Scottish Parliament Region: Highlands and Islands

Case 200501331: A Dentist, Argyll and Clyde NHS Board[1]

Summary of Investigation

Category

Health: Dentist

Overview

The complainant (Mr C) raised a number of concerns about the care and treatment which he and his wife (Mrs C) received from their dentist (Dentist 1). He also complained that Mrs C had been unfairly removed from Dentist 1's dental list and that she was not advised of the reasons for the decision.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Mr C's waiting time for each appointment with Dentist 1 was unreasonable (*no findings)*;

(b) Dentist 1's examination of Mr C's teeth was inadequate *(not upheld);*

(c) Dentist 1 incorrectly advised Mr C that he had a restricted mouth opening (*no findings);*

(d) Dentist 1 should not have advised Mr and Mrs C that they had 'very serious' or 'serious' gum disease or to avoid drinking tea, coffee and red wine *(no findings);*

(e) Dentist 1 was not entitled to discuss with or offer advice to Mr C on his medical history or medication *(not upheld);*

(f) Dentist 1 unfairly removed Mrs C from his dental list *(partially upheld)*;

(g) Dentist 1 did not advise Mrs C of the reasons for his decision *(not upheld)*; and

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[1] Argyll and Clyde Health Board (the former Board) was constituted under the National Health Service (Constitution of Health Boards) (Scotland) Order 1974. The former Board was dissolved under the National Health Service (Constitution of Health Boards) (Scotland) Amendment Order 2006 which came into force on 1 April 2006. On the same date the National Health Service (Variation of the Areas of Greater Glasgow and Highland Health Boards) (Scotland) Order 2006 added the area of Argyll and Bute Council to the area for which Highland NHS Board is constituted and all other areas covered by the former Board to the area for which Greater Glasgow Health Board is constituted. The same Order made provision for the transfer of the liabilities of the former Board to Greater Glasgow Health Board (now known as Greater Glasgow and Clyde Health Board) and Highland Health Board. In this report, according to context, the term 'the Board' is used to refer to the former Board or Highland NHS Board as its successor.

(h) Dentist 1 failed to address all points of complaint raised by Mr C *(upheld).*

Redress and recommendations

The Ombudsman recommends that Dentist 1:

(i) apologises to Mrs C for failing to follow the correct notification process for de-registration and takes steps to ensure that he and his staff become conversant with the legal provisions in this area; and

(ii) apologises to Mr C for failing to address the points of complaint raised by Mr C and takes steps to ensure that, in future, he responds appropriately to all points of complaint made by patients in letters of complaint.

Main Investigation Report

Introduction

1. Mr C and his wife (Mrs C) first visited Dentist 1 on 20 May 2005 when Dentist 1 carried out an examination of Mr and Mrs C's teeth. Mr C was advised that he required further treatment and a follow up appointment was made for 28 June 2005. Mr C mistakenly arrived at Dentist 1's surgery on 21 June 2005 and was advised that he could not be seen that day and would have to return on 28 June 2005 for the scheduled appointment. Mr C duly returned to Dentist 1's surgery on 28 June 2005. The outcome of this appointment was that Dentist 1 refused to treat Mr C and removed Mr and Mrs C from his dental list.

2. Mr C wrote two letters of complaint to Dentist 1, the first dated 28 June 2005, the day of the scheduled appointment, and the second was undated. In Dentist 1's letters of response, one undated and one dated 11 July 005, he disputed Mr C's version of events.

3. On 19 August 2005 the Ombudsman received a complaint from Mr C regarding the care and treatment which he and Mrs C had received from Dentist 1. He also complained that Mrs C had been unfairly removed from Dentist 1's dental list and was not advised of the decision.

