat it. Since the aim of a no-fault scheme is to do away with inquiries in which a doctor's behaviour is measured against a certain standard of competence, an approach based on more objective facts is desirable.

In the case of failure to diagnose, the criterion for inclusion in the scheme should be whether, on the basis of symptoms which were probably observable at the time of the consultation, current medical knowledge was such that the condition *could* have been diagnosed. This focus on what was medically possible (which could usually be established from medical textbooks and journal articles) seems simpler and clearer than requiring a determination of what a doctor *should* have been capable of doing.

When the injury arises out of an omission to take available steps to cure the condition, the test should be whether, according to current medical knowledge, the treatment was clearly more likely to benefit the patient than harm him. In cases of disagreement between responsible sections of the profession about this, no compensation would be payable. The injury would be covered only if the patient had clearly placed himself under the provider's care and advice. General rules would have to be devised to establish when this would be deemed to have occurred. Such a test comes very close to simply restating the negligence test, but it seems necessary here to define coverage in terms of whether the treatment was likely to be beneficial, as it would not make sense to compensate someone because a treatment which was likely to do more harm than good had not been administered. As it will not often be the case that significant and permanent harm is done by an omission which cannot be remedied by redressing the omission, this test will not need to be used very often.[83]

82. Legal Services Commission of South Australia *Submission to Patients' Rights Task Force* (SA Task Force Submission) 22.

83. Danzon supra n 6, 26.

For injuries caused by active treatment measures, an inclusive approach should be taken. An injury that is the result of a known risk being taken still results in a need for compensation, as the Task Force has recognised.[84] Such a situation can be distinguished from the deliberate taking of a risk of an injury which is less serious than the original condition. A patient could be deemed to have accepted the risk of a relatively minor injury, as he would presumably have gone ahead with the treatment even if he believed that he would suffer such an injury. In contrast, where the injury is graver than the original ailment, it would be unexpected, as the patient would not have agreed to undergo the treatment if he actually expected to be worse off afterwards.[85] Compensation should be paid whenever the patient is left worse off than before because of medical treatment. The criterion could be drafted along the following lines : a new injury (as distinct from a deterioration of the original condition) arising out of medical treatment or care will be compensated, unless the patient knew of the risk of this type of injury *and* his condition is on the whole better after the treatment than before. The exception would cover known and acceptable (to the patient) side effects of treatment, such as hair loss from chemotherapy. To compensate for such side effects would be beyond the scope of a scheme whose focus is to compensate where medical treatment has caused harm, because in such instances the treatment will have resulted in a net benefit to the patient.[86]

C. Problems of Causation

The causation issue is a complex and problematic one in medical injury claims. Plaintiffs seek medical treatment because they have health problems, thus it is often hard to establish whether a subsequent injury is due to the doctor's negligence or to a pre-existing condition. Since the no-fault scheme being proposed is specific to medically caused injuries, this issue still remains. Two difficult causation situations come to mind. First, in making the distinction between, on the one hand, a failure to halt the natural progress of a condition and, on the other hand, a new injury caused by medical treatment, it is difficult to know into which category the aggravation of a condition by treatment would fall. This is really a question of causation : whether the true cause of the deterioration in condition was the treatment or the progress of the

84. Task Force supra n 3, 60.
85. W Gellhorn "Medical Malpractice Litigation (US) - Medical Mishap Compensation (NZ)" (1988) 73 Cornell Law Review 170, 191.
86. *Pearson Report* supra n 7, vol 1, para 1307.

condition itself. Also, for the injury to be compensable, it would have to be shown that the deterioration would not have occurred in any case. The other difficult causation problem is post-operative infection. As the action here takes place on a microscopic level, it will usually be impossible to know the source of the infection, and therefore whether it should be attributed to the operation or subsequent care. Sweden's no-fault medical injury compensation scheme deals with this problem with a rule that infection injuries will be compensable except when it seems probable that the bacteria responsible were already present in the patient (this will be presumed when the operation was on certain parts of the body which are assumed to have bacteria present), or when the patient had an unusually low resistance to infection. This seems to be the best way of dealing with the causation problem posed by post-operative infections.

