Communication skills in dental practice

Theory, relationship models, consultation structure, consent, health literacy, special groups and difficult conversations

Practical Class 12 · Social Medicine with Medical Ethics · Dental Medicine (English) · 2026/2027

Chief Assistant Professor Kostadin Kostadinov, MD, PhD

Department of Social Medicine and Public Health · Medical University of Plovdiv

“There is no need for so many questions”

Opening case (course case 1)

A 45-year-old woman attends for a dental implant. She is slightly anxious and asks whether the procedure will hurt. The dentist replies: “It’s okay, everything will be fine, there is no need for so many questions”, and no written informed consent is obtained. After the procedure she has marked swelling and pain, concludes that something went wrong, stops attending and posts a negative review.

Was the swelling a complication, an expected effect or an error? The patient cannot tell, because nobody prepared her for what is normal after implant surgery.

The surgery may have been technically correct. The **communication** failed: her question was closed down, her anxiety ignored and the statutory consent process omitted.

Reassurance without information is not kindness. It moves uncertainty from the consultation to the days after it.

What you should be able to do after this lecture

1. Define communication, describe its channels and the barriers that distort it in the dental surgery.
2. Compare the models of the dentist–patient relationship and explain the move from paternalism to partnership.
3. Structure a consultation with the Calgary–Cambridge guide, ICE, chunk and check, teach-back and safety-netting.
4. Respond to emotion (NURSE) and support behaviour change (motivational interviewing, stages of change, SMART goals).
5. Conduct a consent conversation, communicate risk in numbers people understand and respect a refusal.
6. Recognise limited (oral) health literacy and adapt explanations to it.
7. Adapt communication to anxious patients, children, adolescents, older people, people with disabilities and patients who need an interpreter.
8. Handle anger, complaints, bad news and errors, and communicate safely inside the team and in the records.

Resources: 15-minute reading · student tasks. Class 13 analyses challenging situations in depth; class 14 is the individual written assignment.

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What communication is

The word comes from the Latin *communicare*, "to make common, to share": knowledge, feelings and ideas are exchanged between people (Borisova & Veder, p. 24). Communication succeeds when it produces the intended understanding or response in the receiver, not when the sender has finished speaking (p. 8, p. 161).

Social psychology describes **interaction** as a unity of three sides (Yolov, p. 91):

- **communicative** — exchange of information;
- **interactive** — organisation of joint action (the dentist and patient do the treatment together);
- **perceptive** — how the two perceive and understand each other.

Communication in health care

Health communication is a multidisciplinary approach to reaching different audiences and sharing health information in order to influence, engage and support individuals and communities (Karanesheva, 2022, pp. 5, 40). In the dental chair it has three practical aims:

1. to **gather** accurate information for diagnosis and safe treatment;
2. to **give** information that allows informed choice and correct self-care;
3. to **build a relationship** of trust in which both can happen.

Borisova & Veder, 2011, pp. 8, 24, 161 · Yolov, pp. 91–92 · Karanesheva, NCPHA 2022, pp. 5, 40

The communication process: from what is meant to what is done

Element	Meaning in the dental surgery
Sender / encoding	The dentist turns a clinical idea into words, gestures and images.
Message	"The nerve inside this tooth is inflamed and needs treatment."
Channel	Speech, tone, facial expression, a radiograph, a leaflet, a text message.
Receiver / decoding	The patient interprets the message through knowledge, fear, culture and expectations.
Feedback	The patient's reply, question or teach-back shows what arrived.
Noise	Anything that distorts the message: drill noise, mask, pain, anxiety, jargon, time pressure.

Why messages are lost

- What is **meant** may not be said.
- What is **said** may not be heard.
- What is **heard** may not be understood.
- What is **understood** may not be done.

This chain, taken from team-safety training, applies equally to patients. Every link can be checked: plain words, a quiet moment, teach-back, written instructions and a follow-up question at the next visit.

Cooper & Frain, ABC of Clinical Communication, 2018, p. 30 (Figure 5.1) · Borisova & Veder, pp. 8, 20

Barriers that distort communication

Type of barrier	Examples	Dental example and response
Physical and environmental	Noise, distance, poor light, interruptions, a mask, lack of privacy.	Explaining a diagnosis over the sound of the suction; switch it off, sit up the patient, remove the mask.
Physiological	Pain, hearing or visual impairment, fatigue, medication, local anaesthesia.	Numb lips and a dry mouth make speaking hard; ask yes/no questions, agree hand signals.
Psychological	Fear, shame, anger, mistrust, preconceived opinions.	A phobic patient retains little; repeat key points and give them in writing.
Semantic (language)	Jargon, a foreign language, ambiguous words, numbers without context.	"Periapical lesion" means nothing to most patients; "an abnormal area around the tip of the root" does.
Personal skills	Inability to speak clearly, to listen, to ask questions, to read non-verbal signals.	Interrupting the opening statement; listening for the diagnosis instead of the person.
Organisational and cultural	Rushed scheduling, hierarchy, a culture that discourages questions; cultural norms on touch, eye contact, decision-making.	Fifteen-minute slots for a consent conversation; an assistant who does not dare to speak up.

Borisova and Veder also describe a barrier of **rejecting contradictory information**: when a message conflicts with prior beliefs, people discount it and forget it easily (p. 20). Correcting a myth therefore requires exploring the belief first, not repeating the fact louder.

Borisova & Veder, pp. 18–20 · Yolov, pp. 92–94 · Cooper & Frain, pp. 3, 30

Verbal and paraverbal communication

Verbal: choosing the words

- Greet the patient warmly and address them by name.
- Use words the patient understands; explain any technical term you must use.
- Choose words that do not frighten: "you will feel pressure" rather than "cutting", "drilling", "bleeding".
- Prefer positive, indirect instructions: "keep your mouth open, please" rather than "don't close!".
- **Never give false promises** such as "it won't hurt" or "I'll just have a look".

