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Title Page: Children's rights in their oral health care: How responsive are oral health professionals to children's rights

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Children's rights in their oral health care: How responsive are oral health professionals to children's rights

L.A. Smith, E. Tumilty, L. Foster Page, W. M Thomson and B. Gibson

Research on children's rights in oral health care is lacking, and this study aims to partially fill this gap. In 2015, we conducted research in one region of New Zealand using video methods to explore the rights of 22 children during a specific oral health treatment, the placement of stainless steel crowns. Our findings show that many children did not receive a professional standard of care, there were gaps in the delivery and standard of care, and there were numerous examples of children's rights' violations. At the same time, however, some of the children's dental practitioners' (CDPs) actions may have been acceptable practice within the profession if children's rights have not yet fully been embedded into the practice of oral health care workers. We conclude with a discussion of the implications of our findings and suggestions for a more rights based standard of oral health care.

Introduction

Prior to the twentieth century, children were viewed as miniature adults or the property of their parents, and therefore they had few rights (Howson, 2013). Over the last three decades, however, children's rights have become increasingly recognised as a result of legislation such as the United Nations Convention on the Rights of the Child (UNCROC) (Marshman et al., 2015; Marshman & Hall, 2008). The New Zealand government ratified the UNCROC in 1993, and in doing so, made a commitment to incorporate the recommendations into its policy and law (Jones & Welch, 2010). For instance, article 3 of UNCROC was included in the *Care of the Child Act 2004*, in which a 'child's best interests and welfare'[1] are given primary consideration in family and private law proceedings (personal correspondence, Nicola Taylor, 2016). At the same time, however, New Zealand has one of the highest rates of child abuse and child poverty in the OECD[2]. It appears therefore that the New Zealand government is not meeting its commitment to recognise childrens' right to safety (articles 19 and 34) and the right to 'a standard of living adequate for the child's physical, mental, spiritual, moral and social development' (article 27)[3].

Like New Zealand, the countries of the UK ratified the UNCROC in the early 1990s. Under article 12 of the UNCROC, children have the legal 'right to express [their] views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child'[4]. As a consequence of the UNCROC and other health care policies, health practitioners in the UK are being called upon to give children and their parents detailed information on the child's treatment and options in their treatment (Department of Health, 2007; Marshman et al., 2015).

New Zealand legislation and oral health care

In the New Zealand context, under the *Code of Health and Disability Consumer Rights 1996,* patients as consumers of health care services ought to be provided with

[1] http://legislation.govt.nz/act/public/2004/0090/latest/DLM317233.html
[2] https://nzfvc.org.nz/news/nz-children-rate-poorly-oecd-unicef-report; http://www.childmatters.org.nz/55/learn-about-child-abuse/facts
[3] http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx
[4] (http://www.ohchr.org/en/professionalinterest/pages/crc.aspx).

information in a manner consistent with their level of understanding.[5] Since children are consumers of oral health care, they should have their choices respected and be provided with information in a manner that is consistent with their levels of understanding. Dental practitioners are also bound by the *Principles of Ethical Conduct for Oral Health Practitioners*[6]. Under this code of ethics, dental practitioners are expected to provide treatment that 'respects patients' dignity and choices' and deliver 'a good standard of oral health care'[7].

The registering body for all oral health practitioners in New Zealand is the Dental Council of New Zealand (DCNZ), which has published the *Standards Framework for Oral Health Practitioners*[8]. The *Standards Framework* can be seen as laying down the foundations for safe, ethical and professional standards of practice for all oral health practitioners in the national context. Examples of ethical principles can be summarised as putting patients' interests first, ensuring safe practice, communicating effectively, providing good care and maintaining public trust and confidence.

In 1998' the New Zealand Ministry of Health (henceforth, MOH) released a document titled *Consent in child and youth health: A guide for practitioners* which provides guidance to health professionals who work with children in regard to issues of informed consent and their legal and ethical obligations under the UNCROC. The MOH stated, that under UNCROC, health professionals should provide information on children's treatment in a manner consistent with a child's level of understanding, and include children's choices in their treatment. They also said that children should be provided with an explanation of what is about to occur prior to treatment.

Children's rights in their oral health care

[5] (https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Information-choice-of-treatment-and-informed-consent.pdf).
[6] (http://www.dcnz.org.nz/assets/Uploads/Codes-of-practice/Statement-on-ethics.pdf).
[7] (http://www.dcnz.org.nz/assets/Uploads/Codes-of-practice/Statement-on-ethics.pdf).
[8] http://www.dcnz.org.nz/i-practise-in-new-zealand/standards-framework/

Despite searching extensively, we were unable to locate any national or international literature specifically focusing on children's rights[9] during dental treatment. Perhaps this is because children's perspectives have been ignored in most dental research (Marshman et al., 2015; Marshman & Hall, 2008). Nevertheless, in a scoping review of literature focusing on children's rights in health care, Coad and Shaw (2007) found that, although many researchers state that children are capable of making responsible health care choices, few studies have documented how such choices are included in children's treatment. They also report that, in the context of the United Kingdom, health care policies and frameworks exist which encourage health practitioners to include children's choices in their treatment. However, they found no research focusing on how these policies are being utilised or whether health care providers, such as hospitals, have become more receptive to children's needs. For these reasons (amongst others), Coad and Shaw (2007) concluded that more needs to be done before children's choices are fully realised in their health care.

