TS0198/03

# Scottish Public Services Ombudsman Act 2002

Report by the Scottish Public Services Ombudsman
of an investigation into a complaint against:

A General Dental Practitioner in the Lothian Health Board Area

## Introduction

Background to Investigation

1. The complainant (Mr C) was 64 years old when he started receiving treatment and regular check-ups from a Dentist (Dentist 1) towards the end of 1996. He last saw her on 20 March 2001. On 5 November 2001 he attended the Dental Practice for an emergency appointment. Dentist 1 had left the Practice so he saw a different dentist. He was told that he had bad gum disease and treatment for this condition commenced. Mr C was shocked by this revelation as he said Dentist 1 never told him that he had a problem with gum disease.

2. Mr C complained via Lothian Primary Care NHS Trust[1] on 8 April 2002. A response to his complaint was received from both the Dental Practice and Dentist 1 but Mr C remained dissatisfied and asked for an independent review of his complaint.

3. On 21 January 2003 an Independent Review Panel considered Mr C's complaint. The Panel concluded that Mr C had experienced an acute episode of his periodontal condition (gum disease) towards the end of 2001 which caused a rapid deterioration of his oral condition and that this could not be attributed to any lack of care provided by Dentist 1. The Panel recommended that dentists should, wherever possible, ensure that patients understood more about gum disease, through leaflets or verbally.

[1] Lothian Primary Care NHS Trust was dissolved under the National Health Service Trusts (Dissolution) (Scotland) Order 2004 which came into force on 1 April 2004. On the same date an Order transferring the liabilities of the Trust to Lothian Health Board came into effect.

4. Mr C remained dissatisfied and complained to my office on 26 February 2003. Part of Mr C's concern was that the Dental Practice had failed in what he saw as its duty to ensure that Dentist 1 kept proper records and provided appropriate care. However, as an Associate at this Dental Practice, Dentist 1 was responsible for alleged errors or failures in her treatment. Additionally, within the terms of the Scottish Public Services Ombudsman Act 2002 she was the person liable for investigation by my office and not the Dental Practice.

5. Accordingly, when I decided to investigate this complaint the matters subject to investigation were specified as:

a) Dentist 1's record keeping failed to meet a reasonable standard; and

b) The diagnosis and care provided by Dentist 1 failed to meet a reasonable standard.

6. Relevant parties were notified of my decision to investigate this complaint on 23 May 2003.

Summary of Investigation Procedure

7. I authorised one of my Complaints Investigators to conduct this investigation on my behalf and we obtained advice from two Independent Clinical Advisers. Their advice is in paragraphs 12 – 15 and 30 - 44 of this report and is shown in italics.

8. Dentist 1's comments on the complaint were sought at the outset of the investigation. My Investigator interviewed Mr C and, along with the two Clinical Advisers, my Investigator also interviewed Dentist 1. Mr C's dental records were obtained and examined.

9. I have drawn on all of this material in the preparation of this report. I have not put into this report every detail investigated but I am satisfied that nothing of significance has been overlooked.

10. Mr C and Dentist 1 have been given an opportunity to comment on the key facts contained within this report prior to the report being issued. Where appropriate their comments have been reflected in the text.

## The Investigation

Background Clinical information

11. The Clinical Advisers have provided the following background clinical information:

*12. Dentists refer to gum disease as periodontal disease. The mildest form of periodontal disease is gingivitis which is characterised by a reddening and swelling of the gums which can bleed easily although there is usually little or no discomfort. The main cause of gingivitis, and periodontal disease more generally, is bacterial plaque, a sticky colourless film that constantly forms on teeth. Gingivitis is reversible with scaling and polishing by a dentist or oral hygienist and good oral hygiene by the patient. In the absence of such treatment gingivitis can advance to a more severe form of periodontal disease known as periodontitis.*

*13. Periodontitis occurs when plaque has spread and grown below the gum line. This stimulates a chronic inflammatory response and the gum tissues and bone that support the teeth are broken down and destroyed. The gums can then separate from the teeth forming pockets between the teeth and the gums. These pockets can become infected. Periodontitis normally progresses slowly but there can be acute episodes when the rate of progression accelerates for a period. As periodontitis progresses, the pockets deepen and more gum tissue and bone are destroyed. As the gum tissue and bone are progressively destroyed the teeth which are normally supported by these gum tissues and bone may become loose and may have to be removed. Periodontitis can be treated by more specialised forms of periodontal treatment, including very deep scaling and cleaning of the pockets and sometimes surgical intervention which can slow down and often stabilise the periodontal condition.*

