The Australian Litigation Landscape - Oral and Maxillofacial Surgery and General Dentistry (Oral Surgery procedures): An Analysis of Litigation Cases

Running title: Evidence Based Consent for Third Molar Tooth Extractions

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Keywords: law, negligence, oral surgery, oral and maxillofacial surgery
Abstract

Background: There are persistent concerns about litigation in the dental and medical professions. These concerns arise in a setting where general dentists are more frequently undertaking a wider range of oral surgery procedures, potentially increasing legal risk.

Methods: Judicial cases dealing with medical negligence in the fields of general dentistry (oral surgery procedure) and Oral and Maxillofacial Surgery were located using the three main legal databases. Relevant cases were analysed to determine the procedures involved, the patients’ claims of injury, findings of negligence, and damages awarded. A thematic analysis of the cases was undertaken to determine trends.

Results: Fifteen cases over a twenty-year period were located across almost all Australian jurisdictions (eight cases involved general dentists; seven cases involved Oral and Maxillofacial Surgeons). Eleven of the fifteen cases involved determinations of whether or not the practitioner had failed in their duty of care; negligence was found in six cases. Eleven of the fifteen cases related to molar extractions (eight specifically to third molar).

Conclusions: Dental and medical practitioners wanting to manage legal risk should have regard to circumstances arising in judicial cases. Adequate warning of risks is critical, as is offering referral in appropriate cases. Pre-operative radiographs, good medical records, and processes to ensure appropriate follow-up are also important.

Keywords: law, negligence, oral surgery, oral and maxillofacial surgery

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Introduction

General dentists in Australia are carrying out an increasing number of oral surgery procedures, particularly third molar tooth extractions and placement of dental implants. It is likely that this trend is due, in part, to current market forces, with an increased supply of general dentists in Australia in recent years and saturation of the market, particularly in city areas.\(^1\) In the current climate, general dentists may be more willing to take on complex procedures with which they have less experience.

Building on a growing body of work examining the law and dental practice,\(^2,3\) this paper is the first to map litigation patterns in a key area of legal risk: Oral and Maxillofacial Surgery (OMS) and general dentistry (oral surgery procedures). By locating and analysing all publicly available Australian medical negligence cases in this field, we identify those issues which have prompted litigation or been found to be problematic by the courts. We draw on this analysis (in the context of broader medicolegal principles) and pertinent information from the dental literature to outline recommendations for OMSs and dentists who are practising in this area to better manage legal risk.

Methods

A search for cases was undertaken on the legal databases Westlaw AU, LexisNexis AU, and AustLII for published civil court cases about medical negligence in the field of OMS and general dentistry (oral surgery procedures). Search terms used included “negligence”, “oral surgery”, “dental surgery”, “maxillofacial surgery”, “dental implant”, “dental extraction” and combinations such as “negligence AND dentist AND surgery”. No specific time period was set for the search. Each case identified through this search was examined to determine its...
relevance and those outside the scope of the study were excluded, for example where
dental evidence was given in assault cases or other types of negligence cases such as those
involving motor vehicle accidents.

We undertook a detailed analysis of the cases meeting our inclusion criteria and present
summary data for each case (Table 1). A methodological limitation of this study is that not all
cases are indexed in these databases, so for example, some District/County Court cases may
not have been located. Further, this review only includes disputes that were judicially
resolved and does not include claims settled outside of the courts (it is not possible to
determine how many legal claims are initiated but settled out of court).

Results

Our search revealed fifteen cases of medical negligence in the field of OMS and general
dentistry (oral surgery procedures) over a twenty-year period (Table 1). Litigation occurred
in all Australian jurisdictions except for the Northern Territory, and was conducted in the
High Court of Australia, State Courts of Appeal and Supreme Courts, as well as in various
District/County Courts. Eleven of these cases involved determinations of whether or not the
dentist or medical practitioner was negligent and damages were awarded to patients in six
of those cases. Awards of damages ranged from over $1,000,000 to approximately $60,000
(although this latter case was twenty years old).
Eight of the fifteen cases involved general dental practitioners with the remaining seven cases dealing with OMSs (including one trainee). Of the eight general dentist cases, seven involved molar tooth extractions (four relating specifically to third molar), with the remaining case involving implant treatment. Cases involving OMSs were for orthognathic surgery (three cases) and third molar tooth extraction (four cases).

