IN THE DISTRICT COURT
AT WELLINGTON

I TE KŌTI-Ā-ROHE
KI TE WHANGANUI-A-TARA

[2023] NZACC 49 ACR 238/19

UNDER	THE ACCIDENT COMPENSATION ACT 2001
IN THE MATTER OF	AN APPEAL UNDER SECTION 149 OF THE ACT
BETWEEN	GENEVIEVE McCLEAN Appellant
AND	ACCIDENT COMPENSATION CORPORATION Respondent

Hearing:	16 February 2023
Heard at:	Auckland/Tāmaki Makaurau
Appearances:	The Appellant in person Ms K Anderson for the Respondent
Judgment:	30 March 2023

RESERVED JUDGMENT OF JUDGE C J MCGUIRE
[Treatment Injury, Section 32; Causation, Accident Compensation Act 2001]

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[1] At issue in this case is whether the appellant suffered a physical injury caused by orthodontic treatment by her orthodontist, beginning in July 2008 and concluding on 1 February 2012.

[2] ACC declined cover for a dental treatment injury on 24 November 2016. The circumstances of injury described in ACC's treatment injury report were:

> Claim lodged for TMJ disfunction, headache, severe underbite and front jaw posteriorly displaced by orthodontic treatment.

Factual Background

[3] In June 2000, the appellant had veneers set on her upper front teeth "to minimise diastema", that is to minimise gaps between the teeth.

[4] She reports that over time the veneers moved outward and became strongly angled. In 2008, a veneer broke, prompting the appellant to seek treatment from a new dentist. She saw this dentist and was recommended to seek orthodontics treatment from orthodontist, Catherine Porter.

[5] Dr Porter assessed a number of orthodontic problems, being:

(a) Poor alignment and spacing of the upper and lower teeth.

(b) The upper back teeth on the right side bite further forward.

(c) Asymmetric alignment of the lower teeth.

(d) An increased overjet, where the upper front teeth bite further forward.

(e) Proclined upper incisors.

(f) A tooth size discrepancy.

(g) A traumatic deep bite.

(h) Generalised wear facets.

[6] A recommended treatment plan was set out, which inincluded putting braces on her teeth and later removing two of her top teeth. Treatment commenced after the appellant returned a signed copy of the assessment report and treatment plan. By June 2012, treatment had not been completed. The appellant was dissatisfied.

[7] Ms McClean lodged a complaint with the Dental Association about Dr Porter's treatment. On 23 November 2012, the Chair of the Northern Regional Peer Review Committee of the New Zealand Dental Association completed a report after interviewing the appellant and Dr Porter. It found that clinical treatment to date by Dr Porter was of an acceptable standard however progress was very slow and there is no evidence that Dr Porter recognised that treatment was not progressing within the indicated timeframe.

[8] The Committee found that communication by Dr Porter during treatment was deficient. Although the Committee found the quality of work done by Dr Porter was adequate, there was no evidence that Dr Porter was proactively monitoring and managing Ms McClean's treatment. The Committee said:

> By October 2011, Ms McClean had been wearing elastics for 19 months, with no investigation into reasons for lack of progress, or consideration of alternative treatment options.

[9] The Committee recommended refund of $4,004.00 to Ms McClean to complete her treatment with another orthodontist.

[10] In December 2012 Ms McClean went to three other orthodontists who would not agree to reverse the process but were prepared to finish Dr Porter's intended course of treatment.

[11] The appellant lodged a claim for a treatment injury stemming from Dr Porter's treatment in March 2016.

[12] The appellant considered that her treatment had resulted in her suffering from temporomandibular joint disorder, which is temporomandibular dysfunction (pain and issues caused by the main jaw joint, the temporomandibular joint).

[13] The appellant saw physiotherapist, Tejo Van Schir, on 25 October 2012.

[14] He reported on the condition of her jaw joints and musculature, saying:

> Considerable tightness and separation of the muscle into its separate fasciculi is evident, indicating a long period of above average contraction.
>
> The condition of the masseter muscles on both sides is affected by the positioning of the lower jaw, which Genevieve is retracting. She reports that she is doing so in order to match her lower teeth to the teeth in her upper jaw, which have been moved back through an orthodontic procedure over the last four years.

[15] Dr Anderson, the appellant's new dentist, wrote to ACC on 1 August 2016. He recorded that Ms McClean had first consulted him in March 2012. In his report of 1 August 2016, he said:

> She [the appellant] stated that her initial concern was the tipping forward of her upper front teeth, so she was transferred to Dr Porter by her dentist. She felt that she was not fully informed of the treatment plan and did not fully understand the treatment

recommended. Dr Porter decided to remove two upper pre-molar teeth to correct the overjet and planned to close the midline diastema, which Genevieve states that neither of these were a concern for her at the time.