Paraverbal: how the words sound

Tone, pace, volume, rhythm, pauses and emphasis. A calm, slow and distinct voice reduces anxiety; intonation can reverse the meaning of the same sentence ("That's fine."). Pauses give the patient room to ask.

Yolov's chapter on the psychology of communication in dental practice recommends saying important things at the beginning and at the end of the visit, after attracting the patient's attention, because anxious people remember poorly (p. 93). Honest language is part of building predictability, which is itself anxiety-reducing.

Yolov, Psychology of communication in dental practice, pp. 92–93 · Borisova & Veder, pp. 160–162

Non-verbal communication

Non-verbal behaviour consists of **signs** (deliberate) and **signals** (emitted regardless of intention). It can support, contradict, complement or replace speech (Borisova & Veder, pp. 163–164). Argyle's functions:

- managing the social situation (turn-taking, interest, boredom);
- self-presentation and first impressions;
- expressing emotions and interpersonal attitudes;
- accompanying and regulating speech.

When words and body disagree, patients feel uneasy and mistrustful (Yolov, p. 93). Congruence is the aim.

Channel	**In the dental surgery (Yolov, p. 93)**
Posture	Face and body turned towards the patient; arms not crossed; at eye level for important conversations.
Eye contact	Look at the patient when speaking; watch reactions; eyes over the mask carry much of the emotion.
Facial expression	Confirms or casts doubt on what is said; boredom or irritation are easily read.
Touch	May calm or control; always announced and appropriate.
Agreed signals	A raised hand to stop lets the patient keep control when speech is impossible.
Appearance, setting	Clothing, hygiene, waiting room, light and colour shape trust (p. 94).

Proxemics: the dentist works in the intimate zone

Zone	Distance
Intimate	15–45 cm
Personal	45–120 cm
Social	120–300 cm
Public	over 300 cm

Zones after E. T. Hall, as given by Yolov (p. 94). Distances vary between cultures.

Dental treatment takes place in the **intimate zone**, with physical contact that many patients consciously or unconsciously resist. Lying back with a stranger's hands in one's mouth is a position of exposure and dependency.

Practical consequences:

- discuss findings, options and costs at **social or personal** distance, with the patient sitting upright;
- announce each move into the intimate zone ("I'm going to look at the back teeth now");
- empathy, warmth and trust are what make the intimate distance acceptable (Yolov, p. 94).

Yolov, p. 94 · Cooper & Frain, p. 11 (non-verbal behaviour in the Calgary–Cambridge guide)

A popular number to treat with caution: “7–38–55”

Many textbooks, including Yolov (p. 91), cite the claim that the impact of a message is about **7–10% words, up to 38% voice and up to 55% body language**.

The figures come from small laboratory experiments by Mehrabian and colleagues in 1967. Listeners judged a speaker’s **feeling or liking** from single words spoken in a tone, or shown with a face, that **contradicted** the word. Mehrabian himself warned that the figures do not apply to communication in general.

What we can safely conclude

When verbal and non-verbal messages about **feelings and attitudes** are inconsistent, people tend to believe the tone and the face. That is why “Don’t worry” said with an irritated voice does not reassure.

What we cannot conclude

That the content of an explanation hardly matters. Consent information, risks and after-care instructions are carried by words, and they must be accurate.

A useful habit for evidence-based practice: before repeating a famous number, ask which study produced it and what it actually measured.

Yolov, p. 91 · Mehrabian A, Wiener M, 1967; Mehrabian A, Ferris SR, 1967 (original experiments)

The dental setting makes communication harder than it looks

Feature	Why it matters	Practical response
Supine position, light in the face	The patient feels exposed and less in control.	Explain while the patient is upright; sit at eye level for important conversations.
Hands and instruments in the mouth	The patient cannot speak or ask questions.	Agree a stop signal (raise the left hand) and honour it every time.
Mask, visor and noise	Facial expression and part of the voice are lost.	Speak more slowly, use the eyes and tone; remove the mask for key explanations.
Unseen procedures	The patient hears and feels but cannot see.	Announce sensations in advance: "You will feel pressure, not sharp pain."
Cost and choice	Many treatments are partly or fully paid out of pocket.	Discuss options and costs openly, before treatment, as the dental code requires.
The ambulatory patient	Usually not in danger, but in pain; fears the procedure more than the consequences of not treating.	Address the fear first; then explain what happens if nothing is done (Yolov, p. 87).

After fear of pain, the second most common barrier to dental care is fear of not being able to pay (Yolov, p. 87). In a survey cited by Daly et al., fear and cost were named as the two main barriers to seeking dental care; other barriers included loss of control, the personality of the dentist, sounds and smells, feeling vulnerable in the chair and "being treated like a mouth" (Box 23.3, p. 243).

Why communication belongs to clinical competence

What the evidence shows

- The history accounts for roughly 80% of diagnoses in medicine, and interrupting the opening statement or relying on closed questions lowers the quality of the information obtained (Cooper & Frain, p. 1).
- Poor communication affects diagnostic accuracy, adherence, satisfaction, patient safety, team satisfaction and malpractice risk (Box 1.5, p. 4).
- In general practice, clinician empathy was associated with higher satisfaction and enablement and lower anxiety and distress (7 studies; Derksen et al., 2013).

In dentistry

A review of dentist–patient communication describes good communication as clear, correct, concise, complete and cohesive and links it with lower dental anxiety, better adherence and higher satisfaction (Ho et al., 2024). Most of the department's five course cases fail in communication, not in technique.