Of the eight cases about third molar tooth extraction, there was nerve damage in four cases, post-operative infection in two cases, prolonged and excessive post-operative discomfort in one case and temporomandibular joint complication in one case. Of the three cases for orthognathic surgery there was nerve damage in two of those cases and temporomandibular joint complication in one case.

Table 1

Discussion

An Overview of the Law

The law imposes a duty of care on a doctor and dentist to his or her patient. For a practitioner to be found negligent, it must be established that he or she breached that duty of care and that the breach caused the damage suffered. Negligence claims can arise in relation to issues such as warning of risks, investigation (including failure to diagnose), treatment/procedure, post-operative complications and patient follow-up. (In contrast valid consent requires that the patient be advised about the proposed procedure in broad terms only and is relevant to actions framed in trespass.)
The standard of care imposed by the law of negligence has traditionally come from the common law, where decisions are based on principles of previous legal cases. More recently, however, legislation has been passed in this area in each State/Territory (see footnote for relevant Acts, collectively referred to as the ‘Liability Acts’), although previous case law remains influential. Under this legislation, a doctor will not be negligent if acting in a manner widely accepted in Australia by peer professional opinion as competent professional practice (provided the court does not think this opinion is irrational). This is consistent with the modified Bolam principle from the UK cases of Bolam v Friern Hospital and Bolitho v City and Hackney Health Authority.

For risk disclosure, only some jurisdictions’ Liability Acts deal with this issue but those that do appear to have legislated to restate the common law as outlined in Rogers v Whitaker. Accordingly, a patient must be warned of all material risks, that is a risk:

- if ‘a reasonable person in the patient’s position, if warned of the risk, would be likely to attach significance to it’ (objective limb); 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’ in light of their own values and interests (subjective limb)

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Although the vast majority of disputes settle without the need for judicial resolution, the cases analysed represent the apex of medical negligence litigation in terms of cost and emotional stress on dental practitioners and so are worthy of examination.

Litigation Risks Identified in the Case Review

Consent and warning about risks

Our review highlights a number of cases involving failure to warn of a material risk. It appears particularly important to warn of the risk of post-operative infection, and the risks of permanent nerve damage and post-operative neuropathic pain (Hookey v Paterno and Hribar v Wells)\(^ {9,18} \) for relevant procedures. While post-operative neuropathic pain occurred in cases involving orthognathic surgery (both compensated), it may be prudent to warn of this risk for any surgery with the risk of nerve damage.

For nerve damage associated with inferior alveolar nerve blocks, there was one judgement (albeit of limited precedent value) which concluded that this risk need not be warned about.\(^ {23} \)

The need or otherwise of the proposed treatment should be borne in mind. The requirement for disclosure of risks is greater for cosmetic procedures (for example orthognathic surgery for cosmetic purposes only) and for procedures where the need is less critical (for example prophylactic third molar tooth removal). In McKellar v Blake (third molar tooth removal)\(^ {16} \) the patient’s primary concern was cosmetic (crowding of teeth) and this was critical in establishing causation for failure to warn of the risk of nerve damage.

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While there is a limited legal basis for discussing the statistical risk of complications with patients, this information helps to guide clinicians in the consent process. In a number of the cases analysed, the courts considered the incidence of a risk in determining whether it was material.\(^9,^{14,17}\)

**Referral to another dentist/specialist**

There is case law authority that suggests medical practitioners should consider disclosing to a patient the opportunity for a more experienced practitioner to undertake the procedure.\(^{24}\) General dental practitioners too should consider whether to offer patients referral to a more experienced practitioner or a specialist for complex oral surgery procedures, particularly those beyond their level of skill or experience. This may include referral during a procedure, particularly where it becomes clear that the risks of proceeding outweigh the benefits.\(^2\) For some procedures, there may be a similar duty for specialists as well. The reason for the referral, namely to reduce risks of harm, should be explained in all cases.\(^2\)