The bioethical, legal, and medical literature focusing on children's rights in health care generally centres on extreme cases such as a child's right to refuse life-saving treatment (Rosato, 1996; Weir & Peters, 2007), or seek treatment without parental knowledge (Committee on Adolescence, 1996; Sanci, Sawyer, Haller, Patton, & Kang, 2005), and on parental-child conflict in life-changing decision-making (Giordano, 2007; Shaw, 2001). However, discussions of children's rights in everyday practices on a smaller scale are lacking. While bioethical principles (such as dignity, participation and best interests) and their relation to the UNCROC articles are debated in the literature, there is a lack of specific studies on their application in practice (Alderson, 2007; Streuli, Michel., & Vayena, 2011; Wade, Melamed, & Goldhagen, 2015). How do health care workers respect children's rights while providing healthcare that children may refuse due to fear or pain (such as vaccination), when their parents have consented? *Consent in child and youth health: A guide for practitioners* (mentioned above) describes the need for attention to the timing of information giving and decision-making in resolving these kinds of issues, while simultaneously reporting that time is lacking in most healthcare settings (Ministry of

[9] Databases searched included the University of Otago library database and catalogue, Pubmed, Scopus, Web of Science and Google Scholar. Search terms included, dentistry, dental, child, children, children's rights, UNCROC, UNCRC and the United Nations Convention on the Rights of the Child.

Health, 1998). Pain and fear are said to impair consent-giving capacities in children and therefore parent's proxy consent is sufficient for treatment (Ministry of Health, 1998). Contravention of a child's consent in difficult circumstances is not meant as contrary to children's rights to be informed and give their consent, but should be a last resort after other avenues have been explored.

There is a dearth of bioethical literature addressing children's rights in oral health care. A rights-based framework for oral health care would require greater responsiveness to children within the clinical encounter. The document *Consent in child and youth health: A guide for practitioners* (although somewhat dated)[10] seems to provide the best guidance in New Zealand, given the nature of interactions in the paediatric dental clinics, especially those involving decision-making and consent. Anxiety and pain are a common feature of the oral health care setting (Shim, Kim, Jeaon, & An, 2015), and so similarly, attention to providing appropriate levels of information and care to gain consent should be attempted with parental cooperation where a child is unsure or non-cooperative within a rights-based framework. Standards of care and its provision should not differ for children and adults, and neither should attention to children's bodily autonomy and integrity. More research with children is required to understand how children's rights are incorporated into oral health care and what training may be necessary for health professionals who treat children and young people.

The aim of this study was to provide information on how children's rights are being included in one form of dental treatment in New Zealand; that is, the placement of stainless steel crowns (SSCs). The following research questions guided the study:

1. As consumers of oral health care services, are children's rights respected in their dental treatment;
2. Do children receive information on their treatment in a manner that is consistent with their level of understanding; and
3. Are children's choices included in their oral health treatment?

[10] Literature from clinical and non-clinical settings regarding the incorporation and recognition of child/youth voices, recognises a responsiveness to the capacity and ability of individuals, and the importance of incorporating all levels of this capacity into a decision appropriately to meet a rights based framework (Alderson, 2007; Grover, 2004; Krafti, 2013).

Poststructuralism, children and childhood

The notion of children's rights has been deeply contested in many societies, including New Zealand. This can be seen in the considerable public backlash to what became colloquially known as the 'anti-smacking bill'. The aim of the anti-smacking bill was to repel section 59 of the *Crimes Act 1961*, which stated that parents could use 'reasonable force' against their child/ren for the purpose of 'correction'. This "loophole" was commonly used as a legal defence by parents who were on trial for assaulting their child/ren. Societal backlash meant that the bill was modified considerably. The *Crimes (Substituted Section 59) Amendment Act 2007* now lists a number of situations where it is acceptable for parents to use force against their children, when that force is reasonable, including for instance, 'preventing or minimising harm to the child or another person'.

The notion of children's rights has also been contested in academia (Mayall, 2000). For instance, King (2007) explained that the last 30 years have seen the rise of what he terms the "new sociology of childhood", which is similar to children's rights legislation in that it frames children as autonomous capable agents. According to King (2007), those who critique this "new sociology of childhood" are accused of favouring paternalism, which implies authoritarianism rather than advocating children's rights. Nevertheless, we do not see children's rights and paternalism as opposing categories and neither do we see paternalism as solely an oppressive force. For instance, the *Care of the Child Act 2004* [11] can be seen as supporting children's rights while at the same time being paternalistic, endeavouring to place the welfare of children at the centre of family law.

