The Interface of Law and Medicine in the South Pacific

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INTRODUCTION

Medical law and medico-legal issues involve a relatively new subject area, and this is especially so with respect to the South Pacific region. Previously medical law was regarded as a mixture of criminal law, tort, contract and property concepts. Nowadays medical law has emerged as a subject in its own right, but there is still debate as to what, if anything, makes it a discrete area of the law. Medical law does not respect the traditional compartments with which lawyers have become familiar, such as torts, contracts, criminal law, family law and public law. Instead medical law cuts across all of these subjects and today must be regarded as a subject in its own right...it is a discrete area concerned with the law governing the interactions between doctors and patients and the organization of health care.

In the South Pacific region, the development of medical law as a subject in its own right, is still very much in its early stages. Case authorities in this paper will reveal that principles of torts law, Contracts and Administrative Law are still applicable to the issues of Medical law especially medical negligence.

This paper is concerned with medical negligence in the South Pacific. The main focus of the researches undertaken was on the issue of limited resources of Health authorities in the region. The thesis I wish to put forward is ; Can limited health resources be a basis for suing in medical negligence in the South Pacific? and alternatively, is the lack of these health resources a valid legal defence? The fact is no resources are infinite and a compromise must be achieved between demand and supply. The distribution of scarce resources poses some of the more complex ethical problems of modern medicine and permeates every aspect of its structure. There is little law established on the subject. To determine whether negligence is alleged, I have tried to research the duty of care of health authorities by referring to statutory and common law authority. I have then discussed these authorities comparatively, with those of other jurisdictions beyond the region.
The issue of limited health resources and their allocation is very relevant in the region. There is a continuing debate whether the criticisms of our health care systems reflects an unrealistic public expectation of the range and quality of services that could be reasonably expected to provide. On the other hand, one could ask if the regions health care delivery system are responsive enough to the needs of patients within the confines of the resources that are currently available. This paper also seeks to discuss some of these medico-legal issues, as well as essentially, being a research paper on the possible development of the law on Medical negligence in the South Pacific.

a) The Duty of care of the Health Care Provider.

For the purposes of this paper, the Health care provider means the health worker in the private and public medical/nursing professions This includes doctors and nurses and other hospital staff. Subsequently this duty of care will be extended to include the hospital authority, the Permanent Secretary, the Minister for Health and ultimately the Government or State. The duties imposed on these "Health care providers" will be relevant when discussing the alleged breach of duty in negligence for the limited or lack of resources provided by these Health care providers.

It should be noted that most of the alleged medical negligent cases in the region, that I have researched, have by virtue of vicarious liability, included as defendants, the Doctor, Attorney General, Minister of Health and the Government or State. It is well settled law in the region that these authorities are vicariously liable for the negligent actions of their medical staff and employees.

Medical law is about rights and duties which are legal and ethical as well as moral. Where issues of medical law and practice are concerned, human rights issues abound. Modern medicine has increasingly been seen in terms of human rights. This approach has yet to be witnessed in the South Pacific region. It has become fashionable to talk about 'rights' for everyone, and patients and their providers are no exception. While there are many groups in society that desperately need their rights recognized and enforced, perhaps none is as vulnerable as the desperately ill patient. This vulnerability and the potential abuses it permits have led many to suggest that the provider-patient relationship should be made more equitable, and that the status of the patient should be improved with this goal in mind.

It is therefore important, at the outset, to try and ascertain the extent of the duty that is owed by the alleged negligent party to a patient. These duties may lie with the health workers, doctors and nurses, hospitals and subsequently with the Government which controls the operations of hospitals and dispensaries. The extent of these duties may be found in health legislation in the countries of the region. Once this duty is established, either by legislation or common law, only then may a patient have a chance of being successful in suing the negligent party for breach of this duty.

As such, the duty of care needs to be clearly established, otherwise the action fails without any further consideration. In terms of medical negligence the term 'duty of care' has become synonymous with the concept of the 'undertaking' towards the patient. This concept of undertaking and the essence of the medical negligence action was most effectively put, in the English case, R v Bateman :

> If a doctor holds himself out as possessing such skill and knowledge,
> and he is consulted, as possessing such skill and knowledge, by or on
> behalf of the patient, he owes a duty to the patient to use due caution in
> undertaking the treatment. If he accepts the responsibility and undertakes
> the treatment and the patient submits to his discretion and treatment accordingly,
> he owes a duty to the patient to use diligence, care, knowledge, skill and
> caution in administering the treatment. No contractual relation is necessary,
> nor is it necessary that the service be rendered for reward.

i) Regional legislation and Common law Authorities on duty of care.

