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Judgment: approved by the Court for handing down | *Delivered:* **10/01/11**
*(subject to editorial corrections)**

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

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QUEEN'S BENCH DIVISION

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BETWEEN:

LOUISE MURPHY

Plaintiff;

-and-

PETER JOHN KING

Defendant.

———

GILLEN J

Cause of Action

[1] In this matter the plaintiff claims damages for alleged negligence and breach of contract on the part of the defendant during the course of dental treatment which she received from him on 9 March 2005. It was clear from the running of the case that the issue of contract added no material element to the claim in tort .

Background

[2] The plaintiff is a woman who is now 42 years of age and is a housewife with three adult children. She was a patient of Alexander and Howell Associates a dental practice located in Ballymoney where the defendant was employed as a dentist.

[3] It was her case that on 9 March 2005 she attended for what she thought was routine dental treatment. She was accompanied by her partner Kevin Donnell.

[4] She contended that the defendant informed her that she had two choices that day namely either to treat gum disease which she had or to have

extraction of the upper right eight (UR8) wisdom tooth . It is common case that the UR8 was a very decayed tooth. The plaintiff claimed that she had been unaware that she required an extraction before attending that day. It was the plaintiff's contention that she was not given any warning about any problems or risks prior to the extraction and that the defendant had told her that the extraction would not take any longer than 10 minutes . Some gel was applied to her gum and then she was given an injection. There was an issue in the case as to whether at that stage she was asked to wait in the waiting room or remained in the surgery. Nothing turns on that matter in my view.

[5] The plaintiff went on to relate in evidence that the dentist spent nearly an hour working at her tooth. During that time he left her twice, once returning with another instrument which seemed to break whereupon he threw it into the bin. She then heard a crunch after about an hour. During the time he had been working at her she described him "running in and out and near the end, by the look on his face, he was panicking and then there was a crunch when the tooth came out and I saw skin on it". It was the plaintiff's case that she then took a panic attack. Her recollection was that her partner was brought into the surgery and Mr King showed him an x-ray and told him that the tooth was fused to the bone.

[6] She was also spoken to by Colin Howell ,a dentist in the practice , who put his hand on her hand, told her not to worry and said she was going to a specialist for a few stitches. He had arranged for her to go to Rosconnor Clinic for treatment which was about 10 minutes away. She was driven there by a receptionist and taken home after treatment.

[7] The plaintiff claimed that she was in Rosconnor for about an hour where she was given further sedation and treatment.

[8] I note that it was the evidence of the plaintiff and her partner Mr Donnell that the defendant had been dressed in jeans and a checked shirt. Again there was little that turned on this but having heard the defendant stoutly reject this in evidence my own view was that it was unlikely that the defendant would have been so attired whilst carrying out professional duties.

[9] The dental notes dealing with the relevant period recorded as follows:

> "2.2.05 – Patient complaining of nil. Discussed UR8. Advise not in occlusion therefore extraction. Patient happy. Topical 2 ml Articaine UR3. Access filed to 35F at 18 mm hypo-irrigation …
>
> 11.2.05 – Refix UR3 fuji.

> 9.3.5 – Topical 2 ml Articaine. Elevated UR8 tuberosity fracture with UR8. Patient informed explained shown on radiograph. Apologised. Refer Rosconnor Dental Clinic at 11.00 am. Appointed 12 noon.
>
> 9.3.5 – Escorted patients to Clinic and returned to take home at 1.30 pm. Collected script on way. Patient fine.
>
> 10.3.05 – Follow up call. Patient not home. Called back. Swollen and very sore throat. Patient had also been advised this by Alison McCall as she had been contacted last night."

[10] The dental records from Rosconnor Dental Clinic for 9 March 2005 contained the following notes:

> "Extraction U8 by GAP entire tuberosity attached to tooth distally …"

[11] In short therefore, during the course of the extraction the maxillary tuberosity had fractured and had come away with the tooth at the time of the extraction.

[12] OPG radiograph after the extraction of the UR8 tooth showed several features. First, the crown of the tooth was heavily broken down and was therefore likely to fracture on extraction. Secondly, it had long roots which appeared to be virtually fused to the bone and were in close proximity to the distal aspect of the maxillary sinus.