Problems in establishing causation have been seen by some as significant obstacles in the way of a specialised medical injury scheme.[87] However, the style of adjudication of claims in a no-fault system would ease this problem. The injured patient would no longer be in the position of trying to prove a case against a hostile opponent; rather, the adjudicators would work with him to identify the probable cause of his injury.[88] They could gather a group of experienced physicians in different areas of specialty, each of whom could be trusted to give a fair and competent view on causation,[89] and would only need to go beyond the opinion of the relevant specialist if the claimant could find several experts who disagreed with the chosen specialist's opinion. This seems a reasonable way to balance the aims of simple and non-contentious procedure and fairness to claimants. In cases in which the adjudicators are almost, but not quite, satisfied of causation to the required standard, an ex gratia payment of part of the compensation which would be payable under the scheme would be possible.[90]

87. Danzon supra n 6, 214; *Pearson Report* supra n 7, vol 1, para 1364; Starr supra n 60, 813.
88. Mann and Havard supra n 33, 170.
89. Mann supra n 52, 10.
90. Starr supra n 60, 813.

D. Exclusion of the Common Law

* The scheme ought to exist instead of the common law system in this area, rather than as a supplement to it.[91]

It has been argued by some that, were a no-fault scheme for medically caused injuries established, the tort remedy should remain for those who might wish to use it.[92] However, if it were retained, the medical profession would need to keep paying liability insurance premiums in addition to levies.[93] This double payment would make the scheme politically unacceptable to the profession and might prevent it from being passed. Also, the possibility of being sued for negligence would revive such negative effects on provider behaviour as evasiveness to injured patients, jeopardising the openness that would otherwise be a benefit of a no-fault approach.[94] In addition, if, as some have proposed, a ceiling were to be placed on the amount of compensation available from the no-fault scheme, with tort available for the rest of the loss, it would be the most seriously injured who would need to use the common law option, even though they are the group for whom it works most inefficiently.[95]

E. Quality of Care and Accountability

* Quality assurance and disciplinary proceedings would need particular attention if a no-fault scheme were introduced.[96]

The Swedish no-fault scheme collects information about causes of injury. This information has been used to inform the medical profession about risks, and also to pinpoint some areas of high risk on which to concentrate research into safer methods.[97] Also, reports of paid claims are sent to the provider of the treatment,[98] and this tends to encourage self-examination of conduct and thought about whether the standard of care being delivered could be improved. This practice continues the connection between the injured patient

91. Task Force supra n 3, 70.
92. SA Task Force Submission supra n 82, 23; *Pearson Report* supra n 7, vol 1, para 299-305.
93. For a discussion of the sources of funding of the scheme, see infra pages 357-359.
94. See page 341.
95. Cane supra n 7, 550-552.
96. Task Force supra n 3, 70.
97. C Oldertz "Compensation for Personal Injuries : The Swedish Patient and Pharma Insurance" in Mann and Havard supra n 33, 29; Ham supra n 10, 24; Rosenthal supra n 36, 185.
98. Rosenthal supra n 36, 185.

and the provider, rather than having the patient comfortably out of the provider's sight, and perhaps out of his mind. Both these Swedish procedures should be adopted in the event of a no-fault scheme being introduced.

However, if tort were to be replaced by a no-fault compensation scheme, more than these mild prevention and accountability measures would need to be taken.[99] One suggestion for incorporating a deterrence function into a no-fault scheme is to make the levies payable by health care providers depend on their claims experience; that is, impose higher levies on those who have had a greater number of paid claims arising from their activities.[100] However, there are several reasons why this would not be a good idea. First, it would give providers a financial incentive to be obstructive to claimants, rather than helpful, and this would undermine the aim of an effective non-adversarial compensation system.[101] Secondly, such experience rating is administratively expensive.[102] Thirdly, it must necessarily rely on information from years past, so that any effort on the part of a provider to improve his record would not be reflected in costs for some time: this would significantly reduce its deterrent effect. Fourthly, given that a claim against a provider does not necessarily mean that he is at fault, it seems unfair and contrary to public policy that his contribution rate could be affected.[103] For example, a doctor's specialty may involve procedures which pose a considerable risk to patients, but which have the potential for great benefit. Under a system of experience rating, such doctors would pay high levies, even though their conduct would not necessarily be undesirable.[104]

