Maybe the last editorial on hand-over-mouth technique

Hand over mouth technique (HOM) elicits the same kind of polarizing reaction from pediatric dentists as does abortion from our society at large. It seems as if there's a line drawn in the sand and each of us is on one side or the other, merely closer or farther from the line. Practitioners either use HOM or they don't, some more than others. Rarely is the literature debate over HOM tempered with a balanced presentation of points of view. So little research supports or refutes the technique, that fact seldom participates meaningfully in the discussion.

To watch HOM work well in the hands of a skilled clinician is impressive. It appears effective, quick, and harmless, leaving the child no worse psychologically and a better dental patient. On the other hand, to watch a struggling dentist resort to HOM in desperation is downright ugly and it's no wonder the technique has gotten a bad reputation. No doubt, as well, that "trigger happy" clinicians have added to HOM's infamy. Allen et al.[1], for example, reported in *Pediatric Dentistry* a couple of years ago that 1% of board diplomates used HOM on cooperative children (although those familiar with the literature hope this was a typographical error)!

The arguments against HOM are essentially two: *first*, it is unethical and immoral; and, *second*, it inflicts long-term psychological harm on some children and creates dental phobics. The latter argument will probably remain untested because the research needed to settle that point can't be done easily, if at all. If the experts can't decide if divorce has negative effects on children or if sexual orientation is a nature or nurture phenomenon, it's unlikely that we'll ever know whether HOM causes irreparable damage to the psyche. As suggested by this issue's *Letters to the Editor*, available information is limited and controversial. So many variables contribute to one's behavior that to blame HOM for someone's fear of dentistry is like attributing a life of violence to a single abusive event in one's life. We'll never know, either, whether an HOM experience is one of several cumulative events over a childhood that create a dental phobic adult.

The first point or argument against HOM—that it is unethical and immoral—can be argued, but the outcome of that debate is already in the tea leaves. Our society is moving to eliminate HOM from the behavioral armamentarium in subtle and not so subtle ways, just as it is curtailing sedation and other elements of dental and medical practice. Courts in various jurisdictions and several state boards of dentistry have taken on the issue, acknowledging its significance to the public. Suffice it to say that regulations and case law are not building on the side of aversive techniques!

It wasn't so long ago that this journal published an official letter from a committee of the American Academy of Pediatrics about HOM[2] indicating the growing interest in the medical profession about how children are handled by dentists. The fact that the AAP group addressing HOM was the Committee on Child Abuse and Neglect should escape no one. HOM hasn't been taken up as a *cause celebre* by any child advocacy group to my knowledge, but it's only a matter of time.

We, as a specialty, also may have unwittingly compromised our position on HOM with behavioral research that indicates we are using it less often and more often seeking parental consent before we do.[3] Our Academy's *Guidelines for Behavior Management* provide a two-edged sword to any legal consideration of HOM, on the one hand protecting the child and provider with clear indications for HOM's use, then, on the other, setting it apart as an aversive and nonroutine procedure requiring special consent. The interpretation of what HOM is and if it should be used in a particular situation waits for the clever attorney and malleable jury.

It's only a matter of time before HOM joins dental amalgam, Nisentil,™ and conscious sedation as primetime TV fare. Of these three reluctant dental stars, one is deceased, and the other two are still in poor health. Want to place your bets on HOM if it gets air time on *20/20* or *Sixty Minutes*? Who of us in organized dentistry would want to handle questions from the likes of Morley, Ed, or Diane after half of America sees a cute little kid get HOM for a routine dental procedure?

The debate over HOM will undoubtedly continue. Perhaps in other countries, where customs and attitudes differ, the research will be done to attempt to separate out fact from fiction. I believe that here in the United States, HOM will disappear slowly. Like sedation, HOM will fall into disuse because of the risk, public pressure, and (we hope) alternative techniques. HOM will die a slow but inevitable death with the retirement of a generation of dentists who used it well and not so well and will some day be found only as an obscure reference in texts on pediatric dentistry or the law.

1. Allen KD, Stanley RT, McPherson K: Evaluation of behavior management technology dissemination in pediatric dentistry. Pediatr Dent 12:79–82, 1990.
2. Committee on Child Abuse and Neglect, 1991–92, American Academy of Pediatrics: Guidelines for behavior management of pediatric dental patients. [letter] Pediatr Dent 14:281–82, 1992.
3. Nathan JE: Management of the difficult child: a survey of pediatric dentists' use of restraints, sedation and general anesthesia. ASDC J Dent Child 56:239–301, 1992.

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