[13] I pause to note at this stage two matters that I accepted by way of background information found in literature placed before me. First , in the article "Surgical Emergencies in the Dental Office" by Hardman that "a more common happening is the fracture of a maxillary tuberosity. This usually occurs when a molar tooth has been unopposed by a tooth in the mandible for a long time allowing the bone structure of the tuberosity to become weakened. When force is applied to the tooth a large segment of bone, often including the floor of the maxillary antrum, may be fractured. If the tooth is unopposed and takes no part in mastication it can be left in situ and a second attempt made to remove the tooth some months later when the bone has healed." It was common case in the instant case that UR8 was an unopposed tooth thus rendering the bone potentially weaker

[14] Secondly the contents found in "Fractures of the Maxillary Tuberosity occurring during Tooth Extract" by Cohen where it records:

> "Occasionally during the course of extraction of the maxillary second or third molar the maxillary tuberosity may be fractured and can be felt to be moving with the forceps. The operator is then confronted with the problem of whether or not to proceed with the extraction. If he does proceed, he must be prepared to dissect out the fractured tuberosity; in so doing, he is faced with a large oroantral communication. The predisposing causes of a fractured maxillary tuberosity are a large maxillary sinus with thin walls and tooth with large divergent roots or an abnormal number of roots."

Experts

[15] Two experts were called on behalf of the plaintiff. Dr Anthony Halperin who has been a practising dental surgeon with some 30 years experience in all forms of general and surgical dentistry. He has

- held the position of consultant to the Guardian Health Group,
- written the private dental scheme for Guardian Health and acted as consultant for the Claims Department in analysing insurance claims and dealing with dental claims
- served on the panel of the Action of Victims of Medical Accidents
- written a number of articles on general dental matters over the years for the British Dental Journal amongst others.

[16] Secondly Mr Michael Hodge is a consultant oral and maxillofacial surgeon at Stoke Mandeville Hospital, Aylesbury.

[17] Two experts were called on behalf of the defendant. Dr Marley is a consultant of ten years experience in Oral surgery and is a consultant and senior lecturer in oral surgery employed by the Belfast Hospitals Trust and Queen's University of Belfast. He is the Training Programme Director for Oral Surgery in the province having oversight of higher specialist training in this discipline.

[18] I also heard from Ms H J Firestone, an expert witness in the field of general dental practice who is a part-time clinical teaching fellow at Manchester Dental Hospital and a part-time general dental practitioner with a mixed NHS/private practice in Cheshire.

[19] As is now customary in clinical negligence cases, there was a meeting convened on 17 June 2010 of the medical experts (with the exception of Ms Firestone) by way of conference telephone. The experts drew up a schedule of issues and agreed conclusions as follows:

"1. Is it agreed that the initial attempt to extract a tooth using subluxators and forceps was reasonable?

JM (Mr Marley) and MH (Mr Hodge) agree with the statement. AH (Dr Halperin) agrees with the proviso that there is only the defendant's evidence to say subluxators were used (*I pause to observe that I was satisfied that subluxators were used by the Mr King*).

2. How long was it reasonable to continue working on the tooth with forceps before attempting an alternative approach?

JM and MH agree that a reasonable time would be approximately 20 minutes. AH maintains approximately 3-5 minutes with subluxator and 10 minutes with forceps.

3. Had a surgical approach been undertaken initially by Mr King, would on the balance of probabilities the fracture tuberosity still have occurred?

MH and JM agree that, whilst possible, it is unlikely that a fractured tuberosity would have occurred with a surgical approach. AH notes that he has never had a fractured tuberosity when using a surgical approach.

4. What bearing, if any, did the length of time spent on the extraction by forceps have on the propensity of the tuberosity to fracture?

MH and JM agree that a fracture of tuberosity is more likely to occur in the early part of a forceps extraction based on the physiological and mechanical responses of the tissues and the operator. AH believes more likely to occur if the forceps are applied for a long period of time because of operator fatigue and subsequent loss of tactile feedback i.e. the operator then misjudges the amount of force being applied to the tooth."

Issues in the case

[20] It soon became clear that there were three fundamental issues in this case:

(i) Was the plaintiff appropriately warned about the dangers and risks of this extraction?