In emergency oral surgery, where a patient may be suffering significant pain, a dentist may feel compelled to perform a procedure or persevere with a procedure, where the patient would benefit from referral. In *Robinson v Ng*,\(^2\) a general dentist was found to be negligent for failing to abort an emergency tooth extraction and refer the patient to either a specialist or a general dentist with more experience, when it became clear that it was problematic. Of note in this case was that the patient expressly wanted to continue with the extraction, but negligence was still found, as although the dentist raised the issue of referral, he did not clearly explain that a referral would reduce the risks of complications.
Negligence may be claimed for an inappropriate treatment plan, inappropriate surgical technique/equipment or for insufficient skills and experience required to perform a procedure. Dentists who have limited experience for a particular oral surgery procedure should be mindful that the courts will often refer to a dentist’s history of practice for that procedure. This is particularly pertinent for complex oral surgery, where Australian university dental degrees often provide insufficient training for those procedures. For difficult tooth extractions (particularly third molars), general dentists can augment their skills over time. For placement of dental implants, graduate training is necessary. Manufacturer-based training is common although seldom sufficient.\textsuperscript{2,25}

In \textit{Hookey v Paterno},\textsuperscript{9} the trial judge found the surgeon negligent in advising an inappropriate treatment plan (orthognathic surgery). Two of three judges from the Court of Appeal did not agree that the treatment plan was inappropriate, although the appeal was dismissed on the basis of failure to warn of a material risk.

Dental practitioners should also consider the possibility of a claim related to ‘loss of chance’ for specialist opinion in oral surgery treatment planning. In \textit{Banerjee v Shah},\textsuperscript{5} a case of full dental clearance due to advanced periodontal disease, the judge noted that a review by a specialist periodontist regarding the possibility of retaining some teeth did not occur.

In \textit{Delphin v Martin}\textsuperscript{6} and \textit{Royal Dental Hospital of Melbourne v Akbulut},\textsuperscript{13} the practitioners were negligent in surgical technique. In the former case, this was due to the use of excessive force during a third molar tooth extraction. It was also claimed in this case that the dentist used an inappropriate (non-surgical) drill, although the judge made no finding on this
matter. In Banerjee v Shah, a case where negligence was admitted, the general dentist was unsuccessful in attempting full mouth rehabilitation with dental implants and implant-supported bridges (there were loose implants and broken bridges).

The litigation hazards for a second practitioner (often a specialist) completing a failed procedure before the local anaesthetic administered by the first practitioner wears off has been previously referred to in the literature. This is particularly relevant for the risk of nerve damage, where it can be difficult to establish the timing of the injury.

Follow-up

The legal duty of care to the patient continues well after the doctor-patient interaction, irrespective of whether there is initiative taken on the part of the patient for their own healthcare. Several court cases (most notably Tai v Hatzistavrou and Kite v Malycho) highlight the necessity of appropriate and timely follow-up of investigations, referrals and procedures. The duty cannot be ended by the will of the doctor; it continues until the patient no longer requires treatment, or until the doctor-patient relationship is formally dissolved by either party.

In respect of oral surgery procedures, it is important to follow up patients regarding post-operative complications. Our review highlighted the importance of follow-up for severe post-operative infection and neurological damage. In one case (Royal Dental Hospital of Melbourne v Akbulut), a trainee surgeon was found negligent for failing to advise a patient...
in a timely fashion of the possibility for remedial surgical intervention for nerve damage sustained.

**Diagnosis**

Case law concerning failure of diagnosis has focused on failure to diagnose cancer. It came into focus in the case of *O'Shea v Sullivan* where a general medical practitioner failed to diagnose a cervical cancer. All dental practitioners (including surgeons) should routinely screen for oral cancer. A long delay in diagnosis of oral cancer was associated with poor defence outcomes in a US review.