4. The complaints from Mr C which I have investigated are that:

(a) Mr C's waiting time for each appointment with Dentist 1 was unreasonable;
(b) Dentist 1's examination of Mr C's teeth was inadequate;
(c) Dentist 1 incorrectly advised Mr C that he had a restricted mouth opening;
(d) Dentist 1 should not have advised Mr and Mrs C that they had 'very serious' or 'serious' gum disease or to avoid drinking tea, coffee and red wine;
(e) Dentist 1 was not entitled to discuss with or offer advice to Mr C on his medical history or medication;
(f) Dentist 1 unfairly removed Mrs C from his dental list; and
(g) Dentist 1 did not advise Mrs C of the reasons for his decision

5. Mr C complained about several other aspects of his care and treatment by Dentist 1. While I can appreciate that Mr and Mrs C feel that all of their complaints raise cause for concern, it is part of the role of the Complaints Investigator to identify and focus on the areas of the complaint where an investigation could produce evidence or opinions to allow conclusions and

appropriate recommendations to be made.

6. It was clear to me that some aspects of Mr C's complaint concerned matters for which there would be no means of obtaining independent witness statements to allow appropriate conclusions to be reached. These include the disputed details of the conversation between Mr C and Dentist 1 about Mr C's erroneous visit to Dentist 1's surgery; Mr C's complaint that Dentist 1 was aggressive towards him; Mr C's belief that Dentist 1 inferred that he would not treat someone with mental health problems and Mr C's general concerns about the manner in which he was spoken to by Dentist 1. All of these concerns arose as a result of conversations between Mr C and Dentist 1. No independent witnesses were present and, as a result, it would not be possible to reach defensible conclusions on these matters. In the circumstances, I have, therefore, excluded these matters from my investigation of Mr C's complaint.

7. It is also the case that there are some complaints where it will never be possible to determine, even on the balance of probabilities, whether the complainant's version of events is correct. Mr C's complaint that Dentist 1's examination of his teeth was painful falls into this category and has, therefore, been excluded from my investigation.

8. As my investigation progressed, I identified issues concerning the way in which Dentist 1 had dealt with Mr C's letters of complaint. In my investigation, I, therefore, additionally considered whether:

(h) Dentist 1 failed to address all points of complaint raised by Mr C.

Investigation

9. The investigation of this complaint involved reading all the documentation supplied by Mr C, assessing Mr and Mrs C's relevant dental records and background correspondence and studying relevant legislation in this area. I also made enquiries of Dentist 1 and Mr C and obtained the views of the Ombudsman's dental adviser (the Adviser) on the complaint.

10. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mr and Mrs C and Dentist 1 were given an opportunity to comment on a draft of this report. I feel it is important to note that, throughout this investigation, Dentist 1 and Mr C have presented very different versions of events and that both parties feel very strongly that their recollection of the events of 20 May and 28 June 2005 is

correct.

(a) Mr C's waiting time for each appointment with Dentist 1 was unreasonable

11. Mr C stated that, on 20 May 2005, he and his wife were kept waiting for one hour before being called for their appointment and that, on 28 June 2005, he had to wait 20 minutes before being seen by Dentist 1.

12. Dentist 1 did not respond to this complaint about alleged delays in his response to Mr C's letter of complaint.

13. The Adviser commented that a typical day in a dental practice can on occasion be very busy and that it is often difficult to know how much time or treatment a particular patient may require. In addition, emergency patients have to be accommodated and it is not unusual for a dentist to be running late on a particular day. He added that if a patient was indeed kept waiting for one hour, it would be helpful for the receptionist to tell the patient that the dentist is running late and keep them updated as to the time when they are likely to be seen.

14. When questioned, Mr C explained that at his appointment on 20 May 2005 he was advised by the receptionist that Dentist 1 was running a bit late and that he may have a little wait. He said that at his appointment on 28 June 2005 he was not given any information on potential delays. He claimed that he was not offered any apology for the delays at either appointment.

15. In response to my enquiries, Dentist 1's wife, the Practice Manager, explained that it was standard practice to apologise for delays and to give the patient the opportunity to book an alternative appointment. She said that there were no records of the alleged delays as the events in question took place before they introduced their computerised system. She added that as the events occurred so long ago, she was unable to remember exactly what had happened and that the dental nurses who were present during each of the appointments no longer worked at the surgery.

(a) Conclusion

16. I have taken on board the Adviser's comments and understand that it is not always possible for appointment times to be adhered to. The Practice Manager is unable to recollect whether there were any delays in Mr C's

appointments and I note that Mr C seems clear about his version of events. However, in the absence of any written evidence or independent witness statements, I am unable to determine whether or not the reported delays occurred and, if so, whether apologies or explanations were offered to Mr and Mrs C. I am, therefore, unable to reach any findings on this complaint.