Poststructuralism allows us to interpret an excerpt or text in multiple ways, which in part, influenced our decision to use it as a theoretical framework in this study. Central to poststructuralism is the term discourse, which in a poststructural sense refers to a series of statements, beliefs, and ideas which are forged in institutions and impact on

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[11] http://www.legislation.govt.nz/act/public/2007/0018/latest/DLM407671.html

our understandings of particular things, objects, phenomenon and so on (Foucault, 1972; St Pierre, 2000). For instance, contemporary societal discourses construct children as vulnerable, immature and in need of protection although this has not always been the case (Humphries, 2010; Valentine, 1998; Valentine, Skelton, & Chambers, 1998). Some discourses become so socially entrenched that they become "normalised" or, alternatively, the only socially acceptable way to view things (St Pierre, 2000). For instance, within the field of childhood studies, a number of discourses about children have been created which constitute them as naïve, emotional, irrational and lacking the intellectual capacity associated with adulthood (Mayall, 2000; Valentine, 1998). The societal entrenchment of these discourses also impacts on how we interact with children. For example, we are likely to talk and behave differently with children than with other adults. Often, parents and professionals decide what children "need" and act without consulting them (Valentine, 1998). In doing so, however, children are treated as inferior to adults (Marshman & Hall, 2008; Mayall, 2000).

Rather than seeing individuals as autonomous rational beings who freely act out of their own best interests, poststructuralists also consider people's "identities" as discursive products (Davies, 2000). That is, discourses create specific categories, or alternatively subject positions, which people "take up" or perform (for instance, men, women, and children). Societal discourses constitute what is normal (or normative) for a person located in that category. For example, in most Western cultures children will normally attend school, but this has not always been the case since children were once considered as a source of labour (Humphries, 2010). Furthermore, poststructuralists reject the term identity because of its associations with autonomy and free choice (Davies, 2000; Smith, 2015). Instead, they favour of the term "subjectivity", which refers to the process through which we become the products of discourse (Davies, 2000; Smith, 2015).

Based on the subject positions that they inhabit, a person's subjectivity also impacts on how they interpret texts and language itself. In a poststructural sense, texts do not solely refer to written texts, but also include all the ways people communicate meaning (such as our bodily deportment and dress among others) (Kamler, 1997). For instance, if a person performs the subject position of dentist or patient who is visiting

the clinic for the first time, then they are likely to interpret a white gown differently and attach different meanings to gown depending on how they are located. We discuss how the subject positions of adult/child and CDP/patient impact on the clinical behaviours and interactions of the participants in the Results section. In the following section, however, we describe the oral health treatment procedures for a non-dental audience, as well as the data collection methods chosen for the study.

Methods

The procedures and CDPs

In 2015, six experienced Children's Dental Practitioners (CDPs), ranging in age from approximately 30 to their late 50s, treated the caries (decay) of 22 children with stainless steel crowns (SSC). The CDPs used the Hall Technique or a more conventional method of fitting crowns, where the tooth was prepared (drilled) but the caries (decay) was not removed. In the Hall Technique the caries is not removed but instead is sealed under a SSC, which is cemented in place (Innes, Marshman, & Vendan, 2010; Innes, Ricketts, & Evans, 2007). As the caries is not removed then drilling and injections of local anaesthetic (LA) are not required. Consequently, the Hall Technique is often considered a more child-friendly method of treatment than the more conventional method (Foster Page et al., 2014; Santamaria et al., 2015; Santamaria, Innes, Machiulskiene, Evans, & Splieth, 2014).

During the procedures two CDPs injected some children with LA while the other four applied topical anaesthetic (TA) using cotton rolls. These procedures were filmed with a small video camera that was attached to the light on the dental chair. The number of treatments undertaken by each CDP ranged from one to 14, while videos ranged in length from 2:47 to 24:24 minutes.

The 22 children included 11 boys and 11 girls, who ranged from 4 years 11 months to 9 years and 2 months. The majority (20) were Māori and Pasifika, while two were Pākehā/New Zealand European and all resided in one of New Zealand's most socially disadvantaged regions. We do not name this region or assign the CDPs or children an individual pseudonym. Instead, we discuss the participants as a generic group because

New Zealand is a relatively small country, and an important ethical requirement of this study was to protect the anonymity of participants.

Prior to embarking on fieldwork, ethical approval was gained from a Health and Disability Ethics Committee (14/NTA/141). The consent of the CDPs, parent's proxy consent for their child's treatment to be videoed, as well as children's assent were obtained.

Data analysis

LS (who has experience in analysing visual data, but is not an oral health practitioner), conducted the data analysis (Smith, 2012; Smith, Nairn, & Sandretto, 2015). As a non-dental professional, LS was unaware of those behaviours that may be constructed as necessary for dental treatment, which oral health practitioners may perform automatically (Haidet, Tate, Divirgilio-Thomas, Kolanowski, & Happ, 2009). As such, we argue that LS was more likely to identify specific aspects of treatment where children's rights may have been breached than if a person who has a background in dentistry undertook the analysis. Consequently, LS's 'dental naivety' is likely to have enriched the research findings.

