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Some Nigerian children's perceptions and involvement in consent to dental treatment

Olubunmi Olusola Bankole*[1], Oluwole Oyekunle Dosumu*[2], Elizabeth Bosede Dosumu*[3] and Obafunke Olufunmilayo Denloye*[1]

*[1] Department of Child Oral Health, Faculty of Dentistry,
*[2] Department of Restorative Dentistry, Faculty of Dentistry,
*[3] Department of Preventive Dentistry, Faculty of Dentistry,
College of Medicine, University of Ibadan, NIGERIA

Abstract The objective of this study was to evaluate the perceptions of some Nigerian children regarding consenting to their dental treatment. The sample consisted of 100 child patients with an age range of 8–13 years. Children requiring emergency treatment were excluded from the study. A semi-structured questionnaire was administered and the dentists carried out interviews following dental treatment. The outcome of the study revealed that 64% of the respondents were of the opinion that children generally should be involved in deciding about their dental treatment. Results showed that 37% of these children were actually involved in the decision about the dental treatment they had received whereas 66% believed that they should have been part of the process. Responses from the children revealed that 49% wanted the dentist to talk to them about their dental treatment while 41% felt it was the responsibility of both their parents and the dentist. The results of this study have suggested that children want to be more involved in consenting to their dental treatment.

Key words
Children,
Consent,
Dental treatment

Introduction

In many parts of the world an individual is legally a minor and presumed incompetent until at least the age of 16 or even 18 years[1)] and consequently, parental consent is required prior to obtaining health care. Despite this, many children possess the capacity to take part in the decision making process at some level. What really matters is whether the child has the capacity to clearly understand the nature and implication of any proposed treatment and is able to willingly make a decision[2)].

However, it is important that health care professionals understand and respect the evolving capacity and autonomy of children and consider their views in all matters, medical decision making being inclusive. The consequences of non involvement may have no immediate effects but the danger of excluding children from the decision making process may in the future lead to resentful and unhappy children who have had to live with consequences of decisions in which they did not participate[3)]. Even when children are not old enough to consent to treatment they should be allowed to have a say in the decision making process.

According to Alderson[4)], in a study of school age children slated for orthopaedic operation, it was found that children less than 10 years of age were able to grasp the concepts of treatment and the consequences and some were even better informed than their parents. Fortunately however, these operations were elective and not life saving as most dental procedures are. It therefore becomes important to involve children in consent.

In Nigeria, studies on this rather controversial but important aspect of dentistry in children appears to be scarce. The aim of this study is to evaluate the perceptions of some Nigerian children regarding consent to dental treatments and also to determine

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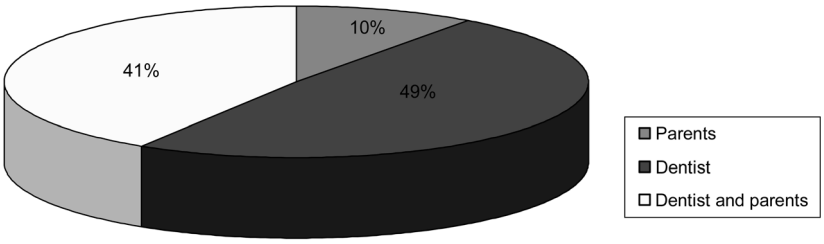

Fig. 1 Children's perceptions about source of information before dental treatment

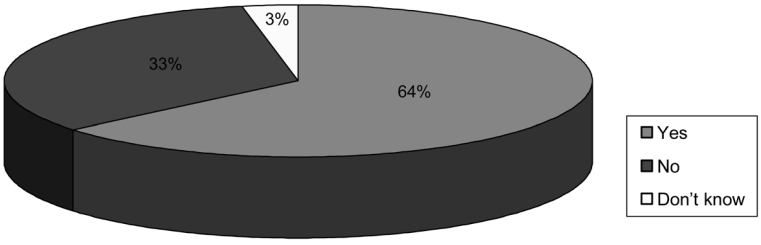

Fig. 2 Children's perceptions about their involvement in decision making before dental treatment

their involvement in consent to treatment.

Materials and Methods

The study was carried out at the out-patient clinic of Paediatric Dentistry, University College Hospital, Ibadan. The subjects consisted of 100 child patients. All the children seen over a period of 9 months in the age range of 8 to 13 years were included in the study. Children requiring emergency dental treatment were excluded from the study. A semi-structured questionnaire was administered and interviews were carried out following dental treatments by two dentists (O.B. and O.D.). The parents were present as observers. Apart from the basic demographic details, questions were asked about the age at first dental visit, who they thought should talk to them about dental treatment and if they thought children should be involved in deciding about their dental treatment. The subjects were also asked if any information about treatment was given to them. For those given information it was inquired if they thought the information given was enough and whether they fully understood the explanation.

