

**CRISIS AND REFORM: IS NEW ZEALAND'S NO-FAULT
COMPENSATION SYSTEM A REASONABLE ALTERNATIVE TO THE
MEDICAL MALPRACTICE CRISIS IN THE UNITED STATES?**

Matthew Hitzhusen*

I. INTRODUCTION

It must be considered that there is nothing more difficult to carry out, nor more doubtful of success, nor more dangerous to handle, than to initiate a new order of things. For the reformer has enemies in all those who profit by the old order, and only lukewarm defenders in all those who would profit by the new order.¹

Written nearly four hundred years before the medical malpractice quagmire currently facing the United States, Machiavelli's understanding of the problems facing reformers is as accurate for American would-be tort reformers of the twenty-first century as it was for Italians in the sixteenth century. Legislators and legal scholars alike have proposed numerous responses to the crisis. However, none of these responses successfully addresses the issue in a way that presents a cogent solution that will also enjoy widespread public support.

In January 2004, for the third consecutive year, President Bush included in his State of the Union Address an explicit statement of his desire for tort reform in the area of medical malpractice litigation. According to the President, "[t]o protect the doctor-patient relationship, and keep good doctors doing good work, we must eliminate wasteful and frivolous medical lawsuits."² To further this goal, President Bush has strongly advocated for the imposition of a \$250,000 cap on non-economic damages and an undisclosed cap on punitive damages for all cases of medical malpractice. He claims these measures would "curtail frivolous lawsuits, decrease insurance costs, and ultimately lead to lower healthcare costs and better care for patients."³ The President has directed much of his criticism at

* J.D., University of Arizona James E. Rogers College of Law, 2005; B.A., History, Trinity College (CT), 2001. Special thanks to my editor, Dana Smith, for her insight and patience. I would also like to thank my parents for providing a physician's perspective on this issue and for their willingness to answer my phone calls, regardless of the time.

1. NICCOLO MACHIAVELLI, *THE PRINCE AND THE DISCOURSES* 21 (E.R.P. Vincent ed., Luigi Ricci trans., Modern Library 1950) (1513).

2. Lara Jakes Jordan, *PA Lawmakers Hope Third Time is a Charm for Bush Push on Malpractice Reform*, ASSOCIATED PRESS, Jan. 21, 2004.

3. Jim VandeHei, *Medical Malpractice Sparks Partisan Battle; Democrats Say Bush Caters to Insurers*, WASH. POST, Feb. 17, 2003, at A4.

trial lawyers⁴ for their alleged pursuit of “frivolous” claims that drive up the federal government’s health care costs by twenty-eight billion dollars a year⁵ and clog up the courts to the detriment of more deserving litigants.⁶

Legislators who oppose the proposed cap on damages supported by the President recognize the potential crisis in healthcare reform but do not “want to solve this very legitimate problem on the backs of the most innocent and badly injured of the victims.”⁷ In July 2003, Senate Democrats successfully stalled a bill containing the statutory cap provisions that had already been passed by the House of Representatives. The Democrats defended their position by arguing that a bill containing a statutory cap on damages would only benefit insurers.⁸ According to Senator Edward Kennedy, one of the Senate’s most outspoken critics of the plan, “[t]he Bush administration is again advocating a policy which will benefit neither doctors nor patients, only insurance companies.”⁹ Despite the contentiousness concerning solutions for medical malpractice reform, most legislators and legal scholars would agree with President Bush’s assertion that the malpractice system is “a national problem that requires a national solution.”¹⁰

In the United States, the tort regime claims the three primary goals of compensation, deterrence, and corrective justice.¹¹ Support for this system reflects a moral sentiment that “justice (however it be defined) demands that the

4. Scott Lindlaw, *President Pushes Effort to Limit Malpractice Awards*, ASSOCIATED PRESS, Jan. 26, 2004. In a speech in Little Rock, Arkansas in the week following his State of the Union Address, the President exclaimed, “The health care system looks like a giant lottery . . . and somehow the trial lawyers always hold the winning ticket . . . Lawyers walk away with up to 40 percent – 40 percent! – of every settlement and verdict.” *Id.*

5. *Id.*

6. Some suggest that partisan politics have played at least some role in the President’s desire for tort-reform. Opposing sides in this battle have aligned themselves with political parties through financial support. Over a twelve year period, trial lawyers contributed \$49 million to Democratic candidates, while giving only \$1 million to Republicans. Conversely, the pharmaceutical manufacturing industry and tobacco industry, often defendants in tort cases, have contributed approximately three times as much money to the Republicans as they have to the Democrats. Thomas B. Edsall, *Battle Over Damage Awards Takes a More Partisan Turn; Trial Lawyers – Key Democratic Donors – Say They’re Targets*, WASH. POST, Aug. 10, 2003, at A4. For a summary of President Bush’s record on tort reform as Governor of Texas, see George Lardner Jr., *‘Tort Reform’: Mixed Verdict; Bush’s First Priority in Office Pleased Business, Spurred Donations and Cut Public’s Remedies*, WASH. POST, Feb. 10, 2000, at A6.

7. Jordan, *supra* note 2 (quoting Rep. Joe Hoeffel).

8. Lindlaw, *supra* note 4.

9. VandeHei, *supra* note 3, at A4.

10. Edwin Chen, *Curb Malpractice Suits to Fix ‘Badly Broken’ System, Bush Says*, L.A. TIMES, July 26, 2002, at pt. 1, p. 30.

11. W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS 20-26 (5th ed. 1984).

doer of an injurious act compensate an innocent person who has suffered as a direct result of that act.”¹² Furthermore, supporters of the current tort system argue that “the right of citizens to bring suit for private wrongs, reinforced by widespread knowledge of that right, provides an important outlet for conflict that otherwise would break into violence.”¹³

Despite favorable results predicted from application of a tort system to the commission of wrongful conduct, fissures have appeared in the American tort system, prompting criticism of the system and arguments for various systemic changes and tort-alternatives. Commenting on the current state of tort law, Professor Stephen Sugarman claims, “The law is failing. It is incomplete as a compensation device, terribly wasteful of legal and other resources, doubtful as a promoter of safety, the probable cause of significant socially and economically undesirable conduct, and generally unsuccessful as a mechanism for doing justice between injurers and victims.”¹⁴ In spite of the growing list of its actual and perceived shortcomings, the current tort system has survived, if only because no “sensible alternative” to the fault system has been presented and accepted.¹⁵

With the United States perched on the precipice of its first medical malpractice crisis, New Zealand became the first country in the world to enact a comprehensive no-fault system of accident compensation in 1974.¹⁶ Intended to address skyrocketing healthcare costs and clogging of the courts based on increasing numbers of negligence claims, the complete overhaul of the existing New Zealand system aggressively confronted and replaced the perceived deficiencies of the common law tort system.

12. Walter Gellhorn, *Medical Malpractice Litigation (U.S.) – Medical Mishap Compensation (N.Z.)*, 73 CORNELL L. REV. 170, 176 (1988) (emphasis omitted).

13. *Id.* (quoting Marshall S. Shapo in ABA SPECIAL COMMITTEE ON THE TORT LIABILITY SYSTEM, TOWARDS A JURISPRUDENCE OF INJURY: THE CONTINUING CREATION OF A SYSTEM OF SUBSTANTIVE JUSTICE IN AMERICAN TORT LAW 3-16 (1984)).

14. STEPHEN SUGARMAN, DOING AWAY WITH PERSONAL INJURY LAW: NEW COMPENSATION MECHANISMS FOR VICTIMS, CONSUMERS, AND BUSINESS 211 (1989).

15. See GUIDO CALABRESI, THE COSTS OF ACCIDENTS: A LEGAL AND ECONOMIC ANALYSIS 307 (Yale Univ. Press 1970). According to Judge Calabresi:

justice will support the fault system only if there is no sensible alternative system presented, only if the choice is solely between crushing one relatively wrongful and one relatively innocent party. . . . [T]he moral aims of our society . . . can be better met through systems that concentrate on the deterrence and compensation we want than through an archaic system of liability that presumes an organization of society in which the best that can be done is to treat each accident . . . as a universe unto itself.

Id.

16. IAIN HAY, MONEY, MEDICINE, AND MALPRACTICE IN AMERICAN SOCIETY 12 (1992).

This Note will trace the historic trajectory of New Zealand's no-fault system of compensation, from its origins through the various legislative attempts to perfect the scheme, including a detailed explanation of the structure of the current accident compensation system.¹⁷ Furthermore, this Note will outline the various ways that legislators and physicians in the United States have attempted to combat the effects of the three different medical malpractice crises since 1975. Finally, this Note will consider whether any of the reforms affected in New Zealand are transferable to the United States and identify the roadblocks that might preclude such a change.

II. THE HISTORY OF NEW ZEALAND'S NO-FAULT SYSTEM

A. Historic Context and Legislative Development

New Zealand's interest in no-fault liability began more than a century ago and has developed considerably during the past thirty years. Although New Zealand law pertaining to personal injury initially followed the English common law model, a mine disaster at the end of the nineteenth century prompted passage of the Workers' Compensation for Accidents Act in 1900.¹⁸ The Act is "generally regarded as the earliest example of statutory social insurance. It provided for payment of compensation to all workers employed under a contract of service who suffered personal injury by accident or occupational disease arising out of and in the course of employment."¹⁹ Furthermore, the Act required employers to insure against such liability but did not limit the employee's right to sue under a theory of negligence.²⁰ Instead, the statute prohibited double recovery from both the worker's compensation system and damages from the court system.²¹ Despite the legislature's statutory improvement on common law remedies available to employees, the Act raised significant problems in determining which injuries were compensable, provided meager benefits for relatively short duration (ending after six years, regardless of severity of the injury), and proved ineffective in furthering

17. The Injury Prevention, Rehabilitation, and Compensation Act (IPRCA), 2001, 2001 S.N.Z. No. 49.

18. THE LAWS OF NEW ZEALAND, *Accident Compensation 1* (2005). In 1897, sixty-seven miners died at the Brunner Mine. The difficulty that the miners' families experienced in pursuing common law claims led the New Zealand government to pass the Workers' Compensation for Accidents Act in 1900, which remained in force until 1974. *Id.* New Zealand's enactment of the Worker's Compensation Act was also strongly influenced by the enactment of a similar statute by the English Parliament in 1897. *Id.*

19. Stephen Todd, *Privatization of Accident Compensation: Politics and Policy in New Zealand*, 39 WASHBURN L.J. 404, 408 (2000).

20. History of ACC in New Zealand at <http://www.acc.co.nz/about-acc/> (follow "History of ACC in New Zealand" hyperlink) (last visited Oct. 16, 2005).

21. Todd, *supra* note 19, at 408-09.

prevention of future accidents and inadequate in providing rehabilitation for the injured party.²²

Nearly thirty years after the implementation of the Worker's Compensation Act, New Zealand's legislature again attempted to enact a no-fault system within a limited setting. The new law made liability insurance mandatory for drivers of motor vehicles, in order to protect third parties who suffered death or injury on the highway.²³ Again, the efficacy of the legislation was somewhat limited as recovery still hinged on whether the claimant could prove that the death or injury resulted from driver negligence, and coverage under the act extended only to fare-paying passengers.²⁴

1. The Woodhouse Report of 1967

Finally, during the 1960s, serious questions began to arise as to the effectiveness of the workers' compensation legislation.²⁵ In order to address the issue, the legislature appointed a Royal Commission, led by Sir Owen Woodhouse, to investigate the matter.²⁶ In 1967, the Commission submitted its findings in the Woodhouse Report, which provided a blueprint for the future of injury compensation. The Woodhouse Report recommendations included a complete overhaul of the existing common law system²⁷ and replacement of fault-based liability with a new no-fault approach.²⁸ According to former Prime

22. History of ACC in New Zealand, *supra* note 20.

23. The Motor Vehicles (Third Party Risks) Act, 1928 (N.Z.).

24. History of ACC in New Zealand, *supra* note 20.

25. THE LAWS OF NEW ZEALAND, *supra* note 18. Specific concerns included the inadequacy of the six-year limitation on payment of entitlements, which forced many injured workers to rely on their social security benefits prematurely. In addition, weekly benefits compensated injured workers at fifty-two percent of their average weekly wage in 1974. *Id.*

26. *Id.*

27. Commenting on the Woodhouse Report recommendation to abandon the common law for personal injuries, former Prime Minister Sir Geoffrey Palmer noted:

The common law was excoriated . . . for a strategic reason. The common law had to go in order to capture the compulsory insurance money with which to fuel the new system. New money would not be available for a reform of this sort, [sic] the fact that you could do the reform without using any new money was one of the scheme's major selling points.

Colloquy, *Beyond Compensation: Comments: The New Zealand Experience*, 15 U. HAW. L. REV. 621, 648 (1993) [hereinafter *Beyond Compensation*].

