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# **Material Risk and Causation in relation to failure to warn: Dental Negligence Cases after *Rogers v Whittaker*.**

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## **Abstract**

*This paper reviews three dental negligence cases before the courts from 1995-1997. Some guidelines as to how failure to warn and causation have been interpreted by the courts in dental cases are outlined. Some clinical implications for dental practitioners are discussed*

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## Introduction

The tort of negligence has a number of elements - duty of care<sup>1</sup>; standard of care; causation; and reasonable foreseeability. Lack of consent to treatment also gives rise to negligence where consent would not be given if material risks had been disclosed and explained.

It is not the purpose of this paper to exhaustively discuss the elements of negligence. However in discussing the dental cases which relate to provision of information to support valid consent, causation, the standard of care and reasonable foreseeability will be examined.

Consent can be defined as an exercising of an informed choice, with a withstanding capability to make an informed choice, and the choice has to be voluntary<sup>2</sup>. These have been referred to by Jones<sup>3</sup> as volition; information; and capacity<sup>4</sup>.

This research paper will deal with primarily the second element - that of information as provided by dental practitioners to patients about procedures they consent to, and whether failure to warn of a foreseeable risk vitiates that consent. Also causation will be examined, in the event that the failure to warn is negligent.

The question relating to the duty of disclosure is whether adequate information has been presented to a patient and that it has been understood to allow the patient to give valid consent to the procedure. In *Chatterson v Gerson*<sup>5</sup>, the plaintiff sued in both negligence and battery. It was held that the suit for battery could not lie where there had been consent to the procedure which had been explained in broad terms. This establishes the branching of consent into broad consent in relation to the procedure, which if not valid gives rise to battery, - and the more difficult area of the attendant risks of undergoing the procedure, which in Australia goes to negligence.<sup>6</sup>

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<sup>1</sup> Duty of care will generally be presumed in a clinical health relationship once advice diagnosis or treatment is commenced *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582

<sup>2</sup> Jones M, 1991, *Medical Negligence*, p 200, London Sweet and Maxwell

<sup>3</sup> Jones M, 1991

<sup>4</sup> Devereaux John, 1997, *Medical Law: Text, Cases and materials*, p 51 Sydney, Cavendish Australia

<sup>5</sup> *Chatterson v Gerson* [1981] QB 432 pp 443-44

<sup>6</sup> So battery will only be at issue where the patient does not consent to the operation or procedure.

Where the risks and information regarding the procedure and its sequelae ( what could be called collateral matters) have not been explained adequately or at all, this amounts to negligence and not battery unless there has been misrepresentation or fraud. <sup>7</sup>

It is the information provision to a patient going to negligence not battery <sup>8</sup> which is the essence of this paper- the amount and quality of the information necessary to be disclosed to meet the legal standard of care after the broad nature of the procedure has been explained.

Once a patient has been told of the broad fundamental nature of the procedure, and consent to battery has been established, there is also a duty to disclose certain information in relation to risks or side effects in relation to those procedures.

If an undisclosed risk materializes, and if the patient can successfully claim to have been unprepared to consent to the procedure if the risk had been disclosed, then causation has been established. Thus the lack of disclosure is the negligent act.

Modern dental practice in Australia like most of the Western world, now involves many modalities in quite complex treatment. Much of the treatment has significant benefits and risks. After the formal duty of disclosure was established in this country since *Rogers v Whittaker*<sup>9</sup>, some ratio as to materiality of risk and causation can be found in the dental negligence cases that have come to court. This paper will outline the law in relation to duty of disclosure and causation and then examine three dental cases in detail, and attempt to distill some implications for general and specialist dental practitioners from the law as it stands.

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<sup>7</sup>*Reibl v Hughes* (1978) DLR 3d 112

<sup>8</sup>In “*Structuring the Issues in Informed Consent*” (1981) 26 McGill Law Journal 740, Somerville suggests that battery could arise where the consent although given to the basic nature of the procedure, information about an inevitable consequence is not given, ( such as sterility after a hysterectomy to relieve pain) and as such this vitiates the primary consent and battery is established. So where collateral matters become basic or essential matters, the water becomes a little murky. So battery could only arise in consent regarding non disclosure of risks in a procedure where there has been an intention to misrepresent the information ( e.g.. not tell of an inevitable risk).

<sup>9</sup>*Rogers v Whittaker* (1992) 179 CLR 479

## Negligence and *Rogers v Whittaker*

### Negligence

For negligence to occur there must be a breach of duty. This breach of duty of care can be a negligent act that causes damage or injury. How the standard of care is measured can be established by the case law that follows.

### Standard of Care

In *Bolam v Friern Hospital Management Committee*<sup>10</sup> Mc Nair J explained what standard of care a skilled person (medical practitioner) is to be judged by...

‘where you get a situation that involves the use of some special skill or competence, then the test as to whether there has been negligence or not is not the test of the man on the top of a Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising or 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 man is not negligent if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view.... as long as you accept what the defendant did was in accordance with a practice adopted by responsible persons’

### *Doubts about Bolam*

In *Sidaway v Governors of Bethlehem Royal Hospital*<sup>11</sup> after *Bolam*, there was a progression from the ‘doctors know best’ ratio of *Bolam*, to the patient’s right of self determination of *Reibl v Hughes*<sup>12</sup> and *Canterbury v Spence*<sup>13</sup> from Canada and the USA respectively. In Australia there has been an approval of the judgement of Lord Scarman at the expense of the views of the other Lords.

In South Australia the groundbreaking case of *F v R*<sup>14</sup> was decided, and this decision really set the legal stage for *Rogers v Whittaker*.

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<sup>10</sup>*Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 pp 586-88

<sup>11</sup>*Sidaway v Board of Governors of Bethlehem Royal Hospital* [1985] AC 871

<sup>12</sup>*Reibl v Hughes* [1980] 2 SCR 880

<sup>13</sup>*Canterbury v Spence* (1972) 464F (2d) 772

<sup>14</sup>*F v R* (1983) 33 SASR 189

In *F v R*, a tubal ligation performed by an obstetrician was not successful in terms of the desired result of sterilisation, and a patient became pregnant. The worldwide failure rate of this procedure at the time was held to be 0.5 %.

King CJ quoted from *Chatterton v Gerson*<sup>15</sup> .....

“...it is the duty of the doctor to explain what he intends to do, and its implications, in the way a careful and responsible doctor in similar circumstances would have done.” per Bristow J.... It is my opinion that that is a correct statement of the law, and that the duty extends, not only to the disclosure of real risks of misfortune inherent in the treatment but also any real risk that the treatment, especially if it involves major surgery, may prove ineffective’

After these cases and others, the High Court had an opportunity to rule on this conflicting area of law.

### ***Standard of Care redefined -Rogers v Whittaker***

#### **Facts**

The patient Marie Whittaker had consulted Dr Rogers in relation to one eye which suffered a penetrating injury some 40 years ago. Marie Whittaker had raised a family, but now about to enter the work force again, wanted to see if she could have the appearance of the right eye improved and also have some improvement in sight.

In *Rogers v Whittaker*<sup>16</sup> in the High Court, the physician Dr Rogers was held to have failed to warn the patient Mrs. Whittaker about a remote risk of sympathetic ophthalmia, which could and did result in blindness in the opposite eye to that which was operated on in the procedure. Because of an elective procedure, Mrs Whittaker was made blind and was not warned of the risk of this unfortunate event happening.

The question before the court was not one of causation, nor negligence in diagnosis or treatment, but one of negligence by failure to warn of the risk of sympathetic ophthalmia.

### ***What was wrong with Bolam***

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<sup>15</sup>*Chatterton v Gerson* [1981] QB 432

The court discussed at length the decisions above, *Siddaway, Bolam, Battersby and Reibl*, and decided that the *Bolam* test was no longer applicable., and quoted with approval from *Sidaway*...

‘Lord Bridge of Harwich (with whom Lord Keith of Kinkel agreed) accepted that the issue was "to be decided primarily on the basis of expert medical evidence, applying the Bolam test" ((13) *ibid.*, at p 900) but concluded that, irrespective of the existence of a responsible body of medical opinion which approved of nondisclosure in a particular case, a trial judge might in certain circumstances come to the conclusion that disclosure of a particular risk was so obviously necessary to an informed choice on the part of the patient that no reasonably prudent medical practitioner would fail to make it. Lord Templeman appeared even less inclined to allow medical opinion to determine this issue. He stated ((14) *ibid.*, at p 903): "(T)he court must decide whether the information afforded to the patient was sufficient to alert the patient to the possibility of serious harm of the kind in fact suffered"'.<sup>17</sup>

Lord Scarman in particular, had refused to apply the Bolam test..

