A v COLONIAL WAR MEMORIAL HOSPITAL and 2 Ors (HBC0184 of 2005)

HIGH COURT — CIVIL JURISDICTION

COVENTRY J

20 November 2006, 14 March, 27 April, 8 May 2007

Negligence — application for special damages — negligence for loss of specimen — loss of confidence — unnecessary period of pain and upset, apprehension and anxiety — whether delay would alter outcome of tests — whether other consequences of delay resulted from negligence.

The Plaintiff was found to have a lump in her breast which was considered malignant. She was referred to the Defendant hospital where she underwent four tests over 2 months without any findings of malignancy. She later went back to the doctor because of severe breast pain. The findings were consistent with wound infection most likely due to the stitches. The Plaintiff sought medical treatment in New Zealand instead of going back to the Defendant because she had lost confidence in the Defendant. She was subsequently diagnosed with cancer and underwent four cycles of chemotherapy to reduce the size of the lump before undergoing surgery. She filed the proceedings against the Defendants for negligence. The Defendants denied negligence, although they accepted that some tests were inconclusive and, on one occasion, samples either did not reach the pathology laboratory or the results were lost.

Held — (1) Loss of the specimen was negligent. This loss resulted in the Plaintiff having to undergo further procedures and delay in knowing the result of the biopsy. Although there was no evidence to suggest that this delay would have altered the ultimate outcome, there was that further period of anxiety and apprehension as a result of the loss of the specimen.

(2) On the second biopsy procedure, it would seem that the affected area was missed when the tissue was removed. However, the "benign" result from the second biopsy was not negligent.

(3) Other claims for damages were not granted due to the fact that when the Plaintiff first sought medical attention, the size of the lump was such that a mastectomy was the only reasonable course of treatment, so all other consequences that would follow in any event did not arise from any negligence of the Defendant hospital.

Accordingly, the Applicant was entitled to total damages of $4750.

Application granted.

Cases referred to

Bolitho v City and Hackney Health Authority [1998] AC 232; [1997] 4 All ER 771; [1997] 3 WLR 1151; *Bowlam v Friern Hospital Management Committee* (1957) 1 BMLR 1; [1957] 2 All ER 118; [1957] 1 WLR 582, cited.

Airedale NHS Trust v Bland [1993] AC 789; [1993] 1 All ER 821; [1993] 2 WLR 316, considered.

D. Prasad for the Plaintiff

A. Uluiviti and *L. R. Ligabalavu* for the Defendants

[1] Coventry J. On 9 April 2004, the Plaintiff, A, experienced sharp pain in her right breast. She felt the breast and discovered a lump.

[2] On 13 April, she saw Dr Wata. He examined the breast and found a lump 8 cm in diameter. He considered it "highly suggestive of malignancy" and referred A to the Colonial War Memorial Hospital (the hospital). Over the next 2 months four tests were undertaken without yielding any definitive results of malignancy.

[3] On 21 June, A returned to Dr Wata complaining of severe breast pain. On examination of the breast he noted "an infected wound with stitches still open … The wound was discharging pus, breast was slightly larger than initial size of two months earlier". He considered his findings were consistent with wound infection most likely due to the stitches. A told him that she was frightened to go back to the Hospital after what had happened and that she had lost confidence in them.

[4] On 5 July, as a result of the actions of Dr Wata and others A flew to New Zealand for diagnosis and medical treatment. A report, dated 8 July 2004, of the core biopsy on her right breast showed "a poorly differentiated infiltrating duct carcinoma".

[5] Vernon Harvey, a clinical Associate Professor of Oncology, in his report dated 26 July, stated "she came to New Zealand where she was found to have a large, clinically obvious right breast cancer with core biopsy reporting poorly differentiated infiltrating duct carcinoma. The cancer is considered inoperable and she is therefore referred for primary medical treatment". On examination he had found "there is a huge 12 cm diameter mass in the upper part of the right breast …".