(b) Dentist 1's examination of Mr C's teeth was inadequate

17. Mr C stated that he felt that the examination of his teeth during his appointment was inadequate. He stated 'on previous occasions each tooth was checked and the number given to the assistant along with any information about it. This did not happen'.

18. In his response to Mr C's letter, Dentist 1 did not comment on Mr C's concern about the basic examination of his teeth.

19. The Adviser stated that the dental records show that the examination of Mr and Mrs C's teeth was quite reasonable.

20. In response to my enquiries, the Practice Manager said that she did not understand why Mr C had complained about the basic examination of his teeth as she said that Mr C's teeth were 'charted' and that it is a basic standard procedure.

(b) Conclusion

21. The Adviser has indicated that, in his professional opinion, the dental record shows that the examination of Mr and Mrs C's teeth was adequate. I accept that view and, therefore, do not uphold Mr C's complaint.

(c) Dentist 1 incorrectly advised Mr C that he had a restricted mouth opening

22. Mr C said he was concerned that Dentist 1 complained that Mr C's mouth had a restriction, as Mr C claimed never to have been told this before.

23. In his response to Mr C's letter, Dentist 1 confirmed that Mr C had a 'restricted mouth opening which may require further investigation'. He suggested that Mr C may wish to ask his medical or future dental practitioner about this matter.

24. The Adviser explained that a restricted mouth opening means that a

patient is unable to open their mouth very wide, and this does make the examination more difficult for a dentist. He advised that it would indeed be appropriate for the dentist to comment if a patient suffers from this condition.

(c) Conclusion

25. The Adviser has explained that if Mr C had a restricted mouth then it would be appropriate for Dentist 1 to advise him of this. It has not been possible, within the confines of my investigation, for me to independently determine if Mr C does, in fact, have such a restriction. I am unable to reach a conclusion on this part of Mr C's complaint and must, therefore, show no findings.

(d) Dentist 1 should not have advised Mr and Mrs C that they had 'very serious' or 'serious' gum disease or to avoid drinking tea, coffee and red wine

26. Mr C stated that Dentist 1 advised him that he had 'a very serious gum disease' and advised Mrs C that she had a 'serious gum disease'. Mr C stated that he was aware 'there is a slight recession of [his] gums, that one tooth is loose and another, which has a gold cap is something to keep an eye on.' Mr C said that he was concerned about Dentist 1's advice and claimed that his wife was very worried about the advice she had received. Mr C also claimed that Dentist 1 told both him and his wife that they should not drink tea, coffee or red wine. He complained that this was none of Dentist 1's business.

27. Dentist 1 did not specifically comment on the 'very serious gum disease' or 'serious gum disease' in his response. He did, however, explain that his advice to Mr and Mrs C was to avoid substances such as tea, coffee and red wine whilst using the mouthwash which he had recommended for their periodontal condition, due to possible staining of their teeth. He added 'your periodontal health is…of utmost importance and should not be neglected, in particular your own efforts in oral hygiene and maintenance'. Dentist 1's notes on Mr C's dental records noted that Mr C had 'very poor oral hygiene', that he was advised to use a 'Chlorhexidine mouthwash' and that its 'use and stain' were discussed. Mrs C's records noted 'below average oral hygiene, oral hygiene instruction, flossing advice, Chlorhexidine mouthwash, advice'.

28. Mr C later claimed that the reasons for avoiding tea, coffee and red wine were not explained to him by Dentist 1.

29. The Adviser stated that Mr C's records showed that on 12 August 2004 a

basic periodontal examination (BPE) of Mr C's teeth was carried out by Mr C's previous dentist and the BPE scores recorded showed the presence of 'periodontal disease'. He added that the periodontal condition, or gum disease, required appropriate periodontal treatment to stabilise the condition. However, he stated that Mrs C's records did not show any entry of a BPE and that the notes relating to her periodontal condition were very sparse.

30. The Adviser also confirmed that the advice on Mr and Mrs C's record was to use chlorhexidine mouthwash, and one of the effects of this mouthwash is to cause tooth staining. He stated that it was appropriate, therefore, for Dentist 1 to advise avoidance of tea, coffee and red wine when using this mouthwash as it can make staining more severe.