‘His Lordship stated ((17)(1985) AC, at p 876.): "In my view the question whether or not the omission to warn constitutes a breach of the doctor's duty of care towards his patient is to be determined not exclusively by reference to the current state of responsible and competent professional opinion and practice at the time, though both are, of course, relevant considerations, but by the court's view as to whether the doctor in advising his patient gave the consideration which the law requires him to give to the right of the patient to make up her own mind in the light of the relevant information whether or not she will accept the treatment which he proposes.'<sup>18</sup>

The High Court held that

(Under the Bolam test) even if a patient asks a direct question about the possible risks or complications, the making of that inquiry would logically be of little or no significance; medical opinion determines whether the risk should or should not be disclosed and the express desire of a particular patient for information or advice does not alter that opinion or the legal significance of that opinion<sup>19</sup>

The court went on to discuss how in Australian cases such as *F v R*, the *Bolam* principle had been rejected.

The approach adopted by King C.J. is similar to that subsequently taken by Lord Scarman in *Sidaway* and has been followed in subsequent cases ((31) *Battersby v. Tottman*; *Gover v. South Australia* (1985) 39 SASR, at pp 551-552; *Ellis v Wallsend District Hospital*, unreported, Supreme Court of New SouthWales, 16 September 1988; *E Australian Red Cross* (1991) 99 ALR, at pp649-650). In our view, it is correct.<sup>20</sup>

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16<sup>16</sup> *Rogers v Whittaker* (1992)179 CLR 479

17<sup>17</sup> per Mason CJ Id at 9

18<sup>18</sup> per Mason CJ Id at 10

19<sup>19</sup> per Mason CJ Id at 11

20<sup>20</sup> per Mason CJ Id at 14

If the court had applied the *Bolam* test, which the appellant suggested, then the failure to warn could not be held to be negligent as there was a responsible body of medical opinion which held that there was no need to warn the patient of the remote risk - held to be in the vicinity of 1 in 14,000.

The present case was a perfect example of where the *Bolam* test would provide an unjust result - if the *Bolam* test were used on a strict interpretation, an existing body of medical opinion that said a warning was not necessary- it would mean the failure to warn was not negligent. That would mean that Mrs. Whittaker who specifically addressed the issue of damage to her only sighted eye was not due a warning of the rare but catastrophic complication of sympathetic ophthalmia.

***Does the Bolam test still apply and to what does it apply ?***

The court then developed a dichotomy between diagnosis and treatment on one hand, and advice as to risk on the other.

There is a fundamental difference between, on the one hand, diagnosis and treatment and, on the other hand, the provision of advice or information to a patient. In diagnosis and treatment, the patient's contribution is limited to the narration of symptoms and relevant history; the medical practitioner provides diagnosis and treatment according to his or her level of skill. However, except in cases of emergency or necessity, all medical treatment is preceded by the patient's choice to undergo it. In legal terms, the patient's consent to the treatment may be valid once he or she is informed in broad terms of the nature of the procedure which is intended

**Whether** a medical practitioner carries out a particular form of treatment in accordance with the appropriate standard of care is a question in the resolution of which responsible professional opinion will have an influential, often a decisive, role to play; **whether** the patient has been given all the relevant information to choose between undergoing and not undergoing the treatment is a question of a different order. Generally speaking, it is not a question the answer to which depends upon medical standards or practices. Except in those cases where there is a particular danger that the provision of all relevant information will harm an unusually nervous, disturbed or volatile patient, no special medical skill is involved in disclosing the information, including the risks attending the proposed treatment ((34) See Fleming, *The Law of Torts*, 7th ed. (1987), p 110). Rather, the skill is in communicating the relevant information to the patient in terms which are reasonably adequate for that purpose having regard to the patient's apprehended capacity to understand that information.<sup>21</sup>

In *Rogers v Whittaker*<sup>22</sup>, it was decided that there was no special medical skill in the giving of advice as opposed to diagnosis and treatment and as such a court supervision of the standard required in information disclosure was preferred. So whilst the *Bolam* test was held to still apply to diagnosis and

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<sup>21</sup> Id

<sup>22</sup> Id

treatment but not exhaustively, the test for materiality of risk was both subjective and objective. Gauldron was less enthusiastic about the *Bolam* test...

Accordingly, even in the area of diagnosis and treatment there is, in my view, no legal basis for limiting liability in terms of the rule known as "the Bolam test" .....That is not to deny that, having regard to the onus of proof, "the Bolam test" may be a convenient statement of the approach dictated by the state of the evidence in some cases. As such, it may have some utility as a rule-of-thumb in some jury cases, but it can serve no other useful function.<sup>23</sup>

***What test then should be used ?***

The court then went on to specifically reject the notion of informed consent and preferred instead the concept of a duty of disclosure.

***Informed Consent***

'In this context, nothing is to be gained by reiterating the expressions used in American authorities, such as "the patient's right of self-determination" ((35) See, for example, *Canterbury v. Spence* (1972) 464 F2d, at p 784) or even the oft-used and somewhat amorphous phrase "informed consent". The right of self-determination is an expression which is, perhaps, suitable to cases where the issue is whether a person has agreed to the general surgical procedure or treatment, but is of little assistance in the balancing process that is involved in the determination of whether there has been a breach of the duty of disclosure. Likewise, the phrase "informed consent" is apt to mislead as it suggests a test of the validity of a patient's consent ((36) *Reibl v. Hughes* (1980) 114 DLR (3d), at p 11). Moreover, consent is relevant to actions framed in trespass, not in negligence. Anglo-Australian law has rightly taken the view that an allegation that the risks inherent in a medical procedure have not been disclosed to the patient can only found an action in negligence and not in trespass; the consent necessary to negate the offence of battery is satisfied by the patient being advised in broad terms of the nature of the procedure to be performed ((37) *Chatterton v. Gerson* (1981) QB, at p 443).'<sup>24</sup>

***The Test***

'We agree that the factors referred to in *F v. R.* by King C.J. ((39)(1983) 33 SASR, at pp 192-193) must all be considered by a medical practitioner in deciding whether to disclose or advise of some risk in a proposed procedure. The law should recognize that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach

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<sup>23</sup> per Gauldron J Id at 4

<sup>24</sup> per Mason CJ Id at 15

significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it. This duty is subject to the therapeutic privilege.<sup>25</sup>

The test is then, a two limb test subject to a privilege.

The first limb relates to a reasonable person attaching significance to the risk.

The second limb catches those like Mrs. Whittaker who the medical practitioner should reasonably have been aware would attach significance to it. The material risk assessment is different for every procedure and every patient, so some thought needs to be addressed to each case. (A simple percentage risk analysis for example is not determinative of materiality.)

The test was plainly expressed in this way so that even though a patient may not be able to ask a scientifically accurate question, the doctor still has a responsibility to advert to what the patient might attach significance to.

When Mrs Whittaker asked about damage to her left eye, the second limb of the test became applicable. Even though she did not ask about the possibility of sympathetic ophthalmia, Dr Rogers should have been aware that Mrs Whittaker ( a particularly inquisitive patient) would attach significance to that risk. Thus his failure to disclose the risk was held to be negligent.

It should be mentioned that the procedure involved was an elective procedure. If a procedure is elective, not essential to the person's health (as it was in this case because the surgery was largely for the improvement in appearance of the affected eye), then does this change the duty to disclose?

Common sense would suggest that there would be higher duty to disclose as the patient is voluntarily bringing him or herself into an area of risk without necessity, and so it would seem even more necessary to disclose the potential risks involved.

This is perhaps what King CJ in *F v R*<sup>26</sup> meant when he referred to the nature of the procedure. The more life threatening the procedure, the less likely that the risk will be material. The less threatening, more elective and more optional the proposed treatment, the more likely that the risk should be disclosed.

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<sup>25</sup> per Mason CJ Id at 16

<sup>26</sup> *F v R* (1983) 33 SASR 189

In a case like *Rogers v Whittaker*<sup>27</sup> the identification of the High Court's application of a material risk is quite clear- the small percentage risk of blindness was a dire risk and should be warned of, even though the 1/14,000 incidence was small, the event which befell Mrs Whittaker was catastrophic. Mrs Whittaker was inquisitive and Dr Rogers should have been aware she would attach significance to the risk of blindness.

After *Rogers v Whittaker*, it may be said that doctors carrying out elective procedures should regard themselves as under a much greater duty than may have been previously imagined to properly inform their patients of the risks. Also, an elective cosmetic procedure might carry a greater onus of disclosure than an elective functional procedure such as a knee reconstruction.<sup>28</sup>

### ***The therapeutic Privilege***

The therapeutic privilege<sup>29</sup> can be stated as "a doctor may withhold information where disclosure would be adverse to the patient's interests"<sup>30</sup>

In the case of *Battersby v Tottman*<sup>31</sup> a woman suffering severe mental illness had been unsuccessfully treated by all available methods. Her psychiatrist felt she could be helped with a therapy which may threaten her sight. Blindness resulted and the Doctor claimed a therapeutic privilege. This was accepted by both the trial judge and the majority of the Full Court on appeal. Gibbs J in the High Court in refusing leave to appeal, stated that the facts did not lend themselves for the consideration of the question of law.<sup>32</sup>

Gauldron J stated in *Rogers v Whittaker*.<sup>33</sup>..