Another possible way to deter injury-causing conduct would be to publicise the names of those providers who have had a high incidence of claims against them.[105] However, this is open to some of the same objections as experience rating, namely, that it would be unfair because it is not based on fault, and would be likely to cause providers to contest claims.[106]

99. Starr supra n 60, 809; Ham supra n 10, 18, 26, 33.
100. Starr supra n 60, 811-812; Havighurst supra n 10, 1250-1252.
101. Mann and Havard supra n 33, 110-111.
102. Bowles and Jones supra n 24, 113; Stapleton supra n 64, 136; Danzon supra n 6, 95; Hellner supra n 74, 36.
103. Carlson supra n 7, 364.
104. Schwartz and Komesar supra n 19, 1289.
105. Starr supra n 60, 811-812.
106. Ibid, 824.

It seems clear that structures for accountability and prevention external to the no-fault scheme would have to be established, always ensuring that they do not adversely affect compensation and are not unfair to providers. Compensation claims would be a good source of information for these purposes, but again this would give providers an incentive to obstruct claimants and cover up injuries.[107] It seems that these separate prevention and accountability systems would have to rely on patient complaints and perhaps references from within the medical profession to obtain information about incidents which might require investigation. This would have the advantage of encouraging providers to cultivate good relationships with their patients, so as to decrease the possibility of patient dissatisfaction. Overseas and Australian experience has been that a large proportion of patient complaints are due to a breakdown in communication between a provider and his patient.[108] It seems appropriate to have a separate system to deal with these complaints from the one which deals with complaints arising from a perceived inadequacy in the treatment administered.[109]

A possible model for dealing with minor complaints is the Victorian complaints unit, which handles complaints against public and private health care services, both institutional and individual.[110] The unit is an autonomous statutory body, answerable directly to Parliament, and is headed by a Health Services Commissioner, who has a general responsibility for quality control in health services. The unit finds that many complaints are settled simply by referring the patient back to the point of service, and offers clerical support to complainants for this purpose. If the problem is not resolved by such communication, a more formal conciliation procedure takes place. This is made more effective by the fact that evidence given during conciliation is confidential, and may not be used in litigation or registration board proceedings. The unit has been successful, having reconciled 80 per cent of the claims with which it has dealt. The Health Services Commissioner also has the power to make investigations into appropriate matters.[111] The Western Australian Health Department is currently planning a complaints unit based

107. The Swedes have given force to this objection; contra, Starr supra n 60, 825-826 and Carlson supra n 7, 366.
108. P Fouracres "Victorian Complaints Unit" (1990) 6 Headway 8.
109. Rosenthal supra n 36, 156.
110. Supra n 108; Health Services (Conciliation and Review) Act 1987 (Vic).
111. Ibid; Law Council of Australia supra n 25, 5-7.

on this model,[112] which will be a very significant step towards accountability and good doctor-patient relations.

The body which currently deals with major complaints about medical practitioners in Western Australia is the Medical Board ("the Board"), which is in charge of the register of medical practitioners. It consists of six medical practitioners, one lawyer, one public servant from the consumer area and one lay person.[113] It must hold an inquiry when it appears that a medical practitioner may be :

(a) guilty of infamous or improper conduct in a professional respect;
(b) affected by a dependence on alcohol or addiction to any deleterious drug;
(c) guilty of gross carelessness or incompetence;
(d) guilty of not complying with or contravening a condition or restriction imposed by the Board with respect to the practice of medicine by that medical practitioner; or
(e) suffering from physical or mental illness to such an extent that his or her ability to practise as a medical practitioner is or is likely to be affected[114]