The countries of the region do not have legislation which specifically outline and define this duty, but this duty may be implied from health legislation in the region.
In Fiji the Public Hospitals and Dispensaries Regulations (Cap 110) contains provisions which imply the duty of Public Hospitals and staff to their patients. Section 4. states;

> The Permanent Secretary shall exercise general control and
> supervision over the organization and management of all
> public hospitals and public dispensaries and over the expenses
> of their administration...

Section 5, although not specifically stating what these duties are, further states;

> The duties of officers and employees of all classes employed
> in public hospitals or public dispensaries shall be such as may

be from time to time be laid down in writing by the Permanent Secretary and such officers shall at all times obey all orders and directions relating to their duties or to the administration and management of the hospital dispensary issued by the Permanent Secretary.

The extent of this duty of care is therefore left in many regards, to be determined by the common law courts of the region. The common law cases from the region establish and acknowledge the duty of a doctor and hospital to a patient. In the Federated State of Micronesia case, The Estate of Esther Leeruw v FSM Government, Dasuo Harry and Wilton Mackwelung. Edward C. King CJ explained the extent of this duty when he said, "There can be no question that the doctor owed a duty to the deceased acting pursuant to statutory authorizations and administrative directives, the national government has caused the doctor to assume responsibility for providing medical referral assistance to FSM citizens".

In the Vanuatu case, Harold Qualao v The Government of the Republic of Vanuatu and Dr. Ronald Peach Lunabeck Acting CJ, outlined this duty when he said;

the defendant in this case is the Government of the Republic of Vanuatu and as such is responsible for the public health in Vanuatu. There is no doubt that doctors and nurses employed by the hospital are employees of the defendant. As such I find and hold that the Defendant as the controlling authority of the hospital and employer of doctors and nurses working at the hospital, owes the hospital patients a duty of care.

The common law cases on medical negligence from the region, all establish the duty of a doctor and hospital to its patients. But the question that arises is to what extent can this duty be imposed on these authorities for not providing medical and health resources to patients in hospitals and are these authorities negligent for not complying with these duties?

By way of comparison in the United Kingdom, The National Health Services Act 1977 (UK) imposes on the Secretary of State a duty to make provision for a 'comprehensive health service' Section 3 (1) of the Act sets out in some detail the duties of the Secretary of State:

3. (1) It is the Secretary of States duty to provide throughout England and Wales, to such extent as he considers necessary to meet all reasonable requirements-

(a) hospital accommodation
(b) other accommodation for the purpose of any service provided under this Act;
(c) medical, dental, nursing and ambulance services;
(d) such other facilities for the care of expectant and nursing mothers and young children as he considers are appropriate as part of the health service;
(e) such facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness as he considers appropriate as part of the health service;
(f) such other services as are required for the diagnosis and treatment of illness.

Therefore, common law authorities from the region have clearly established the duty of a health care provider to a patient. However, there have been numerous attempts to argue that there is no clear duty of the government for the vicarious liability of its employees.

b) Duty of care: vicarious liability of the Hospital and the Government.

In the Vanuatu case of Qualao, the Defendants submitted that it was not possible for the plaintiff to maintain an action against the defendant as the government could not have undertaken in any way to be responsible for the way in which doctors or nurses employed by the government performed their duties.

The defendant argued that this would open the flood gates to litigants to readily sue the government for everything that went wrong in a hospital.

To support this argument, the defendant relied on Hillyer v St Bartholomew's Hospital where Kennedy LJ said that he did not consider it a proper legal inference that the hospital authority is liable in damages for members of its professional staff, whose competence is not in question but who act negligently in the treatment of patients and use of apparatus. He continued to say that he would be prepared to hold that the hospital authority is legally responsible to the patients for the performance of their servants within the hospital of their purely ministerial or administrative duties.

