Scottish Parliament Region: Glasgow

Case 200600276: A Dentist, Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Dental treatment

Overview

The complainant (Mrs C) raised a number of concerns about the care and treatment she received from her dentist (the Dentist), and about his attitude in handling her complaint.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the Dentist failed to provide Mrs C with dental treatment of a reasonable standard on 4 April 2006 in that he broke her tooth (*not upheld*);

(b) the Dentist mishandled Mrs C's complaint (*not upheld*); and

(c) the Dentist's attitude towards Mrs C was demeaning (*no finding*).

Redress and recommendations

The Ombudsman recommends that the Dentist ensures that appropriate records are kept, including x-ray, in respect of root canal treatment.

Main Investigation Report

Introduction

1. On 4 April 2006, Mrs C visited her Dentist (the Dentist) for root canal treatment, during which time her upper right first premolar tooth (UR4) became fractured. The following day Mrs C telephoned the Dentist to complain about the treatment. Mrs C also said that she had not been warned of the possibility her tooth would fracture or given a choice of treatment. She then put her complaint in writing to the Dentist.

2. The Dentist responded to Mrs C's complaints on 5 and 20 April 2006, however, she felt that these responses and his attitude during the treatment were demeaning.

3. On 4 May 2006 the Ombudsman received a complaint from Mrs C about the Dentist.

4. The complaints from Mrs C which I have investigated are that:
(a) the Dentist failed to provide Mrs C with dental treatment of a reasonable standard on 4 April 2006 in that he broke her tooth;
(b) the Dentist mishandled Mrs C's complaint; and
(c) the Dentist's attitude towards Mrs C was demeaning.

Investigation

5. In investigating this complaint I have had access to Mrs C's dental records and the correspondence between Mrs C and the Dentist. I also obtained clinical advice from the Ombudsman's professional dental adviser (the Adviser) and my conclusions are based on the information and advice I have received.

6. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C and the Dentist have been given the opportunity to comment on the draft of this report.

(a) The Dentist failed to provide Mrs C with dental treatment of a reasonable standard on 4 April 2006 in that he broke her tooth

7. Mrs C attended an appointment with the Dentist on 28 February 2006 complaining of toothache. It was not possible at that time to establish which tooth was causing the pain, as such the Dentist advised Mrs C to return when

the pain was more specific. However, he did note in the clinical records that it was possibly UR4 and that root canal treatment may be required.

8. On 16 March 2006 Mrs C returned and UR4 presented as tender to percussion. Root canal treatment for UR4 was commenced, the nerve of the tooth was removed and a dressing was placed on it.

9. On 4 April 2006 Mrs C attended for the remainder of the root canal treatment, whereby the root was filled with a root filling material called gutta percha and sealed with a proprietary sealant called 'tubiseal'. During this stage of the treatment the UR4 fractured.

10. The Dentist advised Mrs C that he would fit her with a crown (cap) once the symptoms from her tooth had settled down.

11. Mrs C complained that she was not advised of the possibility that the tooth could fracture before or during the root canal treatment and was unhappy about having to wait for a crown to be fitted. The Dentist responded to Mrs C's concerns stating that he was unable to predict that the tooth would fracture from an x-ray, unless the x-ray beam is exactly in line with the fracture line. In addition fractures are often obscured by metal fillings. He also stated that it was advisable to wait a few weeks before fitting a crown to ensure that the bacteria remains settled.

12. The Adviser was specifically asked to look at whether the Dentist provided Mrs C with a reasonable standard of dental treatment on 4 April 2006. The Adviser examined the records including the x-rays and made three observations.

13. The Adviser was able to establish that there was a large amalgam filling in the tooth in question. He has stated that where root canal treatment is required on a filled tooth it is necessary for the dentist to drill through the filling down into the nerve, and that this can lead to fracturing which is not predictable beforehand. As such the Adviser agreed with the Dentist that it was not possible to predict that Mrs C's tooth would fracture, nor was it possible to detect that this may happen from an x-ray.

14. The Adviser also stated that the need for a crown in this case was quite normal and the timescales for this were reasonable. In short the Adviser agreed with the Dentist's clinical comments in his letters to Mrs C.