[6] A then underwent four cycles of chemotherapy to reduce the size of the lump preparatory to surgery. By early October it was approximately 9–10 cm in size and on 8 October a mastectomy (removal of the breast) was performed. There was follow up radiotherapy and convalescence before she returned to Fiji.

[7] On 21 April 2005, she filed proceedings against the Colonial War Memorial Hospital, the Ministry of Health and the Attorney-General alleging negligence. She alleged she had suffered permanent incapacity as a result of the loss of her right breast leading to constant pain in that area and her back and detrimental effects to her sexual life and generally. She has to attend for regular scans and treatment in New Zealand. She also claims for the extra time and testing needed for a definitive diagnosis and the pain and suffering involved in that. A schedule of special damages was lodged.

[8] In closing written submissions at p 11 counsel for the Plaintiff then put her claim thus:

> The plaintiff is not claiming that due to doctors' negligence in not making proper diagnosis she lost her breast. What she is claiming is the pain and suffering that she underwent for four months when the doctors could not make proper diagnosis and few months that she underwent treatment in New Zealand.

This followed upon the evidence of Dr Iferemi Waqanabete, a consultant surgeon at the hospital. One of his specialist fields of interest is breast cancer. His view was clear. By the time a breast lump had reached 7 by 8 cm the breast could not be saved. He cited the Australian guidelines which say that if the lump is more than 4 cm then the breast can not be saved. There was no evidence to the contrary. In these circumstances, counsel for the Plaintiff had no option but to limit the claim to any negligence in the slowness and errors in the testing for and diagnosing of cancer by the hospital and any harm that flowed from that.

[9] The hospital and ministry denied negligence. It was accepted that some tests were inconclusive and on one occasion samples either did not reach the pathology laboratory or the results were lost. However, they allege the Plaintiff did not turn up for review on one particular date, nor attend for an operation on a later date. They responded that doctors, laboratory staff and other staff had all acted competently and reasonably and that the Plaintiff was kept informed throughout that the suspicion of malignancy remained. The procedures carried out to make the diagnosis were correct. They allege that if there was any negligence then it did not give rise to any pain or suffering above and beyond that which necessarily flowed from her condition when she first sought medical attention.

[10] I have before me a bundle of amended copy pleadings, an agreed bundle of documents, Plaintiff's bundle of documents vols 1–3, a list of exhibits, a schedule of special damages, the opening speech of the Plaintiff and the closing submissions of both parties.

[11] The reality of this case is that there is very little disagreement upon the facts.

[12] I set out below a chronology of the pertinent events:

9.4.04	—	A suffered pain in her right breast and felt a lump there.
13.4.04	—	Dr Wata examined the breast, found the lump to be 8 cm in diameter, suspected malignancy and referred A to the hospital.
16.4.04	—	The first fine needle aspiration was performed, (FNA1). The result was described as inconclusive. By a report dated 4 May Dr Eka Buadromo, the consultant pathologist, was "highly suspicious of malignancy" but stated there was a paucity of cellular material to work on.
23.4.04	—	The second fine needle aspiration (FNA2) was performed. The results of that test were inconclusive but expressed the suspicion of cancer.
19.5.04	—	A tissue biopsy under local anaesthetic was carried out. Tissue samples were taken but they or the results were lost.
28.5.04	—	A was told that the laboratory had not received the biopsy specimen.
3.6.04	—	A was told there was no report on the biopsy specimen.
7.6.04	—	Another tissue biopsy was carried out. Dr Buadromo examined the results and found them to be "benign". Nevertheless, there were still real concerns that there was a malignancy.
16.6.04	—	A returned to work, but was in pain.
21.6.04	—	A, in great pain, saw Dr Wata again. He found the breast wound was infected and treated it. He sought urgent action to address A's condition.
6.7.04	—	A travelled to New Zealand.

8.7.04	—	New Zealand biopsy showed carcinoma, cancer. Chemotherapy was arranged, A's condition was kept under review and preparations were made for a mastectomy.
8.10.04	—	A mastectomy was performed on A's right breast. This was followed by radiotherapy, convalescence and A return to Fiji.

