Overview

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Definitions and scope of pediatric dentistry

"Pediatric dentistry is an age-defined specialty that provides both primary and comprehensive preventive and therapeutic oral health care for infants and children through adolescence, including those with special health care needs."[1]

To become a pediatric dental specialist, a dentist must satisfactorily complete a minimum of 24 months in an advanced education program accredited by the Commission on Dental Accreditation of the American Dental Association. Such programs "**must** be designed to provide special knowledge and skills beyond the D.D.S. or D.M.D. training..."[2] The curriculum of an advanced program provides the dentist with necessary didactic background and clinical experiences to provide comprehensive primary oral health care and the services of a specialist. Pediatric dentists provide care, conduct research, and teach in a variety of clinical and institutional settings, including private practice and public health. They work in coordination with other health care providers and members of social disciplines for the benefit of children.

The primary focus of most dental specialties is a particular area of dental, oral, or maxillofacial expertise. Pediatric dentistry encompasses a variety of disciplines, techniques, procedures, and skills that share a common basis with other specialties but are modified and adapted to the unique requirements of infants, children, adolescents, and those with special health care needs. By being an age-specific specialty, pediatric dentistry encompasses disciplines such as behavior guidance, care of patients with medical conditions and physical and developmental disabilities, supervision of orofacial growth and development, caries prevention, sedation, pharmacological management, and hospital dentistry, as well as other traditional fields of dentistry. These skills are applied to the needs of children throughout their ever-changing stages of development and to treating conditions and diseases unique to growing individuals.

The American Academy of Pediatric Dentistry (**AAPD**), founded in 1947, is the membership organization representing the specialty of pediatric dentistry. Its members put children first in everything they do and aim to achieve the highest standards of ethics and patient safety. They provide care to millions of our nation's infants, children, adolescents, and persons with special health care needs and are the primary contributors to professional education programs and publications on pediatric oral health.

The AAPD, in accordance with its vision and mission, advocates optimal oral health for all children. It is the leading national advocate dedicated exclusively to children's oral health. Advocacy activities take place within the broader health care community and with the public at local, regional, and national levels. *The Reference Manual of Pediatric Dentistry* (*https://www.aapd.org/research/oral-health-policies--recommendations/*) is one of the components of the AAPD's advocacy activities.

Intent of *The Reference Manual of Pediatric Dentistry*

The Reference Manual of Pediatric Dentistry is intended to encourage a diverse audience to provide the highest possible level of care to children. This audience includes, but is not limited to:

- pediatric dentists.
- general dental practitioners and other dental specialists.
- physicians and other health care providers.
- government agencies and health care policy makers.
- individuals interested in the oral health of children.

The Reference Manual of Pediatric Dentistry is divided into five sections: (1) Definitions, (2) Oral Health Policies, (3) Recommendations, (4) Endorsements, and (5) Resources. Oral health policies are statements relating to AAPD positions on various public health issues. Recommendations are developed to assist the dental provider in making decisions concerning patient care. This section has two subcategories, Clinical Practice Guidelines and Best Practices, distinguished by the methodology employed to develop the recommendations. Adherence to the recommendations increases the probability of a favorable practice outcome and decreases the likelihood of an unfavorable practice outcome. The endorsements section includes clinical recommendations relevant to the practice of pediatric dentistry that have been developed by organizations with recognized expertise and adopted by the AAPD. Resources contains supplemental information to be used as a quick reference when more detailed information is not readily accessible, as well as clinical forms offered to facilitate excellence in practice.

Proper utilization of *The Reference Manual of Pediatric Dentistry* necessitates recognizing the distinction between standards and recommendations. Although there are certain instances within the recommendations where a specific action is mandatory, *The Reference Manual of Pediatric Dentistry* is not intended nor should it be construed to be either a standard of care or a scope of practice document. *The Reference Manual of Pediatric Dentistry* contains recommendations for care that could be modified to fit individual patient needs based on the patient, the practitioner, the health care setting, and other factors.

Definitions

For the purpose of this document, the following definitions shall apply:

Standards: Any definite rule, principle, or measure established by authority. Standards say what must be done. They are intended to be applied rigidly and carry the expectation that they are applied in all cases and any deviation from them would be difficult to justify. The courts define legal standards of care.

Clinical practice guidelines **(*CPG*):** "statements that include recommendations intended to optimize patient care. They are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options."[3]

CPG are intended to be more flexible than standards. They should be followed in most cases, but they recognize that treatment can and should be tailored to fit individual needs, depending on the patient, practitioner, health care setting, and other factors. Deviations could be fairly common and could be justified by differences in individual circumstances. CPG originate in an organization with recognized professional expertise and stature. They are designed to produce optimal outcomes, not minimal standards of practice.

Best practices: "the best clinical or administrative practice or approach at the moment, given the situation, the consumer's or community's needs and desires, the evidence about what works for this situation/need/desire, and the resources available."[4] Like CPG, best practices are more flexible than standards and originate in an organization with recognized professional expertise and stature. Although they may be unsolicited, they usually are developed following a stated request or perceived need for clinical advice or instruction.

Must or shall: Indicates an imperative need and/or duty; an essential or indispensable item; mandatory.

Should: Indicates the recommended need and/or duty; highly desirable.

May or could: Indicates freedom or liberty to follow a suggested alternative.