Most of this evidence is observational: it shows association, not that communication alone causes better outcomes. Communication is necessary for good care, not a substitute for clinical competence. Silverman calls it "part of the science of medicine itself", not an optional extra (Cooper & Frain, p. 8).

Cooper & Frain, pp. 1, 4, 8 · Derksen et al., 2013, doi:10.3399/bjgp13X660814 · Ho et al., 2024, doi:10.2147/PPA.S465221

The duty to inform is written into law and the dental code

> *As a patient, everyone has the right to: … be informed in accessible language of his or her rights and obligations; clear and accessible information about his or her health status and the methods of possible treatment; … prevention of pain and suffering during treatment, as far as possible.*
>
> — Health Act, Art. 86(1), items 7, 8 and 12 (teaching translation)

> *The treating physician shall inform the patient about: 1. the state of health and the need for treatment; 2. the disease … and its prognosis; 3. the planned preventive, diagnostic, treatment and rehabilitation activities and their risks; 4. the diagnostic and therapeutic alternatives; 5. the name, position and specialty of the persons taking part in the diagnostic and treatment process.*
>
> — Health Act, Art. 92(1) (teaching translation)

Item 5 makes a simple act of courtesy a legal duty: introduce yourself and your role. The dental code adds what must be explained **before** treatment: necessary investigations, proposed treatment and all reasonable alternatives with their risks and approximate cost, duration, expected results with and without treatment, and how costs are covered (Art. 15(1)). Treatment may not start before this and informed consent (Art. 15(2)).

Health Act, Arts 86, 92 · Code of Professional Ethics of Dentists, Art. 15

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From the paternal healer to the partner

For most of history the relationship was healer-dominated, with brief periods of partial egalitarianism (Cooper & Frain, Figure 1.1, p. 2). The **Hippocratic, paternalistic** model remained dominant until the 1960s: the doctor decided, the patient complied (Yolov, p. 62).

Several 20th-century developments changed this:

- **1956** — Szasz and Hollender describe three models, including **mutual participation**.
- **1976** — Byrne and Long advocate **patient-centredness** in the consultation.
- **1977** — Engel's **biopsychosocial model**: not only what is the matter with the patient, but what matters to the patient.
- Post-war rights movements: self-determination, autonomy and equality reached health care (p. 1).

Patient-centred care

Mead and Bower's five dimensions, as summarised in the clinical-communication literature: (1) a biopsychosocial perspective, (2) the "patient as person", (3) sharing power and responsibility, (4) the therapeutic alliance, (5) the "doctor as person", whose own feelings shape the encounter.

The question shifts from "What is the matter?" to "What matters to you?" (Barry and Edgman-Levitan, cited in Cooper & Frain, p. 21).

Cooper & Frain, pp. 1–3, 21 · Yolov, pp. 62–64 · Mead & Bower, Soc Sci Med 2000 (in Cooper & Frain, p. 3)

Szasz and Hollender (1956): three basic models

Model	Dentist	Patient	Dental situations where it fits
Activity–passivity	Acts on the patient.	Recipient; cannot participate.	Emergency care of an unconscious patient; work under general anaesthesia or deep sedation. Prototype: parent and infant.
Guidance–cooperation	Tells the patient what to do and why.	Cooperates, follows advice, asks questions.	Acute pain or infection: the patient wants help now and accepts a clear recommendation. Prototype: parent and adolescent.
Mutual participation	Helps the patient help themselves.	Partner who carries out most of the care.	Caries and periodontal prevention, orthodontic treatment, choosing between an implant, a bridge or a denture. Prototype: two adults.

The models are not good or bad in themselves; each fits a clinical state. Problems arise when a dentist uses one model for every patient, for example **guidance** with a capable adult choosing a costly prosthesis, or **mutual participation** with a patient in severe pain who cannot yet deliberate.

Most of dentistry is the management of chronic, behaviour-dependent disease (caries, periodontitis), where the outcome depends on the patient's daily self-care. This is why mutual participation is the default model in modern dental practice.

Szasz & Hollender, 1956, doi:10.1001/archinte.1956.00250230079008 · Cooper & Frain, p. 2

Emanuel and Emanuel (1992): four models

Model	Dentist's role	Patient's role	Main ethical risk	Dental example
Paternalistic	Selects the option judged best for the patient.	Receives protection; little influence.	Values imposed; information withheld "for the patient's good".	"You need an extraction, we'll do it now."
Informative	Supplies facts and carries out the chosen option.	Chooses by fixed preferences.	Patient left without guidance; dentistry as a menu of services.	A price list of options without a recommendation.
Interpretive	Helps clarify values and recommends what fits them.	Examines what matters and chooses with support.	Dentist mistakes own interpretation for the patient's.	"You said appearance matters most for your work — let's look at the options with that in mind."
Deliberative	Discusses health-related values and argues for a defensible option.	Considers reasons; keeps authority over the choice.	Persuasion may become manipulation.	Recommending a root canal over extraction, with reasons, while accepting the patient's decision.

The models are analytical tools; a consultation may move between them. A firm recommendation is not paternalism: **paternalism** is overriding or restricting a person's choice for their supposed benefit. Autonomy permits refusal of an offered treatment but creates no entitlement to an intervention without a reasonable clinical indication (code, Art. 15(5)).

Emanuel & Emanuel, 1992, doi:10.1001/jama.1992.03480160079038 · Department ethics book, ch. 4, "Relationship models"

Paternalism, autonomy and partnership in the Bulgarian dental literature

Paternalism (Yolov, pp. 62–63)

Childress (1982): paternalism is the refusal to accept or acquiesce in another person's wishes and choices for that person's own good. It is **strong** when the patient is competent and the dentist still limits their informed choice, and **weak** when the patient cannot consent (a young child, severe mental disorder). Paternalistic action may be appropriate in danger, under severe pain, stress or a psychotropic substance when the patient cannot decide, when there is no alternative, and with small children.

