NEW ZEALAND’S STATUTORY COMPENSATION SCHEME FOR TREATMENT INJURIES: A CRITICAL ANALYSIS OF ITS ETHICAL PREMISES

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ABSTRACT

In most Western countries liability for adverse events in healthcare is considered by the courts within a tort-based adversarial system. In New Zealand personal injuries caused by medical treatment are covered under a no-fault accident compensation statute. This legal regime represents society-wide liability for personal injuries caused by accident. The no-fault statute is universally considered as a unique and successful alternative to tort law. However, the scheme is not ideal and is subjected to criticism in several respects. The most common point of criticism is that under this system resources are allocated on the basis of injury causation rather than on incapacitated persons’ needs. That results in people with similar disabilities getting disparate levels of assistance from the state. Furthermore, the fairness of imposing a statutory bar on litigation in exchange for the universal access to cover and entitlements is also questioned.

The goal of this research is to explore whether this legal regime is ethically sound. Using ethical analysis as a research methodology this dissertation examines the fundamental ethical principles underpinning the goals and objectives of the accident compensation statute, focussing on its treatment injury provisions. It identifies distributive justice, beneficence and non-maleficence as the key ethical premises in the foundation of the scheme, and the competing interests between social utility of the scheme and distributive justice as the key ethical tension. To answer the research question, this dissertation examines fairness of distribution based on cause of injury, and fairness of the terms of cooperation that relinquished civil litigation for compensation in exchange for the social insurance model.

This paper argues that moral intuition alone is insufficient for making decisions on morality of rules and institutions, and appeals to two most prominent moral theories of distributive justice, utilitarianism and egalitarianism, for guidance in the ethical evaluation of the treatment injury legislation. The discourse asserts that the no-fault regime has maximised social utility of redress for adverse events in healthcare, and advanced justice. While not ideal by the virtue of being the product of the non-ideal
world with its political and economic pressures, the legislation seems to be ethically robust from the perspectives of both theories as it has achieved ‘a proper balance between competing claims’ (Rawls 1971, p.5) and is to everybody’s rational advantage. The conclusion articulates that the no-fault statute represents a reasonable balance of utilitarian interests and egalitarian concerns, and a reflection of the moral values prevalent in New Zealand society.
PREFACE

This dissertation is submitted as part of the requirement towards the completion of the Master of Bioethics and Health Law degree.

Researching for this paper was a great intellectual pleasure but articulating and debating the issues turned into a very challenging exercise. A number of factors contributed to this challenge. First, this dissertation attempts to look at the treatment injury legislation from a unique perspective that is rich in potential scope but undeveloped, with many of its aspects warranting more in-depth academic research. Second, applying a bioethical framework to the evaluation of a legal regime has its problems. Third, the ethical issues are closely related to and influenced by other disciplines, such as legal studies, political and legal philosophy, public health and economics. Maintaining focus on the ethical aspects, while acknowledging other disciplines but not deviating from the intended course was another challenge. Lastly, the debates around this piece of legislation are permeated with conflicting opinions and a paucity of empirical evidence supporting either side of the argument. Overall, I am afraid this paper does not do justice to this fascinating subject, and hope that the debate on the ethical tensions within the treatment injury scheme will continue.

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in particular for providing data and the case studies used as a practical illustration to what could have been otherwise a rather abstract discourse.

CONFLICT OF INTERESTS STATEMENT

Several years of my professional experience in assessing cover for medical misadventure and treatment injury claims equipped me with the intimate knowledge of the issues within the legislation. Although I am not part of the treatment injury claims assessment team any longer, my long standing interest in these issues remains.

However this potentially could be construed as a conflict of interest. I am an employee of the Accident Compensation Corporation, and the Corporation supported this study as part of my professional development. I have tried to mitigate this potential conflict of interest by being aware of my possible bias, and in my research was guided by reason and logic rather than by intuition. I believe this dissertation to be an objective and impartial piece of academic research. It does not represent the official view of the Corporation.
Laws vary from one society to another, morality does not.

(Honore, 1993, p1)
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INTRODUCTION

In most Western countries liability for adverse healthcare events\(^1\) is considered by the courts within a tort-based adversarial system. In New Zealand medical liability is covered under the treatment injury sections of the accident compensation statute. In essence, this legislation signifies that the state provides comprehensive cover to individuals for personal injuries caused by medical treatment. In exchange, litigation through the courts for compensatory damages arising from any covered injury is barred. This legislation is unique and well integrated into the no-fault accident compensation scheme currently governed by the Accident Compensation Act 2001\(^2\).

At its early stages, the no-fault system was seen as possibly ‘the most effective remedies for the ills of … tort reparation system’ (Bernstein 1973), and ‘a requiem for the common law’ (Palmer 1973, p.1). The scheme has evolved over the years; however, its key founding principles of social responsibility and comprehensive entitlements have remained constant. Three decades later the scheme is regarded as ‘unquestionably an enduring success’ that ‘avoids the economic and social injustices that the common law inflicts upon injured persons’ (Johnston 2007, p.295), and a legal reform that assumed ‘Messianic tendencies’ (Palmer 2004, p.906).

Over time the legislative provisions related to adverse events in healthcare have been refined and transformed. The latest and probably the most remarkable changes were enacted in the Injury Prevention, Rehabilitation, and Compensation Amendment (No 2) Act 2005. This Act considerably extended the scope of cover for medical injuries. It introduced a new concept of treatment injury, set out the cover criteria, and repealed the previous legislative requirement to prove fault on the part of health professionals. While the overall satisfaction with the latest change in the statute is high (Dowden et al. 2009, Stewart 2010), several significant concerns about the scheme remain unresolved.

\(^1\) The term ‘adverse events’ is used in this dissertation as an all-inclusive terminological umbrella for harm and untoward events occurring in the context of medical care.

\(^2\) The title of the accident compensation statute has been changed several times since its original name the ‘Accident Compensation Act 1972’. It has currently returned to its initial name and referred to as the ‘Accident Compensation Act 2001’. For convenience, from hereon in the text I refer to the accident compensation legislation as the AC Act, regardless of its full title.
First, exclusion of illness and disease from the scheme continues to produce tensions as it is seen as leading to significant inequities. Cover and associated entitlements are linked to the cause of disability and not to the individual’s needs. It is particularly disquieting in cases of perinatal injuries, when a cause of often life-limiting pathology, such as hypoxic brain injury, can be problematic to establish because of scientific uncertainty. In these cases children with similar needs end up getting disparate levels of support from the state.

Second, fairness of the statutory bar on litigation for personal injuries and the adequacy of compensation for harm caused by treatment are questioned. In monetary terms, tort jurisdictions provide higher recompense, particularly in cases of non-earners who cannot claim earnings-related entitlements (Bismark and Paterson 2006, Duffy et al. 2001).

Finally, it is questioned whether the no-fault approach could compromise quality of medical care through lack of financial incentives for clinicians to improve the standard of care and reduce numbers of iatrogenic injuries. The opponents of the no-fault approach claim that a tort-based system is better suited to serve the social purpose of improving quality of healthcare through penalising clinicians for substandard services (Howell 2004, Studdert et al. 2011).

This dissertation is an attempt to analyse these concerns from the ethics perspective.

The structure of the dissertation

The dissertation consists of four interrelated parts. The introductory chapter gives a brief overview of injuries covered under the treatment injury regime, and as a way of illustration provides several scenarios commonly considered under the treatment injury legislation. It describes ethical analysis as a research methodology and outlines the research design, its goal, objectives and method.

The first chapter provides background to the origins of the accident compensation regime and a synopsis of the treatment injury legislation’s conception and evolution.
It refers to the relevant sections of the AC Act, and emphasises that the treatment injury legislation does not exist in a legislative vacuum. The chapter alludes to several other statutes that can complement the AC Act or address some of the concerns brought about by adverse events in healthcare.

The second chapter is concerned with the ethical premises underlying the treatment injury legislation. First it outlines the founding principles of the AC Act, such as the intent to provide equitable access to remedies for personal injury and to reduce healthcare-related harm to society. Then it examines the core ethical premises underlying these principles, and identifies justice and fairness, beneficence and non-maleficence as the relevant ethical premises. The chapter elaborates on the concepts of justice and fairness, and considers justice for individuals who experienced adverse events in healthcare, efficiency as prerequisite for justice, and raises the issue of inequity in distribution of benefits. The chapter examines the concepts of beneficence and non-maleficence that underlie the commitment to enhanced patient safety and healthcare-related harm reduction. It discusses the effects of the no-fault system-oriented approach on reduction of incidence of medical injuries. In conclusion the chapter identifies the competing interests between social utility of the scheme and distributive justice as the ethical tension that warrants further discussion.

The final chapter outlines two major philosophical theories of distributive justice deployed in ethical analysis: utilitarianism and egalitarianism, with Rawls’ justice as fairness as its most prominent theory. These theories were selected for analysis because they both provide powerful analytical tools and represent two most influential philosophical schools distinct in their views on justice and utility. The chapter examines the key ethical tension between social utility of the scheme and distributive justice through the prism of the utilitarian theory and egalitarian framework, in particular the Rawls’ theory of justice as fairness.

The conclusion sums up the arguments, reflects on the application of the critical analysis, and considers whether there is a better alternative to the current scheme for redressing medical injuries.
Treatment injuries profile

Under the no-fault treatment injury legislation, the accident compensation scheme covers a wide range of physical injuries caused by medical treatment. The most commonly covered injuries are generally high volume, low cost, such as allergic reactions to medications, wound infections following surgical interventions, haematomas secondary to intravenous cannulation, dental injuries during anaesthetic intubation, skin damage attributed to inadequate nursing care, and others (Tapp and Frew 2011).

In a majority of cases, cover decisions can be relatively straightforward. However, a considerable proportion of claims is categorised as complex, and a person’s underlying pathology could be a significant precursor and contributor to the adverse outcome. As the legislation excludes ‘personal injury that is wholly or substantially caused by a person’s underlying health condition’ (AC Act 2001, section 32(2)(a)), claims for delayed diagnosis are particularly challenging. Furthermore, unlike in cases of personal injuries caused by accident, it is more difficult to determine when medical acts or their omissions caused a problem, and define a specific medical problem attributable to the acts or omissions.

To illustrate some points in the subsequent discussion, it is helpful to describe common scenarios that are routinely considered within the scope of the treatment injury legislation. In cases of diagnostic-related claims, the challenging questions are what could have been done and whether it would have made a difference to the underlying disease. Juxtaposition of these cases informs the discourse on benefit distribution that is based on injury causation and not on need.

Case study 1 – Delay in diagnosing subarachnoid haemorrhage (SAH)

Shane suddenly developed a headache and neck pain while lifting a heavy object. The next day his GP diagnosed a neck sprain. As the pain did not improve, Shane repeatedly went back to see his GP but was advised to keep taking painkillers for his neck injury. Several days after the initial consultation, Shane collapsed at home and was admitted to hospital. Investigations revealed extensive subarachnoid haemorrhage.
as a result of a ruptured cerebral artery aneurysm. Shane suffered significant impairment due to the brain haemorrhage. Shane’s treatment injury claim was covered by ACC on the basis that earlier diagnosis and treatment of the ruptured aneurysm would have resulted in a less severe brain damage, and that Shane’s presentation to his GP warranted further investigations.

