Dental Teachers or Dental Technicians?

I would like to share some thoughts from the recent American Academy of Pediatric Dentistry (AAPD) meeting in San Francisco. I can attest that year after year I return to my private practice and graduate students refreshed, recharged and stimulated with new ideas. There is something for everyone to learn at the meeting. This year, the highlight of the conference for me was the panel discussion on behavior management. It was a unique opportunity to see and hear many pioneers of our specialty discuss the sensitive subject of patient management. The panelists represented the full spectrum of opinions and, at times, opposing views. Audience participation was welcome and both informing and thought-provoking.

My thought is that the debate on how we are to practice behavior management in the near future boils down to how we define ourselves as pediatric dentists. Are we communicators? Are we teachers and educators trying to interact with our young patients? Are we giving the child a dental experience and developing a relationship that will be a long-term benefit to the child? Or are we supposed to limit our ambitions and just treat the dental needs of the child and nothing beyond that?

Many axioms were questioned on the dais. Two very obvious comments should be brought to our readers' attention. Both contradict the principles of patient management that I was taught just 12 years ago in my postgraduate training. The first: "Dentists treat the disease not the child." The second: "The best way to communicate with a child is through the parent."

In my opinion, both of these statements are the opposite of what should be taught and practiced in pediatric dentistry. We foremost treat the child. Communicating through the parent will change our standing as teachers. Do teachers communicate with their students via parents?

One of the panelists mentioned the changing trend in parenting and the resultant no-limit, typical behavior of contemporary children. It was suggested that our methods of dealing and treating children would need to change and adapt to modern society and parents' expectations. The panelist envisioned that future treatment of the uncooperative difficult child would ultimately be administered in the operating room or under deep sedation. A member of the audience challenged this assumption and suggested that perhaps the AAPD could try and reverse this trend. I wholeheartedly agree with this suggestion. I heard from a friend involved in the garment industry that due to Americans' changing diet, eating habits and subsequent gain in weight the manufacturers have simply adjusted their clothing sizes by increasing the width of an article of clothing without changing the size number. A size 34 manufactured five years ago would actually be smaller than a similar cut of the same size sold this year. The result—people are happier, but fatter and less healthy. In a similar vein, should the AAPD change its guidelines and refer more children to the operating room who could have been managed by other techniques, perhaps resulting in a more cooperative patient? If all uncooperative children will be treated under pharmacosedation and only the cooperative children treated routinely in our offices, we will have canceled the need for pediatric dentists. Any general practitioner can place a preventive resin restoration or a sealant on a cooperative child or treat the unconscious defiant one in the operating room.

The only aspect of pediatric dentistry that attracted me to the specialty was the challenge of connecting with a fearful child and through communication and trust, making a difference in that child's life, transforming the anxious child to a cooperative and healthy patient. Treating the disease is easy. It's technical and boring. But to gain the trust of a defiant 5-year-old child and his or her parents, through personal patient management techniques enabling that child to successfully accomplish treatment—that is the challenge. That is pediatric dentistry!

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