The 2003 Behavior Management Conference – What's At Stake?

In November 2003, the AAPD will host its second behavior management conference in Chicago, Ill. Like its predecessor in the 1980s, this conference will bring together both the pediatric dentistry community and external communities with vested interest in the care of children. Unlike the first conference, this one will occur in a new century characterized by changed societal views of children, a dramatically different health care system, an accelerated medico-legal environment, a general questioning of institutions like education, religion, and government, and a more diverse population. Dogging all aspects of dentistry is also access to care and health disparities. Finally, our specialty faces a very different complexion with approaching gender balance and 20% or more of our senior specialty retiring.

Given this view of the environment, what is the importance of this new behavior conference, and why do we need it? The answer comes from the daily news, from our own literature, and from happenings outside our specialty. In studies published over the last few years, it is clear that we have shifted our approach to managing children.[1,2] Both seasoned and fledgling practitioners have shifted their approaches to children. The aggressive ways, whether effective or not, are not being chosen. Even sedation, long a stalwart part of our overall management paradigm, is waning as a choice to manage children in our offices.

The role of parents has changed. While many practitioners maintain a policy of parental exclusion, many more have modified that stance to maximize parental support while minimizing risk and interference with the doctor-patient relationship. We are well behind the rest of pediatric care–our pediatrician colleagues consider parents a keystone of the treatment triangle; pediatric hospitals put parental presence in their list of patient rights; and even our surgical and emergency department colleagues are seeking ways to include parents in the care of their children in those intensive areas. Parents are also making it clear that they want to participate, and we need to respond if we want to hold our market share.

Our challenge is to meet these competing interests and trends while maintaining control of this important aspect of who we are as professionals. This is no easy task, as we have seen in a parallel process of addressing access to dental care for children. Every organization–the American Dental Association, the dental products industry, National Institute of Dental and Craniofacial Research, auxiliary organizations, and our medical colleagues–have ideas on how to improve access to dental care for children, and very often these ideas do not include the specialty of pediatric dentistry! The risk we face by inactivity on behavior management is that someone–government, medical, or advocacy groups–may take over this issue and impose upon us a new way of practice life.

I believe we need to do several things in this conference and thereafter. The first is to use the conference to reassert our ownership and leadership in this issue. This will come with responsible address of critical issues, including aggressive management, sedation, education of our professionals, the role of parents, and safety, posed by those in and out of our specialty. We need to address these issues carefully and thoughtfully, using science and our knowledge of societal and health system factors, to fashion our policies.

We need to look at our educational system. Looking objectively at what we do, it is difficult for an outsider to reconcile that a surgical and primary care specialty has such a variation in education of its practitioners. Some pediatric dentists have taken child development and psychology and performed dozens of sedations while others have watched or done only a few. For us to maintain our dominance, we need to address the range of educational experiences. Our pediatric colleagues, teachers, child psychologists and a host of other pediatric-oriented professions can demonstrate far more consistency in training, certification, and renewal than we can.

Our behavior guidelines need revision. If we look at our sedation guidelines, we see a process-oriented document that provides safety, as well as leeway for providers to use a full range of medications to accomplish what needs to be done. Listing some behavior techniques may seem desirable, but in fact this boxes providers into set ways to approach care. Techniques like hypnotism, relaxation, and biofeedback, to name a few, are not listed. Coincidentally, these are often billable procedures by therapists in other fields. Our guidelines should become more process-oriented with attention to protecting children and practitioners, as well as educating our partnering communities.

We need to develop a stronger body of literature. Those who have made behavior management a research interest will attest to the lack of strong literature upon which to build policies and guidelines. We have entered an age of evidence, and without it, we will always con-

front the issues of professional protectionism, parochialism from our critics, and risk competition from those with evidence. Some reading this will ask, "So what?" While others will see that as a group of 5,900, we are a small voice in a huge crowd of powerful child-oriented groups with political clout. We would be naive to think that it is "our way or the highway" because before we know it, there will be a new superhighway right next door. We have seen this with access to care as state legislatures and dental boards have addressed the issue without concern for opinions of the practicing profession.

We need to broaden our view of behavior management. In fact, the term itself may need retirement because it fails to grasp the breadth of the relationship between doctor, parent, and child. The role of behavior management in the dental home concept, the need to develop an entirely new culturally appropriate skill set, and the incorporation of a realistic set of expectations and skills for working with children under age 3 are just a few issues that should be on the table.

Finally, we need to be wise in our deliberations. We cannot disarm ourselves or set unrealistic regulations on simple interactive techniques. When all is said and done, with primary dentition caries rates remaining static, it will still be pediatric dentists facing tentative, anxious, or fearful children in dental operatories everyday across the country, when the conference ends.

In November, we will take on a topic that is dear to the hearts of almost every pediatric dentist. Each of us has a unique approach to the children we treat. Our challenge will be to preserve the ability of a practitioner to exercise clinical judgment within each unique patient population and community, yet assure the public and other professionals that our specialty has carefully and comprehensively addressed this important part of pediatric oral health care.

References

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