[13] Fine needle aspiration is the procedure whereby a needle is put into the breast, cells are removed via the needle from the lump and the cells are then sent for pathological examination. A tissue biopsy is performed under local anesthetic, an incision is made into the breast and a wedge of tissue is removed from the lump, again for the purposes of pathological examination.

[14] The Plaintiff, A, gave evidence. Dr Batrap, Dr Wata, Dr Buadromo and Mr Waqanabete also gave evidence. The order of giving evidence was not in the usual sequence due to the commitments of the doctors. This has no bearing on the issues. Dr Batrap, Dr Wata and Dr Buadromo have had direct involvement with this case. Mr Waqanabete, the surgeon, has had no direct involvement.

[15] I accept the evidence of the Plaintiff. I found her to be honest and reliable, I did not find she was exaggerating her evidence in the hope of proving her case or gaining a larger award. Indeed, given the events of 2004, she gave her evidence in a restrained and objective fashion.

[16] I accept the three doctors and the surgeon are experts in their respective fields and each was doing his or her professional best to relate what had happened and provide objective opinions.

[17] I will briefly deal with the evidence in the order in which it was given. Dr Batrap gave evidence first. He had been in Fiji for 3 years working as a general surgeon. He stated how A was seen by other doctors upon referral in April 2004. He described how FNA1 was "highly suspicious of malignancy". He states he did the tissue biopsy on 19 May and a second on 7 June. The latter was a wedge biopsy and the result was "benign breast disease". That means it has ruled out the possibility of cancer. Given the clinical observations, particularly the size of the lump, he was suspicious that it was still malignant and discussed the pathology finding of "benign" with Dr Buadromo. His clinical suspicion was "strongly in favour of malignancy" and he fixed 6 July for "total excision of the tumor, plus frozen section biopsy". However, A did not attend on that day. She had already gone to New Zealand. Dr Batrap did keep A informed of the results of the tests and his continuing concern that the lump was malignant.

[18] Dr Batrap followed up the lack of a report upon the first biopsy, taken 19 May. He stated "I went personally to sort the matter out with the sister-in-charge … The sister took a firm stand that the specimen had been dispatched to the pathology laboratory. There was no definite answer of what happened". He informed the head of department and, apparently this was looked into.

[19] He was asked would the lost specimen make a difference to treatment, Dr Batrap replied "a delay of one month would not have changed the ground plan of management and the final outcome of the disease". He accepted he was not a specialist on oncology. He stated "ductile carcinoma" is one type of breast cancer. He stated there was no quantifying method by which one could see the effects of the delay of a few weeks especially because the tumor was already sufficiently advanced in itself. He continued "had the first biopsy shown malignancy then the

main stay of treatment would still have been removal of breast with adjuvant chemotherapy". He stated there was no significant delay between the two biopsies. When asked about the result of the second biopsy he replied "when referred, the cancer was in an advanced stage. I cannot explain how the pathology department said it was benign. The biopsy I took was from the diseased area, because I obtained a gritty sensation when taking the wedge. It is particular of cancer, this sensation".

[20] Dr Wata was working as a general practitioner. He gained his degrees in 1988 and had worked at CWM Hospital. In 1993 he gained a qualification in general surgery and moved into general practice a year later. He was and is the family doctor for A and her family.

[21] When Dr Wata first examined the lump in A's breast his opinion was that it was "highly suggestive of malignancy, breast cancer". He referred her for immediate treatment and followed up in ways to assist her. He says that on 21 June she came back to him with severe breast pain. He noted an infected wound with stitches still open. A told him she had had two aspirations which had not been conclusive and that the wound on her breast was from a second biopsy. A told him the first biopsy results had been lost and that she had a second open tissue biopsy about 2 weeks after the first. He could see that the wound was discharging pus, the breast was slightly larger than the initial size of 2 months earlier. He said his findings were "consistent with wound infection most likely due to stitches. I put her on oral antibiotics. I discussed her hospital management. She said she was frightened to go back due to what had happened. She had lost confidence".