At the time of her initial consultation with me, she felt that as a result of her treatment with Dr Porter, she had a reduction of space for her tongue, her mandible felt "trapped back" and that she needed to force her jaw back to get her back teeth together. The reduction of tongue space resulted in breathing issues, her pronunciation and singing were affected, and it has also caused a feeling of claustrophobia. Her bite was now causing facial muscle issues, with generalised tenderness, but especially in the masseters, which is indicative of TMJ disfunction.

Looking at the x-ray we took in 2012, there does appear to be some change in the anatomy of her TMJs. It is hard to say that this was entirely due to the orthodontic treatment, as it is only one point in time and it may have been like this prior to the starting treatment with Dr Porter. The lateral cephalometric x-ray taking by Dr Porter shows a retruded mandible. In situations like this, I would hesitate to extract upper teeth and reduce the overjet by retracting the upper front teeth, as this can increase the risk of TMJ problems. It would have been safer to bring the retruded mandible forward to reduce the overjet, as this would have reduced the chances of TMJ problems and would have given Genevieve a more pleasing profile. However, at her age, the only real way to achieve this would have been via orthognathic surgery and I am unsure if this treatment option was discussed.

…

In conclusion, to answer your questions:

(1) Have you identified any evidence of TMJ disfunction?

Yes. Generalised facial muscle tenderness …

(3) Displacement of the lower jaw?

As stated previously, it is my opinion that treatment of a class 2 bite by extracting upper pre-molar teeth and retracting upper front teeth risks causing/contributing to TMJ disfunction.

[16] Dr Buchanan, Oral and Maxillofacial Specialist, saw Ms McClean in September 2016. She confirmed that Ms McClean was likely suffering myofascial tension and hyperextension of the TMJ.

[17] The appellant saw Dr Buchanan at the oral health unit at the Greenlane Clinic Centre on 25 September 2016. She confirmed that the appellant was likely suffering myofascial tension and hyperextension of the TMJ. She also noted that Ms McClean had significant psycho social stressors that may be contributing to the pain. She did not comment on cause.

[18] Dr Buchanan referred Ms McClean to the Auckland Regional Pain Service for assessment and possible treatment.

[19] In October 2016, Dr Quick, Orthodontist, was engaged by ACC to provide clinical advice on behalf of ACC for a treatment injury application.

[20] In his report of 8 October 2016, Dr Quick recorded at the outset:

> I have not clinically examined the client, nor have had any involvement with clinical decision making or management.

[21] In his report, he noted that there was little evidence to suggest that TMJ symptoms are associated with orthodontic treatment, or the extraction of upper pre-molar teeth. He also said:

> There is no evidence from the supplied documentation that suggests that the lower jaw has been displaced posteriorly.

[22] He did say however that:

> A specific TMJ examination by a specialist is recommended to establish fully whether injury has occurred.

[23] On the basis of the evidence available, in November 2016 ACC declined cover for the claimed dental treatment injury in its decision of 24 November 2016.

[24] Following ACC's decision, the appellant was assessed by a multi-disciplinary team at the Regional Pain Service in February 2017. It recorded that the appellant had chronic myofascial TMJ pain and dysfunction, as well as chronic headaches, bilateral arm tingling, back pain, occipital and posterior neck pain.

[25] Dr Burford, of Burford Dental Group, compiled a TMD (Temporomandibular joint disorder) report on the appellant on 28 June 2017.

[26] Under the heading "Assessment" is this:

> My working diagnosis is:
>
> - Bilateral myalgia;
> - Cephalgia on both sides;
> - Nocturnal grinding/clenching (bruxism);
> - Late effects of complications of dental/medical care;

- Bilateral facial/cervical myositis;
- Cervicalgia on both sides;
- Chronic daily headache (CDH).

[27] Dr Burford followed this up with a further report on 10 August 2017. His report was headed "Report on TMJ Relationships for Genevieve McClean".

> I enclose two prints of temporomandibular joints. One is of condyles placed normally in the fossae, the other is Genevieve McClean.
>
> The condyles should be in what is referred to as the "Gelb 4/7 condyle position". It will be observed that the reference images show the condyles vertical and with the retrodiscal (area between the back of the condyle and the bone in front of the ear) approximately 4mm, and larger than the space between the condylar head and the eminence of the fossa.
>
> Ms McClean's images reveal condyles at the back of the joint spaces and bending (looking like hockey sticks) to remain in the fossae. The condyles will be compressing the posterior lamina and being a factor in her head and facial pain, jaw clicking and associated symptoms.