The inquiry resembles a court proceeding, with witnesses and representation for the parties (complainant and defendant) before the Board. If any of the matters in paragraphs (a) to (d) is found to be made out, the Board may deregister or suspend the doctor, or fine or reprimand the doctor, or impose restrictions and conditions on the doctor's practice of medicine. If the matter is one of physical or mental illness, the Board may do any of the above except fine or reprimand the doctor. An appeal lies for the medical practitioner to the Supreme Court.[115]

The Board's role is significant in that it informs the profession about standards and holds inquiries into the quality of treatment being delivered, thus signalling to the public and the profession that medical practitioners are accountable for the quality of care they provide.[116] However, as the Board's overall effectiveness is limited, its activities should be extended in a number

112. Supra n 108, 8; Media Statement, Premier of Western Australia, P91/23, 25 February 1991; personal communication to the author. The necessary legislation will be put to the spring session of Parliament.
113. Medical Act 1894 (WA) s 4(1a).
114. Ibid, s 13(1).
115. Ibid, s 13.
116. Rosenthal supra n 36, 202.

of ways, especially if the tort system were to be abolished. First, its jurisdiction should be extended to cover all the individual health providers covered by the no-fault scheme; otherwise, there would be no real sanction for sub-standard care against health care providers who are not doctors. Secondly, lay and consumer representation on the Board should be increased significantly; for example, the Board could consist of equal numbers of providers and non-providers, plus one lawyer. This would place more emphasis on accountability of health care providers to the public. The Swedish Medical Responsibility Board has a similar composition, and the medical profession there is not dissatisfied, as the doctors on the Board still exert a strong influence on proceedings.[117] A third suggestion is that the Board be empowered (but not required) to inquire into cases of negligence and carelessness that are not gross. This would be necessary to ensure that the Board has the potential to examine even relatively minor negligence, which may be appropriate if the negligence is habitual. Since these changes would necessitate more expenditure by the Board, an increase in resources would be necessary. This could be achieved by increasing annual practise fees, or by the Western Australian government providing the extra funds in recognition of the savings in court costs resulting from the abolition of medical negligence actions. Matters could be referred to the Board by the complaints unit, or by complainants themselves. However, individual complainants could be subject to an order against them for costs if the allegation was found to be unjustified. This would encourage patients to take their complaints initially to the unit, rather than straight to the Board.

F. Funding and Cost

* Funding should come from within the health care arena, including health care institutions, government,[118] and registered health professionals;
* Further cost analysis is required in each state.

The recommendation of the Task Force regarding the source of funds for the scheme seems fair and should be politically acceptable, since it largely preserves the status quo. In addition, it would ensure that the costs of

117. Ibid, 133, 148.

118. Contributions from the Commonwealth government could be in recognition of the savings that would be made in social security benefits (Task Force) supra n 3, 73 and contributions from the State government (other than through health care institutions) could be in recognition of savings in court costs.

accidents were taken into account at a planning level in institutions like hospitals.[119]

The major question is whether such a scheme would be affordable. Because so few injured patients are successful in establishing a claim of negligence, a no-fault scheme is likely to see a dramatic increase in paid claims over successful tort cases. The overall increase or decrease in the cost of compensation would depend on (a) whether a significant saving could be achieved in each case and (b) whether the number of claims increased. The percentage of expenditure on administration in the proposed scheme would likely be greater than that in the comprehensive New Zealand scheme (which is six per cent), because medical injuries often involve a difficult causal issue,[120] and because, as the proposed scheme will be smaller, there will be less economies of scale. The administrative cost would probably be over 10 per cent of expenditure, but would almost certainly still be significantly less than the 50 per cent that the tort system consumes in administration.[121] However, there is unlikely to be any saving in the amount of actual compensation paid out on each claim. Even though the Task Force recommended a discount of 15 to 20 per cent on compensation for loss of earnings,[122] most common law settlements are also discounted for uncertainty.