28. Former Prime Minister Palmer commented that in New Zealand, before enactment of the ACA of 1972, "compulsory liability insurance had blunted or removed

Minister Palmer, trading the tort system for a no-fault system increased the social utility of the entire system of compensation:

[M]ore victims are paid, they do not have to prove fault from which massive savings result, and overall, everyone is better off. It is true that claims that every individual victim will be financially better off cannot be convincingly made. However, judged in the broad spectrum, the reforms provide a better set of arrangements than tort.²⁹

The Woodhouse Report assessed the state of the common law in New Zealand, and established a number of justifications in support of abandoning it in favor of its newly recommended system of compensation.³⁰ According to Sir Owen Woodhouse, under the common law system:

[J]ust as the test of fault against standards of *reasonable* care was becoming confused with standards of near perfection, so did the final result depend too often upon the fortuitous assessment of the evidence or the fortuitous skill of the attorney. . . . [I]t all seemed not only expensive but wasteful to the point of extravagance, as was demonstrated so clearly by the high proportion of funds which never reached the injured persons in respect of whom they had been collected. And there was the affliction of protracted delays.³¹

The Woodhouse Report based its recommendations on the five underlying principles of community responsibility, comprehensive entitlement, complete rehabilitation, real compensation, and administrative efficiency. Under the first principle, the Commission urged that the community should “protect all citizens . . . from the burden of sudden individual losses when their ability to contribute to the general welfare by their work has been interrupted by physical incapacity.”³² Second, the Commission found that all injured persons should receive compensation “from any community-financed scheme on the same

whatever deterrent effect tort law may have had . . . Damages tended to overcompensate less serious injuries. In addition, the process of adjudication was a lottery . . . There were strong incentives to maximize misery. In short, accident prevention was impeded by the entire system.” Sir Geoffrey Palmer, *The Design of Compensation Systems: Tort Principles Rule, O.K.?* 29 VAL. U. L. REV. 1115, 1120 (1995).

29. *Id.* at 1159.

30. Todd, *supra* note 19, at 407-09.

31. Sir Owen Woodhouse, *The New Zealand Experience, in* MEDICAL MALPRACTICE SOLUTIONS 171, 174 (Thomas Books 1989).

32. Todd, *supra* note 19, at 407 (quoting REPORT OF THE ROYAL COMMISSION OF INQUIRY, COMPENSATION FOR PERSONAL INJURY IN NEW ZEALAND, ¶ 55 (1967)).

uniform method of assessment, regardless of the causes which gave rise to their injuries.”³³ Third, the compensation scheme should be “deliberately organized to urge forward the physical and vocational recovery . . . while at the same time providing a real measure of money compensation for their losses.”³⁴ Fourth, the Commission found that real compensation requires the provision of income-related benefits for lost income for the entire period of incapacity and for any permanent bodily impairment, regardless of its effect on earning capacity.³⁵ Finally, the Commission found that the achievements of such a system of compensation would be “eroded to the extent that its benefits are delayed, or are inconsistently assessed, or [if] the system itself is administered by methods that are economically wasteful.”³⁶

The compensation scheme recommended in the Woodhouse Report would provide a comprehensive system of accident prevention, rehabilitation, and compensation for all injuries, irrespective of fault and regardless of cause, which would alleviate the problems associated with previous statutory attempts.³⁷ It would cover both motor vehicle injuries and injuries to “wage-earners,” whether the injury occurred at work or not.³⁸ The report further advised that such a system could be financed through levies on employers and self-employed individuals who would support such measures in exchange for protection from being sued for damages.³⁹ Although public sentiment and opinion within the legal profession was undecided,⁴⁰ and trade unions offered only cautious approval, in December 1971 parliament introduced an incomplete bill, which included a diminished version of the Woodhouse Report recommendations.⁴¹

2. Accident Compensation Act of 1972

Within a year, the New Zealand Parliament had unanimously passed the Accident Compensation Act of 1972 (ACA of 1972). However, in its original form, coverage under the Act extended only to employees who suffered work-

33. *Id.*

34. *Id.*

35. *Id.*

36. *Id.*

37. *Id.* at 409-10.

38. History of ACC in New Zealand, *supra* note 20.

39. *Id.*

40. See Woodhouse, *supra* note 31, at 175. Woodhouse has suggested that initial support of the Woodhouse Report recommendations was tempered because of “the heavy influence of inertia allied with natural reluctance on the part of the public at large to have present methods replaced by untried substitutes,” and from “opposition from those with economic interests who wished to preserve what they regarded as a justified field of business.” *Id.*

41. THE LAWS OF NEW ZEALAND, *supra* note 18.

related accidents and victims of accidents involving motor vehicles.⁴² Furthermore, tort remedies remained available for individuals suffering injury from accidents in all situations other than the two categories provided for by the Act.⁴³ Before the ACA of 1972 became law, with its limited acceptance of the Woodhouse Report recommendations, the populace elected the Labour Party, an administration supportive of a more extensive compensation scheme.⁴⁴ Following the election of the Labour Party in 1972, the government expanded the initial version of the ACA to twenty-four hour coverage of all accidents occurring in New Zealand, including injuries to students, non-earners, and visitors to New Zealand.⁴⁵ In exchange for this comprehensive coverage, the ACA barred those covered under the new scheme from suing for damages.⁴⁶

With its stated purposes of promoting safety, rehabilitation, and the provision of compensation to individuals suffering personal injury,⁴⁷ the ACA of 1972 came into effect on April 1, 1974. The Act provided twenty-four hour coverage for the entire population of New Zealand.⁴⁸ The ACA delegated administration of the scheme to the newly-established Accident Compensation Commission (ACC).⁴⁹ Funding for injury compensation was derived from three distinct funds created under the ACA: (1) an earner's account, funded by levies on employers and self-employed individuals; (2) a motor vehicle accident account, funded by levies on owners of motor vehicles; and (3) a supplementary account, subsidized solely by the government.⁵⁰ Under its statutory mandate, the ACC determined which individuals were entitled to benefits and made payments to such individuals, either in the form of weekly compensation or lump sums.⁵¹

42. The ACA of 1972 does not explicitly define "personal injury by accident." However, subsequent interpretations have applied the court's language in *Fenton v. Thorley*, [1903] A.C. 443, an English House of Lords decision which defined the term as "including an unlooked for mishap or an untoward event which is not expected or designed." *Beyond Compensation*, *supra* note 27, at 621.

43. Todd, *supra* note 19, at 410.

44. History of ACC in New Zealand, *supra* note 20.

45. *Id.*

46. Todd, *supra* note 19, at 410. The exchange of comprehensive coverage for denial of the right to sue has been referred to as a "social contract" or "social compact." See *Queenstown Lakes Dist. Council v. Palmer*, [1999] 1 N.Z.L.R. 549, 555 (C.A.).

47. Todd, *supra* note 19, at 410.

48. Woodhouse, *supra* note 31, at 171.

49. Subsequent legislation (the ACA of 1982) changed the name of the administrative body to the Accident Compensation Corporation (ACC), without changing its essential function.

50. History of ACC in New Zealand, *supra* note 20.

51. Todd, *supra* note 19, at 411. The ACC paid weekly compensation for economic loss at a rate of eighty percent of the individual's previous earnings, up to \$17,000 (N.Z.). *Id.* Despite opposition to lump sum compensation in the Woodhouse Report, lump sums were made available for loss of bodily function and pain and suffering. *Id.*

3. Accident Compensation Act of 1982

Within a decade of the enactment of the ACA of 1972, the public began voicing its dissatisfaction with the ever-increasing costs. Especially pointed criticism came from employers forced to pay the cost of non-work related claims.⁵² In response, the government appointed another commission to report on the problems with the current system, with the clear goal of reducing the overall cost to the public for administration of the compensation scheme.⁵³ The Quigley Report was authored by this newly-appointed commission.

Just as the ACA of 1972 closely followed the recommendations of the Woodhouse Report, the ACA of 1982 adopted many of the changes suggested by the Quigley Report.⁵⁴ While the ACA of 1982 left many of the essential features established under its predecessor untouched,⁵⁵ it changed the funding of the scheme from a “fully funded” structure to a “pay-as-you-go” funding structure.⁵⁶ The three funds were combined into a single account, and the maximum amount recoverable for permanent loss or impairment nearly doubled.⁵⁷ In 1984, following the implementation of the Quigley Commission reforms, the average levy rate for employers quickly decreased from \$1.07 per \$100 of income to \$0.70,⁵⁸ but this rate reduction eventually depleted fund reserves to emergency levels, forcing a large hike in rates again in the mid-1980s.⁵⁹

In the late 1980s, facing renewed opposition to the accident compensation scheme, the government again turned to Sir Owen Woodhouse to

52. See THE LAWS OF NEW ZEALAND, *supra* note 18.

53. *Id.*

54. *Id.*

55. Palmer, *supra* note 28, at 1121.

56. Todd, *supra* note 19, at 412.

Pay-as-you-go funding means that premiums or levies for the year pay all of that year's costs, including both old and new claims In comparison, under full funding, premiums must meet all the costs of claims made during that year. They do not include past claims, but do include the continuing cost of claims for the full duration of an injury.

Id.

57. History of ACC in New Zealand, *supra* note 20. Under the ACA of 1982, the maximum lump sum amounts recoverable were \$17,000 for loss of bodily function and \$10,000 for pain and suffering. Accident Compensation Act, 1982, 1982 S.N.Z. No. 181, pt. 6, §§ 78-79.

58. Woodhouse, *supra* note 31, at 178. The \$1.07 per \$100 of income represents the ten-year average (1974-84) levy rate. *Id.* The reduced rate (\$0.70 per \$100) came into effect in 1984. *Id.*

59. *Id.* In 1987, the average levy increased more than three-fold to \$2.50 per \$100. *Id.*

lead a commission to review the efficiency of the ACA.⁶⁰ Specifically, critics expressed dissatisfaction with the burgeoning expense of the scheme and the inconsistent coverage offered in dealing with the distinction between injury and illness.⁶¹ The Law Commission Report was the result of the new effort to review the efficiency of the ACA.

Published in 1988, the Law Commission Report recommended manifest changes to expand the administration of the ACA. These recommendations included the provision of coverage for sickness and non-accidental incapacity,⁶² the abolition of lump sum payments to be replaced with periodic payments, and the inclusion of “medical mishap” within the ACA system.⁶³ The Law Commission concluded that implementation of its recommendations for expansion could continue to be funded by levies, without an increase in costs.⁶⁴ However, soon after the Law Commission announced its recommendations, parliamentary power shifted, this time to the National Party. Using recommendations from a contemporaneous report,⁶⁵ the newly elected government found the existing compensation scheme to be too expensive,⁶⁶ and announced a new policy in opposition to the Law Commission recommendations. The new policy included a substantial reduction in accident benefits.⁶⁷

4. Accident Rehabilitation and Compensation Insurance Act (ARCIA) of 1992

In 1992, the New Zealand legislature, still in the hands of the National Party, tried its hand at improving the accident compensation scheme, which again faced funding problems that necessitated either further levy⁶⁸ increases or a

60. LAW COMMISSION, PERSONAL INJURY: PREVENTION AND RECOVERY – REPORT ON THE ACCIDENT COMPENSATION SCHEME (1988) [hereinafter LAW COMMISSION].

61. Todd, *supra* note 19, at 412.

62. *Id.* at 412-13.

63. History of ACC in New Zealand, *supra* note 20.

64. Todd, *supra* note 19, at 413.

65. See ROYAL COMMISSION ON SOCIAL POLICY, 2 REPORT OF THE ROYAL COMMISSION ON SOCIAL POLICY—FUTURE DIRECTIONS 757 (1988).

66. Despite the government’s concern over increasing costs, the annual cost of the accident compensation scheme from 1974 to 1992 averaged one billion dollars, or the equivalent of one dollar per day for every citizen of the entire country. Geoffrey Palmer, *New Zealand’s Accident Compensation Scheme: Twenty Years On*, 44 U. TORONTO L.J. 223, 227 (1994).