In *Wilson v Tier*, an OMS was taken to court over a claim that he failed to diagnose and treat a post-operative infection before it spread to the deep fascial spaces, although no damages were awarded because he was not found negligent.

**Medical records**

Quality medical records are a crucial part of medical and dental practice, not only for continuity and quality of care and efficiency of treatment, but for their use in litigation.

In *Hribar v Wells*, *McKellar v Blake* and *Delphin v Martin*, cases involving failure to warn of a material risk, the practitioners defended the claims on the basis of ‘invariable practice’, rather than documented evidence of risk disclosure, and were all unsuccessful on this point. In *Hribar v Wells* and *Delphin v Martin* the judges preferred the version of events claimed by
the patient and in both cases felt that there was a significant degree of reconstruction in the practitioners’ evidence. In McKellar v Blake, the trial judge accepted that the surgeon would have given a warning, but concluded that it was not sufficient to allow the patient to make an informed choice. (This conclusion was not disturbed on appeal although the surgeon successfully appealed on other grounds.)

Radiographs

It is widely accepted within the dental community that a practitioner should view a pre-operative radiograph that visualizes the root structure prior to embarking on any tooth extraction. While this view has generally been adopted by the courts (Delphin v Martin and Jung v Son), in Becke v Nguyen, failure to take a pre-operative periapical or panoramic radiograph prior to extraction of two periodontally involved teeth was not considered inappropriate (although the patient was self-represented at the trial).

Interestingly, in Delphin v Martin, the judge determined that the duty of care required the dentist not to extract the lower third molar tooth without first viewing a panoramic X-ray, even though a periapical (intra-oral) radiograph had been taken. This judgement was based on expert evidence regarding the limitations of the periapical radiograph to indicate the position of the inferior alveolar nerve.

Extra-oral radiographs, including panoramic radiographs and computed tomography (CT), are being increasingly utilized by dental practitioners for oral surgery procedures, and improved affordability has meant that many dentists now have extra-oral X-ray equipment.

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in their own practices. Practitioners should consider the associated medicolegal risks, particularly relating to radiation dose and the possibility of a claim for failure to diagnose, i.e. where the survey reveals pathology that is not diagnosed either because the dental practitioner is not familiar with the pathology and/or the entire data set is not examined. Dental practitioners who capture their own extra-oral images should consider whether the survey ought to be examined by a dento-maxillofacial radiologist, where available, particularly for CT images where the risks are greater.

Conclusions

Dental practitioners should be aware of contemporary Australian law surrounding medical negligence. A better understanding of the law can improve patient outcomes and reduce litigation risks for practitioners.

Drawing on our review of the judicial cases considering OMS and general dentistry (oral surgery procedures), we make the following recommendations:

- Ensure adequate disclosure of material risks, including warnings of the risk of post-operative infection, and for relevant procedures, the risk of nerve damage.
- Warn of possible post-operative neuropathic pain for orthognathic surgery.
- In determining risks to disclose, take into consideration the incidence of the risk and how necessary the treatment is.
- Strongly consider referral for all complex oral surgery procedures in the general dental setting and discuss the relative risks of accepting or declining the referral.
- In the general dental setting, always assess whether you have sufficient skills and experience for an oral surgery procedure. Ensure adequate graduate training prior to placing dental implants.

- Ensure adequate follow-up of post-operative complications. Advise patients of the possibility of surgical intervention for nerve damage sustained.

- Keep quality medical records. In particular, adequately document risk disclosure for oral surgery/OMS procedures

- Take an appropriate pre-operative radiograph. If a periapical radiograph is used for lower third molar tooth extraction consider whether the angulation accurately reflects the position of the inferior alveolar nerve.

Reference List


4. Robinson v Ng [2014] ACTSC 227


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11. Mulcahy v Monsour [2005] QSC 348
13. Royal Dental Hospital of Melbourne v Akbulut [2002] VSCA 88
15. Jung v Son [1998] NSWSC 698 (Court of Appeal)
17. Anderson v Bowden [1997] WASC (Unreported)
20. Bolam v Friern Hospital Management Committee [1957] 1 WLR 582.
21. Bolitho v City and Hackney Health Authority [1997] 3 WLR 1151
22. Rogers v Whitaker (1992) 175 CLR 479
27. Tai v Hatzistavrou [1999] NSWCA 306

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31. Lydiatt DD. Cancer of the oral cavity and medical malpractice. Laryngoscope 2002;112:816-819


Table 1 Australian medical negligence cases in the field of OMFS and general dentistry (oral surgery procedures).