(ii) Was excessive force used by the defendant leading to the fracture of tuberosity?

(iii) Ought the defendant to have realised that the tooth was fused to the bone and to have referred the plaintiff to surgical treatment?

Legal principles

[21] The general principles of law applicable in clinical negligence cases including that of dental negligence are rarely in dispute in modern cases. The test is still that set out by McNair J in Bolam v Friern Hospital Management Committee (1957) 1 WLR 582 at 586. This is so well known that it does not require detailed recitation by me. To the defendant in this case is to be applied the standard of dentistry that a dentist acting with ordinary skill and care or a responsible body of dental opinion would have followed. Such dentists must act in accordance with the practice accepted at the relevant time as proffered by a responsible body of dental opinion. The standard of care must reflect clinical practice which stands up to analysis and is not unreasonable.

[22] Given the division of expert opinion in this case, it is appropriate to draw attention to the views expressed by Lord Scarman in Maynard v West Midlands Regional Health Authority (1984) 1 WLR 634 where he said:

> "It is not enough to show that there is a body of competent professional opinion which considers that there was the wrong decision, if there also exists a body of professional opinion, equally competent, which supports the decision as reasonable in the circumstances … differences of opinion in practice exist, and will always exist in the medical as in the other professions. There is seldom any one answer exclusive of all others to problems of professional judgment. A court may prefer one body of judgment to the other but that is no basis for a conclusion of negligence."

[23] That reflects the views expressed in Hunter v Hanley (1955) SC200 where Lord President Clyde dealt with the question of different professional practices in these terms:

> "In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion and one man clearly is not negligent because his conclusion differs from that of other professional men, nor because he has displayed less skill or knowledge than others would have done. The true test for establishing negligence and diagnosis or treatment on the part of the doctor is whether he has proved to be guilty of such failure as no doctor of ordinary skill would be guilty if acting with ordinary care."

[24] I must also be conscious of the cautionary words of Lord Brown-Wilkinson in Bolitho v City and Hackney H.A. (1998) AC 232 at p. 240:

> "… The court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of the opinion that the defendant's treatment or diagnosis accorded with sound medical practice … The court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion had a logical basis. In particular in cases involving … the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts had directed their mind to the question of comparative risks and benefits and have demonstrated a defensible conclusion on the matter."

[25] However as Lord Scarman made clear in Maynard's case, it would be wrong to allow assessment of medical (or dental) risks and benefits as a matter of clinical judgment to deteriorate into seeking to persuade the judge to prefer one of two views both of which are capable of being logically supported. It is only where a judge can be satisfied that the body of expert opinion cannot be logically supported at all that such opinion will not provide the benchmark by reference to which the defendant's conduct falls to be assessed.

[26] There is a duty in the law of negligence to warn and counsel the patient on the inherent risks of treatment and of possible alternatives that may be available .To this duty however the Bolam test applies with its protection for the dentist who acts in accordance with an accepted body of opinion. Thus in Sidaway v Bethlem Royal Hospital [1985] A.C. 871 the House of Lords held that as the defendant surgeon had acted in conformity with a reasonable body of opinion in electing not to warn a patient of a remote risk of partial paralysis ,he was not guilty of clinical negligence.

[27] A patient ,alleging injury by way of the materialisation of a risk of which he was not and should have been warned, must prove that the injury results form that breach of duty. He must prove that ,had he been warned of the risk, he would not have consented to the treatment. See White v Turner (1981)120 D.L.R.269.

The plaintiff's case

[28] Essentially the plaintiff's case rested on the evidence of Dr Halperin. Although the plaintiff also called Mr Michael Hodge, the maxillo facial expert, if anything his evidence in the main supported that of the defendant. His oral evidence greatly diluted the effect of his written report. In particular Mr Hodge expressly disagreed with Dr Halperin when he conceded that the fracture of the tuberosity did not of itself suggest excessive force being used because the tooth was unopposed and thus the bone would be weaker and not as strong as the rest of the jaw bone. Dr Halperin made the case that not only had the defendant failed to adequately warn the plaintiff and give her the necessary choice of treatment, but, on the basis of her evidence of a lengthy forceps extraction, the tooth should not have been extracted with forceps unless it could have been performed within 10 minutes. Either a surgical approach should have been invoked or the patient referred to a specialist unit. He considered that the very fact of the tuberosity being fractured was in itself evidence of excessive force being used. Dr Halperin contended that once the defendant discovered that the tooth was fused – which he should have been aware of tolerably swiftly in view of the fact he did not consider that a fused tooth would move significantly at all – he should have opted for a surgical approach.

