Date: 19971002
Docket: A961371
Registry: Vancouver

IN THE SUPREME COURT OF BRITISH COLUMBIA

BETWEEN:

KIMALENE A. HOWE (THOMSEN)

PLAINTIFF
(RESPONDENT)

AND:

DR. E. MARKS
DR. P.H. TRESTER, and
DR. H.T. DAVID

DEFENDANTS
(APPELLANTS)

REASONS FOR JUDGMENT

OF THE

HONOURABLE MR. JUSTICE VICKERS

Counsel for the Plaintiff: J.S. Stanley

Counsel for the Defendant: D.W. Yule

Place and Date of Hearing: Vancouver, B.C.
September 11 and 12, 1997

[1] This is an appeal by the defendants from a decision of the Provincial Court of British Columbia, Small Claims Division, awarding damages against the defendants. The appeal procedure under the old rules, applicable to this case, is by way of trial de novo. The plaintiff's action is against the defendants for negligence prior to, during and after the surgical removal of a wisdom tooth by Dr. H. T. David. Dr. David is a specialist in oral and maxillofacial surgery and practices his profession together with Drs. Marks and Trester.

[2] Ms. Thomsen's dentist recommended the removal of her upper left wisdom tooth. On June 16, 1993 she attended at his office to have him perform the tooth extraction. When her blood pressure rose and she became fearful, he concluded she might not be able to tolerate the procedure under local anesthetic. He was aware she had a temporal mandibular joint (TMJ) disorder. He referred her to the defendants to have the extraction performed by a specialist in oral surgery.

[3] The referral card, a part of the defendants' records, notes a referral for the extraction of two upper wisdom teeth, one now in pain. Ms. Thomsen says it was never her intention to have two teeth removed.

[4] She was seen by Dr. Marks on June 18, 1993 and advised him of the TMJ condition. She says she also showed him the mouth guard which she used each night during sleep. There was a discussion about removing two teeth and she made it clear she wanted only one tooth removed. This was noted on the chart by Dr. Marks. She says that no oral examination was performed. He reviewed the x-ray provided by her dentist and concluded the removal of the impacted tooth, angled towards the cheek, was a relatively simple procedure requiring no more than 10 minutes of operation room time. Ms. Thomsen said that Dr. Marks told her it was a simple operation and that she would be able to return to work the next day. She said he provided her with a prescription for pain and a post-operative instruction sheet entitled "Care Following Oral Surgery". She denies being told that there would be pain and discomfort, and that there would be some swelling. The surgery was scheduled for June 22, 1993.

[5] Dr. Marks said he did a routine oral examination of her teeth and the soft tissues of the mouth. He made no measurements and did not note any restrictive opening of the mouth. He acknowledges he was made aware of a TMJ condition but does not recollect seeing a guard. He said he discussed the procedure for tooth extraction with her and told her he would use intravenous anesthetic as well as a local anesthetic. There would be some stitches. She would be given a prescription for her current pain and instructions in writing from the nurse before leaving. He said he told her there would be some degree of swelling, some discomfort and some stiffness that medication would address. He said he advised her there was always a risk of infection. He denies saying she would be able to return to work the next day.

[6] Prior to surgery, Ms. Thomsen returned to her dentist because she remained concerned about the removal of two teeth. He confirmed that only one tooth needed to be removed.

[7] Dr. David said that before performing the surgery on June 22, 1993 he reviewed Ms. Thomsen's chart and x-ray. He noted the chart reflected that only one tooth was to be removed and he said that he did not have a discussion with her about the removal of two teeth. He reviewed her medical history and she told him her dentist had attempted to remove the tooth about eight days earlier. He noted that fact on the chart. He told her about the anesthetics to be used and informed her there would be swelling, tightness of the mouth and pain associated with the procedure.

[8] He said he also examined her mouth and the tooth to be removed. He satisfied himself there were no significant problems associated with the extraction. He understood she used a splint and experienced the occasional click from her TMJ. He, like his colleague Dr. Marks, did not advise her of any additional risks associated with the TMJ disorder because he viewed the extraction as entirely routine.

[9] Ms. Thomsen said she had a discussion with Dr. David about the removal of only one tooth because he was of the opinion that two were to be removed. The significance of this evidence is that the information concerning the removal of two teeth could only have come from the referral card which Dr. David said he did not see. As well, if he consulted the chart, as he said he did, he would have noted there was only one tooth to be removed. I accept Dr. David's evidence on this point and conclude that Ms. Thomsen is mistaken in her recollection when she says she had a conversation with him about whether one or two teeth were to be removed.

[10] I conclude Drs. Marks and David did not tell Ms. Thomsen that surgery might aggravate her TMJ because in the many extractions of this type they have performed, there have been no difficulties experienced with the TMJ. They provided her with the routine warnings about pain, swelling, discomfort and tightness, and did not discuss the possibility of trismus or a muscle spasm because once again, that would not be expected in their experience.