The number of claims that would be made on a no-fault scheme is the most important variable in the calculation but is also the hardest to estimate. The Task Force used the Swedish system as a guide to the possible increase; this suggested that claims would less than double.[123] However, the Swedish social security system must be taken into account; its no-fault system is only a top-up for generous earnings-related social security benefits.[124] Western Australians, who might otherwise be dependent on flat-rate subsistence level social security benefits, would seem much more likely to find claiming compensation worthwhile. Also, the proposed scheme is wider in scope than the Swedish scheme. The situation might in reality be more accurately estimated by using a Californian figure that only one in 25 injured patients claim under

119. Bowles and Jones supra n 24, 115.
120. See pages 351-352.
121. See page 345.
122. Tasl Force supra n 3, 69.
123. Ibid, 74.
124. *Pearson Report* supra n 7, vol 3, para 590-594, 633; Ham supra n 10, 23; Hellner supra n 74, 17-18, 28.

the tort system.[125] Assuming that most of those entitled to claim will do so, this would mean that claims would increase 25 fold. If a 40 per cent saving in administrative costs could be achieved, a no-fault system would still cost 15 times the amount of the tort system for medical malpractice.

The lower estimate would mean that the cost of the scheme was affordable. But if the higher estimate was more realistic, implementation of the scheme would be unlikely. However, three matters should be borne in mind. First, the difficulties of suing for medical negligence mean that it is only those who are seriously injured who sue. The potential increase in claims, then, would be made up of those with less serious injuries, some of whom would be excluded from the scheme because of the relatively minor nature of their injuries.[126] Secondly, a no-fault scheme could compensate at a lower level than tort to reduce costs, for instance by not compensating for non-economic loss. Thirdly, the increase in expenditure would be relieving injured patients and tax-payers of the portion they now bear of the loss resulting from medically caused injury.

IV. CONCLUSIONS

Introduction of a no-fault scheme limited to medically caused injuries would be a positive and appropriate step to take in the face of the problems of the tort system. The no-fault idea has the support of the major medical liability insurers.[127] However, the feasibility of such a scheme would depend on its cost to providers of health care and to the community in general. Further research should be undertaken into the incidence of medical injury to enable a more accurate prediction of the number of people who would be eligible for compensation under the proposed scheme. Although such research may be expensive, it is necessary so that an informed decision on the question whether to proceed with the implementation of a no-fault scheme can be made. A complaints unit should be established and the Medical Board's function extended to compensate for the removal of tort's deterrent influence.

Those who decide whether to proceed with the proposed reform should not lose sight of the plight of patients injured by medical treatment. The real benefits which a no-fault compensation scheme would confer on this group must be given proper weight against considerations of cost.

125. Danzon supra n 6, 19-24.
126. Task Force supra n 3, 69.
127. M Thomas "Negligence Litigation a 'Nightmare'" The Weekend Australian 3-4 August, 1991.

APPENDIX : QUESTIONNAIRE RESULTS

The stories that appear below are taken from responses to a qualitative survey conducted by the author in 1990. The aim of the survey was to obtain an insight into the plight of victims of medically caused injury and learn their views on the current system of dealing with injured patients. The stories are printed here in the hope that they will enrich readers' understanding of the issues at stake in compensation for this type of injury. Some of the points which emerge are: a common reluctance to take legal advice; a general belief that it is not possible to successfully sue a doctor for malpractice; that those who do sue find the prospect of being liable for all the costs of the action very frightening; that the response of medical practitioners to complaints is often seen as uncaring; and that patients are often not fully informed about procedures they undergo.

Names used are fictional for reasons of confidentiality. The methodology of the survey and the text of the questionnaire used are set out at the end of this appendix. Note that the survey simply reflects the patients' subjective perception of the treatment they received and the difficulties they encountered in obtaining redress. Doctors and hospitals were not surveyed, so the questionnaire reflects only one side of the story.

"Anne"

During an operation under general anaesthetic to cauterise some abnormal cells in Anne's cervix, the laser machine being used malfunctioned and burned a hole through her vagina and small bowel. At the time, the extent of the injury was not realised, and it was only after thirty hours of extreme pain that it was realised that serious damage had been done. A laparoscopy showed the hole in the bowel and extensive faecal leakage into the abdominal cavity, so a resection of the bowel was done, and the faecal leakage cleaned out. It took Anne six weeks to recover from this operation. Four months later, adhesions from the first operation had developed in her bowel, necessitating another laparotomy. Anne's fertility is now uncertain.

