Within the practice of the profession these days there is now a legal entity known as a ‘Duty of Care’. In dentistry, this means that every dentist who takes on a patient for dental care or treatment must make every effort to ensure that the patient receives a proper standard of care.

In paediatric dentistry there remains some degree of controversy as to what such a term means. The problem arises because of two factors. Firstly, children are not always easy to care for because of differing levels of cooperation, and secondly, because the primary teeth eventually exfoliate. Therefore, any treatment that is needed must be of limited duration. Adding the two entities together, many dentists have taken the view that there is no need to carry out restorations in primary teeth, but to leave them to be shed as and when the permanent teeth erupt.

The converse approach is to take the view that leaving any active disease in the mouth of children goes against the basic tenets of Hippocrates. Thus, all disease (dental caries and gingivitis) in a child’s mouth must be effectively treated. This means removal of caries and the restoration of teeth, as well as treatment to reduce any gingival and periodontal disease. This approach presupposes that the behaviour of the child will be managed to allow restorative care to be carried out.

Even in the mid-19th century there were concerned dentists writing in the dental literature that the primary dentition was important, and should be restored by the best techniques available. However, this was not always easy because of the limited use of suitable local anaesthesia and an insufficient understanding of child behaviour management. Added to these problems was the almost overwhelming level of dental caries. Nevertheless, some dentists through the second half of the 20th century were advocates of an integrated approach. In the UK, these dentists were in a very small minority as the universal approach was palliative treatment of dental caries and any pain, with ultimately mass extractions under general anaesthesia.

For one of us (Curzon), the experience as an undergraduate was exemplified by the first child patient to be treated. ‘Cornelius’ was an 8 year old boy with acute abscess of a mandibular molar. He was wearing torn shorts and shirt, dirty knees and a cheery grin, living in one of the poorest areas of London. His first communication was to say that he hated dentists, he attempted to kick my shins, drank the mouthwash and fused the dental unit by squirting the three-way syringe into the electrical socket. He had multiple carious cavities, some already patched up with zinc oxide. Further attempts to treat him were met with punches and kicks, and so the teaching was to ‘just try and put in some zinc oxide-eugenol and bring him back later’.

This approach became known colloquially as ZOBB—‘zinc oxide and bring him/her back later’. Of course at that time, in the early 1960s, needles were 25/27 gauge and had to be re-sharpened before each patient and there was no short-acting local anaesthesia solution. The teaching was also that it was impossible to use local anaesthesia on children and certainly not mandibular blocks.

All of the above was in contrast to later experiences, firstly as a travelling paedodontist in Canada, and then as a postgraduate student in paediatric dentistry. The latter period revealed that, yes, one could use local anaesthesia even for pre-school children. Rubber dam greatly enhanced behaviour co-operation and quality of restorations, pulpectomies enabled carious teeth to be saved even with deep cavities, and preformed metal crowns ensured that teeth only needed treating once. This approach is aspects and risks in taking the ZOBB approach.

Within the past five years the authors have been involved in a number of cases of litigation where general dental practitioners have been sued for not restoring decayed primary teeth. When these cases have been settled, the damages have been substantial, running into many thousands of pounds. In addition, in Germany there have been cases where dentists have been tried in court for not providing adequate dental care for young children. While not within the jurisdiction of English common law, these European cases indicate that there is a growing awareness by parents that a proper duty of care requires quality care.

What therefore, constitutes an acceptable duty of care by dentists who care for children? In the authors’ opinion, this means a full and thorough dental examination, with the taking of bitewing radiographs whenever there is any sign of dental caries in a child’s mouth. All dental caries, generated though the enamel, require restoration. Early enamel lesions, seen clinically or on radiographs, necessitate a comprehensive preventive program based on good oral hygiene and the use of fluoride.

Restorative care must be conducted with good pain control and management of a child’s behaviour. Local anaesthesia is therefore mandatory and easily performed these days with topical anaesthesia, fine gauge needles and short-acting local anaesthesia agents. Due consideration should be given to the use of rubber dam, which ensures a much higher quality of restorations that last for the duration of a tooth, as well as being an aid in behaviour management. Where there is pulpal involvement of primary teeth, pulpotomies or pulpectomies are essential. Such teeth also need restoration with preformed metal crowns, which have repeatedly been shown to have one of the highest success rates of any restoration for children’s teeth.

Undoubtedly, the ZOBB approach can be the correct one for some children, but it is vital this is integrated within a treat-ment plan that is in the best long-term interest of the child, and not an ‘easy way out’ for the dentist. If ZOBB predisposes the child to repetitive treatment and worse still, pain, abscesses and extractions under general anaesthesia, then it should be rejected in favour of comprehensive care using restorative techniques. Some of these techniques have been described in the Smile-on course: Effective Restoration for Carious Primary Molars, and which have been shown to have a low failure rate in children.

We accept that the financial constraints within the NHS (National Health Service) practice have somewhat limited the acceptance of these techniques by general dental practitioners. Maybe, the new contract will make a difference. Only time will tell.

For a dentist in this day and age to fulfill his or her obligations under ‘Duty of Care’, the philosophy of QUACC must be used. The outdated approach of ZOBB, or ‘supervised neglect’ to use a more up to date term, is a relic of the past, which should only be read about in the dental history books.

References

Please visit www.smile-on.com for information about their courses.

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