[22] He gave her advice and she returned on 23 June with the results from the second pathology report. That showed diagnosis of benign breast tissue. He continued "after receiving this, I thought something gone wrong. I could not agree with diagnosis. Because lump was clinically obvious and malignant. Highly likely cancer. It was 7 by 8 cms in diameter and roughly spherical".

[23] Dr Wata concluded by saying that A still comes to him concerning ongoing pain from the area where the breast was removed.

[24] Dr Aka Buadromo gave evidence. She is the consultant pathologist at the hospital. She gave her qualifications and stated that she is the only pathologist at the hospital and when she is away on other commitments or on leave there is no pathologist at the hospital.

[25] She stated that the technicians do all the technical work, fixing, staining etc and will have a provisional look at the results. She will then look at the specimens and make her decisions. She stated that it normally takes 4–5 days from receipt of specimen to the giving of an opinion. This is, of course, subject to her presence at the hospital.

[26] Dr Buadromo confirmed her finding from the FNA1 that it was highly suspicious of malignancy but there was a paucity of cellular material. FNA2 had been suspicious of cancer. She maintained that her opinion was correct over the second biopsy and she did indeed discuss this directly with Dr Batrap. They both looked at the slides together. Her view was that when the biopsy tissue was removed the suspect tissue had simply been missed.

[27] Dr Buadromo described the system for recording receipt of specimens and their progress to the report stage. She stated as far as the pathology laboratory was concerned the first biopsy specimen did not arrive there. She stated it is for

the clinician to get the specimen to the laboratory. She stated in normal circumstances if the specimen came straight to her then she could make an assessment and report within 3 days.

[28] In cross-examination she stated that she would not be happy for anyone to go to mastectomy on a pathology that said the tissue was "highly suspicious". She said that is not conclusive. She stated she has spent 13 years in pathology and seen hundreds of breast cancer specimens. She stated tissue biopsy is more conclusive then fine needle aspiration. She said it is not unusual to miss a tumour and have to "go in again and get another specimen".

[29] Iferemi Waqanabete is the consultant surgeon at the hospital. He stated that breast cancer is one of his particular fields of interest. He stated that in a month he will probably consider about 40 cases of breast disease of which 10 will be breast cancer.

[30] Mr Waqanabete stated that malignant tumours generally grow rapidly. He said he had seen cancers expand to 7 cm within 6 months. He stated that the basic rule is that any lump in a breast is regarded as cancerous until the opposite is proved. He continued that under the guidelines from Australia/New Zealand and the United States/United Kingdom a breast should not be removed without histological examination. He stated that FNA only takes cells whereas biopsy takes tissue and the latter is far better for diagnostic purposes. He stated that it can in Fiji take up to 3 weeks for the results of a biopsy. This is because of the shortage of pathologists. He stated that technicians process specimens and we follow them up if no results come back. He said it is possible a sample will get lost in transit.

[31] Mr Waqanabete stated that once a cancer is proven it is important we give all treatment modality as soon as possible. He continued that early stage breast cancer diagnosis is rare in Fiji as there is no mammograph screening. "We don't screen every woman over 50". He said this is the case in New Zealand.

[32] Mr Waqanabete stated that a 7 by 8-cm lump is significant. It doesn't appear overnight. He said that delay does not affect treatment, but it may affect prognosis. He was then asked if A had come earlier would it have been possible to save her breast. He replied "no, not a 7 by 8 cm lump. The guidelines are — less than 4 cms lump then can save breast. These are the Australian guidelines".

[33] Mr Waqanabete said if it was a lump size 8 by 7 cm, even if it was benign, I would still take it out. This is a significant lump. He continued that if a tumour was aggressive it could grow to a size of 7 cm within a period of 3–6 months.