She finds it unjust that she is expected to prove a case of negligence when her injuries are so clearly not her fault. Being self-employed, she lost a substantial amount of income, and despite receiving a social security benefit for four weeks and some help from her parents, she has been unable to meet her mortgage payments. She has had no legal bills yet, apart from $200 for the retrieval of her medical records.

"Barbara"

Barbara had a cartilage injury to one knee, which required three operations. These operations began a chapter of disasters for Barbara. The surgeon was allegedly careless, necessitating further surgery to remove the knee cap, and later to effect a total knee replacement. However, the wrong prosthetic knee joint was used, so this had to be removed. The leg was then stiffened and a stainless steel rod inserted. This rod was too long, and it damaged Barbara's leg, eventually working its way out. Several further operations on Barbara's leg, hip and back were performed, but some years later she was still experiencing severe pain and undergoing surgery.

Barbara accepted $16 500 (three years after the original medical injury) presuming that she would suffer no further effects. She had had no legal advice, but her general practitioner had warned her of the difficulty of successfully suing a specialist, and about her liability for costs if she lost. Barbara has been unable to work since the injury.

"Colin"

Colin's bowel ruptured during a colonoscopy operation. At the time, this was not discovered, but his severe pain upon awaking prompted a nurse to call the anaesthetist (the surgeon had already left the premises). Colin was sent to another hospital by ambulance, and was

operated on the next day. Being under sedation at the time, Colin did not have a chance to discuss the quality of his treatment with those responsible. He did not take legal advice about the incident, citing expense, delay, doubt about the cause of the injury and the belief that the medical profession "protects its own" as his reasons. He pointed out that it is very easy for medical practitioners to "muddy the water" with regard to an internal problem, because of their medical knowledge and the fact that they are often the only witnesses.

"Diane"

Two weeks after undergoing surgery for a uterine prolapse and a sterilisation with clips, Diane noticed numb patches in her thighs, which also felt tender. A neurologist told her that a nerve had been damaged because of the position she had been in during surgery. He predicted that it would take six months to heal, but six months later, she still experiences pain even from walking. The doctor involved denied that her condition had anything to do with the surgery, and laughed at her for thinking that it had. Diane has not taken legal advice or action, partly due to other crises and a very full life, and partly because she dislikes the idea of everybody taking legal action for the slightest problem. She feels angry about the incident, and says that she would feel better if records were kept to ensure that doctors do not repeat this type of thing.

"Gail"

Gail was experiencing hypokalaemia (low blood potassium) as a side effect of diuretic medication. Her condition was quite dangerous to her life, and made her continually lethargic and dizzy. She collapsed and was taken by ambulance to a hospital's emergency department, having broken same facial bones. Her case was handed over to an ear, nose and throat doctor, who did not investigate the cause of her collapse. Medical staff assumed because of her age (35 years) that she was in good health, and put her under a general anaesthetic without any tests. It is believed that the rate and rhythm of Gail's heartbeat was affected at this time, but although the anaesthetist recorded that her ECG was abnormal, he did not investigate. Gail was ill after the operation, but was discharged after four hours due to the minor nature of the surgery. Gail consulted a general practitioner, who immediately suspected hypokalaemia without even knowing of her medication, and sent Gail for intravenous replacement.

Gail described her experience as a nightmare, and said that the doctors were "incredibly arrogant", dismissing her as someone who got out of bed too quickly. Although Gail tried to obtain her medical records for treatment purposes, she was not able to do so. She did not seek legal advice as she has no lasting injury and because of the expense involved.

"Helen"

Helen had a breast reduction done, and the incision burst open. She was left in a worsening condition for three days while the plastic surgeon was away. On his return, he restitched the incision, but it did not heal, and a skin graft was necessary. Helen now has extensive scarring and suffers from pain. She saw a lawyer regarding the incident, who advised her that the surgeon was negligent, but that she would have little chance of success in a lawsuit, as no plastic surgeon would testify against another. Helen is angry that she has no recourse, and concerned that the plastic surgeon involved is still working.

