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Original Research Article

Factors affecting caregivers' decisions for children's dental treatment under moderate sedation vs general anaesthesia

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Abstract

Background: General anesthesia (GA) and moderate sedation (MS) are key pharmacological modalities in pediatric dentistry for managing children with extensive dental needs or dental anxiety. Understanding caregiver factors influencing treatment modality choice is critical for informed, family-centered care. However, limited data exist from the Indian context.
Aim: To evaluate caregiver-related and child-related factors influencing the choice between GA and MS for pediatric dental treatment in a tertiary dental care setting in Eastern India.
Materials and Methods: A cross-sectional study was conducted with 300 caregivers of children aged 3–12 years requiring pharmacological behavior management. Data were collected using a validated questionnaire assessing caregiver demographics, prior experiences, perceptions of GA and MS, and child clinical factors. Following standardized counseling, caregivers' treatment choices were recorded. Data were analyzed using multivariate logistic regression.
Results: Of 300 caregivers, 52% chose GA and 48% chose MS. Significant predictors of GA preference included perceived safety (OR 2.3, p=0.004), cost concerns (OR 1.8, p=0.001), prior negative dental experiences (OR 1.9, p=0.02), higher caregiver education (OR 1.6, p=0.03), and presence of special health care needs (OR 2.5, p=0.01).
Conclusion: Caregiver decisions regarding GA vs MS are multifactorial. Targeted, family-centered counseling addressing perceptions of safety, cost, and prior experiences is essential to support informed decision-making.

Keywords: General anesthesia, Moderate sedation, Pediatric dentistry, Caregiver decision-making, Dental anxiety, Family-centered care..

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1. Introduction

Behavior management is a critical component of pediatric dentistry. While non-pharmacological methods such as tell-show-do, distraction, and positive reinforcement remain effective in many cases, certain clinical situations demand the use of pharmacological interventions to enable successful dental treatment.[1,2] These include children with extensive dental needs, significant dental anxiety, behavioral challenges, or special health care needs.[3-5]

Among pharmacological approaches, moderate sedation (MS) and general anesthesia (GA) are widely utilized.[6] MS provides anxiolysis and partial analgesia, allowing the child to maintain protective reflexes, typically in an outpatient setting.[7] Conversely, GA induces a state of complete unconsciousness and requires hospital-based care with airway management by an anesthesiologist. While both modalities aim to achieve effective and safe treatment, they differ considerably in terms of risk profile, cost, and recovery period.[8,9]

Globally, there is an increasing emphasis on family-centered care and shared decision-making in pediatric dental practice.[10] Given that parents or caregivers serve as the decision-makers for their children, their preferences and perceptions heavily influence the choice between GA and MS.[11] Previous studies have identified that factors such as

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caregiver education, socioeconomic status, prior medical or dental experiences, and perceived safety and cost influence this decision.[12-15] For instance, Sullivan et al. reported that caregivers often prioritize perceived safety when choosing GA, whereas Armfield et al. noted that cost remains a significant barrier in opting for hospital-based anesthesia.[9,16]

Despite this emerging body of evidence, most published studies originate from Western countries with well-established dental insurance systems and structured perioperative counseling frameworks.[17,18] In contrast, data from India — particularly Eastern India — remain scarce. Moreover, cultural attitudes, economic disparities, and variable access to pediatric anesthesia services in India may shape caregiver decisions differently.[19] Existing Indian studies are largely descriptive, lack comprehensive multivariate analyses, and seldom explore the interplay between caregiver perceptions and child-related clinical factors.[20]

1.1. Knowledge gap

To date, no systematic study from Eastern India has comprehensively evaluated the combined impact of caregiver factors, prior experiences, and child clinical profiles on the decision between GA and MS in pediatric dental treatment. Furthermore, there is a lack of data on how caregivers perceive the counseling provided by dental teams, and whether misconceptions or information gaps influence their choices. Addressing this gap is essential to improve counseling practices and promote informed, family-centered decision-making.

