

Are We FAILING Our CHILDREN?

THE DENTAL LITERATURE is replete with admonishments that we are our own worst enemy when we criticize our colleagues and create an environment for lawsuits.

Yet let me pose a question. What should we say to parents who bring their two-, three- or four-year-old child to our dental offices for an emergency and upon examination we find that the child's lower first primary molar is grossly decayed and his or her lower jaw is severely swollen? What should we say when we find the maxillary anterior teeth are decayed to the gum line, and the child is in pain and toxic! And what should we say when our diagnosis and treatment recommendation is complicated by receiving one or more of the following reactions from the parent:

1. "My family dentist (or the dentist's receptionist) told me that the dentist does not treat children under five." (If the office does not offer to refer the parent to a dentist who will examine the child, parents often are left with the impression that nothing needs to be done.)

2. "I took my child to my family dentist three months ago and was told everything was fine and no X-rays were taken." (Actually, a clinical evaluation indicated decay present and a set of bitewing radiographs revealed eight class II lesions in various degrees of decay, some needing pulpotomies, some crowns and some extractions. All upper front teeth were decayed to the gum line.)

3. "My child has been going to a dentist since he was three. I was told that the upper

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front teeth were stained. I was never told anything about nursing bottle decay, but I was told to call the office if the child developed pain and then the dentist could pull the teeth out."

4. "My dentist told me to see an oral surgeon and have all the decayed teeth pulled."

5. "My dentist told me the teeth were infected. Three months ago he put my child on antibiotics, and no further follow up care was discussed."

6. "When my dentist tried to treat my child he told me she was too young to cooperate and have this type of treatment completed. I was told to wait until my child was a little older and could cooperate better before undergoing any dental treatment."

7. "My pediatrician said the discolored areas were just stains and that my child did not need to see a dentist."

Professional Neglect

We all know that information given a patient or parent is often ignored, misinterpreted or misunderstood. But it is disconcerting to parents when they bring their children to the dentist and are told not to worry about baby teeth and tooth decay or that baby teeth do not need to be restored. Where in our dental training were we ever taught that baby teeth do not have roots or nerves, and when they

are carious a parent should just wait until the child's teeth fall out or until the child has pain and then extract the teeth? Often a child is brought to a dental office because the parent is concerned about a small cavity. When radiographs are taken, many more cavities are diagnosed. The failure to take radiographs on children where interproximal contacts are close and the child is cooperative is not the standard of care we should be practicing.

I believe it is important to take a close look at our professional responsibilities. Have we crossed the line from being required reporters of neglect and abuse to persons guilty of both?

We can fail our pediatric patients in two ways. First and foremost, the failure to diagnose, treat and refer is neglect and, as such, leaves the dentist open to malpractice claims. Secondly, providing parents with false or misleading information about the need for dental care can result in permanent harm to children's health and to their attitude about going to the dentist. When this occurs, we begin to erode the public's trust in our profession.

Dentists who do not treat patients below a defined chronological age leave themselves open to charges of neglect or malpractice if they fail to properly advise patients that their decision not to treat these children does not mean that the children do not require care. Dentists are obligated to assist the parent with a referral to a pediatric dentist or to a general dentist who can adequately tend to the child's dental needs.

Rampant Decay

The National Health and Nutrition Examination Survey (NHANES), III (1988-1994), conducted by the National Center for Health Statistics of the Centers for Disease Control and Prevention, U.S. Public Health Service, reported that in children ages two to nine as much as 47% of decay goes untreated. According to former Surgeon General C. Everett Koop, 17% of children aged two to four have already had decay. By the age of eight, approximately 52% of children have experienced decay. And by the age of 17, dental decay affects 78% of children.

Despite tremendous declines in childhood cavities, tooth decay remains the single most common chronic disease of childhood. Untreated tooth decay may result in pain, infection, dysfunction, poor appearance and low self-esteem among affected children. Early childhood caries is associated with poor growth and poor nutrition.

The dental profession cannot attain its stated public health goals when all dentists are not fully informed about the efficacy of fluoride, sealants and other preventive measures, about the anatomy, physiology and pathologies 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 being "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 containing milk or juice as a pacifier or those who are breast-fed on demand, specifically at times other than normal feedings and throughout the evening, often develop early, multiple carious lesions. It is probable that a meaningful portion of the caries observed in young children (12 to 24 months) is traceable to such nursing practices." (Oral Health Policies Manual: American Academy of Pediatric Dentistry, p. 24)

Nursing bottle caries has an easily recognizable pattern of decay, which begins on the lingual surfaces of the primary incisors and if not treated, may spread to the first primary molars and eventually all teeth except, usually, the lower anterior teeth. Children who are allowed to breast feed at will when

sleeping with the mother during the night are at risk for a similar pattern of caries, one that begins on the facial surfaces of the maxillary incisors.

Early Childhood Education

A child's initial exam, at age one, is directed not only towards the infant, but also toward educating a parent in proper oral health care. This is the first step in a child's oral health development. During the infant's first few visits, important information concerning fluoride, dietary habits, oral hygiene counseling, feeding practices (nursing bottle and breast feeding), treatment of traumatic injuries and counseling for oral habits should be discussed and reviewed. Seeing children at around age one can help launch a child down the right path for a life free of decay and fear of the dentist.

The family dental practice that provides care to children is subject to the same standards of care the specialty of pediatric dentistry is held to. It is important to refer a child when a dentist feels the care required is either beyond his or her level of skill or desire. It is important to provide comprehensive care, to treat all the oral structures, use appropriate materials, remove all decay and begin interceptive orthodontic care before malocclusions become crippling and costly to correct.

The National Institute of Dental Research (NIDR) states that approximately 80% of cavities in American children now occur on the occlusal surfaces of the teeth. The Journal of Public Health Dentistry carried a report on a workshop on guidelines for sealant use that was sponsored by the University at Albany School of Public Health and the New York State Health Department, in which it was stated that sealants are an important dental caries prevention technology that has been proven to be a safe and effective long-term method to prevent pit and fissure caries.

The American Academy of Pediatrics, the American Academy of Pediatric Dentistry and the American Dental Association recommend that when community water levels of fluoride are below .3ppm, supplemental fluoride should be given to children, beginning at age six months.

Returning to the question posed at the top of this article, when is it appropriate to remain silent when parents ask pointed

questions about the failure of healthcare professionals to properly diagnose or treat their child? Our professional responsibility is to provide optimal care for our patients. To meet this need we need to improve our communications with parents and patients, and to increase access to pediatric dental continuing education courses for dentists. ■

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