67. THE LAWS OF NEW ZEALAND, *supra* note 18.

68. Under the ARCIA of 1992, charges previously referred to as “levies” were explicitly redefined as “premiums.” Richard S. Miller, *An Analysis and Critique of the 1992 Changes to New Zealand’s Accident Compensation Scheme*, 52 MD. L. REV. 1070, 1071-72 (1993).

restructuring of the scheme.⁶⁹ Adverse public response to climbing levies prompted reforms aimed at reducing costs by reallocating the scheme's funding base and further restricting coverage for personal injury.⁷⁰ To effectuate these goals, statutory definitions contained in the Accident Rehabilitation and Compensation Insurance Act of 1992 restricted the scope of coverage by requiring that injuries fit strictly within one of the statutorily provided categories of compensable injury.⁷¹ Furthermore, the Act rejected the broader concept of "personal injury by accident," which had previously allowed for coverage of injuries not specifically defined in the legislation.⁷² As a result of this exclusive definition of personal injury contemplated in the ARCIA, the ACC no longer covered instances where "only the result was accidental, where the injury could not be attributed to any identifiable external event, and where a person . . . suffered harm from observing physical injury to another person."⁷³ In order to further limit costs, benefits were reduced for individuals who were capable of working, but were unable to find gainful employment.⁷⁴

Finally, in one of its most radical departures from its accident compensation antecedents, the ARCIA of 1992 sought to define coverage for harm caused by the acts or omissions of health care professionals.⁷⁵ Because of this new stricter definition of "medical misadventure," claimants sustaining injuries outside of the statutory definition were no longer covered by the accident compensation scheme and were thus able to circumvent the bar to common law actions for medical negligence or malpractice.⁷⁶ Additionally, the ARCIA included a number of other new provisions⁷⁷ that, taken together, created a more

69. Todd, *supra* note 19, at 415.

70. *Id.*

71. Accident Rehabilitation and Compensation Insurance Act, 1992, pt. 2 § 8(2), (N.Z.). Professor Miller argues that the election of the National Party prevented the Labour Party from implementing an even more comprehensive compensation plan than previous statutory attempts. Miller, *supra* note 68, at 1082.

72. Todd, *supra* note 19, at 415.

73. Palmer, *supra* note 28, at 1126. As a result of the ARCIA's narrowed definition of "personal injury," there was a greater opportunity for victims to bring common law actions, a "situation that the framers [of the original accident compensation scheme] were determined to prevent." *Id.* at 1128-29.

74. Todd, *supra* note 19, at 416. Beginning in 1992, benefits for such individuals ended after twelve months of the claimant having the "capacity to work." *Id.*

75. See Accident Rehabilitation and Compensation Insurance Act, 1992, No. 5, (N.Z.).

76. Miller, *supra* note 68, at 1074.

77. *Id.* at 1085. These provisions include: (1) a requirement that the ACC have expert advice in determining a claim; (2) a requirement that medical negligence be reported to a disciplinary body; (3) a rating system for health professionals based on their experience level; (4) permission for both claimants and health care professionals to request review by the ACC of its decision; and (5) permission to appeal the ACC's decision through the court system. *Id.*

adversarial series of proceedings that were a prerequisite to the award of benefits. Though the changes to medical misadventure ultimately undermined the overall efficacy of the accident compensation scheme, they also served to considerably strengthen deterrence and injury prevention by health care professionals.⁷⁸

In another departure from the previous accident compensation structure, the ARCIA created an account specifically devoted to injuries caused by medical misadventure.⁷⁹ Funds to pay victim benefits were derived from premiums “payable by registered health professionals of the same class as the registered health professional responsible for the medical misadventure.”⁸⁰ The creation of categorized accounts to fund certain types of accidents, in conjunction with the implementation of an “experience rating” system⁸¹ resulted in a system of economic accountability to third persons where, for the first time, “one class of injury-causers [were] charged for the costs of injuries not just to that class’s employees but to other persons whom that class . . . injured.”⁸²

According to Professor Richard Miller, the changes implemented under the National Party leadership signaled a “clearly identifiable change in the underlying philosophy of the accident compensation scheme. . . . [T]he basic principle of the original program [was] community or collective – as opposed to individual – responsibility. . . . [T]he [original] scheme reflected a concept of social insurance”⁸³ In sharp contrast to this original concept, Miller argued that the National Party government, as evinced by the changes made in the ARCIA of 1992, viewed the compensation system as an accident insurance scheme, “including premiums to be paid by individuals who will benefit under the program.”⁸⁴

Finally, in accordance with original Woodhouse Report policy, the ARCIA abolished lump-sum compensation for non-economic loss. In its place, the ARCIA provided for an “independence allowance” in instances where the individual’s injury resulted in more than a ten percent degree of disability.⁸⁵

78. *Id.* at 1091.

79. *Id.* at 1080. “Medical Misadventure Injury” was one of five separate accounts created under the ARCIA, with each account collecting premiums and paying out benefits to its stated set of beneficiaries. *Id.* at 1079-80.

80. Accident Rehabilitation and Compensation Insurance Act, 1992, No. 122(1)(a), (N.Z.). The ARCIA provided that the Medical Misadventure Injury account could be divided into certain fields of specialization and different categories of health care professionals. *See id.*

81. *See id.* Nos. 104, 111, 116, and 124.

82. Miller, *supra* note 68, at 1081.

83. *Id.* at 1071.

84. *Id.*

85. Accident Rehabilitation and Compensation Insurance Act, 1992, No. 54, (N.Z.). The allowance could not commence until thirteen weeks after the injury occurred. The ARCIA also set a compensation ceiling of \$40 per week for an individual with 100%

According to the then-Minister of Labour, the purpose of the allowance was “to enable those injured to meet the additional costs arising from a permanent disability during the remainder of their lives.”⁸⁶ Despite the government’s attempts to cut administrative costs for the ACC, the revisions included in the ARCIA could not withstand substantial public disapproval⁸⁷ with the curtailing of benefits, and the government soon began planning future changes to the scheme.⁸⁸

5. Accident Insurance Act (AIA) of 1998

Following the opprobrium heaped upon the ARCIA of 1992, the National Party-run government repealed the Act and passed legislation intended to replace the existing compensation scheme with a system of universal compulsory insurance.⁸⁹ The government’s new philosophy underlying the Accident Insurance Act reforms was to “replace state control by private enterprise, and thereby to facilitate freedom of choice, promote a greater emphasis on safety, and encourage rehabilitation and the efficient management of claims.”⁹⁰ Despite this philosophical change of direction, the AIA retained many of the essential components of the previous scheme and continued to support a “no fault accident compensation scheme to provide statutory entitlements for all persons – (a) who suffer personal injury for which they have cover under this Act; or (b) who are the spouses, children, or other dependants of persons [with coverage].”⁹¹ The most significant changes to the system included the replacement of the ACC monopoly

disability, to be scaled down accordingly for a lesser disability. Miller, *supra* note 68, at 1075.

86. Miller, *supra* note 68, at 1075.

87. In addition to the general decrease in benefits, the reductions had a particularly discriminatory effect on non-earners, the majority of whom were women. Palmer, *supra* note 28, at 1151.

88. *Id.* at 1119. In evaluating the ARCIA three years after its implementation, Palmer, the former Prime Minister of New Zealand, commented:

It is hard to imagine a more poorly-put-together policy than this one The levels [of compensation] could have been much more generous without incurring financial problems It is already plain that the policy cannot be sustained. . . . [T]he New Zealand scheme now, with its benefits cut back, does not provide full compensation for economic loss, for pain and suffering, or for loss of enjoyment of life.

Id. at 1151.

89. Todd, *supra* note 19, at 419.

90. *Id.* at 474.

91. Accident Insurance Act, 1998, pt. 1, § 7(1) (N.Z.).

with partial privatization of coverage⁹² and the reinstatement of a fully-funded⁹³ system for all other accounts still maintained by the ACC.⁹⁴ Ultimately, the result of this legislation, enacted under the National Party leadership, was to replace lump sums with periodic payments, to again separate ACA funds into distinct accounts, and return to a “fully-funded” system.⁹⁵

Though the stated goals of the National Party backed legislation were to create incentives for employers to make the workplace safer and to decrease the overall cost of injuries to society, these goals were ultimately unrealized. Parliamentary power again shifted to the Labour Party, whose victory on election day was significantly bolstered by its platform promise of revoking the reform measures laid out in the AIA and returning accident compensation to administration by a single state organization, the ACC.⁹⁶ The Labour Party kept its promise with quick passage of the Accident Insurance (Transitional Provisions) Act in 2000, which rejected the privatization of employer insurance and reinstated the Accident Compensation Corporation (ACC) as sole administrator of all forms of accident compensation.⁹⁷ The Labour Party further capitalized on the popularity of its ACC platform by introducing more changes, contained in the Injury Prevention, Rehabilitation, and Compensation Act (IPRCA) of 2001.⁹⁸

B. The Injury Prevention, Rehabilitation, and Compensation Act of 2001

In April 2002, IPRCA officially came into force, replacing the Accident Insurance Act of 1998⁹⁹ with the aspiration of “enhanc[ing] the public good and reinforc[ing] the social contract represented by the first accident compensation scheme . . . by providing for a fair and sustainable scheme for managing personal injury . . . [by] minimising [sic] both the overall incidence of injury in the

92. *Id.* pt. 7, § 169. Employers were required to insure with private insurance companies while self-employed workers were given the choice of staying under ACC coverage or using a private company. *Id.*

93. Proponents of the Accident Insurance Act identify three undesirable implications from pay-as-you-go funding: (1) “it results in intergenerational cost transfers, with future payers subsidizing past payers,” (2) “historical costs minimize the impact that experience rating has on encouraging safety measures,” and (3) “the real cost of claims is obscured, tending to weaken disciplines in managing claims efficiently.” Michael Mills, *The Case for ACC Reform*, 11 SOC. POL’Y J. OF N. Z. 83, 88-89 (1998).

94. Accident Insurance Act, 1998, pt. 10, § 290 (N.Z.).

95. Todd, *supra* note 19, at 457-58, 473-74.

96. THE LAWS OF NEW ZEALAND, *supra* note 18.

97. History of ACC in New Zealand, *supra* note 20

98. *Id.*

99. See THE LAWS OF NEW ZEALAND, *supra* note 18, at *Accident Compensation 2*, n.1 for a detailed analysis of the limited continued application of the Accident Insurance Act.

community, and the impact of injury on the community.”¹⁰⁰ More specifically, IPRCA re-established the ACC as the sole administrator of the accident compensation scheme, and refocused its attention on implementing new measures emphasizing restoration, “to the maximum practicable extent,” of an injured person’s health, independence, and participation in society through rehabilitation and fair compensation.¹⁰¹

1. Scope of Coverage and Definition of Recoverable Injury

To recover under IPRCA, a claimant must have suffered a cognizable personal injury within the borders of New Zealand.¹⁰² As with previous injury compensation legislation in New Zealand, IPRCA provides that compensation from the ACC shall be the exclusive remedy for individuals seeking compensation for personal injury.¹⁰³ IPRCA specifically defines “personal injury” as death, physical injury, mental injury suffered by a person because of physical injuries sustained, or mental injury suffered because of criminal acts. Furthermore, personal injury also includes gradual-process injuries, diseases, and infections caused wholly or substantially by “medical misadventure.”¹⁰⁴

For a claimant to recover for an injury caused by “medical misadventure,” the injury must satisfy three requirements:¹⁰⁵ (1) the claimant must have been injured as a result of seeking or receiving treatment;¹⁰⁶ (2) the treatment must have been given by, or at the direction, of a “registered health professional;”¹⁰⁷ and (3) the injury must have been caused either by medical error or medical mishap.¹⁰⁸

100. The Injury Prevention, Rehabilitation, and Compensation Act, 2001, pt. 1, § 3 (N.Z.).

101. *Id.*

102. *Id.* pt. 2, § 20. *See also*, Doyle v. Accident Compensation Corporation, [1997] 3 N.Z.L.R. 160 (H.C.).

103. *Id.* pt. 9, § 317(1). For exceptions to the general principle of IPRCA as the exclusive remedy, see THE LAWS OF NEW ZEALAND, *supra* note 18, at *Accident Compensation* 73, n.1.

104. *Id.* pt. 2, § 26(1)-(2). In *Childs v. Hillock*, [1994] 2 N.Z.L.R. 65, the court held that the definition of “personal injury” was to be non-exhaustive.

105. IPRCA specifically established an independent body, the Medical Misadventure Advisory Committee, whose duties included determining whether an injury had been caused by medical misadventure. *See* THE LAWS OF NEW ZEALAND, *supra* note 18, at *Accident Compensation* 8, n.1.

106. The courts have defined “treatment” as “the application of medical care or attention to a patient ailment [and] . . . is not confined to overt acts of intervention by way of care.” *Accident Rehab. & Compensation Ins. Co. v. RW*, [1999] High Court, Auckland.

107. According to IPRCA, pt. 2, § 34(1)(a), “registered health professionals” include chiropractors, dental technicians, dentists, medical laboratory and radiation technologists,

The statutory language of IPRCA specifically distinguishes between the two potential causes for medical misadventure.¹⁰⁹ “Medical error” roughly equates to common law negligence, and refers to the failure of a registered health care professional to follow a standard of care and skill reasonably expected under the circumstances.¹¹⁰ Medical error also may refer to an organization if the error is not readily attributed to a particular individual. Medical error must occur at the time of treatment. IPRCA specifically states that medical error does not exist if (1) the procedure did not achieve the desired result, (2) future events clearly show that a different course of treatment may have produced better results, or (3) the failure involved is attributable to the organizational allocation of resources.¹¹¹ In contrast to its definition of medical error, IPRCA defines “medical mishap” as an adverse consequence of medical treatment.¹¹² For personal injury to fit within the restrictive definition of medical mishap, correct treatment must have been provided to the claimant by a registered health professional, the likelihood that the treatment provided would have adverse consequences must be “rare,”¹¹³ and the adverse consequence to the treatment must be “severe.”¹¹⁴

2. Administration and Funding

The stated goal of the ACC is to provide coverage for injuries, eliminate the wasteful process of overusing the courts, reduce physical and emotional suffering by providing timely care and rehabilitation, and minimize financial loss by paying weekly earnings compensation for those unable to work because of injury.¹¹⁵ Structurally, the ACC is headed by its board, which consists of up to

midwives, nurses, occupational therapists, optometrists, pharmacists, physiotherapists, podiatrists, and any other registered medical practitioners.