[11] Dr. David performed the surgery, a simple procedure lasting about five minutes. It began by placing a prop or block in her mouth to stabilize the jaw. She opened her mouth to allow for the insertion of this item. He used a small mouth prop on the right side, the usual procedure for the removal of upper teeth.

[12] Ms. Thomsen has no recollection of the prop being placed in her mouth. Once again, I accept the evidence of Dr. David who explained that his routine for almost 20 years has been to place the prop prior to the administration of the anesthetic when the patient is capable of opening her mouth.

[13] He then applied the intravenous anesthetic followed by the local anesthetic. After sedation, he placed a guard in her mouth to protect the airway. He then extracted the tooth. He retracted her cheek using a retractor, or mouth mirror. The gum was cut at the location of the tooth to be extracted and a tooth elevator was used to nudge the tooth out. Her mouth was then packed on the surgical side and the prop removed. The removal of the prop was routine and did not require a wide opening of her mouth. The surgery itself took between three or four minutes and there were no complications.

[14] During the post-operative procedure Ms. Thomsen would have had the mouth gauze changed at least once but there is no evidence of how wide her mouth would have been opened when this was done.

[15] The day following surgery Ms. Thomsen was in a great deal

of pain and discomfort. She could not insert the guard into her mouth. She remained in bed and applied ice packs throughout the day. The next day, her jaw and the left side of her face were extremely sore. She continued to apply ice packs and attempted to see her dentist but without success. She was unable to eat, unable to take liquids from a cup and only succeeded in taking liquids through a straw.

[16] On June 25, she could not open her mouth and while the pain continued, she attempted unsuccessfully to return to work. She then tried to make an appointment for the defendants' North Shore office. Late that afternoon she was told to attend the Vancouver office but she declined to drive back into the city.

[17] On that day, she was able to see her chiropractor whom she had been attending for stiffness in her neck, shoulders and back. He massaged the outside of her face, and told her to return home and apply ice.

[18] On June 26 she awoke unable to open her mouth to speak. She experienced foam coming out of her mouth. She was taken to the Lion's Gate Hospital for emergency treatment. There she was prescribed an antibiotic drug and told to return to her oral surgeon.

[19] On the Sunday following the surgery she reached the defendants' office on the telephone and arrangements were made for her to pick up a prescription at her local pharmacy. The next day, Monday, June 29 she was seen by Dr. Marks. He diagnosed trismus, or a muscle spasm, and he attempted to pry open her mouth with a prop. She said she could not tolerate the pain of the procedure which lasted about two hours. He said it was no longer than 15 to 30 minutes. He recalled that on arrival Ms. Thomsen could not open her mouth more than a fingernail. He said that he did not consider any diagnosis other than trismus and that when she left she could open her jaw as much as 25 millimeters or two fingers. She was instructed to take the prop home with her and continue the procedure. There was no discussion of the TMJ on this day.

[20] On July 5, 1993 she attended Dr. J. N. Nasedkin, a specialist in prosthodontics. She said she could not open her mouth when she arrived for this first visit but his notes reflect that her ability to open her mouth was restricted to 20 millimetres. He diagnosed left TMJ disc displacement without recapture. On that day and thereafter on several occasions, he manipulated her jaw to recapture the disc in the left TM joint. Her jaw recovered over a period of time but she continues to suffer pain and discomfort on the left side on a continuing basis.

[21] Dr. Nasedkin was critical of the examination performed prior to surgery. He said that for the fee charged, a comprehensive examination should have been performed. In his opinion, a differential assessment of her TMJ condition was required before surgery. Such an examination would measure the range of motion of the jaw and would include a palpation of the TMJ to determine the presence or absence of a click. Dependent on the severity of the condition, the patient could then be informed about the implications for surgery, prior to giving

consent. Dr. Nasedkin said there was nothing in the clinical notes to reflect such an examination or accommodation for Ms. Thomsen's TMJ disorder.

[22] He also said that the wider opening of the mouth, possible in a sedated patient whose protective reflexes are diminished, makes wisdom tooth surgical procedures a frequent cause of jaw problems. In cross examination, he conceded that problems are more likely where the tooth removed is in the lower jaw rather than the fixed and rigid upper jaw. In his opinion, however, it is likely there was an over-extension of Ms. Thomsen's jaw in the course of the tooth extraction.

[23] Dr. Nasedkin made two assumptions when he expressed this opinion, both of which were in error. First, he assumed Ms. Thomsen's dentist could not access the tooth for removal and that a wider opening of her jaw was required. This was to be achieved through the use of sedation. He is in error in that regard. Her dentist could access her tooth but discontinued the extraction because of her anxiety. A wider opening of her jaw was not required and the use of sedation was not for that purpose.

[24] Second, he assumed the surgeon was not informed about the TMJ disorder and previous jaw problems. He is also in error in making that assumption as both Drs. Marks and David were advised and aware of the historical problem.