*14. Carrying out a Basic Periodontal Examination (BPE) at patients' check up visits can screen for, and monitor the progress of, periodontal disease.*

*This involves running a ball-ended probe under the gum margin to see how far below the gum line it can be placed and if there is any bleeding. A score of between 0 and 4 is recorded on the patient's clinical records with a BPE score of 4 being indicative of the deepest pockets and most advanced periodontitis. Taking x-rays of the teeth and surrounding bone over appropriate time intervals for patients and written reports on any x-ray findings in the clinical records are also of benefit to assess and monitor the periodontal condition.*

*15. A certain amount of bone loss and shrinkage of gum tissues also occurs naturally as a person becomes older even if they do not have periodontitis. However, in a patient with periodontal disease, bone loss and gum shrinkage is often due to a combination of age and disease.*

Mr C's written complaint

16. Mr C's complaint was first forwarded to the Dental Practice in April 2002. The Practice Complaints Officer responded but Mr C remained dissatisfied and wrote on 29 May 2002 explaining:

> '… my poor dental condition has now been seen and confirmed by a total of three dentists in the new surgery. …
>
> The new dentist has also embarked on a rigorous deep scaling and cleaning regime in an attempt to prevent the problem getting worse. … I have been advised that this treatment may not be successful and that I am probably going to lose more teeth. I find all this very depressing, particularly as I think the whole problem should have been dealt with years ago. Surely what is being done now should have been done earlier. …
>
> … I would like to see this whole episode examined by an independent body and a report given as to whether the previous treatment was up to the standard expected.'

Dentist 1's written response to the complaint

17. On 7 August 2002 Dentist 1 wrote to Mr C in response stating:

'... On the occasions that I saw you I cannot remember you complaining of any of the classic symptoms of gingivitis and periodontitis, namely bleeding of the gums, tooth mobility, bad breath, bad taste etc., in fact my recollection is that on the whole your general oral condition appeared to be good relative to your maturity and not indicative of any acute, rapidly progressing condition which required specialist treatment.

Periodontal disease is thought to proceed in a series of "bursts of activity" with periods of quiescence. On looking at your dental records, I see that you did experience a couple of periods of activity when you lost two teeth but over the period there appeared no obvious symptoms. ...

... As far as progress of the condition is concerned, a radiograph taken in October 1999 shows that in the upper right quadrant there is a small degree of bone loss. You do not comment on nor did I detect any symptoms such as mobility of the teeth or sensitivity of the gums or necks of the teeth and I must have concluded that the clinical situation did not require immediate or intensive treatment. ...

... Obviously I am very distressed and disappointed to learn that you feel that you have cause to complain. ...'

18. Dentist 1's reference to a radiograph taken in **October** 1999 appears to have been an error as Mr C's records show that x-rays were in fact taken on 21 **December** 1999.

Mr C's Comments

19. Mr C explained to my Investigator that while he was registered as a patient with the Dental Practice he normally saw Dentist 1. He felt he had a good relationship with her and he thought that she was a good dentist. However, he could not recall Dentist 1 giving significant advice regarding oral hygiene and he said she never gave him any indication that he had any significant dental problems. While she may have mentioned that he should use dental tape, her advice was never 'heavy'.

20. Mr C had a tooth extracted in January 1999 by one of Dentist 1's colleagues. His dental records indicated that this was done due to localised mobility because of periodontal reasons. Dentist 1's colleague noted in a letter to Mr C that he felt sure he would have explained to Mr C that the tooth required extraction because of localised bone loss. However, Mr C could not recall being told that he had periodontal disease nor being given advice as to how that condition ought to be treated.

Dentist 1's comments

21. Dentist 1 explained to my Investigator and the Clinical Advisers her practice for monitoring patients' periodontal condition. This involved both x-rays and BPE scoring (see paragraph 14). She would normally take routine bitewing x-rays approximately every two years (bitewing x-rays usually show the upper and lower teeth on one side of the mouth. They are typically used to diagnose the presence of decay between teeth but can also diagnose loss of bony support around the teeth). This would be more frequent, possibly every six months, if she was concerned that the patient had specific problems. The frequency with which she would x-ray teeth at the front of a patient's mouth would depend upon both their BPE scores and/or the patient's reports of problems but she explained that, in general, she now takes x-rays more frequently.

