Behavior Management Conference Panel IV Report–Educational issues

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Abstract

Panel IV convened to address whether and how dental education curricula on behavior management needs to adapt to the changing needs and expectations of families and patients. There was a general consensus that behavior management should have a greater focus in dental education. Predoctoral and postdoctoral students may be expected to have different levels of exposure to behavior management concepts and techniques, but communications training should be a greater emphasis throughout dental education. Panel members specifically addressed behavior management techniques, including immobilization, restraint, sedation, and general anesthesia. Major recommendations from the panel included: 1) promote more research in behavior management; 2) update the AAPD guidelines on behavior management; 3) develop competencies/proficiencies for training programs and defining standardized outcomes; 4) introduce an AAPD task force to examine sedation issues that pertain to pediatric dental education; 5) explore new teaching methods of behavior management strategies and techniques; 6) develop a public awareness campaign to educate the public regarding what pediatric dentists do best. (*Pediatr Dent.* 2004;26:180-183)

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There is general recognition that dental education needs to adapt to the changing needs and expectations of today's patients, parents, and families. Currently, pediatric dentists employ standards on behavior management that are pegged to the clinical guidelines of the American Academy of Pediatric Dentistry (AAPD). The current AAPD behavior management clinical guidelines refer to individual techniques, most of which have anecdotal evidence, but not strong scientific evidence, to support their use and efficacy for many years. While there was consensus among panel and audience members that substantial research is needed across all behavior management areas, there was also agreement that recommendations for which behavior management concepts, strategies, and approaches to teach at all levels of dental education cannot wait to follow the research. As such, the panel commended the AAPD for convening a conference on behavior management at this time.

The panel was asked to address the following questions:

1. What behavior management techniques should be taught to advanced education students in pediatric dentistry, predoctoral students, and general practitioners in continuing education courses?
2. Do pediatric dentistry residents need more structured didactic and clinical training in child development, psychology, pain control, and child/parent/family dynamics?
3. What type of communication training would be most valuable to include in pre and postdoctoral programs and for continuing education?
4. Should graduate programs provide in-office (clinic) deep sedation/general anesthesia experiences for their residents (to teach competency in sharing an airway with a certified provider/monitor)?
5. Should advanced education students in pediatric dentistry receive more training in sedation and administering general anesthesia?
6. How will training programs "standardize" this training and ensure competency for all residents?

Behavior management training for different dental education levels

There was consensus among panel members that behavior management should have a greater focus across the entire spectrum of dental education. Safe and effective behavior

management was recognized to be an art as well as a science. Individuals who do not possess the natural abilities to manage child behaviors may, nevertheless, become competent with adequate training.

At all dental education levels, greater emphasis is needed to provide students with the didactic and clinical instruction to communicate well. Aside from specific techniques, students would benefit greatly if they were taught how to properly talk to child patients and their parents. Communications training should include the principles of informed consent. Parents should be informed of treatment options and the rationale for those options, including child behavior management strategies, and invited to be involved in the care and treatment of their children.

At the same time, communication should also include educating parents and families about what is expected of them and their children. Specific communication skills should include patient and parent interviewing skills and techniques. Communication strategies and techniques should be introduced early in predoctoral education and reinforced throughout pre and postdoctoral education.

Aside from communications training, pre and postdoctoral students may be expected to receive different levels of exposure to other behavior management concepts. Since the majority of children receive their dental care from general dentists, predoctoral dental students should have the opportunity to achieve competency in most behavior management strategies and techniques. The limited time available within the existing dental school curriculum will likely not allow much more time devoted to behavior management to be added to the undergraduate curriculum.

As such, a practical approach is to train the predoctoral student to become proficient in treating the cooperative child. Where possible, undergraduate dental students should be given opportunities to observe the entire range of behavior management strategies and techniques in practice (eg, shadow pediatric dentists in their private practices). Such exposures will allow predoctoral students to better understand the context in which pediatric dentists apply these concepts and techniques, as well as when and which child patients to refer to the pediatric dentist.

Postdoctoral students should receive adequate didactic and clinical exposure and experience to be able to apply the entire range of child behavioral management concepts and techniques. Upon successful completion of their specialty educational programs, postdoctoral students should have gained the required proficiency in caring for uncooperative as well as cooperative children. Advanced communication training should encompass a substantial component of the didactic and clinical behavior management instruction during postgraduate training.

Additionally, postdoctoral students should receive more structured didactic and clinical training in the following areas: (1) child development; (2) child psychology; (3) family dynamics; (4) parenting practices; (5) stress physiology; (6) parenting; (7) environmental factors affecting child behavior; (8) multiculturalism; (9) customer service; (10) patient and family advocacy; (11) legal issues; and (12) third party/insurance issues.

Immobilization and restraint

When addressing specific child behavior management techniques, deep philosophical differences emerged over whether pediatric dentists should continue to use and teach some techniques. The hand-over-mouth exercise (HOME) was a deeply dividing issue that garnered significant discussion among the panel and audience. A 2003 survey of postgraduate educational program directors and practicing pediatric dentists confirmed the use of HOME has continued to further decline. Many panel members and the audience expressed concern that, without societal acceptance of HOME, its use is no longer justified. As such, its clinical use should not be taught. On the other hand, there were some panel and audience members who strongly opposed discarding HOME at this time, contending that HOME is a safe and effective technique. There was also concern that, if HOME could not be used and pharmacologic management were not available under particular conditions or situations, pediatric dentists will be left with very few options to safely and effectively manage disruptive child behaviors.

