Shoudering the burden of disclosure: Wighton v Arnot

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Unlike many medical negligence cases, the Supreme Court decision in Wighton v Arnot [2005] NSWSC 637; BC200504663, handed down on 1 July 2005, was not concerned with the injury itself, but with the post-operative failure to investigate, diagnose, disclose or treat, in a timely manner, the plaintiff’s injury. The decision restated established principles of the duty to disclose and the duty to follow up patients who may have suffered iatrogenic injuries during surgical procedures.

This was a complex case with conflicting evidence regarding the cause of the plaintiff’s injuries, raising some interesting legal and ethical issues which this article will review. The article will also briefly raise the issue of whether doctor–patient confidentiality is breached if the treating medical practitioner provides a defendant with a report that discusses liability or causation.

The case was complicated due to the fact that an earlier independent electromyogram (EMG) report interpreted by a leading neurologist, which the parties accepted as being correct, was ultimately found to be incorrect. In addition, the plaintiff became pregnant with her first child, which may have prevented her from having her injury repaired in a timely manner.

An auxiliary issue in this case related to the doctor–patient fiduciary duty of confidentiality. The issue arose when the defendant obtained a medico-legal report discussing issues of liability and causation from the patient’s treating neurosurgeon. The defendant failed to disclose that report and used the report during the hearing to suggest that the plaintiff’s treating neurosurgeon was a ‘hired gun’.

Facts

On 9 November 1999, the plaintiff, aged 26, was admitted by the defendant to Inverell District Hospital (the hospital) for removal of a right sided neck abscess. The surgical procedure was described as a ‘radical neck
dissection' and a brachial cyst was removed. Immediately following the surgery, the plaintiff allegedly complained of severe right shoulder pain and an inability to lift her arm above the shoulder line.

The plaintiff continued to complain of right sided shoulder pain throughout her hospitalisation, but stated that the defendant paid no attention to her complaints or to her symptoms. The defendant stated that he reviewed the plaintiff on at least two occasions and that she made no complaints of shoulder pain or any inability to raise her arm above the shoulder line.

The plaintiff and the defendant agreed that, during the post-operative period, the defendant examined the plaintiff's cranial facial nerves. However, they disagreed as to whether the defendant examined the plaintiff's accessory nerve. The plaintiff was discharged from hospital on 12 November 1999. She was instructed by the defendant to make an appointment for review in approximately two to three weeks’ time.

On 18 November 1999, the plaintiff consulted her general practitioner, who was not in receipt of the post-operative discharge summary, complaining of right shoulder dysfunction and pain. She stated that the pain had remained unabated from the date of surgery. The plaintiff was diagnosed by the general practitioner as having a 'frozen shoulder' and was advised to continue with physiotherapy.

The plaintiff alleges that on 25 November 1999, she attended the defendant's rooms for her post-operative consultation, accompanied by her grandmother. She stated that she informed the defendant about her ongoing severe right shoulder pain and her inability to raise her arm above the shoulder line. The plaintiff stated that the defendant was only interested in ensuring that her cranial nerves were intact. The defendant stated that the plaintiff failed to attend the post-operative consultation and pointed to the lack of documentation of the appointment being made or any examination being performed.

In early to mid-December 1999, the plaintiff became pregnant with her first child. She gave birth to him in September 2000. From 9 November 1999 onwards, the plaintiff complained of right shoulder dysfunction and pain. She had consulted several medical experts who failed to diagnose the cause of her condition. In mid-May 2001, the plaintiff contacted the defendant and described her right shoulder dysfunction and pain. An appointment was made and the plaintiff attended the defendant's Lismore rooms on 31 May 2001.

The defendant noted the plaintiff's severe right trapezius muscle atrophy, her pain and her inability to raise her arm above the shoulder line. He made the diagnosis of 'iatrogenic injury to the right accessory nerve'. The plaintiff was referred to an orthopaedic surgeon, who advised that the accessory nerve had been sectioned and could not be repaired due to the amount of time that had lapsed.

In July 2001, the plaintiff was reviewed by a peripheral neurosurgeon, who ordered an EMG. The EMG stated that there was partial denervation and reinnervation to the right spinal accessory nerve. He confirmed that the opportunity for surgical repair had passed and that, based on the EMG, it appeared that the spinal accessory nerve had been 'nicked' during the surgical procedure.

The causation defence

The defendant argued that the plaintiff's injuries and disabilities were not causally related to the defendant's alleged negligence. In particular, the defence argued the following.

