Scottish Parliament Region: Lothian

Case 200602971: A Dentist, Lothian NHS Board

Summary of Investigation

Category

Health: Dentist

Overview

The complainant (Ms C) raised a number of concerns about the dental treatment which she had received from her General Dental Practitioner (the Dentist) during the period 2005 to December 2006.

Specific complaints and conclusions

The complaints which have been investigated are that the Dentist:

(a) failed to provide Ms C with an appropriate level of dental treatment *(upheld*); and

(b) failed to keep accurate and contemporaneous records (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Dentist:

(i) apologises to Ms C for the failings which have been identified in this report;

(ii) arranges postgraduate training on root canal treatment and periodontal monitoring and screening;

(iii) carries out a clinical audit on the justification, quality and use of radiographs in providing adequate information to make effective treatment planning decisions; and

(iv) conducts a review of his record-keeping and treatment planning procedures.

The Dentist has accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. On 3 January 2007 the Ombudsman received a complaint from Ms C about the dental treatment which she had received from the Dentist during the period 2005 to December 2006. Ms C complained to the Dentist but remained dissatisfied with his response and subsequently complained to the Ombudsman.

2. The complaints from Ms C which I have investigated are that the Dentist:
(a) failed to provide Ms C with an appropriate level of dental treatment; and
(b) failed to keep accurate and contemporaneous records.

Investigation

3. In writing this report I have had access to Ms C's dental records and the complaints correspondence with the Dentist. I obtained advice from the Ombudsman's professional dental adviser (the Adviser) regarding the clinical aspects of the complaint.

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. An explanation of the abbreviations used in this report is contained in Annex 1. A glossary of the clinical terms used in this report can be found at Annex 2. Ms C and the Dentist were given an opportunity to comment on the draft of this report.

(a) The Dentist failed to provide Ms C with an appropriate level of dental treatment

5. Ms C complained that she had not been satisfied with the treatment which the Dentist had provided since early 2005. Ms C said her main concerns related to her lower left front molar tooth (LL6) and lower right first molar tooth (LR6), which had caused her great discomfort. The amalgam fillings which the Dentist had put in LL6 caused her discomfort and kept falling out on numerous occasions. Ms C noted the Dentist had numerous attempts to replace the amalgam filling. She said it had dried out before he could finish and each time he had to drill it out to replace it. Ms C said that when the Dentist finally managed to put in an amalgam filling which did not break, he left a narrow gap between LL6 and LL7 and this caused food to become trapped. She explained the Dentist would only dig out the compacted food and adjust the height of the filling. Ms C subsequently developed an abscess in LR6 and also in LL6. Ms C

said the Dentist then performed root canal treatment (RCT) on both these teeth, however, infections developed because of long delays and inadequate restoration by the Dentist in between each course of RCT. Ms C said that when completing the RCT on LR6 the Dentist cracked the tooth by filling it with amalgam and recreated the food trap in LL6. He also failed to adequately restore LR6 until it was falling apart. While removing the amalgam from LL6 and refilling it, Ms C said the Dentist embedded a shard of silver amalgam in her gum causing severe infection. Ms C said that the Dentist ignored her complaints about the amalgam wound and performed an unnecessary second root treatment on LL6 without her consent.

6. Ms C said that at no time did the Dentist suggest that she should be referred for any type of specialist opinion, although she said he had threatened to refer her to a private dentist in September 2006 after he had cracked LR6. Ms C thought he had done this because she had questioned his treatment methods and she stated he also threatened to stop all work immediately. In November 2006 Ms C said the Dentist refused her request to refer her to another NHS Dentist for a second opinion and he advised her there was nobody to refer her on to. Ms C said the Dentist had not taken time to treat her problems properly, as she had attended at least 50 appointments since April 2005, with 40 being in 2006 alone.