<table>
<thead>
<tr>
<th>Case</th>
<th>Year Decided</th>
<th>Case Summary and Judgement</th>
<th>Court</th>
<th>Damages</th>
</tr>
</thead>
</table>
| Robinson v Ng | 2014         | - A general dentist displaced a tooth root into the maxillary sinus during an upper right second molar (17) tooth extraction  
- The patient developed post-operative osteomyelitis, facial pain and Bell’s palsy  
- The causation for Bell’s palsy was not clear cut but the chance that the onset after the procedure was a coincidence was considered low  
Judgement: Dentist negligent for continuing with the procedure where a reasonably competent dentist would have recognised that the risks of continuing were outweighed by the benefit of referral to a specialist or to a practitioner with more experience | Supreme Court of the Australian Capital Territory | $80,8,114  |
| Banerjee v Shah | 2012    | - A general dentist extracted all of a patient’s remaining teeth (20 periodontally involved teeth) and placed dental implants and implant secured bridges  
- Due to the dentist’s admitted negligence there were ongoing problems with that treatment (including broken bridges and loose implants)  
Judgement: Negligence had been admitted | District Court of Western Australia | $401,459     |
so the purpose of the trial was assessment of damages.

<table>
<thead>
<tr>
<th>Case</th>
<th>Year</th>
<th>Description</th>
<th>Court</th>
<th>Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delphin v Martin</td>
<td>2012</td>
<td>A general dentist displaced a fragment of tooth into the soft tissue of the floor of mouth during extraction of an impacted lower right third molar (48) - The patient suffered permanent lingual and inferior alveolar nerve damage - No pre-operative radiograph was taken</td>
<td>Supreme Court of Tasmania</td>
<td>Dentist found negligent in (1) failing to take a pre-operative radiograph; (2) failing to warn of the material risk of lingual nerve and inferior alveolar nerve damage; and (3) use of excessive force</td>
</tr>
<tr>
<td>Donmez v Neissa</td>
<td>2012</td>
<td>The patient claimed that her head was held in an extended position by a dental nurse during the extraction which took more than one hour and that this caused the injury (tooth number not reported) - The patient also claimed that the adjacent tooth was damaged during the procedure</td>
<td>Supreme Court of Victoria</td>
<td>The issue in question was not negligence but whether the patient was able to bring the action due to the limitation of actions statute. The absence of a further case on the negligence issue suggests it was settled without judicial resolution.</td>
</tr>
<tr>
<td>Becke v Nguyen</td>
<td>2011</td>
<td>A patient claimed that a general dentist was negligent in extraction of his upper right first molar (16) and upper right second molar (17) due to the use of excessive force - The patient also claimed that the general dentist was negligent for failing to advise of alternative treatment options, failing to take appropriate pre-operative radiographs and failing to provide adequate follow-up treatment - The patient was self represented at the trial</td>
<td>County Court of Victoria</td>
<td>General dentist not negligent</td>
</tr>
<tr>
<td>Hookey v Paterno</td>
<td>2009</td>
<td>A patient underwent orthognathic surgery for correction of a class II malocclusion by an Oral and Maxillofacial Surgeon - The patient suffered non-union of the osteotomy and permanent nerve damage</td>
<td>Court of Appeal of Victoria</td>
<td>No damages</td>
</tr>
</tbody>
</table>
with neuropathic pain

Judgement: Oral and Maxillofacial Surgeon negligent in failing to warn of the material risk of non-union of bone and of nerve damage. Special leave to appeal to the High Court was refused.