However, the plaintiff relied on Lord Denning's judgment in Cassidy v Ministry of Health , where he stated that where a person is under a duty of care, he cannot dispose of his responsibility by delegating the performance of it to someone else, regardless of whether the delegation is to a servant under a contract or an independent contractor . The plaintiff also relied on Lord Greene's comments in Gold v Essex County Council where he stated that where a defendant treats patients, it also has an obligation, and is liable if the people employed by it to perform this obligation act without due care. It cannot assume no greater responsibility than to provide a skilled person and proper appliances
The defendant also referred to Swift J's comments in Marshall v Lindsay County Council . He said that the Committee of the hospital contracts with a patient to provide a hospital, that is a building with domestic staff to run it. He commented that they also contract that they will employ or engage competent doctors and nurses, but they do not undertake to be responsible for the way the doctors and nurses perform their duties because these are skills and cannot be controlled by the committee. Therefore, he said, the committee is not responsible for any negligence doctors and nurses may be guilty of in their duties.

The defendant submitted that the government could not possibly supervise or control the actions the doctor and the nursing staff, and therefore were not liable. The government could not be responsible for matters of skill and care within the competence of the surgeon and the nurses of the hospital.

However, the plaintiff submitted that the unsafe system in place at the Villa central hospital was the cause of the negligence of the hospital staff. The nurses stated that only doctors could order patients to be placed in the Intensive Care Unit. In addition, the hospital did not ensure 24-hours access to doctors. In situations where modern facilities were not available and operations such as those that could have been performed on the deceased. Lunabeck CJ said that if access to doctors was already available in emergency situations, then it appeared that the system of calling them was not efficient. Lunabeck CJ was persuaded by the authority of Collins v Hertfordshire County Council and another that a hospital is responsible for its negligent system and therefore followed and applied it to that case.

c) The rights of the patient.

Modern medical law has began to take on the language of rights. It has also taken on the concurrent language of duties. Duties pervade the whole study of medical law. This duty of care is incumbent on the medical practitioner as a matter of negligence, contract and public law. The vast majority of duty of care cases in medicine are medical negligence actions. In general terms where there is an allegation of negligence against a doctor, the patient has to show, on the balance of probabilities, that the particular defendant owed the patient a duty of care, has breached that duty, by acting below the standard prescribed by law and that this breach has caused legally recognized damage. There are also significant difficulties for the patient plaintiff. The difficulties lie in the particular rigours of negligence actions as a whole, but more significantly for the disgruntled patient, by the historical dominance of the medical profession in the doctor-judge as well as the doctor-patient relationship.

The regional cases researched reveal that a plaintiff in a medical negligence case is faced with the prospect of being left at the mercy of the medical profession. In the South Pacific the instances and case law on

medical negligence are very few. This does not mean that there are very few medical malpractices in the region. There are arguably many cases of medical negligence, but these rarely get to the courts because the public are unaware of their rights to sue negligent medical professionals. The medical profession in the region is also very protective of their members. A plaintiff in the South Pacific region would be faced with even greater hurdles in trying to discharge the burden of proof that a doctor was negligent.

In 1995 the World Health Organisation (WHO) published a document entitled Promotion of the Rights of Patients in Europe: Proceedings of a WHO Consultation. This is a significant modern piece of work for the study of human rights and medical law. It indicates that there are certain international unifying rights themes for medical law. The principles of patients rights which emerged focused more than ever before on a beneficial doctor-patient relationship which encouraged the participation of and respect for the patient and protected the patients dignity and integrity. Further it would allow patients to obtain the fullest possible benefit from the health care system and would encourage a wider dialogue between societal pressure groups, doctors and patients.
The document makes a number of important points which are considered to be general guiding principles for the fullest expression of human rights in health care:

(a) Everyone has the right to respect of his or her person as a human being
(b) Everyone has the right to self determination.
(c) Everyone has the right to physical and mental integrity and to the security of his person
(d) Everyone has the right to respect for his or her privacy.
(e) Everyone has the right to have his or her moral and cultural values and religious and philosophical traditions respected.
(f) Everyone has the right to such protection of health as is afforded by appropriate measures for disease prevention and health care, and to the opportunity to pursue his or her own highest attainable level of health .