‘Again leaving aside cases involving a medical emergency or a situations where the circumstances of the individual require special consideration, I see no basis for treating the doctor's duty to warn of risks (whether involved in the treatment or procedures proposed or otherwise attending the patient's condition or circumstances) as different in

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<sup>27</sup><sup>27</sup>*Rogers v Whittaker* (1992) 179 CLR 479

<sup>28</sup><sup>28</sup>Dunn Ian, 1993, *Law Institute Journal* (LIV), April 1993, p 271

<sup>29</sup><sup>29</sup>The term appears to have its origin in the United States. See *Canterbury v Spence* (1972) 464 F 2d 772 at 789; *Sidaway v Governors of Bethlehem Royal Hospital* (1985) AC 871 at 889.

<sup>30</sup><sup>30</sup>*Breen v Williams* (1995) FC High Court 96/025 Medicine: Dawson and Toohey JJ at 9

<sup>31</sup><sup>31</sup>*Battersby v Tottman* (1985) 37 SASR 524 (FC)

<sup>32</sup><sup>32</sup>*Battersby v Tottman* [1985] 9 Leg Rep SL 3 per Gibbs J

<sup>33</sup><sup>33</sup>per Gauldron J at 8 *Rogers v Whittaker* (1992) 179 CLR 479

nature or degree from any other duty to warn of real and foreseeable risks. And as at present advised, I see no basis for any exception or "therapeutic privilege" which is not based in medical emergency or in considerations of the patient's ability to receive, understand or properly evaluate the significance of the information that would ordinarily be required with respect to his or her condition or the treatment proposed.'

So although the therapeutic privilege still applies, the likelihood of its success as an effective defence to failure to warn has been limited by Gaudron J's comments.

***The law after Rogers v Whittaker***

In *Karpati v Spira*<sup>34</sup> the plaintiff brought proceedings against the defendant neurosurgeon and defendant neurologist for damages for failure to warn of the risk of a stroke in an operation designed to help with the symptoms of Parkinson's Disease.

Spender AJ held that subjective terminology such as slight risk, or little risk should not be used and a percentage risk or band or range of figures should be used. He held further that this duty to warn was non delegable by the referring doctor (where the risk was able to be quantified), to a doctor who was to actually perform the procedure.<sup>35</sup>

In *Tai v Saxon*<sup>36</sup>, the failure to warn of the risk of perforation of the rectum while conducting a non-essential hysterectomy because it would cause the patient to worry more was held not to be a valid exercise of the therapeutic privilege. The court said

'In circumstances where the proposed treatment is non essential and where it is reasonably possible that the patient might exercise a choice to decline to undergo the treatment, an obligation under which a medical practitioner might otherwise have to disclose attendant risks cannot be avoided on the grounds that disclosure might make an anxious patient more anxious.'<sup>37</sup>

This would suggest that where there is an elective nature to the procedure, the therapeutic privilege does not exist, or is likely to be vitiated by the electiveness of the procedure.

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<sup>34</sup><sup>34</sup> *Karpati v Spira* (Unreported Sup Ct (NSW) No 15853 of 1992, June 6 1995

<sup>35</sup><sup>35</sup> *Karpati v Spira* reported in *Australian Health Law Bulletin* (1995) 3 HLB p 113-6

<sup>36</sup><sup>36</sup> *Tai v Saxon* ( Sup Ct WA 1 Mar 1996 960113 ; [1996] ACL Rep 280 WA 1)

<sup>37</sup><sup>37</sup> *Tai v Saxon* [1996] in *ACL Express* 1996 Issue 6 - 3/4/96 page 6

In the case of *Chappel v Hart*<sup>38</sup>, Ms Hart consulted Dr Chappel, an ENT specialist regarding a nine month long throat soreness. A pharyngeal diverticulum was diagnosed and surgery was recommended and carried out. Ms Hart's sole claim was that Dr Chappel did not warn her of the small risk of vocal damage posed by the surgery. In the event the remote risk of vocal damage became a reality.

The patient admitted that she would have had the surgery anyway if she had been warned of the risk, but that if the warning had been given, she would have had either put off the operation and/ or made further enquiries, taken further advice or sought the most experienced surgeon to do the procedure. The argument was that on another occasion, the infection and complications would not have occurred. This was accepted by the trial judge and so he found for Ms Hart, but did not award damages specifically on the basis of a lost opportunity.

On appeal, the evidence of the plaintiff Ms Hart was accepted and the appeal was dismissed. The court found that if the surgery was delayed, there was a likelihood the damage would not be suffered so causation was established- using the line of authorities such as *McGhee v National Coal Board*<sup>39</sup>- because the breach of duty - the failure to warn had exposed the plaintiff to an increased existing risk. This decision is worrying because the plaintiff in any similar negligence case could claim successfully that for one reason or another, they would have postponed the date of the surgery or changed surgeons.<sup>40</sup>

***In what ways might a dentist breach his duty of care ?***

A dental practitioner may breach his duty of care by failing to perform procedures in a way that meets the standard of care as set out by the *Bolam* test. This could be by way of any one of a plethora of clinical misadventures from prescription of a drug to which the patient is allergic, failure to diagnose a clinical problem which causes damage or loss, preparation and construction of a crown which leads to the loss of a tooth, through to surgery causing a sinus perforation (OAF).

The second area where a breach of a duty may be negligent is that of failure to warn, or breach of duty to disclose and in dentistry this means failure to warn of a material risk in treatment which is foreseeable or might be inherent within the procedure. The failure to warn is a breach of the dentist's duty of care. This

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<sup>38</sup>*Chappel v Hart* ( Unreported, NSW Court of Appeal, 24 December 1996, No 40438/94)

<sup>39</sup>*McGhee v National Coal Board* (1973) 1 WLR 1

standard of care in relation to failure to warn will be assessed by a court imposed standard, although the *Bolam* test may be used as a guide. This could be failure to warn of numbness or pain after a procedure, or that a procedure will not likely be effective, or one particular treatment may have a limited life.

‘In the dental context the most common “failure to warn” claim arises in cases of nerve damage following the elective extraction of third molars....Other cases of failure to warn would include those where the level of pain is far worse and the time for recuperation is far longer than the patient was led to expect’<sup>41</sup>

The risk must be a material risk for the dental practitioner to be found negligent.

If there has been a breach of duty by a failure to disclose a material risk under either limb of the test set out in *Rogers v Whittaker*, then for the dentist to be found liable for the injury, causation must be established.

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<sup>40</sup>Milstein Bob , (1997) *Informed Consent and causation - recent decisions*: Australian Health Law Bulletin 6 HLB April 1997 p 26

<sup>41</sup>Hirsch David, 1998, ‘*The Plaintiff’s perspective*’ at p 9 in Dental Negligence 1998 Medico-legal Seminar Papers, LAAMS, NSW

### Causation and Reasonable Foreseeability

For a dental practitioner to be found negligent, and damages to flow from the negligent act, there must be a causatory link between the negligent act and the damages. That is to say that the negligence must have caused the damage.

This test of causation in tort has been assessed by a number of means in common law.

#### ***“But For” or sine qua non***

The “but for” test of causation has been the most commonly used approach. The test is “would the plaintiff’s injuries have been suffered ***but for*** the defendant’s negligence?”

This test seems to be a very simple yes or no question. If the answer to the question is no, then there is *prima facie* causation. If the answer is yes, the plaintiff would have been injured anyway, then the negligence was not the cause.

The problem with this test ( as used in for example *Barnett v Chelsea and Kensington Hospital Management Committee* <sup>42</sup>) is that it is hypothetical, because the analysis of what would have happened can only be hypothetical.

Also, it has been observed ( Martin Davies<sup>43</sup> at 35) that the test is better at stating what is not a cause than what is the actual cause.

Recently the High Court made statements on the matter of causation in relation to tortious acts in *March v E.H. Stramere Pty Ltd* <sup>44</sup>

In *March v Stramare*, a truck was parked in the middle of a major road in Adelaide in the early hours of the morning. A drunk driver drove into the back of the truck and was injured. The question was whether the parking of the truck by the defendant was a cause of the injuries. The trial judge had found that it was

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<sup>42</sup>*Barnett v Chelsea and Kensington Hospital Management Committee* [1969] 1 QB 428

<sup>43</sup>Davies Martin ,1992 “*Torts - Australia*”, Butterworths, Australia p 35

<sup>44</sup>*March v E. & M.H.Stramare Pty Ltd* (1991) 171 CLR 506

one of the causes, but the appeal court felt that the drunkenness of the driver was sufficient to displace the liability of the parked truck driver.