31. In response to my enquiries the Practice Manager said that both Mr and Mrs C had 'serious gum disease'.

(d) Conclusion

32. It is clear from the evidence that Mr C has a gum disease and it was, therefore, appropriate for him to be advised of this. Within the confines of this investigation, it has not been possible to determine if, as has been alleged, Mr C's gum disease is 'very serious'. In Mrs C's case there is insufficient evidence for me to determine whether or not she has such a condition. As I am unable to fully establish the condition of Mr and Mrs C's gums, I cannot determine whether Dentist 1's advice was correct. In conclusion, I am, therefore, unable to make any findings on this part of the complaint.

33. From the Adviser's notes it is clear that it would have been appropriate for Dentist 1 to advise Mr and Mrs C to avoid tea, coffee and red wine whilst using the mouthwash. Dentist 1 has indicated that he explained why the avoidance of these drinks was necessary. Mr C has said that he was not advised of this reasoning. As there is no way for me to establish which is the correct version of events, I am unable to reach any conclusion on this part of this complaint.

(e) Dentist 1 was not entitled to discuss with or offer advice to Mr C on his medical history or medication

34. Mr C stated in his letter to Dentist 1 that during his appointment on 28 June 2005 Dentist 1 asked him if he had had any problems with his teeth since his last appointment. Mr C said he indicted that he had not. Mr C claimed that Dentist 1 then asked him if he had had any other problems. Mr C said that

he advised Dentist 1 that he did not feel it was any of his business to know about his problems other than dental ones. Mr C stated that Dentist 1 then came very close to him and said that he meant 'with [Mr C's] health and tablets'. Mr C stated that he advised Dentist 1 that he suffers from mental health problems, namely 'depression anxiety panic attacks'. Mr C stated that he asked Dentist 1 what treatment he intended to do and Dentist 1 advised that he would not treat Mr C.

35. Dentist 1 stated in his response 'the most important advice I feel impelled to give you, in view of your own repeated admission regarding your mental health, is that your reported list of medications are not without their side-effects and require at times close specialist monitoring and attention. Considering aspects of your behaviour, and with due respect, I would recommend that you see your medical practitioner for advice possibly with regard to reviewing your medication regime'.

36. Mr C subsequently complained about Dentist 1's comments regarding his medication and care and said that it was not something which he believed Dentist 1 should be concerned with. He said that he felt that Dentist 1 was insinuating that the Psychiatrist and Community Psychiatric Nurse (CPN) along with Mr C's GP were 'not doing their job right'. He added that his medication for his mental health was correct and that 'the reason [he] was upset was [Dentist 1's] attitude, not any of [his] conditions'. Mr C explained that he had also just lost his father and had returned from the funeral a few days earlier. He said that he felt that Dentist 1 did not have any 'empathy with how any of [Dentist 1's] customers may be feeling at any given time'. Mr C also claimed that, since visiting Dentist 1, he had had to increase his medication and have extra sessions with his CPN.

37. The Adviser commented that it is appropriate and good clinical practice for a dentist to take a medical history for all patients. He advised that oral health is viewed as part of total health for a patient. He said that it was, therefore, reasonable for Dentist 1 to enquire about Mr C's medication, and if a dentist does have concerns, then it is good practice to ask a patient to visit his doctor and possibly for the dentist to write a letter to the doctor would be helpful.

(e) Conclusion

38. In light of the Adviser's comments, which I accept, I conclude that it was reasonable for Dentist 1 to enquire about Mr C's general health and medication.

I, therefore, do not uphold this complaint.

(f) Dentist 1 unfairly removed Mrs C from his dental list; and (g) Dentist 1 did not advise Mrs C of the reasons for his decision

39. Mr C stated in his letter to Dentist 1 that after Dentist 1 had advised him that he would not be receiving any treatment, Dentist 1 asked him to leave the surgery. Mr C claimed that Dentist 1 advised him 'leave or I will get the police'. Mr C added that he then 'left the surgery with what was supposed to be the practice manager with whom [he] would be able to discuss the situation in private but no, [he] had to discuss this in full view of the public'.