[34] On the undisputed evidence before me it is clear, very sadly, that when A first went to see Dr Wata the lump was of such a size that mastectomy, removal of the breast, was the only viable cause of treatment. That inevitably would involve chemotherapy, radiotherapy and the pain, discomfort, sexual shyness and the other consequences of a mastectomy. It was in the light of this evidence that counsel for the Plaintiff correctly modified the claim from one in respect of removal of the breast to the very limited scope of the pain, discomfort and upset as a result of the delay, loss of results and unnecessary testing at the Hospital. It is unfortunate that the evidence concerning the 4-cm limit was not discovered or disclosed before this case came to trial. This is not some obscure medical opinion but evident on the face of the medical guidelines for breast cancer. The result is that this claim has been drastically reduced in its scope. It dramatically reduces the damages A can hope for or expect.

[35] In the House of Lords case of *Airedale NHS Trust v Bland* [1993] AC 789 at 818; [1993] 1 All ER 821 at 844; [1993] 2 WLR 316 the court stated:

> A doctor owes a duty of care towards his patient and in the case of a patient unable to give instructions or consent to treatment, a duty to treat him in the patient's best interest; The general duty of a doctor is to act in accordance with a responsible and competent body of relevant professional opinion based upon the principles laid down in *Bowlam v Friern Hospital Management Committee* (1957) 1 BMLR 1; [1957] 2 All ER 118; [1957] 1 WLR 582; (The Bowlam test).

[36] "The Bowlam test" states:

> 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; it is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art.
>
> A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art … Putting it the other way round, a doctor is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view.

[37] In *Bolitho v City and Hackney Health Authority* [1998] AC 232; [1997] 4 All ER 771; [1997] 3 WLR 1151 it was stated that:

> it is enough for a defendant to call a number of doctors to say what he had or did was in accordance with accepted clinical practice. It is necessary for the judge to consider that evidence and decide whether that clinical practice puts the patient at unnecessary risk.

[38] In *Hatcher v Black* (The Times, 2 July 1954) Denning LJ stated:

> You must not, therefore find him (the doctor) negligent simply because something happens to go wrong; … You should only find him guilty of negligence when he falls short of the standard of a reasonably skilled medical man …

[39] Dr Wata referred A to the hospital on 13 April and FNA1 took place on 18 April. There can be no complaint, on the evidence before me, of this test undertaken by the hospital nor the speed with which it was done. The result was that the specimen was highly suspicious of malignancy but there was a paucity of cellular material.

[40] Given the size of the lump and the finding of FNA1 the question must be asked whether a tissue biopsy should not have been carried out as the next step. However, it appears that Dr Buadromo's opinion was not available until 4 May. Mr Waqanabete states that tissue biopsy is far more useful in making a diagnosis as you get "tissue" and not just "cells".

[41] The result of FNA2 was inconclusive, but again suspicious of cancer. FNA2 was taken on the 23 April. The first biopsy was carried out on 19 May. The result of FNA2 was not available on 14 May. Thus there was a delay of nearly 4 weeks between FNA2 and the first tissue biopsy. There is no evidence that a delay of nearly 4 weeks did or could have made any difference to the eventual outcome nor the intervening testing and treatment of A. I do of course accept that it added an extra 4 weeks of anxiety and apprehension.

[42] Whether or not the result of FNA2 was available by 19 May, in my judgment on the evidence before me a tissue biopsy would inevitably have been carried out. The evidence is that, while every lump in a breast is treated as cancerous until it is shown not to be, no surgeon would perform the "mutilating"

operation of mastectomy without a clear diagnosis of cancer. I therefore cannot find that this procedure was other than what would and should have taken place.

[43] It is not disputed that the resulting tissue sample was lost. On the face of the evidence I cannot with any certainty say where and when that happened. The short answer is that it should not have happened. The hospital is responsible for it and in my judgment the loss of such a specimen was negligent. This was not a matter of medical negligence; it was administrative or basic practical error. I accept there are laid down procedures for handling of and records for tracking specimens. I also accept that from time to time systems do not work. However, the plain fact is the specimen was lost and that should not have occurred.

