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 di-
rected at the clinician, perhaps as a means of deflecting any sugges-
tion 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 embrac-
ting two or more of them.

Consent
While this is generally obtained from a parent, the legal situation varies from one country to an-
other. A useful general principle to bear in mind is that while the needs and best interests of the
child should always be the para-
mount consideration, the child’s wishes must also be taken into account. This can lead to difficult
judgements on the part of a cli-
nician, who must assess the child’s capacity to understand the na-	ure and purpose of the treat-
ment 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 understand-
ing 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 pro-
cceed against the wishes of either
the child, or the parent(s).

Caries
A failure to treat caries (and par-
ticularly, rampant caries in the
very young child) and/or to insti-
tute appropriate preventive treat-
ment or advice (oral hygiene,
diet etc). Sometimes, a decision
is taken to keep caries under re-
view, or temporary restorations
are used where young and nerv-
ous children find it difficult to ac-
cept treatment. Such approaches
can later be misinterpreted as
supervised neglect. Meticulous
record keeping is important in these
cases, and careful communi-
cation with parents is essential.
In primary teeth, it can be a short
step from caries to an acute alve-
olar abscess, with all the associa-
ted pain, suffering and distress.
It is sometimes forgotten on these
occasions that the dentist did not
actually cause the caries which
led to the abscesses.

Trauma
Cases tend to relate either to the
actual management of an acute
traumatic episode where ante-
rior teeth have been damaged, or
to the absence of emergency
arrangements outside surgery
hours, or to the delay in accom-
plishing a child presenting
with an acute traumatic prob-
lem. 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 carry-
ing 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 per-
sonally, or by referral to a spe-
cialist. Many cases relate to the
delay, or failure, in recognising
and acting upon incipient ortho-
dontic problems.

Behaviour
Not all children are as coopera-
tive as one might wish, and par-
ents tend to have their own views
on how their child is best man-
aged. Treatment should never be
imposed forcibly upon 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 extrac-
tions are exaggerated in the case
of children, who may not always
follow postoperative instruc-
tions. Lips and tongues bitten
while anaesthetised are not un-
common and warnings given to prevent this occurrence should be
recorded in the notes. A fur-
ther problem is a breakdown in
communication somewhere be-

tween an orthodontist, a re-
ferring dentist, and an oral sur-
egon, 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 succes-
sive before removing deciduous
tooth is another common cause
of litigation.

Orthodontics
The main problems arise in di-
agnosis and treatment planning
(including the presence of su-
pernumerary, or congenitally ab-
sent teeth), in root resorption or
the loss of vitality of teeth during
orthodontic movement, and in
dissatisfaction with the final out-
come – usually, but by no means
always, from an aesthetic view-
point. Very often, problems arise
when treatment does not proceed
as quickly, or a successfully as
originally hoped. It is important
to act upon any lack of compi-
ance or co-operation on the part
of the patient, and to keep parents
fully informed and involved. This
helps to avoid a situation where
the clinician is blamed for the
lack of progress.

GA/sedation
General anaesthesia (GA) and
sedation should be avoided in
children if possible, although
relative analgesia carries fewer complications and can be used
to good effect in trained and
experienced hands. Tragically,
deaths and other serious conse-
quences still occur under GA and
where children are involved, the
predictable media interest in-
duces a further threat to the
dentist’s reputation and integrity
at an already stressful and emo-
tional 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, le-
gal proceedings in child cases
are brought at any time up to
(and for a short period after)
the time when the child reaches
the age of adulthood. Though-
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 subse-
quent development, means that
progress can be painfully slow.
This can be an added burden for clinicians who may have a case hanging over their head for man-
ys years. In cases with long-term consequences (brain damage, for example, or cases involving
restorative dentistry which would need successive replacement over a lifetime) the long life expect-
cancy of children can have a huge impact upon quantum in the amount of damages payable. Finally,
once again, emotions can get in the way of a reasoned and balanced
determination of cases involving children. On the one hand is the ever-present parents’ perspective,
and on the other, the emotions and sensitivities to which reference has already been made, and
which can pervade particularly unfortunate or tragic cases.

Summary
Treatment of children carries all
the dento-legal risk of treating
adults, but is further complicat-
ed by a number of other factors.
An awareness of these factors
should prompt a suitably prudent
approach to the treatment of
child patients.