108. *Id.* § 32(1).

109. Determinations of whether medical misadventure has occurred are handled by the Medical Misadventure Advisory Committee, an independent body specifically constituted under IPRCA. See THE LAWS OF NEW ZEALAND, *supra* note 18, at *Accident Compensation* 8, n.1.

110. IPRCA, pt. 2, § 33(1). Medical error can occur in deciding whether to give treatment, what treatment to provide, obtaining consent to administer treatment, during the administration of treatment, and during the diagnosis of a person’s medical condition. *Id.*

111. *Id.* § 33(4).

112. *Id.* § 34(1).

113. *Id.* Adverse consequences are considered “rare” only if the probability that an adverse consequence would occur is less than in one percent of cases in which treatment is given. *Id.* § 34(3).

114. IPRCA, pt. 2, § 34(2). The “severity” requirement is fulfilled by death, hospitalization of more than fourteen days, or a significant restriction of “normal” daily ability for the individual for more than twenty-eight days.

115. About ACC, <http://www.acc.co.nz/about-acc/> (follow “accident compensation scheme” hyperlink) (last visited October 15, 2005).

eight members, selected for renewable three-year terms.¹¹⁶ In its administrative capacity, the ACC's primary function is to "promote measures to reduce the incidence and severity of personal injury, including measures that create supportive environments that reduce the incidence and severity of personal injury; strengthen community action to prevent personal injury; and encourage the development of personal skills that prevent personal injury."¹¹⁷ This pledge is supported by accident insurance coverage, injury prevention services, case management, and rehabilitation services.¹¹⁸

Each year, the ACC allocates approximately \$1.4 billion towards rehabilitation, treatment, and weekly compensation for personal injury.¹¹⁹ The ACC is able to fund these programs by collecting premium payments from all citizens of New Zealand at government-regulated rates.¹²⁰ The money collected by the government is then assigned to the seven distinct funds maintained by the ACC, including an account set aside specifically for medical misadventure.¹²¹ According to IPRCA, medical misadventure account funds may be derived from levies, payable by all registered health professionals or organizations that provide treatment under the Act.¹²² Furthermore, if the levy relates only in part to the injury suffered, the remainder of the compensation derives from either the earners account or non-earners account, depending on the status of the claimant.¹²³

3. Making a Claim

In order to receive coverage under IPRCA for a personal injury resulting from medical misadventure, a claimant must first lodge a complaint with the ACC. The complaint must set forth the injury suffered by the claimant as well as

116. The Injury Prevention, Rehabilitation, and Compensation Act, 2001, 2001 S.N.Z. pt. 7, § 267(1).

117. *Id.* § 263(1). See *id.* § 263(2) for examples of specific ways for the ACC to further its function.

118. See About ACC, <http://www.acc.co.nz/about-acc/> (last visited October 15, 2005).

119. About ACC, <http://www.acc.co.nz/about-acc/> (follow "How ACC is funded" hyperlink) (last visited October 15, 2005).

120. *Id.* (noting that since 2001, premiums have dropped nearly twenty-five percent because of improved administrative efficiency).

121. *Id.* The other six accounts are: employers, self-employed work, residual claims, motor vehicle, earners, and non-earners. *Id.*

122. The Injury Prevention, Rehabilitation, and Compensation Act, 2001, 2001 S.N.Z. pt. 6, § 228. The levy rates are statutorily regulated in the IPRCA, pt. 6, § 229(2).

123. THE LAWS OF NEW ZEALAND, *supra* note 18, at *Accident Compensation* 59. Funds for the earners account are derived from premiums paid by citizens, while the non-earners account is subsidized by appropriations made by Parliament. *Id.* at *Accident Compensation* 57-58.

the coverage or entitlement to which the claimant believes (s)he is permitted.¹²⁴ If the claimant is seeking coverage or entitlement, the claim must be lodged within twelve months of the date of the injury or the date upon which the need for entitlement arose.¹²⁵ However, the ACC is prohibited from declining coverage on the basis of lapsed time limits unless the delay prejudices the ACC in its ability to make a decision.¹²⁶ In addition to lodging a claim, every claimant must, if requested, provide the ACC with a certificate signed by a registered health professional regarding the injury in question, any other relevant information requested by the ACC, including medical or other records, and must submit to any medical assessments at the expense of the ACC.¹²⁷

Under IPRCA, after receipt of a claim for personal injury resulting from medical misadventure, the ACC has the responsibility of making a decision on reasonable grounds and in a timely manner.¹²⁸ First, within two months of the claim being lodged, the ACC must investigate the claim at its own expense.¹²⁹ Following its investigation, the ACC must either notify the claimant of its decision on the injury or notify the claimant that it needs a time extension to obtain additional information and investigate the claim further.¹³⁰ Ultimately, the ACC must notify the claimant of its decision on the claim within nine months of the claim being lodged.¹³¹ In considering a claim for coverage in the case of medical error or medical mishap, the ACC must first obtain independent advice from a suitably qualified expert or have access to information obtained in a similar case or class of cases.¹³²

If the ACC fails to comply with the time limits set forth in IPRCA, the claimant is then considered to be eligible for coverage by the ACC.¹³³ The ACC must comply with this provision by alerting the claimant when the time limit has expired and explaining that the individual is considered to be covered for the claimed injury.¹³⁴ If the ACC declines to extend coverage to a claimant, it must give notice of the reasons for its decision and alert the claimant of the right to apply for review of any of the decisions on the claim and the time constraints for

124. The Injury Prevention, Rehabilitation, and Compensation Act, 2001, 2001 S.N.Z. pt. 3, § 48.

125. *Id.* § 53(3)(a)-(b).

126. *Id.* § 53(2).

127. *Id.* § 55(1)(a)-(b).

128. *Id.* § 54.

129. *Id.* § 56(2)(a). The time limit is twenty-one days for most injuries, but expands to two months for medical misadventure, mental injury, work-related gradual process injury, or when the claim has been lodged outside of the time limit. The Injury Prevention, Rehabilitation, and Compensation Act, 2001, 2001 S.N.Z. pt. 3, § 57.

130. *Id.* § 56(2)(b).

131. *Id.* § 57(4).

132. *Id.* § 62(a)-(b).

133. *Id.* § 58(1).

134. *Id.* § 58(2).

filing for such a review.¹³⁵ Finally, for all claims of personal injury caused by medical error, the ACC must provide notice of its decision for coverage to every treatment provider, registered health professional, or organization whose action or inaction provided the basis for the claim.¹³⁶

4. Process of Review

A claimant may apply to the ACC for review of any decision regarding denial of a claim, unreasonable delay in claim processing, and any decision under the Code of ACC Claimants' Rights.¹³⁷ However, any registered health professional or organization may also apply for review of a claim in cases where the ACC decided that the professional or organization contributed to a personal injury caused by medical error.¹³⁸ The claimant must submit an application for review of a coverage decision, in writing, within three months of the date of receipt of the decision.¹³⁹ Once the ACC has received an application seeking review, it must appoint as many independent reviewers as necessary to assess the appeal.¹⁴⁰ IPRCA charges these independent reviewers with adopting an investigative approach in conducting a review of the facts and instructs them to conduct a hearing at which representatives of the ACC may attend. Furthermore, in the case of alleged medical error, any registered health professional or organization implicated in causation of the injury may also be present at the hearing.¹⁴¹ Following the hearing, the independent reviewer has twenty-eight days in which to make a decision, and is responsible for looking at the matter "afresh"¹⁴² and deciding the matter based on its substantive merits without taking into consideration the policy and procedure followed by the ACC in making its

135. The Injury Prevention, Rehabilitation, and Compensation Act, 2001, 2001 S.N.Z. pt. 3, §§ 63-64. If at any time the ACC believes that it has made a decisional error, it may revise or revoke its initial decision and substitute a new decision in its place. *Id.* § 65(1)-(3).

136. *Id.* § 64(3).

137. *Id.* pt. 5, § 134(1). *See also id.*, pt. 3, § 40(1), setting forth the purpose of the *Code of ACC Claimants' Rights*.

138. *Id.* pt. 5, § 134(4).

139. The Injury Prevention, Rehabilitation, and Compensation Act, 2001, 2001 S.N.Z. pt. 5, § 135(2). However, the ACC may accept a late application for review where it is satisfied that extenuating circumstances affected the claimant's ability to meet the statutory time limits. *Id.* § 135(3).

140. *Id.* §§ 137-38(1).

141. *Id.* § 142(b). However, if the applicant for review is the registered health professional or organization, the claimant also has the right to be present and to be heard at the hearing. *Id.* § 142(c).

142. This is known in the United States as *de novo* review.

initial decision.¹⁴³ Although any decision rendered by the independent reviewer is binding upon the ACC, applicant, and any other person involved in the claim (including registered health professionals or organizations),¹⁴⁴ the ACC or claimant may appeal a review decision to the District Court. Registered health professionals or organizations are entitled to appeal to the District Court only in cases where the independent reviewer concluded that the individual or organization had contributed to the injury by medical error, but not by medical mishap.¹⁴⁵ Similar to the appeals process used in the United States, a party dissatisfied with the District Court's decision on a question of law may petition to be heard first by the High Court, followed by petition for review by the Court of Appeal.¹⁴⁶

5. Recovery for Injury: Entitlements, Rehabilitation, and Treatment

The ACC has developed a scheme of recovery consistent with its pledge “to prevent injury, to provide the best treatment and care if injury occurs, and to quickly rehabilitate people back to work or independence at a price that offers high value to premium payers and all New Zealanders.”¹⁴⁷ Once the ACC has extended coverage for personal injury, the claimant is permitted one or more entitlements,¹⁴⁸ which the ACC may pay in weekly installments or through a survivor's grant.¹⁴⁹ Entitlements are provided only to persons to whom the ACC is liable to provide entitlements, and the entitlements must be applied exclusively for the maintenance, education, advantage, or benefit of the claimant.¹⁵⁰ In addition to pecuniary entitlements, IPRCA also provides coverage for rehabilitative measures to restore the claimant's “health, independence, and participation, to the maximum extent practicable.”¹⁵¹ In furtherance of this

143. The Injury Prevention, Rehabilitation, and Compensation Act, 2001, 2001 S.N.Z. pt. 5, § 145(1)(a)-(b).

144. *Id.* § 147(1).

145. *Id.* § 149(5).

146. *Id.* §§ 161-63. In New Zealand, the Court of Appeal stands as the highest court in the land. Furthermore, as in the United States, judges are afforded discretion as to whether or not to accept review of a case. *See* New Zealand Courts, <http://www.justice.govt.nz/supremecourt/> (last visited Oct. 27, 2005).

147. About ACC, <http://www.acc.co.nz/about-acc/> (last visited October 16, 2005).

148. *See* The Injury Prevention, Rehabilitation, and Compensation Act, 2001, 2001 S.N.Z. pt. 4, § 123(1). “[E]ntitlements are absolutely inalienable, whether by way of . . . sale, assignment, charge, execution, bankruptcy, or otherwise.” *Id.*

149. *Id.* § 131. The ACC, with a few enumerated exceptions, is clearly prohibited from making payments to claimants “in advance.” *Id.*

150. *Id.* § 125(3).

151. *Id.* § 70(a). “Rehabilitation” comprises treatment, social rehabilitation, and vocational rehabilitation. The Injury Prevention, Rehabilitation, and Compensation Act, 2001, 2001 S.N.Z. pt. 1, 6(1).

service, the ACC is responsible for paying or contributing¹⁵² to the cost of any service “reasonably required . . . as an ancillary service related to rehabilitation, if the service facilitates rehabilitation.”¹⁵³

Although the ACC is required to provide for the costs of rehabilitative services, IPRCA also charges the claimant with responsibilities in order to maintain coverage. According to the Act, a claimant must submit to assessments administered by a registered health professional specified by the ACC, cooperate with the ACC in developing and implementing a rehabilitation plan, and participate in rehabilitation measures consistent with the specifications of the plan.¹⁵⁴ The New Zealand Judiciary has also interpreted IPRCA’s requirements on the claimant to be rigorous: the claimant has the responsibility to rehabilitate himself “as much as possible.”¹⁵⁵ In addition to the rigorous requirements on a claimant, the ACC will only pay for treatment that is “necessary and appropriate” and has been approved prior to the actual treatment, absent special circumstances.¹⁵⁶

Finally, the ACC is empowered under IPRCA to suspend or even cancel entitlements if it is not satisfied that the claimant is still entitled to receive compensation, or the claimant unreasonably refuses to comply with the requirements of treatment set forth in the individualized rehabilitation plan.¹⁵⁷ However, the ACC may not recover payment because the decision under which the payment was made has been revised on medical grounds.¹⁵⁸ Nor may it recover any payment awarded because of an error not intentionally contributed to by the claimant, provided that the claimant received the payment in good faith and has put himself or herself in a position of reliance on the funds such that requiring repayment would be inequitable.¹⁵⁹

6. Exemplary Damages and Alternate Remedies

From its inception with the ACA of 1974, until the most current version as outlined in IPRCA, the accident compensation scheme has consistently maintained a bar to bringing suit for damages arising from personal injury.

