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Parents' Perceptions of the Consent Arrangements for Dental Public Health Programmes in North London: A Qualitative Exploration

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Abstract : Background: Over one-third of five-year-olds and almost half of all eight-year-olds in the UK have obvious caries experience that can be detected by visual screening techniques. School-based caries preventions programs to apply fluoride varnish to young children's teeth operate in many areas in the UK. Their aim is to reduce dental caries in children. The Department of Health guidance (2009) on consent states information must be provided to parents to enable informed autonomous decision-making prior to any treatment involving their young children. Fluoride varnish schemes delivered in primary schools use letters for this purpose. Parents are expected to return these indicating their consent or refusal. A large proportion of parents do not respond. In the absence of positive consent, these children are excluded from the program. Non-response is more common in deprived areas creating inequality. The reason for this is unknown. The consent process used is underpinned by the ethical theory of deontology that is prevalent in clinical dentistry and widely accepted in bio-ethics. Objective: To investigate parents' views, understanding and experience of the fluoride varnish program taking place in their child's school, including their views about the practical consent arrangements. Method: Schools participating in the fluoride varnish scheme operating in Enfield, North London, were asked to take part. Parents with children in nursery, reception, or year one were invited to participate via semi-structured interviews and focus groups. Thematic analysis was conducted. Findings: 40 parents were recruited from eight schools. The global theme of 'trust' was identified as the strongest influence on parental responses. Six themes were identified; protecting children from harm is viewed by parents as their role, parents have the capability to decide but lack confidence, sharing responsibility for their child's oral health with the State is welcomed by a parent, existing relationships within parents' social networks strongly influences consent decisions, official dental information is not communicated effectively, sending a letter to parents' and excluding them from meeting dental practitioners is ineffective. The information delivered via a letter was not strongly identified by parents as influencing their response. Conclusions: Personal contact with the person(s) providing information and requesting consent has a greater impact on parental consent responses than written information provided alone. This demonstrates that traditional bio-ethical ideas about rational decision-making where emotions are transcended and interference is not justified unless preventing harm to an unaware person are outdated. Parental decision-making is relational and the consent process should be adapted to reflect this. The current system that has a deontology view of decision making at its core impoverishes parental autonomy and may, ultimately, increase dental inequalities as a result.

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