If HOME was better understood and considered within the general group of advanced behavior management techniques and the context for their use, it may receive greater acceptance by the public and pediatric dental professional community as a behavior management technique. For example, immobilization is a necessary part of safe delivery of dental care to children. Parents and the public alike less frequently question brief and mild restraint of the hands and head during delivery of a local anesthetic. Mouth props and rubber dams may also be considered forms of restraint. Using the term "protective stabilization" in place of "medical immobilization" or restraint may also garner better acceptance by the public.

In general, improving communication with parents and patients regarding behavior management strategies and techniques and setting appropriate expectations by the practicing clinician who is considering employing the techniques would greatly help to mitigate potential misunderstanding. Furthermore, it is critical that the general public becomes aware of and develops an understanding of the rationale and indications of all behavior management concepts, strategies, and techniques. With an improved understanding by the public of the armamentarium of behavior management rationale, strategies, and techniques—the defining cornerstones of pediatric dentistry—the image of pediatric dentists and pediatric dentistry as a specialty would be enhanced.

Sedation and general anesthesia

Sedation was a topic that generated much discussion. There was recognition that great differences exist in the educational

and training experiences received by advanced education pediatric dentistry students across the United States, especially regarding clinical sedation instruction and experiences gained. Educators who did not receive adequate training to perform intravenous (IV) and oral sedation are unlikely to be qualified to teach the techniques to their students. Without sedation as a behavior management option for uncooperative children, general anesthesia will necessarily become more common.

However, third-party-payer and cost issues may already prohibit or restrict the use of general anesthesia in many situations. It is common for medical insurance plans to exclude general anesthesia/outpatient surgery benefits for routine dental procedures for children. Geographic restrictions on licensure and conflicting scope of practice acts may limit the ability of pediatric dentists to perform IV and oral sedations in their offices. Furthermore, institutional restrictions may limit IV sedation and even oral sedations outside the operating room setting, without the presence of an anesthesiologist in a dental clinic located within a hospital facility.

Establishing regional training centers may be a cost-effective mechanism to provide interdisciplinary education to students enrolled in disparate pediatric dental residency programs. Such training centers may be able to offer residents sedation training, including the management of adverse outcomes. Individual pediatric dental residency programs may be unable to offer significant sedation training because of limited resources, faculty shortage, and lack of faculty training. The types of experiences and levels of exposures to the various sedation and rescue techniques offered at the regional training centers will need to be discussed. An AAPD task force or committee may be best suited to address postgraduate education training and explore interdisciplinary education and regional training centers.

Competencies, outcomes assessment, and training standardization

Since it is difficult to measure how well students are trained to manage the behavior of their patients, competency assessment was the focus of intense discussion among the panel and audience. Medical education has instituted core sets of competencies into its professional education and accreditation process. The introduction of core competencies in medical education has been in response to the persistent and substantial variation in patient care across geographic settings—variation that does not relate to patient characteristics and the increased accountability expected by public payers and consumers of care. The goal is to have an outcome-based education system that focuses on making the learning outcomes for courses explicit and on evaluating how well students have mastered these competencies.

The AAPD has already established a residency standards task force to examine how pediatric dental residency programs are preparing professionals for practice. The task force is also responsible for developing core proficiencies and competencies and defining the outcomes to assess. Dental education may not need to completely reinvent the wheel. Instead, it could examine the experiences of medical education in defining our own appropriate set of competencies and outcome measures.

There was a lack of consensus regarding whether current standards established by the Commission on Dental Accreditation for dental training programs are adequate to assess the competencies and proficiencies of residents and students. There was also a lack of agreement on whether a standardized curriculum is necessary across all training programs. Reasons given in opposition to a standardized curriculum include institutional barriers, faculty shortage and preparedness, and geographic restrictions on licensure and scope of practice.

Although there are benefits to having diversity among training programs, defining and determining the desired outcomes for postgraduate students in training and how to assess those outcomes were perceived as important. For example, how do we determine that a pediatric dentistry residency program graduate has been successfully trained? How do we measure success? It may be answered through a broad question such as, "Would I allow my child to be treated by this resident?" On a more specific level, has a successful graduate achieved proficiency in specific areas of behavior management strategies and skills? For example, does a successful graduate require proficiency in multiple sedation techniques?

Pediatric dental training programs would benefit from working creatively and cooperatively to educate and train their students. Having regional training centers may help address faculty shortage and training issues. Developing standardized teaching modules on topics such as communications training and cross-cultural understanding would benefit all educational programs. The AAPD's Committee of Postdoctoral Program Directors of the Council on Postdoctoral Education has been charged with developing proposals for a mentorship program for new faculty and a new communication and teleconferencing system for educational programs.

Recommendations

The panel recommended the following:

1. Further research should be promoted across all areas of behavior management, particularly nonpharmacologic approaches.
2. The AAPD's behavior management guidelines should be updated.
3. Competencies/proficiencies for training programs should be developed, and standardized outcomes should be defined.
4. An AAPD task force to examine sedation issues pertaining to pediatric dental education should be

introduced. The sedation task force would explore the feasibility and logistics of developing regional training centers, especially for the purpose of providing sedation and rescue training.

5. The AAPD should encourage exploring new teaching methods of behavior management strategies and techniques. The AAPD could facilitate the development of teaching modules (eg, communication and cross-cultural training).
6. The AAPD should develop a public awareness campaign to educate the public about what pediatric dentists do best—using specialized training in communication and behavior management while providing safe and effective dental care to infants, children, adolescents, and individuals with special health care needs.
7. The AAPD should develop a continuing education course on nonpharmacologic management of children that includes communications training for dentists and staff.

Panel IV Members

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