‘Do you see me?’

Pediatric patients require a unique touch that may not be intuitive for some adults

By Cathy Hester Seckman, RDH

As Thanksgiving host for my family one year, I was rushing around like a manic finding space for casseroles, juggling desserts and corralling extra chairs. In the middle of the madness, a 4-year-old niece tugged at my shirt.

“Aunt Cathy?” she asked anxiously, “did you see me yet?” I stopped in my tracks and bent to her level. “Hi, Morgan.” I smiled. “I’m glad you’re here.”

I remember that episode when new patients come to our pediatric practice. They have the same desire Morgan had, to be seen.

Children need to believe that people in power see them, know them and care about what happens to them. That’s what they’re really asking with those anxious eyes: “Do you see me?”

Bad examples

Starting off right with a new pediatric patient will set the relationship up for success in future dental visits. Pediatric management, it is said, begins in the waiting room. Here are two bad examples I’ve witnessed.

• A speech therapist came into a waiting room, walked up to a 5-year-old girl, looked down and bellowed, “Tiffany! I’m so glad to see you today!” Tiffany cringed behind her mother’s leg, obviously terrified.

• A medical assistant entered a waiting room, eyes on a clipboard, and intoned, “Gavin Smith? Time to go.” Seven-year-old Gavin didn’t budge, just looked at his mother apprehensively.

It’s easy to see what’s wrong with these examples. The therapist assumed a dominant position, used an intimidating voice and didn’t introduce or explain herself. The assistant didn’t make eye contact and didn’t explain what was going to happen. There was no mutual, caring connection in either case.

Good examples include a two-minute warning

Here are two better examples from a typical day in our pediatric practice.

• A dental assistant walks into the playroom and greets a child. “Hi, Anniston, my name’s Beth. I’m going to take care of you today. Hey, those are pretty cool shoes you have on. Do they light up? Wow!”

“Anniston, the first thing we’re going to do is pick out a new toothbrush, then the doctor will count your teeth, then you’ll be able to play some more. You and Mommy can come around the corner with me now to look at toothbrushes.”

• A dental hygienist enters the playroom and stoops down to eye level with the child. “Hi, you must be Tyler. I’m Cathy. How do you like that car race game? Are you the red car guy? Looks like you’re winning.”

“I’m going to clean your teeth today, Tyler. I’ll show you all my cool stuff, then I’ll polish your teeth with an electric toothbrush and put fluoride vitamins on them, then you can come back and play. I’ll be ready in two minutes, Tyler, so go ahead and race some more. I’ll be back.”

In these examples, a personal connection is established first. Children can be confident that we see them, know them and care about them well before treatment begins. I’ve also discovered that the two-minute warning is a great way to relieve anxiety.

Behavior guidance

Basic behavior guidance in the operatory is easier once a comfortable relationship is established. Tell-show-do, voice control, nonverbal communication, positive reinforcement and distraction can be integrated as part of an ongoing subjective process for each patient.

The American Academy of Pediatric Dentistry (AAPD) offers descriptions for each technique.

• Tell-show-do: Verbal explanations appropriate to the patient’s developmental level; demonstrations of the visual, auditory, olfactory and tactile aspects of each procedure in a nonthreatening setting; and completion of the procedure.

• Voice control: Controlled alteration of voice volume, tone or pace to influence and direct behavior.

• Nonverbal communication: Reinforcement and guidance of behavior through appropriate contact, posture, facial expression and body language.

• Positive reinforcement: Positive voice modulation, facial expression,
Editor’s Letter

The customer is always right?

Anyone with any training in dealing with the public has heard the saying, “The customer is always right.” But does that hold true in the dental office? Every dental professional will recognize this scenario. The patient comes in and tells the clinician what they do want, or more often times, what they do not want done. The request might sound something like, “I know I haven’t been in for a cleaning in a really long time, but I don’t want any X-rays taken today because I can’t afford them.”

Then the patient continues with comments such as: “Don’t spray any water in my mouth,” “my teeth are sensitive to cold so don’t scrape at them,” and “don’t polish my teeth, the paste is too gritty.” How is the clinician supposed to respond to patients such as these?

There are two ways to approach this situation. One is for the dental professional to make a case for what “needs” to be done. This begins with the clinician making a case for the necessity for X-rays, water, scraping and polishing. This is followed by the patient reiterating that he doesn’t want any of those things done in a slightly louder and firmer voice. At this point, the struggle has begun. This scenario will usually end up with one of the individuals being upset over the turn of events, and can even lead to the loss of a patient. Worse, yet, it can lead the patient sharing a less-than-glowing opinion of your practice to other potential patients. The result of this approach may be lose-lose for all parties involved.

What would happen if the clinician would say, “OK” when the patient lays down the ground rules? There is a camp that would say, “Give the customer what they want and keep them happy.” If the patient is happy, would it not be a more enjoyable appointment for all involved?

Taking baby steps to get this patient educated may be the best way to approach this dilemma. The focus here is on making the appointment pleasant enough to get the patient to come back for future appointments so progress can be made toward better oral health. This approach may result in a happy patient who is willing to return and a clinician who feels fulfilled because she was able to work with this patient and make progress.

As with all things, there are pros and cons to each scenario. Because there is no clear-cut answer to this predicament, the office needs to have a policy in place about how it will handle such patients. Is the office going to stand firm in its treatment procedures or is the office going to work with patients who present with these challenges?

Once the policy is put into motion, team members know what is expected of them and they are to act accordingly. This will certainly cut down on the drama and complaining that these types of patients usually cultivate in the office.

Best Regards,

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Editor in Chief

References


About the author

Cathy Hester Seckman is a dental hygienist, speaker, writer and index-er. She is a 1974 graduate of West Liberty State College. As a hygienist, she has been in general and specialty practices for 29 years, including three years as a temporary hygienist. Since 2005, she has worked in a pediat-ric practice.

For the past four years, she has presented continuing educa-tion programs for hygienists on pediatric management, nutri-tion, communication and pre-natal to preschool care. She has published nearly 100 articles in dental magazines.

‘With modern parenting styles, children may be ill-equipped with the coping skills and self-discipline necessary to deal with new experiences such as a dental visit.’