40. In his response, Dentist 1 stated that he felt that Mr C's behaviour was aggressive and violent. He claimed that Mr C persistently and aggressively refused to leave the surgery, making violent gestures. He stated that this was why he advised Mr C of his intention to call for police presence and assistance in removing him from the premises. He went on to explain that 'due to the aggressive nature of [Mr C's] behaviour [he] was not allowed to enter the office area, but [was] dealt with in the overflow waiting area away from direct public attention, but in view of other members of staff'. Dentist 1 has indicated that both the Practice Manager and his assistant witnessed the events, and Mr C's dental records contain the assistant's supporting account of events.

41. Mr C denied that he was aggressive or violent and has said that he was very anxious due to the events of his initial visit to the surgery.

42. Dentist 1 also explained in his first letter to Mr C that he had written to the Scottish Dental Practice Board and 'removed' Mr C from his list of patients 'together with [Mr C]'s wife, for obvious reasons'. In his response, Mr C thanked Dentist 1 for removing him and his wife from Dentist 1's list as they had already decided, after their first visit to the surgery, to try someone else.

43. The Adviser explained that if a dentist feels that there has been a breakdown of the dentist/patient relationship, the dentist can de-register the patient using a standard form. He confirmed that these forms, dated 5 July 2005, were present in both Mr and Mrs C's dental records and noted that the reason given for the de-registration was that Mr C was violent. The comments on the forms showed that the de-registration for Mr C was with immediate effect. The Adviser explained that violence is a reason where patients can be de-registered immediately and made reference to Dentist 1's

undated letter to Mr C in which he mentioned that the intention of the Practice was to call the police.

44. The Adviser added that it was reasonable for Dentist 1 and his staff to record the details of the events of 28 June 2005 on Mr C's dental records as the prompting for the de-registration was the alleged violence. He concluded by saying that he sympathised with the complainants, but sometimes a dentist/patient relationship does not work out and that 'the right appears equally to the patient who could terminate an agreement with a dentist and indeed go to see another dentist'. In this case, Mr C has already confirmed he intended leaving Dentist 1's list anyway.

45. In response to my enquiries, the Practice Manager claimed that on 28 June 2005 she heard Mr C talking loudly and saw him making a punching action towards Dentist 1. She explained that she took Mr C into the foyer as she was too frightened to deal with him in private. She said that she sat with Mr C for about 20 or 30 minutes and tried to get him to calm down and leave. In his response, Mr C strongly denied that he behaved this way.

46. The Practice Manager said that they then asked Argyll and Clyde NHS Board (the Board) to de-register Mr C and Mrs C. The necessary standard forms dated 5 July 2005 supplied by Dentist 1 for Mr and Mrs C showed a completed entry indicating Dentist 1's intention to withdraw from care arrangements with Mr and Mrs C three months from the date of completion of the form. However, Mr C's form also stated 'Patient was violent. DPB [Dental Practice Board] have said that under these circumstances de-registration would be immediate'. Mrs C's form, dated 5 July 2005, stated 'Husband [Mr C] was violent and is being de-registered with immediate effect'.

47. The Practice Manager provided a copy of a letter from the Dental and Ophthalmic Practitioner Services Officer at the Board dated 25 July 2005. In the letter the officer asked 'With regard to your recent application to remove the above named patient because of violent behaviour. I have to inform you that in order for the arrangement to be terminated immediately you must have reported the incident to the police. Please confirm that the police have been informed and advise me of the incident number. If you have not informed the police, the Health Board cannot terminate the arrangement immediately but must inform the patient that he is being removed and give him the opportunity to make representations against your application'.

48. The Practice Manager provided a copy of her response dated 3 August 2005 in which she stated 'The Health Board advised us that due to violent conduct [Mr C] would be removed immediately. We managed to get [Mr C] to leave the Practice without police intervention. Could you please just go through your normal procedures to remove [Mr C] from [Dentist 1's] patient list'.