152. To aid the claimant, the ACC may advise a claimant as to which treatments from named treatment providers will result in the ACC paying less than the full cost of the treatment. *Id.* sched. 1, cl. 6(2).

153. *Id.* cl. 11(1). Ancillary services include accommodation, escort for transport, and transport. *Id.*

154. *Id.* pt. 4, § 72(1)(b)-(h).

155. THE LAWS OF NEW ZEALAND, *supra* note 18, at *Accident Compensation 25*, n. 1.

156. The Injury Prevention, Rehabilitation, and Compensation Act, 2001, 2001 S.N.Z. sched. 1, cl. 2(1).

157. *Id.* pt. 4, § 117(1)-(3).

158. *Id.* pt. 6, § 251(1).

159. *Id.* § 251(2).

IPRCA clearly continues this tradition by prohibiting individuals from bringing proceedings independently of the statute “for damages arising directly or indirectly out of personal injury covered by the Act or personal injury covered by the former Acts.”¹⁶⁰ However, this statutory bar extends only to those injuries covered by the legislation. Thus, an individual may bring suit under other legislation for injuries not covered by the Act.¹⁶¹ Furthermore, individuals may also bring suits relating to or arising from property damage, breach of express terms of an agreement, or unjustified dismissal.¹⁶²

Finally, ICPRA explicitly states that its statutory bar does not prevent an individual from bringing proceedings in any court of New Zealand seeking exemplary damages¹⁶³ for conduct by a defendant that has resulted in personal injury covered by ICPRA or any of the former Acts.¹⁶⁴ The rationale for this exception to the bar, first expressed by the Court of Appeal in *Donselaar v. Donselaar*, is that exemplary damages do not directly or indirectly arise out of personal injury by accident, but rather arise from the defendant’s conduct.¹⁶⁵ Although this exception is available in only a small percentage of medical misadventure cases, the New Zealand judiciary has still been circumspect in limiting the amount of exemplary damages recoverable to an amount that reflects a punitive element, but which does not serve as another means to provide compensation for the plaintiff’s injury.¹⁶⁶ In general, findings of exemplary damages have been restricted to instances where the act is committed “with the utmost degree of malice or vindictively, arrogantly or high handed with a contumelious disregard for the plaintiff’s rights.”¹⁶⁷ This judicial caution has been displayed most recently by a test requiring proof of the defendant’s subjective awareness of the risk to plaintiff, and an objective assessment of the deliberate actions or recklessness of the defendant in still taking the risk.¹⁶⁸

7. Code of Patients’ Rights and Disciplinary Actions against Providers

160. *Id.* pt. 9, § 317(1), (3).

161. THE LAWS OF NEW ZEALAND, *supra* note 18, at *Accident Compensation* 73.

162. IPRCA, pt. 9, § 317(2).

163. In the United States, exemplary damages are referred to as punitive damages.

164. The Injury Prevention, Rehabilitation, and Compensation Act, 2001, 2001 S.N.Z. pt. 9, § 319(1).

165. *Donselaar v. Donselaar*, [1982] 1 N.Z.L.R. 97 (C.A.).

166. THE LAWS OF NEW ZEALAND, *supra* note 18, at *Accident Compensation* 75, n. 4.

167. Palmer, *supra* note 28, at 1122 (quoting STEPHEN TODD ET AL., THE LAW OF TORTS IN NEW ZEALAND 871 (1991)).

168. *Bottrill v. A.*, [2001] 3 N.Z.L.R. 622 (C.A.). *See also* *Donselaar*, 1 N.Z.L.R. 97; *McLaren Transport Ltd. v. Somerville*, [1996] 3 N.Z.L.R. 424 (H.C.) (stating that the standard for determining the appropriateness of exemplary damages was whether the negligence was so high that it amounted to an outrageous and flagrant disregard for the plaintiff’s safety, meriting condemnation and punishment).

In conjunction with the implementation of a new variation on the accident compensation scheme, IPRCA also revitalized the system to address patient complaints first introduced in 1996 by the Code of Patients' Rights.¹⁶⁹ New Zealand's initial implementation of an accident compensation scheme in 1974 extended coverage to victims of accidents who previously would have been barred from recovering damages in tort. However, an unforeseen consequence of implementing the scheme was that, at a time when Anglo-American medico-legal jurisprudence was rapidly developing in the area of patients' rights, similar advancements in judge-made law did not occur in New Zealand.¹⁷⁰

Because of this stasis in the development of patients' rights, until 1996 the only recourse available for a patient to complain about sub-optimal medical treatment was to bring a complaint before a professional health board to seek disciplinary action against the healthcare provider. This option proved both ineffective and unsatisfying for patients as the medical disciplinary boards were roundly criticized for their lack of independence, slowness of process, and secrecy in decision-making.¹⁷¹

Despite the inadequate options available to patients, public support for a Code of Patients' Rights did not pick up momentum until 1987, when a scandal involving cancer research became public, thus underscoring the need for reform in the area of patients' rights.¹⁷² News reports revealed a research study, conducted by New Zealand's leading women's hospital, in which a number of women, already diagnosed with cervical carcinoma *in situ*, were denied conventional treatment for their cancer, without their knowledge or informed consent, in order to study the natural course of the disease.¹⁷³ Fueled by public outcry over this denial of treatment, the legislature ordered an inquiry, which resulted in the Cartwright Report. This report made basic recommendations that would form the

169. Ron Paterson, *The Patients' Complaints System in New Zealand: A Unique System that Addresses Individual Complaints and then Uses the Remedies to Improve Everyone's Health Care*, HEALTH AFFAIRS, May-June 2002, at <http://content.healthaffairs.org/cgi/reprint/21/3/70>. Furthermore, under the Code, the rights delegated to patients are additional to any rights conferred upon patients under IPRCA or any other generally applicable New Zealand law. The Injury Prevention, Rehabilitation, and Compensation Act, 2001, pt. 3, § 40(2).

170. Paterson, *supra* note 169, at 71.

171. *Id.*

172. *Id.* at 71-72.

173. *Id.* Cervical carcinoma *in situ* refers to a cancer that has not spread to the surrounding tissue. In 1987, the prevailing view in the medical profession was that carcinoma *in situ* was a condition that warranted treatment. *Id.* Eventually, forty of the women who were denied treatment developed invasive cervical cancer. *Id.* at 72.

foundational concepts underlying the Code of Patients' Rights later enacted in 1996.¹⁷⁴

In 1994, New Zealand legislators created the independent ombudsman position of Health and Disability Commissioner whose role was to investigate claims, make recommendations to improve provider services, act as a public advocate for patient safety, and to function as a gatekeeper for all complaints alleging breach of patients' rights. The Commissioner also dealt with subsequent professional discipline related to breach of patients' rights.¹⁷⁵

Two years after the creation of the independent ombudsman position, the New Zealand legislature approved the initial version of the Code of Patients' Rights. The Code delineated the rights of the patient including (1) to be treated with respect; (2) to be free from discrimination and exploitation; (3) to have effective communication; (4) to be fully informed and to give informed consent; (5) to get services that meet an appropriate standard of care; and (6) to lodge complaints when treatment was inadequate.¹⁷⁶ In addition to providing patients with a mechanism to resolve their individual complaints, the Code was also "intended to serve as a catalyst for quality improvement throughout New Zealand's health care system."¹⁷⁷ As to the first goal of resolving patient complaints, the rights of patients are neither comprehensive nor absolute. A provider may successfully defend against an alleged violation of the Code by proving that it took "reasonable actions" under the relevant circumstances, which may include the claimant's clinical circumstances as well as the provider's resource constraints.¹⁷⁸

First set forth in 1996, the Code of Patient's Rights was explicitly adopted in the text of IPRCA for all claimants seeking compensation from the ACC.¹⁷⁹ Under the Code, the ACC must act consistently with regard to claimants, by upholding the rights conferred on all claimants by the Code. Furthermore, the

174. Paterson, *supra* note 169, at 72. The report is also known as the Report of the Cervical Cancer Inquiry.

175. *See* Health and Disability Commissioner Act, 1994, § 14 (N.Z.). The rights conferred to patients were meant to apply to a broad definition of patient, including users of both publicly and privately funded health and disability services, and in both institutional and community settings. Paterson, *supra* note 169, at 72.

176. *See* Schedule to Health and Disability Commissioner (Code of Health and Disability Service Consumer's Rights) Regulations, 1996, 1996 S.R. No. 116 (N.Z.).

177. Paterson, *supra* note 169, at 71.

178. *Id.* at 72. According to Paterson, the Health and Disability Commissioner, the reasonableness of the provider's actions serves as an explicit acknowledgment of the need to ration publicly funded health care and that in New Zealand, "costs constrain the quality of care." *Id.*

179. The Injury Prevention, Rehabilitation, and Compensation Act, 2001, pt. 3, § 40 (N.Z.).

ACC must make the Code accessible to members of the public in order to promote awareness, by publishing the Code in a variety of media sources and languages.¹⁸⁰

In order to ensure that any amendments or revisions to the Code reflect a wide range of views and opinions, the ACC must prepare a preliminary draft of potential amendments to the Code and subject it to a battery of procedural checks before the amendments are enforced by the Health and Disability Commissioner. First, the draft must be sent to the Commissioner for his or her approval. Then, it must be published in the largest national newspaper and the daily newspapers of four other specific geographic areas of the country, with an invitation to the public to submit proposals for amendments to the Code.¹⁸¹ Following a report on submissions by the public, the Commissioner must decide whether any further amendments are to be added and must again publish the approved draft in the same national and regional newspapers before submitting the draft Code to the House of Representatives. Following House approval, the Commissioner must publish the finalized version of the amended Code for a third time in the national and regional newspapers before it is finally subject to enforcement.¹⁸²

Although implementation of the Patients' Code of Rights resulted in a significant spike in the number of complaints about providers, critics point to the "equally significant drop in the number of medical practitioners held over for disciplinary action."¹⁸³ In his own critique of the effect of the independent ombudsman, Health and Disability Commissioner Ron Paterson observed, "although the . . . mechanism has secured a level of accountability for suboptimal outcomes in individual cases, the system's ability to spur sustained quality improvement remains murky."¹⁸⁴

C. Critique and Analysis

In the thirty years since enforcement of New Zealand's accident compensation scheme first began, the government has continued to modify, adapt, restructure, and redefine the parameters of the system. Yet the underlying principles of the scheme, first laid out in the Woodhouse Report, are still apparent. While even critics must admit that the accident compensation scheme has been largely successful, it remains an imperfect work, still in progress. To remedy this imperfection, legal scholars have suggested potential ways in which the scheme may be improved for the future.

Professor Richard Miller has strongly supported the reintroduction of a modified version of tort law as a "back-up" to the current compensation

180. *Id.* § 45(1)-(3).

181. *Id.* § 43.

182. *Id.* § 47.

183. Paterson, *supra* note 163, at 70.

184. *Id.*

scheme.¹⁸⁵ Under Professor Miller's proposed tort law add on, the ACC would be permitted to bring suit, by way of subrogation,¹⁸⁶ "against tortfeasors who cause injury requiring payment of compensation. Such an approach would not only help to finance the system but could also reinstitute an interest and concern for safety."¹⁸⁷ Furthermore, since there is no constitutional right to a jury trial in New Zealand, "the approach could be tailored to avoid the abuses that New Zealanders claim to see in the tort system."¹⁸⁸

Professor Miller's rationale for advocating the reintroduction of common law actions for personal injury is closely tied to ideas of corrective justice, and he believes that "a system of pure accident compensation like New Zealand's that does not charge those . . . for the accidents they cause denies accident victims access to an important source of power."¹⁸⁹ Furthermore, according to Professor Miller, the system in New Zealand "does not contain any effective corrective justice. With regard to accidents, it does not punish wrongdoing or reward wrongdoing . . . [and] leaves victims with little sense of justice, particularly in cases of serious, fault-caused injury."¹⁹⁰ Finally, because of the high standard required, exemplary damages "are not an effective avenue to achieve justice; [therefore] the victim's access to rectitude is severely limited."¹⁹¹

According to Miller, reintroduction of common-law actions would rectify this loss of essential values. In practice, the injured party and the ACC could jointly bring suit against the defendant who may have negligently caused the accident. While the individual could not receive duplicate benefits, (s)he could recover those losses not covered by the accident compensation scheme, and the ACC could recover the amount it paid out or would pay out over the life of the accident victim.¹⁹²

Whether implementation of Professor Miller's recommendations would improve the corrective justice aspects of the compensation scheme is a matter of opinion. Other scholars claim that such a move would bring New Zealand full-circle to its pre-1974 predicament in which corrective justice was thwarted by widespread liability insurance which "only increas[es] the enterprise costs of economic activities."¹⁹³ Sir Geoffrey Palmer, who played one of the instrumental roles in creating the accident compensation scheme claims that:

185. See *Beyond Compensation*, *supra* note 27, at 633.

186. Subrogation is "the substitution of one party for another whose debt the party pays, entitling the paying party to rights, remedies, or securities that would otherwise belong to the debtor." BLACK'S LAW DICTIONARY, 1467 (7th ed. 1999).