Partnership (Yolov, p. 64)

Paternalism and pure autonomy are the two extremes. In the **partnership model** both parties are autonomous, respect each other and reach consensus on diagnostic and treatment questions through active exchange of information, discussion and negotiation. From the point of view of rights, duties and responsibilities, it is the most defensible model.

Yolov notes that personalising the relationship and moving from paternalistic to partnership contact rests on respect for autonomy and informed consent (p. 87).

Partnership is not equality of knowledge. It is shared responsibility: the dentist brings expertise, the patient brings values, circumstances and daily self-care.

Yolov, pp. 62–64, 87 · Department ethics book, ch. 4

Trust and unequal power

The dentist–patient relationship is a professional relationship directed to the patient's health needs. **Trust** is the patient's willingness to become vulnerable in the expectation that the professional will use the role competently and for proper purposes. Trust is not obedience: a trusting patient may disagree, ask for another opinion or refuse.

Fidelity is faithfulness to the commitments of the role: honesty, confidentiality, attention to welfare, avoidance of exploitation (ethics book, ch. 4).

Where the dentist's power comes from

Knowledge; control of time and setting; the chair and the instruments; access to records; the price list; the ability to postpone or refuse treatment. Pain, fear, an open mouth and cost increase the patient's vulnerability.

In dentistry, the patient usually **cannot judge expertly** which treatment is needed or what quality was delivered (Yolov, p. 91). This information asymmetry is why the code forbids recommending unnecessary treatment (Art. 15(5)) and misleading promotion (Arts 10, 16).

Communication skills are how professional power is used responsibly: they make the patient's knowledge and values count.

Department ethics book, ch. 4 · Yolov, p. 91 · Code of Professional Ethics of Dentists, Arts 10, 15(5), 16

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Consultation models: a family of frameworks

Model	Core idea
Patient-centred clinical method (Brown, Stewart et al., 1986)	Explore both the disease and the illness experience; find common ground.
Pendleton et al. (1984)	Seven tasks; introduced the routine elicitation of the patient's **ideas, concerns and expectations** and of "anything else".
Neighbour, The Inner Consultation (1987)	Five checkpoints: connecting, summarising, handing over, **safety-netting**, housekeeping (the clinician's own state).
Calgary–Cambridge guide (Kurtz & Silverman, 1996; 2003)	Five sequential tasks and two continuous threads, each broken into observable, evidence-based skills.
Four Habits (Frankel & Stein, 2001)	Invest in the beginning; elicit the patient's perspective; demonstrate empathy; invest in the end.
SEGUE framework / Kalamazoo consensus (Makoul, 2001)	A checklist of essential elements used for teaching and assessment.

All of these models agree on more than they disagree: open the consultation well, discover the patient's agenda and perspective, explain in a way the patient can use, share decisions and close safely. They are frameworks of skills, not scripts. This course uses the Calgary–Cambridge guide because it is the most detailed and is widely used to teach and assess consultations.

Cooper & Frain, Box 1.3 (p. 3) and Box 10.2 (p. 63) · Kurtz et al., 2003, doi:10.1097/00001888-200308000-00011

The Calgary–Cambridge guide

Task	Dental example
1. Initiating the session	Prepare, greet, introduce yourself and your role, identify all reasons for the visit: "What brings you in, and is there anything else?"
2. Gathering information	The patient's story of the pain, then focused questions, medical history and medicines, ideas, concerns and expectations.
3. Physical examination	Explain what you will examine and why; ask permission; announce what the patient will feel.
4. Explanation and planning	Findings, options, risks and costs in chunks; shared decision; written information.
5. Closing the session	Summary, next steps, safety-netting: what is normal, what is not, whom to call.

Two tasks run throughout

Providing structure — making the organisation overt (summarising, signposting) and attending to flow and timing.

Building the relationship — non-verbal behaviour, rapport, empathy, involving the patient.

Silverman distinguishes three kinds of skill: **content** (what we ask and say), **process** (how we do it) and **perceptual** (what we think and feel). Structure, he writes, "sets us free": it allows flexibility because one always knows how to return to the path (Cooper & Frain, pp. 8, 63).

Cooper & Frain, ch. 2 (Silverman), Figures 2.3–2.5, pp. 9–11 · Kurtz et al., 2003, doi:10.1097/00001888-200308000-00011

Initiating the session: the first minute decides a lot

Skills (Cooper & Frain, p. 11)

- **Preparation**: read the record, finish the previous task, focus.
- **Initial rapport**: greet and obtain the patient's name; introduce yourself, your role and the purpose of the visit; show interest and respect; attend to physical comfort.
- **Identify the reasons**: an open opening question; **listen to the opening statement without interruption**; confirm the list and screen for further problems ("anything else?"); negotiate the agenda.

What the evidence on interruption shows

- Family physicians redirected the patient's opening statement after a mean of **23.1 seconds**; patients allowed to finish used only **6 seconds more** on average, and late-arising concerns were less frequent when concerns were solicited (14.9% vs 34.9%) (Marvel et al., 1999; 264 consultations).
- Twenty years later, clinicians elicited the agenda in 36% of 112 recorded encounters and interrupted after a median of **11 seconds**; uninterrupted patients needed a median of **6 seconds** (Singh Ospina et al., 2019).

In dentistry the "real" reason may not be the presenting tooth: fear of cancer, a wedding next month, a bad experience elsewhere, or the cost. The agenda question costs seconds and prevents the "doorknob" concern at the end of the visit.