49. During my enquiries, the Practice Manager advised me that dentists can de-register a patient for any reason.

50. The National Health Service (General Dental Services) (Scotland) Regulations 1996 (the Regulations) state that a dentist who wishes to terminate a continuing care agreement shall give the patient three months' notice in writing of the termination of the agreement and notify the Health Board accordingly. The Regulations do not comment on the reasons for which a dentist may terminate a continuing care agreement. In cases where a dentist wishes the agreement to be terminated on less than three months' notice, the Regulations state that the dentist must apply in writing to the Health Board asking that it terminate the agreement and setting out the reasons why he wishes the agreement to be terminated. The Regulations state that after considering representations made by the patient, the Board may terminate the arrangement on such a date as it thinks fit.

(f) Conclusion

51. It is clear from the documentation that Dentist 1 wished to de-register Mr C with immediate effect because of Mr C's alleged violent behaviour and that Mrs C was to be de-registered three months hence. Dentist 1 indicated to Mr C in his undated letter that he had written to the Scottish Dental Board and 'removed' Mr and Mrs C from his list of patients, thus suggesting that the removal of Mr and Mrs C from his dental list had already taken place. The evidence shows that although the Practice Manager later clarified with the Board that the normal de-registration process should be followed for Mr C, no steps were taken by Dentist 1 to advise Mr C that this was the case and Mrs C was still left with the impression that she had already been removed fro the list. It is clear that, in terms of his communication with Mr and Mrs C, Dentist 1 did not follow the procedure laid down in the Regulations, as he did not provide Mr or Mrs C with three months notice of his intention to terminate the care agreements. Further, Dentist did not have the authority to advise Mr C that he

and his wife had been 'removed' from his list of patients. However, it is noted that, although Mr C feels that his wife did nothing wrong and that her removal was unfair, Dentist 1 was entitled to take steps to initiate Mrs C's removal from his dental list. It is also noted that, on being advised of their removal, Mr and Mrs C thanked Dentist 1 and said they had already decided to try someone else.

52. In conclusion, although Dentist 1 had the right to remove Mrs C from his dental list, as he did not follow the correct notification process, I partially uphold Mr C's complaint.

(f) Recommendation

53. The Ombudsman recommends that Dentist 1 apologises to Mrs C for this failing and takes steps to ensure that he and his staff become conversant with the legal provisions in this area.

(g) Conclusion

54. Mrs C's removal from Dentist 1's list was initiated under the 'three months' notice' procedure contained in the Regulations. This did not required Dentist 1 to provide reasons for his decision to remove Mrs C from his dental list. I, therefore, do not uphold this complaint.

(h) Dentist 1 failed to address all points of complaint raised by Mr C

55. In his letters of complaint to Dentist 1, Mr C raised several points of complaint about the care and treatment which he and his wife had received from Dentist 1. Dentist 1 did not respond to several of the issues raised by Mr C, as detailed in paragraphs 12, 18 and 27 of this report.

56. In his comments to the Ombudsman's office, Dentist 1 explained that he felt that Mr C's original letter of complaint was extremely long and made a considerable number of statements which Dentist 1 felt he could not address. Dentist 1 said he felt that if he had addressed all the points in Mr C's letter, then his response would have been nothing more than a succession of rebuttal statements.

(h) Conclusion

57. It is clear that Dentist 1 did not respond to all of the points of complaint made by Mr C, although it is noted that Dentist 1 has said that he did not think it was appropriate to do so. As a matter of good complaint handling practice, I

would expect a dentist to respond to the issues raised by a complainant in a letter of complaint. In a case such as this, it would be deemed wise and appropriate for Dentist 1 to have explained that he had difficulty in responding to Mr C's letter and to ask for clarification of the main points of complaint, to allow an appropriate response to be provided in due course. I, therefore, uphold this complaint.

(h) Recommendation

58. The Ombudsman recommends that Dentist 1 apologises to Mr C and takes steps to ensure that, in future, he responds appropriately to all points of complaint made by patients in letters of complaint.

23 May 2007

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Mrs C	The complainant's wife
Dentist 1	The complainant and his wife's dentist
The Adviser	The Ombudsman's dental adviser
BPE	Basic periodontal examination
CPN	Community Psychiatric Nurse
The Regulations	The National Health Service (General Dental Services) (Scotland) Regulations 1996

Annex 2

List of legislation and policies considered

The National Health Service (General Dental Services) (Scotland) Regulations 1996