187. *Beyond Compensation*, *supra* note 27, at 633.

188. *Id.*

189. *Id.* at 631.

190. *Id.* at 632.

191. *Id.* at 632-33.

192. *Id.* at 650.

193. *Beyond Compensation*, *supra* note 27, at 652.

[I]f you take the tort system seriously, you ought to have a system where wrongdoers pay. You ought to have a system which gives plaintiffs a sense of corrective justice. [In New Zealand before 1974] the common law was backed by a compulsory insurance system. Wrongdoers did not pay, their insurance companies did.¹⁹⁴

D. Options for the Future of the Accident Compensation Scheme

Despite favorable changes to the accident compensation scheme promulgated through IPRCA in 2001, questions have again been raised as to whether New Zealand should maintain its no-fault system. Furthermore, assuming that New Zealand maintains its current scheme, which areas are in need of further reform and improvement? While there is strong support throughout for the maintenance of a no-fault compensation system, the current scheme still needs refinement in order to best effectuate the original Woodhouse ideals, most obviously by improving administration, the disbursement of funds, and clear boundaries of coverage for compensable injury. Further, legislators must also carefully weigh the prospective positive effects on administrative efficiency predicted by privatization against the administrative costs of allowing an aggressive field of private insurers to compete for shares of the insurance market in New Zealand.

While certainly a minority, there is a vocal constituency, comprised largely of individuals from the business community, who seek outright abolition of the no-fault system and a return to the common law tort system. Chief among these critics is the New Zealand Business Roundtable, which considers the accident compensation scheme to be an “unjustifiable intrusion by the state upon individual freedom and decision making” and would like to see it disappear altogether.¹⁹⁵ In 1998, the Roundtable proved successful, if only temporarily, in its goal of dismantling the accident compensation system with the enactment of the Accident Insurance Act. Bolstered by substantial support from the Roundtable, the Act signaled a significant policy shift toward contraction of accident compensation coverage. By suspending the ACC’s statutory monopoly on the administration of benefits and beginning the process of privatizing the ACC, the Act ended most mandatory insurance coverage until the statutory re-institution of the ACC’s monopoly in 2000.¹⁹⁶

This legislative “hiccup” of briefly shifting direction of the accident compensation scheme is attributable to a change in parliamentary power between the Labour and National parties. However, support for the accident compensation

194. *Id.* at 640-41.

195. Todd, *supra* note 19, at 487.

196. *Id.*

scheme is relatively broad in New Zealand and will presumably continue as long as the scheme faithfully maintains the original ideals expressed in the Woodhouse Report of 1967.¹⁹⁷ Accordingly, abolition of the scheme is not currently a viable option as the Woodhouse ideals “still maintain their resonance The coverage is still comprehensive, the cost is relatively low and the lessening of human suffering clear.”¹⁹⁸

Concomitant with the idea of abolishing the no-fault system is the reintroduction of the common law right to sue for personal injuries. Another potential alternative involves retention of the compensation scheme with a more limited scope, while also allowing common law suits for further recovery of damages. Removal of common law rights without providing sufficient entitlements under the compensation scheme will logically lead to public disapproval of the scheme. However, reintroduction of common law remedies would make the system extremely cumbersome, expensive, and would open up possibilities for dual claims,¹⁹⁹ all of which would substantially frustrate the original purposes and current goals of the no-fault system. Furthermore, allowing tort recovery would reintroduce the problem of arbitrary judgments that the Woodhouse ideals explicitly sought to avoid.²⁰⁰ Finally, assertions that reintroduction of the common law would improve methods of deterrence and corrective justice are rebutted by the “manifest weaknesses” of the tort system to exact any corrective role.²⁰¹ Furthermore, in the context of widespread liability insurance, any potential corrective or deterrent effect of the tort system tends to disappear.²⁰²

Accepting as true the premises that neither the abolition of the no-fault system nor the reintroduction of common law remedies would further serve the interests of individuals suffering personal injury in New Zealand, the inquiry that follows is how the existing system may be improved to serve its purpose more efficiently. Primary among issues of improved quality of care is whether benefits are delivered most effectively through private or public administration. Though ICPRA reassigned the statutory monopoly on the administration of benefits to the ACC after the temporary privatization in 1998, Professor Stephen Todd argues for the continued viability, and perhaps even improved facilitation of services, under a privatized system:

Privatization of state enterprises often has led to improvements in the quality and efficiency of services . . . and accident compensation is not inherently immune from such beneficial

197. *See infra* section II.A.1.

198. Todd, *supra* note 19, at 489.

199. *Id.* at 490.

200. *Id.*

201. *Id.* at 495.

202. *Id.*

consequences If we accept that the scheme should retain its comprehensive, compulsory, and no-fault character, there is a clear public interest in its efficient administration. . . . [It] would be sensible to persevere with the private model.²⁰³

Professor Todd's argument for implementation of a privatized model is tantalizing because it could increase administrative efficiency while at the same time maintain the same comprehensive and compulsory coverage. However, this potential benefit must be offset against the potential for problematic outcomes stemming from increased competition among private providers and the business instinct to put profits ahead of services.²⁰⁴ The current publicly-run insurance system does not suffer from these problems.²⁰⁵

In addition to the question of the manner in which the compensation system should be administered for maximum efficiency is the issue of the sufficiency of funds actually allocated to individuals with compensable injuries. Currently, weekly compensation provided at eighty percent of pre-accident earnings is generally accepted as satisfactory.²⁰⁶ Of more pressing concern is the unrealistically low compensation provided for in "independence allowances" and the need for a lower threshold for injury that does not exclude large populations of permanently disabled individuals.²⁰⁷ Without increased compensation in the form of independence allowances, conferred on a broader category of permanently disabled persons, discontent with the compensation system and support for reintroduction of a fault-based system of recovery for personal injury will continue to grow.

Finally, future success of no-fault accident compensation in New Zealand depends heavily on continued expansion of the original Woodhouse Report conception of compensation as well as the establishment of reasonable and clear boundaries. Expansion towards the Woodhouse ideals includes moving towards coverage for all forms of personal disability, including disability caused not only by injury but also by illness.²⁰⁸ Currently, standards for compensable injury as enumerated under ICPRRA do not include coverage for injury caused "wholly or substantially by a gradual process, disease, or infection" unless such a condition

203. *Id.* at 492.

204. See Colloquy, Barry Furrow & David Hyman, *The Medical Malpractice Crisis: Federal Efforts, States' Roles and Private Responses, Session 1: Federal Efforts and State Approaches to the Crisis*, 13 ANNALS HEALTH L. 521, 526 (2004). According to Dr. David Hyman, the insurance industry is a "rapacious industry, stocking up on easy premium dollars to invest and luring innocent doctors with seductively low premiums Malpractice insurance is a subset of an insurance market that is a very competitive market with economic behavior that can lead to what you find in a free marketplace." *Id.*

205. Todd, *supra* note 19, at 487-95.

206. *Id.* at 492.

207. *Id.*

208. *Id.* at 493.

was caused by a job-related condition or by medical misadventure.²⁰⁹ Neither cardiovascular nor cerebro-vascular episodes are compensable unless the same criteria are met.²¹⁰ Finally, injuries caused “wholly or substantially by the aging process” or by “natural use” are exempted from compensation.²¹¹

Ultimately, boundaries to determine the limits of compensable injury are necessary to define the scope of the compensation scheme and to give citizens reasonable notice as to what these limits are. These limits are by nature arbitrary, relying on the will of the legislature, the impact of public opinion, and the amount of funding available for compensation. Each person may be disadvantaged in some respect when compared to others, but the importance lies in determining boundaries based on common sense values and beliefs.²¹² According to Professor Todd:

The boundaries to the accident compensation scheme as they presently exist may be hard to defend, but there is no natural limit upon which all can agree. A line has to be drawn somewhere, and wherever it is will create difficulties and anomalies in relation to cases that are excluded. The point at which an egalitarian ideal should give way to human individuality involves a judgment about values, and . . . common sense.²¹³

In summary, there is little support in New Zealand for the abolition of no-fault compensation or for the reintroduction of common law tort claims for personal injury. While the foundation of no-fault is not in any immediate danger, an approach of eternal vigilance must be adopted by the legislature of New Zealand in order to ensure that the system is efficiently pursuing the original Woodhouse ideals. Inroads toward this goal arise in the areas of administration, disbursement of funds, and boundaries of coverage for compensable injury. The debate continues between the publicly administered compensation system currently maintained by a statutory monopoly, and the proposed privatized insurance system. In determining the future administration of the scheme, legislators must carefully weigh the prospective positive effects on administrative efficiency predicted by privatization against the administrative costs of allowing an aggressive field of private insurers to compete for shares of the insurance market in New Zealand.

209. The Injury Prevention, Rehabilitation, and Compensation Act, 2001, pt. 2, § 26(2) (N.Z.).

210. *Id.* § 26(3).

211. *Id.* § 26(4).

212. Todd, *supra* note 19, at 493.

213. *Id.* at 495.

Furthermore, the continued viability of the accident compensation system relies on the ability of the government to adapt the scheme to provide satisfactory compensation for those who suffer personal injury. Lagging compensation packages that fail to make the injured party “whole” will necessarily raise public interest in reviving the common law tradition of tort recovery for personal injury. To combat this, the scheme must maintain compensation levels that do not put victims in a disadvantaged position because of their injury, while also avoiding the windfall of overcompensation that plagues the tort system. Finally, expansion of the boundaries of coverage can only help to increase public support and acceptance of the system. Boundaries limiting compensation are by their very nature subjective, and for every extension, there will be a certain group of injured persons at the periphery who will be denied compensation. However, pursuing a set of rational boundaries that conform to common sense ideas about injuries deserving compensation, in conjunction with attempts to increase coverage where economically feasible, should more than offset any criticism of the arbitrary nature of the limits of compensation.

III. MEDICAL MALPRACTICE IN THE UNITED STATES

Fifty years ago, the doctor . . . was a family friend, confidant, and community leader. Doctors were easily forgiven if they were not always perfect, or if they made occasional mistakes “The doctor did all he could,” we would say, and that was that Sue the doctor when treatment failed? Back then, you might as well have sued your priest, minister, or rabbi. Now . . . we take them all to court.²¹⁴

Although litigation in the area of medical malpractice was an “established phenomenon” in the courts of the United States by as early as 1850,²¹⁵ medical malpractice suits were “rare occurrences” prior to the 1970s.²¹⁶

214. Alan Feigenbaum, *Special Juries: Deterring Spurious Medical Malpractice Litigation in State Courts*, 24 CARDOZO L. REV. 1361, n.5 (2003) (quoting Fulton Haight, *Doctor, Heal Thyself: Strong Medicine for Professional Woes*, LEGAL TIMES, May 8, 1989, at 25).

215. James C. Mohr, *American Medical Malpractice Litigation in Historical Perspective*, 283 J. AM. MED. ASS'N. 1731, 1731-32 (2000). Two of the seminal cases in the development of medical malpractice common law were *Leighton v. Sargent* (1853) and *Pike v. Honsinger* (1898). See HAY, *supra* note 16, at 7-8.

216. Feigenbaum, *supra* note 214, at 1361-62 (quoting the U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE'S REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE 2 (1973) [hereinafter HEW REPORT]). According to Geoffrey Palmer, the upsurge in litigation against doctors and hospitals in the past decades is a “peculiarly American common law preoccupation.” GEOFFREY PALMER, COMPENSATION

However, between 1975 and 1984, medical malpractice claims increased at an annual rate of fourteen percent, and national medical malpractice payments doubled from \$500 million to \$1 billion between 1974 and 1976 alone.²¹⁷ Overall, the American medical profession has experienced at least three distinct crises during the past thirty years, each consisting of “fluctuations in rates of litigation, steady increases in costs and severity of claims, instability in malpractice insurance markets, and resultant concerns about access to medical care.”²¹⁸ In the face of these crises, legislatures, courts, and even physicians themselves have attempted measures, both effective and ineffective, to combat the deleterious effects of these crises.