Parent: Unless otherwise indicated, the term parent as used in these oral health policies and recommendations has a broad meaning encompassing:

1. a natural/biological or adoptive father or mother of a child with full parental legal rights,
2. a person recognized by state statute to have full parental legal rights,
3. a parent who in the case of divorce has been awarded legal custody of a child,
4. a person appointed by a court to be the legal guardian of a minor child,
5. a person appointed by a court to be the guardian for an incapacitated adult,
6. a person appointed by a court to have limited, legal rights to make health care decisions for a ward,
7. or a foster parent (a noncustodial parent caring for a child without parental support or protection who was placed by local welfare services or a court order).

Development of oral health policies, best practices, and clinical practice guidelines

The oral health policies, best practices, and clinical practice guidelines of the AAPD are developed under the direction of the Board of Trustees (**BOT**), utilizing the resources and expertise of its membership operating through the Council on Clinical Affairs (**CCA**), the Council on Scientific Affairs (**CSA**), and the Evidence-based Dentistry Committee (**EBDC**) of the AAPD Pediatric Oral Health Research and Policy Center. CCA and CSA are composed of individuals representing the five geographical (trustee) districts of the AAPD, along with additional consultants confirmed by the BOT. The EBDC is comprised of two members from each of these councils as well as the AAPD's editor-in-chief. Council/committee members and consultants derive no financial compensation from the AAPD for their participation in development of oral health policies, best practices, and clinical practice guidelines, and they are asked to disclose potential conflicts of interest. The AAPD has neither solicited nor accepted any commercial involvement in the development of the content of this publication.

Proposals to develop or modify oral health policies and best practices may originate from four sources:

- the officers or trustees acting at any meeting of the BOT.
- a council, committee, or task force in its report to the BOT.
- any member of the AAPD who submits a written request to the BOT as per the AAPD Administrative Policy and Procedure Manual, Section 9 (the full text of this manual is available on the Members' Only page of the AAPD website).
- officers, trustees, council and committee chairs, or other participants at the AAPD's annual strategic planning session.

Regardless of the source, proposals for oral health policies and best practices are considered carefully, and those deemed sufficiently meritorious by a majority vote of the BOT are referred to the CCA for development or review/revision. The CCA members are instructed to follow the specified process and format their development. Oral health policies and best practices utilize two sources of evidence: the scientific literature and experts in the field. The CCA, in collaboration with the CSA, performs a literature review for each document. When scientific data do not appear conclusive or supplemental expertise is deemed beneficial, authorities from other organizations or institutions may be consulted.

The CCA meets on an interim basis to discuss proposed oral health policies and best practices. Each new or reviewed/revised document is deliberated, amended if necessary, and confirmed by the entire council. Once developed by the CCA, the proposed document is submitted for the consideration of the BOT. While the Board may request revision, in

which case it is returned to the council for modification, once accepted by majority vote of the Board, it is referred for Reference Committee Hearing at the next Annual Session. The Reference Committee Hearing is an open forum for the membership to provide comment or suggestion for alteration of the document. The CCA carefully considers all remarks presented at the Reference Committee Hearing prior to submitting its final document for ratification by a majority vote of the membership present and voting at the General Assembly. If accepted by the General Assembly, either as proposed or as amended by that body, the document then becomes the official AAPD oral health policy or best practice for publication in *The Reference Manual of Pediatric Dentistry* and on the AAPD's website (*https://www.aapd.org/research/oral-health-policies--recommendations/*).

The EBDC provides oversight and management of the CPG development process. The topic for each guideline is recommended by the EBDC and approved by the BOT. Once a topic has been affirmed, the process begins with searches for an existing CPG from another organization with recognized expertise and for related systematic reviews. The EBDC will evaluate available publications and recommend either endorsement of an existing guideline or development of a new CPG. If a CPG is to be developed, the EBDC recommends to the BOT individuals for the guideline workgroup. Workgroup members are respected clinicians (end users), authors of peer reviewed publications in the topic under review, and methodology experts. All workgroup members should be capable of knowledgeably assessing a body of evidence using criteria approved by the EBDC. The duties of each workgroup may include:

- develop a research protocol.
- develop the PICO (Patient, Intervention, Comparison, Outcome) question for each guideline.
- select studies for full-text retrieval and extraction, and extract for each study selected.
- perform evidence synthesis: meta-analysis or narrative synthesis.
- grade evidence (based on GRADE criteria[5]).
- write a systematic review.
- review and edit a guideline.
- modify a guideline according to external review recommendations.

AAPD may choose to develop CPG in collaboration with other organizations of recognized expertise and stature. Such joint guidelines would undergo a similar development process and be based on a systematic review of the evidence.

Each proposed CPG is circulated to the CCA, CSA, and BOT for review and comment prior to submission for publication. These documents, however, do not undergo ratification by the General Assembly. Rather, once finalized by the EBDC, the document becomes an official CPG of the AAPD for publication in *Pediatric Dentistry*, reprinting in *The Reference Manual of Pediatric Dentistry*, and posting on the AAPD's website (*https://www.aapd.org/research/oral-health-policies--recommendations/)*.

Review of oral health policies and clinical recommendations

Each AAPD oral health policy, best practice, and clinical practice guideline is reviewed for accuracy, relevance, and currency every five years, and more often if directed by the BOT. After completing a new literature search, reviewers may recommend reaffirmation, revision, or retirement of the document. Policies and recommendations of other organizations that have been endorsed by the AAPD are reviewed annually to determine currency as well as appropriateness for the AAPD's continued endorsement.

References

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