22. In the past Dentist 1 would take BPE scores approximately every six months but this might be annually if she did not consider that the patient had a specific problem. She explained that in her earlier records it was her practice to record BPE scores of 3 or 4 but she would not have made a record if the BPE score was 0, 1 or possibly 2 as this would indicate good oral health. Dentist 1 accepted that it was not possible to identify trends in BPE scores over time if no record of scores was kept. Dentist 1 commented that she now takes BPE scores more regularly and is meticulous about recording all scores.

23. Dentist 1 pointed out that she first saw Mr C in November 1996 because he was reporting pain. Normally when she first saw a patient she examined their teeth and soft tissue using mirror and probe; took bitewing x-rays; and carried out an examination using a periodontal

probe. The time allowed for such examinations at the Dental Practice was sometimes restricted and so whether she carried out a periodontal examination might depend upon the patient's circumstances and presentation. Dentist 1 felt that she may have been side-tracked from carrying out her normal new patient examinations when she first saw Mr C because he was reporting pain. Additionally, the subsequent appointments Mr C had in 1996 and 1997 appeared to have been following requests for emergency treatment because he was in pain. Accordingly, it was not clear at what point Mr C became one of her regular, ongoing patients.

24. On 16 January 1999 Mr C had his lower right 8 tooth removed by one of Dentist 1's colleagues. The reasons for this were noted as being 'mobility' and 'perio'. Dentist 1 had seen Mr C previously because of his concerns about this tooth. She had diagnosed sensitivity in that tooth but for different reasons. She considered that her colleague's comment about 'perio' was a provisional assessment, rather than a definite diagnosis, but she accepted that she might have been 'blinded' to the possibility that there were periodontal reasons for the removal of this tooth by her earlier suspicion that sensitivity was caused by other reasons.

25. Mr C was seen again by Dentist 1's colleague on 26 November 1999. Her colleague suspected an un-erupted upper right 8 tooth or root as the possible cause for Mr C's symptoms. Dentist 1 saw Mr C at his next visit on 21 December 1999 when she took x-rays and carried out a full check-up. She explained that she would have done a BPE score as part of that check-up but she also felt that Mr C had been clear that he was not in pain and she did not recall identifying any swelling of the gums. The x-ray taken on 21 December 1999 showed no un-erupted tooth or root but did show a degree of bone loss. Dentist 1 noted in Mr C's records at the time that she should monitor his upper right 5 crown. She would normally do so by taking another x-ray approximately six months later but she accepted that she had not done so in this instance. Her note had been made at the end of a record card. Subsequent notes were made on a new record card and the old card kept folded inside the new card. Dentist 1 thought this might explain why she apparently overlooked her note to monitor Mr C's upper right 5 crown. At interview, Dentist 1 told

my Investigator that she now uses a different format of record card and this reduces the risk of such an oversight occurring.

26. Dentist 1 confirmed that it had been her assessment that Mr C was suffering from a periodontal condition during the period that she was treating him. However, while she acknowledged that Mr C had experienced bone loss, she felt this was mainly a consequence of his age. Dentist 1 accepted that in the past she primarily looked for acute signs of periodontal disease and she did not consider that Mr C had such symptoms while she treated him. She told my Investigator that she agreed with the assessment of the Independent Review Panel that Mr C had experienced an acute episode of periodontal disease, against a background of his generalised periodontal condition, and in her view this could have accounted for the apparent rapid and significant deterioration in Mr C's dental condition.

27. Dentist 1 recalled discussing with Mr C that he had a periodontal condition but it was not her practice at the time to explain in a lot of detail what this meant. She tended to explain to patients that they were becoming 'long in the tooth' or that there was 'increased sensitivity because areas of tooth were becoming exposed which had not previously been exposed'. She did not refer to periodontal disease because her experience was that this tended to make patients anxious. However, Dentist 1 told my Investigator that her practice is now to give patients considerable information about periodontal disease including a leaflet on this condition. Indeed, Dentist 1 commented that she might now be giving patients 'too much information'. Additionally, Dentist 1 explained that if she now identifies significant periodontal problems in a patient, her practice is to refer them to a colleague or the Dental Institute in Edinburgh for advice.

28. When asked, Dentist 1 accepted, with hindsight, that she should have kept more detailed records but she thought that she was recording sufficient information at the time. She confirmed that her practice on record keeping has changed significantly following Mr C's complaint.

