A pain in the back case

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This article discusses a Supreme Court case[1] involving a patient who was referred to a chiropractor for treatment of neck pain. The case highlights some important issues, including the:

- importance of good medical record keeping
- duty to read patient documentation, including previous medical records
- duty to perform a physical examination, and
- duty to consider if a referral is appropriate.

Case history

Mr G suffered a neck injury on 23 April 1990. He was driving a truck and hit his head on the cabin roof as he was going over a bump. After about 1 week, Mr G also began to suffer low back pain. The neck pain eventually settled, but Mr G continued to suffer from tingling and paraesthesia in his left arm. On 3 July 1990, Mr G saw a neurosurgeon for review. At this time, he complained that moving his neck caused tingling down his left arm. He also complained of problems with his lower back, with pain radiating into the gluteal region. The neurosurgeon referred Mr G to a physiotherapist which resulted in marginal improvement in his symptoms.

In June 1992, the occupational health nurse at Mr G's place of employment observed Mr G rotating his arm, as was his habit when he experienced tingling and paraesthesia in his left arm. The nurse suggested Mr G see the company doctor and, on 18 June 1992, Mr G s a w Dr M. The 42 year old patient gave Dr M a history of longstanding symptoms referrable to his neck and arm which had been exacerbated by the accident in his truck. According to Dr M, he performed a physical examination mainly looking for muscle wasting, muscle weakness and loss of reflexes. He tested the range of movement in the patient's neck, shoulders and limbs. He palpated the area around the neck to see if there was any tenderness or any palpable abnormality. Dr M was aware that the patient had seen a neurosurgeon in the past and he had access to the patient's complete medical records. Dr M recorded the following notes in the medical records: 'History of neck pain and brachialgia aggravated in incident in April when hit head on roof of truck breaking four teeth. Has seen neurologist. No specific treatment. Physio no help. Ref Dr A (take X-rays)'.

During the consultation, Dr M gave Mr G a written referral to a chiropractor. The referral letter stated: 'Thank you for seeing Chris. He injured his neck (along with four teeth) on 23 April 1990 when he hit his head on the top of his truck. He has had pains radiating into the arms but no neurological deficit. He should have X-rays by then. Hope you can help'.

On 30 June 1992, Mr G saw the chiropractor, Dr A. Dr A performed a manipulation of Mr G's neck and back. Following the chiropractic treatment, Mr G's back and neck symptoms deteriorated markedly. Mr G was subsequently referred back to the neurosurgeon for review. O n 3 September 1992, the neurosurgeon carried out an anterior cervical discectomy and fusion. On 12 February 1993, the patient underwent an L4/5 spinal posterolateral fusion, however, this was unsuccessful. By June 1994, Mr G was found to be permanently unfit for work. Mr G subsequently commenced legal proceedings against both Dr M and Dr A.

Medicolegal issues

In his Statement of Claim, Mr G alleged Dr M was negligent in referring him to the chiropractor. Against the chiropractor, Mr G alleged the manipulation procedure was performed negligently. As a result of the alleged negligence of both practitioners, Mr G claimed his neck and back conditions were aggravated and accelerated, resulting in him becoming unfit for his employment.

The case proceeded to trial in 2000 and judgment was handed down in March 2001, almost 10 years after the initial consultation with Dr M. At trial, there was a dispute in evidence between Dr M and Mr G as to whether a physical examination and review of the previous medical records was undertaken during the consultation on 18 June

1992. The judge found that Dr M did not physically examine Mr G, nor did he look at the patient's medical records in any detail, or if he did, he failed to have regard to previous medical records. These records included the neurosurgeon's previous reports, which referred to the left sided brachialgia with radiating pain in his arm and a cervical spine X-ray report of 23 April 1990 which reported osteophytic impingement at the C5/6 foramina bilaterally. These findings, along with the patient's numbness in his arm and fingers, indicated nerve root irritation in the cervical spine. At the trial, an orthopaedic surgeon and neurosurgeon gave evidence that it was not acceptable medical practice to refer Mr G to a chiropractor in these circumstances.

The judge found that Dr M was liable for the consequences of aggravation of the neck injury and that the chiropractor was responsible for the aggravation and acceleration of both the neck and back symptoms. The damages awarded included compensation for loss of earnings, out of pocket expenses, domestic services and for the additional continuing pain and disabilities. The judge awarded a total of $559 818. The award of damages was shared between Dr M and Dr A, with the majority borne by Dr A.

Dr M appealed against the judgment. The appeal was unsuccessful. The New South Wales Court of Appeal[2] found that Mr G's injuries would not have occurred had he not been treated by a chiropractor. Mr G was only examined by a chiropractor because of Dr M's referral. The referral was negligent in that chiropractic treatment was contraindicated in Mr G's case. The fact that Dr A's treatment was administered negligently did not negate Dr M's liability.

Discussion

Medical negligence claims and complaints often involve a factual dispute between the patient and the medical practitioner. For example, the patient may claim they were not warned of the risks of a procedure, while the practitioner asserts that it is his/her usual practice to warn of risks. Where there are conflicting versions of events between the patient and the medical practitioner, the medical practitioner's version is more likely to be accepted where there is documentary evidence in the contemporaneous medical records.

In this case, the judge had to determine whether the patient's or Dr M's version of the events during the consultation on 18 June 1992 should be preferred. In the absence of any notation in the records that Dr M performed a physical examination, the judge preferred the patient's evidence that Dr M did not examine him during the consultation.

Risk management strategies

This case highlights two important issues relating to medical record keeping:

- the importance of reviewing the patient's previous medical records before providing advice and treatment, and
- the need for 'good' medical record keeping that should include:
  - patient identification
  - information relevant to diagnosis and treatment, including history and physical examination
  - clinical opinion
  - treatment plan
  - medication and dosage (if relevant), and
  - information and advice given to patient, including follow up instructions.

Conflict of interest: none declared.

References

1. Maguire v McGroder [2001] NSWSC 122.
2. McGroder v Maguire [2002] NSWCA 261.

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