Marvel et al., 1999, doi:10.1001/jama.281.3.283 · Singh Ospina et al., 2019, doi:10.1007/s11606-018-4540-5 · Health Act, Art. 92(1), item 5

Gathering information: listen first, then focus

The open-to-closed cone

Start open: "Tell me about the pain." Let the patient tell the story from its beginning. Then narrow: "Is it worse with cold or with biting? Does it wake you at night?" Closed questions confirm details; they cannot discover what you did not think to ask. Establish dates; clarify vague statements ("What do you mean by 'sensitive'?").

Active listening has three phases: readiness to participate, readiness to receive the information, and giving the speaker the chance to finish and responding to what was heard (Borisova & Veder, p. 22). It is shown by nodding, short encouragers ("Go on"), a pause before the next question, reflecting and summarising.

Picking up cues

Patients often signal concerns indirectly: "My mother lost all her teeth early...", a glance at the price list, a sigh before an injection. A cue is an invitation: "You mentioned your mother — is that something that worries you?"

Skill	What it sounds like
Facilitating	"Mm", "Go on", nodding, silence.
Reflecting	"So the pain wakes you at night."
Summarising	"Let me check I have this right..." — invites correction.
Explaining the rationale	"I ask about blood thinners because they affect bleeding after an extraction."

Cooper & Frain, p. 11 · Borisova & Veder, p. 22 · Kurtz et al., 2003

Two perspectives: the disease and the patient's illness

Biomedical perspective

Sequence of events, symptom analysis, relevant systems review, medical history, medicines and allergies, previous dental experience. This produces the **diagnosis**.

Patient's perspective: ICE + impact + feelings

Ideas: "What do you think is causing it?"
Concerns: "What worries you most about it?"
Expectations: "What were you hoping we could do today?"
Effects on life: "How is this affecting your eating, sleep, work?"
Feelings: "How do you feel about having treatment?"

The ICE questions come from Pendleton's model (Cooper & Frain, p. 63). They change the consultation because patients hear everything that follows through their concern: a patient who fears oral cancer does not listen to a hygiene explanation; one who expects antibiotics will be disappointed by a filling unless the expectation is addressed.

Dental example

A 50-year-old asks for "a whitening". ICE reveals that her real concern is that a dark front tooth makes her look old at job interviews. The appropriate options (assessment of the non-vital tooth, internal bleaching, a veneer or a crown) only become visible because the expectation was explored.

Cooper & Frain, pp. 7–8, 11, 63 · Kurtz et al., 2003

Physical examination and procedures: keep the patient informed and in control

- **Explain the process and ask permission** before examining: "I'd like to look at your gums and take two small X-rays; is that all right?"
- **Share your thinking** where appropriate: "I'm checking whether the filling is leaking."
- **Announce sensations** before they occur: pressure, cold, vibration, noise.
- **Agree a stop signal** and honour it every time; the possibility of signalling reassures the patient that they can be understood without speaking and keeps some control (Yolov, p. 93).
- **Deal sensitively** with embarrassing findings (halitosis, neglect, signs of an eating disorder).

Consent during treatment

Consent is continuing. If the patient withdraws it during a procedure, stop as soon as this can be done safely and explain any immediate risk of stopping (ethics book, ch. 2). The Health Act allows refusal of the continuation of a medical activity that has already begun (Art. 90(1)).

"You will feel pressure. If you feel anything sharp, raise your hand and I will stop." — information, honesty and control in one sentence.

Cooper & Frain, p. 11 · Yolov, p. 93 · Department ethics book, ch. 2 · Health Act, Art. 90(1)

Explanation and planning: the correct amount and type of information

Objective (Calgary–Cambridge)	Skills
Correct amount and type	**Chunk and check**: give information in manageable chunks and use the patient's response as a guide. **Assess the starting point**: what does the patient already know, and how much do they want to know? Discover what other information would help (cause, prognosis). Avoid giving advice, information or reassurance prematurely.
Aiding recall and understanding	Organise the explanation into sections; **signpost** ("There are three things I'd like to discuss. First..."); repeat and summarise; use concise language and avoid or explain jargon; **use visual methods** — radiographs, intra-oral photographs, models, drawings, written instructions; check understanding by asking the patient to restate it.
Shared understanding	Relate the explanation to the patient's ideas, concerns and expectations; invite questions and doubts; pick up signs of information overload or distress; ask how the patient feels about what was said.
Planning: shared decision-making	Share your thinking; offer choices rather than directives; ascertain how involved the patient wants to be; negotiate a mutually acceptable plan; check acceptance and whether concerns were addressed.

Cooper & Frain, Figure 2.5, p. 11 · Kurtz et al., 2003, doi:10.1097/00001888-200308000-00011

Patients forget much of what they are told

- Anxiety reduces memory: say the most important things at the start and at the end, after attracting attention, and ask the patient to repeat them (Yolov, p. 93).
- In a small exploratory study cited by Daly et al., dentists recalled the consultation well, but patients could not accurately recall the dental health advice or the agreed actions (p. 245).
- Adherence — "the extent to which a person's behaviour corresponds with agreed recommendations from a health care provider" (WHO, Sabaté 2003) — depends on understanding and agreement, not on instruction alone (Daly, pp. 128, 244).

Jargon	Plain alternative
Irreversible pulpitis	The nerve inside the tooth is inflamed and will not settle by itself
Periapical lesion	An abnormal area around the root tip; tests show its cause
Obturation	A filling
Calculus	Hardened deposits on the teeth (tartar)
Endodontic treatment	Root canal treatment: cleaning and sealing the inside of the tooth
Alveolar osteitis	"Dry socket": a painful socket after an extraction
Periodontitis	Gum disease that destroys the bone holding the teeth

The aim is not that you said it, but that the patient understood it, remembers it and can act on it.