[28] A report was obtained from Professor Farella, Head, Discipline of Orthodontics at Otago University, dated 7 August 2017.

[29] Professional Farella gave a provision diagnosis as follows:

> The history of multiple and frequent somatic complaints associated with masticatory muscle pain and a feeling of occlusal discrepancy is consistent with a provisional diagnosis of occlusal dysaesthesia. Treatment modalities that are aimed at "fixing" your bite, including orthodontics and orthognathic surgery, cannot be recommended as they may ultimately reinforce the somatic symptoms (occlusal dysaesthesia is described in the Journal of Oral Rehabilitation as "a condition in which tooth contacts that are not clinically identifiable as premature contacts, nor associated with other disorders … perceived as disturbing or unpleasant").

Appellant's Submissions

[30] Ms McClean spoke of the years of pain and discomfort since she undertook the orthodontic treatment.

[31] She said that Dr Porter's big mistake was not acknowledging what was happening back in 2012 and that "tucking her jaw back quickly became the norm". This means that her jaw was pushed back into the jaw joint.

[32] She said that no one would listen to her point of view that she had received the wrong treatment.

[33] She said that when she was dealing with ACC, she was told by her case manager, Ms Chua, that ACC could not take account of overseas experts. Reference was made to a discussion between the appellant and the case manager on 21 June 2016 where Ms Chua notes the following:

> Genevieve is not happy with this, as she has a problem with the discipline of orthodontics, as they are all trained in the same way and all support each other's thinking. I explained that we must ask orthodontic advice, as the claim relates to treatment by an orthodontist and this is in their scope of practice …

[34] Ms McClean says that Ms Chua told her that the reason why overseas opinion cannot be considered is because the overseas person has not examined the appellant.

[35] Referring to the report of Professor Farella, she says that it was actually one of his orthodontic students who examined her, not Professor Farella and that Professor Farella had never seen the appliance that was being used in her mouth.

[36] She says that Dr Burford was wrongly ignored by ACC and that there has been "purposeful obfuscation of the facts".

[37] She says that the orthodontist, Ms Porter, kept virtually no notes and that she had been forced to hold her jaw in a certain way.

Respondent's Submissions

[38] Ms Anderson submits that for there to be cover there must be a physical injury and there was no physical injury in this case.

[39] She says that Dr Quick was an independent clinical expert.

[40] In his report of 8 October 2016, Dr Quick says:

> The question asks "Has an injury to the TMJ occurred in this case?". The claimant has classic symptoms of TMD, largely muscle tenderness, tension and clicking. There is no evidence in the supplied documentation of limitation of jaw opening or jaw joint

> pathology. A specific TMJ examination by a specialist is recommended to establish fully whether injury has occurred.

[41] Ms Anderson also refers to the report of Nicolas Anderson of Alpers Dental Group dated 1 August 2016. He says "looking at the x-ray we took in 2012, there does appear to be some change to the anatomy of her TMJs. It is hard to say that this was entirely due to the orthodontic treatment, as it is only one point in time and may have been like this prior to starting treatment with Dr Porter.

[42] She refers to Dr Burford's reports in 2017 and notes that Dr Burford speaks of a working diagnosis. She submits that this expression is used before any firm diagnosis is made.

[43] She says that Dr Burford does not say what has caused the appellant's condition.

[44] She refers to the report of the Northern Regional Peer Review Committee of the New Zealand Dental Association dated 23 November 2012, which found that, in spite of other deficiencies, the quality of the work done by Dr Porter was adequate.

[45] Ms Anderson submits that ACC was correct to decline cover, as when it made that decision no other one could have been made in the circumstances.

[46] She refers to the report of Professor Farella dated 7 August 2017, where a post graduate student took the appellant's history, and a provisional diagnosis of occlusal dysaesthesia, a syndrome in which tooth contacts are permanently perceived as disturbing or unpleasant.

[47] She notes Professor Farella went on to say:

> Treatment modalities that are aimed at "fixing" your bite, including orthodontics and orthognathic surgery, cannot be recommended as they may ultimately reinforce the somatic symptoms.

[48] Ms Anderson submits further that the evidence of Dr Anderson and Burford fall short of findings of a physical injury that caused a mental injury.

Appellant's Reply

[49] In her reply, Ms McClean says in her case there is material evidence of harm to her bodily tissue and that the orthodontists are avoiding this. She says what occurred to her was not a normal orthodontic procedure, it was an orthodontic procedure gone wrong. She says that the orthodontist should not have been pushing her condyles backwards, causing injury.

