IN THE SUPREME COURT OF
THE REPUBLIC OF VANUATU
(Civil Jurisdiction)

Civil Case No.36 of 2001

BETWEEN: BENUEL TARILONGI
Claimant

AND: THE MINISTER OF HEALTH
Defendant

Coram: ***Chief Justice Lunabek***

Counsel: ***Robert Sugden for the Claimant***
Frederick Gilu for the Defendant

Date of Judgment: ***4th June 2014***

JUDGMENT

INTRODUCTION

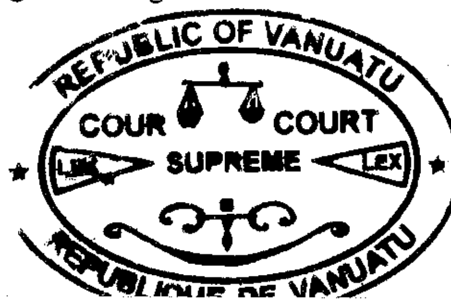
1. This is a claim for damages for alleged medical negligence on the part of doctors and staff at the Port Vila Central Hospital (VCH) which is controlled and operated by the defendant.

2. The matter has proceeded to trial only on the question of liability.

BRIEF FACTS

3. The claimant was admitted to the VCH on 7th March 1998 following a motor vehicle accident in which he was injured. His injuries included a fracture in his left wrist and a fractured right femur. The wrist injury is not relevant to this claim.

4. The medical officer who treated the plaintiff at the hospital from the time of his admission until about 8 July 1998 was Doctor Liu Wen-Yong. Dr. Liu was at that time a Chinese doctor holding qualifications obtained in China as a general surgeon. His services were at the time



made available to Vanuatu under an inter-governmental agreement between the Republic of Vanuatu and the Peoples Republic of China.

5. The claimant's leg injury was treated by confining him to bed and placing his leg in traction.

6. The claimant and his wife expressed concern about this treatment and unsuccessfully explored the prospect of the plaintiff being transferred to New Zealand either under an insurance policy the claimant held with Australian Family Assurance (AFA) Agencies Ltd or under a scheme in place between Vanuatu and New Zealand.

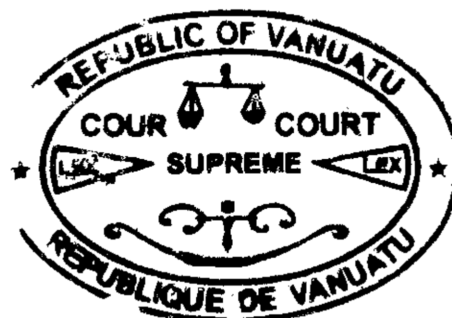
7. The traction treatment of the kind undertaken if no unforeseen event happened could have been expected to lead to fusion of the bones and healing of the fracture in about 20 weeks.

8. On 18th May 1998, the claimant was examined by two visiting Australian orthopedic surgeons. The healing process was apparently thought by them to be too slow and they recommended operative treatment. The claimant and his wife were concerned about the risk of infection if the operation were undertaken at the VCH, and declined the recommended treatment.

9. On 8 July 1998 the claimant agreed to have the fracture surgically repaired. A metal blade and screws were inserted into his leg securing the fracture by Dr Capuano who was then stationed at the VCH. Within 7 days he was mobilized and, apart from a temporary infection at the operation site, made an uneventful recovery.

10. The claimant has been left with permanent residual disability in his right leg which involves stiffness in the knee, some quadriceps muscle wasting and a minor fixed flexion deformity. The medical experts who have given evidence are in general agreement that the claimant is left with a permanent 15% disability of his right knee and above.

11. At the time of the accident the claimant was the Principal Plant Protection Officer in the Quarantine Section of the Vanuatu Government Service. He was married with three school aged children.



SUMMARY OF THE EVIDENCE

12. **For the plaintiff**

    The tender of interrogatories and answers.

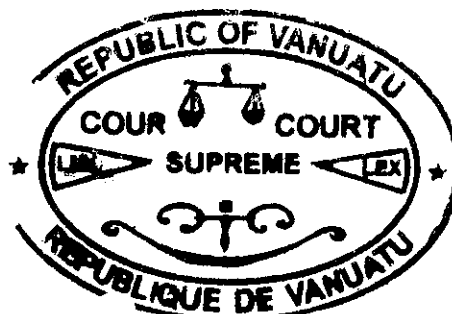
    Statements of the claimant dated 24 May 2004 and 12 April 2005

    Statements of the claimant's wife, Aniva Tarilongi sworn 21 May 2004 and 12 April 2005

    Expert medical reports from Doctor Mark Horsley dated 19 December 2001 and 6 May 2002.

13. The interrogatories established the role of Dr Liu at the VCH and confirm that the claimant's fracture was initially treated by traction. The claimant gave evidence that he arrived at the VCH in the early hours of the morning of 7 March 1998 but was not treated until late the following day. He and his wife were concerned about the delay and concerned about proposed traction treatment so they asked Dr. Liu to arrange for the claimant's evacuation to New Zealand or Australia so that the claimant would get faster treatment. The claimant says he received no response to that request, and Dr. Liu proceeded with the proposed traction treatment.