Yolov, p. 93 · Daly et al., 2013, pp. 128, 244–245

Teach-back checks the explanation, not the patient

Course case 4: post-extraction instructions

After a complex extraction the dentist tells the patient, orally only, not to smoke, eat hard or spicy food or rinse during the first 24 hours. The same day he smokes and eats spicy food; two days later he has inflammation and pain and blames "poor-quality work".

Teach-back in practice

"I have given you a lot of information. To make sure **I** explained it clearly, can you tell me in your own words what you will avoid today and why?" Correct any gap, then ask again; give the same points in writing. "Do you understand?" almost always receives "yes".

What the evidence says

A systematic review found 20 heterogeneous studies; teach-back improved outcomes in 19. Yet fewer than a quarter of 1,994 US dentists surveyed routinely asked patients to repeat instructions or to say what they would do at home (Burt & Eklund, Table 22.2, p. 251).

The case keeps the department's wording; current after-care advice usually extends the smoking pause beyond 24 hours (often at least 72 hours) — follow the clinic's protocol.

Talevski et al., 2020, doi:10.1371/journal.pone.0231350 · Burt & Eklund, 7th ed., p. 251 · course cases, Cases II SMME DM

Closing the session: summary, contract and safety-netting

Forward planning

Contract with the patient about the next steps for both sides: "Next week we'll finish the root canal; until then take the painkiller as we agreed."

Safety-netting

Explain possible unexpected outcomes, what to do if the plan does not work, and when and how to seek help: "Some swelling for two or three days is expected. If it keeps getting worse or you have a fever, call us the same day. If you have difficulty breathing or swallowing, or the swelling spreads to your eye or neck, go to emergency care immediately."

Ensuring an appropriate point of closure

Summarise briefly and clarify the plan; make a final check that the patient agrees and is comfortable; ask whether there are corrections, questions or other items. Neighbour's model adds a last checkpoint, **housekeeping**: "Am I in good shape for the next patient?"

Course case 1 shows what is lost without closure: had the implant patient been told what is expected (some swelling and discomfort for several days) and which signs need review, she could have judged her swelling — and sought assessment if it was severe or worsening — instead of concluding that an error had occurred.

Cooper & Frain, p. 11 (closing the session) and p. 63 (Neighbour) · course case 1

A kind but closed consultation: what goes wrong

Silverman describes a review appointment he witnessed. The young doctor was warm, respectful and competent; he greeted the 92-year-old patient by name and introduced himself. But he:

- opened with two **closed questions** ("Any pain when walking? At night?") and never asked "How have you been?";
- did not screen for her agenda, so a recent emergency admission with chest pain never came up;
- did not summarise or signpost, so she did not know when to speak;
- explained in one long block, full of jargon, without chunking or checking understanding.

The patient left satisfied with his charm, but with her real question unanswered and a wrong clinical picture in his notes (Cooper & Frain, pp. 10–12).

Dental parallels

"Any problems with the bridge?" — "No." The patient does not mention that she has stopped eating on that side because it moves, or that she fears it will fall out at a family celebration.

Kindness is necessary, but structure is what makes a consultation accurate, efficient and supportive.

Cooper & Frain, ch. 2, pp. 10–12

BATHE: a brief psychosocial check in a busy surgery

Step	Question and dental example
Background	"What is going on in your life at the moment?" — a patient with new bruxism and jaw pain.
Affect	"How do you feel about that?"
Trouble	"What troubles you most about it?"
Handling	"How are you handling it?"
Empathy	"That sounds really difficult; it makes sense that you clench your teeth at night."

BATHE was developed for family practice by Stuart and Lieberman (*The Fifteen Minute Hour*) as a short way of exploring the psychosocial context in a few minutes.

It is useful in dentistry because some oral conditions are strongly associated with stress and emotional life: bruxism and other parafunctions, temporomandibular pain, burning-mouth symptoms with a normal mucosa (Yolov, pp. 97–98). These need a dental **and** sometimes a medical or psychological assessment; BATHE opens the door without turning the dentist into a therapist.

Stuart MR, Lieberman JA. The Fifteen Minute Hour (book) · Yolov, pp. 97–98

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Empathy: understanding and showing that you understand

Empathy is the effort to understand the patient's perspective and **communicate** that understanding. It does not require the dentist to share the patient's belief or to offer a clinically inappropriate intervention (ethics book, ch. 4). It has two steps: recognising the patient's distress, then expressing it: "I can see how frightened you are" (Helman's folk model, Cooper & Frain, p. 63).

Response	Example
Empathy	"It sounds as if the last extraction was really painful for you."
Sympathy	"Oh, poor you." — feeling for, not with; may sound patronising.
Premature reassurance	"Don't worry, it's nothing." — closes the conversation.

Emotional intelligence

Salovey and Mayer (1990) described emotional intelligence as the ability to monitor one's own and others' feelings, to discriminate between them and to use this information to guide thinking and action; Goleman popularised it as self-awareness, self-regulation, motivation, empathy and social skill (Borisova & Veder, pp. 162–163, 174).

For the dentist this includes **managing one's own emotions**: an anxious patient can transfer anxiety to the dentist, increasing tension and fatigue (Yolov, p. 88). Empathy is a skill expressed in words and behaviour, not only a personality trait, and it can be trained (Cooper & Frain, p. 4).

