Treating children in practice

Complaints of litigation involving dental treatment provided for children occur less frequently than in many other areas of dentistry, say Dental Protection

When complaints involving dentistry for children do arise, their management is complicated by a number of factors, over which the clinician has little or no control. Dentists, hygienists and therapists can all be involved in the provision of dentistry for children, and many of the problems they face are the same. It is easy to overlook the fact that the treatment of children – particularly, of young and/or nervous children – can be clinically very challenging and highly demanding in terms of time, concentration, and personal skills. Juggling the clinical and personal needs of the child with the sometimes irrational and disproportionate demands of the parent(s) can also be very stressful. Another factor which can arise in private practice, or any clinical setting where fees are charged for the treatment of children, is the imbalance which can arise between the expectations and demands associated with the treatment of children, and the reality of the fees that tend to be charged and/or that the parents find acceptable.

Undercurrents

Cases involving children tend to be affected, to a greater or lesser extent, by factors that can easily be overlooked. Firstly, patients in this group are vulnerable and sometimes apprehensive, and emotional pressures can often influence the progress and outcome of a case, as well as the perception of those involved in it. Secondly, treatment is generally being provided in an ever-changing environment as the child continues to grow and develop; as a result, clinical decisions tend to have immediate short-term consequences and also some broader and longer-term implications. Sometimes, this impacts upon a case in the sense that it is asked how things might have developed if a specific event had not happened, or if a certain treatment which was not provided, had been provided. Thirdly, these cases can often be fraught with conflicts and hidden agendas. Parents are invariably involved in the situation and not uncommonly, responses are clouded by feelings of guilt, or natural parental protectiveness (or over-protectiveness on occasions) of anger and sometimes a single-minded determination to see a dentist “punished” for some actual or perceived act or omission towards the child. One of the classic situations arises when attempting to treat widespread caries in a very young child who is only brought to a dental surgery when the child is in pain (perhaps from an abscess) and acutely distressed. If problems arise during or following the treatment, some parents will be unable (or unwilling) to consider, let alone accept, that the child’s problems might have been avoided altogether, if they had acted differently, or more quickly in the child’s best interests. This can sometimes produce a reaction
whereby the parent’s wrath is directed at the clinician, perhaps as a means of deflecting any suggestion of blame or responsibility on their own part.

Key issues

Eight recurring factors tend to arise in cases involving children, often with a single case embracing two or more of them.

Consent

While this is generally obtained from a parent, the legal situation varies from one country to another. A useful general principle to bear in mind is that while the needs and best interests of the child should always be the paramount consideration, the child’s wishes must also be taken into account. This can lead to difficult judgements on the part of a clinician, who must assess the child’s capacity to understand the nature and purpose of the treatment being proposed for them. In older children who may not yet have reached the legal age of adulthood/majority, but who are perfectly capable of understanding the issues surrounding a proposed dental procedure, this can create some very difficult situations. This is particularly likely when the child and the parents do not agree as to what treatment should be provided. If in doubt, it is always wiser to postpone treatment than to proceed against the wishes of either the child, or the parent(s).

Caries

A failure to treat caries (and particularly, rampant caries in the very young child) and/or to institute appropriate preventive treatment or advice (oral hygiene, diet etc). Sometimes, a decision is taken to keep caries under review, or temporary restorations are used where young and nervous children find it difficult to accept treatment. Such approaches can later be misinterpreted as supervised neglect. Meticulous record keeping is important in these cases, and careful communication with parents is essential.

In primary teeth, it can be a short step from caries to an acute alveolar abscess, with all the associated pain, suffering and distress. It is sometimes forgotten on these occasions that the dentist did not actually cause the caries which led to the abscess.

Trauma

Cases tend to relate either to the actual management of an acute traumatic episode where anterior teeth have been damaged, or to the absence of emergency arrangements outside surgery hours, or to the delay in accommodating a child presenting with an acute traumatic problem. Dentists have been accused of negligence on the grounds that they should have suggested/ provided a sports mouthguard for a child who was known to be involved in contact sports carrying a high risk of injury to the front teeth.

Growth and development

Practitioners have a duty to monitor the child’s dental and oral development, and the need for orthodontic intervention should be considered either personally, or by referral to a specialist. Many cases relate to the delay, or failure, in recognising and acting upon incipient orthodontic problems.

Behaviour

Not all children are as cooperative as one might wish, and parents tend to have their own views on how their child is best managed. Treatment should never be imposed forcibly on a child, and the child’s best interests must always be paramount.

Local anaesthetic

All the well-recognised problems associated with local anaesthetic administration and with extractions are exaggerated in the case of children, who may not always follow postoperative instructions. Lips and tongues bitten while anaesthetised are not uncommon and warnings given to prevent this occurrence should be recorded in the notes. A further problem is a breakdown in communication somewhere between an orthodontist, a referring dentist, and an oral surgeon, resulting in the extraction of incorrect teeth. Referrals for extractions should always be made in writing, and the details checked both by the referring, and accepting dentist. A failure to check for permanent successors before removing deciduous teeth is another common cause of litigation.

Orthodontics

The main problems arise in diagnosis and treatment planning of cases involving children. On the one hand is the ever-present parents’ perspective, and on the other, the ‘emotions again, emotions can get in the way of a reasoned and balanced way of a reasoned and balanced approach. General anaesthesia (GA) and sedation should be avoided in children where possible, although relative analgesia carries fewer complications and can be used to good effect in trained and experienced hands. Tragically, deaths and other serious consequences still occur under GA and where children are involved, the pressable media interest, introduces a further threat to the dentist’s reputation and integrity at an already stressful and emotional time.

Dento-legal complications

When negligence claims do arise, the first problem is the extended limitation period in which legal proceedings can be brought. In many countries, legal proceedings in child cases can be brought at any time up to (and for a short period after) the time when the child reaches the age of adulthood. Through-out this extended period, legal costs can continue to accrue. Because of this, lawyers acting for the child patient are under no pressure to act quickly; this, coupled with the natural wish to make a measured assessment of the eventual consequences in the context of the child’s subsequent development, means that progress can be painfully slow. This can be an added burden for clinicians who may have a case hinging over their head for many years, and which long-term consequences (brain damage, for example, or cases involving restorative dentistry which would need successive replacement over a lifetime) the long life expectancy of children can have a huge impact upon quantum i.e the amount of damages payable. Finally, once again, emotions can get in the way of a reasoned and balanced approach to the treatment of children. On the one hand is the ever-present parents’ perspective, and on the other, the ‘emotions again, emotions can get in the way of a reasoned and balanced approach. General anaesthesia (GA) and sedation should be avoided in children where possible, although relative analgesia carries fewer complications and can be used to good effect in trained and experienced hands. Tragically, deaths and other serious consequences still occur under GA and where children are involved, the pressable media interest, introduces a further threat to the dentist’s reputation and integrity at an already stressful and emotional time.