14. The claimant and his wife both say that they had difficulty communicating with Dr Liu whose English language was deficient. The claimant complains that he was given inadequate information about treatments other than traction or his options to obtain them. He believes he could only gain admission to and treatment at an overseas hospital if the doctors in Vanuatu recommended that he be treated overseas. The plaintiff and his wife endeavoured to get such a recommendation. They applied first to their insurer, Australian Family Assurance, but the insurance doctor would not recommend evacuation as he believed the fracture could be adequately treated in Vanuatu. The claimant's boss, the Director of Agriculture and Water Culture, then wrote to Dr Tambisari, the medical superintendant at the VCH, asking that he give consideration for an early evacuation of the claimant to New Zealand under a special scheme that he understood existed for medical treatment paid for by the New Zealand government. That request also failed. Doctor Tambisari replied to the Director saying that the length of time spent in traction with good alignment is almost the same in any hospital and that evacuation to New Zealand will not necessary hasten the claimant's recovery. His advice therefore was that he remain at the VCH. (Doctor Tambisari in his evidence said he had discussed with the claimant's wife the fact that a stay in New Zealand could be quite expensive because of the length of the stay).



15. After the traction treatment began the claimant said he learned that Doctor Liu was not an orthopedic surgeon and he asked the hospital authorities if he could be seen by an orthopedic surgeon, but this request was ignored. The claimant says that from the beginning of treatment he considered his leg was able to move around and his right foot appeared to be always tilting outwards. This was pointed out to Dr Liu but the doctor said that everything was in order. The claimant made many complaints and Dr Liu had numerous x-trays of his leg taken. He complained frequently to Doctor Liu that the x-ray showed his fracture was not uniting.

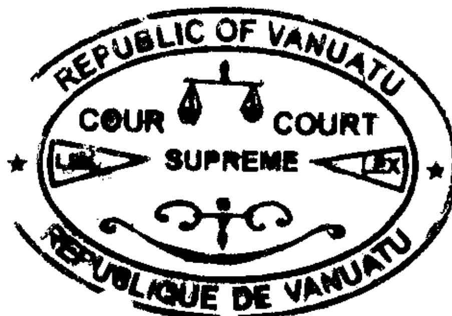
16. Finally on 18 May 1998, the two doctors from Australia saw him with Dr Liu. They told the claimant that another way of treating the leg was by operating. They said an operation would result in the bones reuniting more quickly unless he contracted an infection through the operation. They said there was a high risk of infection with the operation. If the claimant continued with traction they said the bones would take another two months to heal but the risk of infection was small.

17. The claimant discussed having the operation with his wife who was very much against the operation. They were both concerned about infection. They did not consent to the operation.

18. The claimant raised the question of an operation with Dr Liu but the doctor did not offer any advice. However he adjusted the traction following the Australian doctor's visit so that his foot no longer tilted outward and his leg could not move about so much so the claimant did not ask him further about an operation.

19. The bones still did not unite and on 17 June 1998 the claimant asked Dr Tambisari to replace Dr Liu with Doctor Basil Mc Namara who practice as a general surgeon at VCH. But this did not happen.

20. On 29th June 1998 Doctor Capuano came to see the claimant and told him he needed an operation. The claimant discussed this with his wife. She was not in favour of having the operation carried out at VCH. However a couple of days later the claimant himself decided to go ahead despite her opposition and signed a consent form for the operation.

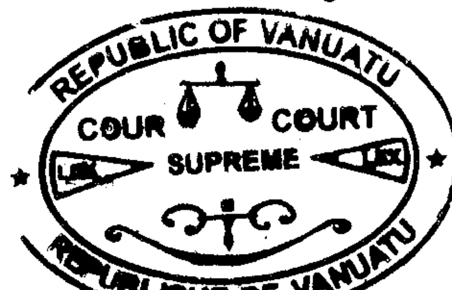


21. The operation was carried out on 8 July 1998. The claimant was able to get up six days later. Shortly afterwards he began physiotherapy. At that stage he realize that he had residual stiffness at the knee and that it was a common problem associated with traction treatment for broken femur. He began to walk again on 5 August 1998.

22. His evidence went on to describe his discomforts during his time in hospital, his distress through loss of contact with family and work, and problems he now has with the residual disability in his leg. These would be matters to be further explored on an assessment of damages, but are not here relevant on the question of liability.