The jurisdictions of the South Pacific region do not have any health policy or legislation that outline the rights of a patients. These rights however, may be implied from the Fundamental Rights sections of the respective Constitutions. In the Professional Services Clause of the Constitution of the Federated States of Micronesia, the national government recognizes the "right of the people" to "health care" and pledges that it "shall take every step reasonable and necessary" to provide such service. The interpretation of that clause would be significant in cases such where plaintiffs claim, that the national government did not take the "reasonable and necessary" steps to provide adequate health facilities and thereby deprive a plaintiff of their "right...to...health care." The Government usually respond to such claims pertaining to health care with an assertion of limited liability and limited resources. This is also based upon an underlying assumption that sovereign immunity is available against such a claim but it would seem profoundly inconsistent with the promise of the Professional Services Clause in the Constitution.

It would seem appropriate for Governments of the South Pacific region to use the above World Health Organisation model on the rights of patients, and this could be implemented into health related legislation.

d) Duty of care and the Minister of Health.

In the Federated State of Micronesia case Andonio Amor v The Government of the State of Pohnpei and George Fleenor and Others King, C. J. said that so long as a state retains its role as the primary provider of health care services in that state, it is legally obligated to make a reasonable effort to provide a health care system reasonably calculated to meet the needs of the people of the state, but the state may make decisions to limit the scope of medicines to be maintained, so long as the decisions are based upon sound medical judgment arrived at through consideration of the health needs and financial realities of the state.

The Court also held however, that it was not, sufficient to argue, as the state seemed to have been doing in

that case, that the lack of sufficient funds justifies any and all absences of medicine from the Pohnpei health care system. Lack of funds may have required the cutting back on medicines and it was surely the right of the state to make the decision as to which medicines to discontinue. However, such cutbacks must themselves reflect reasonable care. The court held that they should be based upon sound medical judgment arrived at through consideration of the health needs of the people of Pohnpei as well as financial realities.
In the UK The National Health Services Act 1977 imposes on the Secretary of State a duty to make provision for a 'comprehensive health service'. Section 3 (1) of the Act sets out in some detail the duties of the Secretary of State:

It is the Secretary of States duty to provide throughout England and Wales, to such extent as he considers necessary to meet all reasonable requirements-
(g) hospital accommodation
(h) other accommodation for the purpose of any service provided under this Act;
(i) medical, dental, nursing and ambulance services;
(j) such other facilities for the care of expectant and nursing mothers and young children as he considers are appropriate as part of the health service;
(k) such facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness as he considers appropriate as part of the health service;
(l) such other services as are required for the diagnosis and treatment of illness.

In the South Pacific region financial restraints and lack of resources would clearly place the respective Ministers of health and Permanent Secretaries, in some difficulty in discharging their statutory and common law duty to provide, to such extent as they thinks necessary to meet all reasonable requirements including, inter alia, hospital accommodation.

There haven't been many regional cases where this issue was judicially considered. In the English case, R v Secretary of State for Social Services, ex p Hincks patients in an orthopaedic hospital complained that they had waited an unreasonable time for treatment because of shortage of facilities, accordingly they sought a declaration that the Secretary of State and the Health Authorities were in breach of their duty. In dismissing the application, Wien J said it was not the Court's function to direct parliament what funds to make available to the health service and how to allocate them. The duty to provide services ' to such extent as he considers necessary' gave the Minister a discretion as to the disposition of financial resources. The court could only interfere if the Secretary of State acted so as to frustrate the policy of the Act or as no reasonable minister would have acted; and no such breach had been shown in the particular case. Moreover even if a breach was proved, the Act did not admit of relief by way of damages.

The patients failed in their action against the Secretary of State. At first instance, Wien J appeared to regard the phrase 'as he considers necessary' in the legislation as providing the Secretary of State with an excuse. As Wien J argued the issue is one of financial resources, which is not a matter for the courts but one for parliament. 'If the money is not there then the services cannot be met in one particular place'.

In the English case R v Central Birmingham Health Authority, ex parte Walker the reason that an operation could not be performed on a baby was due more to financial constraints, which led to a lack of intensive care beds and specially trained nurses. Macpherson J revealed the dilemma:

> I find it impossible to say that there is any decision made by the health authority or by the surgeons who act on their behalf, any illegality nor any procedural defect, nor any such unreasonableness. The fact that the decision is unfortunate, disturbing and in human terms distressing, simply cannot lead to a conclusion that the court should interfere in a case of this kind.

