How can we provide person-centred dental care?

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In brief

Explains person-centred care.

Provides a practical example of a person-centred approach.

Offers an opportunity to reflect on our own clinical approaches and tweak them if necessary.

Patient- or person-centred care is the current paradigm in the health profession yet there is still no clear understanding of what it means or how it could be implemented in dentistry. Building on a previously proposed person-centred model in clinical dentistry, in this article a person-centred dental clinical approach is presented. The approach consists of three guiding principles – humility, hospitality and mindfulness – that influence the different processes of the dental clinical encounter: connecting, examining, sharing, and intervening. The presented approach provides a rich opportunity for dentists to fine tune their own clinical approach in order to keep up with the upcoming expectations of their patients.

Introduction

For centuries dentists have adopted clinical approaches with little scrutiny to their philosophical foundations. The implicit philosophy (and sciences) that has been fundamental to dental care since the eighteenth century is the biomedical model: health is understood mechanistically, and optimal health is thought to be achievable independent of each person's values and interpretation.[1] In medicine, this biomedical model has become antiquated and is being progressively replaced by patient-centred models,[2] whose primary objective is to humanise medical care by putting the patient's whole health and values at its core. Contrary to medicine,[3-7] dentistry still fully endorses the biomedical model and is characterised by a paucity of articles addressing patient-centredness.

Along with parallel and independent efforts from the UK,[8-11] we recently proposed a person-centred model that challenged the reigning tacit biomedical model. We chose the terms 'person-centred' instead of 'patient-centred' to emphasise the human instead of the disease and to include the notion of the dentist-as-person.[12] Our endeavour[2] was to introduce, develop and bring into dental practice the patient-centred movement that has reformed other health professions. Our model, however, like the very few that have been described in the dental literature, is conceptual and does not describe clinical processes; it thus remains relatively abstract for practitioners who may need more guidance in terms of clinical methods. The aim of this paper is to fill this gap and describe a clinical approach that is in line with our person-centred model.

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The clinical approach

We must emphasise that although the previously presented person-centred model includes concepts that are deemed to be universal, the clinical approach that we present here is specific to my context of practice and my personality. Consequently, we do not expect it to be *generalisable* but rather *transferable* to other contexts. *Transferability* is a concept borrowed from qualitative researchers. Applied here, it refers to the capacity to adapt my clinical approach to other environments while staying true to its core principles. For instance, the way dental clinics are organised, which includes the composition of the dental team, may greatly vary from a place to another and influence the way professionals apply our person-centred model. Furthermore, we do not want to reduce our approach to a recipe or a checklist of mandatory steps and activities. This would go against its foundations, which considers patient-centredness as a 'way of being' of a health professional.

Twenty years ago, I, Nareg Apelian, started my career as a private practitioner in one of the poorest neighbourhoods of Montreal, Canada. I worked in a small clinic with an assistant and a receptionist and provided basic dental care to the local community. A confident new graduate then, equipped with the latest knowledge and techniques dentistry had to offer, I looked forward to applying everything I had learned. Most of my patients being recent Southeast Asian refugees with little disposable income, it soon became clear that my academic background was not adequate: my patients did not speak well any languages that I understood and did not seem interested in the 'ideal treatment plans' I was proudly trained to offer. Moreover, my 'oral hygiene instructions' to patients were not having an impact on their oral health. Despite having been taught how to improve their oral health, their lifestyle habits continued trumping all my interventional efforts. I could have pretended that everything was going well and anchor on the few positive experiences – and I did for a while. However, this was not what I

had become a health professional for: I wanted to make a positive difference in my patients' lives. To achieve that I had to emancipate myself from the influence of my university training and develop a clinical approach more appropriate to me and my patients. My professional identity was a barrier that I had to reconsider and transform.