Mason CJ stated at 22...

‘the "but for" test, applied as a negative criterion of causation, has an important role to play in the resolution of the question. ....The "but for" test gives rise to a well-known difficulty in cases where there are two or more acts or events which would each be sufficient to bring about the plaintiff's injury. The application of the test "gives the result, contrary to common sense, that neither is a cause" ....In truth, the application of the test proves to be either inadequate or troublesome in various situations in which there are multiple acts or events leading to the plaintiff's injury .....The cases demonstrate the lesson of experience, namely, that the test, applied as an exclusive criterion of causation, yields unacceptable results and that the results which it yields must be tempered by the making of value judgments and the infusion of policy considerations.’

The hypothetical question should be answered on the basis of balance of probabilities.<sup>45</sup>

### **Common Sense and Policy**

The simple *but for* test in tort has been amended in the High Court.

In *March v Stramare*, the court held that as a result of the apportionment legislation in the *Wrongs Act (1936) SA*, there was a freedom to decide causation afresh. The court held that as a result of the apportionment legislation, contributory negligence and last opportunity tests no longer were relevant - they were in effect abolished in South Australia

The court held that the question of causation is one of fact and should be decided by applying common sense to the facts of each case.

McHugh J stated in relation to modifications or qualifications of the but for test at 15.....

‘ Whatever label is given to such a rule - "common sense principles", "foreseeability", "novus actus interveniens", "effective cause", "real and efficient cause", "direct cause", "proximate cause" and so on - the reality is that such a limiting rule is the product of a policy choice that legal liability is not to attach to an act or omission which is outside the scope of that rule even though the act or omission was a necessary precondition of the occurrence of damage to the plaintiff. That is to say, such a rule is concerned only with the question whether a person should be held responsible for an act or omission which ex hypothesi was necessarily one of the sum of conditions or relations which produced the damage.

That a policy choice is involved in the use of some rules which limit liability for wrongful acts and omissions is obvious. Thus, the rule that a defendant is only legally liable for damage "of such a kind as the reasonable man should have foreseen" ....(The Wagon Mound) (1961) AC 388, at p 426) is clearly a rule of policy. ....In general, however, the "but for" test should be seen as the test of legal causation. Any other rule limiting responsibility for damage caused by a wrongful act or omission should be recognised as a policy-based rule concerned with remoteness of damage and not causation.’

Toohey J also stated at 2...

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<sup>45</sup>*Sellars v Adelaide Petroleum NL* (1994) 179 CLR 332

‘In particular, I share the Chief Justice's view that the "but for" or "causa sine qua non" test is not and should not be a definitive test of causation where negligence is alleged. The limitations of the test, particularly where there are two or more acts or events, each of which would be sufficient to bring about the plaintiff's injury, or where a defendant seeks to rely upon a "supervening cause" or "novus actus interveniens", are apparent.’

Deane J stated at 6 that

‘For the purposes of the law of negligence, the question of causation arises in the context of the attribution of fault or responsibility: whether the identified negligent act or omission of the defendant was so connected with the plaintiff's loss or injury that, as a matter of ordinary common sense and experience, it should be regarded as a cause of it’

So it would seem that the but for test is applied first as a legal test of causation, using a balance of probabilities. Then a common sense assessment of any apportionment should be made as well as policy considerations of reasonable foreseeability of damage.

### ***Subjective or Objective Tests of Causation***

In determining whether the failure to advise or warn is causally related to the damage, the courts have had to decide whether the matter could be judged by according to what that particular patient's response would have been had proper information been given ( the subjective test) or according to the response that a reasonable person in the patient's situation would have made (the ‘objective’ test)<sup>46</sup>

This has not been addressed in the High Court in or after *Rogers v Whittaker*, but *Ellis v Wallsend*<sup>47</sup> and *Gover v State of South Australia*<sup>48</sup> are authority for the proposition that the subjective test will be applied.

In *Gover v State of South Australia*, the defendant eye specialist performed two eye operations on the plaintiff's eyes at the same time - one was therapeutic and one was cosmetic. The plaintiff had not been warned of the risks involved in the treatment. Blindness was a possible complication of the cosmetic operation, but did not ensue. Turning in of the eyelids and lashes was a possible consequence of the therapeutic operation and this did result. The court used a subjective test of causation to hold that the actions failed on both counts. In the cosmetic eye operation, the defendant was not to know of the complication of blindness, so no duty arose because of foreseeability. In the therapeutic operation, causation was not established as the court found that the plaintiff would have had the operation as the correction of the unfortunate result was simple.

In *Ellis v Wallsend*<sup>49</sup>, a doctor operated on the plaintiff in the defendant hospital.. The cervical rhizotomy was a rare procedure performed for the relief of pain. The surgery rendered the plaintiff a quadriplegic.

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<sup>46</sup> Milstein Bob, 1997, *Australian Health Law Bulletin* Vol 6, #3, November 1997 at p 23

<sup>47</sup> *Ellis v Wallsend District Hospital* (1989) 17 NSWLR 553

<sup>48</sup> *Gover v State of South Australia*(1985) 39 SASR 543

The patient was held not to have received any warning in relation to paralysis. The patient believed the operation had only a 30% chance of success. The doctor had died and after settling with the doctors estate the plaintiff commenced proceedings against the hospital.

The test in relation to causation was a subjective one ( *Gover v State of South Australia* approved) and the court held that the patient had not proved that she would not have had the operation if a warning of the slight risk were given. The court held that even if the objective test were applicable, causation would still not be proven.

#### ***Causation after Rogers v Whittaker***

In *Chappel v Hart*<sup>50</sup> the issue of causation in relation to medical negligence was considered. The court held that a patient, who would admit that even if warned of the risk, would have had the operation anyway, may still be successful in establishing an entitlement to damages if they testify that they would have either - postponed the surgery so they could think about it a bit further; sought a second opinion; sought an opinion from a more experienced practitioner, or sought an opinion from the most experienced practitioner in the land.<sup>51</sup>

If this ratio is approved in the High Court<sup>52</sup> ( as the decision has been reserved since November 1997) the issue of causation in the sense of loss of a chance will revolutionize the way health care is practiced in this country.

#### ***Reasonable Foreseeability :Remoteness of Damage***

Once it has been established that the defendant was negligent and that the negligence caused the damage, the court asks the further question -: should the defendant be required to compensate the plaintiff for his or her damage or is the damage too remote a consequence of the defendant's negligence ?<sup>53</sup>

Mason J ( in *March v Stramare*) stated at 8....

"In *Chapman v Hearse* (1961) 106 CLR 112, the High Court stated that the term reasonably foreseeable is not a test of causation but that it marks the limits of responsibility"

In *Overseas Tankship (UK) Ltd v Mort's Dock and Engineering Co Ltd (The Wagon Mound (No 1))*<sup>54</sup> , the defendants were not liable because the loss of a wharf was not a reasonably foreseeable consequence

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49<sup>49</sup> *Ellis v Wallsend District Hospital* (1989)

50<sup>50</sup> *Chappel v Hart* (unreported NSW Supreme Court, No 404 38/94)

51<sup>51</sup> Milstein Bob 1997, ' *Informed consent* ': *The envelope expands (again)*; Australian Health Law Bulletin, April 1997 Vol 5 No. 7 p 67

52<sup>52</sup> *Chappel v Hart* [1997] HCA S88/1997

53<sup>53</sup> Davies Martin 1992 " *Torts - Australia* " Butterworths Australia p 51

54<sup>54</sup> *Overseas Tankship (UK) Ltd v Mort's Dock and Engineering Co Ltd (The Wagon Mound (No 1))* [1961] AC 388

of the defendant's negligence. Thus the modern test of remoteness of damage is reasonable foreseeability of damage.

In the *Wagon Mound (No 2)*<sup>55</sup> (where the evidence led was different to *Wagon Mound No 1*) the Privy Council held that the injury or damage (spilling oil onto the water which caught fire - destroying two ships) was foreseeable as a possible consequence of the defendant's negligence. If it is not 'far fetched or fanciful' then it is not too remote.

This has been confirmed in Australia by *Mt Isa Mines v Pusey*<sup>56</sup>, where schizophrenia was held to be not too remote a damage as a result of the defendant's negligence.

Windeyer stated in that case at 402.....

"Foreseeability does not mean foresight of the particular course of events causing the harm. Nor does it suppose foresight of the particular harm which occurred, but only some harm of a like kind. .... This comfortable latitudinal doctrine has, however, the obvious difficulty that it leaves the criterion for classification of kinds or types of harm undefined and at large."<sup>57</sup>

Thus a court has a wide discretion to decide the issue of foreseeability of damage .