While he refused to allow the action to proceed in the Court of Appeal, Donaldson MR referred directly to

the public law concept of Wednesbury unreasonableness (Associated Provincial Picture Houses Ltd v Wednesbury Corporation). The essence of 'unreasonableness' relates to :

> ... a decision which is so outrageous in its defiance of logic or of accepted moral standards that no sensible person who had applied his mind to the question to be decided could have arrived at it. Whether a decision falls within this category is a question that judges by their training and experience would be well equipped to answer, or else there would be something wrong with our system.

It appears that the only case from the region which came close to discussing the concept of Wednesbury unreasonableness was the FSM case of Amor, the court held that once a state health services decision has been made that a particular medicine or health service should be obtained for patients, the state health services staff and other responsible state officials are under a duty to take reasonable steps to obtain the medicine. The next question then was whether the state, by virtue of having undertaken operation of a health care system, was under a duty to obtain and maintain for patients in Pohnpei, including the plaintiff, a supply of medicine. The Court held that Pohnpei, like every place else in the world, had limited resources. There can be no doubt that the state retains the right to make reasonable decisions to limit the scope of medical supplies to be maintained at the hospital.

In R v Central Birmingham Health Authority, ex parte Collier a four year old child was suffering from a hole in the heart. The consultant involved in the clinical management of the child described him as 'desperately needing surgery'. The child was then placed on the top of the waiting list. Some five months later the operation had been cancelled a number of times. It was clear that unless an intensive care bed was found the child would die. The Court of Appeal was clear in its view that:

> ... even assuming that [medical evidence] does establish that there is immediate danger to health, it seems to me that the legal principles to be applied do not differ from R v Central Birmingham Health Authority, ex parte Walker. This court is in no position to judge the allocation of resources by this particular health authority... there is no suggestion here that the hospital authority have behaved in a way that is deserving of condemnation or criticism. What is suggested is that somehow more resources should be made available to enable the hospital authorities to ensure that the treatment is immediately given.

The list of attempts to invoke the concept of Wednesbury unreasonableness to achieve treatment where the refusal results from limited resources was added to and given a wealth of publicity by the ultimately tragic case of R v Cambridge Health Authority, ex parte B . This case was an emotionally charged one as it concerned a 10 year old girl with leukemia. The child had been in the care of the Cambridge Health Authority since 1990. By 1995 the child's condition had become grave and she was expected to die within months without treatment. The Health authority refused, apparently on clinical grounds, to fund this treatment, deciding instead that the child's chances of survival were so poor that she should only receive palliative treatment (to relieve suffering rather than cure) to make the last months of her life comfortable. There was some difference of medical opinion as to the effectiveness of the treatment, so the matter went to court to question this refusal. Laws J indicated to the authority in direct terms that:

> ... merely to point to the fact of finite resources tells us nothing about the wisdom, or ...the legality of the decision to withhold funding in the particular case... Where a question is whether the life of a 10 year old child might be saved, by however slim a chance, the responsible authority must do more than to toll the bell of tight resources. They must explain the priorities that have led them to decline to fund the treatment.

It would seem that while there appears to be a statutory duty to provide a comprehensive health service

under the 1977 Act, there is considerable difficulty in enforcing that duty through public law.

This was also an issue in the FSM case of Amor, the issue was whether there ever is any duty owing by the State of Pohnpei to obtain medicine for any of its citizens. The Pohnpei Constitution contained provisions of a governmental duty to "provide health care services for the public." That language has been interpreted as merely directory, empowering the government to undertake responsibilities for the health needs of the people, but not creating a duty enforceable in the courts.

In the UK an attempt was made to enforce a duty on the Secretary of State in negligence. The litigation was based on the importing of a blood concentrate for haemophiliacs called Factor VIII, contaminated with HIV from the USA. Nine hundred and sixty two haemophiliacs had developed AIDS as a result of using this concentrate. The allegation against the Secretary of State was that there had been a failure to ensure that the country was self- sufficient in blood supplies. The failure in this duty had caused the plaintiffs to develop AIDS. The court went on to find that it would be difficult to maintain an action concerning the existence and breadth of the duties of the Secretary of State under the 1977 Act, mainly because the legislation allowed for the exercising of discretion on the Ministers part. This would also allow for discretion in the allocation of resources. In general then, as a matter of medical law, the Secretary of State is under a statutory duty of care according to ss.1 and 3 of the National Health Service Act 1977, and this duty is potentially enforceable in a court of law through judicial review or even possibly common law negligence. There has as yet been little sign of either proving successful.