A few years ago, quite fortuitously, I met co-authors CB, a McGill University dentistry researcher interested in equity of care among communities, and JNV, a colleague from Toulouse, France with a background in epidemiology – all of us interested in patient-centred care. JNV and I, over the course of a month, through in-office observations of my clinical practice, analysed and fine-tuned my encounters with patients. Between each patient we discussed the observations and brought modifications to the approach until we were both satisfied. This process led us to develop (a) a practical dental clinical approach that is person-centred and (b) an underlying, and more abstract, person-centred model for dentistry. In a recent publication, we presented this person-centred model, which describes the dental encounter as going through three main phases: understanding, decision-making, and intervening, and places a humanist equal-powered dentist-patient relationship at the centre.

In this article, we will present the practical clinical approach that was at the starting point of our person-centred model.[2] It is guided by three principles, *humility, hospitality* and *mindfulness,*[13–15] and consists of four processes: connecting, examining, sharing, and intervening (Table 1). Although we invite the readers to adapt these processes to their own context, we believe that the three guiding principles are universal and essential to becoming person-centred.

The guiding principles

Humility, 'the quality of having a modest or low view of one's importance',[16] is fundamental to creating equal-powered relationships[2] between myself and the patient. It implies that I recognise that my expertise is uncertain and incomplete. Uncertain because disease models in dentistry are far from fully explained for most oral conditions, especially when they are multifactorial and chronic (such as periodontal and periapical diseases). Uncertain also because I, as a dentist-as-person, am fallible and should critically assess the limits of my clinical abilities. In addition, I consider that my expertise is incomplete because, as a professional, I lack the knowledge of the patient with respect to his experiences and values related to health and illness.[13] The patient's knowledge of his illness mirrors my knowledge of the disease. As a humble professional I become more approachable, human, and thus in a better position to mend the patient's 'wounded humanity'.[17]

Hospitality is the ability of the professional to invite patients to 'fall into conversations'. It means to welcome others without judgements, criticism or stereotype and to be truly open to what they have to say. In nursing, hospitality is understood as the patient 'being welcomed, received, connected, and "at home", from which well-being, ease, hope, freedom, creativity and quality of care emerge'.[13] In this perspective, it is not sufficient for me to open the door to forging a relationship; I need to be proactive and invite the person to join me through my words, attitudes and actions. Being hospitable also means that I am not afraid to express my own humanity, and the uncertainties and vulnerabilities associated with it, thus becoming less intimidating. Hospitality also implies generosity in my attention,[18] care, and curiosity.[19]

Mindfulness means 'paying attention in a particular way: on purpose, in the present moment, and nonjudgementally'.[15] The mindful practitioner is 'present' during the conversation, examination, and interventions and thus more effective at them all.[20] From a broader perspective, we propose the interpretation that as a mindful practitioner, I should also be in tune with the pulse of my profession and the social context I operate in. I should be aware of the latest knowledge acquired by my profession, evaluate it with scrutiny, and apply it with scepticism. I should appreciate the relevance of the population-based evidential literature while exploring the individual particularities of my patient, thus bridging the gap between evidence-based and personalised care.

Table 1 The person-centred dental encounter

Guiding principles	Process	Method	Objective	Dentist's attitude
Humility Hospitality Mindfulness	Connect	Conversation Validation	Understand one another Build relationship	Warm Positive Non-judgemental
	Examine*	Visual Radiographic Tests Interview	Gather data Diagnose	Objective Thorough
	Share*	Presentation Discussion	Share explanatory models Understand one another Address uncertainty	Clear Inviting questions
	Decide*	Discussion Negotiation	Co-determine the problem list Co-author a treatment plan	Sharing power Creative
	Intervene*	Non-Surgical Surgical Homecare Lifestyle	Address all illness and disease Heal	Respectful Alliance forming

*Connect is also an element of this step

The four processes

The patient encounter goes through four distinct processes, which could sometimes span over multiple visits. Although presented here chronologically, there is a dynamic fluidity between the processes, and the rigidity with which we describe them should not be taken literally. Moreover, although the processes are presented in the context of an examination appointment (initial, recall, or emergency), it could also apply to procedural appointments.