A. Legislative Responses to the Medical Malpractice Crises

Following the crises of the mid-1970s and 1980s, state legislatures adopted a variety of constraints on the tort system for negligent medical injuries.²¹⁹ The most common constraints are offsets of collateral source payments,²²⁰ caps on pain and suffering damages,²²¹ limits on contingency fees,²²² and the institution of screening panels to eliminate frivolous claims before they are filed or go to trial.²²³ Of these measures, the statutory cap on pain and suffering damages, usually modeled after California’s Medical Injury Compensation Reform Act of 1975 (MICRA) has generally been recognized as the most successful in limiting the expansion of medical malpractice costs.²²⁴

FOR INCAPACITY: A STUDY OF LAW AND SOCIAL CHANGE IN NEW ZEALAND AND AUSTRALIA 43 (1979). During the same period, there has been no similar upsurge in Great Britain. *Id.*

217. Feigenbaum, *supra* note 214, at 1365-66.

218. David M. Studdert et al., *Can the United States Afford a “No-Fault” System of Compensation for Medical Injury?*, 60 *LAW & CONTEMP. PROBS.* 1, 16 (1997).

219. Paul C. Weiler, *The Case for No-Fault Medical Liability*, 52 *MD. L. REV.* 908 (1993).

220. *See* LA. REV. STAT. ANN. § 40:1299.42 (1990); R.I. GEN. LAWS § 9-19-34 (1984).

221. *See* CAL. CIV. CODE § 3333.2(b) (West 2001) (providing that, “[i]n no action shall the amount of damages for non-economic losses exceed two hundred and fifty thousand dollars.”).

222. *See* DEL. CODE ANN. tit. 18, § 6865 (1989).

223. *See* MD. CODE ANN., CTS. & JUD. PROC. §§ 3-2A-01 – 3-2A-09 (West 1989). *See also* Robert Berg, *A Summary of the Legislative Responses to the Medical Malpractice Crisis*, 71 *J. MED. ASS’N. GA.* 511, 512 (1982).

224. *See* Grace Vandecruze, *Has the Tide Begun to Turn for Medical Malpractice?*, 15 *HEALTH LAWYER* 15, 15 (2002). In 1975, the year MICRA was first enacted, California had the highest medical malpractice premiums in the country. Since 1975, premiums have risen only 167% in California as compared with 505% for the entire country. *Id.* The American Medical Association (AMA) is also a proponent of MICRA-like legislation and has proposed that other states follow California’s model. *Id.* *See also* Mark A. Finkelstein,

However, courts have split as to whether such legislation violates the Equal Protection Clause of the Fourteenth Amendment or various analogous clauses of state constitutions.²²⁵ While such cutbacks on tort remedies decrease the cost of liability insurance and reduce the non-pecuniary damages assessed against defendants, they do not address the root of the problem, but rather one of the symptoms of the medical malpractice crisis.²²⁶ These statutory caps on jury awards also “do little or nothing to improve deterrence, compensation, and fairness in the administration of justice.”²²⁷

B. Physicians’ Responses to Escalating Costs

In addition to the regular statutory relief granted by state legislatures,²²⁸ physicians have sought other judicial remedies, such as countersuits, to combat the onslaught of what they perceive to be frivolous lawsuits.²²⁹ These attempts by physicians to protect against lawsuits illustrate both the financial and emotional costs of medical malpractice litigation,²³⁰ but have little relation to the success of plaintiffs in medical malpractice suits. Results from the Harvard Medical Practice Study of New York (Harvard Study) reveal that one percent (1,000 of 100,000) of discharged patients suffered an adverse event as a result of medical malpractice. Furthermore, of these 1,000 injuries, just over ten percent result in legal claims,

California Civil Section 3333.2 Revisited: Has It Done Its Job?, 67 S. CAL. L. REV. 1609 (1994).

225. Compare *Hoffman v. United States*, 767 F.2d 1431, 1437 (9th Cir. 1985) (holding that California’s statutory cap on non-economic damages in medical malpractice cases does not violate the Equal Protection Clause), with *Arneson v. Olson*, 270 N.W.2d 125,136 (N.D. 1978) (holding that North Dakota’s \$300,000 cap on recovery in medical malpractice cases violates the Equal Protection Clause).

226. Furrow & Hyman, *supra* note 204, at 545.

227. Randall Bovbjerg & Frank Sloan, *No-Fault for Medical Injury: Theory and Evidence*, 67 U. CIN. L. REV. 53, 62-63 (1998).

228. Weiler, *supra* note 219, at 910 (arguing that statutory relief is granted more often to physicians because “both legislators and voters can more readily empathize with the plight of their family doctor than . . . drug manufacturers or asbestos producers.”).

229. Feigenbaum, *supra* note 214, at 1373-79 (describing countersuit theories of malicious prosecution, abuse of process, defamation, and intentional infliction of emotional distress). See also Sandra C. Segal, *It Is Time to End the Lawyer’s Immunity from Countersuit*, 35 UCLA L. REV. 99, 103 (1987); William Gunnar, *Is There an Acceptable Answer to Rising Medical Malpractice Premiums?*, 13 ANNALS HEALTH L. 465, 480 (2004).

230. PAUL C. WEILER ET AL., *A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION* 126 (1993). The Harvard study conducted by Paul Weiler and colleagues found that physicians being sued spent an average of six days working on the litigation, thereby foregoing an estimated \$7,000 in income per claim. *Id.*

with fewer than half of those legal claims resulting in compensation for the plaintiff.²³¹ Furthermore, another analysis of jury verdicts found that “doctors rarely lose a case they should win, but win a significantly high proportion of cases their own insurers think that they should lose, because juries often bend over backwards to make sure they are not unfairly stigmatizing a doctor with a malpractice verdict.”²³²

Although physicians tend to be uncommonly successful in defending malpractice claims once they go to trial,²³³ many physicians “sharply overestimate the threat of litigation, and have a strong aversion to being sued, because they cannot insure against the emotional trauma of a malpractice action.”²³⁴ Doctors often view malpractice claims as a personal challenge to their professional performance and reputation,²³⁵ sometimes altering their mode of care to “defensive medicine,”²³⁶ in which the physician takes extra precautionary measures, such as ordering non-essential tests or performing more elaborate procedures in an attempt to avoid future liability.²³⁷

On its face, the concept of defensive medicine may seem benign or even beneficial to the patient as a way for the doctor to be most thorough. However, the added cost of such precautionary measures accounts for an estimated five to fifteen billion dollars of extraneous medical expenses per year,²³⁸ which ultimately inflates the price that patients must pay for medical care. This threatens to make medical treatment unavailable to a great number of patients. Another potential consequence of the spread of defensive medicine is the stagnation of

231. PAUL C. WEILER, *MEDICAL MALPRACTICE ON TRIAL* 12-14 (1991).

232. Weiler, *supra* note 219, at 914.

233. According to a survey of 5,524 malpractice cases conducted in 2002 by the Physician Insurers Association of America, 0.9% of cases resulted in jury verdicts for the plaintiff, 27.4% settled before going to trial, 67.7% were dropped or dismissed, and 4% resulted in verdicts for the defendant. Christopher H. Schmitt, *A Medical Mistake*, U.S. NEWS & WORLD REP., June 30, 2003, at 24-27. Therefore, at trial, a plaintiff in a medical malpractice suit has only a 20% chance of a jury returning a verdict in her favor. *See id.*

234. Weiler, *supra* note 219, at 916.

235. *See* Gunnar, *supra* note 229, at 476. According to Dr. Gunnar, “Physicians have come to believe that every patient is a potential lawsuit associated with ridicule, public disclosure of events and circumstances surrounding the patient’s care, comparison with a colleague’s ‘expert opinion’ as to the standard of care, and time away from practice.” *Id.*

236. Defensive medicine has been defined as “the alteration of modes of medical practice induced by the threat of liability, for the principal purposes of forestalling the possibility of lawsuits by patients as well as providing good legal defense in the event such lawsuits are installed.” Feigenbaum, *supra* note 214, at n.52 (quoting HEW REPORT, *supra* note 216, at 14).

237. Feigenbaum, *supra* note 214, at 1371.

238. *Id.*

medical progress.²³⁹ As the potential costs of malpractice rise, many doctors are becoming increasingly reluctant to perform hazardous or risky procedures, meaning that “progressive, innovative and imaginative physicians [who] are more inclined to use newer procedures which have not yet met with general acceptance . . . [are] more vulnerable to suits.”²⁴⁰

Physicians’ protective reactions to the various medical malpractice crises of the past thirty years have resulted from a number of common perceptions and misconceptions regarding the American common-law tort system. Physicians significantly overestimate their chances of being brought into court because of malpractice.²⁴¹ Although medical malpractice claims have increased from one claim for every 100 doctors in the late 1950s to ten claims per 100 doctors in the early 1990s, this increase is low in proportion to the amount of actual medical injuries that occur.²⁴² Regardless, physicians continue to perceive themselves as being much greater targets of litigation than they really are.²⁴³ Doctors feel that “their profession is being unfairly singled out not only by the tort system but by the government, the insurance industry, and the general public.”²⁴⁴ Further exacerbating this feeling of frustration among physicians is the continued escalation of medical malpractice premiums, concomitant with the decline in physician income resulting from widespread paring down of reimbursements to healthcare providers.²⁴⁵ In fact, the combination of rising costs and falling income has driven some doctors to leave the medical profession entirely.²⁴⁶ In some instances, this threatens the continued viability of entire areas of practice, including neurology and obstetrics.²⁴⁷

239. Randall R. Bovjberg, *Medical Malpractice: Research and Reform*, 79 VA. L. REV. 2155, 2187 (1993). This stagnation is also referred to as “resistive defensiveness.” *Id.* at 2188.

240. Feigenbaum, *supra* note 214, at n.19 (quoting James W. Brooke, *Medical Malpractice: A Socio-Economic Problem from a Doctor’s View*, 6 WILLIAMETTE L.J. 225, 230 (1970)).

241. Gunnar, *supra* note 229, at 476.

242. Weiler, *supra* note 219, at 912 (claiming that one disabling injury occurs for every twenty-five hospitalizations, and that one in four injuries occur as a result of medical negligence).

243. *See generally* WEILER, *supra* note 230.

244. Feigenbaum, *supra* note 214, at n.63 (citing *Patients, Physicians, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York*, THE REP. OF THE HARV. MED. PRAC. STUDY TO THE STATE OF N.Y. 9-60 (1990)).

245. Neil Versel, *Inevitable Climb: Once-flat Malpractice Insurance Premiums Are Heading Up*, MOD. PHYSICIAN, Feb. 12, 2001, at 26.

246. Maria Newman, *In Mass Trenton Rally, Doctors Protest Malpractice Insurance Costs*, N.Y. TIMES, June 14, 2002, at B5 (quoting Raymond Berrios, director of a New Jersey Ob/Gyn clinic, who estimated that “25% of doctors could leave the profession because of this crisis.”).

247. Feigenbaum, *supra* note 214, at n.24 (2003) (quoting Fulton Haight, *Doctor, Heal Thyself: Strong Medicine for Professional Woes*, LEGAL TIMES, May 8, 1989, at 25).

Further increasing the fear of litigation felt by physicians is the seemingly arbitrary nature of jury verdicts, and more specifically, the idea that juries base their verdicts on “sympathy for plaintiffs and the perceived ability of the defendants to pay, rather than the merits of the case.”²⁴⁸ In fact, American Medical Association chairman Dr. Edward Hill has gone so far as to refer to the system of tort recovery as a “litigation lottery, where select patients receive astronomical awards, and others pay higher costs for healthcare and suffer access problems because of it.”²⁴⁹ Although juries are generally reluctant to return a verdict against a physician, they often register their moral condemnation of truly substandard care by rendering very large damage awards, through subjective categories such as pain and suffering and punitive damages, once it has been determined that negligent treatment has occurred.²⁵⁰

In spite of such overwhelming verdicts, the damages assessed do not go directly toward deterrence of future negligent conduct by the defendant. Instead, the burden is absorbed by the insurance provider and borne equally by all physicians practicing medicine in the same specialty or region of the country as the defendant.²⁵¹ On the other side of the “litigation lottery” are a great majority of deserving parties who receive much less than their actual economic losses.²⁵²

C. Application of New Zealand No-Fault Principles to Medical Malpractice Cases in the United States

As previously mentioned, President Bush has put the issue of medical malpractice reform on the “front-burner” of his political agenda, repeatedly imploring legislators to enact a nation-wide cap on non-economic and punitive damages.²⁵³ The most recent legislative push for such a measure stalled in July 2003 when the Senate failed to pass a bill that would have imposed a cap on damages.²⁵⁴ Criticism of the bill by House and Senate Democrats reflects not only

248. *Id.* at 1363 (describing the “deep pockets” theory).