Information about whether they had wanted their treatment immediately or at a later date was sought and also their feeling about the dental treatment they had just received. The general age they felt children should consent to their dental treatment, who decided about the treatment they had received and who they thought should have decided were also asked.

After ensuring proper completion of the forms, the data was analyzed by the SPSS and Epi-Info statistical package and frequency tables were generated. The Chi-square test was used to determine association of variables.

Results

Findings revealed that 47 (47.0%) of the respondents were males while 53 (53.0%) were females. None of these children belonged to the lower socioeconomic class.

More than half, 54 (54.0%) of the children had previously experienced dental treatment with a mean age of 9.2 years for their first dental visit. Only 17 (17.0%) children were regular attenders.

Responses from the children revealed that about half, 49 (49.0%) wanted the dentist to talk to them about their treatment while 41 (41.0%) felt that both their parents and the dentist should be involved. Ten children (10.0%) said it should be parents alone (Fig. 1).

When asked about whether children should be involved in deciding about their dental treatment, 64 (64.0%) said they should be (Fig. 2). Reasons given ranged from the fact that some (51.6%) felt

Table 1 Reasons for children's involvement in decision making during their dental treatment

Reasons	n	%
I am old enough to reason about the treatment	33	51.6
It will allow me to cooperate better	19	29.7
It's my teeth so my views should be heard	12	18.7
Total	64	100

n = Number of respondents

Table 2 Children and informed consent in dental care

Questions asked		n	%	Total
Were you given any information?	Yes	85	(85.0)	100
	No	15	(15.0)	100
Was the information enough?	Enough	65	(76.5)	85
	Not enough	20	(23.5)	85
Do you fully understand the explanation?	Yes	57	(67.1)	85
	No/Not sure	28	(32.9)	85
Would you have preferred your treatment now or later.	Now	79	(79.0)	100
	Later	21	(21.0)	100
What do you think of your treatment?	Very good	79	(79.0)	100
	Fair	17	(17.0)	100
	Bad	4	(4.0)	100

n = Number of respondents

they were old enough to reason about the treatment, 29.7% said they felt it will make them more cooperative during treatment while the remainder (18.7%) believed that it was their teeth and their views should be heard (Table 1). Thirty-three (33.0%) children answered "no" to the question. They felt they were too young to decide and they did not want to take the responsibility. Three children (3.0%) answered "Don't know" (Fig. 2).

When asked if any information had been given to them about the treatment they had received, 85 (85.0%) children reported being given information. Of these, 65 (76.5%) children felt the information given to them was enough. However, only about two-thirds (67.1%) felt they understood the explanation (Table 2). On asking if they would have preferred their treatment when it was done or at another appointment, most of them (79.0%) said they wanted it when it was done. Reasons given included the fact that they had to go back to school, some said they wanted to look nice and a few said they liked things done once and for all. Majority of the children (79.0%), enjoyed and were satisfied with the dental treatment they had received (Table 2).

The mean age at which they felt children should be able to give consent is 12.2 years.

When asked the question "who decided about your dental treatment?", 22 (22.0%) children said it was a collective decision involving themselves, the dentist and their parents, 10 (10.0%) claimed it was between themselves and their parents while 5 (5.0%) said they decided alone. With respect to this only 37% of the children were actually involved in making decisions about the treatment they had received. When asked the question "who should decide about your dental treatment", 44 (44.0%) claimed the dentist, parents and child should, 17 (17.0%) felt it was the responsibility of the parents and the child while 5 (5.0%) children were of the opinion that they alone should decide ($P<0.01$)

Table 3 Showing who decided about the children's treatment and who the children felt should have decided?

	Who decided?		Who should decide?	
	n	%	n	%
Dentist	25	(25.0)	17	(17.0)
Dentist and parents	19	(19.0)	10	(10.0)
Dentist, parent and child	22	(22.0)	44	(44.0)
Parent alone	19	(19.0)	7	(7.0)
Parent and child	10	(10.0)	17	(17.0)
Child alone	5	(5.0)	5	(5.0)
Total	100		100	

n = Number of respondents, $\chi^2 = 19.0$, $P < 0.01$

(Table 3). Considering this, 66% of the children felt they should have been involved in deciding about their dental treatment.

Discussion

Although parents and physicians have traditionally made most medical decisions on behalf of their children, the developing autonomy of children is increasingly being recognized in medical decision making[5]. The results of this study have revealed that not all children needing dental treatment are involved in participating in the decision making process concerning there various treatments. This study shows that 64% of the children felt generally that they should be involved in deciding about their dental treatment. The reasons given ranged from the fact that many believed they were old enough to reason about treatment while some others felt that being involved would make them cooperate better during treatment. A few were of the opinion that it was their teeth and they should have a say concerning it. This proportion however is lower than the study conducted in Britain[3] in which 75% of children believed that their views should be heard concerning their dental treatment. The Nigerian culture where children are to be seen and not heard may have contributed to the lower proportion in this study.

