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Hand-over-mouth: Another Perspective

Among the many things I've learned in my 30+ years of pediatric dentistry, keeping my emotions under control...is at the top of the list. However, Dr. Adair's letter regarding the hand-over-mouth (HOM) technique...caused me to do something that even the most obstinate child cannot—become upset! Dr. Adair's arguments against its use are based mostly on other people's criticism and potential civil claims.

At least part of the problem is the negative perception inspired by the term itself "hand over mouth". If we altered the term slightly to "holding of the mouth" and did a better job of explaining how it works, the perception would change dramatically. The following is a portion of the explanation and consent form that we give to every parent:

Some children, however, are very strong willed; they believe that if they fuss enough they might "get out of it." Our ultimate goal with managing the behavior of these children is simple—we need them to hold still! Our instruments are very sharp, and our "drill" spins at 300,000 rpm. The children can cry or make noise, but they can not move while we are working. Any movement at all is extremely dangerous, and compromises the quality of the dentistry, both of which are unacceptable.

It is important to realize that with current techniques and materials – nothing in children's dentistry hurts—nothing! However, if the patient "thinks" that something is going to hurt, they may worry and focus on it so much that they literally "obsess about it" and become more and more agitated, such that they can't stop fussing or even hear what we say to them, let alone follow our instructions.

So, how do we get the child to pay attention and convince them that they aren't going to get their way? We don't want the children to be afraid of us, so we never scold them or even raise our voice. We want every child to know that we want to help them, but also know that they must obey us. In my 30+ years of dentistry, I have found the kindest, most gentle way to do that is to hold their mouth still for several seconds. It diverts their attention away from their obsession and fear and puts it on our hand, allowing them to settle down so that they can really listen to us as we say—"We're not trying to be mean and we're not angry with you, but you need to help us and hold your mouth still or we'll have to help you hold it still!" Be assured, holding their mouth doesn't hurt at all, nor harm them in any way! Nor do we even portray it as negative. It not only gets their attention, it sends the message to them that "we are in control." Once they accept that, they quit trying to get their way, relax, and cooperate.

The perception of HOM also depends in part on the value one places on dentistry. If an ER physician used HOM to get a child to hold still while suturing a bleeding facial wound, or reattaching a partially severed finder, would

he be criticized? I think not. If people valued a tooth as they do a finger, their perspective about HOM would be much different!

HOM must also be considered within the context of the alternatives available to manage behavior and complete the needed dental work. There are usually 3 choices—HOM, parenteral sedation (oral sedation is ineffective for severe management cases), and general anesthesia. I rule out general anesthesia immediately. We have treated over 1,000 cases (many with mental disabilities) with intramuscular (IM) sedation without one serious complication and have always been able to complete the needed dental treatment. With the cost and risk differential, IM sedation is almost always preferred over general anesthesia. That leaves the choice between parenteral sedation and HOM. If the current lack of support for HOM continues, we will indeed be left with an environment in which, as Dr. Ari Kupietzky stated in his recent article, "all uncooperative patients will be treated under sedation."

With developmentally disabled patients sedation is often the only alternative. Choosing between HOM and sedation for normal children is much more difficult. As safe as IM sedation is, there are always risks. Even one catastrophic result would ruin my life, not to mention that of the patient and the parents. Only the doctor can really understand this responsibility when deciding to sedate. Therefore, my criteria for sedating normal children is to do so as a last resort, if nothing else, including HOM, will work. Many children under age two, especially nursing decay cases, are so over indulged, they literally cannot comprehend the possibility of not "getting their way." No amount of HOM will work with these children, so we sedate them.

The criticism and even civil claims regarding HOM would be reduced significantly if the pediatric dental community supported its use 100%. Having other professionals judging the technique is simply not valid as they have neither the knowledge or experience. Physicians shouldn't even comment on our handling of behavior management; their approach to behavior management relies wholly on drugs. If you go to the hospital to drain a boil, you will be sedated or go to the OR. Psychologists can't wait to assign "a name" to even the slightest misbehavior, so they can justify their involvement and treat it. There is no way that putting a hand over someone's mouth has some serious psychological impact. When a parent claims that her child is terrified to return, and tries to blame HOM, the truth is that the child is acting to manipulate the already "over indulging" parent so that they can, as usual, "get their way." How can they be terrified when nothing hurt? The only thing they are afraid of is being in an environment in which they aren't in control.

Finally, the problem isn't the technique. The problems are: (1) a growing litigious society with *too many lawyers;* (2) a community of education academia and psychologists who regard discipline with disdain; (3) a country full of single moms who don't have the energy or will to discipline their children, either because they work so hard to survive that they are literally too tired (especially when the time comes to take the bottle away at sleep time) or they feel so guilty about the absence of a father they can't say "no" to their children; and (4) a pediatric dental community that doesn't stand together in support.

HOM is the kindest, most gentle way to impose our will and manage obstinate behavior, and the professional lives of those of us who use it would be much easier if the pediatric dental community abandoned what's "expedient" and endorsed what's best for many, many children!

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