The law of causation in the tort of negligence can be summarized as follows...

1. The but for test is applied using a balance of probabilities on a subjective test of causation
2. Where there are more than one possible cause - common sense is used to assess what proportion should be applied to each tort-feasor
3. Reasonable foreseeability tests are applied to limit the extent of liability.

Three dental negligence cases which have been before the courts after *Rogers v Whittaker* will be analysed with the legal principles discussed above - material risk, causation and where applicable - reasonable foreseeability.

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<sup>55</sup>*Overseas Tankship (UK) Ltd v Miller Steamship Pty Ltd* [1967] 1 AC 617

<sup>56</sup>*Mt Isa Mines v Pusey* (1971) 125 CLR 383

<sup>57</sup> in *Mt Isa Mines v Pusey* as quoted in Davies Martin 1992 "Torts - Australia", Butterworths, Australia at p 54

**DAVAR HRIBAR V KAREN LESLIE WELLS (1995) SASR 64 129**

In the Supreme Court of South Australia in 1995, the issue of failure to warn was considered for the first time in a dental negligence case by a Superior Court.

**Facts**

Davar Hribar was an oral surgeon who treated a patient, Karen Wells, as a result of a referral from an orthodontist. The reason for the referral was to correct a severe malocclusion and the resulting pain and dental problems which are not uncommon as a result of tooth grinding or parafunction.<sup>58</sup>

The treatment was provided by way of a bimaxillary osteotomy which is a fracture and repositioning of the two bony jaws, upper and lower, and fixation of these into a different position in relation to each other and to the rest of the orofacial complex. This was performed on the fifteenth of April 1989.

These procedures have become popular since the mid 1970's and are generally performed by either dentists with specialist qualifications, or dentists who have medical and dental specialist qualifications (Oral and Maxillofacial surgeons) and somewhat less frequently by Plastic Surgeons<sup>59</sup>.

**Relevant facts**

Ÿ There were a number of consultations with the defendant before the surgery, at which discussions were held on most visits to advise the patient as to the risks and benefits of the surgery. Pamphlets were issued to the patient regarding the doctor's usual practice.

Ÿ The surgery was performed on 15/4/89.

Ÿ There was a readmission to hospital soon after the surgery.

Ÿ Postoperative treatment was instigated by a number of specialists ( Oral and Maxillofacial surgeons and ENT surgeons) and a general medical practitioner.

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<sup>58</sup>Dr. Hribar was not medically qualified and was a dental surgeon although a specialist dental surgeon. This may be the first Supreme Court trial in relation to failure to warn since *Rogers and Whittaker* that the failure to warn duties have been applied specifically to a dental practitioner.

<sup>59</sup>Young Ian Dr MBBS BDS Sc MSc FDSRCS (Ire) Oral and Maxillofacial Surgeon Buderim Qld.- personal correspondence

Ÿ The pain from the infra orbital nerve was stopped by resection of the nerve, performed by a subsequent third surgeon. It was treated initially by a second surgeon temporarily by cryofreeze- this was followed by drainage of an abscess.

Ÿ The jaw pain in the lower right hand jaw and neck gradually disappeared as a result of removal of the fixation screws and general anaesthetic manipulation of the mandible by subsequent surgeons.

Ÿ The patient was treated for pethidine addiction ( prescribed by Mrs Wells GP - not Dr Hribar) and joined a methadone programme

Ÿ The patient has required care from her husband in her convalescence and has lost the opportunity to work as she had.

Ÿ The patient now has altered sensation, function and numbness in the lower lip and jaw on the right hand side, and numbness in the right infra orbital nerve.

Mrs Wells claimed negligence by Dr Hribar in the performance of the surgery, lack of postoperative care and a failure to warn. The injuries suffered appear to be as follows-

1. temporary and permanent paraesthesia to the face and mouth ( predominantly due to damage to the inferior dental nerve and lingual nerve on the right hand side).
2. pain in the right lower jaw, and neck which were not able to be controlled initially (apparently temporarily) due to either screws placed for mandibular fixation OR exacerbation of a pre-existing TMJ-myofacial pain.
3. altered sensation in the mouth and face as a result and concurrent with the above injuries.
4. Pain in the right eye area as a result of trauma to the infra orbital nerve. This was treated subsequently by cryofreeze and ultimately resection which resulted in permanent loss of sensation to this area below the right eye.

These injuries resulted in

1. prescription of medication ( pethidine by Mrs Wells' general medical practitioner) leading to methadone addiction.
2. inability to work as previously and lifestyle disruption because of pain, addiction and alteration of orofacial function.

### **Issues before the Court**

There was no question at the trial as to the standard of operative care provided by the defendant,- it came down to two matters- the first being a failure to advise the plaintiff of possible adverse effects of the procedure, and the second in relation to the inadequate post operative instructions. (Bollen J).

The issue of failure to warn ( or, what Bollen J unfortunately refers to as informed consent) was the principle issue on appeal to the Supreme Court and the area I will analyse here, as the court held that there was no case to answer in relation to inadequacy of post operative instructions.

The trial judge found that there was a failure to warn, and that the plaintiff would not have had the operation if she had been adequately advised of the likely risks and side effects of the procedure - thereby if accepted, causation had been established.

The expert witnesses generally agreed that the patient was already suffering from myofacial pain before the operation. As a result of this, the myofacial pain problems<sup>60</sup> in relation to the TMJ (Temporomandibular joint or complex) were held to be unrelated to the surgery, and, as there was no causation that flowed from the surgery and treatment, this could not be included in the damages claim.<sup>61</sup>

The operation would not according to all expert witnesses change the TMJPDS. The defendant planned to treat the TMJ problem after the surgery. The trial judge found that the pain in the TMJ ( myofacial or TMJ pain) was not due to negligence on the defendant's part. As a result, the only pain and other orofacial symptoms to be considered on the basis of damages are those related to what has been referred to nerve damage.

So to clarify the matter, the questions before the court were

1. Was the possibility of pain and paraesthesia (temporary and permanent) warned of ?
2. (If not) should it have been warned of ( i.e) was it a material risk ?
3. If it had been disclosed, would the patient have consented to the operation ?
4. (And if so) was the damage that flowed caused by the possible undisclosed risk ?
5. (And if so) was the damage reasonably foreseeable ?

### **1. Was the pain and (permanent) paraesthesia warned of ?**

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<sup>60</sup>TMJ ( Temporo-mandibular Joint) pain seems to originate from that joint and constitutes a syndrome called TMJPDS ( Pain dysfunction syndrome).

The trial judge examined at length the duties which the doctor must provide in order to allow the plaintiff to decide whether to undergo the procedure recommended ( in this case bimaxillary osteotomy in to correct a malocclusion).

The trial judge stated that it does not matter whether oral or written instructions regarding advice or risks are provided. He stated that the totality of the information must be adequate. That is to state plainly, that if the written instructions and advice is not complete, the additional information ought to be explained. The trial judge stated that a particular point ought to be made that the omitted information is important but was not covered in the pamphlet.

This amounts to common sense, but leaves some issues unresolved. If the pamphlet contains five points, and the patient has then been advised of all other information by a forty-five minute consultation, is this balance between written and oral information acceptable ? Some patients will read the information. Others will not. Some will hear what the surgeon says, others will not. Does giving a patient some written information alone suffice ? It would seem that the quality of the effectiveness of the communication needs to be assessed on a case by case basis.

In the present case, warnings were held to be given in relation to the common post operative sequelae - pain and numbness- but no warning was given in relation to permanent paraesthesia.

It appeared that the defendant gave an outdated pamphlet to the plaintiff - one which dealt with wire fixation after surgery ( which did not mention even temporary paraesthesia) as opposed to fixation by intra maxillary plates and screws ( rigid fixation)- which warned about temporary paraesthesia. Neither pamphlet contained a warning about permanent paraesthesia.

The defendant claimed to have warned about the risks of paraesthesia being permanent, but the plaintiff claims not to have been told of this possibility orally or in writing.

The trial judge held that at no time in the three months of contact ( February to April 1989) did the defendant explain in any reasonable sense the risk of permanent nerve damage.

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<sup>61</sup>The Court held that the surgery no doubt exacerbated the symptoms of TMJPDS but that this exacerbation would be temporary, and that there was no reliable basis for determining whether there was permanent damage.