<table>
<thead>
<tr>
<th>Wilson v Tier</th>
<th>2008</th>
<th>A patient developed a deep fascial space infection following extraction of three third molar teeth by an Oral and Maxillofacial Surgeon</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>- It was claimed that the surgeon was negligent in failing to promptly diagnose the post-operative infection and treat those symptoms before the infection spread to deep fascial spaces</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Judgement: Oral and Maxillofacial Surgeon not negligent</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mulcahy v Monsour</th>
<th>2005</th>
<th>A patient with a predisposing medical condition (a ventricular peritoneal shunt) claimed she suffered ongoing severe infections following extraction of lower third molar teeth by an Oral and Maxillofacial Surgeon</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Judgement: the claim was struck out by the court because of delays in proceedings by the patient</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hyland v Huen</th>
<th>2004</th>
<th>Following extraction of her upper left third molar tooth (28) by a general dentist, a patient suffered damage to her left temporomandibular joint leading to ankylosis of that joint which required surgical treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Judgement:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Trial judge: dentist negligent in failing to warn of the material risk of infection and the availability of antibiotics to prevent infection. This caused the damage suffered.</td>
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<td></td>
<td></td>
<td>Court of Appeal: set aside the judgement of the trial judge and ordered a retrial. The absence of the retrial suggests this dispute was settled without judicial resolution.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Royal</th>
<th>2002</th>
<th>A patient suffered permanent bi-lateral</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Court of Appeal of the Australian Capital Territory</td>
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<td></td>
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<td>$371,5</td>
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<table>
<thead>
<tr>
<th>Case Study</th>
<th>Year</th>
<th>Details</th>
<th>Court</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Hospital of Melbourne v Akbulut</td>
<td>2013</td>
<td>Lingual nerve damage following extraction of her lower left and right impacted third molars (38 and 48) by an Oral and Maxillofacial Surgeon trainee</td>
<td>Appeal of Victoria</td>
<td>00</td>
</tr>
<tr>
<td>Rosenberg v Percival</td>
<td>2001</td>
<td>A patient suffered severe temporomandibular joint complications following an osteotomy performed by an Oral and Maxillofacial Surgeon</td>
<td>High Court of Australia</td>
<td>No damages</td>
</tr>
<tr>
<td>Jung v Son</td>
<td>1998</td>
<td>Patient claimed general dentist negligent in extraction of the lower left third molar (38) due to prolonged and excessive post-operative discomfort</td>
<td>Court of Appeal of New South Wales</td>
<td>No damages</td>
</tr>
<tr>
<td>McKellar v Blake</td>
<td>1998</td>
<td>A patient suffered permanent left inferior alveolar nerve damage after extraction of all four third molar teeth by an Oral and Maxillofacial Surgeon (the 18, 28, 38 and 48)</td>
<td>Court of Appeal of New South Wales</td>
<td>No damages</td>
</tr>
</tbody>
</table>
his ‘invariable practice’ which was to verbally warn of the risk of inferior alveolar nerve damage, rather than documented evidence of risk disclosure.


<table>
<thead>
<tr>
<th>Anderson v Bowden$^{17}$</th>
<th>1997</th>
<th>A patient suffered left lingual nerve damage following extraction of four impacted third molar teeth (18, 28, 38 and 48) by a general dentist</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>-It was claimed that the dentist was negligent in failing to warn of the risk of permanent lingual nerve damage and was negligent in surgical technique, including the use of excessive force</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Judgement: Dentist not negligent. Found that a warning of permanent lingual nerve damage was not given but failed to establish causation.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hribar v Wells$^{18}$</th>
<th>1995</th>
<th>A patient had orthognathic surgery by an Oral and Maxillofacial Surgeon to correct a malocclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>-The patient suffered permanent nerve damage and persistent severe pain following the operation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Judgement: Oral and Maxillofacial Surgeon negligent in failing to warn of the material risk of permanent and painful nerve damage</td>
</tr>
</tbody>
</table>

Supreme Court of Western Australia &amp; Supreme Court of South Australia

$^\text{Note that there would have been a delay between the incident and when the judgement of the court case relating to that claim was decided}$