Case study 2 – Delay in diagnosing subarachnoid haemorrhage

John presented to his GP complaining of neck pain and headaches. The GP diagnosed neck strain and prescribed Voltaren. Three days after the consultation John collapsed at home and was taken to hospital. At admission John was diagnosed with SAH and underwent emergency clipping of the ruptured brain aneurysm, and sustained significant neurological deficit following the surgery. A claim was lodged for failure by the GP to diagnose SAH. The claim was declined because it was determined that at the point of the GP consultation John did not display any symptoms or signs that would have warranted further investigations, and had John been sent to hospital, he was likely to have been sent home because of non-specific and non-alarming nature of his complaints. John’s neurological impairment was attributed to the underlying medical condition (ruptured brain aneurysm) and not to medical treatment.

Case study 3 – Delay in diagnosing breast cancer

Susan visited her GP complaining of experiencing pain in the left breast for around two months. The GP detected no abnormalities on clinical examination and advised Susan to attend a planned screening mammography. The mammogram results were reported as normal and no follow up was arranged. Nine months later Susan returned to the GP with more complaints. Further investigations detected advanced breast carcinoma, and Susan required extensive treatment. The claim was accepted because it was established that earlier diagnosis of breast cancer would have resulted in less aggressive treatment, and screening mammography was not an appropriate choice of diagnostic pathway in this case.

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3 The cases 1 and 3 are based on the treatment injury case studies, the cases 2 and 4 are fictional and reflect common scenarios
Case study 4 – Delay in diagnosing kidney cancer

Mary consulted her GP complaining of pain and frequent urination. An ultrasound scan detected multiple cysts in the left kidney. These cysts were rendered benign and no follow up was arranged. Several years later Mary complained of abdominal pain and weight loss. Repeat ultrasound detected malignant carcinoma in the left kidney. The carcinoma metastasised into other organs. Mary required extensive treatment and her prognosis was poor. Mary’s family lodged the claim for a failure to diagnose renal carcinoma at the initial consultation. The claim was declined because it was determined that the benign lesions on the initial ultrasound had no relation to the malignancy, and that Mary’s ill health was caused by the underlying cancer and not by the allegedly delayed diagnosis.

Comparing Shane’s and John’s situations with those of Susan’s and Mary’s, it is evident that the needs of these people could be very similar. However, compensation and rehabilitation they will be receiving would differ. The overall benefits Shane and Susan receive through the accident compensation scheme could be substantially greater than John’s and Mary’s. John and Mary do not get entitlements because their ill-health was due to natural progression of the underlying medical conditions.

In the subsequent chapters I use these case studies to examine the ethical underpinnings of the cover provisions and to illustrate the discussion on a) whether Shane and Susan get satisfactory redress for their treatment injuries; b) whether it is fair that John and Mary may end up worse off than Shane and Susan.

Ethical analysis as a research methodology

Much has been written about the history of this piece of legislation and how compensation for adverse medical events became part of the scheme (Butler 2004, Coates 2005, Easton 2004, Oliphant 2007). However no critical analysis of the ethical premises underpinning its founding principles has ever been undertaken.
Apart from the natural curiosity to inquire into new and uncharted territories, it is a worthwhile topic for exploration. How do we assess whether law is ethically sound? A direct appeal to moral intuition is insufficient for making a considered moral judgment. Our capacity to assess justice and recognise injustice is conditioned by our subjective perceptions and judgements. To test intuition, applied ethics deploy a variety of methods of systematic evaluations of goodness of rules, practices and institutions. Critical analysis made on moral grounds helps with exposing law’s weaknesses and correct injustice, if it exists. As Honore submits, ‘[i]t is true that morality is in important respects separate from law. But the separateness consists in the critical role of moral thinking, in the fact that all laws are subject to moral criticism.’ (Honore 1993, p.17)

Evaluation of legal rules can be carried out either through a methodical examination of the implications of these rules for particular cases or through general application of a theory of justice. Ethical analysis is defined as a systematic application of moral reasoning, or considered moral judgement. The overall purpose of ethical analysis is to reach conclusion on whether the object of scrutiny is moral and ethically sound. To use Rawls’s definition, the practical application of ethical analysis is ‘to focus on deeply disputed questions and to see whether, despite appearances, some underlying basis of philosophical and moral agreement can be uncovered’ (Rawls 2001, p2).

To achieve this purpose, the first step is to ascertain the facts of the case and the ethical premises underpinning the facts. The next step is to highlight the key competing interests and tensions. Finally, through presenting and arguing conflicting positions and applying relevant philosophical theories the analysis is set to achieve its purpose objectively, without imposing the writer’s personal values on the issue in question.

This analytical framework can be applied to ethical reasoning on individual cases, particular situations, institutions, legislation and such alike. The law is a social force and as such it overlaps with morality, with the expectation that any legislation must be designed to bring about fair and just results. However, Mill acknowledges that a law is not ‘the ultimate criterion of justice’, and that there may be unjust law that benefits some people over others (Mill 1991, p.218). Furthermore, although fairness and
justice are essential in assessing ethical robustness, these concepts represent only one facet of overall morality. It is not uncommon when in complex situations and cases the quest for justice and fairness competes with other ethical claims. Ethics in law involve a complex interplay between guarding justice to the individual, protecting common good and ensuring a fair distribution of resources.

The goal of this research is to scrutinise the ethical foundation of the treatment injury legislation through the prism of two major philosophical theories so as to evaluate whether this regime is ethically sound.

Hence, the first step in this analysis is to define the core ethical premises underlying the founding principles of the treatment injury legislation, then to identify and test the key ethical tension by deploying the theories of justice, and finally to make conclusions on ethical robustness of the legislation.

**Research method**

To provide a structure for moral deliberations on justice, Rawls advanced a method of reflective equilibrium, grounded in inductive logic (Rawls 1971). A reflective equilibrium can be summarised as a process of reflecting and revising one’s beliefs and intuitions through a systematic application of moral perspectives (Daniels 2011).

Rawls’ reflective equilibrium framework integrates two approaches: narrow and wide. A narrow reflective equilibrium analysis focuses on particular cases or groups, and applies one moral perspective, without challenging its view by alternative moral theories. Hence narrow reflective equilibrium is limited in its capacity to answer the questions on what is morally right, and it does not help with resolving disagreements if they arise. Under a wide reflective equilibrium framework the principles are tested against well established moral theories, so as to juxtapose and explore competing principles, and arrive at a conclusion on morality of the principles.

Within an analytical framework similar to Rawls’, Sen suggests two approaches to examining moral dilemmas. First, a ‘case-implication critique’ considers ethical tension through checking the implications for particular cases when the consequences
of these implications can be illustrated. Second, a ‘prior-principle critique’ reasons through moral dilemmas by shifting ‘from the general to the more general’, and considering the principle under scrutiny in light of another fundamental principle (Sen 1979).

To answer the research question, I deploy both narrow and wide reflective equilibrium methods to explore morality of the treatment injury regime. I test the ethical tensions through applying two major philosophical theories of justice: utilitarianism and egalitarianism, in particular Rawls’ framework of justice as fairness. In essence, utilitarianism is concerned with maximising public good, and producing maximal goodness for the greatest number. The utilitarian approach provides a valuable analytical framework for comprehensive assessment of rules and policies. Sen asserts that ‘consequentialist reasoning may be fruitfully used even when consequentialism as such is not accepted. To ignore consequences is to leave the ethics story half told’ (Sen 1987, p.75).

Conversely, egalitarianism, with Rawls as its most prominent theorist, emphasises equality and fairness in distribution of public good. While these theories differ, in analysis of the treatment injury legislation they should be combined. A fairness-based analysis independent of the impact of the statute on society and consequences for individuals would have provided an incomplete picture. If a legal rule is fair, but its negative effects over time eventually produce more harm than benefit, then can it be regarded moral?

CHAPTER ONE - BACKGROUND

Knowledge of the history of the statute’s conception and evolution is essential for understanding its ethical premises. This history provides a rich context and a good illustration of how these premises relate the legislation’s origin.

This chapter first gives a brief overview of the history of the New Zealand statute on redressing the consequences of adverse medical events, its conception and development. The chapter’s final section refers to the relevant provisions of the AC
Act and its founding principles as set out in the Woodhouse report, and outlines other jurisdictions relevant to adverse events in health care.

Historical overview

The history of development of the treatment injury statutory concept is a fascinating chronicle that reflects the changes in the New Zealand political scene over the last forty years. Throughout its existence, cover for medical injury was ‘vulnerable to changing ideologies and political interference’ (Manning 2010, p.14). The changes were precipitated and influenced by a complex tangle of multiple political and economic factors. As Sir Geoffrey Palmer succinctly described it ‘the ultimate issues in the New Zealand accident compensation reforms were not about the law. They were about values. They concerned social priorities. The choices were political.’ (Palmer 2004, p.906)

Several publications provide a detailed history of the evolution of the part of the accident compensation regime dealing with the adverse outcomes of medical treatment (Butler 2004, Collins 1992, Corkill 2002, Oliphant 2007). The inception of the accident compensation scheme goes back to December 1967, when the Royal Commission of Inquiry reported its findings on the inquiry into the worker’s compensation scheme. The inquiry was precipitated by dissatisfaction with the then existing means of seeking redress for personal injuries arising out of work- and motor-vehicle-related accidents. The Commission was chaired by a Judge of the Supreme Court, Mr Justice Woodhouse.

The Commission’s findings and recommendations were summarised in the Report of the Royal Commission of Inquiry. While much has been written about the Woodhouse Report and its recommendations, they are so fundamental to understanding of the subsequent developments that it is impossible to avoid multiple references to the Woodhouse Report in any academic writing on this subject.

The Report highlighted the key inadequacies of the existing redresses that were ‘a form of lottery’, leaving a majority of citizens ‘to fend for themselves’ (Woodhouse

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4 Commonly referred to as the Woodhouse Report
In essence, the Report recommended a fundamental law reform, replacing the common law action for damages with no-fault statutory compensation.

The Report emphasised three fundamental foci for addressing injuries arising from accidents: prevention, rehabilitation and compensation, and stressed the priority of the first two foci over compensation: ‘The most important is obviously prevention. Next in importance is the obligation to rehabilitate the injured. Thirdly, there is the duty to compensate them for their losses. …’ (Woodhouse 1967, p.19).

The recommendations set up five founding principles of the accident compensation regime:

- Community responsibility
- Comprehensive entitlements
- Complete rehabilitation
- Real compensation
- Administrative efficiency (Woodhouse 1967, p.20)

The first two principles were defined as ‘fundamental’, and the subsequent three ‘rules’ were supplementary and pragmatic, so to make the scheme affordable to the nation (Woodhouse, 1967, p.20).

These fundamental principles are stated as:

First, no satisfactory system of injury insurance can be organised except on a basis of community responsibility;

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

(Woodhouse 1967, p.20)

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5 It is worthwhile to note that the meaning of the words ‘treatment’ and ‘treat’ in this dissertation depends on the context of their use. When used in a medical context their meaning is clinical care. In the legal and ethics contexts, their meaning is ‘application’, ‘dealing with’, and ‘consideration’.
In the subsequent chapter these principles and the ethical premises underlying these principles are discussed in more detail.

It is important to note that the medical injury compensation regime was initiated by the Woodhouse Report that suggested including medical injuries in the scope of cover for accidental injuries. The Commission’s recommendations on inclusion of iatrogenic injuries were generic and cautious:

289 (c) *We recommend that, in general, protection should be afforded in respect of injury conditions which fall within the categories of external cause of injury... perhaps some categories of therapeutic misadventure or late complications of therapeutic procedures*....