23. The claimant complains that he was not told that traction treatment was likely to lead to permanent stiffness in his knee. Further, he says that he was not given adequate information about options for treatment overseas. He continued in the belief whilst in hospital that he could not obtain overseas treatment anywhere without the recommendation of a doctor in Vanuatu which was not made available to him. He says that he was not told about an operation using an intramedullary nail and its advantages over the operation he eventually had using a metal blade. After he left hospital he was informed that the hospital could not afford to stock a range of intramedullary nails. He said that had he been given proper advice about that option he could have paid for a nail himself. He says that if someone had told him about the risks of residual stiffness in the knee, and if he had been told he could obtain treatment at an overseas hospital without the recommendation of a Vanuatu doctor, he would never have agreed to traction but would either have purchased the intramedullary nail and had the operation in Port Vila, or would have paid to go overseas. He says that the combined resources of himself and his wife who had worked for many years and held a senior position at Telecom would have been sufficient to pay for either course; but he gave no information about his family's financial position or assets to support his claim that he could pay for overseas treatment.

24. Mrs Anniva Tarilongi's evidence generally corroborated that of the claimant. She said that when traction was being discussed they asked Dr Liu if the claimant could be sent to New Zealand or Australia, but doctor Liu said it wasn't necessary and he repeated that in the days that followed. She tried to get other doctors to look at the claimant instead of Dr Liu but no one at the hospital would arrange this. She confirmed that no advice was given to them that

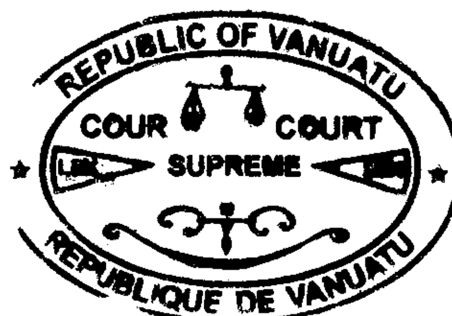


the traction treatment could lead to disability in the knee and hip or that surgical treatment would have almost eliminated that risk. She confirmed that she was very much against an operation when it was suggested by the Australian doctors. When possible surgery by doctor Capuano was raised she was not happy for that operation to be carried out at VCH. She thought the claimant would be in danger and when asked to sign a consent form for the operation she refused to do so.

25. Mrs Tarilongi confirmed that once the operation was performed the claimant recovered rapidly thereafter and was soon back on his feet. Mrs Tarilongi said it was not until later that she learned that they could have obtained the claimant's admission to an overseas hospital if they had undertaken to pay for it themselves.

26. Doctor Horsley was the medical expert called by the claimant. He had examined Mr Tarilongi on 1 May 2000 in Sydney. His report summarizes the course of treatment received by the claimant, and the claimant's complaints to him that he was treated in the VCH only by a "general doctor" and not by an orthopedic surgeon. He reported that his leg was "flopping around too much" traction continued until the open reduction and internal fixation of the fractured femur occurred on 8th July 1998. He sets out his findings on examination, and reports on the degree of residual disability, and that evidence is directed to issues that would arise on an assessment of damages. Doctor Horsley wrote:-

> *"In my opinion, if Mr Tarilongi had had his femoral shaft injury managed in the way I have described at a Sydney hospital, he should not have been subjected to such management. The appropriate treatment is as follows:-*
> *This fracture would be managed with an intramedullary nail within 24 hours of the injury. The patient would then be mobilized and ambulate non weight bearing for a period of 6 weeks with the aid of crutches. This would have been made more difficult with the plaster on his left wrist, however the patient would still be able to use a gutter crutch to ambulate. His hospital stay would be approximately one week. The fracture of the femur would still take 16 to 20 weeks to unite, with the rate of union approximately 98%. The advantage of the femoral nail is that the knee and hip joint begin movement immediately, leading to very little long terms stiffness or other complication.*
>
> *The intramedullary nail fixation is to be preferred to the plate fixation that was used in Mr Tarilongi's case. Plate fixation of a femoral shaft fracture it not ideal treatment. There is a higher chance of implant failure in comparison with intramedullary fixation. Furthermore, with internal fixation using a plate the quadriceps muscle is reflected off the femur and the scar tissue that is laid down*



following this surgical procedure can lead to lack of flexion in the knee. It is normal for this stiffness to be painless.

Stiffness is also a well recognized complication of prolonged skeletal traction. It is the main cause of Mr Tarilongi's knee stiffness. There is a definite disadvantage using traction for these fractures due to the long term stiffness of the knee that it causes and the prolonged period of bed rest required. Long term bed rest has potential complications, which include marked muscle wasting, bed sores and hypostatic pneumonia.

However, if traction is used, it usually takes a long bone, such as the femur, a period of 16 to 20 weeks to unite. This is about the length of time Mr Tarilongi remained in traction. If union has not occurred at four (4) months, an X ray taken at that stage would be helpful."

27. Doctor Horsley's second report was written after he had read the first sworn statement from Doctor Mc Namara that informed him that the VCH did not carry a range of intramedullary nails that would have permitted the surgical use of one on Mr Tarilongi. He was asked what the intramedullary nails cost. He said "There are 9 different thicknesses of nail and 10 different lengths of nail. Each nail cost approximately AUD $ 600 so that a full set would cost about AUS $54,000. In addition these nails require cross locking screws which cost about AUS $4,810.