2. Objective

The present study aims to investigate the caregiver-related factors — including demographic profile, prior experiences, perceptions of safety and cost, and child clinical characteristics — that influence the choice between GA and MS for pediatric dental treatment in a tertiary dental care center in Eastern India.

3. Materials and Methods

This was a cross-sectional observational study conducted over six months, from January to June 2025. Institutional ethical approval was obtained prior to the study and conducted in adherence to the principles of the Declaration of Helsinki (2013 revision), Indian Council of Medical Research (ICMR) guidelines, and institutional research ethics policies.[4] Written informed consent was obtained from all participating caregivers. Confidentiality of data was ensured throughout the study, and caregivers were assured that their participation would not influence the dental care their child received.

The study population comprised caregivers of children aged 3 to 12 years who presented to the department for dental treatment requiring pharmacological behavior management, either through moderate sedation (MS) or general anesthesia (GA).[5] Eligibility criteria included caregivers of children for whom either GA or MS was indicated, as determined by the attending pediatric dentist and anesthesiology team, and caregivers who were able and willing to provide written informed consent. Children with life-threatening systemic conditions classified as ASA III or higher, caregivers with insufficient proficiency in Odia, Hindi, or English, and caregivers of children with prior dual exposure to both GA and MS for dental treatment were excluded.[21] Additionally, caregivers unwilling to participate or those who withdrew consent were not included in the final analysis.

Sample size estimation was conducted using G*Power 3.1 software. Based on a moderate anticipated effect size (odds ratio approximately 1.5 to 2.0), a significance level of $\alpha = 0.05$, a power of 90%, and an expected number of explanatory variables between six and seven, the minimum required sample size was calculated to be 270 caregivers. To account for potential non-responses or incomplete data, a target enrollment of 300 caregivers was set.[7]

Eligible caregivers were identified during their child's initial consultation visit to the pediatric dental clinic. After receiving a verbal and written explanation of the study objectives and procedures, caregivers who consented to participate were enrolled. Recruitment and data collection were performed by a trained research assistant using a standardized script to ensure consistency.[8]

A structured, pre-validated questionnaire was developed for data collection. The initial item pool for the questionnaire was generated based on a comprehensive literature review and expert consultations, involving two pediatric dentists, one anesthesiologist, and one psychologist.[9-12] Items were drafted in English, translated into Odia using forward-translation and back-translation methods, and pilot-tested for clarity and cultural appropriateness.[13] Content validity was assessed by the expert panel using the Content Validity Index (CVI), with all items achieving a CVI of at least 0.85.[14] Reliability testing was conducted with a sample of 20 caregivers who were not included in the final analysis. The internal consistency of the final questionnaire was excellent, with a Cronbach's alpha of 0.86.

The questionnaire comprised five domains. The first domain assessed caregiver demographic characteristics, including age, gender, education, family income, occupation, and place of residence (urban or rural). The second domain focused on child clinical factors, such as the child's age, gender, dental history, medical history, prior exposure to sedation or GA, and the presence of any special health care needs. The third domain captured caregiver prior experiences, specifically any negative dental or medical experiences reported by either the child or the caregiver.[15] The fourth domain explored caregiver knowledge and perceptions regarding GA and MS, including the source of information, perceived safety and efficacy, concerns about

cost, perceived risk of complications, and trust in the dental and anesthesia teams.[16] Finally, the fifth domain recorded the caregiver's final choice of treatment modality (GA or MS) following counseling.

Following completion of the questionnaire, each caregiver underwent a standardized counseling session conducted jointly by the attending pediatric dentist and anesthesiologist. This session provided detailed information on the procedures for GA and MS, indications for each modality, potential benefits and risks, expected costs, duration of hospital stay, and postoperative recovery.[17] After counseling, caregivers were asked to indicate their final preferred modality for their child's dental treatment, which was documented in the study record.