The first step in the data analysis involved watching the videos in their entirety and then transcribing the large amount of audio-visual information contained on the video recordings (Hostsgaard & Bertlesen, 2012). The transcription of the videos involved frequent rewinding and watching of video material and consequently, LS became an authority on the data (Quinn et al., 2016). The use of video methods also meant that complex aspects of treatment were recorded, such as spatial usage and verbal exchanges. We contend that such aspects would be less likely to be noted in more traditional observations that rely on written notes or audio-recordings (Knoblaunch, Tuma, & Schnettler, 2015).

An initial thematic analysis of the transcripts was undertaken using the constant comparative method of data analysis, which is frequently used in qualitative data analysis (Glaser, 1965; Knoblaunch et al., 2015; Maykut & Morehouse, 1994). As the transcription was occurring, an initial thematic analysis was being undertaken where

common patterns or key themes that were re-occurring in the participants' clinical behaviours and verbal exchanges were noted, and an initial list of these themes was then made. At the same time, a discourse analysis was being conducted, where dominant societal constructions of children and childhood that presented in the clinical exchanges were identified (Cameron, 2001). Excerpts that illustrated these discourses and themes were then coded (using highlighter pens) and grouped into categories. The most dominant thematic category that emerged, which we address in this article, was children's rights in their oral health care. In the following discussion section, we divide the theme of children's rights into four subthemes and discuss how dominant societal constructions of children and childhood played out in the clinical exchanges.

Before moving on, however, we acknowledge that, since this paper focuses on children's rights, then children's perspectives should be included in this article. However, because the theme of children's rights emerged from a secondary analysis of the audio-visual material (which was initially collected for a study focusing on children's experiences of the placement of SSCs (Smith, Foster Page, Boyd, Thomson, & Gibson, under submission), this was unfortunately not possible. The perspectives of the CDPs are also not included in the paper for the same reason[12]. On one hand, the failure to include the children's and CDPs' perspectives can be considered to be a limitation of the paper. Nevertheless, because children's rights in oral health care is an under-researched topic in dentistry and health generally, the findings of this exploratory study can then be used as an initial conversation starter.

Results

In this section, we discuss four subthemes in regard to children's rights in their oral health care. In the discussion of subthemes one (children's rights to information and a professional standard of care), three (children's bodies), and four (troubling practices) we refer to legislation and codes of practice that underpin the work of oral care practitioners in the New Zealand context. However, the discussion of subtheme two (children's voices and choices in their treatment) centres on article 12 and 17 of the

[12] All participants consented for data to be used for further research.

UNCROC, as well as suggestions on culturally-competent practices. At the same time, we discuss how (on the one hand) certain aspects of treatment could be seen as breaching children's rights, but on the other may also be considered necessary for their treatment.

Subtheme 1: Children's rights to information and a professional standard of care

Under the *Principles of Ethical Conduct for Oral Health Practitioners*[13] and the *Standards Framework for Oral Health Practitioners*[14], children have the right to a professional standard of treatment. However, on three occasions, two CDPs' equipment malfunctioned, or alternatively, they did not know how to use it. This resulted in no air or water being available, which meant that two children were unable to rinse, while one had her tooth dried with cotton rolls. On one of these occasions, an assistant instructed the CDP on how to use a foot-pedal so that water became available. Prior to treatment, the two CDPs whose equipment malfunctioned or did not know how to operate it should have ensured that their equipment was fully operational, and that they could operate it to ensure the children had a professional standard of treatment.

Under the New Zealand Dental Council's *Standards Framework for Oral Health Practitioners* and *Principles of Ethical Conduct for Oral Health Practitioners*, the CDP must also 'justify the trust placed in [them] by patients'[15]. Two CDPs either called for, or used elevators[16] to remove crowns, which had become lodged on a tooth during initial sizing. Another CDP also used a drill to remove a crown that was not seated properly. One CDP had children bite down on a pair of tweezers rather than cotton rolls, during the seating of SSCs. In addition, after one CDP failed to place separating rings[17] between a boy's teeth, she endeavoured to fit a mesial band using an applicator but was unable. She then tried to fit the mesial band manually, but again

[13] (http://www.dcnz.org.nz/assets/Uploads/Codes-of-practice/Statement-on-ethics.pdf),
[14] http://www.dcnz.org.nz/assets/Uploads/Practice-standards/Standards-Framework-for-Oral-Health-Practitioners.pdf
[15] (http://www.dcnz.org.nz/assets/Uploads/Codes-of-practice/Statement-on-ethics.pdf).
[16] Elevators are used for extracting teeth.
[17] Separators and mesial bands are used to separate teeth in close proximity so placement of SSC, braces and so forth, is easier (http://cyberdentist.blogspot.co.nz/2006/08/orthodontic-separators.html.)

was unsuccessful, so she prepared the tooth without the use of separator or a mesial band. While she was preparing the tooth, the CDP said to the boy and her assistant 'I have to be very careful because there's another tooth right beside this one'.