Connecting

It is important to clarify that person-centred care is not about getting to the 'chief complaint' as quickly as possible, it is about learning about the context in which the person lives, the medical history within the life story. This does not usually involve long conversations with patients but rather engaging with them in a conversation with careful attention to their health and the ways they experience it. These conversations allow you to build trust and learn from each other in a humanistic way.[21]

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The initial connection with the patient is thus based on a genuine conversation: it does not focus on data gathering, or 'history taking', but rather on creating an authentic relationship.[22] The authentic conversation is one that spontaneously opens the possibility for more or deeper exchanges. Gadamer says,

'We say that we "conduct" a conversation, but the more genuine a conversation is the less its conduct lies within the will of either partner. Thus a genuine conversation is never the one we want to conduct. Rather, it is generally more correct to say that we fall into conversation, or even that we become involved in it. The way one word follows another, with the conversation taking its own twists and reacting its own conclusion, may well be conducted in some, but the partners conversing are far less the leaders of it than the led. No one knows in advance what will "come out" of a conversation. Understanding or its failure is like an event that happens to us. Thus we can say that something was a good conversation or it was ill fated. All this shows that a conversation has a spirit of its own, and that the language in which it is conducted bears its own truth within it- that is, that it allows something to "emerge" which henceforth exists.'[23]

Given professionals' tacit or socially constructed position of power, [17] I remain mindful to keep the relationship on an equal footing. Thus, I minimise any symbols of power during this initial conversation by not wearing gloves and a mask, and by not placing the bib on the patient at this time. I am also seated at the patient's level, face to face, with little distance between us. Throughout the discussion, I do not take notes and avoid distractions to keep my whole attention on the patient and his story. I strive to not rush the pace and to keep a positive, friendly, and curious attitude.

This connecting process is a time when advancing my expertise and maybe contradicting the patient would not be appropriate; it is rather the time to listen, understand, and validate his experiences as well as his emotions. If the patient describes his oral illness, I try to understand and validate his feelings, even if scientific knowledge conflicts with his interpretations. Without being intrusive, I also explore the emotional components of his illness as well as his personal (psychosocial) context if he is willing to share it. As a general rule, I try to leave the door open to explore more facets of the person if the discussion goes in a particular direction: literature shows that a wider conversation could indeed lead to a better relationship, a better diagnosis and a more personalised treatment.[20] Although most people do not have many concerns to discuss, especially at recall visits, I nevertheless invite them to share their thoughts with me. Sometimes, an entire appointment can be spent in a conversation if the situation demands it. I value this encounter, albeit uncommon, and do not consider it as a waste of time.

Examining

Once the initial conversation comes to a natural end, I present to the patient the roadmap of the appointment explaining what this visit should entail. As opposed to the initial connecting step, which is subjective and reactive, the examining step tends to be objective and prescriptive. Hence, my attitude in this step is to be wary of potential cognitive predispositions.[24] The objective, in case of an initial encounter, is to gather clinical and medical history data without immediately interpreting it. It is important for me to separate the examination (findings) from the interpretation (diagnosis) in order to provide the proper 'mental resting space'[25] and avoid hurried diagnoses that could be too shallow or narrow in scope.[24] For example, detecting carious lesions (examination/findings) then intervening would lead to a surgical management of the lesion, regardless of the presence or absence of the caries disease (interpretation). Detecting caries, then diagnosing the disease and its risk factors, leads to a much broader management strategy that might or might not involve an operative approach.

In this examining process, I first look at the medical questionnaire that the patient has already filled in. I do not review it with the patient yet but rather screen it to identify anything that might be a contraindication to the examination or the clinical tests that I may need to conduct (for example, latex allergy, need of premedication, back pains, etc). I then place the patient in the examination position, place the bib, put gloves and other adjuncts on and proceed to the examination. I advise the patient she can intervene at any moment. I explain what I am doing before doing it and proceed with the clinical examination and any tests deemed necessary (radiographs, periodontal probing, thermal tests, etc).[24,26] I record the tests using a descriptive, non-diagnostic language ('periapical radiolucency' instead of 'lesion', 'no response to cold' instead of 'necrotic', etc). During this examination, I ask specific clinical questions to the patient – anything that might not have been covered during our initial conversation.