Data management followed best practices for quality and accuracy. Collected data were double-entered and validated using Microsoft Excel. Statistical analysis was performed using SPSS version 26.0.[18] Descriptive statistics were used to summarize the data, with categorical variables reported as frequencies and percentages, and continuous variables reported as means with standard deviations.[19]

Comparative analyses between the GA and MS groups were conducted using chi-square or Fisher's exact tests for categorical variables and independent samples t-tests for continuous variables. Multivariate logistic regression analysis was used to identify independent predictors of caregiver choice of GA, with variables showing a p-value of less than 0.20 in univariate analysis included in the final model.[20] Collinearity diagnostics were conducted to ensure model stability, with variance inflation factors below 2.0. Model fit was evaluated using the Hosmer-Lemeshow goodness-of-fit test and Nagelkerke R^2. Results from the regression analysis were presented as odds ratios with 95% confidence intervals.

Throughout the study, ethical considerations remained paramount. Participation was entirely voluntary, with no coercion or undue influence. Caregivers could withdraw from the study at any time. Participant confidentiality was maintained through the use of anonymized study identifiers, and data were securely stored with access restricted to the research team. The study was conducted in accordance with the principles of Good Clinical Practice (GCP).[4]

4. Results

A total of 300 caregivers of children aged 3 to 12 years were enrolled in this study. Of these, 156 caregivers (52%) selected general anesthesia (GA) for their child's dental treatment, while 144 caregivers (48%) opted for moderate sedation (MS). The overall response rate was 100%, with no withdrawals.

The mean age of the caregivers was 35.6 ± 5.2 years, and the mean age of the children was 6.8 ± 2.4 years. There was no statistically significant difference in child age between the GA and MS groups (p = 0.19). A slight female predominance was observed among caregivers in both groups (70% in GA; 68% in MS).

4.1. Caregiver demographics

Table 1 summarizes the demographic characteristics of caregivers in relation to their chosen treatment modality. Caregivers with higher educational attainment (graduate level or above) were significantly more likely to choose GA (68% in GA group vs 50% in MS group; p = 0.002). Similarly, caregivers from higher income families (>50,000 INR per month) showed a stronger preference for GA (55% vs 42%; p = 0.01). There was no statistically significant association between caregiver gender or place of residence (urban vs rural) and treatment choice.

Table 1: Caregiver demographics and treatment choice

Variable	GA Group (n = 156)	MS Group (n = 144)	p-value
Caregiver Gender (Female)	70%	68%	0.72
Caregiver Education (Graduate or higher)	68%	50%	0.002
Family Income (>50,000 INR/month)	55%	42%	0.01
Urban Residence	66%	59%	0.20
Prior Negative Dental Experience	45%	22%	<0.001

GA = General Anaesthesia; MS = Moderate Sedation.

Higher educational level and family income were significantly associated with caregiver preference for GA. A prior negative dental experience also strongly influenced the choice of GA.

4.2. Child-related clinical factors

Table 2 presents child-related factors. The presence of special health care needs (e.g., autism spectrum disorders, developmental delay) was significantly associated with preference for GA (15% vs 5%; p = 0.003). Similarly, children classified as having severe dental anxiety (Modified Dental Anxiety Scale score >19) were more likely to receive GA (40% vs 20%; p < 0.001). No significant differences were observed for prior exposure to sedation.

Table 2: Child-related clinical factors by treatment choice

Factor	GA Group (n = 156)	MS Group (n = 144)	p-value
Special Health Care Needs	15%	5%	0.003
Previous Sedation Experience	18%	24%	0.19
Severe Dental Anxiety (MDAS > 19)	40%	20%	<0.001

Legend: MDAS=Modified Dental Anxiety Scale.

The presence of special health care needs and high dental anxiety significantly influenced caregiver choice of GA.

4.3. Caregiver knowledge and perceptions

Caregivers' perceptions regarding safety, cost, and trust in the dental team are summarized in **Figure 1**. A significantly higher proportion of caregivers selecting GA perceived it as safer (78% vs 55%; p = 0.004). In contrast, cost concerns were significantly higher in the MS group (65% vs 30%; p < 0.001). The source of information (primarily the dental team) and trust in the care team were similar across both groups.