What would be the effects on the medical profession and patients seeking compensation. It is inevitable that, so long as there is a restriction on resources and there must be a limit-some principle of maximum societal benefit must be applied; the individuals right to equality must, to some extent, be sacrificed to the general need. The precise determination of a maximum benefit policy is difficult to make, but the decision is societal rather than medical and involves a "cost benefit" analysis and all that that entails as to the quality of life. Essentially there are three potential measures of a free health service-comprehensiveness, quality and availability.-and the situation is that the goal of fully comprehensive, high quality medical care that is freely available to all on the basis of medical need is unattainable in the face of steadily increasing costs; the temptation is to lower one standard in favour of the other two.

e) The incidence of medical negligence in the regional courts.

In the FSM case of Amor, The court held that the standard of care for doctors at the Truk State hospital is that they were to exercise professional judgment in the attempt to diagnose the illness of the patient, and then, consistent with available facilities and supplies, act on that diagnosis. The evidence in that case indicated the absence of any diagnosis, it failed to show any attempt at treatment of the problem rather than some preliminary treatment of the symptoms. Because there was not demonstrable effort at diagnosis, and no treatment as a result of diagnosis, the standard of care expected of a doctor at the Truk State hospital was not met. The evidence proved negligence and the State was found liable to the plaintiff.

At common law, the usual practice or 'custom test'-the test whereby defendant's conduct is tested against the normal usage of his profession or calling-is one that is applied in all areas of negligence law. The courts have given expression to this test in the medical context in a number of decisions. In the important Scottish case of Hunter v Hanley, there was a clear endorsement of the custom test in Lord Clyde's dictum:

> To establish liability by a doctor where deviation from normal practice is alleged, three facts require to be established. First of all it must be proved that there is a usual and normal practice; secondly it must be proved that the defendant has not adopted the practice; and thirdly (and this is of crucial importance) it must be established that the course the doctor adopted is one that no professional man of ordinary skill would have taken if he had been acting with ordinary care.

There is a problem with this simple exposition of law. In many cases it may be possible to prove that there is a 'usual and normal practice' and this might be seen as helpful to the plaintiffs case. On the other hand, there will always be disagreement as to what is the appropriate course to follow in a number of medical areas. In some circumstances the existence of two schools of thought may result in more than one option being open to a practitioner.

The Bolam test was formulated by Justice McNair in the English case Bolam v Friern Hospital Management Committee. The test essentially was that the standard of care to be observed by a person with some special skill or competence was that of the ordinary skilled person exercising and professing to have that special skill. This standard was to be determined by reference to the practice followed or supported by a responsible body of opinion in the relevant profession or trade. Therefore, in cases of alleged professional negligence, the standard of care is determined by whether the conduct in question accords with the profession or trade and not the standard of reasonable care as demanded by the courts.

f) Regional application of the Bolam principle.

In the High Court of Fiji case Wati v The Attorney General for Fiji (Civil Action No. 0222 of 1998) Fatiaki. J applied the Bolam Test as the standard of care required of a doctor in Fiji. In his judgment he reproduced the oft-cited direction given to the jury by McNair J. in Bolam v. Friern Hospital Management Committee [1957] 2 ALL E.R. 118 where he said at p.121 :

` where you get a situation which involves the use of some special skill or competence, then the test whether there has been negligence or not is not the test of the (ordinary) man ..... the test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill at the risk of being found negligent. It is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art.

Fatiaki J. went on to hold that with the Bolam Test in mind and having carefully considered the evidence of other doctors in the case, he reluctantly came to the conclusion that the evidence failed to positively establish any negligence (beyond misadventure) on the part of the surgeon who operated on the plaintiff, and in her care and treatment thereafter, nor was the evidence of a nature and quality from which it could be reasonably inferred that there was negligence on the part of any of the staff of the hospital in Suva.