29. In summary, Dentist 1 confirmed that she now 'monitors everything, records everything and tells [patients] everything'. She acknowledged

that she had lost some of her confidence as a practitioner as a result of Mr C's complaint and this was reflected in her increased tendency to refer patients for advice/treatment. She had also undertaken a number of additional courses on periodontal disease because of the complaint.

**Clinical Advisers' report**

30. *We were asked to advise on each aspect of Mr C's complaint:*

a) *Dentist 1's record keeping failed to meet a reasonable standard; and*

b) *The diagnosis and care provided by Dentist 1 failed to meet a reasonable standard.*

*Analysis of Complaint*

*31. Mr C complained because he maintains that he was never told by Dentist 1 that he had a problem with gum disease but, less than eight months after last seeing her, he was told by a different dentist that he had bad gum disease.*

*Dentist 1's record keeping failed to meet a reasonable standard*

*32. Patients' records should include a soft tissue check, full chart of the teeth present; existing restorations present; any cavities; periodontal monitoring; possibly the patient's initial reason for attending; a diagnosis; a treatment plan where appropriate, and any advice given to the patient should also be recorded.*

*33. Most of these elements are missing from the records Dentist 1 kept in relation to Mr C. Dentist 1 did not make any record of discussing or advising Mr C about his periodontal condition. There are also no written recorded notes on periodontal monitoring. In particular, although Dentist 1 states that she did carry out BPE scoring to monitor the periodontal condition of Mr C's mouth, she did not make any written clinical record to this effect.*

*34. Dentist 1 explained that in the past it was her practice to only record BPE scores of 3 or 4 and so the absence of a BPE score in Mr C's records would indicate a score of 0, 1 or possibly 2 and indicated good oral health. However, the lack of any written recordings of BPE scores means there was no way of monitoring whether or not the periodontal condition of Mr C's mouth was deteriorating.*

*The diagnosis and care provided by Dentist 1 failed to meet a reasonable standard*

*35. Mr C is certainly currently exhibiting signs of periodontal disease; this is evident from the records of his current dentist. These show that Mr C has deep pocketing around several teeth relating to bone loss. He has had infection around teeth because of periodontal problems for which he has been prescribed antibiotics and he has lost several teeth because of periodontal disease.*

*36. It is difficult to establish Mr C's clinical condition whilst he was under the care of Dentist 1 because of the limited information in his records as noted above. However, his records during this period do indicate that he may have had mobility in certain teeth because of periodontal disease and there is evidence on x-rays of bone loss which could well have been indicative of periodontal problems.*

*37. During our interview with Dentist 1 she indicated that she believed Mr C did have a periodontal condition during the period he was in her care. However, she did not record such a diagnosis in Mr C's records.*

*38. To make a diagnosis of periodontal disease one would have to monitor the periodontal condition of the mouth, primarily by BPE scoring and the taking of x-rays. While Dentist 1 states that in the past she would take BPE scores approximately every six months, she did not record any BPE scores in Mr C's records and so there was no way to assess clinical changes in Mr C's periodontal condition. Additionally, while Dentist 1 indicated that in the past she would normally take routine bitewing x-rays approximately every two years for her patients, she did not do so in Mr C's case.*

*39. Dentist 1 did scale and polish Mr C's teeth on more than one occasion during the period he was in her care. This would have made some contribution to the management of Mr C's periodontal condition. However, it appears the treatment Dentist 1 provided Mr C may have been more aimed at treating acute dental problems reported by Mr C rather than treating any periodontal disease which may have been present.*

*Conclusions*

*Dentist 1's record keeping failed to meet a reasonable standard*

*40. The records kept by Dentist 1 for Mr C were not of a reasonable standard. It is however clear from our interview with Dentist 1 that she has accepted she should have kept more detailed records for Mr C and that she has changed her practice on record keeping significantly since this complaint.*

*The diagnosis and care provided by Dentist 1 failed to meet a reasonable standard*

*41. As noted above, it is difficult to establish Mr C's clinical condition whilst he was under the care of Dentist 1 because of the limited information in his records.*

*42. Dentist 1 indicated that she believed Mr C did have a periodontal condition, but as a result of inadequate record keeping she failed to take reasonable steps to monitor any changes in his periodontal condition. As such she did not place herself in a position to be able to diagnose the true extent of Mr C's periodontal problems. For this reason we consider her diagnosis was not of a reasonable standard and Dentist 1 was not able to ensure that she offered him appropriate care and advice about his condition.*

*43. We are aware from our interview with Dentist 1 that as a consequence of Mr C's complaint she has significantly changed her practice and records and routinely monitors appropriately her patients' periodontal condition and gives them clinical advice regarding any*