**2. Should it have been warned of - i.e was it a material risk ?**

This was addressed by the trial judge in a confusing way. He questioned whether the risk was inherent in the procedure, as *Rogers v Whittaker* states the material risk must be inherent. Materiality of risk is a two limb test in relation to the patients perception.<sup>62</sup> The fact that the risk exists is beyond doubt. Its materiality relates to whether the patient would have attached significance to it. The trial judge misunderstood materiality of risk .I believe he was really discussing foreseeability of the risk which is not determinative of either causation or materiality. <sup>63,64</sup> However, when he decided that the patient would have attached significance to it, the materiality of the risk was confirmed. So this was a material risk and according to the High Court in *Rogers v Whittaker* it meets the test of the first limb of materiality.

**3. If the material risk had been disclosed, would the patient have consented to the operation ?**

The plaintiff had to be questioned a number of times before at trial she positively affirmed that she would not have had the surgery if the possibility of (permanent) numbness was explained. The court here seemed ready to accept that the plaintiff, although equivocal at times on this point, would not have had the surgery. The plaintiff was ready to accept apparently all other sequelae, but not permanent numbness.

This is a subjective finding and probably the most difficult area of this part of law. The courts understand that as Dr Hribar would be likely to substitute his current practice for that of the past by constructing his policy with today's eyes, the patients are very likely to assess the correctness of a decision with additional information from the considerable advantage of hindsight.

Cox J stated in *Battersby v Tottman*<sup>65</sup>, that there is a difference in authorities as to whether the test of causation was objective or subjective. The trial judge held that in either case, causation had been established. Bollen J followed this, but it is an area which was not decided with persuasive authority or judicial reasoning. It does little to create any certainty in this area of law.

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<sup>62</sup>*Rogers v Whittaker* (1992)

<sup>63</sup>Mason J ( in *March v Stramare*) stated at 8....“In *Chapman v Hearse* (1961) 106 CLR 112, the High Court stated that the term reasonably foreseeable is not a test of causation but that it marks the limits of responsibility”

<sup>64</sup>For example, that the patient may have been unable to play a trumpet for some months may be foreseeable and contribute to its materiality, but would the patient attach significance to it. If not, it is not a material risk, even if it is foreseeable.

<sup>65</sup>*Battersby v Tottman* (1985) 37 SASR 524 (FC)

**4. Was the damage that flowed caused by the undisclosed risk ?**

The trial judge held that “orthodontic treatment, the surgery itself, readmission into hospital, cryofreeze, admission for treatment of an abscess, investigation by the pain clinic, prescriptions for pethidine and the tricylates, removal of the screws, the resection, and finally the methadone programme” were all major relevant events during the period around the surgery and its aftermath. The major symptoms were “jaw pain following the surgery and during convalescence, pain alternating with numbness under the right eye, numbness in and around the mouth, and the effects and side effects of medication.”

Bollen J found that there was a link between the injury to the infra orbital nerve and the surgery which the plaintiff would not have had were it not for the failure to disclose - specifically numbness under the right eye, about which it was held there was no duty to warn .

The defendant’s counsel suggested that liability for the damage could only result from injuries about which there was a failure to warn. That is to say, the plaintiff cannot be compensated in this case for injuries which resulted from the surgery that did not arise from the failure to warn.

Bollen J then tries to make new law in this regard, after quoting with approval from Cox J in *Gover v State of South Australia*<sup>66</sup>, where Cox J expressly states that compensation extends only to those injuries which were not warned about, or which were material risks about which no warning was given, he goes on to say..

‘I think that, logically, if a patient has had an operation which he or she would not have had if not negligently advised then any adverse consequence of the operation must have been caused by the negligent advice and must sound in damages. Would he or she have suffered those consequences had he or she been fully warned about the risk of other consequences? No. Well, then, damages must cover both sets of "consequences". That I think to be the logical conclusion. Yet I can see that as a matter of policy that the law might seek to confine the assessment of damages in cases like this to the "products of failure to warn". The incremental approach to issues of proximity and causation nowadays always have regard (even if the regard comes to nothing in the end) to questions of policy.’<sup>67</sup>

This attempt to resort to a simple but for test of causation if approved would have important ramifications for health practitioners. In any case the other Judges expressly rejected the concept of compensation for

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<sup>66</sup>*Gover v State of South Australia* (1985) 39 SASR 543

<sup>67</sup>*Hribar v Wells* at 31

injuries which did not arise from a failure to warn. Duggan J stated that the but for test espoused here by Bollen J was inappropriate. King CJ also states that there were good reasons of fairness and policy that a strict but for test was not to be applied in instances of complex causation in regard to foreseeable injuries possibly flowing from a failure to warn.

The trial judge mentioned the orthodontic treatment as a major event but did not expressly state whether this was to be accounted for in terms of compensation as a result of the surgery. This is an important point, as orthodontic treatment of some description may have been necessary if the surgery was not done. No comment was made by the Supreme Court in this matter.

### **Was the damage reasonably foreseeable ?**

Bollen J discussed the element of reasonable foreseeability, in relation to both the methadone programme and then in general terms of the injuries suffered in toto after the surgery.

It was held that the damage to the nerves was reasonably foreseeable. Also it was held that the loss of amenities and inability to work were also reasonably foreseeable. The pethidine addiction and consequent methadone programme were also held to be reasonably foreseeable.

Bollen J discussed at length a minority judgement by Glass JA *Havenaar v Havenaar*<sup>68</sup> where pancreatitis as a result of alcoholism following some significant injuries was compensatable. Glass JA felt that this was a convergence of the eggshell skull principle and the test of reasonable foreseeability. He held in that case that that injury (pancreatitis) was compensatable.

Bollen J uses this judgment to justify the classification of the infra orbital numbness as being a type of injury which was caused ( in the 'but for' sense) by the surgery. It is far more appropriate to use it to justify the patient's need for a methadone programme and pethidine addiction damages.

In any event, all judges, on the point of quantum of damages, decided that it was fair and would not change the order.

The result was that Dr Hribar was held to have been negligent in his failure to warn in relation to paraesthesia. The failure to warn caused the injury as the patient would not have had the operation had she

been warned of the risk of injury. The question of what other treatment she may have had was not addressed, as to meet the test of reasonableness of disclosure a likely alternative should be expressed<sup>69</sup>, but this was not addressed in this judgement.

#### **MAZURKIEWICZ V SCOTT (1996) 16 SR (WA) 162**

In 1996, the District Court in Perth considered a dental negligence case in relation to failure to warn. The resultant paraesthesia(e) were a result of a simple and routine local anaesthetic. The plaintiff was a 46 year old taxi driver, the defendant was a general dentist, with some 16 years experience.

#### **Relevant Facts**

A patient had an anaesthetic for a lower tooth (3.6) which was painful. There had been two prior visits to the defendant for another lower tooth and the same tooth (3.6) and both times they were anaesthetised, and there had been no untoward symptoms. After the third visit the lower left tongue side of the gum was numb and has remained so ever since. The patient then consulted neurologists and then asserted negligence in both the procedure and a failure to warn about the risk of paraesthesia.

It appears that the fact that the tooth in question had been treated previously by Dr Scott with no adverse effects, may have helped establish the idea in the plaintiff's mind that something different had happened at the subsequent visit.

#### **The relevant facts in relation to the injury**

An inferior dental block (lower jaw anaesthetic) was administered by the defendant to the plaintiff. This was in the usual manner and there was no unusual effects except that there was an electric shock sensation at the time of anaesthetic injection. This was held later to be insignificant save that it can mean some temporary discomfort and possible temporary numbness.

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<sup>68</sup>*Havenaar v Havenaar* (1982) 1 NSWLR 626

<sup>69</sup>The existence of reasonably viable alternative methods of treatment must be an important factor in the determination of what reasonableness demands in the way of disclosure... per King CJ in *F v R*(1983) 33 SASR 189

The anterior two thirds of the left hand side of the plaintiff's tongue is numb, there is a aberrant sensation in the tongue when the left lower lip is touched. Taste is affected (diminished) on the left side. There is little likelihood of the return of normal sensation.

### **The Facts at issue**

1. Was the lingual numbness and loss of sensation and aberrant sensation a material risk ?
2. Was it ( the injury) reasonably foreseeable ?
3. Was the manner of the injection negligent ?
4. What factors are to be considered when deciding if the risk is material ?

### **The Expert Evidence in relation to injury**

There was significant disagreement among the experts on the nature of the nerve damage. The neurologists called as plaintiff witnesses felt there was some inferior dental nerve damage as well as lingual nerve damage. The oral and maxillofacial surgeons called as witnesses for the defence felt that the damage was consistent with lingual nerve damage only. The evidence of the oral and maxillofacial surgeons seemed to be preferred over that of the neurologists in relation to likelihood of damage and chances of a good prognosis.

The incidence of lingual nerve damage lasting more than one year was held to be in the order of 1:12,000.

### **The expert evidence in relation to normal practice regarding warnings**

Both expert witnesses in relation to the necessity to warn patients strongly stated that there was no need to warn as in some cases this would exacerbate the likelihood of damage as a worried patient may actually move more and so would be more likely to be injured.