It is only after this clinical examination that I review in detail the medical questionnaire. Conducting this medical-specific interview this late into the appointment provides multiple advantages. It first prevents the yes/no trap at the beginning of the appointment thus encouraging an open initial conversation. When people are primed by questions that require short answers, it indeed becomes difficult to engage later in a less structured conversation. Secondly, this unstructured connecting phase promotes trust, which then allows me to gather more accurate medical information and deepen the information provided by the medical questionnaire; the patient, indeed, often feels more comfortable in sharing details or divulging important information that otherwise she might have been reluctant to share. Finally, it minimises situations of confirmation bias and satisfaction of search where during the interpretation of a test or radiograph, I might be blinded to all the findings once I find what I think I'm looking for.[24] Although this medical interview is narrower in scope than the initial 'connecting' phase, I remain attentive to cues from the patient showing that she may like to discuss something in particular. Once all the data collection is done, I interpret it and come up with the different possible diagnoses.

Sharing

Once the examination step is completed, I place the patient back up in a seated position, and remove my gloves, my mask as well as the patient's bib. This facilitates the 'sharing' of the findings and the participation of the patient in the discussion. Again, I invite her to intervene at any time. At this stage, since I have not yet shared and explained the findings, I avoid talking about any treatment options. I first present the patient with the findings as neutrally as possible, explaining, using appropriate language, what I observed without judging or blaming the person. For instance, I avoid sentences like 'the hole in this tooth has gone into the nerve *because you waited too long to come see me*.' By keeping the language neutral, I aim at creating the proper space for the patient to participate in the interpretation.

Then, I offer my interpretations of these neutral findings: I present my diagnoses and share with the patient the biomedical models that support them. For instance, I explain what, according to scientific knowledge and my own experience, may cause caries or contribute to periodontitis. If appropriate, I use models

or metaphors or make sketches to illustrate my presentation.[27] This process of sharing is bilateral: I indeed invite the patient to share her own disease models – her explanations and understanding of what might be going on. Getting to know and understand the patient's explanations about her illness will help eventually in establishing common ground and a treatment strategy that the patient adheres to.[28] Also, this trusting relationship makes delivering bad news (for example, a catastrophically split tooth) result in a potentially reduced psychological distress experienced by the patient.[29]

At this stage – if necessary – I explore the patient's lifestyle, dietary habits, and oral hygiene practices and put them in the context of the findings and diagnoses.

The mutual trust built during the initial conversation and my non-judgemental attitude helps in keeping this discussion open, honest and thorough. This conversation around the patient's lifestyle habits after previously exploring the disease models helps the patient come up with her own solutions and lifestyle changes that she could be able to maintain.

Intervening

For first visits or examination appointments, the intervention consists in co-authoring a treatment plan with the patient. This *shared* decision-making[7] is the natural extension of the previous process, as the sharing of our interpretations (disease and illness) logically leads to a conversation about possible avenues of treatment, management, prevention and prognoses.

In this process, I try to remain mindful of any ethical dilemmas between patient autonomy of decision and non-maleficence of intervention. I evaluate the state of our (scientific) knowledge and medical models: I weigh them against the gravity of the consequences, all the while appreciating the uncertainty inherent in the outcomes and expressing it clearly to the patient. I also invite conversations around the patient's expectations and values. I help him acquire some of the language necessary to express his situation clearly (for example, different types of pain) and empower him to co-author the treatment plan. I make all efforts to understand his concerns and express my

