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Viewpoint

The Case for Pediatric Dentistry

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The Dental Society of the State of New York has en-acted policy that speaks to the profession's support for early oral health care. These policies, requiring that children receive dental and medical checkups be-fore entering public school, restate dentistry's belief that good oral health is as necessary to a child's overall health and devel-opment as is general medical care.

Moreover, DSSNY's efforts to make child abuse detection ed-ucational mandates meaningful, by providing a training program that encompasses an overview of pediatric dental diagnosis and development, are consistent with the profession's commitment to assuring that children receive ac-cess to dental care and treatment

Pediatric patients have needs that are different from those of adult patients. Their den-tition is in a dynamic state of development; therefore, preven-tion and interceptive procedures are major parts of pediatric den-tal care. At least as early as the time a child's teeth begin erupt-ing, the dentist must educate the parents about the need for effec-tive oral hygiene, the dangers of nursing bottle syndrome and pro-longed breast-feeding, the import-ance of correct fluoride supplemen-tafion, and the use of pit and fissure sealants. It is also the dentist's re-sponsibility to oversee the need for restorative care and to vigi-lantly monitor the need for orthodontic care.

Many of these requirements may be met by the general practi-tioner, but not all generalists treat pediatric patients. For children with behavior management diffi-culties, or other special demands, but also for children in general, pediatric dental practices are bet-ter prepared to meet the younger patient's full range of needs.

The question now arises, are dentists really doing all they can to prevent children from suffer-ing from oral infections and dental disease?

Parents Turned Away

Parents presenting to a pediatric practice with an infant having advanced nursing bottle decay, systemic infections resulting from undiagnosed or untreated dental caries or other infections, or ram-pant caries often say that they tried to have their child treated but were told by other dentists and/or their staffs that that prac-tice did not see children until they were over the age of three, or that children do not need to see the dentist until after they are three.

If that is the case, parents are getting the wrong message. It is disconcerting to parents when they bring

their children to the dentist and are told not to worry about baby teeth and tooth de-cay, that baby teeth do not need to be restored, that baby teeth do not have roots or nerves and they should just wait until the child's teeth fall out, or until the child has pain, and then pull the teeth out.

What message do dentists give to parents when they say, fluoride is bad for children's teeth, or that sealants are just a rip off? And is the failure to take radiographs on children where interproximal contacts are close and the child is cooperative ap-propriate dental treatment?

While a dentist may choose to exclude pediatric patients from his/her practice, he/she still has a professional obligation to those patients-the same as a dentist who does not perform surgical or endodontic procedures retains the responsibility to properly di-agnose and refer.

Dentists who do not treat patients below a defined chrono-logical age are vulnerable to charges of neglect or malpractice if they fail to properly advise pa tients that their decision not to treat those children does not mean that these children do not require care. And they are obli-gated to assist the parent with a referral to a pediatric dentist or to a general dentist who can ad-equately tend to the child's dental needs.

Bad for Profession and Patient

Dentists can fail pediatric patients in two ways. First and foremost, the failure to diagnose, treat and refer is medical neglect and, as such, leaves the dentist open to malpractice claims. Second, pro-viding parents with false or misleading information about the need for dental care can result in patient harm and may diminish the public's trust in our profes-sion.

Our profession cannot attain its stated public health goals when all dentists are not fully informed about the efficacy of fluoride, sealants and other pre-ventive measures, about the anatomy, physiology and pa-thologies associated with the primary dentition, about the need for restoration of primary teeth and the importance of early oral examinations and treatment.

In its reference manual the American Academy of Pediatric Dentistry describes itself as be-ing "dedicated to improving the oral health of infants, children and adolescents." The academy further says:

"It is recognized that infants who use a nursing bottle contain-mg milk or juice as a pacifier or those who are breast-fed on de-mand, specifically at times other than normal feedings and throughout the evening, often develop early, multiple carious lesions. It is probable that a mean-ingful portion of the caries observed in young children (12 to 24 months) is traceable to such nursing practices."

These other policy state-ments appear in various places in the Academy manual.

§ Fluoride should be con-sidered the bulwark of caries prevention programs.

§ Optimal systemic fluoride supplementation should be pro-vided through fluoridation of public water supplies.

§ Where fluoride-deficient drinking water is obtained, supplementation should be achieved through the use of drops or tablets.

§ The combination of pit and fissure sealants and fluoride provide the most effective method for reducing caries.

If prevention is to be maxi-mized, initial examinations and the education of parents in the application of preventive proce-dures should begin during the first year of life.

Early Intervention

Pediatric dentistry can be defined as the dental specialty of oral care for infants, the growing child and adolescent, as well as the special needs patient. This standard of care reflects the conviction that

children should be seen for the initial dental visit no later than six months after the first tooth appears in the oral cavity. This will usually assure that the child's first office visit will begin around 12 to 18 months of age.

According to the Academy of Pediatric Dentistry, "The in-fant oral health care visit shoitld be seen as the beginning of a life of regular dental visits that truly prevent a child from experienc-ing the negative effects of dental disease."

The education of a parent is the first step in the child's oral health development. During the infant's first few visits, important information concerning fluoride, dietary habits, oral hygiene coun-seling, feeding practices (nursing bottle and breast-feeding), treat-ment of traumatic injuries and counseling for oral habits should be discussed and reviewed.

We all know, at times, what we tell a patient is often ignored, misinterpreted or misunderstood. But when a dentist fails to diag-nose obvious dental caries, misleads parents on the appro-priateness of treating infant dental disease, improperly pre-scribes fluoride or deliberately omits it from preventive treat-ments, fails to use appropriate diagnostic procedures or appro-priately placed sealants, one has to ask if members of the dental profession have gone from re-quired reporters of neglect and abuse to persons guilty of neglect and abuse?

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