When one CDP uses a drill to remove a crown, and a second prepares a tooth without a separator or mesial band, they risk the healthy dentine of the tooth and the enamel of those either side of it. Consequently, engaging in such behaviour can be seen to undermine the trust children and parents place in the CDPs (Welly, Lang, Welly, & Kropp, 2012). At the same time, however, the SSCs were indeed firmly stuck on the children's teeth, which meant they would need considerable force to dislodge. Consequently, the extra leverage that elevators provide the CDPs could be justified, but using this tool was not ideal. However, we argue that using a drill to remove hardened cement after a SSC was not seated properly was less than ideal since the risk posed to tooth structure was too great.

Furthermore, we argue that children are likely to feel discomfort when biting on tweezers during the seating of a crown because it involves pressing metal against metal. Consequently, we argue that the CDP who had children bite on tweezers should have used cotton rolls, which is standard practice in the HT and is more comfortable for children (Innes, Evans, & Stirrups, 2007; Wassell, Barker, & Steele, 2002).

Under the *Code of Health and Disability Consumer Rights 1996,* New Zealand health practitioners must convey information to patients in a manner, which is consistent with their level of understanding[18] (Wood & Tuohy, 2000). The MOH (1998) also suggests that medical practitioners should provide children and adolescents with information 'tailored to a child's ability to understand' (p. 8). However, one CDP commented to a girl that she would feel the drill "vibrating" on her tooth, and another used the terms 'bacteria, cavity and plaque'. We contend that the terms 'vibrating' and 'bacteria, cavity and plaque' are too advanced for the children's developing understandings. Consequently, in order to meet their responsibilities under the *Code of Health and Disability Consumer Rights 1996* and the recommendations of the

[18] (https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Information-choice-of-treatment-and-informed-consent.pdf).

MOH, the two CDPs should have used less complex and technical language. We argue that this does not only apply to children, but also when dental practitioners are treating adults.

During training, CDPs are taught about the importance of communication, and are encouraged to use “child-friendly” language (Cameron & Widmer, 2013). By conveying information in a manner inconsistent with children’s understandings, the three CDPs appear to be transgressing one of the fundamental components of paediatric dentistry.

S*ubtheme 2: Children’s voices and choices*

All of the CDPs told the majority of children to raise their hands if drilling became painful and they would stop. However, one CDP told a girl who received this instruction to ‘put your hand down, good girl’ after she raised it during drilling. A second CDP, who was placing a SSC using the HT (where LA is not usually used), overruled a boy’s choice not to have an injection of LA. The boy initially asked the CDP if he had to have ‘those little drops’ (the CDP’s term for an injection) and she responded with ‘No’. The boy replied, ‘I hate those little drops’. After experiencing difficulty removing the crown that she had initially tried for size, the CDP decided to inject LA. For instance:

Visual	*Audio*
CDP has her left index finger in boy’s mouth. His head moves as she tries to get crown off with explorer.	CDP: ‘Now would you like me to put a little bit of sleepy medicine…‘cause it’s going to be a little tight when it goes on’?
	Boy: ‘Argh arnt’…
	CDP: ‘Are you sure? Put a little bit of sleepy medicine on it aye, then it won’t hurt you

when it goes on okay?’

A[19] places her right hand on boy’s shoulder as he begins to cry.

CDP: ‘Hold on I’ll just get this off’.

CDP: ‘Local (to Assistant)’.

CDP: ‘You alright’?

Boy nods slightly.

CDP: ‘Good boy it’s going to stop in a minute…’

A hands CDP a tube of local across the boy’s chest.

A: ‘I’m just. Shall I get Mum?’

CDP: ‘No’…

Assistant: ‘Has he had this before’?

CDP: ‘Yeah. He’s not that keen on it but I don’t want to hurt him’.

Under the *Principles of Ethical Conduct for Oral Health Practitioners*[20] and article 12 of the UNCROC, children ought to have the right to express their views in their treatment and have their voices heard. After telling children to raise their hands if drilling became painful (so that they would stop), one CDP ignored a girl’s raised hand. A second CDP overruled a boy’s request not to have an injection of LA despite treating the boy with the Hall Technique (which does not involve the injection of LA). We provide a number of readings of this behaviour.

[19] A is an abbreviation for assistant

[20] (http://www.dcnz.org.nz/assets/Uploads/Codes-of-practice/Statement-on-ethics.pdf).

It could be argued that, by ignoring the girl's raised hand and the boy's request not to have LA, the CDPs are in breach of the aspirations of the UNCROC, and the *Principles of Ethical Conduct for Oral Health Practitioners,* because they are failing to include the children's choices in their treatment (Mayall, 2000). However, in an additional reading, because numerous children experience anxiety in the dental clinic (Jones & Watson, 2014), it is possible that the girl raised her hand out of fear and not pain. If this was the case, the CDP's dismissal of the girl's raised hand may be based on her previous clinical experience of distinguishing physical pain from emotional responses. The CDP in this instance can therefore be read as helping the girl learn the behaviours expected of dental patients in clinical settings.