The witnesses stated standard practice is that no warning should be given in these matters (and dental education does not suggest a warning should be given). The risk of injury is so slight that most general dental practitioners would be unaware of the risk of the injury themselves.

### **Was the anaesthetic necessary ?**

It was suggested by the defendant and also the expert witnesses that the procedure was sufficiently likely to produce pain, that it would have been practically impossible for the treatment requested by the patient to have been performed without adequate anaesthesia.

Even though the patient claims to have had a dental restorative procedure without anaesthetic some years ago in his native Poland, there was no useful evidence as to whether this was relevant to the present problem

### **What the Court Decided - Materiality of risk and remoteness / foreseeability**

The court held that despite the plaintiffs claims to the contrary, there is no need to give a warning, not merely in a body of professional opinion, but “with most relevant opinion.”

The court then discussed the law in *Rogers v Whittaker* in relation to a material risk. They also mentioned (as did the trial judge in *Hribar v Wells*), that King CJ’s statement as to relevant factors outlined in *F v R* were guidelines for weight to be given in these matters.

1. nature of the matter to be disclosed
2. nature of the proposed treatment
3. desire of the patient for information
4. temperament and health of the patient
5. general surrounding circumstances.

The court quoted with approval from *Tai v Saxon*<sup>70</sup> from the Western Australian Supreme Court in relation to the criteria for assessing materiality of risk outlined in *Rogers v Whittaker*.

1. magnitude of risk
2. nature of the potential harm
3. need for treatment ( including consideration of alternative measures)
4. physical and mental state of the patient.

The court went on to use examples ...

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<sup>70</sup>*Tai v Saxon* Sup Ct WA 1 Mar 1996 960113

”the possible remoteness of the risk has to be weighed against the potential gravity of the possible consequences. The more remote the risk, the less need to impart information concerning it.; on the other hand, the more serious the possible consequences, the greater the need to make an appropriate disclosure. The need or otherwise of the proposed procedure is highly relevant. One extreme could be to preserve the life of the patient. At the other extreme would be for example minor cosmetic surgery being considered for aesthetic reasons. The less critical the need for the procedure, the greater the need for advice as to the possible risks involved and as to possible different means of treating the problem. In addition the particular circumstances ( both physical and mental) of the patient concerned should be borne in mind.”<sup>71</sup>

This seems a most erudite statement of the factors to be used in relation to whether a risk is material or not.

The court in the present case went on to say that it accepted the defendant’s expert evidence that the lingual nerve was damaged; that the incidence of injury would ordinarily be in the order of 1/12000; that the treatment was necessary ; that a reasonable person in the plaintiff’s position if told of the risk would not have attached significance to it.

As Macknay J. stated “ a reasonable person would simply have regarded the information as being no more than confirmation ( if any be needed) that any human activity is attended by some slight degree of risk.” Another interpretation of this passage would suggest that the risk of the injury was so remote as to be unforeseeable and this greatly reduced its potential materiality

**Causation- whether the patient would have declined the injection if informed of the risk of paraesthesia.**

Macknay J stated that the decision as to causation was to be decided by a hypothetical question <sup>72</sup> In *Sellars v Adelaide Petroleum NL* <sup>73</sup>, it was stated by a majority of the court that a question of causation as to whether , as a result of the defendant’s act or omission, some event would have occurred will be determined by the balance of probabilities.

The fact that the patient says he would not have had the injection if told of the risk is not determinative of the issue is an important factor to be considered.<sup>74</sup> However, the fact that the patient had undergone

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<sup>71</sup><sup>71</sup>*Tai v Saxon* ( FUL23/1995)

<sup>72</sup><sup>72</sup>*Malec v J.C Hutton Pty Ltd* (1990) 169 CLR 638 at 642-3

<sup>73</sup><sup>73</sup>*Sellars v Adelaide Petroleum NL* (1994) 179 CLR 332 at 355

<sup>74</sup><sup>74</sup>*Ellis v Wallsend Hospital* (989) 187 NSWLR 533 at 560,581.

similar treatment does not raise a strong inference that he would have elected to have the treatment despite a warning.<sup>75</sup>

Macknay J was unpersuaded by the plaintiff's evidence, and felt that the hypothetical answer was coloured by his experience. On the balance of probabilities, it was more likely than not that there would have been no change in the patient's consent in relation to the injection if he had been informed of the risk.

### **Lack of care by the defendant**

The court held that there was no lack of care on the part of the defendant and he was not negligent in the manner of the injection.

### **Decision**

The plaintiff fails as there was not a material risk and the defendant was not negligent in either providing advice or treatment.<sup>76</sup> Causation was not established because the patient would have on the balance of probabilities had the anaesthetic in any case. (If causation had been established, the lack of foreseeability would have likely defeated the defendant's liability for damages as a result of the injury.)

### **ANDERSON V BOWDEN Unreported Sup Ct WA 970674 Appeal Ful 162 of 1996**

This was the most recent dental negligence case to go to a Superior Court in Australia.

This case involved a plaintiff who suffered left hand side lingual nerve damage and associated salivary gland effects, after removal of all (four) wisdom teeth under a general anaesthetic. This resulted in nerve damage only on the left hand side.

The defendant was a general dentist who performed the extractions with warnings about mandibular paraesthesia but did not warn of lingual paraesthesia.

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<sup>75</sup><sup>75</sup> *Hribar v Wells* (1995) SASR 64 129 at 140.

<sup>76</sup><sup>76</sup> In personal correspondence with the defendant, in the defendant's opinion, it appears that the case was only pursued because of poor advice by neurologists - there was no dentist who examined the patient for the plaintiff. The defendant was able to rebut the poor level of understanding of dental innervation displayed by the neurologists. If

The assertions of the plaintiff were essentially that the teeth were removed in such a manner to cause the damage, that there was a failure to warn in regard to the paraesthesia, and that the force used was undue.

**Relevant Facts (District Court)**

The plaintiff consulted the defendant for the first time because of a history of swelling and infection in relation to the lower wisdom teeth. At that visit, in discussion of the risks and procedure for surgery, a warning was given in relation to numbness of the lower lip due to an anticipated difficult extraction on the lower right. The lower left extraction was expected to be routine and non surgical. The plaintiff claimed the warning was given in an off hand and joking manner.

The teeth were removed with no special difficulty on the affected side, but the patient presented with some paraesthesia ( both lingual and inferior dental), split lips, a swollen tongue, and a very sore jaw.

Over three months the defendant was regularly consulted and gradually the inferior dental paraesthesia abated, but the lingual paraesthesia did not.

The plaintiff was referred by her general medical practitioner to see other specialists of whom none were able to help. Also, a consultant prosthodontist, Dr MacNamara was consulted and he gave evidence as to the potential damage to the TMJ complex and how that may have been caused by the surgery even though no claim was made in relation to this. His evidence was that the surgery must have involved a degree of undue force and roughness to cause the soreness and symptoms that the plaintiff suffered. His evidence was not preferred by the trial judge.

An Oral and Maxillofacial surgeon, Mr Booth examined the plaintiff. His evidence with another surgeon Mr Rosenberg was preferred by the court. He stated that the incidence of lingual paraesthesia occurred approximately in 1:200 cases. This statistic was in relation to surgical extractions of lower teeth, not in relation to non-surgical extraction of lower wisdom teeth. Mr Booth was of the opinion that the extraction which caused the damage was simple and that the paraesthesia was due to misadventure and not negligence. Mr Booth also stated that he would not warn of lingual paraesthesia in the case of a simple

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the plaintiff had sought out dental specialists and not medical ones, he may well have not pursued the matter. Even though the defendant was awarded costs, the plaintiff was declared bankrupt and there the matter ended.

non-surgical extraction. He also stated that the procedure outlined by the defendant would be that followed by him in the normal course of events for the procedure in similar circumstances.

A neurologist Dr Stell felt that there must have been a complete severance of the lingual nerve but declined to suggest how this might have happened. His evidence in relation to innervation of the face and jaw was rebutted by the defendant. His evidence was held to be largely equivocal and unhelpful.

The second Oral and Maxillofacial Surgeon Mr Rosenberg suggested that an accidental fracture of the bony lingual plate may have caused the severance of the lingual nerve. Mr Rosenberg stated that he warned of the risk of lingual paraesthesia before all lower wisdom tooth extractions. He discounted the evidence of Dr MacNamara the prosthodontist. He also stated that he would have performed the extraction in substantially the same way as the defendant.