(Woodhouse 1967, p.113)

The selection of injuries to be covered under the accident compensation scheme was based on the classification of external causes of injuries coding system. It did not arise from concerns about medical malpractice (Bismark and Paterson 2006, Butler 2004), and its purpose was to compensate the injured and not to punish the injurer. Before the AC Act was introduced, for the period from 1881 to 1972, only seven court decisions on medical negligence were reported (Butler 2004). It was in contrast to the medical malpractice crisis in the United States that markedly escalated in the 1970s. It is possible to speculate that this was attributable to the differences in the societal values, with New Zealand being a less litigious society.

The original Act that came into effect in April 1974 did not include any references to medical misadventure. However the Accident Compensation Commission\(^6\) regarded personal injury caused by treatment as being within the scope of the legislation. A more detailed description of what injuries were to be considered under the AC Act, including medical misadventure, was published in the guidelines on how to respond to undefined provisions of the AC Act (Collins 1992).

\(^6\) The original title of the Accident Compensation Corporation
The first direct reference to medical injuries was enacted in the 1974 amendments to the AC Act, when personal injury by accident was defined as inclusive of ‘medical, surgical, dental, or first aid misadventure’ (AC Act 1972, section 2). At this point the statute did not elaborate on the definition of medical misadventure, and the courts adopted informal and rather loose concepts of medical error and medical mishap. The former implied incorrect treatment and diagnostic failures, as well as a failure to inform of the risks associated with treatment. The latter covered cases when treatment was correct but resulted in a rare adverse outcome (Oliphant 2007).

The lack of any statutory definition caused concern due to what was considered to be ‘widely varying interpretations’ (Birch 1991, p.31) of the concept and blurred boundaries of the scheme. A series of High Court decisions highlighted the need for clarifying the scope of medical misadventure (Butler, 2004). These issues were augmented by the concerns about financial viability of the scheme (Oliphant, 2007). Subsequent developments resulted in the new Act setting out an elaborate definition of medical misadventure. It formalised the scope of medical error and medical mishap. Incongruent with the rest of the scheme, medical error required establishing negligence on the part of a health professional (Accident Rehabilitation and Compensation Insurance Act 1992, section 29).

The next 13 years were the years of growing dissatisfaction with the medical misadventure criteria, and with the concept of medical error being misaligned with the rest of the no-fault scheme. A large scale review of medical misadventure provisions identified the need for change (Dyson 2003). In July 2005 the concept of medical misadventure was replaced with new criteria of treatment injury (Injury Prevention, Rehabilitation, and Compensation Amendment Act (No 2) 2005, section 32). These criteria are described in more detail in the successive section on the relevant statutes.

These changes endeavoured to achieve three key objectives:

- to make the scheme fairer through extending scope for cover
- to align this part of the legislation with the rest of the no-fault scheme through abolishing the error criterion
• to advance patient safety through encouraging open disclosure, information sharing and system approach (Dyson 2003).

The change signified a further shift toward the state accepting a greater responsibility for medical injuries. It moved the focus from an individual health professional’s actions or omissions to act to the systems’ deficiencies. In this new paradigm the state assumes responsibility for most medical injuries, as well as for a system approach to prevention of adverse events in healthcare.

**Statutes related to adverse events in healthcare**

The AC Act remains the key statute for redressing medical injuries. It stipulates, however, that certain proceedings can be held under jurisdictions other than the courts (AC Act 2001, section 317(4)). The AC Act permits bringing proceedings for exemplary damages in the courts (AC Act 2001, section 319) as such proceedings serve a punitive and not compensatory purpose.

Personal grievances that did not result in physical injuries can be pursued through the Health and Disability Commissioner, the Human Rights Review Tribunal, and the Health Practitioners Disciplinary Tribunal. These avenues are important because they provide a means of redressing alleged negligence and substandard but non-injurious care. The statutes governing these agencies are complementary to the AC Act and set to facilitate exchange of information between the agencies.

The scheme was never intended to act as a platform for ‘retribution, punishment or deterrence’ (Ferguson 2003, p.489). The separation of the compensation scheme from the complains and disciplinary proceedings mitigates the tension between compensation and accountability (Manning 2010).
The Accident Compensation Act 2001

The expressed purpose of the AC Act is to enhance the public good and reinforce the social contract. It is set out

to enhance the public good and reinforce the social contract represented by the first accident compensation scheme by providing for a fair and sustainable scheme for managing personal injury that has, as it overriding goals, minimising both the overall incidence of injury in the community, and the impact of injury on the community.

(AC Act 2001, section 3)

In respect to treatment injuries the Act is set out to mitigate consequences of adverse events for those who sustained injuries caused by treatment, and to reduce medical injuries through reduction of adverse events in healthcare.

As a trade-off for the state providing for all accidental injuries, the statute enacted a bar on court proceedings for compensatory damages arising out of personal injuries covered under the AC Act:

**Proceedings for personal injury**

(1) No person may bring proceedings independently of this Act, whether under any rule of law or any enactment, in any court in New Zealand, for damages arising directly or indirectly out of—

(a) personal injury covered by this Act; or

(b) personal injury covered by the former Acts.


Since personal injuries caused by medical treatment were covered by the accident compensation statute, ban on medical litigation took away the health services consumers’ right to pursue claims for personal damages through the courts.
The treatment injury legislation enacted in July 2005 is regarded as a significant step forward in developing a fairer scheme and creating a culture supporting quality improvements in patient safety. Under the treatment injury regime the key criterion for cover is causal link between injury and medical treatment. Several exclusion criteria are incorporated; the most commonly applied are the injury being ordinary or necessary part of treatment, or being caused ‘wholly or substantially’ by the underlying medical condition.

(1) **Treatment injury** means personal injury that is -

(a) suffered by a person –
   (i) seeking treatment from 1 or more registered health professionals; or
   (ii) receiving treatment from, or at the direction of, 1 or more registered health professionals; ... and

(b) caused by treatment, and

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

(2) **Treatment injury** does not include the following kinds of personal injury:

(a) personal injury that is wholly or substantially caused by a person’s underlying health condition;
(b) personal injury that is solely attributable to a resource allocation decision;
(c) personal injury that is a result of a person unreasonably withholding or delaying their consent to undergo treatment.

(AC Act 2001, section 32)

There is no reference in the legislation to a standard of care, and the focus is on patients, rather on the actions of health professionals. The other important new elements enacted in the amendments are the reporting of potential harm to the public.
(AC Act 2001, section 284) and closer collaboration with the Health and Disability Commissioner (AC Act 2001, section 50(20)). Between 2005 and 2011 the Corporation made 1958 notifications of belief of risk of harm to the public (Tapp and Frew 2011). The relevance of these amendments is discussed in the subsequent chapters.

Other relevant statutes

The AC Act providing cover and entitlements for medical injuries does not exist in a legislative vacuum. For the completeness of the scene it is essential to mention other avenues health services consumers can pursue when seeking redress for their personal injuries, or when dissatisfied with the quality of medical care.

The no-fault approach led to development of other statutes with the focus on safeguarding quality of healthcare and health practitioners’ accountability. The key statues that complement the AC Act in redressing damages and ensuring medical accountability are:

- The Health and Disability Commissioner (H&DC) Act 1994 and the Code of Health and Disability Consumers’ Rights
- The Health Practitioners Competence Assurance (HPCA) Act 2003
- The Human Rights Act 1993
- The Privacy Act 1993.

These pieces of legislation focus on health services consumers’ rights and the agencies administered under these statutes are interrelated. Each of the corresponding agencies has a specific function, and in most cases initiating proceedings under one of these statues does not preclude individuals from bringing their cases under other statutes’ jurisdictions.

The Health and Disability Commissioner’s office is the most common avenue dealing with non-injurious claims. The H&DC was established following the findings of the national inquiry into the treatment of cervical smear at National Women’s Hospital (Cartwright 1988). The H&DC Act sets up the Commissioner’s purpose as
to promote and protect the rights of health consumers and disability services consumers, and, to that end, to facilitate the fair, simple, speedy, and efficient resolution of complaints relating to infringements of those rights.

(Health and Disability Commissioner Act 1994, section 7)

When a breach of patient’s rights warrants it, the Commissioner can refer a case to the Human Rights Review Tribunal (HRRT) or to the Health Practitioners Disciplinary Tribunal (HPDT), or both (Health and Disability Commissioner Act 1994, section 34).

The HRRT also considers cases brought under the Human Rights Act 1993 and the Privacy Act 1993. The HRRT can reward punitive damages when there was a ‘flagrant disregard’ of the consumer’s rights (Health Practitioners Competence Assurance Act 2003, section 57(1)).

The Health Practitioners Disciplinary Tribunal, governed by the Health Practitioners Competence Assurance Act 2003, has the authority to redress harm arising from professional misconduct (Health Practitioners Competence Assurance Act 2003, section 101).

In addition to the above statutes criminal proceedings can be initiated for death allegedly caused by negligence. It is not a common route and by the year 1998 only eight cases of negligent conduct and prosecutions for manslaughter were reported (Skegg 1998).

To sum up, the accident compensation law reform was brought about by the concerns with unfairness of tort law, and inclusion of medical injuries into the scheme was not driven by concerns about medical malpractice. The legislative framework addressing medical injuries has evolved over the last four decades. It has eventually substituted tort law with no-fault redress for personal injuries caused by treatment. Throughout its evolution the founding principles of the scheme have remained constant, and grounded in two distinct paradigms of community responsibility and causation.
CHAPTER TWO – ETHICAL PRINCIPLES UNDERLYING THE TREATMENT INJURY LEGISLATION

The previous chapter outlined the history of the conception and evolution of the treatment injury legislation, and sketched the philosophical values laid in the foundation of the accident compensation scheme. These values were defined as community responsibility and comprehensive entitlements in the belief that ‘the achievement of real security was important for building a better society’ (Palmer 2004, p.907).

This chapter explores the ethical premises underpinning the fundamental principles of the scheme in relation to the treatment injury provisions of the AC Act. It examines the multiple dimensions of the conceptions of justice and fairness, and elaborates on the notions of beneficence and non-maleficence in the context of the treatment injury legislation. The chapter defines the key ethical tension as the conflict between distributive justice and social utility of the scheme.

The accident compensation statute based on the Woodhouse Report’s recommendations translated the Report’s philosophical values into two fundamental goals:

- to enhance the public good
- to reinforce the social contract (AC Act 2001, section 3).

These goals were to be achieved through the key objectives:

- providing a fair and sustainable scheme for managing personal injury
- minimising the overall incidence of injury and its impact on the community (AC Act 2001, section 3).

The intent of the scheme encompasses a profound concept that interweaves throughout several interrelated and complex disciplines, such as political philosophy, economics, social science, law and moral inquiry. It is at times impossible to separate one paradigm from another, and to disentangle political issues from economic considerations, and social issues from moral problems.
The goals and objectives of the statute suggest that the scheme is set to enhance both social utility (through increased efficiency and decreased injury costs) and justice (through fairer distribution of risks and benefits). It appears that both utility and justice are essential in shaping up the scheme.

**The key issues of the no-fault regime**

The treatment injury legislation holds a unique status within the accident compensation scheme. Adverse events in healthcare account for only a small fraction of the total burden of accidental injuries. However these events get disproportionate publicity because of the special nature of patient-clinician relationship.

As briefly alluded to in the previous chapter, in most developed Western countries iatrogenic injuries are redressed under tort law. The New Zealand regime is one of very few comprehensive no-fault schemes that completely eliminated the requirement for an injured patient to prove the health professional’s negligence in court. Instead the scheme administered by the Accident Compensation Corporation assesses the claim and, if covered, the injured person receives appropriate entitlements, such as contributions towards treatment costs, weekly compensation for lost income, help at home and with childcare.