- The accessory nerve is a motor nerve without sensory components. The plaintiff's shoulder dysfunction and pain is unrelated to accessory nerve damage.
- There was no opportunity to repair the accessory nerve before November 2000 because of the plaintiff's pregnancy.
- Success rates of accessory nerve repairs are less than 50 per cent and the likelihood of restoring limb and shoulder function to a grade 3 plus level was less than 50 per cent.
- The 2001 EMG report stated that the accessory nerve was not sectioned during the 9 November 1999 surgery and therefore the plaintiff’s complaints were not related to the accessory nerve.

Regarding the first argument, the defendant maintained that the plaintiff's shoulder pain was caused by severing the sensory nerves of the cervical plexus. The defence argued that the accessory nerve is a motor nerve, without sensory components, which innervated the trapezius and sternocleidomastoid muscles. They stated that the usual symptom experienced with a severed accessory nerve was a dull ache in the shoulder.2

To access and dissect the brachial cyst from the anterior triangle of the plaintiff's neck, the defendant had to cut through these sensory nerves. This was an unavoidable aspect of the procedure to remove the brachial cyst and was the cause of the plaintiff's severe 'neuralgic pain'.3 The plaintiff's experts noted that there was no evidence of localised areas of paraesthesia, which one would expect to find with severance of sensory nerve branches of the cervical plexus. They noted that there were no medical examinations that recorded areas of paraesthesia.

In addition, the plaintiff's experts argued that the plaintiff had bilateral cervical ribs.4 They stated that the brachial plexus or branches thereof looped over the cervical rib before supplying the trapezius, deltoid and sternum muscles; but for the atrophy of the trapezius muscle, the effects of the plaintiff's cervical rib would have had no effect. However, with an atrophied trapezius muscle the shoulder sags. This caused the branchial plexus to stretch over the cervical rib, causing thoracic outlet syndrome.

The Court rejected the defendant's argument and held that the cause of the plaintiff's shoulder, sternum and arm pain was caused by thoracic outlet syndrome by the stretching of the brachial plexus over the cervical rib.

The defendant then argued that the plaintiff's pregnancy prevented surgical repair, by way of cable graft of the accessory nerve, until after the plaintiff gave birth. They argued that for the restoration of shoulder function and re-bulking of the trapezius muscle, the accessory nerve should be repaired as soon as possible5 to restore function. The defendant argued that, as surgical intervention was not possible until after the birth of the plaintiff's child (that is,
November 2000, the chance of the plaintiff having a functional shoulder after a 12 month delay was less than 50 per cent.

The plaintiff led obstetric evidence stating that elective surgical intervention could have been performed with minimal risk to the developing foetus and minimal risk of causing the onset of premature labour during the second trimester. The plaintiff's and the defendant's medical experts agreed that they would defer to the opinion of an obstetrician to guide them regarding when it would have been safe to perform the surgical repair of the accessory nerve. The Court held that surgical intervention could safely have been performed during the second trimester (that is, between March and May 2000).

The defence challenged the predicted outcome of restored limb function following a repair to the accessory nerve. They questioned the statistical evidence relied upon in the report of the plaintiff's expert neurosurgeon, which suggested that of 66 cases of surgical repair of iatrogenic severed peripheral nerves, 60 per cent of all limbs were restored to a grade 3 plus function.6 The defendant argued that the statistical evidence relied on by the plaintiff's neurosurgeon was misleading in that it was not specific to the accessory nerve but related to all peripheral nerves. The defence asserted that the success rate of nerve recovery for accessory nerves was less that 60 per cent and, in the alternative, they argued that the 60 per cent of the 66 cases recorded had some improvement in limb function less than grade 3.

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The plaintiff's neurosurgeon was able to shrug her shoulders, which the defendant stated that he did so to determine whether the accessory nerve had been damaged during the surgical procedure. He stated that the plaintiff was able to shrug her shoulders, which confirmed, in his mind, that the accessory nerve was intact.

The plaintiff asserted that the defendant did not perform the shrug test during the post-operative period. She stated that the defendant investigated her cranial facial nerves on two occasions but failed to perform any other investigations.

The plaintiff led evidence stating that there were two basic bedside tests to investigate the integrity of the accessory nerve. These are:
- the 'shrug test' (shrugging the shoulders against resistance); and
- the 'arm raising test' (raising the arms above the head).

The evidence noted that a positive shrug test can be misleading because there are other muscles in the shoulder region which are innervated by other nerves that may assist in minimal shoulder elevation. The shoulder shrug response would be significantly reduced if the accessory nerve were sectioned.7 The arm raising test was universally accepted as the definitive test to determine accessory nerve integrity. Arm elevation is not possible if there is a denervated accessory nerve.