Department ethics book, ch. 4 · Cooper & Frain, pp. 4, 63 · Borisova & Veder, pp. 162–163, 173–174 · Yolov, p. 88

Respond to emotion before information: NURSE

Statement	Purpose	Dental example
Name	Suggest a name for the emotion, tentatively.	"It sounds as if you are quite worried about the injection."
Understand	Show that the reaction makes sense; avoid premature reassurance.	"After a painful experience as a child, that is completely understandable."
Respect	Acknowledge the patient's effort or strength.	"It took courage to come in today, given how you feel."
Support	Express partnership and commitment to help.	"We will go at your pace and you can stop me at any time."
Explore	Invite more about the emotion and what lies beneath it.	"Tell me more about what worries you most."

Fear or anger makes it harder to take in technical information. Acknowledge the emotion, then explain in manageable chunks and check understanding; one empathic statement takes seconds. NURSE comes from oncology communication research but applies to any emotional moment in the dental chair.

Back et al., 2005, doi:10.3322/canjclin.55.3.164 · Cooper & Frain, Figure 9.1, p. 56

Knowledge alone rarely changes behaviour

Daly et al. distinguish three domains of learning in health education (p. 127):

- **cognitive** — knowledge (sugary snacks cause caries);
- **affective** — emotions, feelings and beliefs ("baby teeth don't matter");
- **behavioural** — skills (how to floss effectively).

The relationship is rarely linear. Smokers know the risks and continue: knowledge conflicting with behaviour is **cognitive dissonance** (p. 127). Pushing a patient can be felt as a limit on freedom and provoke **reactance** — resistance to the advice itself (Burt & Eklund, p. 236).

Inglehart's "motivational communication" (Burt & Eklund, ch. 21)

1. **What?** The single behaviour that matters most; changing several at once rarely succeeds.
2. **A-B-C**: how the patient feels about it, what they did before, what they know and believe.
3. **When?** The patient's stage of change.
4. **How?** Motivational interviewing.

Appearance, confidence, saving money and feeling in control often motivate more than avoiding disease (Daly, p. 129).

Daly et al., 2013, pp. 127–129 · Burt & Eklund, 7th ed., ch. 21, pp. 235–238

Stages of change (transtheoretical model)

Stage	The patient…	Helpful dental response
Precontemplation	does not see a problem: "My gums always bleed, that's normal."	Raise awareness gently; personalise findings (show the bleeding on the chart); avoid lecturing.
Contemplation	is aware but ambivalent, weighing pros and cons; can stay here a long time.	Explore ambivalence; help increase the pros and reduce the cons.
Preparation	intends to change and starts small steps.	Agree a specific plan; teach the skill (interdental brushes); set a goal.
Action	has changed the behaviour recently.	Reinforce, praise specifically, solve practical problems.
Maintenance	sustains the change over months.	Plan for difficult situations; involve support from family or friends.
Relapse	returns to the old pattern — common, not failure.	Normalise; review what helped before; restart without blame.

Prochaska and DiClemente developed the model from studies of smoking cessation. For dentistry, its lesson is that change unfolds over time and visits, not as the result of one educational talk (Burt & Eklund, pp. 236–238). Dental teams see patients every 6–18 months, an opportunity to monitor progress (Daly, p. 129).

Prochaska & DiClemente, 1983, doi:10.1037/0022-006X.51.3.390 · Burt & Eklund, pp. 236–238 · Cooper & Frain, Figure 7.4, p. 46

Motivational interviewing: guiding, not lecturing

Definition and spirit

"A client-centred, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence" (Miller and Rollnick, quoted in Burt & Eklund, p. 238). Its roots are in Carl Rogers' client-centred approach: the provider is empathic and genuinely interested; the relationship is cooperation, not compliance. Its spirit rests on partnership, acceptance, compassion and evocation; it is not a trick to make people do what the dentist wants.

Principles (Cooper & Frain, Box 7.6, p. 46): express empathy · develop discrepancy between current behaviour and the patient's goals · resolve ambivalence · support self-efficacy and autonomy · roll with resistance · avoid argument.

Core skills: OARS

Open questions: "What would you like to change about your teeth?"
Affirmations: "You've already cut down on sugary drinks — that's a real step."
Reflections: "You'd like to keep your teeth, but evenings are so tiring that brushing gets skipped."
Summaries: draw together the patient's own reasons for change.

Listen for **change talk** ("I don't want to end up with dentures like my father") and reflect it back. Resist the **righting reflex** — the urge to argue for change, which provokes counter-arguments.

Miller & Rollnick, 2009, doi:10.1017/S1352465809005128 · Burt & Eklund, pp. 238–239 · Cooper & Frain, p. 46

Motivational interviewing in practice: scaling and goals

The importance–confidence ruler

"On a scale from 0 to 10, how important is it for you to clean between your teeth every day?" — "About 8."
"And how confident are you that you can do it?" — "Maybe 3."
"That's quite a gap. What makes it a 3 rather than a 1? What would move it to a 5?"

The same technique appears in Cooper & Frain's worked dialogue with a teenager with diabetes (confidence 3, wish 8), where the gap opens a conversation about the real barrier (Box 7.7, p. 47).

Evidence: a review for general dental practice included eight papers; all five randomised trials among them reported that interventions including MI improved oral health or health behaviour (Kay et al., 2016). Trials were few and heterogeneous: MI is promising, not a guaranteed effect.

SMART goals (Daly et al., p. 129)

Specific — "interdental brushes between the back teeth";
Measurable — "every evening";
Achievable — start with one side;
Relevant — linked to the patient's own reason (fresh breath for work);
Timely — "until your check-up in six weeks".

Then plan for success: practical steps, rewards, support from family or friends, and coping with high-risk situations; monitor and review at each visit (Daly, pp. 129–130).