249. Vandecruze, *supra* note 224, at 15.

250. Weiler, *supra* note 219, at 914 (noting that the average malpractice verdict is three times that of motor vehicle verdicts and twice that of products and government liability verdicts).

251. *Id.* at 915.

252. *See id.* at 914.

253. *See supra*, notes 2-10 and accompanying text.

254. In 2003, the House of Representatives passed the Help Efficient, Accessible, Low-Cost, Timely, Health Care Act (HEALTH Act). However, the version of the Act debated in the Senate (The Patients First Act) did not garner sufficient votes to pass a motion to proceed, and was therefore defeated. The measures proposed in the bill would have limited recovery for non-economic damages to \$250,000, and limited punitive damages to twice the amount of economic damages or \$250,000, whichever is greater. Furthermore, the Act would have restricted attorneys’ fees for both settlements and trial

the problem in the proposed federal cap on damages, but also the problem with every state legislature that has enacted legislation modeled after California's MICRA. While empirical evidence supports the proposition that statutory damage caps significantly decrease medical malpractice premiums and the overall cost of health care, the caps also appear to be supremely inequitable. They place the burden of decreasing healthcare costs on those plaintiffs who, according to the jury, have suffered the most significant harm from substandard medical care.²⁵⁵

President Bush condemns "junk" and frivolous lawsuits as the reason for the escalating cost of health care, yet the proposed cap on damages bears little logical relationship to reducing these "junk" claims. Assuming that the President's reference to "junk" suits is not an explicit condemnation of jury trials in general, but instead refers to claims that do not make it to trial, the proposed cap does nothing to hinder the filing of such suits. Instead, the cap merely serves to reduce the amount of damages recoverable to plaintiffs with claims that have reached the jury. Whether juries render verdicts based on emotion, moral condemnation, belief in "deep pocketed" defendants or any other rationale may be a different issue than that which tort-reformers seek to curtail. However, the federal statutory cap on non-economic damages fails to raise any significant roadblocks to the filing of frivolous claims, and rather seeks to reduce costs by reducing damages in the most high profile cases. In doing so, it ignores the clutter of frivolous cases seeking lesser damages that medical malpractice insurers deem more economical to settle quickly than to litigate, regardless of the merits of the case.

In theory, the system of no-fault compensation first implemented thirty years ago in New Zealand seems to be just the type of "sensible alternative" to the tort system envisioned by Guido Calabresi.²⁵⁶ If, as Professor Stephen Sugarman asserts, the current tort system is failing in each of its three major goals,²⁵⁷ and the five Woodhouse Report principles reflect a reasonable alternative under a system which is actually successfully pursuing such ideals, then why shouldn't New Zealand's no-fault system be exportable to the United States and applicable to medical malpractice? The answer is that such a system could benefit the United States but for a confluence of economic, socio-political, and historical barriers that obstruct its implementation in any meaningful form.

verdicts. Finally, the Act would have imposed a statute of limitations requiring the filing of a suit within three years of the injury or within one year of the claimant's discovery of the injury, whichever came first. See Gunnar, *supra* note 229.

255. See Furrow & Hyman, *supra* note 204. See also Carson v. Maurer, 424 A.2d. 825 (N.H. 1980) (striking down a statutory cap on damages as violating the equal protection clause of the New Hampshire Constitution).

256. See CALABRESI, *supra* note 15.

257. The three goals of tort law are compensation, deterrence, and corrective justice. See SUGARMAN, *supra* note 14.

First, plaintiffs in the United States have become accustomed to large jury awards for personal injury resulting from negligence.²⁵⁸ This type of “litigation lottery” tends to under-compensate the vast majority while providing a veritable windfall to the lucky plaintiff.²⁵⁹ However, implementation of an effective system of no-fault compensation would require all potential plaintiffs to forfeit the right to any future recovery in tort, a requirement that would likely meet with public outcry as well as questions of constitutional validity.²⁶⁰ Furthermore, trial attorneys would stand to lose a significant source of income if a system of no-fault compensation were to be implemented. Conscious of this possibility, the American Trial Lawyers Association (ATLA), a strong lobbying force on both a state and national level, would vehemently oppose any such wholesale systemic changes.²⁶¹ The general resistance to change from a system to which we are all accustomed, in conjunction with the opportunity to be the recipient of that windfall of compensation would make New Zealand’s system a tough sell in this country. Accordingly, “[t]o bring under control unrealistically heightened expectations stirred by the medical malpractice lottery [would] be a political feat of substantial difficulty.”²⁶²

The difference in size between the United States and New Zealand, the strength of the trial lawyers lobby, and the different expectations of damages awards alone provide significant reasons why such a system would face major, if not insurmountable, hurdles if implemented in the United States.²⁶³ In fact, Sir Geoffrey Palmer, one of the original architects and major supporters of export of New Zealand’s no-fault system, has trouble envisioning the system’s success in the United States:

I used to think when I was young and enthusiastic, that possibly the New Zealand reform could be made into a messianic crusade that could export reform to the tort system everywhere. I no longer think so I think the problems in the United States, the complexity of the United States society, the size of the

258. See Weiler, *supra* note 219, at 914.

259. See Robert G. Elgie et al., *Medical Injuries and Malpractice: Is It Time for “No-Fault”?*, 1 HEALTH L.J. 97, 102 (1993).

260. David Studdert et al., *Toward a Workable Model of “No-Fault” Compensation for Medical Injury in the United States*, 27 AM. J.L. & MED. 225, 235 (2001). According to the authors, challenges to the constitutionality of a no-fault system would most likely arise over issues of the right to a jury trial, due process, and the constitutional protection of tort recovery. *Id.*

261. Michelle M. Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 TEX. L. REV. 1595, 1628 (2002).

262. Gellhorn, *supra* note 12, at 206.

263. See generally Bovjberg & Sloan, *supra* note 227, at 72-75.

United States, makes the business of reforming anything in the United States much more difficult.²⁶⁴

In spite of Palmer's negative outlook on the implementation of a no-fault system in the United States, there remains hope that it could be introduced and developed by various state legislatures. Former Supreme Court Justice Louis Brandeis commented: "It is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country."²⁶⁵

In the realm of no-fault compensation, Virginia (1987) and Florida (1988) have volunteered to be such laboratories of social change. Established with the explicit purpose of stabilizing the insurance market for obstetricians, Virginia's Birth-Related Compensation Program²⁶⁶ and Florida's Birth Related Neurological Injury Plan,²⁶⁷ in exchange for limiting tort remedies, provide financial assistance to a recognizable class of sympathetic tort plaintiffs: families of babies who suffered severe brain injury during childbirth procedures.²⁶⁸ In both states, the no-fault systems are administered by independent, legislatively-created organizations in which no-fault recovery²⁶⁹ is the exclusive remedy for injured parties unless they are able to prove some manner of intentional wrongdoing.²⁷⁰ Furthermore, claimants rejected on their no-fault claim are subsequently free to seek tort recovery, and claimants are not required to seek compensation from the no-fault program before resorting to a civil suit.²⁷¹

By circumscribing the expense and the application of the no-fault experiments, both Florida and Virginia have limited the scope of the program by setting strict statutory definitions of eligible injuries²⁷² and by limiting coverage to

264. *Beyond Compensation*, *supra* note 27, at 647.

265. *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).

266. *See* VA. CODE ANN. § 38.2-5002 (2005).

267. *See* FLA. STAT. ANN. § 766.303 (West 1988).

268. *Bovbjerg & Sloan*, *supra* note 227, at 82-83. These cases were commonly referred to as "bad baby" cases. *Id.*

269. Statutory coverage under the no-fault programs includes medical expenses (including rehabilitation and special education), costs of custodial care, transportation incident to care, and supplies and equipment needed to cope with the disability. *See* VA. CODE ANN. § 38.2-5009 (2005); FLA. STAT. ANN. § 766.31.

270. *Bovbjerg & Sloan*, *supra* note 227, at 84. Injured parties may seek tort compensation if the injuries were caused "intentionally or willfully," "in bad faith," with "malicious purpose," or in "willful and wonton disregard of human rights." *Id.*

271. *Id.*

272. In Virginia, the relevant statute only covers extremely serious, birth-related neurological injuries, where the infant survives childbirth but is permanently disabled and in need of assistance in all activities of daily living. VA. CODE ANN § 38.2-5001 (2005). Florida's statutory definition of covered injuries is even more restrictive because it excludes premature babies who are under a certain weight requirement at birth, and

obstetricians or other physicians who deliver babies and voluntarily agree to participate in the program.²⁷³

These strict limits have allowed the program to function based on funding derived from voluntarily participating physicians, all licensed physicians that elect not to participate, and hospitals within the state. The program receives no direct contribution from the state general fund, patients, or the patients' health insurers.²⁷⁴

Early analysis of the limited no-fault systems in Virginia and Florida reveals that each system aided the underlying state goal of stabilizing insurance premiums for certain types of physicians, as well as streamlining the administrative costs of addressing such injuries through civil tort litigation. Furthermore, the high rate of participation clearly signals a willingness by physicians to work towards a feasible alternative to the current tort regime for medical malpractice recovery. However, the inability, or unwillingness of the state legislatures to eliminate the tort "safety valve" and to make no-fault recovery the true "exclusive remedy" takes away from the overall efficiency of the system and reduces certainty that claims have been exhausted. Regardless of the results, the expressions of interest and willingness to experiment with no-fault compensation in limited circumstances in both Virginia and Florida²⁷⁵ reveal both the critical status of medical care in some states, as well as the possibility of future implementation of a no-fault system in the United States.

In addition, the widespread acceptance of no-fault worker's compensation schemes throughout the United States in the early twentieth century, under statutes remarkably similar in structure to New Zealand's no-fault system of accident compensation, provides some hope that public opinion may eventually come to support no-fault for medical malpractice cases. As noted by Professor Gellhorn, "When first introduced . . . many regarded the idea of developing a worker's compensation system as heretical. Now the notion of providing compensation for injured employees, without inquiry into blameworthiness, is accepted without demur."²⁷⁶

requires that the infant be permanently and substantially mentally and physically impaired. FLA. STAT. ANN. § 766.302(2). Both states exclude injuries caused by genetic or congenital abnormality, as well as injuries caused by substance abuse by the mother.

273. Bovbjerg & Sloan, *supra* note 227, at 89-90. Virtually all eligible physicians have chosen to participate in the no-fault program. *Id.*

274. *Id.* at 93-94. As enacted, the statute assesses an annual fee of \$5,000 on participating physicians, \$250 on non-participating physicians, and hospitals are required to pay a fee of \$50 per birth at the hospital. *Id.*

275. See generally Bovbjerg & Sloan, *supra* note 227, at 82-102; Bryan A. Liang & LiLan Ren, *Medical Liability Insurance and Damage Caps: Getting Beyond Band Aids to Substantive Systems Treatment to Improve Quality and Safety in Healthcare*, 30 AM. J. L. & MED. 501, 512-13 (2004).

276. Gellhorn, *supra* note 12, at 205.

IV. CONCLUSION

Nearly six thousand years ago, the Babylonian King, Hammurabi, provided the earliest formalized recognition of punishment for medical malpractice. According to the Code of Hammurabi: "If a physician operate on a man . . . for a severe wound with a bronze lancet and cause the man's death; or open an abscess (in the eye) of a man with a bronze lancet and destroy the man's eye, they shall cut off his fingers."²⁷⁷ Though common law penalties for medical malpractice no longer contain the forms of physical torture that prevailed in ancient times, many physicians currently feel similarly stifled in their chosen profession by the rapidly escalating costs of practicing medicine and the perception that lawsuits will spring forth from every patient who suffers an unsatisfactory outcome resulting from medical care.

In the United States, neither the acts of government nor physicians themselves have sufficiently solved the underlying problems that have caused the various medical malpractice crises of the past thirty years. Statutory caps on non-economic damages have been the preferred method of cutting healthcare costs. However, though such caps are successful in reducing costs, they fail to sufficiently address issues of improved patient care, deterrence, or the reduction of frivolous lawsuits. At the same time, statutory caps unfairly lay the burden of cost reduction squarely on the shoulders of the most severely aggrieved plaintiffs. Certainly, there must be a more effective system of compensation for medical malpractice injuries.

Implementation of a comprehensive New Zealand-style no-fault system of compensation is far from becoming a reality in the United States. However, small expressions of interest may proliferate in the stasis of the current tort system in which doctors are increasingly choosing to change professions in the midst of their careers rather than face the uncertainty of potential lawsuits and the decreasing profitability of their profession based on skyrocketing overhead costs. If medical malpractice reform does occur, it is likely that the impetus for such reform will not be empirical evidence of a better system, but rather a confluence of anecdotes, political lobbying, and a sense of crisis that moves the debate forward.²⁷⁸



277. HAY, *supra* note 16, at 3.

278. See David Hyman, *Medical Malpractice and the Tort System: What Do We Know and What (If Anything) Should We Do About It?*, 80 TEX. L.REV. 1639, 1653 (2002).