It was accepted that a shoulder shrug test should be performed within two to three days post-surgery. The delay in performing the shrug test would have allowed the plaintiff's surgical pain to diminish and also would have given the examiner an opportunity to thoroughly test the integrity of the accessory nerve.

The plaintiff stated that she complained of severe pain in her shoulder region upon her return to the ward. She stated that she informed the defendant on several occasions about her shoulder pain, but the defendant allegedly paid no attention to those complaints.

From 9 November 1999 to May 2001, the plaintiff sought medical treatment for her shoulder pain and was diagnosed with a frozen shoulder. In
May 2001, the plaintiff contacted the defendant regarding her shoulder pain and an appointment was made for 31 May 2001. On that date, the defendant examined the plaintiff in his Lismore rooms. He took a detailed history and asked the plaintiff to shrug her shoulders and raise her arms above her head. The defendant diagnosed that the accessory nerve had been damaged during the November 1999 surgery. He informed the plaintiff that he was not able to repair the accessory nerve and referred her to an orthopaedic surgeon.

The defendant stated at trial that he was unaware of the arm raise test until he had read the plaintiff's medical evidence.

The Court was unconvinced that the defendant had performed any test during the post-operative period. Studdert J sought clarification about certain features of the defendant's evidence and asked the defendant's counsel the following:

In the event that the shrug test was performed, what is the doctor's explanation for the plaintiff's ability to shrug her shoulders in response to that test, and related to that I would like to be further assisted by the doctor's evidence as to the sufficiency of doing the test but once.8

The Court had difficulty reconciling the defendant's evidence with the medical evidence regarding the simple bedside procedures to determine the integrity of the accessory nerve. Rejecting the defendant's evidence, Studdert J held:

It, contrary to the finding I have made, the defendant did perform a single shrug test, then I consider that such a test would have been inadequate.9

Studdert J went on to state:

I find on the balance of probabilities that had the shrug test been performed on two occasions before the plaintiff left hospital the severance of the accessory nerve would have been diagnosed. Moreover, had the defendant been in doubt about the results of that test, the severance would have been confirmed by the arm raise test, a test which should have been carried out in hospital as well. That test the defendant did use when the plaintiff consulted him in May 2001.10

Regarding the issue of failure to disclose, the plaintiff asserted that the defendant should have informed her, and/or her general practitioner, of his suspicion that he may have severed the accessory nerve and/or that he had removed a large nerve from her neck.

The defendant argued that, as the plaintiff was ‘very emotional’ in the post-operative period, he had decided not to advise her of the possible complications of surgery because he believed, at that stage, that there was no injury to the accessory nerve. According to the defendant:

I only saw her for the few occasions in hospital when she was in an emotional state and I did not tell her that because it was only a possibility at the time of surgery. Following the operation on my examination I felt I was probably wrong and it was probably a sensory nerve that I had divided.11

In addition, the defendant argued that any opportunity to diagnose the plaintiff's accessory nerve injury was lost when she failed to attend the post-operative consultation. The defendant did not explain why he failed to advise the plaintiff's general practitioner of the possible injury to the accessory nerve and/or the removal of a ‘large nerve’. The Court was very concerned about the defendant's alleged failure to disclose and again sought assistance from the defendant's counsel:

The next matter is this. The doctor has indicated yesterday that there was some 2 to 3 centimetres of nerve which was severed and there may have been other nerves, according to the doctor, he does not know. What I would like to hear from the doctor is why it was that neither the plaintiff nor her general practitioner nor anybody else associated with the plaintiff was informed about the severance of a nerve, whether it was thought to be the accessory nerve or anything else. I am alerted to the fact that the doctor said that he didn't want to talk to the plaintiff about it when she was in hospital because she was distressed, but what's the explanation for nobody ever having been told of this and what does the doctor say as to why it was that nothing was done by him to determine what nerve or nerves had been severed so as to be able to assess the significance of what had been done.12

It was accepted by all medical experts that the plaintiff and/or her general practitioner should have been advised of the possible iatrogenic accessory nerve injury and/or the removal of 2 centimetres of a 'large nerve' from her neck. Studdert J agreed and stated:

I also conclude that there was a breach of duty on the doctor's part in failing to inform the plaintiff of the severance of a nerve at surgery and his suspicion that the nerve severed may have been the accessory nerve. Dr Arnott said that he did not tell the plaintiff in hospital about the severance of the nerve because of her emotional state and because it was only a possibility that he had severed this nerve, and that possibility he considered to be 'probably wrong' because of his examination following surgery. Acceptance of the doctor's explanation for not alerting the plaintiff to what occurred depends upon acceptance that the shrug test was performed. Since I am not persuaded that it was, I do not find the defendant's explanation for not telling the plaintiff about the division of the nerve to be an acceptable explanation.13

Duty to follow up and contributory negligence

As noted above, the defendant argued that any opportunity he had for correctly diagnosing the plaintiff's iatrogenic accessory nerve injury in a timely manner was lost when the plaintiff allegedly failed to attend the post-operative consultation at the defendant's rooms approximately two to three weeks post-procedure. The defendant relied on the absence of diary or computer records of an appointment. He also noted that there were no examination records on the plaintiff's file, which suggested that she did not attend the follow up appointment.

The defendant had a busy practice and would see up to 25 patients per day. He stated that over the years he probably had thousands of consultations and he would not be able to remember any details without the aid of his medical records.

The defendant's office manager gave evidence stating that the surgery ran independently from the hospital and that there was no system in place to determine who was required for post-operative consultations. The office
The plaintiff stated that she did attend the post-operative appointment approximately two to three weeks post-surgery. She and her grandmother (who provided corroborative evidence) attended the defendant's surgery. The plaintiff stated that she was led into the examination room and waited while the defendant attended to another patient in the adjacent examination room. She stated that the defendant reviewed her wound and stated that everything was progressing well. The plaintiff allegedly stated that she informed the defendant of her continuing shoulder dysfunction and pain but the defendant was not interested. The plaintiff left the surgery distressed.

The plaintiff, her husband and her grandmother were extensively cross-examined regarding whether the plaintiff attended the post-operative consultation. The three were accused of colluding and fabricating evidence to support the plaintiff’s case.

Studdert J held that the plaintiff did attend that post-operative consultation and stated:

I had the advantage of observing closely as the various witnesses gave their evidence. Ultimately, I am persuaded on the balance of probabilities that the evidence advanced in the plaintiff’s case about the post-discharge consultation in the defendant’s rooms was truthful evidence. I have come to that conclusion notwithstanding the evidence given by the defendant and the absence of any record of the attendance at the defendant’s room. The dependability of the computer generated record was, of course, dependant upon human input, and in November 1999 the procedure of record keeping was at a change-over stage. It seems to me that the absence of a record may be explained by human error. I find it more probable than not, having assessed the evidence given by the plaintiff, her husband and her grandmother the plaintiff did attend as she claimed.16

Regarding the issue of appropriate follow up systems, the Court noted that it was insufficient to discharge one’s duty of care by merely advising a patient that they should attend their rooms for follow up. Studdert J went on to state:

There was no system in place in the defendant’s practice to follow up a patient who failed to attend for a consultation. Once the defendant severed a nerve during the operation, suspecting that this was the accessory nerve, the exercise of due care required of him that he do more ...17

Given that the Court found that the plaintiff did attend the post-operative consultation, there was no finding of contributory negligence.

Whose witness is it anyway?

The plaintiff's treating neurosurgeon was also her medical expert. In July 2001, the plaintiff consulted the neurosurgeon to investigate whether the accessory nerve could have been repaired. He wrote to her general practitioner advising that, based upon the 2001 EMG and his examination, the accessory nerve had been nicked, causing partial denervation with partial reinnervation. He also stated that surgical repair was no longer an option due to the extended lapse of time. On 1 July 2002, the plaintiff's solicitors requested and received a treatment report from the neurosurgeon. This report reiterated his earlier opinion that the accessory nerve was nicked during surgery.

On 28 May 2003, the plaintiff identified her treating neurosurgeon in her answers to further and better particulars. The defendant issued a subpoena for production to the plaintiff’s treating neurosurgeon on 3 June 2003 and again on 5 August 2003. On 15 August 2003, the defendant received a Notice of Past Benefits from the Health Insurance Commission, which identified the plaintiff’s treating neurosurgeon. On the same day, the defendant was provided with amended further and better particulars that, again, identified the plaintiff's treating neurosurgeon.

In September 2004, the plaintiff obtained the first of three medico-legal reports from her treating neurosurgeon. In his supplementary report, dated 14 October 2004, the neurosurgeon (having received the 2004 EMG) stated that the 2001 EMG was incorrect and the 2004 EMG correctly interpreted the integrity of the accessory nerve.