Table 2 A conversation vignette between the patient and the dentist

Discussion between a patient (P) and a dentist (D)	Analysis of the discussion
P: What's in your varnish? D: This is a fluoride varnish at higher concentrations to what is in a toothpaste!	We are at the end of an examination appointment and discussing possible management options for the patient's caries disease. We had agreed, during the initial connecting stage, that the patient was welcome to ask questions at any point if he so wished.
P: Oh, then no. I do not want it on my teeth. D: Oh? How come?	The person-centred practitioner tries to not interpret the refusal and the aggressive tone of the patient as a personal attack. Instead of confronting the patient, the dentist expresses his curiosity to know more about the patient's perspective.
P: I am against fluoride. The government uses it to control the masses. It is made from industrial toxic residues. I only buy fluoride-free toothpaste. D: Ah, I have come across this information on the Internet.	The patient reveals crucial information: he is totally against the use of fluorides, which he associates to governmental control, and consequently does not use fluoride toothpaste. It needs to be noted that this important information had not surfaced in the connecting phase; this highlights the necessity to allow pockets of conversation to occur at different stages of the encounter. Here again, the dentist avoids judging and confronting the patient for his opinions and actions. In his response, he thus tries to be careful to offer the patient a safe environment to dialogue. His objective is to understand the patient's perspective to later establish common ground. One of the challenges that the dentist faces is to not feel attacked in his professional identity and keep his openness.
P: There you go. So, for me, no fluoride please. D: Ok, I understand. Do not worry, I will not force you or anything! You just need to know that I think in your case the fluoride application would benefit you.	At this point, though, the patient does not seem open for sharing and discussing. It is up to the dentist, through his relational competency, to pursue or reorient the conversation. His approach is to acknowledge the patient's perspective and assure that he will not impose his own views. By expressing his openness, the dentist shows his flexibility and willingness to help the patient. Having said that, he also shares his opinion about the benefits of fluoride applications, opening the door to a discussion on a scientifically based perspective.
P: You do not think it is dangerous? D: Well, at high dosages, for sure! Just like anything really. I do not believe in purposely ingesting it either. In dentistry, what we like to do is place the fluoride on the teeth occasionally for those who have a lot of caries. It is an interesting mineral that allows us to make smaller holes or even no drilling in the long run for those who have caries. There is solid evidence that caries slow down and even stop when fluoride is applied on teeth. I am not talking here about putting fluoride in the water, just applying it on your teeth since you have this disease.	The patient here seems more open than before to a discussion. This openness provides the dentist with the opportunity to present his perspective. The clinician takes his time to clearly express his views and keep the focus on the situation at hand (to varnish or not) without going into a larger epidemiological discussion (water fluoridation). He also makes efforts to remain neutral and avoid trying to persuade the patient. His objective indeed, is simply to share models as a necessary ground to discuss and co-author a treatment plan.
P: Does your varnish harden? Will I swallow it? D: It looks like toothpaste that I would apply on the teeth. You would most probably swallow some of it. It is highly concentrated so you will indeed ingest some Fluoride. But the quantities you would ingest are far from dangerous doses. Anyway, in my opinion, the benefits you would get from it outweigh the potential risk. Having said that, we could find other strategies to manage your caries.	Although sceptical, the patient shows curiosity towards the varnish application. He seems open to consider it as an option possibly since the dentist did present his perspective in a neutral way. It needs to be noted that the dentist replies with honesty and does not try to hide the potential risks of fluorides. He also expresses flexibility by offering the possibility of alternatives.
P: What other strategies? D: There are some chewing gums you can chew that contain xylitol, but it's not as effective as fluoride. You could also remove sugar and simple carbs from your diet. You should know though if the caries continues advancing, we will end up having to place some fillings. This is possible even if we apply the fluoride by the way. It is just a matter of increasing or decreasing the chances.	The dentist explains the available strategies without exaggerating the risks of any of them. Remaining neutral, he makes effort to not manipulate the patient's decision.

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understanding of his expectations (Table 2). We work together towards a treatment plan that meets his values and pace, while remaining biomedically sound.

Note that these boundaries might vary from a practitioner to another depending on their context and their personal values. My approach strongly assumes that for patients presenting similar conditions, different treatment plans are possible. I do not subscribe to the idea that we should present what we consider an ideal treatment plan followed by several compromised treatment plans. What I might consider as ideal is based on my personal values and does not necessarily reflect the patients'. Therefore, I present all the options and their possible consequences, addressing the uncertainty with each treatment strategy – including no treatment.[30]