The central philosophical principle of the Woodhouse Report is community responsibility, which is to distribute the risks and burdens of its citizens’ accidents amongst all the members. The accident compensation regime translated this philosophical principle into community liability for redressing harm. Society liability is grounded in the notion of a fair cooperation and represents a trade-off between the size of damages and the certainty of redress.

In the context of the treatment injury legislation, underpinning the notion of community-wide liability and its objectives are the fundamental ethical conceptions of

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7 In 2009-2010 out of total 1,662,327 new claims lodged with ACC the number of claims attributed to treatment injury account was 5,210 (0.3%) (ACC Annual Report 2010).
justice and fairness, beneficence and non-maleficence. Each conception has a multitude of facets and I attempt to examine some of them.

Even critics of the scheme concede that the no-fault regime is a model superior to tort law in dealing with healthcare-related harm. It is not the purpose of this essay to compare these two approaches to remediation for medical injuries. However, some degree of comparison is unavoidable and integral to the subsequent discussion so it is worthwhile to sketch some of the key advantages of the no-fault regime. Some of these advantages have been outlined as a faster access to compensation for a greater number of affected patients, more effective dealing with complaints and more effective processes for clinicians’ accountability (Bismark and Paterson 2006).

Being a product of the non-ideal world, the no-fault approach is not a regime without its own imperfections, and several important questions warrant close consideration. First, is the no-fault regime fair to claimants? Does it provide fair and satisfactory remedies for redressing treatment injuries? Does it satisfy their need for justice? Second, providing cover and benefits to groups of people with similar incapacities based on causation of these incapacities suggests inequities. Inequity may be unfair. Is it morally defensible to use injury causation as the main criterion for allocation of benefits? Third, does a no-fault approach compromise safety of clinical practice through not providing incentives for improvements in the quality of medical care? Lastly, are the terms of cooperation resulting in relinquishing the right to litigate in exchange for universal access to the scheme fair? Does the statutory bar on litigation represent a fair trade-off between the size of damages and the certainty of recovery?

The common theme in most of these questions is a concern about justice and fairness. To examine these issues it is first necessary to elaborate on the conceptions of justice and fairness in ethics.

**Justice and fairness**

Justice and fairness are the conceptions fundamental to morality. Both conceptions are interconnected but not identical, and a distinction between their meanings, if made,
can be artificial and subtle. Both terms are often used interchangeably and have a multitude of definitions and interpretations.

Justice is often referred to as a standard of rightness: giving each person what the person deserves. Fairness is a notion commonly referred to in respect to a specific case, as well as being used in relation to our ability to make impartial judgements. A common egalitarian interpretation of justice and fairness is that fairness encompasses the moral intuition, and justice is driven by respect and a desire for fair treatment of people as moral equals (Avraham and Kohler-Hausmann 2005).

Over the centuries the conceptions of justice and fairness have been debated and developed by various philosophical schools. In their modern version the conceptions embrace a multitude of facets. There seems to be a consensus among different philosophical schools that the key attributes of justice and fairness include equality, impartiality, reasonableness and rationality.

Mill asserts that ‘justice implies something which is not only right thing to do, and wrong thing not to do, but which some individual person can claim from us as his moral right’ (Mill 1991, p.223).

Beauchamp and Childress suggest the interpretation of justice as ‘fair, equitable, and appropriate treatment in light of what is due or owed to persons’ (Beauchamp and Childress 2009, p.241).

In his innovative work Rawls unites both conceptions and develops a multidimensional notion of justice as fairness. Rawls applies the conception of justice as fairness to social institutions and practices, and defines justice as ‘essentially the elimination of arbitrary distinctions and the establishment, within the structure of a practice, of a proper balance between competing claims’ (Rawls 1958).

Fairness embraces the notions of equality and impartiality. A fair legislation ought to promote the interests of everyone alike. Aristotle defined equality as equal treatment of equals and unequal treatment of unequals in proportion to relevant inequalities (Gillon, 2003). The justice principle requires that individuals should be treated the
same unless they differ in ways that are relevant to the situation in which they are involved. However, people can be treated differently if criteria for this differentiation are deemed justifiable. One such criterion could be overall utility of the matter: ‘Each person maintains that equality is the dictate of justice, except where he thinks the expediency requires inequality.’ (Mill 1991, pp.19-20)

Aligned with the idea of equality is the notion of desert: each person should receive what he or she deserves. In a general overview of the desert notion Mill holds that ‘a person is understood to deserve good is he does right…’ (Mill 1991, p.218). It would constitute injustice to reward equally deserving persons unequally.

Fairness commands proportional sharing of benefits and burdens, and that can be achieved through society-wide liability. Woodhouse suggests:

[S]ince we all persist in following community activities, which year by year exact a predictable and inevitable price in bodily injury, so should we share in sustaining those who become the random but statistically necessary victims. The inherent cost of these community purposes should be borne on a basis of equity by the community.

(Woodhouse 1967, p.40)

As all society benefits from provision and utilisation of healthcare, it seems fair that society as a whole is to share the costs of medical injuries rather than to shift the loss on those unlucky individuals who were injured in the course of medical treatment.

Fairness requires reasonability and rationality. If a law produces outcomes that ordinary members of public deem unreasonable, it is bound to fall into contempt and precipitate public disquiet. Reasonable terms of cooperation are those that the parties would deem fair, had they to find themselves in each other’s position (Rawls 1958).

Mill asserts that it is ‘inconsistent with justice to be partial; to show favour or preference to one person over another, in matters to which favour and preference do not properly apply’ (Mill 1991, p.219).
Hart assigns particular relevance to justice in the evaluation of law and holds justice as one segment of morality, concerned with the way in which categories of individuals rather than individuals are treated (Hart 1961).

Kaplow and Shavell argue that fairness should not be a solo criterion used for evaluating legal regime, and that morality of legal rules depends on its effects on the well-being of individuals. Their view is that ‘a taste for fairness is no different from a taste for a tangible good or anything else’ (Kaplow and Shavell 2000, p.9). In agreement with this view, arguing with the proponents of the ‘rational choice theory’ that defines rationality as a rigid pursuit of self-interest, Sen holds that a reasonable concern for the interests of others is an intrinsic part of fairness (Sen 2009).

Making a judgement on what is just and fair can be challenging, as Sen succinctly asserts: ‘There could be different arguments suggesting disparate conclusions, and evaluations of justice may be anything but straightforward’ (Sen 2009, p.4).

To assess fairness or unfairness of an action or inaction it is necessary to define the communities of equals in application to whom legal rules could be fair or unfair. In this essay I discuss justice and fairness in relation to three distinct categories:

1. individuals harmed by medical treatment who fall within the remits of the accident compensation regime;
2. individuals with disabilities and needs similar to the first group but not covered by the statute;
3. New Zealand society as a whole.

I start with examining whether the no-fault regime represents a satisfactory arrangement for individuals who are covered under the treatment injury legislation.

**Is this legislative framework a fair means of redressing treatment injuries?**

In many instances injury is not only a physical set back to one’s interests but a complex interaction of a multitude of harms. While Shane and Susan, who were
deemed to have experienced treatment injury, would be receiving some benefits through compensation for their physical injuries, seeking compensation is only one of several reasons that motivate people to pursue justice.

Much has been written about what embodies justice to healthcare services consumers (Bismark and Dauer 2006, Manning 2010). Bismark & Dauer identified four categories of claimants’ motivation: restoration, communication, correction and sanction. Manning corresponds these categories to the objectives of tort law: compensation, corrective justice and deterrence, and highlights that in individual cases one motivation or objective frequently differs from one or more of others (Manning 2010).

Restoration is concerned with redressing physical, financial and economic losses. The focus of the accident compensation scheme is on restoration through providing relevant entitlements when claim cover is granted. These entitlements generally encompass treatment and rehabilitation costs, compensation for lost income and some other interventions as required on a case by case basis. As the scheme has a set award schedule, claimants with similar incapacities get similar levels of compensation (Bismark and Dauer 2006).

Inadequate communication and disclosure is another significant reason for people seeking redress. While in the absence of physical injuries the accident compensation scheme does not address these grievances, dissatisfied health services consumers can pursue their complaints through the Health and Disability Commissioner’s office.

Concerns with quality of clinical practices and processes, and desire to ensure their appropriateness so as to prevent future occurrences of similar adverse event is another category. The inquiries into competencies and quality of practice can be addressed through the H&DC and Health Practitioners Disciplinary Tribunal (HPDT). The latter is also set up to hold health practitioners accountable for their actions.

To reflect on substantive moral content of injury, Lazaar introduces the concept of injury as right-violation and defines two moral dimensions of injury: harm and wrong (Lazaar 2009). Harm represents damage to one’s interests (physical, emotional or
financial), while wrong represents disrespect for one’s moral equality. Lazaar argues that to rectify an injury both facets need to be addressed and devaluing one of the components may be insufficient for justice being attained. It can be argued that when applying this concept, the accident compensation scheme provides redress of harm, while other agencies provide redress for wrong.

Overall, New Zealand has a well balanced system that supports multiple avenues for seeking justice. The accident compensation scheme is concerned with compensation and rehabilitation, leaving accountability to other disciplinary regimes (Manning 2010). The interests of affected individuals are met in an impartial and timely way, and in respect to this group there does not appear to be any significant moral conflict that would warrant further discussion.

‘Horizontal inequity’?

It appears that by limiting access to the scheme to casualties of accidents, society provides for them more favourably than for those who have the misfortune of ill-health. The Woodhouse Report concedes that ‘in logic there is no answer’ to ‘how incapacity arising from sickness and disease can be left aside’, but a sense of realism and cost confined the scheme to injuries caused by accident (Woodhouse 1967, p.26).

Society’s resources are finite, and resources allocated to one commodity (in this case sustaining the scheme) could be limiting resources channelled to other essential commodities, such as social programmes. Any community facing competing priorities and making choices on how to use and distribute limited resources needs robust principles to guide decision making. Distributive justice is concerned with ‘fair, equitable, and appropriate distribution determined by justified norms that structure the terms of social cooperation’ (Beauchamp and Childress 2009, p.241). The theories and practical frameworks of distributive justice are intended to guide fair distribution of resources and benefits. A legal regime that affects material allocation of benefits must be based on the principles of distributive justice, and ensure that individuals receive their fair share of opportunities and benefits available in society (Beauchamp and Childress 2009).
The accident compensation scheme is set to enable a quick access to rehabilitation and restoration of health following injury. Health is regarded as a commodity of special moral importance because it is the means to normal functioning, and it is deemed a duty of the modern society to fairly distribute resources that support normal functioning (Daniels 2008). The gold standard of resource distribution in healthcare is allocation of services based on need and ability to benefit. Distinct from this approach to distribution, the accident compensation legislation sets out a distinct state-determined distribution of benefits based on injury causation.

To obtain cover, there must be established a causal nexus between the physical injury and the medical treatment. Establishing causation can be just as much an obstacle to compensation under the treatment injury scheme as under tort law. It is universally acknowledged that aetiology of medical conditions may be multifactorial. To complicate the matters further, in many cases medical treatment is given to patients who are already compromised by injury or illness. As Gaskins summarises it, ‘injuries and disease are caused by complex web of interactive sources, which are continually reshaped by a dynamic risk environment’ (Gaskins 2004, p.967). The legal test of causation in the case of treatment injury is the balance of probabilities, which is to prove that the probability of iatrogenic causation is greater than fifty percent. Very often the boundaries between iatrogenic injury and pre-existing pathology are blurred. In light of scientific uncertainty, is it fair to distribute benefits according to the cause of incapacity rather than to the incapacitated person’s needs?