During cross-examination, the defendant produced a medico-legal
report, dated 10 September 2003, written by the plaintiff’s treating neurosurgeon on behalf of the defendant. The defendant argued that the plaintiff’s treating neurosurgeon was a ‘hired gun’ and that his opinion should not be relied upon. The defendant asserted that the neurosurgeon’s 2003 report was significantly different when compared to his later reports.

The Court noted that the neurosurgeon was responding to the defendant’s statement of assumptions of facts and had provided an opinion based on the incorrect 2001 EMG report and the defendant’s assumptions.

Obtaining a report from a treating medical practitioner should be reviewed in light of the Supreme Court decisions of McGuire v Ferguson (unreported, NSWSC, Solomon AJ, 11 December 2001) and Kadian v Richards (2004) NSWSC 382; BC200403813. In both cases, the Supreme Court held that the plaintiff’s right to doctor-patient confidentiality was not extinguished when medical negligence proceedings were commenced.

The doctor’s fiduciary duty of confidentiality relates to the dissemination and/or disclosure of a patient’s personal and/or sensitive information to unauthorised persons. There is no doubt that dissemination of such information, unless under extreme circumstance, will amount to a breach of confidentiality. However, does a breach of confidentiality occur if a treating doctor provides a medico-legal report that only discusses issues of liability or causation? Would a doctor breach confidentiality by merely referring to the fact that he or she had once treated the plaintiff without making any other comment? Moreover, could all references of a patient be removed from a medico-legal report that deals with liability or causation without breaching confidentiality?

These issues were not addressed or resolved by the Court. The Court was only concerned with the alleged perceived inconsistent statements between the medico-legal reports of the plaintiff’s treating neurosurgeon.

Conclusion

_Wighton v Arnot_ restates established law relating to the duty to disclose and the duty of follow up. The only issue that remains unresolved is whether the doctor–patient fiduciary duty of confidentiality is breached by a defendant contacting a treating medical practitioner to procure a medico-legal report that comments on liability or causation. It may not be legally or ethically wrong to obtain a liability or causation opinion from treating medical practitioners. However, to do so is fraught with danger in that any reference to the plaintiff’s treatment or personal details may constitute a breach of confidentiality.

The NSW Supreme Court in _McGuire v Ferguson_ and _Kadian v Richards_ stated that the defendant and/or their legal representatives cannot approach a treating doctor without the plaintiff’s consent. Both cases state that a defendant should not induce, either directly or indirectly, a treating doctor to breach confidentiality.

If that is correct, then it follows that the defendant and/or their legal representative will breach the law if they obtain a liability or causation report from a treating doctor that inadvertently discloses the plaintiff’s treatment or personal details. In such cases, the defendant, his or her legal representatives and the treating medical practitioner would be held accountable for breaching and/or causing to induce a breach of confidentiality.

It is, therefore, advisable that a treating medical practitioner should not be retained to provide liability or causation reports without the consent of the plaintiff. To do so exposes the medical practitioner, the defendant and their legal representatives to unnecessary prosecution and disciplinary proceedings if disclosure of confidential information occurs.

_Wighton v Arnot_ reiterated established law and illustrated the need to review medical evidence critically. Many issues in this case could have been resolved prior to hearing had the medical evidence been reviewed.

The issue of whether a defendant and/or a defendant’s legal representatives should be able to approach a treating medical practitioner for a medico-legal report will remain controversial until it is formally resolved by the courts.

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Endnotes

1. Grade 0 = no tone or power; grade 3 = reduced tone and power with some resistance to gravity; and grade 5 = normal tone and power.

2. Complete denervation (excision, incision or blocking of nerve supply) of the accessory nerve causes trapezius muscle atrophy (wasting), leading to scapular winging and rotation and resulting in profound functional shoulder deficits.

3. The sensory nerves of the cervical plexus extend from behind the sternomastoid muscle and spread throughout the neck muscle, ending at the skin.

4. Cervical ribs are congenital abnormalities resulting in an extra rib extending from the seventh cervical rib (C7) or an abnormally long C7 cervical process. Usually cervical ribs are unproblematic. However, according to the literature, when the trapezius muscle has atrophied, causing the shoulder to drop, the brachial plexus is stretched over the cervical rib. This causes a myriad of symptoms described as thoracic outlet syndrome.

5. Muscle nerve plates die after 18 months. For ultimate results, surgical repair should occur within six months of injury.


7. The trapezius muscle is also supplied by the third and fourth cervical nerves.

8. Transcript at 496:35-42.


10. Judgment at [63].


13. Judgment at [69].


15. Transcript at 540:36-58.

16. Judgment at [89].

17. Judgment at [92].