[44] The effect of the loss of the specimen was that A was required to undergo another local anaesthetic to her right breast and the removal of further tissue. That took place some 3 weeks after the first biopsy and approximately 1–2 weeks after the result of the first biopsy should have been known. Again, there is no evidence to suggest this delay would have altered the ultimate outcome, however there was that further period of anxiety and apprehension as a result of the loss of that specimen.

[45] The second biopsy was carried out on 7 June. Dr Buadromo found the tissue was "benign". Dr Batrap was clear that he had not missed the affected area as when taking the specimen he felt a "gritty sensation". On balance it would seem that the affected area was missed when the tissue was being removed. Dr Buadromo regarded this as a possible occurrence in the normal course of events, "The answer is to carry out another tissue biopsy". Dr Buadromo revisited the slides with Dr Batrap and maintained her conclusion. However, for A that would have been the third tissue biopsy and fifth test. By that time she had lost confidence in the hospital. No criticism is made of her for this nor the fact that she did not attend for the third biopsy. It should be noted in passing that counsel for the Defendant raised the question of contributory negligence by not attending appointments. No allegation of contributory negligence was made in the pleadings, I therefore disregard this. In any event, A gave firm positive evidence that in fact she did not miss an earlier appointment and that by the time of the proposed third biopsy she was on her way to New Zealand.

[46] In these circumstances, I cannot find there was negligence in the conduct of nor result of the second biopsy. Dr Waqanabete also stated that in "the normal course of events" some tests may have to be repeated. In normal circumstances, it is probable that A would have gone back for what would have been a second biopsy and it is likely that would have provided acceptable findings. It was the loss of the specimen from the first biopsy that meant such a reattendance would have been the third time for A. It should also be noted that A was being advised that the clear clinical concern was that the lump was malignant.

[47] Dr Wata stated that when A visited him on 21 June the breast was slightly enlarged, the stitching from the second biopsy was infected and there was a discharge of pus. Did this state of affairs and its consequential pain come about as a result of the negligence of the Defendants, their servants and agents? Apart from the description of this state of affairs no evidence was led to this issue. I do not know whether in the ordinary course of events without negligence this can occur or whether it only occurs if there has been some negligence by the Defendants. It is for the Plaintiff to prove her case on the evidence. It has not been shown that this state of affairs came about as a result of any negligence by the Defendants.

[48] It is difficult in this kind of case to be precise when considering the consequences that can reasonably be foreseen to have flowed from acts of negligence. In broad terms A went to the hospital on 16 April and 2 months later on 21 June saw Dr Wata still without a conclusive finding and stating she had lost confidence. At least one fine needle aspiration test would have taken place in any event and also at least one tissue biopsy. In my judgment, in the usual case it is a matter of opinion whether a second FNA should have taken place or whether after FNA1 the move should have been straight to tissue biopsy. It is to be remembered that the former is non-invasive and obviously causes less pain and upset to the patient. I have found that the loss of the specimen from the first tissue biopsy was negligence by the hospital. I find this did prolong matters by some 3 weeks, was one of the causes of A's loss of confidence and gave rise to an unnecessary period of pain and upset, apprehension and anxiety. It is important to remember also that in the period from first presentation to examination in New Zealand the lump had grown from 8–12 cm in diameter.

[49] I also look at the overall time scale from first arrival at the hospital till her departure for New Zealand. On the evidence from Mr Waqanabete a period of 3–4 weeks would be normal in this kind of case. However, given the size of the lump on presentation and the clinical opinions from Dr Wata and Dr Batrap that this was "strongly in favour of malignancy" I consider whether, from the outset, the testing and diagnosis should have been expedited. If A had in fact gone along for the third biopsy the result would not have been known until about 10 July, some 3 months after first referral.

[50] I consider basically the correct approach in this case is to assess how long and with how many tests it should have taken without negligence to make a diagnosis and compare that with what did in fact take place.

[51] The clear evidence was that an 8-cm lump in a breast is highly indicative of cancer. This was not a lump of say 2–4 cm which might well have proved benign. For A the treatment in effect was determined before she first saw Dr Wata.