7. In his response to the complaint, the Dentist said that the treatment of LL6 and LR6 were complex and unexpected problems appeared during treatment. The Dentist said that it was noted that Ms C had problems with previous RCT and that he had offered her the option of being referred to a specialist endodontist or extraction. He explained that extraction should be used as a last resort as not all RCT is successful. The Dentist said he treated Ms C promptly and dealt with the problems with great care and recorded her concerns. The Dentist explained that he had treated the gum infections correctly by irrigating the infected area with antibacterial liquid and that he prescribed antibiotics. In respect of the fillings, the Dentist explained that it can be difficult to obtain a tight contact with an adjacent tooth and care has to be taken not to compromise the amalgam contour at gum level. The fact that the Dentist took time over this issue demonstrated that he had taken care. The Dentist denied that he had packed a shard of silver amalgam into the LL6 gum, as he always took great care during the packing of amalgams. The Dentist also said that he appropriately treated the pain reported in LR6. He also said he did not cause LR6 to crack as there was already a fine crack in existence which was treated

by placing bonding cement between the amalgam and the tooth. The Dentist addressed the issue of the second RCT on LL6 by explaining that the position of the gum swelling indicated that the swelling originated from a canal or canals and removal of the root sealer was essential in order to irrigate existing canals and visually check for any additional canals.

8. At interview the Dentist told me that access to amalgam work for his patients was restricted to two afternoons a week on the instructions of the owner of the Practice. This meant that at times he could not deal with amalgam work immediately and had to make repeat appointments so that the work could be completed. The Dentist felt this was important as the delays were outwith his control.

9. The Adviser said that the main issues of the complaint surrounded the treatment provided at the lower right first molar tooth LR6 and the lower left first molar tooth LL6. It was quite clear from the dental records that Ms C had ongoing problems and treatment with LR6 and LL6. There was also an issue with a food trap between LL6 and the lower left second molar tooth LL7. Food trapping usually occurs when there is a gap between teeth – in this case LL6 and LL7. To correct this problem, the filling at the back of LL6 and the front of LL7 need to have good contact, so that food particles do not get trapped.

10. The Adviser reviewed Ms C's dental records. He said that in a clinical record there should be full dental charting, which would include teeth present; existing fillings; caries; missing teeth and charting of fillings carried out at visits as recorded in writing in the clinical notes. The Adviser was unable to read and interpret a great deal of the clinical records. He felt that the quality of the Dentist's record-keeping was poor and was concerned that the date chronology was not sequential at some entries. The Adviser said that, apart from one sparse grid at the front of the GP25 form (Dental Record Card), there was no other charting in the clinical notes. There was no charting showing the size and extent of any existing fillings and no charting of the fillings carried out at LL6 and LR6 at the numerous visits which were recorded on the written clinical notes.

11. The Adviser said Ms C complained about events from summer 2005. The Adviser noted there were 37 recorded entries during the period 6 April 2005 to 8 December 2006. Of these, over 20 entries related to treatment of LL6 and approximately 15 related to LR6. In the Adviser's opinion, the Dentist's

approach to treating LR6 and LL6 was inadequate as it appeared the teeth were constantly patched up and repaired until these teeth started to deteriorate. As Ms C was obviously having continuing problems with LR6 and LL6, the Adviser felt the Dentist should have re-evaluated the situation and formulated an appropriate treatment plan at an early stage of Ms C's treatment. The Adviser was of the opinion that the number of visits required to treat LL6 and LR6 were excessive in relation to what should have been clinically appropriate to achieve a reasonable outcome.

12. The Adviser explained that the starting point for all periodontal examinations should be a screening or basic periodontal examination (BPE). All dentists should carry out a proper periodontal screening procedure for their patients and should comment and record on any radiographic findings. In particular, they should keep patients well informed of their periodontal status. The Adviser noted there were no BPE screenings for Ms C in the records.

13. The Adviser commented that, following the examination of a patient, a treatment plan should be recorded to set out in a logical sequence the proposed method for dealing with a patient's dental problems. In this case there was no adequate documented treatment plan in the clinical notes which related to LR6 or LL6.

14. The Adviser explained that it is mandatory for all radiographs (x-rays) to be reported in the clinical notes. The use of radiographs for dental applications is controlled by the Ionising Radiation Regulations 1999 and the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). These regulations stipulate that all radiographs must be justified, reported in the notes and that a quality assurance programme is established to optimise the quality of radiographs produced.

