Paediatric dentistry: a *BDJ* themed issue

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EDITORIAL

Paediatric dentistry is unique in dealing with a specific age range rather than a technique, and as guest editor for this themed edition of the *British Dental Journal* I have tried to reflect that with papers reporting the impact of a traumatic injury on children and their families, the use of peer observation to improve chair-side clinical teaching and a strong emphasis on the evidence base as it relates to paediatric dentistry. However, I make no apology for the fact that dental caries features in a number of the research and opinion pieces in this issue. We may be in the twenty-first century, but dental caries remains a problem for the profession and for children and their families both within the United Kingdom and internationally.

In the last decade there has been intense debate on the appropriate management of early childhood caries (ECC), much of it through the pages of this journal. The wide gulf between specialist recommendation and the realities of managing child patients in primary dental care have been clearly illustrated.[1,2] While the rationale and arguments for managing ECC are I believe irrefutable, identifying strategies that can be delivered by the majority of dentists and received by most children has been more problematic. Stephen Fayle's commentary and the evidence-based reviews and techniques suggested by authors from New Zealand and Scotland in this edition offer alternative approaches that can be successful. Chris Deery's paper continues the theme of caries by considering modern approaches to management of the first permanent molar, where 90% of caries occurs.

The use of fluoride is central to the management of dental caries and those of us prescribing it seldom consider how the data on fluoride retention are determined. I am sure I will not be alone in reflecting on the implications of the following sentence in Maguire and Zoohoori's paper '...since body F burden (body retention) is key to determining risk but technically highly challenging and time-consuming in infants and young children who are not toilet-trained.'

In defining Childhood the *Oxford English Dictionary*[3] has the following entry:

CHILDHOOD, The state or stage of life of a child; the time during which one is a child; the time from birth to puberty.

In the strictly temporal sense this is an accurate definition, but I confess I find Ambrose Bierce's definition every bit as helpful, and a deal more humorous:[4]

CHILDHOOD, n. The period of human life intermediate between the idiocy of infancy and the folly of youth – two removes from the sin of manhood and three from the remorse of age.

I prefer not to admit to how close I am to the remorse of old age but in placing the child between 'infancy' and 'youth' this definition perhaps more accurately identifies the journey from birth to adulthood. Physically, emotionally, socially and intellectually huge changes occur during this period as the totally dependent baby transitions to the independently functioning and mature adult. But childhood as we understand it in the twenty-first century is a relatively new concept. In an influential work first translated into English in 1963 Phillippe Aries suggested that childhood did not really exist in the Medieval period, appeared in the upper classes in the sixteenth and seventeenth centuries, solidified fully in the eighteenth century upper classes, and finally mushroomed on the scene of the twentieth century in both the upper and lower classes.[5] That is not to say that that there were no young people but they were viewed as small adults.

Our views of children are to some extent reflected in the language we use, perhaps exemplified in the proverb 'children should be seen and not heard.' Anyone who works with children knows that you will most definitely 'hear' a child who does not want treatment and modern approaches to managing dental diseases of childhood take this into account. However, there is a difference between 'hearing' and 'listening', and the latter approach – listening to and involving children and young people in decisions about their care – is relatively new; use of them as partners in research in dentistry is still in its infancy, but there is a growing body of evidence that suggests they have much to teach us as the review from Fiona Gilchrist and colleagues demonstrates.

The impact of oral health inequalities in childhood can be measured in adult life and the foundation of dental anxiety in adults often lies in dental care received as children. It follows therefore that improving the oral health of our children and young people is the best way to improve the oral health of adults. Children are a fifth of our population but they are 100% of our future and they deserve our very best.

1. Fayle S A, Welbury R R, Roberts J F. British Society of Paediatric Dentistry: a policy document on management of caries in the primary dentition. *Int J Paediatr Dent* 2001; **11:** 153–157.
2. Tickle M, Milsom K, King D, Kearney-Mitchell P, Blinkhorn A. The fate of the carious primary teeth of children who regularly attend the general dental service. *Br Dent J* 2002; **192:** 219–223.
3. OED. *Oxford English Dictionary online*. www.oed.com.
4. Bierce A. *The Devil's Dictionary*. www.thedevilsdictionary.com.
5. Aries P. *Centuries of childhood*. New York: Vintage Books, 1962.

DOI: 10.1038/sj.bdj.2013.534