[52] Testing was needed. A mastectomy was not going to be carried out without testing. In my judgment a period of 4–6 weeks would have been reasonable. One FNA and one tissue biopsy minimum would almost certainly have been needed. It might be a diagnosis could have been made on a first FNA. The loss of the specimen from the first biopsy was negligent. I do not find the "benign" result from the second was negligent, but it did necessitate the carrying out of another. In A's case the negligence in the conduct of the first test meant she had three biopsies when two would probably have sufficed. She underwent an extended period of waiting.

[53] Accordingly I find the procedures and testing should have been concluded by 28 May, that is a period of 6 weeks from first arrival. From then until 8 July, when a conclusive diagnosis was made in New Zealand is nearly 6 weeks. Further testing in New Zealand was needed for that diagnosis. There were then four cycles of chemotherapy to reduce the size of the lump for surgery. It did in fact reduce from 12 to approximately 10 centimetres. The lump had obviously been growing in the interim, and it is a reasonable inference that the more delay, the bigger it grew. Of the 3 months in New Zealand, during which inevitably there would have been chemotherapy, I find 4 weeks can reasonably said to have resulted directly from the delays at the hospital during which the lump was growing.

[54] That means that as a result of the negligence of the hospital A suffered a total of 10 weeks unnecessary pain, suffering and apprehension and she had to undergo one extra test.

[55] Neither counsel has cited to me any authorities setting out the level of damages which have been awarded in cases of this kind nor addressed any argument thereto. I do not think it would benefit anyone were this case to be delayed for such argument. Given the circumstances, particularly the fact that for 6 of the 10 weeks A was facing the prospect of cancer without the knowledge of whether or not she would lose her breast and whether or not, if there was a cancer, it had spread beyond her breast, I award $400 for each of those 6 weeks of delay. I award the same sum per week for the extra 4 weeks in New Zealand. This makes a total of $4000. I award a sum of $500 specifically in respect of the first tissue biopsy and for the pain and suffering therefrom when no result was forthcoming.

[56] I look at the schedule of special damages. In the light of my findings A is entitled to the $5 for the medical report. I find $50 is a reasonable return taxi travel expense from Pacific Harbour to Suva and back even though there are no receipts. A would in any event have had to make several trips to the hospital given her condition and the testing and treatment required. She has claimed for nine trips. I find that four were unnecessary and award $200 under that head. There is a claim of $1000 for "medicines (Fiji)". This figure is not broken up in any way and there is no support or documentary proof for it. I have no evidence as to what extra medicines, if any flowed from the negligence. In these circumstances I cannot make an award. Similarly, there is no proof that the sums she borrowed from the Fiji National Provident Fund and FEA Credit Union for her travel to New Zealand and medical expenses there flowed from this negligence. Indeed, the likelihood is that she would have paid these in any event; they appear to be the "excess" payable under the insurance policy.

[57] In the pleadings there were various other claims such as medical and domestic care for the rest of her life, the grave effect upon her social, domestic and leisure pursuits, cost of domestic/nursing care, costs of treatment for cancer, loss of earning capacity (abandoned) and loss of future earnings (abandoned). The fact that when A first sought medical attention the size of the lump was such that a mastectomy was the only reasonable course of treatment, then all these consequences would follow in any event and did not arise from any negligence of the hospital.

[58] Accordingly I give judgment for the Plaintiff as follows:

General Damages	—	$4500
Special Damages ($5 + $200)	—	$250
TOTAL	—	$4750

[59] I will hear the parties on costs and interest.

[60] No one can help but have sympathy for A and for the periods of anxiety and apprehension which she endured and the pain and suffering that inevitably flowed from the presence of that 8-cm lump in her breast. This case starkly highlights the importance of breast screening programmes especially for women over the age of fifty. Further, where there are not the facilities for such a formal screening programme this case also illustrates the importance of educating

women and men about breast cancer and the measures that can be taken, even without formal medical examination, to detect lumps at an early stage.

Application granted.