28. Doctor Horsley said he had read Dr Mc Namara's report about femoral fracturs and their management and he agreed with the majority of the statements including that "It is also not certain that the claimant would have had full restoration of movement of the leg if he had been given operative treatment". Doctor Horsley said the statement is correct, however there is a very high chance that, in fact, the claimant would have a full range of hip and knee movement if managed with an intramedullary nail in the acute setting (i.e. immediately or very soon after the fracture).

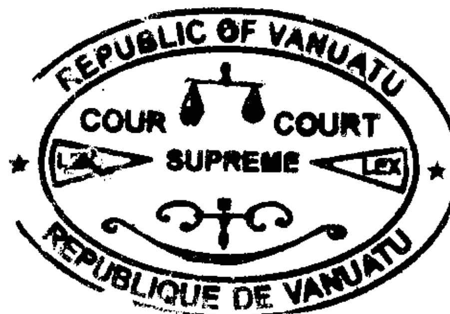
29. That evidence completed the claimant's case.

30. **For the Defendant**

    Statement of Taripu Blandine (registered nurse) sworn 13 July 2004

    Statement of Doctor Edward Tambisari (medical superintendant at VCH) sworn 14 July 2004

    Statement of Peter Robert Griffiths (General Manager, Australian Family Assurance) sworn 6 September 2004



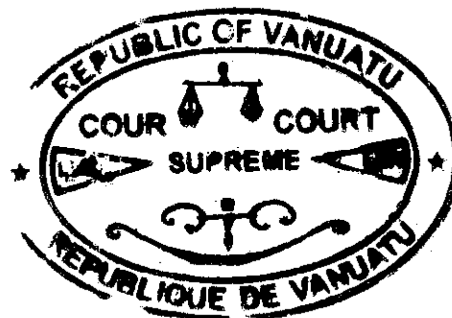
Statements of Doctor Basil Mc Namara (Expert medical witness) sworn 18 December 2001 and 9th July 2004.

31. In the defendant's case, Nurse Blandine said she remembered the claimant as a patient. He complained a lot. This lead him being moved into a private ward. He was under the care of Dr Liu who regularly checked his leg for alignment and healing. She confirmed many X rays were taken. She recalled Doctor Liu consulting with other doctors about the claimant's leg on a number of occasions. The claimant and his wife complained that the treatment was taking too long. She confirmed the visit of the Australian doctors and that Doctor Capuano ultimately did an operation.

32. Doctor Tambisari's statement was directed to explaining the arrangement under which Doctor Liu had been appointed for a 2 year contract to the Surgical Medical Team at the VCH. He confirmed the letter he had written to the Director of Agriculture which did not recommend evacuation to New Zealand. He was of the opinion that it would be the same treatment that Mr Tarilongi would receive down in New Zealand. Under the scheme under which some patients are evacuated to New Zealand there are criteria that must be met. In his capacity as superintendant, he was part of a medical panel called on to consider whether a patient should be treated overseas. One of the criteria is where Vanuatu cannot offer the treatment. Another is that the patient must be in a life threatening situation. The claimant was ineligible under these criteria to receive sponsored treatment overseas from New Zealand.

33. Doctor Tambisari confirmed that there is nothing stopping a citizen of Vanuatu for traveling overseas for medical treatment at his own expense. However the patient must arrange such treatment and pay for it themselves. He said he told Mrs Tarilongi that if they could afford to do so there was nothing stopping them going down to New Zealand.

34. Mr Pierre Griffiths confirmed that the claimant held an insurance policy with Australian Family Assurance, but the doctor they referred the matter to, Doctor Finberg said that the claimant's injuries could be treated in Vanuatu. Based on that opinion the company refused to send the claimant overseas.



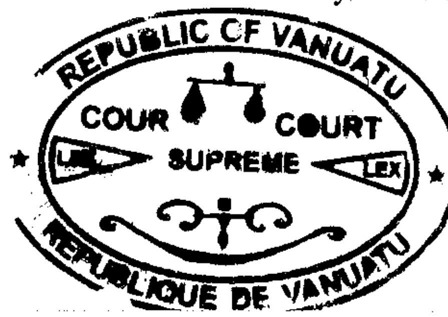
35. Doctor Mc Namara in his first statement discussed the nature and standard of treatment provided to the claimant whilst he was at the VCH. For the purpose of providing his opinion on this matter he had consulted the medical records and X rays held by the hospital. He said that in a First World Country, operative treatment would have been the first choice of treatment for a fracture of the shaft to the femur. However Vanuatu (at that time) is classified as a Least Developed Country, and in the circumstances typically prevailing in this category of nation-state, and in the VCH, the appropriate choice of treatment is a matter of opinion. In his opinion he considered it important to emphasize that in countries such as Vanuatu there is no single correct choice of treatment in this type of case.