Intuitively, exclusion of sickness affronts the natural feeling of justice. From the point of view of a person who lives with a disability caused by a congenital or chronic degenerative condition, the disparity in the levels of support based on cause and not on actual needs or losses seems unfair. However, emotions or intuition without reasoned appraisal are a poor source of valuation. Reason necessitates impartial analysis and considered inquiry, and impartiality requires detachment from one’s own vested interests. Mill asserts that ‘the feeling of justice might be a peculiar instinct, and might yet require, like all other instincts, to be controlled and enlightened by a higher reason’ (Mill 1991, p.216). Sandberg and Juth affirm that basing ethics solely on intuitions is as flawed as basing morality solely on reasoning, and a balance must be achieved between intuition and reasoning (Sandberg and Juth 2011).
In discussions on justice it is imperative to make a distinction between the notions of equity and equality, as they seem to be often used interchangeably and yet they are different. Equity, or idea of fairness in distribution, is an economic concept based on the idea of moral equality. Inequity implies unfairness of distribution. Equality as a concept and its philosophical interpretation has evolved over the years. It involves comparisons between groups of people, and, depending on the discipline that examines it, could relate to moral equality, or to health, economic, or social characteristics of groups. It is important to distinguish the concept of equality deployed in ethics from the meaning of equality in other disciplines.

The modern ethical meaning of equality is understood as treating people with equal respect and concern, rather than treating people uniformly, which is often implausible. Recognising persons’ equality does not necessitate identical treatment in any respects other than to the extent they have a moral claim for equal treatment (Gosepath 2007).

The main criticism of the scheme was that the distribution based on causation creates horizontal inequities for groups of people with similar incapacities (Duncan 2008, Stephens 2004). These inequities relate to preferential access to healthcare services for ACC clients, subsidised treatment costs, better access to work, education, home help, house and vehicle modifications and other assistance. ‘Horizontality’ in this instance refers to differences not based on inherent qualities, such as intelligence or health status, but attributed to factors external to individuals. The issue of inequity arising from the scheme was considered in-depth by the 1988 Royal Commission on Social Policy that examined the policy anomaly between providing for incapacities arising from accidents and non-accident related disabilities (Royal Commission on Social Policy 1988). The Commission concluded that in terms of level of compensation and access to healthcare the former group was ‘far better provided for’ than the latter, and that this resulted in an ‘inequitable’ situation (Duncan 2008, p.33). But does such inequity constitutes ethical inequality?

The interpretation of the notion of ‘equal treatment’ requires some explanation. Beauchamp and Childress list several characteristics for equal treatment that constitute material principles of distributive justice in framing public policies and
legal rules. These principles determine distribution to each person in accordance with and on the basis of equality, need, effort, contribution, merit and free-market exchanges. All or some of these material principles shape public policies and laws that are involved in distribution of resources and grounded in distributive justice (Beauchamp and Childress, 2009).

It appears that while distribution of benefits based on causation can lead to material inequalities, it does not represent unequal treatment of moral equals. As discussed in the subsequent chapter, some inequalities are acceptable if they work to the advantage of the least well-off (Rawls 1999).

The advocates of eliminating discrepancies in distribution of benefits on the basis of causation claim that these discrepancies are an ‘ongoing source of disappointment and grievance’ (Duncan 2008, p.34). However, public acceptance of the legislation appears to remain high and in proportion to the number of cover decisions issued by the Corporation, the number of decisions challenged through the High Court and the Court of Appeal is very small. A search of the New Zealand Legal Information Institute database identified very few treatment injury claims considered by these Courts. Palmer asserts that public acceptance of the accident compensation scheme is high as ‘… despite the glaring social inequalities and discrimination creating by treating the two sets of social problems – sickness and injury – differently, there seems to be no great sense of public disquiet or agitation about the issue’ (Palmer 2004, p.912).

Other jurisdictions, such as the Human Rights Review Tribunal, show very few instances of disagreement with the accident compensation law in general. A high profile case considered by the HRRT drew significant publicity and generated much interest in the issue. Melanie Trevethick, who is suffering from Multiple Sclerosis, appealed to the HRRT on the grounds of discrimination against people with disabilities (Trevethick v Ministry of Health [2007] NZHRRT 7 (4 April 2007)).

In a landmark decision the Tribunal highlighted that ‘there is a substantial social inequity arising out of the fact that similarly circumstanced people are treated differently depending on the cause of their disability. It is far from clear to us how
that state of affairs might be justified.’ (Trevethick v Ministry of Health [2007] NZHRR 7 (4 April 2007), p.2). Melanie’s claim did not succeed because it was ruled out that the basis of the differentiation was the cause of the claimant’s disability and not the disability itself. Hence the people with accident-related disabilities were not a valid comparator group and a case of discrimination was not proven.

At the inception of the accident compensation scheme, the main argument for limiting access to the scheme was its economic viability. Unrestrained commitment to provide for all causes incapacities could diminish commitment to providing other important public goods:

Advocates of a no-fault scheme are therefore faced with a dilemma: if they seek to compensate a greater number of claimants at the current rates they in danger of bankrupting the system; but if the rates are reduced to the levels that are normal with such schemes the integrity of the scheme is in danger of being undermined.

(Capstick et al.1991, p.231)

There does appear to be some tension between competing claims for distributive justice and social utility of the scheme, and I examine this tension in the subsequent chapter.

**Efficiency as a prerequisite for justice**

Efficiency is an important although not commonly discussed aspect of justice. Alluding to the distinction between the conception of justice in classical utilitarianism and the conception of justice as fairness, Rawls asserts that the latter embraces justice, benevolence and efficiency. Rawls states: ‘This conception assimilates justice to benevolence and the latter in turn to the most efficient design of institutions to promote the general welfare. Justice is a kind of efficiency’ (Rawls 1958).

To ensure the scheme is sustainable, this legal regime ought to be efficient so that its total cost to society is lowest. Efficiency implies the ability to redress medical injuries with minimal expenditure and effort.
In considering whether the no-fault approach is efficient, it is helpful to apply the economic framework developed for analysing tort liability rules (Calabresi 1970). Calabresi states that the ultimate goal of any accident liability regime ought to be minimising the costs of accidents. Calabresi framework helps address considerations of both justice and efficiency.

In the discourse on morality of tort law, Calabresi seems to advocate for a social insurance no-fault regime when accidents are viewed as a ‘general societal problem’ rather than incidental events linking ‘one victim with one injurer’ (Calabresi 1970, p.308). Calabresi holds that there is no ‘logical necessity’ to link ‘treatment of victims, individually or as a group, to our treatment of injurers, individually or as group’ (Calabresi 1970, p.297). In the even more powerful statement, Calabresi asserts that claiming a fault-based compensation system is the only solution to a fair remediation is ‘patent nonsense based on simplistic bilateral view of the accident problem’ (Calabresi 1970, p.301).

In the context of healthcare-related harm this approach is justified even more than under the general accident scheme because more often than not there is no wrong done to patients, and, using the repealed definition of medical mishap iatrogenic injuries are often a result of ‘treatment properly given’ (IPRC Act 2001, section 34 (repealed)). It is particularly apparent in cases of adverse reactions to medications.

Calabresi defines three categories of accident-related costs:

1. primary costs determined by incidence and severity of adverse events
2. secondary costs arising as a result of the absence of risk-sharing, when affected individuals have to bear the recovery costs
3. tertiary costs incurred by the judicial system through determining and enforcing liability.

In respect to the treatment injury regime, supporting improvements in quality and safety in healthcare leads to reduction in incidence and severity of medical injuries, and that reduces primary costs. Risk spreading through social insurance and society-wide liability reduces secondary costs because affected people can access
rehabilitation and compensation quickly, and at no additional cost to them. While compensation plays a significant role to individuals in redressing medical injuries, of more importance to society is prompt access to rehabilitation that results in faster return to normal functioning. Distributing benefits and burdens of harm proportionally safeguards justice. The no-fault regime and statutory bar on litigation enables avoidance of seemingly wasteful tertiary costs. Through the integration of the treatment injury legislation into the no-fault accident compensation scheme, the efficiency of redress for medical injuries is considerably greater than under tort law.

There is enough empirical evidence that the no-fault scheme is more efficient than the tort system due to lower transaction costs. Richards and McLean, referring to the medical malpractice litigation system as ‘a failure’, point out that ‘more than fifty percent of the dollars are lost to transaction costs’ (Richards and McLean 2005, p.73).

The proponents of tort law criticise the no-fault compensation scheme for taking away the right to sue for medical negligence. That could suggest impingement of a person’s right to something the person is entitled to intrinsically. But the right to litigate through the courts is set by a legal system, and cannot be regarded a natural moral right, such as the right to life and liberty. Relinquishing the right to litigate through the courts for personal damages does not represent violation of rights because the ‘right to sue’ is a social and political concept, and not a moral right.

The question on the relationship between legal and moral rights is complex and not pursued in this essay. It is relevant to note, however, Mill’s view on the connection between these concepts. Mill holds that society ought to safeguard fundamentals of individual wellbeing: ‘When we call anything a person’s right, we mean that he has a valid claim on society to protect him in the possession of it…’ (Mill 1991, p.226). Buchanan suggests that if Rawls’s theory included a right to litigate, it must have been a right ‘derivative upon the basic rights’ (Buchanan 1996, p.565) laid down by the three principles of the Rawlsian model. There seems to be an agreement that legal rights ought to be based on moral rights but it is not to suggest that the right to litigate for personal injuries belongs to the fundamental human rights.
As a legal right, tort has been relinquished in law in exchange for an alternative right based on social insurance. It does not imply that the opportunity to pursue claims under tort law was a good right in the first instance. Mill asserts that ‘the legal right of which he is deprived, may be the rights which ought not to have belonged to him; in other words, the law which confers on him these rights, may be a bad law.’ (Mill 1991, p.218)

To sum up, efficiency is one of the vital ingredients of justice. It is just and fair to society to support and maintain a no-fault regime because such regime is efficient in dealing with prevention and consequences of medical injuries.

**Beneficence, non-maleficence and patient safety**

Distinct from the conception of justice but related to it in many ways are the fundamental ethical principles of beneficence and non-maleficence. Medical treatment, whether diagnostic or therapeutic, is a high risk activity, and injuries caused by medical treatment are statistically certain to occur. On par with the objective to ensure a fair and sustainable scheme, the statute’s objective is to minimise the burden of medical injury on the community.

Underpinning this second objective are the ethical principles of beneficence and non-maleficence. These two principles differ, although both have similarities in their means and ends. Overall, beneficence is concerned with advancing good, while non-maleficence relates to preventing harm.

In ethical theory beneficence is understood as inclusive of all forms of actions and rules that are designed to promote the benefit of other persons or groups of persons. Often promoting good requires preventing or removing possible harms. Beauchamp describes two variances of this principle: positive beneficence and utility beneficence (Beauchamp and Childress, 2009). The former requires promotion of benefits, the latter dictates that to achieve the best overall results benefits, risks and costs ought to be identified and balanced.

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8 Patient safety is defined as ‘the absence of preventable harm to a patient during the process of health care.’ (WHO 2011)
Discussing the place of beneficence in the utilitarian theory, Beauchamp refers to Mill’s view that beneficence can be a single unifying standard that helps us with forming rational opinions on rightness or wrongness of actions and practices, regardless of moral theory used in decision making (Beauchamp 2008). The principle of utility beneficence suggests that the beneficial consequences of the legislation need to be weighted against risks and possible harms. If an action or a rule results in the greatest possible balance of beneficial consequences, or at least in the least possible balance of harmful outcomes, then the action is regarded as ethically sound.

