MEDICAL WRITING PORTFOLIO

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PORTFOLIO SAMPLE 01

When a Child Refuses Dental Treatment

Rethinking Behavior Guidance in Pediatric Dental Practice

Audience: Dentists and dental teams

Format: Evidence-based professional education article

This sample demonstrates evidence synthesis, clinical subject-matter expertise, and professional health communication for an HCP audience.

When a Child Refuses Dental Treatment

Rethinking Behavior Guidance in Pediatric Dental Practice

Professional education article for dentists and dental teams

Key points

- A child's refusal is clinical information, not simply a behavior problem.
- Behavior guidance should be individualized to the child, treatment need, pain, previous experience, family preferences, and available alternatives.
- Evidence for many nonpharmacological techniques is low or very low certainty, so shared decision-making and clinical judgment remain important.

A child who refuses to open their mouth, turns away from the dental mirror, cries, or repeatedly asks when the procedure will end is often described as "uncooperative." In pediatric dentistry, behavior is more useful when viewed as clinical information rather than simply as an obstacle to treatment.

Dental fear and anxiety are common in young children. A 2024 systematic review and meta-analysis of 25 observational studies estimated a pooled prevalence of 30% (95% CI 25–36%) among children aged 2 to 6 years. Children without previous dental visit experience and children with caries experience had higher odds of dental fear and anxiety.[1]

The practical question is therefore not simply how to make a child cooperate, but what may be driving the behavior and which approach is appropriate for that individual patient.

Behavior Is Only One Part of the Assessment

Two children of the same chronological age may respond very differently to the same procedure. Medical history, temperament, previous behavior during treatment, pain, urgency of treatment, previous behavior guidance techniques, informed consent, and available alternatives can all influence the behavior guidance plan. The American Academy of Pediatric Dentistry (AAPD) recommends that these factors be considered and documented when selecting an individualized approach.[2]

This changes the clinical question from "How do I control this behavior?" to "What does this patient need in order for care to be delivered safely and appropriately?"

Start With Communication

Behavior guidance begins before an instrument enters the child's mouth. Current AAPD best practice describes basic approaches including communication guidance, positive previsit imagery, direct observation, tell-show-do, ask-tell-ask, voice control, nonverbal communication, positive reinforcement and descriptive praise, distraction, and desensitization.[2]

Tell-show-do remains familiar to generations of dentists: explain a procedure in developmentally appropriate language, demonstrate relevant sensory aspects, and then perform the procedure as described. But no single technique should be treated as universally effective.

The AAPD's evidence-based clinical practice guideline on nonpharmacological behavior guidance assessed eight systematic reviews. Overall, basic nonpharmacological techniques produced trivial-to-small improvements in behavior or reductions in anxiety, although some interventions showed larger effects in particular settings. All recommendations were conditional and were mostly based on very low-certainty evidence.[3]

That matters clinically. A conditional recommendation means that different techniques, or combinations of techniques, may be appropriate for different patients. Parent and patient values and preferences should be part of that decision.[3]

Listen to the Child, Not Only to the Behavior

A child who suddenly becomes resistant during treatment may not simply be anxious. Pain, discomfort, difficulty understanding instructions, or other patient-specific factors may alter behavior. Current AAPD guidance specifically includes pain assessment among the factors to consider when developing the behavior guidance plan.[2]

A change in behavior therefore deserves reassessment before it is automatically attributed to lack of cooperation.

Parents Are Part of the Treatment Environment

Parental presence or absence should not be treated as a universal rule. AAPD recognizes parental presence/absence as a behavior guidance technique, while its evidence-based guideline makes a conditional recommendation based on very low-certainty evidence. The choice should therefore be individualized through clinical judgment and shared decision-making with the parent or caregiver, taking the child and planned care into account.[2,3]

When a child refuses treatment: a practical check

- Reassess pain, discomfort, urgency, and whether the planned procedure remains appropriate.
- Check whether the child understands what is being asked and adjust communication to developmental level.
- Select or modify behavior guidance according to the individual child, family preferences, previous response, and available alternatives.
- Consider developmental level, communication difficulties, special health care needs, or sensory factors that may be contributing to distress or refusal.
- Document the assessment, guidance options discussed, consent, and the rationale for the plan.

When Basic Techniques Are Not Enough

There are clinical situations in which basic communication and nonpharmacological approaches do not provide sufficient support for safe and effective treatment. That does not make the behavioral approach a failure.

AAPD describes behavior guidance as a continuum using nonpharmacological and pharmacological options. For anxious patients and some patients with special health care needs, additional options may include sensory-adapted dental environments, animal-assisted therapy, picture exchange communication systems, mind-body approaches such as biofeedback and breathing exercises, and nitrous oxide-oxygen inhalation. Advanced behavior guidance includes protective stabilization, sedation, and general anesthesia.[2]

These options are not interchangeable. Each requires evaluation of objectives, indications, contraindications, precautions, consent, and the clinician's training and skills.[2]

Treatment urgency also matters. An alternative such as deferred care may be considered as part of the overall plan, but the appropriateness of delay depends on the patient's treatment needs and clinical circumstances.[2]

Success Is More Than Completing the Procedure

A technically completed restoration is an obvious clinical outcome. In pediatric dentistry, however, it is not the only outcome that matters. Behavior guidance is intended to support safe, quality oral health care while helping develop a positive dental attitude.[2]

The goal is not perfect behavior. It is safe, effective, individualized care delivered with an understanding of the child's needs and the available evidence.

When a child refuses treatment, the behavior itself is not the diagnosis. It is a reason to reassess the patient, the procedure, the environment, and the guidance strategy being used.

References

1. Sun IG, Chu CH, Lo ECM, Duangthip D. Global prevalence of early childhood dental fear and anxiety: A systematic review and meta-analysis. Journal of Dentistry. 2024;142:104841. doi:10.1016/j.jdent.2024.104841.

2. American Academy of Pediatric Dentistry. Behavior guidance for the pediatric dental patient. The Reference Manual of Pediatric Dentistry. Chicago, IL: American Academy of Pediatric Dentistry; 2025:379-399. Latest revision 2024.

3. Dhar V, Gosnell E, Jayaraman J, et al. Nonpharmacological behavior guidance for the pediatric dental patient. Pediatric Dentistry. 2023;45(5):385-410.

Portfolio note: Prepared as a professional writing sample. It is not a clinical protocol and should be read alongside the full source guidance and local standards of care.