It needs to be recognised that, at least in dentistry, success hinges not only on our interventions in the clinic but mostly on the patient's interventions at home. Oral diseases being mostly chronic, lifestyle changes are crucial to their management. Therefore, one of our goals is to form a therapeutic alliance[12] with the patient and agree on each other's roles and responsibilities. In particular, I do not aim at 'educating' the patient on best hygiene practices or dietary habits: I rather act as advisor and sometimes as a coach to help the patient achieve his goals.[4] Sometimes that involves sharing some of my knowledge about oral hygiene and diet; however, at other times it involves accepting the status quo and finding other solutions. For example, if a patient is unable to change his dietary or oral hygiene habits, I might propose more frequent applications of fluoride through varnish or take-home trays. The clinical intervention is thus adapted based on the realistic implementation of the lifestyle changes.

For appointments where a procedure is performed, I conduct the intervention after having reconnected with the patient, re-examined the situation with her, and verified that the treatments planned during the previous consultation are still appropriate for both of us. Some of the procedures (eg, resin bonding) require the patient to remain immobile. Thus, while reminding the patient that she can intervene at any time, I also explain that there will be specific moments during the procedure where an interruption would be harmful. We often devise a signalling communication system for the times when the patient is unable to speak, and I remain mindful of them. For treatment plans that require several appointments, throughout the successive encounters, I revisit the plan with the patient to make sure it is still in line with our objectives.

Discussion

Patient-centred approaches in medicine seem to lead to better outcomes, including patient and practitioner satisfaction;[31–34] we believe that this also applies to dentistry even though we still lack scientific evidence in this regard. We therefore promote the adoption of patient-centredness in our field as well as the development of research in this domain.

When we present this person-centred approach to clinicians, they often mention that it would take too long: too much time would be 'wasted' talking and listening to the patient. We believe this to be more of a theoretical criticism than a practical one. In our experience, these conversations do not usually take more than a few minutes. On the contrary, by establishing strong relationships, we gain time further along the appointments by reducing patients' anxiety, increasing cooperation with them, and reducing missed appointments. Studies in medicine have shown that patient-centred approaches do not necessarily take more time[35] but research is still needed to support our assertions related to dentistry.

Another criticism of our approach is that it only describes a two-person relationship: a practitioner and a patient. Dental encounters, indeed, often involve other people: patients, for example, are sometimes accompanied by people that are part of the encounter, such as parents, guardians, spouses or even interpreters. On the professional side, the dentists work in teams that also include dental hygienists, assistants and secretaries. This multiplicity of people renders the clinical processes complex and challenging for the dentist; he thus needs skills and organisation to deal with this complexity and apply the principles of person-centred care.

We also need to recognise that there exist external barriers to person-centredness. Mead and Bower[12] provide a good reflection on those barriers where we, patient and dentist, have little control over. They refer to them as 'shapers', and some examples include licensing board regulations, the healthcare system of the country, the physical setup of the clinics, and cultural contexts.

Our clinical approach goes along with recent articles on patient-centred care in dentistry.[36] Scambler and Asimakopoulou, in particular, presented an interesting model of patient-centred care that is built on four foundations of good practice: 1) exploring disease and its context, 2) the patient as a whole person, 3) doctor-patient relationship ethos, and 4) reaching common ground and sharing responsibility.[37] The clinical approach that we propose in this article is original as it provides a practical process that fits well with the four elements this model.

Although our approach might, at a quick glance, look like approaches already well established in dental practices, we would like to emphasise its humanist philosophy, which may make it singular. This humanist attitude is inherent to each step of the dental encounter and has a tangible impact on our professional behaviour, decisions, and even in the words we use. We believe that a self-reflection on how to handle and articulate the initial conversation, clinical examination, presenting of findings and diagnoses, decision-making, and intervention is important to root our practice into this humanist philosophy.

We hope this person-centred clinical approach will provide an applied framework to support those dentists who are willing to adopt a person-centred approach to oral care. It is also a starting point for research to evaluate its efficacy on different outcomes, and a frame of reference for dental faculties to support their curriculum and admissions process.[38,39] Dentistry having never gone through a self-reflection of the tacit models behind its approaches, we would like this paper to trigger this much-needed professional self-reflection and discussion on clinical approaches and philosophy.

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