A boy also started to cry when he was told that he was about to receive LA. The Hall Technique does not involve the injection of LA, which is why as stated previously, it is in part, considered a 'child-friendly' method of treatment (Innes, Ricketts, et al., 2007). We argue that this is why the CDP initially told the boy that he did not need an injection. Although we have no information on why the CDP decided to inject LA, her comment that she 'does not want to hurt' the boy, suggests her actions are driven by her desire not to cause the boy pain. Consequently, we propose that the CDP could be considered as acting paternalistically. Perhaps she does so because she is immersed in a culture where the discourse of children as vulnerable and in need of protection is normative (Raby, 2007; Sartain, Clark, & Heyman, 2000; Valentine et al., 1998) and, subsequently, she wants to shield the boy from any undue pain (although this is purely speculative since we did not talk to the CDP concerned). In doing so, however, the CDP dismisses the possibility that the boy has the capacity for making decisions in his own dental care and effectively usurps his right to do so.

In a study exploring how the dental atmosphere and dentist's behaviour impacted on 88 children's un/co-operative behaviours, Welly et al. (2012) found that honesty is a quality that children value in dental practitioners. Although the CDP did not lie to the boy, we contend that her initial 'No' to his question about whether he would be injected (and her subsequent application of LA) may lead the boy to mistrust dental practitioners in the future. Similarly, the ignoring of the girl's raised hand could also lead her to subsequent distrust of dental practitioners.

Article 12 of the UNCROC is augmented by article 17 (Wood & Tuohy, 2000). Under article 17, children and their parents have the right to access information about their/their child's 'physical and mental health'. When the boy who receives LA becomes upset, the assistant asks the CDP whether she should get the boy's mother, to which she replies 'No'. The CDP therefore can be considered as denying the mother's right to be informed about her son's treatment. Since some children also find a parent's presence comforting during treatment, the CDP also denies the boy this potential form of reassurance (Jones & Watson, 2014). However, Widmer, McNeil, McNeil, and Hayes-Cameron (2013) report that children aged six to eight years wish to be independent, and therefore dental practitioners should encourage parents to remain in the waiting room. Consequently, the CDP may be acting on her previous knowledge of children and also in the boy's best interests by not telling his mother he is about to receive an injection. At the same time, she is also teaching the boy to be an independent dental patient.

Under the *Standards Framework for Oral Health Practitioners* cultural values need to be respected[21]. In Māori and Pasifika cultures health is viewed holistically. For instance, Māori consider health as being comprised of four interrelated dimensions, including physical (tinana) health, spiritual (wairua) health, family (whānau) health, and mental (hinengaro) health[22]. In Māori and Pasfika cultures, wider whānau in conjunction with biological parents often make decisions on children's health care, which is why the MOH (1998) suggests that medical practitioners need to allow time for this consultation process. By not informing the mother that her son is about to receive an injection, the CDP could be considered as ignoring Māori cultural understandings of the link between family and physical health. By telling the assistant not to tell the boy's mother about the injection, the CDP also fails to provide an opportunity for wider whānau to "have a say" in his health care if they so wished. As such, the CDP could be seen as ignoring MOH (1998) guidelines relating to cultural consultation, and the emphasis on respecting cultural values as emphasised in the *Standards Framework for Oral Health Practitioners,* which oral health professionals in New Zealand are legally and morally obligated to follow.

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[21] http://www.dcnz.org.nz/i-practise-in-new-zealand/standards-framework/
[22] http://www.health.govt.nz/our-work/populations/maori-health/maori-health-models/maori-health-models-te-whare-tapa-wha

Furthermore, the boy's mother was likely aware that the Hall Technique does not require LA as the technique was discussed on the information sheet and she gave her consent for treatment based on this assumption. The CDP should have asked for the Mother's consent when giving her son LA, because this was a significant change in treatment procedure. Nevertheless, the incident highlights how consent is not a "one-off" but an ongoing process, not only for the patient but also the caregiver, and throughout the treatment procedure.

Subtheme 3: Children's bodies

Touching is a necessity of dental treatment and therefore CDPs must touch children. At the same time however, patterns of touch differ on the basis of authority, with those in more powerful positions being more likely to initiate touch, and touch those in "subordinate" positions more often than vice versa (Pascoe, 2007). Adults will also often touch children's bodies in a manner in which they would not touch other adults (for example, restraining and holding hands) (Field, 2001; Howson, 2013). In this study, two CDPs hoisted three children into more upright positions in the dental chair. For example:

Video	*Audio*
CDP reaches down to the boy's sides with her left and right hands and pulls him up.	CDP: 'I'm going to slide you up a little bit. There you go'.

After one girl touched the CDP's hands during the seating of a crown, the assistant touched the girl's hands in the following way:

Visual	*Audio*
CDP places her right index finger under the crown and pushes up.	CDP: 'You'll feel better when it's on properly'.