### **The Issues before the Court**

1. Negligence which caused the injury
2. Failure to warn which caused the injury.

The trial Judge stated that the standard of care owed by a dentist is the same as that owed by a medical practitioner. He then listed the factors to be considered in providing information to patients by King CJ in *F v R*.<sup>77</sup> The elements of this are

• An ordinary careful and competent practitioner of the class to which the practitioner belongs

• Disclosure is matter of balancing the best interests of the patient and the right of the patient to control his own life and have the information to do so

• The practitioner should act reasonably in relation to treatment and disclosure of information in relation to risks and ineffectiveness of the procedure

and the decision as to what to disclose depends on

• nature of the matter to be disclosed

• nature of the treatment

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<sup>77</sup>*F v R* (1983) 33 SASR 189 at 190

- desire of the patient for information
- temperament and health of the patient
- general surrounding circumstances

Applying this law and the statement of law that “a duty of care is not a warranty of a perfect result” Mustill LJ in *Wilsher v Essex Area Health Authority*<sup>78</sup>, the trial judge held that there had been no negligence proven in performance of the surgery.

On the failure to give a warning, the issue of breach of duty was held to have been proven in that 1/200 chance of lingual paraesthesia was foreseeable and was a material risk.

### **Causation**

This left the matter of causation. When asked if she would have had the procedure if given a warning, the plaintiff stated “I guess so “. Using the balance of probabilities test for but for causation enunciated by the High Court in *Sellars v Adelaide Petroleum*<sup>79</sup>, the breach of duty was not causative of loss and as such the claim failed.

On appeal, the reasoning of the trial judge was substantially agreed with.

On appeal, the appellants raised the case of *Chappel v Hart*<sup>80</sup> as supporting their case in the sense of a loss of a chance case, and the likelihood that the injury may not have been sustained if there had been an opportunity to see a specialist maxillofacial surgeon.

The present case was held to have been easily distinguished on the basis that the procedure would have been carried out with exactly the same technique by a specialist on the evidence of the two maxillofacial surgeons. Thus it was held that there was no loss of a chance and as such, there was no causation. Causation in this matter of the case was discussed along the lines of common sense test of *March v E and MH Stramare*.<sup>81</sup>

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<sup>78</sup>*Wilsher v Essex Area Health Authority* (1987) 1 QB 730

<sup>79</sup>*Sellars v Adelaide Petroleum* (1994) 179 CLR 332

<sup>80</sup>*Chappel v Hart* (Unreported Supreme Court (CA) NSW No 40438/94 24 Dec 1996)

<sup>81</sup>*March v E and MH Stramare Pty Ltd* (1991) 171 CLR 506.

The respondents note of contention was to the effect that the trial judge was wrong to find a duty to warn on the basis that the 1/200 statistic related to surgical extractions and not simple non surgical wisdom tooth extractions. The judges on appeal rejected this note of contention because there was a statement by Mr Rosenberg that a warning was common practice as far as he was concerned. The fact that the respondent believed that there was no reason to warn was held to be a result of his subjective clinical knowledge, as distinct from the body of general professional knowledge.

If there was objectively a risk known to the profession, the respondent ought to have been aware of it and the need to warn of it.

It seems then that if a risk is less than 1:200, but is known of generally by the specialist members of the profession, then that knowledge is imputed to the ordinary careful dental practitioner.

This result of the case turned on causation - three words - 'guess so'. If the plaintiff was not able to say a qualified yes, to the question of whether she would have had the procedure done with the defendant had she been warned of the incidence of the injury, then the causation may have been found on a subjective basis and the defendant may have been held to be liable.

## **Conclusion**

The three dental cases discussed regarding failure to warn produce some important applications of the law of consent to medical treatment.

It appears unsurprisingly that the courts hold dentists to the same legal tests as medical practitioners in relation to a duty to disclose.

## **Materiality of Risk**

This area has been well explored by the judiciary in the case since *Rogers v Whittaker*.

A known risk inherent in a treatment is material and should be disclosed to a patient if it is a risk that a reasonable patient in the position of the patient would attach significance to, or the practitioner should know the patient would attach significance to it.

Materiality of risk can be judged by a number of factors which include

- nature of the risk to be disclosed and the nature of the potential harm
- nature of the proposed treatment
- desire of the patient for information
- temperament and health of the patient - physical and mental state of the patient.
- general surrounding circumstances ( emergent circumstances, duress etc.)
- magnitude of risk ( perhaps expressed in a percentage term)
- need for treatment ( including consideration of alternative measures)

### **Causation**

The test for causation is a common sense test after the *but for* test on the balance of probabilities- approved and applied by the courts. The courts reasoning with the resolution of the but for test - whether a patient would have elected to have the procedure if warned of the risk- has not always been simple or predictable.

The courts will not always agree with a patient who says with hindsight that they would not have had the procedure if they were warned. Many times the plaintiff, instead of answering the question whether they would have proceeded if warned, in fact answer it on the basis of whether they would if they **knew that they were to have suffered the injuries** that they in fact did.

In applying the subjective test of causation, the plaintiff's response to a but for question is never determinative, although a subjective test necessitates where possible an enquiry as to the plaintiff's beliefs. So if a patient says they would never have had the procedure if warned, it is not enough to prove causation. On a balance of probabilities, it is to be determined whether it is more likely than not that they would have elected to have the procedure.

To have only a subjective test of causation with a subjective and objective test of materiality would not seem logical . It would seem that there needs to be some judicial authority in this area, and perhaps this may come from the High Court in its decision in *Chappel v Hart*. A two limb test of causation (subjective and objective) would seem likely to produce a more predictable legal basis for decisions.

### **Foreseeability**

Reasonable foreseeability continues to play a role in determining the application of damages and is a policy formulation part of causation. It seems that currently (before *Chappel v Hart*) if a risk is not known of and is not foreseeable, then it cannot be compensatable by damages. This continues to be the case, so that in *Mazurkiewicz v Scott*, the lack of foreseeability was a key factor even though there was no causation established. In the other two dental cases, the risk was held to be foreseeable, not too remote and a material risk. The foreseeability and materiality of the risk combined to make the failure to warn negligent.

### **General Rules about Duty of Disclosure**

Some general principles in regards to duty of disclosure can be stated.

The more remote the risk the less likely it is that a dentist should need to disclose it

The more serious the consequences the greater the need to disclose.

The more elective the procedure the more likely that a risk should be disclosed.

If a procedure is necessary and has no alternative treatment, the need for a warning as to a risk decreases. That risk will be less material because of the lack of a real choice. However, there is always the option of doing nothing - particularly in dentistry which is seldom involves a life saving procedure.

Just because a patient has always consented to medical procedures on previous occasions does not mean that it should be assumed that the plaintiff will proceed with a procedure if an adequate warning is given. The material risk should be disclosed.

A percentage or range of risk should be used instead of just a subjective term, such a low risk, or little chance.

A material risk includes temporary and permanent paraesthesia, and pain. Exacerbation of existing conditions may also be material.

The *Bolam* test is no longer relevant to advice in relation to risks and side effects of treatment

A dental practitioner presently ( until *Chappel v Hart*) cannot be expected to warn of a risk of which there is either no general knowledge by the profession as a whole or that the incidence is comparatively minuscule.

**These clinical precautions might be further noted to dentists**

An injury with a permanent nature such as a paraesthesia will always be material if it is foreseeable.

Percentage risk is not the solely determinative factor as to materiality of risk.

Notes of warnings should be issued and documented with a staff member present.

When removing lower wisdom teeth, warnings of temporary and permanent paresthesia of lip and tongue and possible taste and salivary gland effects should be given routinely.

Material risks should be communicated to patients in a combination of written and spoken word. The communications should not be contrary - they should be complementary or reinforce each other.

Pamphlets should be updated and accord with the practitioner's current practice and what is verbally communicated to the patient.

Where oral instructions are given, they should be read from a dated form, a copy of which should be dated and retained so that practitioners have an accurate record of what warnings were given and when they made changes to these practices and warnings.

A poor result from surgery can lead to psychological problems and subsequent treatment leading to damages, for which the surgeon may be liable in the absence of a warning.

In a procedure of a singular nature such as a local anaesthetic, there is less uncertainty about risks and injuries compared with a multidisciplinary treatment of something like endodontic and restorative treatment of a tooth.

There is no duty to warn of a possible paraesthesia as a result of a routine dental local anaesthetic injection. If however a patient asks about the risk, a percentage of 1/12,000 should be warned of for lower inferior dental blocks with enduring lingual paraesthesia.

*The three cases examined have helped clarify what a material risk is in dentistry. The fact that all three cases relate to the permanent injury of paraesthesia perhaps signifies that this permanent injury is of particular materiality. Others might include resorption of teeth roots through orthodontics, paraesthesia from endodontics, and any permanent injury, the risk of which is inherent in the procedure.*

*These and other cases after Rogers v Whittaker have shown that the courts use a predictable way of assessing materiality, although causation still has to be clarified judicially to the same extent as materiality of risk.*

## Table of cases

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