In the context of the treatment injury legislation, positive beneficence is reflected in provision of prompt and comprehensive cover for patients who suffered adverse events in healthcare, and providing compensatory damages, when appropriate. The benefits to society as a whole, as well to individual patients, are improvements in quality of clinical care achieved though no-blame culture conducive to disclosure of adverse events, more open communication and learning from mistakes. It is in contrast to tort law that is ‘positively counter-productive’ to patient safety as it ‘provides a clear incentive not to report, or to cover up, an error or incident. (Tingle 2011, p.1).

Hoppe argues that the principle of non-maleficence is of a very limited interest under tort law because it is only applicable when harm is caused deliberately (Hoppe, 2011). In contrast, under the no-fault regime this principle plays a significant role. First, the legislation supports prevention of more serious harm to individual patients who were injured by treatment. That is achieved through patients getting prompt access to relevant treatment and rehabilitation services. Furthermore, the principle of non-maleficence also underpins a system approach to investigations of causes of adverse events, and prevention of potential harm to the public. Reporting of risk of harm to the Director General of Health and, under some extraordinary circumstances, to professional registration bodies, can result in actions that prevent potential harm from occurring.

The principles of justice are interrelated with the principles of beneficence and non-maleficence. Under certain circumstances principles of justice may need to be
superseded in favour of other categories of moral claims, such as society’s welfare. If the accident compensation statute was to distribute costs and risks fairly but precipitate increase in burden of treatment injuries, then it is unlikely that fair distribution would be an advantage over reasonable risk reduction. Hence harm reduction has a significant utility value and can be regarded as a distinct public good.

In the context of treatment injuries harm has several dimensions. Its private side is harm to affected individuals, whether it is physical, emotional, financial harm or a combination of any of these. In its public dimension not only the affected individuals but the society as a whole suffers a set-back to its interests. Public harm results from substandard medical practices, and it can generate a lack of security and mistrust in the medical profession (Lazaar 2009). Improvements in patient safety are aimed at mitigating both private and public harm.

The treatment injury legislation is set to achieve risk and harm reduction through reducing the incidence and impact of medical injuries. The former is thought to be achieved through improvements in incident reporting, disclosure of adverse events and enhanced learning. The latter is to be attained through expediting cover decisions, which helps with providing timely rehabilitation for those who sustained medical injury.

In the past it was claimed that medical malpractice litigation achieves two social objectives: maintaining good medical standards and compensating victims of negligent treatment (Collins 1992). The ongoing debate about the impact on the no-fault medical injury compensation approach provides two conflicting views on its effects on quality of medical care.

One camp represents the view that a no-fault scheme does not provide incentives for quality improvements and safer medical practice, and that tort law with its fear of litigation is a powerful deterrent for substandard medical care. The proponents of this view claim that the system has eroded individual responsibility, and, in the process, has diminished the extent to which it can offer incentives to those who have an opportunity to influence safety. For instance, Howell argues that this system does not
encourage better quality of care and enhanced prevention, and shifts risks from practitioners and medical administrators to individuals (Howell 2004).


Luntz points out that the threat of litigation deters innovative treatment and discourages ‘worthwhile activity unless insurance against liability can be obtained at an affordable cost’ (Luntz, 2004, p.902). Likewise, Richards and McLean assert that the medical malpractice framework ‘does not provide workable incentives to reduce injuries’ and ‘impedes the adoption of better medical care practices…’ (Richards and McLean 2005, p.18).

The no-fault regime is corroborated by the system approach to analysing causes of adverse events in healthcare. The concept, commonly referred to as the Swiss cheese model, was developed by James Reason (Reason 2000). This concept suggests that nearly all accidents are a result of a chain of failures, when all ‘holes’ in each protective layer align, like a stack of slices of Swiss cheese. The aligned ‘holes’, or weaknesses in defence mechanisms, create opportunities for accident, and it would be unfair to attribute full responsibility for the accident to the last slice of cheese in the stack.

James Reason acknowledges human fallibility and inevitability of accidents in medical care, and recognises that a majority of accidents in healthcare are not egregious or negligent. Hence placing blame on an individual does not help with addressing the causes of ill events. The model regards human errors not as causes but rather as consequences of preceding events, and emphasises that adherence to assigning blame to individual practitioners hinders improvements in healthcare. Reason asserts that creating a culture fair to the practitioners is a vital prerequisite to improvements in patient safety.
Using the Swiss cheese model, Roberts refers to the highly publicised Bottrill case as a classical example of a system failure, and attributes the disastrous outcome to a combination of the individual clinician’s incompetence with the failure to monitor effectively the standard of his performance. Roberts concludes that financial incentives and litigious disincentives do not affect quality of clinical practice, as the healthcare quality is driven by professional virtues and internal morality (Roberts 2004).

In considering overall utility of the scheme if it important to determine whether the no-fault regime facilitates improvements in quality of medical care as well as prevents and diminishes harm. If, as likely, the no-fault scheme results in overall harm reduction, then such legal regime enhances common good.

To sum up, the key objectives of the treatment injury legislation are to provide a fair and sustainable scheme for redressing iatrogenic injuries, and to reduce harm arising from injuries in healthcare. These objectives are grounded in the ethical principles of justice and fairness, beneficence and non-maleficence. The treatment injury regime, complemented by other statutes, provides a just means of redressing medical injuries covered under its auspices, and an efficient structure promoting beneficence (through improvement in quality of medical care) and non-maleficence (through system-focused harm reduction). However the scheme attracts criticism in respect to inequity, claiming unjust resource distribution that is based on injury causation rather than need. It appears that the key ethical dilemma that warrants scrutiny can be defined as the conflict between social utility of the scheme and distributive justice.

9 The high profile ‘Bottrill inquiry’ established that between 1990 and 1996 a semi-retired pathologist Dr Bottrill misread and under-reported a considerable number of smears positive for cervical cancer. At least 16 women have developed cervical cancer following reporting of their smear tests as normal. The Ministerial Inquiry into the case identified several systemic issues that resulted in the failure (Duffy et al, 2001)
CHAPTER THREE – THE MAJOR THEORIES OF DISTRIBUTIVE JUSTICE AND THEIR IMPLICATIONS FOR TREATMENT INJURY LEGISLATION

This chapter outlines two philosophical doctrines on distributive justice, utilitarianism and egalitarianism, with Rawlsian justice as fairness as the most influential egalitarian theory. It then applies both philosophical frameworks to analysis of the ethical dilemma identified in relation to the no-fault treatment injury regime.

The major theories of distributive justice

I have selected utilitarianism and egalitarianism for this evaluation because these theories provide the most influential analytical frameworks of justice and represent two distinct philosophical schools approaching the issue of justice from different perspectives. The concept of wide reflective equilibrium suggests deploying perspectives of divergent moral theories in analysing complex moral problems. If testing by the two theories leads to the same conclusion, then it provides some assurance on the rightness of the action, rule or policy. If the conclusions under each theory do not converge, then it needs to be decided what conclusion ought to take priority.

Utilitarianism

Utilitarianism is the most prominent theory of consequentialism philosophy. It is one of several variations of the classical consequentialism that share a common approach of assessing morality of actions in relation to the consequences these actions produce. Under the utilitarian framework a morally right action generates the overall best result if it brings about the greatest overall utility.

The theory originated in the Jeremy Bentham’s “Introduction to the Principles of Morals and Legislation”. Bentham holds that society ought to adopt laws that will maximise utility and produce ‘the greatest happiness of the greatest number’ (Bentham 1781, p.5).
A subsection of this philosophical doctrine, rule utilitarianism, is concerned with considering the consequences of assuming certain rules. Rule utilitarianism provides an analytical framework that can help with analysing morality of institutions, policies and legislation. The utilitarian approach does not include any commitment to equality of distribution, and its concern with maximising society’s welfare can affect individual interests (Beauchamp and Childress 2009). Under the utilitarian principles the interests of individuals are set to be sacrificed for the greater good - the cumulative interests on the community.

In the original theory the conception of utility was limited in scope and included hedonistic goods, such as happiness and pleasure, as the key goods. The theory was later developed and enhanced by John Stuart Mill, who asserted that the concept of justice bears utility value, and can be explained in utilitarian terms. In the fundamental work “On Liberty and Other Essays” Mill states: ‘It has always been evident that all cases of justice are also cases of expediency: the difference is in the peculiar sentiment which attaches to the former, as contradistinguished from the latter.’ (Mill 1991, p.234)

Extending Mill’s view of justice as a utilitarian good, Kaplow and Shavell argue that fairness is a common good because it possesses instrumental social value and corresponds with internalised social norms. Every community has a set of norms important to that community. When people think of ‘unfairness’ of rules they attach importance to fairness because it is an internalised social norm (Kaplow and Shavell 2000).

Contemporary utilitarianism is described as both, consequences- and beneficence-based, inasmuch as it regards rules and institutions moral if they promote society’s welfare (Beauchamp and Childress, 2009). The modern notion of utilitarian goods is generally broader than under the original conception and includes everything that an individual may value. The goal of modern utilitarianism is to achieve the greatest good to society by balancing competing claims of all affected individuals. Utilitarian goods in a broad sense can embrace a diverse range of elements, from societal wellbeing to efficiency in reaching the goal of maximising benefits for the society as a
Some goods, such as costs, are tangible and measurable. Others, like life fulfilment, security, satisfaction, protection against risk, empathetic feelings for others, are nebulous and impossible to quantify.

Mill asserts that the feeling of security is ‘the most vital of all interests’ and something

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\text{no human being can possibly do without; on it we depend for all our immunity from evil and for the whole value of all and every good, beyond the passing moment; since nothing but the gratification of the instant could be of any worth to us, if we could be deprived of everything the next instant.}
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(Mill 1991, p.226)

Although it is not possible to compute the sense of security, it is one of the fundamental goods the accident compensation statute intended to achieve. As discussed in the previous chapter, the achievement of security was a factor influencing the choice of society-wide liability. Equal distribution of risks and costs of harm provides security through giving assurance of prompt rehabilitation and compensation in case of adverse events in healthcare.

To put it simplistically, a utilitarian perspective is that community’s welfare should be the single important criterion for selecting legal rules governing society. It suggests that if the distribution based on harm causation was eliminated, then good reasons ought to be provided on ‘why a society should willingly make (possibly all) its members worse off in order to advance a particular conception of fairness’ (Kaplow and Shavell 2000, p.6). It is recognised that ‘… under certain circumstances at least, utility could be maximised by providing extensive healthcare only for some groups, perhaps even a minority, rather than for all people.’ (Beauchamp and Childress 2009)

**Egalitarian view on accident law**

Egalitarianism is a theory of justice concerned with fair allocation of burdens and benefits among the members of society. While utilitarian distributive justice emphasises striving towards maximum net social utility, egalitarian theories
accentuate fairness in access to public goods, commonly appealing to material principles of equality and need.

Egalitarian doctrines require that individuals ought to be allocated an equal share of certain goods, such as wealth and medical care. It is important to note that no prominent egalitarian theory suggests equal distribution of ‘all possible social benefits’ (Beauchamp and Childress, 2009 p.247).

Within the distributive justice framework, egalitarians introduce the concept of equalisandum: a property or a factor that is to be equalised, whether it is income, opportunities or other matters that society needs to address. The problem, as Sen points out, is to decide on what properties and to what extent society ought to equalise. Equal opportunities can correlate with substantially unequal income, inequality of income does not necessarily result in unequal wealth, equal wealth does not automatically equate to equal happiness, and equal happiness can represent divergent fulfilment of needs (Sen 1979).