Girl places her hand on CDP’s hand.	Girl: ‘It hurts’.
A reaches up and takes girl’s hand in hers. Pushing it down her body and holds onto her hand. She rubs her thumb back and forward across the top of the girl’s hand	CDP: ‘I’ll give it a rinse aye? So we feel better’. Girl: ‘Argh argh’.

Since the majority of participants were aged between six and seven years, we purport that many lack knowledge of the behaviours expected of patients in dental settings (Jones & Watson, 2014). Consequently, the three children who were hoisted up by the CDPs into a more central position in the dental chair may not have yet developed the understanding of how to sit in a manner that is conducive to treatment. One reading of the above excerpts is that by manipulating the children’s bodies into an upright and central position in the dental chair, the two CDPs were teaching the children how to be good dental patients. Furthermore, if the two CDPs did not move the children’s bodies into an upright position, it may have made it impossible to treat them safely (for both the child and CDP).

In a second reading, however, in paediatric dentistry a number of techniques are utilised for managing the behaviour of “non-compliant” children, which include passive (straps) and overt physical restraint (by the dentist) and the hand-over-mouth technique (Lawrence et al., 1991; Newton, Shah, & Sturmey, 2004; Roberts, Curzon, Koch, & Martens, 2010). These techniques are uniformly accepted and are not recommended for adult patients with anxiety, where multiple other techniques are suggested to address their fear (Armfield & Heaton, 2013). We suggest that these management practices are “at odds” with wider societal codes of acceptability and legal discourses whereby all people, including children, should have a right to determine who touches their bodies and how. Nevertheless, such practices reflect the oral health profession’s view of acceptable behaviour in difficult situations. What they arguably also do, however, is serve to normalise lesser but no less problematic behaviours, by comparison. Disregard for child’s bodily autonomy on a small scale, appears as a minor or even negligible practice, given the knowledge that much more

severe bodily restraint/manipulation is allowable in the dental clinic (Roberts et al., 2010).

Although the CDPs did not physically restrain the three children, two CDPs moved three children's bodies without first informing them or asking for the children's consent. Since the CDPs were more authoritatively positioned than children in both the oral health care practitioner/patient and adult/child binaries, they may think it appropriate to manipulate children's bodies without discussing this with the children and gaining their consent (Nettleton, 1992; Valentine, 1998). Further, the physical manipulation of children's bodies without consultation also serves to reproduce their authoritative status in both the oral health practioners/patient and adult/child binaries. We argue that such an authoritative status is a feature of all paediatric dental practitioners and arguably, necessary for the reproduction of the entire profession (Newton et al., 2004). We also contend that oral health practioners would be unlikely to touch adult patients in the same way, and therefore they need to consider whether it is appropriate to do so with children.

Subtheme 4: Troubling practices

Restraining and punishment are likely to increase children's fear in the dental clinic (Zhou & Humphris, 2014), although they are frequently used to manage "uncompliant children" as stated above (Lawrence et al., 1991; Newton et al., 2004; Roberts et al., 2010). One CDP moved a boy's hand after he became distressed during the seating of a crown, and placed his right hand on his lips. The CDP reacted to the boy's behaviour in the following way:

Audio	*Visual*
	Boy: (Cries).
CDP tops swabbing and takes out the cotton roll. Boy places his right hand on his lips. CDP flicks boy's fingers with her right little	CDP: 'Oh you're alright. Look, have a look

finger and abruptly moves his hand down.	in your mirror’.
	CDP: ‘Have a look in your mirror, have a look’.
Boy raises mirror and calms down. CDP places cotton rolls in his mouth and wipes.	CDP: ‘Okay now just, look’.

We suggest that the CDP’s behaviour and comments highlight how she becomes stern with the boy who places his hand on his lips. Although the boy was not restrained or punished on this occasion, we contend that being spoken to sternly and having his hand moved abruptly might result in greater fear in subsequent dental visits. This is unfortunate as the boy was Māori/Pasifika, and Māori and Pasifika children are statistically less likely to visit oral health practitioners than Pākehā children (Ministry of Health, 2010; 2015).

On another occasion, a CDP stood up and reached across a girl’s face with her body, as she pointed out where the separator was kept to her assistant. The girl moved her head to the left as the CDP’s gown, and it appears her body, came in contact with the girl’s face.

Visual	*Audio*
CDP stands up and leans across the girl’s face and points to the cabinet draw where the separator is kept. The girl is looking at her mouth in a hand mirror.	
The CDP’s gown/body touches the girl’s face. The girl turns her head to the left and stops talking mid-sentence.	Girl: ‘I can see…
Girl carries on her sentence when the CDP stands upright on the girl’s right side, slightly	…I can see my other teeth’.

behind her.

