Damage to spinal accessory nerve during neck surgery performed after hours (03HDC06095, 21 December 2004)

Public hospital ~ Surgical registrar ~ Non-urgent surgery after midnight ~ Standard of care ~ Informed consent ~ Rights 4(1), 6(1)(b)

A 30-year-old woman consulted a surgeon about a lump in the right side of her neck, in the posterior triangle near the sternomastoid muscle. Arrangements were made for the gland to be excised and investigated. Several days after her stitches were removed, the woman presented to her GP complaining that a lump at the wound site was becoming progressively bigger and more painful, and she was feeling generally unwell.

The woman was referred to a public hospital, where arrangements were made to explore the wound and drain it if necessary. The surgical plan was agreed on by the consultant and registrar, and the registrar obtained the patient's informed consent. A note on the consent form stated that information had been given on the risk of damage to surrounding structures. The case was handed over to the night registrar, who again gave the woman information, "including a small risk of nerve damage". The woman disputed this, and said that no one told her of a risk of nerve damage.

Exploratory surgery was performed at 1.22am, with no abscess found and dense scar tissue noted. After the surgery the woman suffered from severe pain and numbness down the right side of her cheek, jaw line, neck and shoulder. She complained that adequate pain relief was not provided, and the attitude of the nurses was poor. Several days after the surgery, with no improvement in her condition and no evidence of infection, the woman was reviewed by a neurologist, who noted that it was likely she had suffered an injury to her right spinal accessory nerve. Subsequent tests and scans confirmed the suspicion. She was transferred to another hospital and had the severed nerve repaired microsurgically.

After her eventual discharge, the woman complained of a lack of support and follow-up care. She continues to suffer from ongoing incapacity and loss of career opportunities as a result of the damage to her nerve.

The Commissioner's independent advisor and ACC's advisor both felt that the registrar should have tried to identify the nerve. On opening the wound and realising that no infection was present, the registrar should have been aware that the dense scar tissue he found could have altered the anatomy of the neck considerably. At this point he would have been wise to abandon the procedure or contact the consultant. Although both advisors noted that it would have been difficult to identify the nerve, the registrar should still have attempted to do so. This failing amounted to a breach of Right 4(1).

The hospital was not found in breach of Right 6(1)(b), as the Commissioner was satisfied that the risk of nerve damage was explained to the patient. However, the Commissioner reiterated concerns expressed by his advisor and the Medical Council over non-urgent surgery being performed at such a late hour. The risk of error is likely to be heightened when surgery is undertaken during night hours, with reduced back-up available, and patients should not be exposed to this additional level of risk unless the surgery is urgent and cannot be safely postponed.