[25] Dr. Nasedkin was also critical of Dr. Marks' post-operative assessment of trismus. In his opinion, it is likely this was an incorrect diagnosis. Again, no differential assessment was performed nor was the TMJ disorder or an exacerbation of the disorder considered. The treatment of forcing the jaw open is, in his opinion, contraindicated where there is an acutely displaced disc, without recapture. Such a procedure would only worsen the condition.

[26] The legal principles to be applied in this case are well settled. In Crits and Crits v. Sylvester et al (1956), 1 D.L.R. (2d) 502, [1956] O.R. 132, (Ont. C.A.), Schroeder J.A., for the court, said at p. 508:

> Every medical practitioner must bring to his task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. He is bound to exercise that degree of care and skill which could reasonably be expected of a normal, prudent practitioner of the same experience and standing, and if he holds himself out as a specialist, a higher degree of skill is required of him than of one who does not profess to be so qualified by special training and ability.

[27] This was affirmed by the Supreme Court of Canada. Sylvester v. Crits et al (1956), 5 D.L.R. (2d) 601, [1956] S.C.R. 991.

[28] The court is required to apply the modified objective test with respect to causation which is set out in Reibl v. Hughes,

[1980] 2 S.C.R. 880, and ask whether a reasonable person in the circumstances of Ms. Thomsen would have consented to the proposed treatment if all the risks had been disclosed: Arndt v. Smith (1997), 148 D.L.R. (4th) 48 (S.C.C.).

[29] There are five discrete areas to be considered including, pre-operative procedures, informed consent, the surgery, post-operative diagnosis and treatment and quantum of damages, if any.

Pre-operative Procedures

[30] I accept that both Drs. Marks and David examined Ms. Thomsen prior to surgery. They were informed of the TMJ problem but did not do what Dr. Nasedkin describes as a differential assessment. No measurements were taken and there was no palpation of the joint. Their examinations revealed normal jaw opening and no clicking was noted. While the examinations were cursory, I am satisfied any additional examination would not have altered their advice to Ms. Thomsen and would not have altered the manner in which the extraction was performed.

Informed Consent

[31] Drs. David and Marks were both aware of the TMJ problem. Both are experienced oral surgeons and both did not consider that the risk of disc dislocation resulting from a simple extraction of a non-bony impacted upper wisdom tooth was worth discussing with the patient. For both of them, the risk was highly unlikely. The risk of trismus from the extraction procedure was equally, highly unlikely. While the consequences were painful for the patient they were not serious in the sense of being life threatening.

[32] I conclude the chance of dislocation of the disc was extremely remote. Furthermore, the consequences of such a remote event were such that they did not require that the risk be disclosed.

The Surgery

[33] Dr. Nasedkin's opinion that there was an over-extension of the jaw during surgery was likely based on his assumption that Ms. Thomsen's general dentist had concluded a wider opening to her jaw was required. As already noted, that assumption is incorrect. He also assumes that Dr. David was uninformed of the prior jaw problems and therefore concludes the precautions were inadequate. Again, his assumption is in error.
[34] The only description of the surgery comes from Dr. David. There is no evidence the jaw was over-extended. On the contrary, the evidence is that it was not. I conclude the surgery was performed with the skill which could be reasonably expected of a normal, prudent oral surgeon.

Post Operative Diagnosis and Treatment

[35] When Ms. Thomsen attended Dr. Marks on June 29, her mouth opening was very minimal. She had been to the hospital and had received antibiotics, and there was a red mark on her face.

Dr. Marks immediately diagnosed trismus and failed to even consider the possibility of a disc dislocation.

[36] I conclude his examination was cursory and in the context of her dental history, superficial. She may have had trismus but I am also satisfied that by this time the disc was, in fact, dislocated. There is no doubt he could have easily examined her for this problem. His failure to examine and diagnose the true condition was negligent.

[37] He then proceeded to attempt to pry the jaw open. This was an extremely painful experience and counter-productive. It would have exacerbated the disc dislocation, making recapture all the more difficult.

Damages

[38] The chiropractor's total account was $575. Not all of the treatments were for the difficulties Ms. Thomsen had with her jaw since she was also receiving treatment for her neck and back. In the circumstances I believe she should only recover a portion of his account and I fix that amount at $200.

[39] Ms. Thomsen is entitled to recover the following special damages.

Chiropractor's fee	$200.00
Loss of wages	755.00
Dr. Nasedkin, for therapy	761.44
Prescription Drugs	52.88
Total	$1,769.32

[40] She suffered additional pain and discomfort because the of the failure to diagnose disc displacement. This pain and discomfort was extreme in the early stages and was resolved after about two months. I fix her general damages, limited to the period from June 29, 1993 forward, in the amount of $3,500.

Summary

[41] Ms. Thomsen is entitled to recover the following:

Special damages	$1,769.32
General damages	3,500.00
Total	$5,269.32

[42] In addition, she is entitled to recover prejudgment interest on her special damages and costs on the scale provided in the Small Claims Division of the Provincial Court.

"Vickers, J."

Mr. Justice Vickers