It should be explained that, due to the drooping of the CDP's gown, we cannot be certain whether her body came in contact with the girl's face. However, it appears that the CDP's breast comes into contact with the girl's face. CDPs must consider how their bodily contact impacts on children, their personal space, and safety. We argue that one CDP's decision to lean across a girl so that her breast/body came in contact with the girl's face is likely to have been unpleasant for the child and is unprofessional. Since many children fear suffocation in dental treatments, we also contend that having a body part make contact with a child's face might heighten the anxiety of some children (Jones & Watson, 2014). If it was indeed the CDP's breast that touched the girl's face (of which we cannot be certain), such contact -even though unintentional, is inappropriate.

The following exchange also occurred in a clinic when a CDP was treating a girl. Present in the clinic were the CDP, the girl, the CDP's usual assistant (UA) and an alternate assistant (AA). The CDP's UA was not depicted in the video, but her voice was recorded.

Audio	*Visual*
	CDP: 'You alright (inaudible)'?
AA is wiping explorer with gauze.	
	UA: 'I just feel sick. I feel like I'm going to throw up. (Names someone)'s boy has got a spew bug. I hope I haven't got that'.
CDP scrunches the tissue in her left hand and then places on the try. Picks up a cotton roll. Holding girl's mouth open with her left index finger.	CDP: 'You've got that. Well you probably won't be here tomorrow either then if you've got that'.

To avoid cross-infection, New Zealand dental practitioners must sterilise instruments, ensure a high standard of personal hygiene and wear protective clothing[23]. Under the *Standards Framework,* all oral health practitioners must also ensure a safe clinical environment by identifying and managing potential hazards. However, one assistant who was present in the clinic during a girl's treatment explains how she feels as if she wants to 'spew'. Although it cannot be ascertained whether the assistant was in protective garb, we argue that being present in the clinic when feeling nauseous risks cross-infection. Consequently, the assistant and CDP who did not ask the assistant to leave are not meeting their professional responsibility to provide a sterile environment during treatment[24]. Furthermore, we also contend that talking over the child as if they are not there is also inappropriate and unprofessional as is discussing the notion of 'spewing' in front of the child.

Conclusion

Under the UNCROC, as well as the New Zealand Dental Council's *Principles of Ethical Conduct for Oral Health Practitioners,* dental practitioners are expected to

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[23] (http://www.dcnz.org.nz/assets/Uploads/Codes-of-practice/OHP-Generic/Code-of-practice-cross-infection-generic.pdf).

[24] (http://www.dcnz.org.nz/assets/Uploads/Codes-of-practice/OHP-Generic/Code-of-practice-cross-infection-generic.pdf).

treat children as capable of making choices in their own treatment (Wood & Tuohy, 2000). Nevertheless, traditional discourses about children and childhood are so socially entrenched, they continue to impact on how people (Valentine et al., 1998), including how CDPs conceptualise children and how they interact with them, which was also a finding of this study.

There is a paucity of research on children's rights in dental settings. Although this study is small, we aim in part to address this knowledge gap. Future studies on children's rights in their oral health care need to include more participants. Since children's experiences are lacking in dental research in general (Marshman et al., 2015), we argue that their perspectives should be central in future studies. If future researchers also use video to collect information on children's rights in dental treatment, follow-up interviews should be undertaken with CDPs so that their perspectives are also included in the research. We acknowledge that this is a weakness of this study; however, due to issues of funding and the secondary nature of the theme, it was not possible to do so on this occasion.

We also report a second limitation of this study. We have not discussed Māori children's rights under the Treaty of Waitangi and the United Nations Declaration of the Rights of Indigenous People[25] (UNDRIP, although the New Zealand Government voted against this legislation and its recommendations). Owing to the secondary nature of the theme of children's rights in their oral health care, we have also only briefly touched on the issue of variation in cultural understandings of health. Future research on children's rights in their oral health care needs to include a discussion of our indigenous people's rights under the Treaty of Waitangi and the UNDRIP, while the perspectives of children from other cultures also need to be reported. As such, more conventional research methods (such as interviews or focus groups), should be paired with videos in order to ascertain whether oral health treatment is culturally competent.

As consumers of oral health care services, New Zealand children (and their parents) have the right to information about their treatment, as well as the right to a

[25] http://www.un.org/esa/socdev/unpfii/documents/DRIPS_en.pdf

professional standard of treatment. Under the UNCROC, children ought to have the right to choice in their dental care and CDPs should respect their choices. Children should also have the right to determine how adults, including CDPs, who are primarily strangers, touch their bodies. Our findings show that this is not the case for a number of New Zealand children. New Zealand CDPs need to reflect on their own practice in order to identify how they are meeting their professional and ethical requirements to include children's choices in their own dental treatment. We argue that children's perspectives (as well as children's rights legislation such as the UNCROC) should be included in the training of CDPs and that such training should specifically cover issues of appropriate information giving, the ongoing nature of consent (rather than a one-off step) of both parents and children, child-responsive practices for difficult situations and so on, and that all of this training should be informed by robust consultation with children and parents. We also suggest that CDPs should treat children not as simply objects of dental treatment, but as individuals who have rights as consumers of oral health care.

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