36. One possible form of operative treatment is the insertion of an intramedullary nail into the bone. However the VCH rarely used that form of treatment because VCH carried a very limited range of the nails. The treatment required the correct size of nail, and unfortunately VCH did not have the resources to buy and replenish that type of prosthesis. A second form of operative treatment potential available, and the one ultimately performed by Doctor Capuano, is the insertion of a plate onto the fracture bone.

37. The hospital adopted a basic policy of being conservative in relation to the choices of operative treatment. The policy was based on the much higher risk of infection in surgery resulting from the lack of resources, and on the limited range and nature of available prosthesis. Treating a fracture using traction was, in his opinion, appropriate. Unlike surgery, traction does not have the advantage of early mobility and does not result in the same degree of accuracy of alignment of the bones as may be achieved by surgery. On the other hand it carries a much lesser risk of infection.

38. Doctor Mc Namara had noted in the hospital records that the claimant had been visited by two Australian orthopedic surgeons. The note seemed to have incorrectly dated that visit as 6th May 1998 whereas the claimant, in a diary that he kept contemporaneously, noted the date as 18 May 1998. Whatever the date, the hospital notes record that the *"patient refused to accept the operation"*.

39. In relation to the claimant's complaint that his foot tilted outwards during traction, Doctor Mc Namara said that if the claimant had suffered some rotation deformity in the course of



that treatment beyond merely a cosmetic degree of deformity, then it is possible that this deformity may have been corrected at the time the surgery was performed upon the fracture. This statement must be understood in the context that Doctor Horsley had not reported any such rotational of deformity at the fracture site. In other words, had the position in fact been as the claimant reported it during the period of his traction, it had been remedied when the surgery was undertaken.

40. Doctor Mc Namara concluded with his opinion that the choice of traction as the appropriate method of treatment of the complainant's fracture was reasonable in all the circumstances.

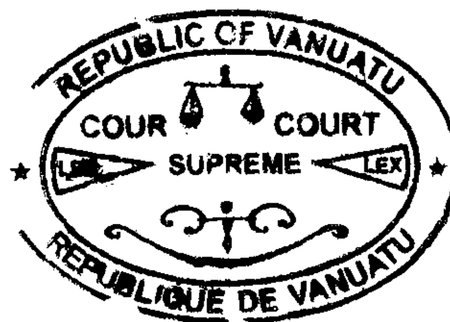
41. In his second statement Doctor Mc Namara repeated much of the information in his first statement. He confirmed that on his review of the information given to him about the claimant and the hospital record and X rays, he considered there is nothing to suggest that the traction was applied and managed in other than a competent skillful manner. He went on to say:-

"When advising patients of treatments options it is not my practice to advice them of options available overseas unless they ask me. For most ni-Vanuatu overseas treatment is not a realistic option. Factors such as the cost, getting visas and getting accepted by the overseas hospital prevents overseas treatment being an option. In the case of broken leg such as this, transport cost alone are high. The patient has to travel with his leg in traction which requires six seats on the aeroplane. He must also travel with a medical escort such a nurse, an expense also borne by the patient. On top of that there is the cost of hospitalization in the overseas country. Operative treatment overseas would have required the claimant to remain in the country where he was treated for a minimum of 4 – 6 weeks."

42. In cross examination Doctor Mc Namara added that another reason that he would not advice a ni-Vanuatu resident about overseas treatment options in a case like this is the difficulty in explaining the complex risks which the patient would ran in undertaking overseas travel whilst injured.

43. Doctor Mc Namara said that if the injured person were an expatriate, and not a ni-Vanuatu resident, he would discuss evacuation as an option, but that was because the overseas resident could access the health schemes available in that person's country of residence which would not be available to a ni-Vanuatu resident travelling there for treatment.

44. Doctor Mc Namara's evidence completed the Defendant's case.



ALLEGATIONS OF NEGLIGENCE

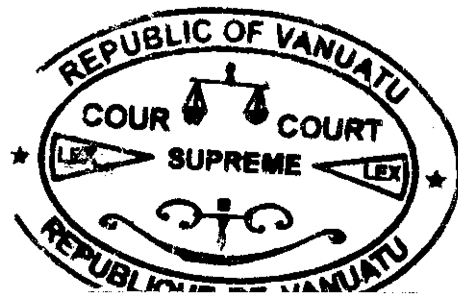
45. The particulars of negligence pleaded in the amended statement of claim are as follows:

"Particulars of negligence

1. *Dr. Liu failed to employ the treatment consisting of either the insertion of an intramedullary nail or the use of an open reduction and internal fixation within 24 hours or as soon as possible in order that the Claimant could be ambulatory at the earliest possible time an so minimize the risk of residual stiffness developing in the Plaintiff's right hip and knee.*
2. *The Defendant failed to advise the Claimant that the best treatment for him in view of the problems of residual stiffness associated with treatment of a broken femur with traction, was to have the operation involving the insertion of an intramedullary nail or else, as the next best choice, the open reduction and internal fixation so that he could be ambulatory at a much earlier time.*
3. *The Defendant failed to advise the Claimant that it could not offer the operation involving the intramedullary nail as it could not afford to keep a range of intramedullary nails.*
4. *The Defendant failed to offer the claimant the choice of purchasing the required intramedullary nails himself, so as to be able to undergo the more desirable treatment.*
5. *The Defendant advised the Claimant that it would make no difference to his treatment even if he went to New Zealand as traction would be used there too, so that the Claimant had not knowledge of the other methods of treatment and therefore could not choose to go overseas to receive that treatment.*
6. *Dr. Liu used traction when, as a treatment for a broken femur, it is outmoded and undesirable due to its well-known adverse effects which include stiffness of the knee.*
7. *Dr. Liu negligently applied the traction equipment in that*
   - *(a) He failed to ensure that the fracture was correctly aligned with the result that, after more than four (4) month in traction, it had a 20° varus deformity and anterior bow.*
   - *(b) He failed to employ a rigid construction of the traction apparatus with the result that the leg was free to flop about and move in all directions.*
8. *The Plaintiff was left in traction for a period of 4 months without the fracture uniting.*
9. *Dr. Liu failed to take steps at a much earlier stage to ensure that the fracture united and so prevent a prolongued period in traction."*

DUTY OF CARE AND LAW (APPLICABLE)

46. In this case the defendant is sued as the authority managing and controlling the VCH. The defendant has now conceded that it is liable for the conduct of the doctors at the hospital if any breach of professional duty on their part is established. This concession is in accordance with *Cassidy v. Minister of Health [1951] 2 KB 343* which was applied in *Qualao v- Government of the Republic of Vanuatu [1999] VUSC 45; Civil Case 146 of 1994 (8 December 1999)*. In this case it is the conduct of Dr. Liu and the advice of Dr. Tambisari that



is central to the case. If either of them was negligent, VCH is liable; if they were not, the VCH is not liable.

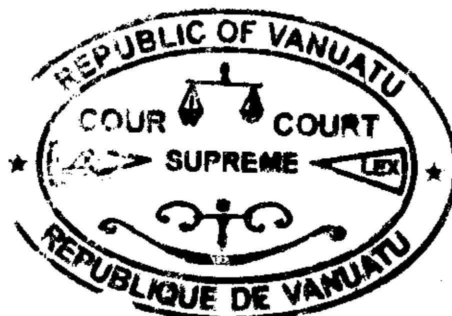
47. In Rogers v. Whitaker [1992] 67 ALJR 47, five members of the High Court of Australia said:-

"The law imposes on a medical practitioner a duty to exercise reasonable care and skill in the provision of professional advice and treatment. That duty is a "single comprehensive duty covering all the ways in which a doctor is called upon to exercise his skill and judgment"; it extends to the examination, diagnosis and treatment of the patient and the provision of information in an appropriate case. It is of course necessary to give content to the duty in the given case.

The standard of reasonable care and skill required is that of the ordinary skilled person exercising and professing to have that special skill..."

48. Whether that standard of care is met is for the Court to judge. Whilst the Court will be guided by the opinion of medical experts in the field, ultimately it is for the Court to judge whether the standard has been met, not for the medical profession to do so. Rogers v. Whitaker was a case concerning an alleged failure to give advice about the risks of proposed treatment. The majority of the High Court approved the following passage from the judgment of the Supreme Court of Canada in Reibl v. Hues [1980] 114 DLR (3d) at 13:-

"To allow expert medical evidence to determine what risks are material and, hence, should be disclosed and, correlatively, what risks are not material is to hand over to the medical profession the entire question of the scope of the duty of disclosure, including the question whether there has been a breach of that duty. Expert medical evidence is, of course, relevant to findings as to the risks that reside in or are a result of recommended surgery or other treatment. It will also have a bearing on their materiality but this is not a question that is to be concluded on the basis of the expert medical evidence alone. The issue under consideration is a different issue from that involved where the question is whether the doctor carried out his professional activities by applicable professional standards. What is under consideration here is the patient's right to know what risks are involved in undergoing or foregoing certain surgery or other treatment."



49. The other member of the High Court of Australia in Rogers v. Whitaker reached a similar conclusion to the majority: see Gaudron J at pages 53-55.

50. If a breach of the duty of care is made out, the claimant must also establish that the breach was the cause of the loss or damage for which he claims. This causation question is of importance in the present case.

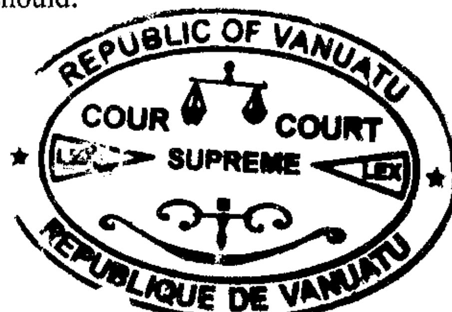
DISCUSSION AND APPLICATION OF THE LAW

51. The content of the duty of care owed by the medical practitioners in this case must be judged having regard to the state of medical knowledge and practice as it existed in 1998 and not by today's standards. It must also be judged having regard to the facilities and circumstances existing in the VCH that was operating in the economic and social circumstances of a Least Developed Country at that time.