However, in another High Court of Fiji case, Abdul Hafeez Ismail v The Medical Superintendent and The Attorney General of Fiji (Civil Action No. HBC of 1998), Shameem J. also applied the Bolam Principle but declined to follow the evidence of other doctors as to the standard of care. The Judge held that there was no dispute that the medical staff at the Suva Hospital owed the deceased a duty of care and that the medical staff at the Hospital were to be judged by the standards of the ordinary, competent practitioner in the relevant field of medicine. The court could take into account the unique circumstances in which the doctors worked, such as the limited resources and facilities of the hospital. The hospital had a duty to treat the deceased for a surgical problem, a duty to ensure that she was properly and adequately monitored, that there was review of the working diagnosis, that she was given enough fluids, that she was reviewed by a surgeon, and that she received surgery for the bowel obstruction.

Having heard the evidence of three doctors and having perused the medical and nursing notes in this case, The judge was satisfied that the surgical registrars and the consultant surgeon failed to properly and promptly review the deceased's condition, and failed to recommend and conduct surgery before her condition deteriorated further.
For these reasons the judge found the defendants liable for the death of the deceased in that they failed to provide a proper standard of care to her. The judge also found that the care the deceased should have

received, was achievable despite the limited medical facilities at the Hospital. Lack of expensive equipment, and a low nurse/patient ratio did not explain a failure to adequately monitor, diagnose or read x-ray reports. They did not explain the failure to get an immediate surgical opinion. Judge Shameem held accordingly that the Medical Superintendent and Attorney General of Fiji were liable for the negligence of their employees at the Hospital.

g) The issue of lack of resources

There has been a great deal of debate about the extent of these duties in a regime where there are finite resources available to fund medical care. One should be aware that the primary duty of the hospital to provide for arrangements, in a regime of limited funding, to be in place in a particular hospital has been, and increasingly is being, questioned in the courts. The focus of this legal debate has been delay or absence of a particular form of treatment alleged to create an unsafe operational system in a hospital. The reply of the hospital authority in turn has been that the level of service is the best that the available money can buy.

The development of the direct duty of care of the hospital itself can be towards patients, visitors or even its own employees. Historically there were few duties incumbent on the hospital or hospital authority. As Teff explains:

> For hundreds of years the hospital was essentially the location where surgeons came to train and practise their skills. Well into the twentieth century, the most that was required of the hospital authority was to provide a properly equipped facility.
> (Reasonable Care(Oxford: Clarendon Press, 1994), p.25).

The existence and scope of the direct duty of care of the hospital is generally as follows. There is a duty to employ those who are suitably qualified for the desired task and are competent to perform the task, in the hospital. Allied to this there is a duty for the hospital to make arrangements to see that these staff are effectively supervised in what they do. These senior employees should also instruct in relevant areas. There is a primary duty on the hospital to provide a system of operation that is safe in terms of its employees and the patients who enter it. Finally, the hospital has a duty to provide proper facilities and equipment in the hospital.

There have been a number of cases and reports from the region which highlight the failure of hospitals to provide a system of operation that is safe in terms of its employees and the patients who use the system. In a 28 May 1997 report of the Vanuatu Ombudsman into the system of operation at Villa Central Hospital. The report and investigation revealed a "shockingly low standard of care and supervision at the hospital". The conditions which emerged involve the entire operation of hospital services in Port Villa, and one of the main findings was that there has not been any gynaecologist/obstetrician since 1993 despite the offer from the British for no cost for Vanuatu which was repeatedly ignored by the Director of Health. The report states that "Appointments to senior positions had been made for personal reasons, instead of medical competence and inexperienced persons have been placed in positions of responsibility which are entirely beyond their competence."
The Ombudsman's report also said that while the excuse of "no funds" has been offered it was clear that the lack of personal ethics and a firm grasp of priorities had resulted in the examples given where it was assessed that there was no money available to pay Vt 1.5 million vatu for a Gynaecological/Obstetrician, appointment, for example, while 2.2 million vatu was allocated for a new hospital sign "because it was flash"! At the same time 25 million were budgeted for the overseas care of families of the top leaders including Ministers and President.
Although the Vanuatu Ombudsman's report does not have judicial authority it raises issues which are very relevant to this paper. Is the Government of Vanuatu negligent and in breach of its duty by maintaining a

shockingly low standard of care and supervision at the hospital.? The conditions which emerged involved the entire operations of hospital services in Port Villa. Was the decision of the Minister of Health to allocate resources reasonable in the Bolam principle sense not regarding the excuse of "no funds"? The Ombudsman's Report concluded that "a thorough and serious overhaul of the entire provision of hospital services is a matter of the greatest urgency, and it is to be hoped that action will be taken urgently by those with the power and authority to do so".