15. The Adviser did have some comments regarding the Dentist's record-keeping. Specifically that there was no charting on the dental grid of any existing or new fillings, and that there was a lack of x-rays taken in relation to the root canal treatment. The Adviser stated that appropriate clinical practice would be to take a current apical x-ray before the procedure, a diagnostic x-ray of the two root canal files in place in the root canals to ascertain that the measurements are correct and a post treatment x-ray following the procedure. It appears in this case that the Dentist did not take any such x-rays of the tooth. Although it is accepted that the lack of x-rays would not have altered the outcome in this case.

16. The Dentist responded via his professional union to the Adviser's comments about record-keeping stating that there is no obligation under NHS Scotland to enclose a charting of specific fillings on the dental grid. A charting of the teeth is available on the dental record. He also stated that an apex locator was used as an alternative to a diagnostic x-ray of the root canal lengths. There was an x-ray of the UR4 available taken on 28 February 2006.

17. Following further advice and discussions between the Adviser and the Dentist's union representative I established that that there is no obligation under NHS Scotland to enclose a charting of specific fillings on a dental grid and that an x-ray of UR4 was taken on 28 February 2006. The Adviser also agreed that an apex locator can be used as an alternative to a diagnostic x-ray; however, there was no written record in Mrs C's notes that an apex locator was used. In addition the Adviser was concerned that the clinical notes for the appointment on the 16 March 2006 have the root canal measurements of palatal 19.5mm and buccal 15.5mm blocked recorded in the date column rather than the treatment column. The Dentist's union representative agreed with the Adviser that this was inappropriate. The same was also true of a note on the last visit 4 April 2006 whereby a note that an x-ray would be required on the next visit was also in entered in the date column.

18. In summary the Adviser stated that the Dentist should ascertain that the measurements taken were correct in relation to the root of the tooth. This can be done either by taking a diagnostic x-ray with the two root canals in place, or

by using an apex locator. However, there was no diagnostic x-ray and no record of an apex locator being used.

(a) Conclusion

19. The Adviser has said that the standard of the root canal treatment was clinically acceptable and agreed with the Dentist's clinical comments to Mrs C. The fracturing of the tooth was unfortunate but is a possibility with root canal treatment and not necessarily something that could have been predicted or prevented by the Dentist. Accordingly I do not uphold the complaint. However, the Adviser was concerned about the quality of the records kept.

(a) Recommendation

20. The Ombudsman recommends that the Dentist ensures that appropriate records are kept, and notes are entered in the correct sections, particularly in relation to diagnostic and post treatment x-rays, during root canal treatments.

(b) The Dentist mishandled Mrs C's complaint

21. Mrs C complained to the Dentist by telephone on the day after her appointment. She complained that she had not been advised that her tooth could fracture and she was not given an option of treatments. She was also unhappy at having to pay for a crown to be fitted on the fractured tooth. Mrs C was unhappy with the Dentist's verbal response and was advised to put her complaint in writing.

22. The Dentist wrote to Mrs C on 5 April 2006 following their conversation to outline the advice he had given her. He explained that it was unfortunate that the tooth had fractured during the procedure but that this was not possible to predict from x-rays, and that any tooth which is heavily filled is at risk of fracture. Mrs C disputes that the tooth was 'heavily' filled. He also advised her that she should wait a few weeks before considering a crown and that she would have to pay for this. The Dentist suggested that payment for the crown was the main cause of her complaint. He suggested that he could recommend another Dentist should she feel unable to return to him.

23. On the same day Mrs C put her complaint to the Dentist in writing, reiterating the above concerns. She stated that she was very unhappy with the way she had been treated, both clinically and his attitude following the treatment. Mrs C said that the Dentist should have advised her that the tooth could fracture. She also claims that in their telephone call he referred to the

NHS as being 'second class' and that he didn't have time to advise all of his NHS patients of all the possible risks. Mrs C goes onto write that had she been fully informed she would have opted to have a crown fitted rather than have the root canal treatment.

24. Mrs C described how the appearance of her tooth following the treatment had made her feel paranoid about how she looked and expressed her anger at the way in which he had dealt with her.

25. It appears that the Dentist and Mrs C's letters crossed in the post.

26. In response to her letter the Dentist wrote to Mrs C again on 20 April 2006. He expressed regret that she was not happy with her treatment and explained that fracturing of the tooth was unfortunate but entirely possible. He advised Mrs C that dental restorations have an average life span of eight years. He denied referring to the NHS as second class and states:

> 'I think I understand your misconception that I would expect NHS patients to accept inferior quality of treatment. This is a completely erroneous and untrue allegation.'