52. I apply the law concerning the duty of care of Dr. Liu and Dr Tambisari to the facts of this case bearing in mind the observations just made.

53. Particular 1 of the negligence alleged criticizes Dr. Liu for not inserting a intramedullary nail or undertaking open reduction within 24 hours or, at least, soon after the claimant's admission. The effect of the medical evidence is that if either of these operative procedures is done very soon after the injury the procedure would be likely to hasten recovery and minimize the risk of residual disability.

54. However when the claimant was admitted to hospital there was no intramedullary nail available. Further, there is no satisfactory evidence that any other suitable prosthesis was available for internal fixation of the fracture. There is a suggestion in the cross examination of Dr. Mc Namara that the prosthesis and supply of antibiotics that made Dr. Capuano's surgery possible in July had been brought to Vanuatu by the two Australian surgeons in May 1998. On the assumption that the claimant was not to be evacuated overseas, I consider traction was the reasonable course of treatment for Dr. Liu to undertake. At the time traction was the recognized treatment for the kind of injury which the claimant had suffered, and I consider it was reasonable for Dr. Liu to continue traction at least until it became apparent that anticipated recovery was not occurring as it should.

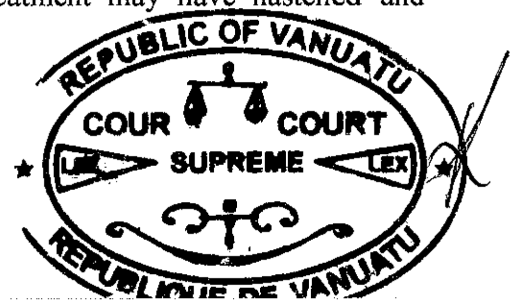


55. When the two visiting Australian surgeons examined the claimant on 18th May 1998 they considered the time had come for surgical intervention, but when it was offered it was refused both by the claimant and his wife. That was their decision, not the decision of the medical staff. The claimant must himself accept the consequence of that decision. Until the claimant agreed to the surgery, traction had to be continued. In my opinion, particular 1 of the alleged negligence is not established.

56. Particular 2 raises an issue of failure to advise about treatment options. However, as there is no evidence that the alternatives suggested in the particular were available in the VCH at the time when traction was selected as the method of treatment, there was no point in discussing options that were not available. Particular 2 is not established.

57. Particulars 3 and 4 together make a different allegation about the failure to advise about a treatment option, namely the possibility of the claimant himself purchasing an intramedullary nail overseas, and importing it to be inserted by a surgeon at VCH. The cost of the nail and screws and its importation may have been within the financial capacity of the claimant, although the vague nature of his evidence about his financial capacity is unsatisfactory. But the evidence has failed to explore how the specification for the required nail would be ascertained, how the ordering process and importation would occur and how long it would take. This is important information as the medical evidence is that to avoid the risks of residual disability and to get a good outcome, the procedure should occur in the first 24 hours or thereabouts after the injury. Plainly that could not have been possible. How long the delay may have been and how this would have affected the outcome is not explored in the evidence. Moreover the evidence makes it very clear that the claimant and his wife were very much against open surgery at the VCH, and had the topic of delay, costs and risk been discussed in detail with the claimant I am not satisfied as a matter of probability that the claimant would have pursued this option. I do not consider these particulars of negligence have been established.

58. Particular 5 alleges that the advice given by Dr. Tambisari that treatment in New Zealand would be the same as in Vanuatu was wrong and negligently given and in consequence the claimant was left ignorant of the fact that overseas treatment may have hastened and



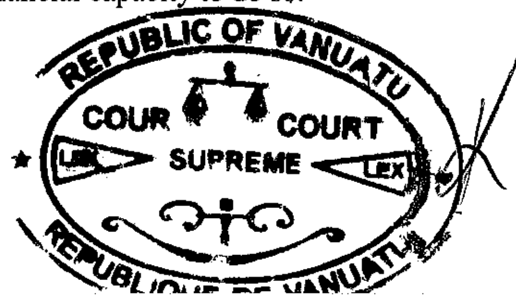
improved his outcome. This allegation makes the assumption that is justified on the evidence that the claimant would have received a copy of Dr. Tambisari's letter which was addressed to the Director.

59. I think it is reasonable to assume that the treatment available in New Zealand would be similar to that available in Australia which Dr. Horsley describes. The opinion given by Dr. Tambisari did not make an adequate disclosure of information about overseas treatment, and in this respect I consider the information was negligently given. However the claimant immediately faces the need to establish as a matter of causation that he would have taken a different course had Dr. Tambisari advised differently about treatment options in New Zealand.

60. I do not consider the claimant has established that things would have been any different if Dr. Tambisari had informed the Director that other treatment options were available in New Zealand.