In the context of accident law, egalitarians use the notion of luck to accentuate accident-related disparities in distribution of burdens and benefits, and to differentiate between adverse outcomes resulting from informed choices and those resulting from fate or fortune (Avraham and Kohler-Hausmann 2005).

In relation to iatrogenic injuries luck has two facets: first being the recipient of ‘bad luck’ in an adverse event in healthcare, and then testing one’s luck through the ‘lottery of compensation’ in medical liability litigation. The no-fault insurance attempts to negate the latter, thus accommodating the substantive commitment to egalitarian fairness.

Dworkin describes the concept of ‘option luck’ and ‘brute luck’ to help distinguish between luck and responsibility for one’s actions (Dworkin 1981). Option luck is associated with an action of choice, and it does not play a major role in this discussion. With rare exceptions, such as injuries due to refusal to give consent to life-saving procedure or non-compliance with therapeutic regime, treatment injuries are beyond the injured person’s control and responsibility. In contrast, brute luck is
brought about by the circumstances outside individual’s control, and not resulted from the individual’s choices and actions. Egalitarians deem it society’s responsibility to mitigate brute luck.

In addition to option and brute luck, luck defined as constitutive is idiosyncratic to one’s genetic make up and lifestyle choices. Predisposition to adverse reaction to certain treatments, for instance, hypersensitivity to antibiotics, could be classed as constitutive luck. In many instances treatment injuries can be construed as a result of brute luck or of a combination of constitutive and brute luck. An example of the former is dental injury caused by anaesthetic intubation. The latter is illustrated by unpredictable reaction to medications, for instance Steven-Johnson syndrome caused by commonly used non-steroidal anti-inflammatory drugs.

Unlike utilitarianism, the egalitarian principles commit to fairness through attempting to negate the role of bad luck in determining one’s burdens and benefits and offering equal terms of remediation.

**Rawls’ justice as fairness**

Rawls’ conception of justice as fairness is the most influential twentieth century egalitarian theory of justice. It was originally set out in “Justice as Fairness” (Rawls 1958), and subsequently developed and revised in “A Theory of Justice” (Rawls 1971, Rawls 1999) and “Justice as Fairness. A Restatement” (Rawls 2001). Rawls argues that classical utilitarianism is unable to account for the aspect of fairness in justice, and that striving towards maximising common good is not to be confused with a good society (Rawls 1958).

Rawls’ theory of justice as fairness asserts three fundamental principles that set out a framework for making considered moral judgements. The first, the Liberty Principle, stipulates greatest equal liberty when each individual is entitled to equal rights to the greatest extent of basic liberties compatible with a similar magnitude of liberties for others.
The second, the Equality Principle, accommodates the Fair Equality of Opportunity and the Difference Principle. Rawls summarises these principles as ‘social and economic inequalities are to be arranged so that they are both:

- reasonably expected to be to everyone’s advantage and
- attached to offices and positions open to all.’ (Rawls 1999, p.53)

In the context of the accident compensation scheme the Equality Principle, and in particular the Difference Principle, are relevant to the discussion on fairness of distribution of benefits based on a single criterion of harm causation, and on fairness of terms of cooperation.

The Difference Principle further stipulates that some inequalities are permissible and fair if they are to the overall advantage of everyone, and primarily to the least well off: ‘…inequalities of wealth… are just only if they result in compensating benefits for everyone, and in particular for the least advantaged members of society’ (Rawls 1999, p13).

In reference to the misfortune and bad luck concepts, and to simplify the argument, it can be asserted that individuals affected by treatment injuries are worse off than those affected by illness. The former not only had an illness for which they sought treatment, but they also had bad luck of either this illness being undiagnosed or suffering adverse event, with the outcome at times being worse than the condition for which they sought medical attention. The most common examples are bowel perforation during diagnostic colonoscopy and rupture of eardrum caused by ear syringing on a blocked ear.

Integral to Rawls’ theory is the concept of primary goods, defined as ‘things which it is supposed a rational man wants whatever else he wants’ (Rawls 1999, p.79). Rawls sets up an index of primary social goods to provide a standard for interpersonal comparison. The index includes rights, income, wealth, and is used to identify the worst-off persons and to compare alternative arrangements from their point of view (Gibbard 1979).
Linked to the concept of primary good and to the utilitarian conception of social utility is the notion of common good defined as ‘certain general conditions that are… equally to everyone’s advantage’ (Rawls 1971).

Rawls construes the choice of principles of justice as an ideal social contract. The idea of a social contract allows us to view principles of justice as the object of a rational and impartial collective choice, where the terms of cooperation are acceptable and agreed upon by all engaged in it. The central feature of the social contract account of justice is the concept of the original position when ‘the principles of justice are chosen behind a veil of ignorance’ (Rawls 1999, p.11).

This philosophical concept suggests selection of fundamental principles of justice by all participants under hypothetical conditions when they would have been deprived of their personal characteristics, and would not have known whether the choice they make would have advanced their personal interests. Rawls suggests that the principle of justice made in the original position would be an indication of the structure of society the participants would have chosen to live in. In respect to treatment injury legislation, had a regime of redress for medical injuries been chosen ‘behind a veil of ignorance’, would have it adopted the no-fault comprehensive scheme?

**Implications of the theories of distributive justice for treatment injury legislation**

There seem to be two problems with deploying Rawls’ theory in the analysis of the treatment injury regime, which essentially is a set of legal rules determined by government policy.

First, Rawls emphasises that his theory is intended as a political conception, applicable to the design of political, social and economic institutions. In his works Rawls appears to be ambiguous on whether justice as fairness can be extrapolated to a general moral conception (Rawls 1985). The Principle of Equality of Fair Opportunity does not appear to be directly relevant to assessing law because it refers not to opportunities in general, but rather to specific equal opportunities for accessing
offices and positions. Second, the theory offers a justice framework for a perfect society, and direct application of this theory may be not appropriate for analysing existing legal rules in the non-ideal world. However, some elements of the Rawls’ model seem to be applicable in this analysis.

Daniels extends Rawls theory to include health needs and argues that health needs are one of the primary social goods. Daniels’ view is that while healthcare is not part of the original Rawls’ index, inclusion of healthcare is justifiable because fair distribution of healthcare provides for fair equality of opportunity. Daniels argues that a just society has an obligation to meet healthcare needs because much of health and disability are determined by social and economic status, and are to a significant extent effects of the social lottery as the result of a natural lottery (Daniels 2008).

The previous chapters defined the key ethical tension as the competing interests of social utility and distributive justice. I limit the scope of the subsequent discussion to two aspects of this tension:
1. fairness of distribution of benefits based on the single criterion of causation;
2. fairness of the terms of cooperation set by the AC Act.

I deploy the egalitarian notion of luck to analysis of the individual cases, assuming the same reasoning can be generalised to fairness of distribution based on injury causation. I then test fairness of the terms of cooperation from the perspectives of utilitarianism and justice as fairness.

**Fairness of distribution based on causation**

Within the scope of the treatment injury cover provisions, apart from several exclusion criteria, the main and essential criterion for cover is a causal link between physical injury and medical treatment. The statute does not single out any other factors, such as age, race, gender, employment or social status to influence eligibility for cover. Is injury causation a fair criterion for distribution of benefits?

Referring to the cited case studies, intuitively it seems unfair that John and Shane, both having similar needs, would be receiving disparate benefits. Shane would be
receiving appropriate entitlements provided under the AC Act, such as ‘rehabilitation, including treatment, social and vocational rehabilitation, and compensation.’ (AC Act 2001, section 69). John’s treatment and rehabilitation needs would be met by the publicly funded health system that is generally prioritises services on the basis of clinical need and ability to benefit.

In reality it is possible that Shane’s and John’s treatment and rehabilitation pathways would be similar in respect to timeliness and level of care. Conversely, it is also possible that John would not be getting the same level and timeliness of services. In case their treatment and rehabilitation routes differ, it would not be possible to ascertain at this individual level whether these differences in care resulted in different outcomes, such as the extent of their clinical, social and vocational rehabilitation. Furthermore, if any differences were identified, it would not have been possible to attribute the differences in outcomes to clinical care. The only significant difference between Shane and John could be in compensation, and only if both were employed at the time of the injury. For the sake of argument let us assume that Shane’s position will be better off than John’s because of the entitlements Shane will be getting under the treatment injury cover.

As discussed previously, the concept of desert in fairness commands that it is unjust to unequally reward equally deserving persons. Assuming that in any other respect John and Shane are equal, the key difference between them is that harm is done to the latter. In the egalitarian terms, John’s misfortune can be construed as a combination of constitutive luck (genetic predisposition) and optional luck (lifestyle choices, such as smoking and diet). Shane’s misfortune is further aggravated by brute luck, which is this case resulted in delayed diagnosis. That makes Shane worse off than John, and that is the brute luck the legislation is set to correct. In this respect it seems fair to expect the burden of assistance to Shane to be borne collectively by society. ‘Some disadvantages are mere unfortunate… while others are unfair, and therefore obligatory in justice to correct’ (Beauchamp and Childress 2009, p.250).

In the given scenarios we assume that Shane and John are equal in all respects except for harm causation, and that may well be the case. They both have the same medical problem (cerebral artery aneurysm) that resulted in the intracranial bleeding, they both
suffered significant neurological damage as a result of the haemorrhage. We know nothing of either person’s circumstances, such as age, race, or socio-economic status, although all these factors are important in a variety of ways for the resulting differences in Shane’s and John’s positions.

It is possible to imagine a scenario where intuitively Shane would appear more deserving than John. For instance, if John’s misfortune was to greater extent due to option luck, such as John’s lifestyle choices that increased his chances of ill-health.

The most common causes of brain aneurysms are congenital abnormalities, high blood pressure, atherosclerosis, and head injury. Let us assume that Shane had a congenital defect in the cerebral artery, but otherwise led an impeccably healthy life, exercising and watching his diet. The aneurysm rupture was due to the natural progression of the congenital pathology and Shane had no means of identifying it earlier or preventing the deterioration and the resulting rupture.

In contrast, John’s unhealthy lifestyle was a major contributor to his stroke, and John could have had considerably reduced the chances of its occurrence had he taken reasonable steps to modify his lifestyle and to control his high blood pressure. Furthermore, John could have had more resources to mitigate for unhealthy lifestyle, such as better education and higher income than Shane, but he did not make an effort to benefit from these resources. Under these circumstances, would it appear fair to reward damages to Shane when intuitively it seems that Shane is more deserving than John?

If we accept that fairness is to give a person what the person deserves and ‘a person is understood to deserve good if he does right’ (Mill 1991, p.218), then Shane, who did no wrong, would be recognised as a more deserving recipient of benefits.

What constitutes fairness in this context is that the law is impartial because it is concerned with a specific event and a causal nexus to this event and not with a person who was harmed or injured through the specific event.
It is conceivable that John could have a misfortune of another adverse medical event, and receive cover and entitlement for that event, so John is not excluded as a person but because of the particular circumstances of his case.

The same logic is applicable in cases of Susan and Mary. In these instances the difference in entitlements could be even smaller because the entitlements relate to a proportion of incapacity, in this case attributable to advancement of cancer, but not to the entire pathology. Mary’s right to healthcare is not compromised because her health needs are likely to be met with the same urgency as Susan’s by the healthcare system funded through general taxation.

On reflection, causation seems to be a reasonable and rational criterion for distribution of benefits if it is universally and systematically applied to injuries and events as it is impersonal and concerned with circumstances of the case and not with an individual.

**Balancing social utility and justice**

The previous discussion identified social utility of the scheme and distributive justice as the key competing interests. Applying and comparing utilitarian and justice as fairness perspectives to this tension helps guide reasoning on ethical robustness of the treatment injury regime.