"Irene"

Irene had a neuroma (tumour on a nerve) in her elbow removed under a local anaesthetic. During the process, the surgeon cut or interfered with some nerves, and Irene now experiences alternate numbness and neuralgia in her elbow and rear forearm, which are aggravated by pressure and temperature changes. When she approached the surgeon about the problem, he told her that she could not possibly be feeling discomfort where she said she was, and told her to

forget about it, as it was unlikely to get better, and that a "slight area of neuralgia" is to be expected after such surgery. (The area affected is not slight, and Irene was not told of such a risk before the surgery). The surgeon implied that Irene was being neurotic and making a fuss about nothing. The injury affects Irene's work as a teacher, and the whole incident has eroded her and her family's trust in the medical profession. However she did not take any steps toward legal action, as she could not afford it, and did not believe that she would be successful, having been told that doctors have a very efficient system of protecting themselves. Irene feels angry and powerless.

"John"

After his "pre-medication" injection before an operation, John immediately experienced "excruciating, unbearable, burning pain" in his buttock and down his leg. He is still in constant pain over eight years later, despite a major operation which attempted to alleviate his pain. When he complained of pain at the time, he was told "Don't be a sook" by a nurse. He was advised by his lawyer that those involved were negligent, so he sued the hospital. He was never able to obtain his medical records. Eight years after the incident, John's case was heard, and he lost, obtaining no compensation. He was liable to pay legal costs, as well as bearing his expenses and loss of income. John thinks that doctors should be honest and accept that some of their procedures go wrong, and should accept fault and pay compensation. He complains that some doctors think they are gods and beyond questioning, while patients trust doctors with their lives.

"Karen"

Karen has a protrusion of the discs in her neck and lumbar which requires surgery. She has previously had some surgery in that area, seventeen years ago. Since then, she has had five epidural injections in her head, neck, throat and lumbar. After the last one (in her lumbar two years ago), the lower part of her body was numb for about seventeen hours. She had been injected with Marcain and Depo-Medrol. She now has arachnoiditis, an inflammation in a layer of her spinal covering. Karen is unable to work, suffering from pain and general ill-health. She has lost all confidence and self-esteem. Her children have to undertake a great deal of responsiblity, and are upset by their mother's pain.

Karen has joined a support and lobby group for people who believe that they have been injured by improper use of the drug Depo-Medrol for epidural injections. Karen, an invalid pensioner, is hoping to obtain legal aid to bring an action against those concerned with the injection. She has attempted to obtain her medical records, but has so far been unsuccessful. She is concerned that she will not be able to prove that the injections caused her injury, as she has a history of back problems. Karen feels that patients are being used too much as guinea pigs, and are not told of possible side effects of treatment. She says that patients are being given no say and no choice.

"Larry"

Larry committed suicide while on prescribed drugs which are the subject of warnings of adverse reactions and side-effects. When approached by Larry's mother, the three doctors involved in Larry's treatment (two consultants and a general practitioner) denied that the drugs prescribed could cause suicidal impulses, and blamed Larry's family for interfering with his treatment.

She saw a succession of lawyers, six in all. The first told her that she had a case. The second and third gave her no helpful advice, just queried her ability to pay. The fourth obtained the general practitioner's records, but was unable to obtain those of the consultants. The fifth and sixth were of no help. The claim was statute-barred before Larry's mother could find a lawyer who would do more than waste her time and money. She paid a total of around $10,000 in legal

fees. She criticises the legal profession for incompetence and lack of medico-legal knowlege. She deplores the unaffordable expense, "legal delay ploys", and "the years out of your life", and especially laments the mounting cost involved in each lawyer reading the thickening file.