15. The Adviser documented the radiographs contained in Ms C's records and commented that a radiograph dated 27 February 2006 had faulty processing and was of poor diagnostic value, as was a radiograph dated November 2006 which had been scratched in the processing. He also commented that the radiograph envelopes dated 27 February 2006, 1 June 2006, 13 September 2006, 23 October 2006, 2 November 2006 and 17 November 2006 had no written tooth notation of which teeth were being x-rayed. The Adviser noted that the envelope for radiographs dated 23 October 2006 was empty and that there was also a lack of radiograph

reporting in the clinical records.

16. The Adviser continued that radiographs are essential for endodontic treatment to assist in diagnosis. An immediate post-treatment radiograph is required to assess the success of the Root Canal Filling (RCF) and to act as a baseline for follow-up radiographs. These were available in the clinical notes of LR6 and LL6. The Adviser noted that both LR6 and LL6 were root filled by the Dentist. Lower molar teeth usually have three root canals and possibly four, as was the case with LL6. The Adviser said it was important to adopt correct procedures when carrying out RCT. It would be appropriate for a dentist to introduce the root canal files into the located root canals and take a diagnostic radiograph. A diagnostic radiograph determines the actual length of each root canal so the dentist is able to work to this length and place the final root RCF. The Adviser noted there were no diagnostic radiographs taken of LL6 or LL7.

17. The Adviser commented on the quality of the RCF carried out in this case. He noted the radiograph dated 13 September 2006 showed the completed root filling at LR6. He felt the RCF was reasonable but it appeared to be under extended (short of the root tips). (Note: this was confirmed in a report from a root canal specialist (the Specialist) - Ms C was subsequently referred there by another dentist). The Adviser noted the radiograph dated 2 November 2006 showed the RCF at LL6 and it was clear that the Dentist had not found an extra canal at the back (distal) of LL6 which he had noted in the clinical records. This RCF was also under extended. The Adviser noted the report from the Specialist dated 16 March 2007 which stated that LR6 was giving Ms C intermittent symptoms and a radiograph taken by the Specialist showed that the RCF placed by the Dentist was short in all four root canals and there was evidence of periradicular disease, with a diagnosis of chronic periradicular periodontitis. The Specialist advised that the RCF at LL6 be redone and that Ms C would be having this treatment carried out. The report also stated that the RCF placed by the Dentist at LR6 is adequate in the distal (back of the tooth) canal and short in the two mesial (front of tooth) canals but showed no evidence of periradicular disease. It was suggested that ideally the RCF at LR6 be redone prior to a definitive restoration and that Ms C was to consider this.

18. The Adviser commented that there are situations when the RCT which is required is beyond the scope of the general dental practitioner. Possible situations may include complex molar treatment and certainly in this case LL6 had four canals so this was a complex tooth to root treat. However, he said

practitioners should assess their individual capabilities and refer appropriately. In summary, the Adviser took the view that the care and treatment at LL6 and LR6 which the Dentist provided to Ms C fell below the standard that would be prescribed by the majority of a peer group (ie NHS general dental practitioners), in regard to record-keeping, treatment planning, periodontal monitoring, radiograph (IRMER) regulations and RCT.

(a) Conclusion

19. Ms C complained about the standard of dental treatment which she received from the Dentist over a prolonged period. The problems included issues such as poorly applied amalgam fillings; cracking a tooth; leaving a gap between teeth which allowed a food trap to develop; delays in treatment which caused abscesses to form; an infection caused by a shard of silver amalgam being imbedded in the gum following work on a filling; performing unnecessary RCT on LL6 without consent; and failure to refer Ms C for a specialist opinion. The Dentist maintained that he spent a lot of time with Ms C which demonstrated he had taken great care with her; he had treated the infections appropriately; he denied he had cracked a tooth or imbedded a shard of amalgam in Ms C's gum; and he explained why he had performed additional RCT.