As the utilitarian objective of the scheme is to maximise common good, it is useful to reiterate the substantive utility goods related to the treatment injury legislation. These goods can be roughly grouped into three categories:

- **measurable benefits**: efficient administration of the scheme, fast and fair access to rehabilitation and compensation for injured patients. Fast access to rehabilitation is expected to be translated into faster return to work, either paid or unpaid;

- **unquantifiable benefits**: feeling of security in accessing remediation, feeling of social solidarity and living in society that is fair to its citizens;
likely but difficult to measure benefits: beneficence and non-maleficence through improved quality of healthcare and harm reduction.

Many of these goods are interconnected and related to the normative elements of justice. As discussed previously, efficiency is a pre-requisite for fairness and maintaining an inefficient legal regime would be unfair to society; the no-fault approach to harm is thought to advance beneficence and non-maleficence.

Economic inequalities and health disparities carry a significant utility weight from the perspectives of both theories. From the utilitarian perspective, overall utility of the scheme is maximised through linking provision of benefits to cause of injury. It is recognised that distribution of benefits based on injury causation results in some degree of material inequalities between groups of people with similar disabilities and needs. However do economic inequalities translate into health inequalities? The notion of health inequalities is a public health concept that does not apply at an individual level. Does the difference in provision of benefits for persons with illness and with treatment injuries lead to health inequalities between these two groups? If it did, then social utility of the scheme would have been diminished.

However, there is no empirical evidence to show that at a population level health status and rehabilitation outcomes for people who do not get cover under the scheme are worse than for those who do get cover. People with ill-health do get access to medical care, and John and Mary would be still receiving treatment and rehabilitation through the publicly funded health system. Furthermore, the numbers of the covered treatment injuries are relatively small, and hence unlikely to become a major contributor to health inequalities at a population level.

In the foundation of the selection of cause of injury as the distribution criterion rests a powerful economic argument. At its inception the scheme was funded from the reduction in compliance costs associated with tort law. If extended to ill-health, no such costs would be released, hence removal of inequalities would require a considerable financial commitment that society would not be able to afford (Easton 2004). To paraphrase Rawls, equalities that are not to the benefit of all are unjust. It is not in disagreement with the Mill’s position that some inequalities are to be
tolerated and social utility ought to take precedence over a right to equality of
treatment. In the treatment injury context the ‘equality of treatment’ applies to making
a distinction between two groups (the injured and the sick). It does not imply,
however, inequality in the ethical sense. Systematically applying causation as the
distribution criterion across the population, the legislation treats all individuals as
moral equals. Furthermore, these material inequalities may be justified in Rawlsean
terms if the alternative is a return to tort law.

To reiterate the Difference Principle, some inequalities are permissible if they are to
the benefit of all, and in particular to the advantage of the least well off. Adopting the
egalitarian principle of brute luck, patients who were injured as a result of treatment
sought for ill-health are worse off then those who suffer ill-health not compounded by
iatrogenic harm.

Society-wide liability represents social insurance that reflects the idea of dispersing
the costs of injuries across the population rather than placing the burden of injuries on
victims who may or may not be able to recover some or the entire burden through
private insurance or tort. It seems fair that the costs associated with treatment injuries
should be shared by all those who benefit from provision of good quality medical
care. However, it is a misleading generalisation to view society as a monolith entity
where all its elements are identical in their preferences. Society is a congregation of
individuals with diverse aims and ends, and the principle of social choice can differ
and directly conflict with the principles of individual choice. Some people may prefer
to opt for legal rules that would allow them to contest their claims through courts, in
an attempt to obtain greater satisfaction and compensation. Honore asserts that ‘in
pluralistic societies people often disagree about the values they should individually or
collectively pursue; disagreement about values is normal and may be valuable’
(Honore 1993, p.12).

To balance diverse views at a societal level the principle of fairness denotes that
disagreements are to be solved by agreed principles of cooperation. Terms of
cooperation are fair if all its participants regard the terms as reasonable, acceptable
and beneficial. Such terms also imply ‘comparing burdens and benefits to those
affected under alternative possible principles of cooperation’ (Keating 2010, p.1867).
This approach could be the key to determining ethical soundness of the treatment injury legislation, and to unify both, utilitarian and justice as fairness, perspectives. If it can be demonstrated that the terms of cooperation are fair, then it would be logical to conclude that the legislation achieves a fair balance between the competing claims.

Rawls defines fair cooperation where the

 terms that each participant may reasonably accept, provided that everyone else likewise accepts them. Fair terms of cooperation specify an idea of reciprocity or mutuality: all who are engaged in cooperation and who do their part as the rules and procedures require, are to benefit in some appropriate way as assessed by a suitable benchmark of comparison.’ (Rawls 1985, p.232)

Hence fair cooperation assumes three main characteristics:

- it is guided by commonly recognised rules and regulations
- it is based on fair terms
- it ought to be to each participant’s rational advantage.

To resolve the tension between social utility and distributive justice, the competing principles ought to be viewed within their historical context. The process through which the scheme was conceived and evolved is another aspect to be considered in assessment of fairness of the terms of cooperation. Rawls’ notion of the multi-staged unfolding of justice suggests that the legal regime resulting from the collective decision making reflects the society’s values.

Rawls sets out a three-step process that ensures acceptability of the resulting regime to society (Rawls 1985). In application to the treatment injury legislation this process could be described as following:

1. the principles of justice were aligned with the societal values as they were based on the recommendations of the Woodhouse Report that identified injustice with redressing injuries arising from accidents;
2. the law reform and a replacement of common law by the no-fault regime followed the selected principles of justice at a ‘constitutional stage’ subsequent to the Woodhouse Report;

3. the statute evolved from medical accidents to the treatment injury provisions, making cover provisions more inclusive, fair and aligned with the no-fault accident compensation scheme.

Applying this model to the treatment injury regime, it appears that in its current form the legislation has been through a robust process of determining its scope, and it reflects the values of solidarity and community responsibility prevalent in New Zealand society.

In an ideal world justice and fairness would favour extending benefits of the accident compensation scheme to sickness and ill-health. In reality, we evaluate one possible set of legal rules against another possible approach, and not against utopian arrangements. To quote Sen, ‘pursuing justice is about making comparisons’ (Sen 2009, p.IX).

The advantages of the no-fault scheme over tort law have been widely recognised. It is universally acknowledged that ‘the purpose of tort law is not to protect but to compensate.’ (Miola 2011, p.49). By contrast, the no-fault social insurance is set out to accommodate both protection and compensation. The advantages and tangible benefits of the no-fault regime can be grouped into three categories. Most of these benefits have been discussed in the previous chapter, but it is helpful to summarise the key points.

First, the treatment injury regime advances justice through consistency of resolution and efficiency of the accident compensation scheme administrative system. The former is accomplished through achieving equal results in similar cases and avoiding arbitrary and disparate redresses (Bovbjerg and Sloan 1998). The latter is achieved through more material benefits gained in relation to insurance premiums.
Second, the no-fault regime advances beneficence and non-maleficence as it facilitates improvements in patient safety and promotion of better quality of medical care through:

- supporting centralised collection of data on adverse medical events, which is helpful in identifying trends and patterns and in its contribution towards developing strategies for preventing further medical injuries;
- enabling reporting of risk of harm to the public to appropriate professional bodies. The reporting facilitates actions that can result in preventing further harm from occurring;
- encouraging faster rehabilitation because there is no incentive for injured patients’ malingering while waiting for a court hearing;
- not providing incentives to health professionals to practice defensive medicine.

Third, the no-fault approach advances both justice and beneficence through efficient and fair compensation and rehabilitation:

- direct access to the scheme expedites access to treatment, rehabilitation and compensation;
- more people are eligible for cover because it does not require treatment to be erroneous. A majority of adverse events in healthcare are not caused by negligent or substandard treatment;
- patients are more willing to make a claim when it is a means of accessing compensation and rehabilitation rather than retribution;
- for the same reason health practitioners are more willing to support patients with making claims and be forthcoming about the circumstances and nature of injury.

As discussed in the previous chapter utility beneficence requires balancing benefits and costs so to produce the best possible results. It seems that the treatment injury regime has achieved a reasonable balance of benefits and costs without infringing any of the key ethical propositions, and as a result has advanced utility beneficence.
The utilitarian and justice as fairness theories are distinct, yet their concepts and ideas are intertwined. While they may disagree on the means, in this context both theories seem to agree on the ends. Both theories agree that the terms of cooperation under which the scheme is set up are fair. Utilitarians appreciate the regime’s overall utility: greater good for the greater number. Justice as fairness conceded that while the scheme brings about some material inequalities, such inequalities are permissible because the terms of cooperation are fair and the scheme is to everybody’s rational advantage.

Reiterating previously made points, some inequalities are not unjust and if terms of cooperation are fair individual expectations should be adjusted accordingly. ‘Society is responsible for distributing the primary social goods in accordance with the principles of justice and individuals must adjust their conceptions of the good accordingly. If they are disappointed but the terms of cooperation are fair, that is too bad for them’ (Daniels 2008, p.75).

**CONCLUSION**

To recapitulate the main points of this dissertation, I have attempted to examine critically the ethical premises laid in the foundation of the treatment injury provisions of the accident compensation statute. Within the narrow scope of this research it is likely that I have not grappled adequately with all concerns.

Justice and fairness, beneficence and non-maleficence were identified as the key ethical premises underlying the no-fault compensation regime. In contrast to tort law, the regime appears to have advanced justice and fairness, and have supported promotion of beneficence and non-maleficence. However, I concluded that the tension between social utility of the scheme and distributive justice remained unresolved and warranted in-depth analysis.

I applied two major theories of distributive justice, utilitarianism and egalitarianism, to examine this tension. Egalitarian implications for treatment injury legislation are that each member of society has access to an adequate level of compensation and
rehabilitation contingent on available resources. Using causation as a distributive
criterion does not violate the principle of fairness as equality because all persons are
treated as moral equals, and the same event activates a response that shifts resources
among contributors and recipients in agreement with this criterion. Justice-based
goals of universal access to all benefits would have made the system inefficient and
unsustainable, and hence unfair. The scheme provides a reasonable trade-off between
equality and efficiency.

Both theories of distributive justice deployed in this analysis seem to agree on the
view that some inequalities are permissible, though they come to this conclusion
through different pathways. Utilitarians accept inequalities as long as these
inequalities lead to increased total utility; egalitarians accept inequalities if they
benefit those who are worse off. While not ideal, the treatment injury legislation
appears to be ethically robust from the perspectives of both theories. To quote Rawls,
the legislation has achieved ‘a proper balance between competing claims’ (Rawls
1971, p.5).

In the discourse on the connection between morality and law Hart holds that society
creates legal rules that reflect accepted social morality prevailing in that society (Hart
1961). The intent and spirit of the accident compensation scheme seem to have
corroborated this view as it mirrors the values prevalent in New Zealand society. Had
John and Mary to chose a legal regime ‘behind a veil of ignorance’, it is likely that
they would have chosen an administrative no-fault scheme rather than medical
negligence law.

All factors considered, the best liability regime for iatrogenic injuries depends on the
interplay of concerns for fairness with pragmatic considerations. I conclude that the
no-fault regime for medical injuries replaced the ethics of individual rights under tort
law with the balanced ethics of common good and fairness. It is what was agreed on
collectively under the fair terms of cooperation. The scheme has achieved a just
balance between competing interests and developed the legal regime that is to
everybody’s rational advantage. The resulting social and economic gains are a
sufficient compensation to New Zealand society as a whole and to all its citizens.
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