In the Fijian case Abdul Hafeez Ismail v The Medical Superintendent and The Attorney General of Fiji (Civil Action No. HBC of 1998), Shameem J was also very critical of the failure of the Hospital to undertake its primary duty to patients and provide a safe system. The court could take into account the unique circumstances in which the doctors worked, such as the limited resources and facilities of the hospital but that the care the deceased should have received, was achievable despite the limited medical facilities at the Hospital. Lack of expensive equipment, and a low nurse/patient ratio did not explain a failure to adequately monitor, diagnose or read x-ray reports. They did not explain the failure to get an immediate surgical opinion. Judge Shameem held accordingly that the Medical Superintendent and Attorney General of Fiji were liable for the negligence of their employees at the Hospital.

Therefore the above regional cases and reports highlight the issues of lack of resources and the failure of regional governments in their duty to provide adequate hospital and health services. Are the Governments reasonable in failing in this duty because of lack of resources and funds?

CONCLUSION

For the year 2002, the Fiji Government alone, has so far paid out F $572,717.00 in damages to victims of medical negligence suits. This is an increase of almost 300% over the previous year. These payments arose out of claims of negligent practices by medical officers in Fiji. The 2002 audit report revealed that in 1998, Government paid out F$13,852.08, in 1999 F$311,267.64, in 2000 F$100,928.01 and last year $F146,669.70 to settle such claims. The Auditor-General was of the firm view that this money could have been used for other purposes had the officers taken more care in the conduct of their work. He observed: "While there is a code of conduct for medical officers working in the public service, it is evident that there is lack of stringent controls to ensure compliance with the code of conduct .As a result, innocent people are victims of sheer negligence on the part of doctors and medical support staff."

The incidence of medical negligence cases in the region is on the increase. There is no doubt that the public expect more and to some extent the health service is able meet some of this expectation. The challenge is to bring about improvements in the health services within the financial reality of most countries in the region. Improvements in the quality of health care delivery can be brought about by legislative change, attitudinal change, and a focus on improving those activities that influences the public perception of the health service.

The medico-legal issues that I have discussed reveal that most governments in the region are aware that they do exist but there is little concerted effort to implement them socially and by legislation. Health legislation are very few indeed and the ones in existence are in great need of reform. The most contentious issue is that of limited resources and this is frequently justified by lack of funding. The courts of the region have all declared that there is a duty of care owed by the health care provider to the patient.

The application of the Bolam principle in the region is also seen as a way of determining the standard of duty in negligence cases. However, there are cases such as Abdul Hafeez Ismail v The Medical Superintendent and The Attorney General of Fiji (Civil Action No. HBC of 1998), where the courts seem to be moving away from the determination of standard and placing it with the courts where it truly belongs. There are not many cases from the region which specifically discuss the issue of limited resources and in the few that do, Vanuatu, Qualao, and Fiji, Ismail, the courts have still found the respective governments negligent despite the fact that limited resources is a major problem in the region. The Bolam test is still applied in the region as the standard of care that is required of a doctor.

Also there haven't been many cases which have alleged a breach of duty by the government for the allocation of limited health resources or the failure to provide these resources. The public law concept of Wednesbury unreasonableness has of yet still to be argued in the Courts of the region in terms of the unreasonable allocation of limited health resources. Wednesbury unreasonableness would be very relevant to the region because of the great incidence of corruption and incompetence in the Health services and Public services. The cases and reports discussed in this paper have discussed the extent of corruption and incompetence in the region.

The final issue is whether the courts of the region should follow the precedent of their overseas counterparts and hold as in R v Cambridge Health Authority, ex parte B [1995] 1 WLR 898. where Laws J indicated in direct terms that the responsible authority must do more than to claim that they have the discretion of allocating their scarce health resources. They must explain the priorities that have led them to decline to fund the treatment and this allocation must not be unreasonable in the Wednesbury sense.
What is unreasonable in the allocation of limited health resources has yet to be judicially decided in the region especially regard to a breach of duty in negligence.

Therefore that while there appears to be statutory and common law duty's for governments in the region to provide adequate health care to their citizens, there is considerable difficulty in enforcing that duty through breach in negligence and public law.