Decision

[50] The issue before the court in this appeal is whether the appellant has suffered a physical injury caused by orthodontic treatment by her orthodontist, beginning in July 2008 and concluding on 1 February 2012. What is clear from the evidence is that, as the New Zealand Dental Association Peer Review Committee found, there was no evidence that the orthodontist proactively monitored and managed her treatment and that the orthodontist had failed to respond appropriately to Ms McClean's concerns about the time taken and the expected outcome of treatment. As a result, it recommended a refund to Ms McClean of $4,040.

[51] The respondent's position in this case is that essentially there is insufficient evidence of an injury caused by the treatment.

[52] It is appropriate to remind ourselves what was said in *ACC v Ambros*[1] relating to causation.

> [67] The different methodology used under the legal method means that a court's assessment of causation can differ from the expert opinion and courts can infer causation in circumstances where experts cannot. This has allowed the court to draw robust inferences of causation in some cases of uncertainty …
>
> However, a court can only draw valid inferences based on facts supported by the evidence and not on the basis of supposition or conjecture …
>
> Judges should ground their assessment of causation on their view of what constitutes the normal course of events, which should be based on the whole of the lay, medical and statistical evidence, and not be limited to expert witness evidence.
>
> …
>
> [70] Finally on this topic, we note that the generous and unniggardly approach advocated in *Harrild v Director of Proceedings* [2003] 3 NZLR 289 at (19) (CA) per Elias CJ, at (39) per Keith J and at [130] per McGrath J was used by the High Court in

[1] *Accident Compensation Corporation v Ambros* [2007] NZCA 304

> this case to modify the causation test. This, in our opinion, is not an appropriate application of the principle, given the plain words of the 1998 Act and the rejection of the increased risk test in *Atkinson*. The generous and uniggardly approach referred to in *Harrild* may, however, support the drawing of "robust" inferences in individual cases. It must, however, always be borne in mind that there must be sufficient material pointing to proof of causation on the balance of probabilities for a court to draw even a robust inference on causation. Risk of causation does not suffice.

[53] In this regard, in this case, I find the following matters important. First, there is the evidence and submissions of the appellant herself. In the course of the appeal hearing, as she related the history, she was at times distressed. I conclude that for her, recall of this period of her life was genuinely distressing. I accept that she had endured long standing pain as a result of her orthodontic treatment between 2008 and 2012.

[54] Referring to the specialist evidence, Dr Anderson says, in his report of 1 August 2016, that there does appear to be some change to the anatomy of the appellant's TMJs and he rather opens the door to consideration of the treatment as a causal factor in this when he says:

> It is hard to say that this is entirely due to the orthodontic treatment …

[55] His conclusion therefore is that some change to the appellant's TMJs was due to the orthodontic treatment.

[56] In Dr Burford's report of 28 June 2017, in his working diagnosis, he says that the appellant's symptoms, which include headaches, jaw pain, tinnitus, ear pain, hearing loss, pain behind the ear, blurred vision, back pain and other pain symptoms are, at least in part, caused by "late effects of complications of dental/medical care."

[57] Most crucially, however, in his report of 10 August entitled "Report on TMJ relationships for Genevieve McClean" which includes an x-ray of condyles placed normally in the fossae, as well as the equivalent x-ray of Ms McClean's condyle presentation, he says:

> It will be observed that the reference images show the condyles vertical and with the retrodiscal (area between the back of the condyle and the bone in front of the ear) approximately 4mm and larger than the space between the condylar head and the eminence of the fossa.
>
> Ms McClean's images reveal condyles at the back of the joint spaces and bending (looking like hockey sticks) to remain in the fossae. The condyles will be compressing the posterior lamina and being a factor in her head and facial pain, jaw clicking and associated symptoms.

[58] Dr Burford is in essence saying that the appellant's condyles have been bent and he contrasts them with "normal" condyles that are vertical.

[59] There is no evidence that the appellant had her present pain symptoms before she undertook the orthodontic treatment. Perhaps if there had been more focussed care by the orthodontist, what has occurred could have been avoided.

[60] I conclude that the combined evidence of Dr Burford, Dr Anderson and the appellant herself, satisfies me that her bent condyles were caused by the treatment from a registered health professional. The bending of the condyles caused by the treatment, I find to be a physical injury for the purposes of s 26, which has resulted in substantial pain and discomfort for the appellant.

[61] Accordingly, the appeal is allowed and the respondent's decision of 24 November 2016 declining cover for a dental treatment injury is reversed.

[62] Costs are reserved.

CJ McGuire
District Court Judge

Solicitors: Katherine Anderson, Barrister, Auckland