[29] Dr Halperin relied on an article headed "Prevention and Management of Surgical Complications" by Larry J Peterson Chapter 11 at page 259 which recorded:

> "The extraction of a tooth requires that the surrounding alveolar bone be expanded to allow an unimpeded pathway for tooth removal. However, in some situations the bone fractures and is removed with the tooth instead of expanding. The most likely

> cause of fracture of the alveolar process is the use of excessive force with a forceps, which fractures large portions of cortical plate. If the surgeon realises that excessive force is necessary to remove a tooth, a soft tissue flap should be elevated and controlled amounts of bone removed so that the tooth can be delivered easily. … During a forceps extraction, if the appropriate amount of tooth mobilization does not occur early, then the wise and prudent dentist will alter the treatment plan to the surgical technique instead of pursuing the closed method."

The defendant's case

[30] The defendant's case, apart from the evidence of the defendant himself, rested largely on the evidence of Dr Marley, Ms Firestone and to some extent Mr Hodge who had been called by the plaintiff.

[31] The defendant's case essentially was that the plaintiff had been appropriately warned and advised and there was no evidence that the defendant had applied excessive force during the extraction especially since it was common case that the fragile state of the crown did not fracture during the extraction process.

[32] It was the defendant's contention that there was not complete fusion and in the presence of brittle bone in this area it is simply one of the risks of dental surgery that this fracture can happen even in the presence of proper and adequate care by the dentist.

Conclusions

[33] I am satisfied that the defendant properly used a subluxator and forceps during the course of this extraction. A subluxator is a sharp edged elevator which is used along the ligament of the tooth. Sometimes the use of the subluxator can be enough to remove the tooth. If it does not, the next step is the use of the forceps. I am satisfied that this was therefore the standard practice for extraction.

[34] Whilst it is common case that the tooth was fused to the bone to some extent, this is not an unusual event in that it can be caused by local factors such as the shape of a number of the roots. However I believe there is merit in the point made by Mr Marley and Ms Firestone that this tooth was not completely fused. It was fused "laterally" as recorded in the Rosconnor note. Mr Marley is a maxillo facial consultant and I believe his expertise and experience renders his account of the nature of the maxillary tuberosity more telling than that of Dr Halperin. In Mr Marley's view this is a brittle piece of

bone and, particularly since it was not fully fused, would allow movement as allegedly experienced by the defendant during the extraction period. I therefore find somewhat suspect the assertion by Dr Halperin that there would be little or no movement during the extraction. His assertion was not shared by any of the other experts in the case. It seems to me that apart from the expertise of the defendant witnesses, common sense dictates, as Ms Firestone asserted, that the degree of movement will depend on the degree of fusion. I therefore do not accept the contention that the defendant ought to have known in fairly short time that the tooth was fused and that a fracture of the tuberosity was going to happen if he pressed on.

[35] I have come to the conclusion that I am not satisfied on the balance of probabilities that excessive force was used in this instance. I found merit in the point made by Mr Marley and Ms Firestone that given the fragile state of the decayed crown before the extraction started, it is significant and an indication of good extraction technique that it did not break during the extraction process. If, as alleged, excessive force had been used, that is precisely what one would have expected to have occurred.

[36] Given the expertise of Mr Marley, Ms Firestone and Mr Hodge, I am inclined to the view that there is a responsible body of dental opinion which would not concur with the view of Mr Halperin that fracture of the tuberosity by itself suggested excessive force. Having heard the evidence of Mr Marley, Ms Firestone and Mr Hodge, I am satisfied that fracture of the tuberosity is one of the risks of dental surgery and can happen without negligence or excessive force. It is clear that there is no way the defendant could have been aware of this fusion by radiograph or otherwise before commencing the extraction The Peterson article relied on by Mr Bentley is thus correct that excessive force *can* lead to fractures but that is not to say that the latter is necessarily caused by the former. In short I accept the evidence that in this case the local and regional anatomy is such that the bone fractured without blame on the part of the dentist.