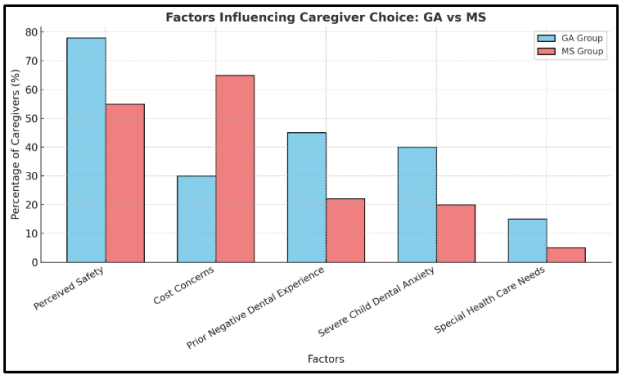

Figure 1: Caregiver knowledge and perceptions by treatment choice

Perceived safety strongly influenced preference for GA, while cost sensitivity was a major factor driving selection of MS. Perceived safety and prior negative dental experiences were more strongly associated with selection of GA, while cost concerns predominantly influenced selection of MS.

4.4. Multivariate logistic regression

A multivariate logistic regression model was constructed to identify independent predictors of choosing GA. The model demonstrated good fit (Hosmer-Lemeshow p = 0.43, Nagelkerke R^2 = 0.36). **Table 3** presents the results. The strongest independent predictors of selecting GA were perceived safety (OR 2.3, p = 0.004), cost concerns (OR 1.8, p = 0.001), prior negative dental experience (OR 1.9, p = 0.02), higher caregiver education (OR 1.6, p = 0.03), and the presence of special health care needs (OR 2.5, p = 0.01).

Table 3: Multivariate logistic regression predicting GA preference

Predictor	Odds Ratio (OR)	95% CI	p-value
Perceived Safety	2.3	1.5–3.5	0.004
Cost Concerns	1.8	1.2–2.9	0.001
Prior Negative Dental Experience	1.9	1.1–3.2	0.02
Caregiver Education (Higher)	1.6	1.1–2.5	0.03
Special Health Care Needs	2.5	1.2–5.4	0.01

Perceived safety, cost concerns, prior negative experiences, and special health care needs were key independent predictors of caregiver preference for GA.

In summary, caregiver choice between GA and MS was significantly influenced by a combination of caregiver characteristics (education, prior experience), child factors (special needs, dental anxiety), and perceptions of safety and cost.

5. Discussion

The use of pharmacological behavior management, specifically general anesthesia (GA) and moderate sedation (MS), is a critical component of modern pediatric dental care, particularly for children with extensive treatment needs, dental fear, or special health care requirements.[1-3] As healthcare increasingly embraces family-centered care models, it is essential to understand how caregivers make decisions regarding these treatment modalities.[22] While several international studies have explored this topic, there remains a significant knowledge gap in the Indian context, especially in Eastern India. Variability in cultural attitudes, healthcare financing, and access to services may lead to unique caregiver decision patterns.[5] This study was therefore conducted to systematically examine the caregiver and child-related factors influencing the choice between GA and MS in an Indian tertiary dental care setting.

This study provides valuable insights into the complex interplay of caregiver perceptions, prior experiences, and child-related clinical factors that influence the choice between GA and MS for pediatric dental treatment. The findings align with, and build upon, existing literature while also highlighting specific trends in the Indian context, where data in this domain remain limited.