Results also reveal that only about a third of these children were actually involved in the decision about their dental treatment whereas 66% believed that they should have been a part of the decision making process. This finding was significant. This is similar to the study carried out by Runeson *et al.*[6], on some Swedish children's participation in decision making during hospitalization. Results indicated that the children were not always allowed to participate in decision making to an extent, which was considered optimal.

About half of the children in this study felt that the dentist should talk to them about their dental treatment whereas a two-fifths believed that both the parents and the dentist should be involved. They were of the opinion that each person had a role in helping them understand the nature of their treatment. Including children in their treatment decisions involves providing information, ensuring the adequacy of this information, checking that the explanation has been understood and that the opportunity to make an informed choice has been created. The study shows that about two-thirds of the children who were given information prior to treatment claimed they understood the information. Even though this was good, more emphasis should be made in explaining and ensuring that children understand information passed across to them as this may help them to be more relaxed and cooperative while receiving dental care.

Childhood is the period of greatest change in life. It sees the maximum physical, emotional, social and psychological development. The children in this study fall into the concrete operational and formal operative stages of cognitive development. These children are able to reason using verbal propositions, and those 12 years and above can think and reflect on their own thinking[7]. This shows a certain level of development has been attained in them and listening to their opinions can be worthwhile. Some parents often encourage their children to participate in decision making about some issues in the home.

Allowing even young children to make decisions about simple matters facilitate the development of skills that they will need to make more complex decisions later in life[8–10].

Generally, the standard age for consent is 18 years of which the individual must be both autonomous and competent[1] even though 16 years is recommended in some places. However, it has been proved that although minors are usually not granted the right of informed consent, several studies have demonstrated that some are capable of providing it[11]. The mean age at which the children in this study felt they should be able to consent is 12.2 years. As children grow older they should be allowed to make their own decisions. Even when children are not legally able to consent to treatment they should be consulted enabling then participate in the decision making process. The American Academy of Pediatrics statement on this question articulates the joint responsibility of physicians and parents to make decisions for very young patients in their best interest and states that "parents and physicians should not exclude children and adolescents from decision making without persuasive reasons"[12].

The study reveals that only 54% of these children had previously visited the dentist and the mean age of the first dental visit was 9.2 years. The reason for this may be due to the fact that in developing countries awareness about dentistry is just increasing. It has been thought that a child's past experience, educational experience and basic general knowledge influences their decision making ability. By virtue of their own experience they have a greater understanding of their condition and issues relevant to the decision to be made. It has been stated that children with chronic illness may be better equipped than their developmental peers to take part in decision making[8].

It is of interest to note that about four-fifths of the children in this study enjoyed their dental treatment. If previous dental experiences are pleasant, children may be more willing to undergo treatment. Thus involving them in the decision making process may likely increase their interest making them more relaxed and cooperative, thus enjoying dental procedures better.

Even though the parents or dentist did not seek the opinion of the children as regarding whether they wanted their treatment then or postponed to another date the study revealed that most of them wanted their treatment immediately. This may further highlight the fact that many children appear to be interested in dental procedures and consequently involving them in the decision making process may further stir this interest.

Unfortunately however, less than a fifth of these children were regular attenders at dental clinics. This gives an insight to the fact that there is still some ignorance about dentistry and therefore a need for enlightenment. Children who attend dental clinics regularly will more likely have a greater understanding about their conditions and it may be safely inferred that this could be vital in their decision making capacity.

Conclusion

The results of this study have suggested that children would want to be more involved in the decision making process concerning their oral health. Even though health care practitioners may find themselves facing the ethical conflict in deciding between the child's views, it is important to look upon children as potentially autonomous individuals and that hospital staffs realize that one of their core duties is to facilitate the children's participation in decision making. Since a lot of dental procedures are not life threatening or emergencies, every opportunity should be given by health care professionals and parents to nurture the development of a trusting relationship that is based on mutual respect in providing dental care for children. This helps to promote the evolving autonomy of the child as they develop into responsible members of the society. Having a voice in decision making helps the child to develop a sense of himself as a person[13]. The concept of autonomy, competence and consent are complex and sometimes difficult to relate to practice. However, they are essential to paediatric care. Practicalities involved in obtaining consent in paediatric dentistry is still largely unexplored, especially in developing countries. This study involved children of the middle and upper socioeconomic classes. Further studies should be conducted among children of the low socioeconomic class.

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