[37] The timings in this case were crucial. I am satisfied that Mr Hodge and Mr Marley reflect a responsible body of dental opinion that a reasonable time working with forceps before attempting an alternative approach would be approximately 20 minutes. Ms Firestone shared their opinion. I find no reason to disbelieve the defendant's assertion that he spent 5-6 minutes with the elevator and 10 minutes with the forceps. I also accept that it is perfectly feasible for him to assert that he was getting some movement notwithstanding the fusion of the tooth to the bone. I consider that the evidence of Mr Marley, Mr Hodge and Ms Firestone is entirely consistent with this proposition.

[38] I found the plaintiff's evidence unreliable in this regard. The passage of time is rarely kind to memory especially where traumatic events may have

already distorted recollection. Clearly Mrs Murphy went through a very nasty experience and the sequence of events may have appeared to take much longer in the event than actually they did because of the stress of the situation.

[39] It seemed to me extremely unlikely that a dentist as experienced as this defendant would have taken the best part of an hour to engage in an extraction especially if he was working with a grossly decayed crown which in the event did not even fracture. How likely is it that it would have withstood excessive force for so long?

[40] Mr Bentley asserted that in cross-examination of the plaintiff Mr Stitt QC, who appeared on behalf of the defendant with Mr Park, had suggested to the plaintiff that the maximum time for the whole operation was between 25 and 30 minutes including the time after the fracture and that he subsequently changed his evidence by producing a document (Exhibit D3) showing that from the moment he had started to discuss the issue with her until she was taken to Rosconnor took 54/69 minutes. I do not think that this was a point of any great moment because the context of Mr Stitt's questions seem to me to be ambiguous given that the figure of 25/30 minutes to which he was referring dealt with the extraction process from the moment she was in chair to the breaking of the bone and excluded the later parts of the procedure including the extraction of the tooth and bone, the treatment etc.

[41] I pause to observe at this that I did not find the plaintiff in the course of her evidence to be a reliable historian. A number of flaws emerged in her evidence. Some examples will suffice. First, she denied discussing with the defendant the possibility of extraction on 2 February 2005. I found no basis to question the note that the defendant had expressly made on that occasion referring to the issue of extraction and that the "patient [was] happy". Why would the defendant have made such a note at that time long before the impugned extraction if it did not happen? I found it curious that the plaintiff said that if she had been told about the extraction on this occasion it did not register with her given that she was someone who was very nervous about visiting a dentist. I would have thought that extraction was something that would have stuck in her mind. I therefore do not believe her contention that the first time she learned of the extraction was on the visit of 9 March 2005 when it actually happened. In this context I also found her evidence highly unsatisfactory in so far as she failed to disclose to Dr Mangan, her psychiatrist for the purposes of a medico legal report for this action, that she had a past history of use of tranquilisers when she cannot have failed to be aware of the importance of giving him an accurate past history.

[42] Similarly I find it highly unlikely that both she and her partner Mr Donnell who gave evidence were correct in asserting that the defendant pointed out on the radiograph that the tooth was fused to the bone. The fact

of the matter is that it is common case amongst all the experts that the radiograph will not show this. Why would the defendant have made this up and pointed to a bogus reference on the radiograph? I think his account is much more likely to be true namely that the purpose of the radiograph was simply to illustrate the presence of the bone and the tooth and that the plaintiff and her witness have embellished, perhaps unwittingly, the account of what was said.

[43] I also find it very unlikely that the defendant threw a broken instrument into a bin. When he gave evidence he struck me as a measured man not given to histrionics. I thought it much more likely that he was correct in saying that if any instrument did break down it was the rotating mechanism of the luxator which he would have placed in a sharp bin.

[44] The plaintiff made two other points which I felt were without merit. First it was contended on her behalf that the notes of 9 March 2005 by the defendant referred to the defendant apologising and that this constituted an admission of liability. I do not agree. I believe the evidence of the defendant that this was simply an acknowledgment by him that the plaintiff had had an unfortunate experience and as a matter of good practice and courtesy he had indicated that he was sorry that it had happened.