27. In relation to giving the option of a crown rather than root canal treatment the Dentist said:

> 'Your suggestion that I may just 'give you the cap' is also misplaced since this would not have alleviated your acute sensitivity which was resolved by root canal therapy.'

28. Lastly the Dentist enclosed a copy of the practices complaints procedure on how Mrs C could advance her complaint.

(b) Conclusion

29. Mrs C was concerned that the Dentist had not handled her complaints properly. The Dentist responded to Mrs C complaints verbally and in writing, addressing all the points raised by her complaint. He also offered to find her another NHS dentist and provided her with details on where to escalate her complaint. In light if this I am satisfied that the Dentist dealt Mrs C's complaints properly and in a timely fashion. Accordingly I do not uphold the complaint.

(c) The Dentist's attitude towards Mrs C was demeaning

30. Mrs C complained that she felt the Dentist's attitude during her treatment and when handling her complaint was demeaning, and that his manner was 'arrogant and ignorant'. In support of her complaint to the Ombudsman Mrs C stated the following examples of how she felt the Dentist's attitude was demeaning.

31. She said that the Dentist was 'chatting' to his assistant throughout the root canal treatment. She particularly recalls him referring to working on the brakes on his father's car when he was younger.

32. The Dentist responded by stating that he does not recall details of the conversation. However, he does talk to his staff whilst treating patients in order to maintain a relaxed atmosphere and most patients appreciate this and it does not distract from the treatment

33. Mrs C said the Dentist kept his hands in her mouth whilst he informed her that her tooth had broken, rather than sitting down and advising Mrs C as to what had happened.

34. The Dentist denies keeping his hands in Mrs C's mouth whilst informing her that the tooth had broken.

35. Mrs C said he failed to show her a mirror to look at the tooth once he had finished. Mrs C said she was very distressed when she returned home and saw her tooth and its affect on her appearance.

36. The Dentist states that Mrs C was given a large hand mirror immediately upon sitting up and the nurse can confirm this.

37. Mrs C stated that the Dentist stood leaning against the units with his hands crossed whilst he explained the situation to her, and that his attitude about the fracture was unprofessional.

38. The Dentist stated that his normal practice is to remain seated when treating patients and when discussing treatments. He said that he did not recall treating Mrs C any differently to any other patient. Whilst he cannot recall his positioning at the time, the Dentist did recall explaining the reason for the fracture and the treatment options available. He also stated that even if he had

been leaning against the units, he did not see how this could be construed as flippant, and could actually present a relaxed posed.

39. Mrs C said that the Dentist did not explain what could happen during the treatment and allow her to decide whether or not she should go ahead with the procedure. When Mrs C raised this with the Dentist on the telephone she states his response was to say that he didn't have time to advise all his clients of the possible risks.

40. The Dentist stated that he and his nurse recollect the discussion with Mrs C immediately after the treatment where the UR4 was fractured. There were two main treatment options that were explained to Mrs C at this time. Firstly to complete the filling, this would have involved a large portion of the 'grey' amalgam being visible from the cheek side of the tooth. Secondly to provide a crown which would match the appearance of the tooth but could not be done straight away and Mrs C would have to wait to ensure the outcome of the root canal treatment had been successful. The Dentist did accept that there could have been a third option to remove the tooth completely; however, given that the root had just been treated there appeared to be no point in pursuing this option at that time.

41. The Dentist said that he and the nurse both remembered the whole appointment on 4 April 2006 taking well over 40 minutes. Mrs C said that the Dentist spent less than five minutes explaining the follow up treatment options to her. The Dentist refutes this and states that Mrs C ample time to discuss further treatment and to return at a later date for more advice. Mrs C has not since returned to the practice.

(c) Conclusion

42. Mrs C has explained in detail why she felt the Dentist's attitude was demeaning. The Dentist has strongly denied Mrs C's view of events. Whilst I do not dispute either view, and this has clearly been a distressing time for Mrs C, I am unable to make any finding on this complaint as it is based on the personal interpretation of one individual over another, with no independent corroborating evidence.

21 November 2007

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
The Dentist	Mrs C's dentist
UR4	The upper right first premolar tooth
The Adviser	The Ombudsman's dental adviser