*periodontal condition. Further, she has undertaken a number of additional training courses on periodontal disease.*

*Recommendations*

*44. Although we have concluded that Dentist 1's record keeping and diagnosis were not of a reasonable standard, we do not consider that specific recommendations are appropriate. This is because we consider that Dentist 1 has undertaken a number of additional training courses on periodontal disease and has already implemented appropriate changes in her practice in response to Mr C's complaint. We are aware that Dentist 1 has lost some confidence as a result of this complaint and we hope that the steps she has taken to change her practice will restore her confidence.*

## Findings

Dentist 1's record keeping failed to meet a reasonable standard

45. The Clinical Advisers have outlined in paragraph 32 what they consider would be an appropriate standard of record keeping and they conclude that records kept by Dentist 1 for Mr C did not meet this standard. Additionally, the General Dental Council guidance 'Maintaining Standards' states that 'full contemporaneous records should be kept for all dental treatment' (section 4.3) and that 'careful contemporaneous records must be kept of all the procedures undertaken' (section 4.21).

46. Dentist 1 acknowledged to my Investigator that, with the benefit of hindsight, she should have kept more detailed records and she confirmed that her practice on record keeping has changed significantly. I also note that Dentist 1 felt it appropriate to apologise to the Independent Review Panel for not recording BPE scores in Mr C's records. Given both Dentist 1's and the Clinical Advisers' comments, I conclude that Mr C's records were not of a reasonable standard and I uphold this aspect of the complaint.

The diagnosis and care provided by Dentist 1 failed to meet a reasonable standard

47. Dentist 1 stated that she did consider that Mr C had a 'periodontal condition' during the period that she was treating him. However, she did not record this on his records. She noted in her letter to Mr C that she could not remember him complaining of any of the classic symptoms of gingivitis and periodontitis, but in the same letter she also acknowledged that he had experienced a couple of periods of active periodontal disease when he lost two teeth.

48. The Clinical Advisers explain that periodontal disease ranges from its mildest form, gingivitis, through to its more severe form, periodontitis. They explain that in order to diagnose the degree and assess the progression of periodontal disease the periodontal condition of the patient's mouth requires to be monitored. They also note that the form of treatment will vary depending upon the degree of periodontal disease present.

49. In this instance, Dentist 1 did not take bitewing x-rays every two years contrary to her routine practice. She has also acknowledged that her previous practice of not recording BPE scores meant that she was not able to identify trends in these, and that she did not monitor Mr C's upper right 5 crown despite noting at the time that she should do so. All of these were means by which Dentist 1 could have monitored the periodontal condition of Mr C's mouth but she did not do so. I therefore accept the Clinical Advisers' conclusion that Dentist 1 did not take reasonable steps to monitor Mr C's periodontal condition and by not doing so she was not in a position to be able to diagnose the true extent of Mr C's periodontal problems. As such, I consider that her diagnosis was not of a reasonable standard.

50. For understandable reasons Mr C questions whether the intensive treatment undertaken by his new dentist should have commenced earlier. The Clinical Advisers explain that the appropriate treatment for periodontal disease will depend upon the patient's clinical condition. In the absence of fuller records, the Clinical Advisers were not able to establish what Mr C's clinical condition was during the period he was

being treated by Dentist 1. However, they did consider that the absence of fuller records had an adverse effect on the monitoring and diagnosis of Mr C's condition. In turn, the Clinical Advisors concluded that because the diagnosis was not of a reasonable standard Dentist 1 was not able to ensure that she provided appropriate care. I accept their conclusions and I uphold this aspect of the complaint.

**Recommendations**

51. It is clear that Dentist 1 has taken Mr C's complaint very seriously and she has reviewed many aspects of her previous practice in light of it. She describes having undertaken additional training and that she now (a) takes x-rays more frequently; (b) takes BPE scores more frequently; (c) is meticulous about recording all BPE scores; (d) provides patients with much more information about periodontal disease; (e) is more likely to refer patients with significant periodontal problems to others for advice or treatment; and (f) keeps more complete records.

52. I am pleased to note Dentist 1's response to the issues arising from Mr C's complaint and I share the Clinical Advisers' hope that this restores her confidence as a practitioner. My only recommendation is that Dentist 1 apologises to Mr C for her records, diagnosis and care of his periodontal condition not having been of a reasonable standard.

Professor Alice Brown
Scottish Public Services Ombudsman

6 April 2005