"Nancy"

After a fall on the way home from her place of work, which was covered by workers'compensation, Nancy suffered a "frozen shoulder": she could not lift her hand or arm. Nancy was referred to a physiotherapist, for six weekly visits. On the last three visits, Nancy was asked to do an exercise in which she had to lift her head from a lying position and hold it there for ten minutes. After five minutes, Nancy was in great pain. Within an hour after each of these visits, Nancy became dizzy. She suffered from dizziness for the next three and a half years, until she went to a chiropractor, who told her that the injury had been caused by bones and muscles pressing on an artery and affecting the blood flow to the brain.

The physiotherapist was "not very interested" when approached about the injury, and Nancy took no legal action, seeing her hands as tied because health professionals are not game to admit that anyone in their profession was at fault.

"Olive"

Olive suffered a blocked ureter caused by a stitch in it during surgery. She has to have two tubes in her body, and is unable to go to the lavatory by herself. The doctor's response to Olive's approach was that he did not believe that there was anything wrong with her. She has sought legal advice. Her legal costs to date are $3 000. Olive thinks that it is disgusting that people should have to go through such stress to be compensated, and feels that when a mistake is made, careless or not, a doctor should be more caring, and not just walk away from his patient.

Methodology

The sample was not comprehensive nor randomly selected, and therefore the results are not in any way statistically valid, being in the nature of a qualitative selection of opinions and reported experiences by patients. The subjects were self-selected, in that they were those who responded to advertising in local newspapers or were reached through personal contacts and agreed to participate. Those who identified themselves as having been injured by medical treatment were sent the following questionnaire. Sixteen completed questionnaires were returned, out of about forty distributed.

The questionnaires were distributed to the patients and not to the doctors and hospitals who treated them. The results therefore reflect the patient's side of the story only. This must be taken into account when evaluating the information given by the patients.

Included in the questionnaire, but not shown here, was a system which enabled respondents to identify and strike out the questions which were not applicable to them. The responses in square brackets were those specified in multiple choice questions (other than simply yes-no questions).

1. Please describe your injury and how it was caused.
2. Do you think that the provider of the medical treatment lived up to a REASONABLE standard of carefulness and competence?
3. Did you approach the provider of the medical treatment about your injury?
4. Why not?
5. What response did you get?
6. What would you say was the reason for this response?
7. Did you try to obtain your medical records?
8. Did you meet with any resistance when you tried to obtain your medical records?

9. Did you obtain your medical records?
10. Did you obtain legal advice about your injury?
11. Why not?
12. Who did you go to for the legal advice?
13. What was the legal advice?
14. Did you take legal action against the provider of the medical treatment?
15. Why not?
16. What was the outcome of your claim? [abandoned, settled out of court, settled by a court, still in progress]
17. Why was your claim abandoned?
18. Why was your claim settled out of court?
19. How long after your injury was the settlement?
20. Did you obtain damages? (that is, did you win the case and get a sum of money)
21. How long after your injury was the case decided?
22. How much compensation did you receive? What form did it take? [lump sum, regular payments, other]
23. What were your total legal costs? (Estimate if you don't know or can't remember)
24. Do you still face some of the costs that the compensation was intended to cover? (eg medical treatment, loss or reduction of wages etc.)
25. Do you still have part of your compensation left?
26. Do you still receive compensation payments?
27. Would you say that your compensation was enough to cover the costs arising from your injury?
28. Would you rather have received compensation in the form of a lump sum or regular payments? Why?
29. Besides compensation payments, did you receive any money to help you cover the costs arising out of your injury? (eg. private health insurance, pensions, paid leave)? Please specify from what source or sources.
30. Did your injury have any effect on your employment? (apart from sick leave) (eg unable to work, can't do overtime, lost job, can't get a job) What effect did it have?
31. Did your compensation payments allow for this?
32. Has the injury had any effect on your family? What effect has it had?
33. Did the process of claiming compensation have any effect on your family?
34. Did you find the process of claiming compensation stressful? Please describe the aspects of the process that caused most stress.
35. Do you believe that you SHOULD have received compensation for your injury?
36. Did you suffer any financial hardship as a result of your injury? Please describe.
37. Please write here any general comments about compensation for injuries caused by medical treatment.