20. As with all investigations which require an opinion on clinical matters, I took advice from the Adviser as to whether he thought the treatment which was provided was of a reasonable standard. The advice which I have received and accept is that this investigation has been seriously hampered by the failure of the Dentist to keep clear records of the treatment he had provided to Ms C and the plans for future treatment. The Adviser has also highlighted that he felt the Dentist's approach to the problems with LL6 and LR6 was inadequate, as it appeared there was an excessive amount of consultations, where these teeth were constantly patched up until they started to deteriorate. The Adviser thought the Dentist should have re-evaluated the situation and formulated an appropriate treatment plan at an early stage of Ms C's treatment. I appreciate there is a difference of opinion between Ms C and the Dentist as to whether the subject of referral for a specialist opinion was discussed but there is nothing recorded in the clinical records which would substantiate the Dentist's assertion. On the balance of probabilities, I am inclined to accept that Ms C's recall of events is more accurate than that of the Dentist. There is, however, reference in the clinical records to a 'sliver of amalgam wedged in a pocket which was removed' on 10 November 2006. This would appear to have been connected

with treatment which took place on 7 November 2006. The Adviser's comments on the recording of radiographs by the Dentist are a serious issue and it is clear to me that the Dentist should address these comments as a matter of urgency. In summary, I have great concerns about the treatment which the Dentist provided to Ms C and, from the evidence which has been obtained, I have decided to uphold this complaint.

(a) Recommendation

21. The Ombudsman recommends that the Dentist:

(i) apologises to Ms C for the failings which have been identified in this report;

(ii) arranges postgraduate training on root canal treatment and periodontal monitoring and screening; and

(iii) carries out a clinical audit on the justification, quality and use of radiographs in providing adequate information to make effective treatment planning decisions.

(b) The Dentist failed to keep accurate and contemporaneous records

22. Ms C said that the Dentist failed to keep contemporaneous and accurate records of the treatment which was provided. When she decided to be treated by another dentist, she was told that before treatment could commence they would need to see radiographs of the Dentist's completed work. Ms C then discovered that, at the consultation on 5 December 2006, the Dentist had failed to take a radiograph on completion of the RCT and had also failed to record what treatment was provided. Ms C was told by her new dentist that she should be referred to the Dental Hospital for urgent treatment.

23. In response to this investigation, the Dentist said he regretted that the record for 5 December 2006 was missing. He had checked all the other patient records for that day and all were present, with the treatment noted. The Dentist said he would continue with his search and would inform me if the search was successful.

(b) Conclusion

24. I have already commented about the poor quality of record-keeping by the Dentist (see paragraph 19) and I have nothing further to add. Accordingly, I uphold this aspect of the complaint.

(b) Recommendation

25. The Ombudsman recommends that the Dentist conducts a review of his record-keeping and treatment planning procedures.

26. The Dentist has accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Dentist notify her when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Ms C	The complainant
The Dentist	Ms C's general dental practitioner
The Specialist	A root canal specialist to whom Ms C was referred by another dentist
The Adviser	The Ombudsman's professional dental adviser
RCT	Root canal treatment
BPE	Basic periodontal examination
RCF	Root canal filling

Annex 2

Glossary of terms

Amalgam fillings	Alloy used in dental restorations
Basic Periodontal Examination (BPE)	Monitoring of the patient's periodontal status
Caries	Tooth decay
Chronic periradicular periodontitis	Inflammatory process which causes periradicular bone resorption that manifests as a periradicular radio-lucency
Dental charting	Graphic description of the condition of a patient's mouth
Diagnostic radiograph	Radiograph which determines the actual length of each root canal so the dentist is able to work to this length and place the final RCF
Endodontist	A dentist who specialises in endodontics (an area of dentistry that deals with diseases of the tooth root, dental pulp and surrounding tissue)
LL6	Lower left first molar tooth
LL7	Lower left second molar tooth
LR6	Lower right first molar tooth
Periodontitis	Destruction of bone around a tooth root

Periradicular	The area around the roots of the teeth
Radiographs	X-rays
Root Canal Filling (RCF)	Material used to fill the root canal of a diseased tooth
Root Canal Treatment (RCT)	The treatment of painful or diseased teeth in which the nerves are removed and the root canal is filled with an inert root filling material