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To calm, to hold or to refer? When managing children becomes managing parents

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Introduction

Paediatric dental care required clinicians to maintain a delicate balance between effective treatment and child cooperation. In recent years, however, this dynamic has become increasingly complex (Yuan *et al.*, 2021). There has been an increase in reports from dental practitioners that managing parental expectations and demands is as critical, if not more challenging, than managing the child's behaviour itself. The intersection of clinical judgement, parental pressure and medico-legal concerns has fostered a climate of uncertainty, particularly within general dental practice, where access to paediatric dental specialists may be limited.

This editorial article highlights the ethical and practical implications of behaviour management decisions within the Malaysian dental context, with a specific focus on sedation, physical restraint and referral protocols.

Behaviour management: techniques and tensions

Behaviour guidance in paediatric dentistry encompasses a variety of techniques, ranging from non-pharmacological approaches such as tell-show-do and voice control to pharmacological strategies including sedation and general anaesthesia. The primary objective is to deliver safe, efficient, and trauma-free dental care.

The clinical landscape is further complicated by absence of a national consensus on the appropriate use of behaviour management techniques, particularly in primary settings. In contrast, the American Academy of Paediatric Dentistry (AAPD) has established a comprehensive guideline that categorize behaviour guidance methods into basic and advanced interventions, with recommendations tailored to patient age, developmental status and medical history (AAPD, 2024). These guidelines emphasize the importance of informed consent and clinical documentation while reinforcing the clinician's authority to determine the most suitable method. However, such structured frameworks remain underutilized in Malaysia due to lack of equivalent local guidelines.

The Malaysian context: access, capacity, and compromise

A recent study conducted by Che Lah *et al.* (2024) underscores the importance of considering parental perspectives in the selection and application of behaviour management techniques while managing children. An increasing number of practitioners report experiencing resistance from parents, particularly regarding protective stabilisation and sedation. This resistance, while rooted in parental concern, has the potential to undermine clinical autonomy and heighten the emotional burden on practitioners.

The 2015 National Oral Health Survey of Preschool Children (NOHPS) reported that more than 70% of five-year-olds in Malaysia experience dental caries (Ministry of Health Malaysia, 2015). Given the significant treatment needs associated with this statistic, the burden placed on primary care providers is considerable. However, the availability of paediatric dental specialists is limited, and unevenly distributed between urban and rural areas. Consequently, general dental practitioners (GDPs) often find themselves responsible for managing complex cases that would typically warrant referral to specialists.

In this context, the pressure to satisfy parental expectation, particularly in the absence of specialist support, can lead to compromised care. Clinicians may be inclined to avoid necessary procedures, delay referrals or opt for less effective management strategies due to apprehension regarding potential complaints or confrontations.

These situations give raise to important ethical considerations. To what extent should parental opinion influence clinical decision-making? How can practitioners reconcile their duty of care to the child with the need to respect parental authority? Furthermore, how can the profession assist clinicians who make ethically sound yet potentially unpopular decisions?

Regulatory gaps and the need for structured support

The Malaysian Dental Council's Code of Professional Conduct (2022) provides broad ethical guidelines, but it does not furnish specific recommendations for managing uncooperative children or addressing parental refusal of clinically indicated interventions. In the absence of national protocols or legal safeguards, many practitioners express a feeling of vulnerability and a lack of support.

Moreover, behaviour management training within Malaysian dental curricula framework often lacks sufficient emphasis on medico-legal documentation, informed consent processes and managing parental expectations. Continuing professional development (CPD) programmes predominantly concentrate on enhancing clinical skills, often neglecting to adequately address communication strategies pertinent to conflict resolution and parental education.

Conclusion

Behaviour management in paediatric dentistry has evolved beyond mere clinical skills, it now encompasses ethical navigation, legal awareness and social diplomacy. In Malaysia, the escalating tension between parental expectations and clinical necessities highlight the need for clearer guidelines, enhanced training and substantial institutional support. Only through these measurers can the dental chair be restored to a space where treatment decisions are made in the best interest of the child, grounded in science and not swayed by pressure

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