[45] It was further the plaintiff's case that it was very unusual for a practice such as the defendant's to have arranged for her to be taken to Rosconnor Clinic and then to have been taken home. Again I do not agree that this amounts to anything remotely touching upon an admission of blame. I consider it was yet another example of good practice on the part of the defendant to look after a patient who had gone through an unfortunate experience.

[46] I observe at this stage however that I was more inclined to accept the evidence of Ms Firestone and that of Dr Halperin than that of Mr Marley on the question of the defendant's notes. Mr Marley indicated that they were consistent with the note-taking of his peers. If this is the case then I am disappointed that that should be the position and I hope that in future more appropriate details should be inserted. I consider that the notes of Dr King should have been more detailed as a matter of good practice. To say the least they were sparse and devoid of the kind of detail that I would have hoped would have been entered when an incident of this kind occurred. However I do not believe that this is any indication of negligence or culpability in the course of the extraction. Rather I suspect it reflects a too casual approach to note-taking in a busy practice.

[47] The plaintiff has not satisfied me that she was given an inadequate warning. It was the evidence of Dr Halperin that the plaintiff should have been warned that she might need a surgical approach including reference to a

hospital unit or to a specialist unit with an oral surgeon and secondly that the closeness of the tooth to the maxillary sinus increased the chance of an oral antral fistula which should have been indicated to her.

[48] I accept the evidence of the defendant's experts that a responsible body of dental opinion would have taken the same view as that of the defendant that it was not necessary to warn her of the very rare complication of a fracture of the tuberosity. I also consider that it was appropriate that the defendant should have followed his usual practice of simply warning her that the tooth could break and he might have to split the gum to extract the tooth. Whilst the defendant could not specifically recall having done this – and there was no note to this effect – nonetheless I think this dentist was sufficiently experienced to have made it likely that he did warn her to do this. The frailties in the plaintiff's evidence as an historian created difficulties for me accepting her version in the first instance. In any event, even if the defendant had failed to do this I do not believe that a warning of this kind of a rare complication would have deflected this plaintiff from having had this extraction carried out. This plaintiff has had several teeth out in the past. Whilst she obviously was anxious about the extraction process, given her past history of teeth extraction I find no reason to believe that such a warning would have prevented her carrying on in the circumstances. I observe at this stage that although Dr Halperin indicated that consent to the treatment should have been in writing, this was not advanced by him in the course of his written evidence and it certainly was not pleaded as an allegation of negligence in the statement of claim. I prefer the view of the defendant's experts that this is not accepted practice. I therefore do not consider that this constituted negligence in this action.

[49] I am satisfied that the defendant in this case was a sufficiently experienced dentist for whom this extraction should have been well within his competence. In coming to this conclusion I share the view expressed by Mr Marley and Ms Firestone that a student under supervision could have performed this extraction.

[50] Dr King gave unchallenged evidence that he had experience working in a group of dental practices in Bradford and Clackheaton from 1998 to 1999, and from 1999 until 2007 he had worked as an associate in the firm of Alexander and Howell. I accept his evidence that he had considerable experience of extracting upper and lower molar teeth having extracted between 720 and 1080 upper and lower molar teeth before treating the plaintiff in March 2005. Hence I consider that he was well qualified to have changed the treatment plan of the plaintiff from that suggested by an earlier dentist on 15 November 2004. The latter had suggested root canal treatment of this tooth rather than extraction. However, as even Dr Halperin conceded, this tooth was functionless as it was unopposed in occlusion and therefore it could not be regarded as inappropriate to have advised extraction. The

crown itself was carious to the extent that only half was left. Ms Firestone indicated that on these facts she would have extracted the tooth rather than invest the time and strain on the plaintiff of root canal treatment. In short it was reasonable to change the plan.

[51] I have come to the conclusion that the experts called on behalf of the defendant have expressed opinions that have a logical basis and which have been the product of directing their minds to the question of comparative risk and benefit of the treatment in question. I am satisfied therefore that the defendant in this case had acted with the ordinary skill and care of a dentist and in the manner consistent with a responsible body of dental opinion. Accordingly I dismiss the plaintiff's case.