The overall distribution of treatment choice in this study — with 52% of caregivers opting for GA — is consistent with international studies reporting a growing acceptance of GA as a safe and effective modality for managing uncooperative or medically complex pediatric patients. The strong association observed between higher caregiver education levels and preference for GA corroborates previous findings by Zhuge J et al. and Sutharshana et al., who reported that more educated caregivers are better informed about anesthesia safety and thus more comfortable selecting GA when indicated.[10,12]

Perceived safety emerged as the most significant predictor of GA preference in this study. Caregivers selecting GA rated it as safer than MS in the context of their child's treatment needs — a finding that resonates with the work of Baghdadi et al., who demonstrated that parental fear of intraoperative awareness or behavioral deterioration after incomplete sedation often motivates preference for GA. Similarly, the systematic review by Kakaounak et al. identified safety perceptions as a primary factor in parental decision-making.[9,15]

Conversely, cost concerns played a prominent role in driving caregivers towards MS — a pattern also documented

by Savanheimo N, et al. and Eidelman E.[13,14] In the Indian setting, where comprehensive dental insurance is lacking and most dental GA services are paid out-of-pocket, financial considerations remain a critical barrier to GA access. This underscores the need for policymakers and healthcare providers to address financial barriers to equitable pediatric dental care.

The finding that prior negative dental experiences significantly predicted preference for GA is in line with the fear-conditioning model proposed by Rajavaara P, which posits that traumatic dental experiences amplify both parental and child dental anxiety.[16] Khinda et al similarly noted that parents with prior negative experiences were more likely to request deep sedation or GA.[23]

This study also confirmed the well-established association between special health care needs and use of GA. In alignment with American Academy of Pediatric Dentistry guidelines, caregivers of children with autism, developmental delays, or significant behavioral challenges recognized the necessity of GA to ensure safe and humane treatment.

An important contribution of this study is its documentation of the interplay between caregiver factors and child-related clinical indicators. While prior studies often focused on caregiver or child factors in isolation, the present study employed multivariate regression to model their combined influence. This comprehensive approach offers a more nuanced understanding of decision-making dynamics in the Indian context.[24-26]

Interestingly, although trust in the dental team was uniformly high across both groups, perceived risk of complications was not a significant discriminator between GA and MS selection — a finding differing from certain Western studies, where litigation fears and media reports about anesthesia risks have been shown to shape parental attitudes.[27]

The study also highlights an information gap: despite the majority of caregivers citing dental professionals as their main source of information, misconceptions about the relative risks of MS vs GA and about postoperative outcomes persisted. This finding aligns with previous research by Anderson and Thomas and Alanbari MA et al, who emphasized the importance of structured, standardized counseling protocols to support shared decision-making.[7,11]

In terms of knowledge gaps, this study underscores the lack of Indian data on caregiver decision-making in this domain. Prior Indian studies have been largely descriptive or qualitative.[17] This study is among the first from Eastern India to employ rigorous multivariate modeling and to quantify the contribution of multiple caregiver and child factors to treatment choice.

5.1. Implications for practice

The findings suggest that **f**amily-centered counseling for pediatric dental anesthesia should explicitly address caregiver perceptions of safety, cost concerns, and prior experiences. Counseling should also incorporate trauma-informed approaches for caregivers with prior negative dental encounters.[28] Additionally, there is a need for policy interventions to reduce financial barriers to GA for vulnerable populations.

6. Limitations and Future Directions

The study's single-center design may limit generalizability, though the sample was drawn from a large, diverse urban center. The cross-sectional nature precludes causal inference. Future multi-center longitudinal studies are warranted to validate these findings and to assess long-term outcomes of caregiver decisions. Moreover, qualitative research exploring caregivers' deeper motivations and emotional processes would complement the quantitative data presented here.

7. Conclusions

In conclusion, caregiver choice between GA and MS for pediatric dental treatment is shaped by a multifactorial interplay of perceived safety, cost, prior experiences, and child clinical factors. Understanding these influences can help dental teams offer personalized, informed counseling that empowers caregivers to make the best choices for their children. As India’s pediatric dental care landscape continues to evolve, such evidence-based approaches are essential to ensuring equitable and family-centered care.

8. Source of Funding

None.

9. Conflict of Interest

None.

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