61. There is no evidence that the Director had any power or opportunity to arrange for the claimant's evacuation to New Zealand and to have the expense of doing so covered. What the Director had asked was that Dr. Tambisari arrange for evacuation under the special scheme with the New Zealand government. However the evidence from Dr. Mc Namara shows that the claimant did not meet the criteria for evacuation under that scheme. Moreover, I consider that the communications between the Director and Dr. Tambisari which the claimant knew about would have made clear to the claimant that there were better treatment options available overseas. It is therefore not right for him to say that he was unaware of these options because the doctors at VCH did not tell him about them.

62. The evidence shows that the claimant knew that there were other options overseas, and it was for this reason that he was seeking to be evacuated at the expense either of the scheme with New Zealand, or his insurance company. The reel problem about being evacuated overseas was how to pay for it, for it became clear that neither the New Zealand Scheme nor the insurance company would cover the costs. I think it must have been clear to the claimant that overseas evacuation was still possible if he was prepared to arrange and pay for it himself. The real problem was the cost, not the need for a doctor in Vanuatu to recommend overseas treatment. That raises the question of whether he had the financial capacity to do so.

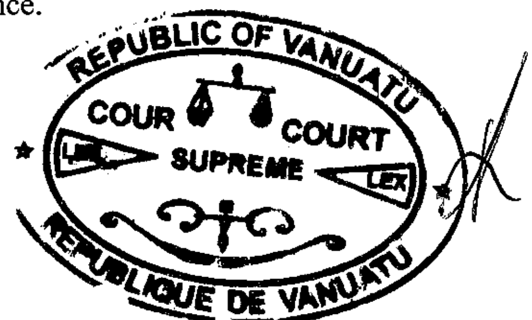


63. The evidence about the claimant's financial capacity is quite unsatisfactory. Both the claimant and Mrs Tarilongi in their evidence simply said that they could have paid for it, but no evidence is given to suggest this was in fact possible.

64. The evidence in the claimant's case makes no attempt to work out what these costs would have been or how he would have raised the necessary money to pay them. To purchase seven air tickets one way, plus a return air fare for the medical assistant and later for himself would be very high. The costs of surgical and hospital treatment in the overseas country would likely be enormous. The claimant would be overseas for some weeks and would need accommodation and sustenance. There would be the added consideration of whether the claimant's wife would accompany him for part of the time at least. All these expenses would likely involve millions of vatu. Without information to show the extent of these costs, and without information about the claimant's own financial means, it is simply wild speculation to say that he could have paid for the treatment himself.

65. Without all this evidence the Court is not able to conclude that the claimant would have done anything other than continue treatment at the VCH. The claimant has not established particular 5 of the alleged negligence.

66. Particulars 6 to 10 alleged that Dr. Liu was negligent in the way traction was applied. This allegation is supported only by the evidence of the claimant and Mrs Tarilongi to the effect that the claimant's leg flopped about in the traction, and this foot tilted outwards. There is no medical evidence to establish that there is anything wrong in the way in which the treatment was applied. The evidence of Nurse Blandine does not support the claimant's case. Nor is there any evidence based on X rays or the hospital notes to show that the traction was negligently administered. On the contrary, even the claimant's evidence shows that Dr. Liu was frequently checking and adjusting the traction and telling the claimant that his concerns were not well founded. The X rays taken just before the open reduction operation show that fusion was commencing. It had been slow and a complete fusion had not taken place in four months, but this fact alone does not prove negligence. To prove the case the claimant needed expert medical evidence to the effect that the failure of the bone to fuse together in four months must be due to negligent treatment of some sort. The evidence is missing and the claimant has failed to establish these particulars of negligence.



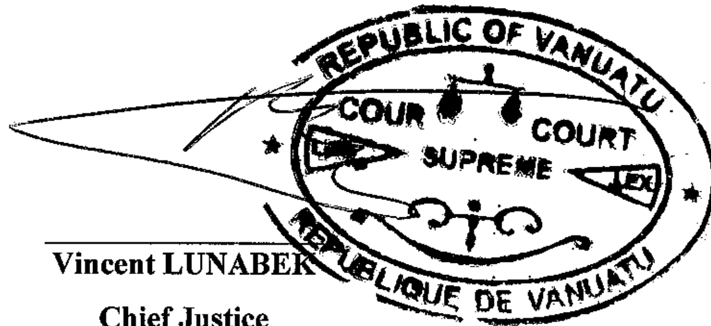
67. The claimant has failed to make out any of the allegations of negligence which he has pleaded. His claim is therefore dismissed. He must pay the defendant's costs on the standard basis. Orders are made accordingly as follow:

ORDERS

1. The Claim in Civil case No.36 of 2001 is hereby dismissed
2. The Defendant is entitled to costs against the Claimant on the standard basis. Such costs shall be taxed failing agreement.

Dated at Port Vila, this 4th day of June, 2014

BY THE COURT



Vincent LUNABEK

Chief Justice