Kay et al., 2016, doi:10.1038/sj.bdj.2016.952 · Cooper & Frain, p. 47 · Daly et al., pp. 129–130

From judgement to motivation (course case 2)

What was said

A 28-year-old man with long-standing caries: "Looks like you haven't seen a toothbrush in a long time!" He feels humiliated, asks nothing, does not return and describes the dentist online as "arrogant and rude".

Elicit–provide–elicit instead

Elicit: "What have you noticed about your teeth recently? What would you like to change?"
Provide: "May I tell you what I see? There are several cavities; most can be repaired if we start soon, and fluoride toothpaste twice a day will help protect the rest."
Elicit: "How does that sound to you? What would make brushing twice a day realistic for you?"

Shame drives avoidance. Feedback should be **specific, about behaviour and future-oriented**: describe findings neutrally, affirm the decision to come, agree one achievable step. Threatening, patronising or prescriptive styles do more harm than good (Daly, p. 129). The dental code requires respect for the patient's dignity (Art. 11(1)).

Course case 2 · Kay et al., 2016 · Daly et al., p. 129 · Dental code, Art. 11

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Shared decision-making

> *An approach where clinicians and patients make decisions together using the best available evidence. Patients are encouraged to think about the available screening, treatment, or management options and the likely benefits and harms of each so that they can communicate their preferences and help select the best course of action for them.*
>
> — Elwyn et al., 2010 (quoted in Cooper & Frain, p. 21)

Shared decision-making applies the definition of evidence-based medicine to the individual patient: best evidence + clinical expertise + the patient's values (Sackett, in Cooper & Frain, p. 21). It is not a priority in a true emergency, but it is the norm in routine care (p. 19).

What the evidence shows

- Over 30 years, the proportion of patients wishing to participate in decisions has risen to about three-quarters; a mismatch between preferred and actual participation increases anxiety (Cooper & Frain, p. 19).
- A Cochrane review of 105 trials (31,043 participants) found that decision aids increased knowledge (high-quality evidence), accuracy of risk perception and congruence between values and choices, and reduced decisional conflict, compared with usual care.
- Effects on behaviour and clinical outcomes are less clear (Shay & Lafata, in Cooper & Frain, p. 19).

Cooper & Frain, ch. 4, pp. 19–21 · Stacey et al., Cochrane 2017, doi:10.1002/14651858.CD001431.pub5 · Elwyn et al., 2012, doi:10.1007/s11606-012-2077-6

The three-talk model with a dental example

Step	Components (Elwyn et al., 2012)	Dental example: a fractured, root-filled molar
Choice talk	Step back; offer choice; justify choice (preferences matter); check reaction; defer closure if needed.	"There are several reasonable ways to deal with this tooth, and the best one depends on what matters to you. Shall we look at them together?"
Option talk	Check knowledge; list options; describe them; explain harms and benefits; provide decision support; summarise.	Crown on the existing tooth; extraction and implant; extraction and bridge; extraction only — each with durability, number of visits, risks and approximate cost.
Decision talk	Focus on preferences; elicit them; move to a decision; offer review.	"What matters most to you — keeping your own tooth, the time involved, the cost?" "Would you like to think about it until next week?"

Deliberation may need more than one visit. The patient moves from **initial preferences** to **informed preferences**, based on what matters most to them and an understanding of relevant benefits and harms (Figure 4.4, p. 24).

The MAGIC programme encourages patients to ask three questions: **What are my options? What are the benefits and harms? How likely are these?** A dental practice can display them in the waiting room (Cooper & Frain, p. 24).

Elwyn et al., 2012, doi:10.1007/s11606-012-2077-6 · Cooper & Frain, Box 4.2 (p. 23), pp. 24–25

Communicating risk: numbers people understand

Principle	Illustration (hypothetical numbers)
Natural frequencies	"Out of 100 people having this, about 2 have..." rather than "a 2% probability".
Absolute risk	"Halves the risk" may mean 2 in 100 → 1 in 100: one person in 100 benefits.
Balanced framing	"95 in 100 have no problem; 5 have...".
Personalise	"Because you smoke, this risk is higher for you."
Pictures	Icon arrays of 100 faces (Cates plots), option grids.
Uncertainty	"We cannot be sure; most people..."

Evidence

A Cochrane review of 35 studies (83 comparisons): **natural frequencies** were understood better than probabilities; **relative risk reductions** were not better understood than absolute ones but seemed larger and were more persuasive (Akl et al., 2011). Natural frequencies also help professionals reason about test results (Hoffrage et al., 2000).

Professional duty

Use the figures from the evidence for that procedure, not invented ones, and watch your own bias towards the option you prefer (Cooper & Frain, p. 22).

Akl et al., Cochrane 2011, doi:10.1002/14651858.CD006776.pub2 · Hoffrage et al., 2000, doi:10.1126/science.290.5500.2261 · Cooper & Frain, pp. 21–24

The consent conversation: what the law requires

> *To obtain informed consent, the treating physician (dentist) shall inform the patient ... about: 1. the diagnosis and nature of the disease; 2. a description of the aims and nature of the treatment, the reasonable alternatives, the expected results and the prognosis; 3. the potential risks of the proposed methods, including side effects and adverse drug reactions, pain and other discomfort; 4. the probability of a favourable effect, and the risk to health of other methods of treatment or of refusal.*
>
> — Health Act, Art. 88(1) (teaching translation)

Form — Art. 88(2): timely, and in an appropriate volume and form enabling free choice. Art. 89(1): for surgical interventions, general anaesthesia, invasive and other methods with increased risk or temporary change of consciousness, information and consent are **written**. The dental code also requires written consent for complex or expensive treatment (Art. 15(3)).

Standard — modern ethics uses the **prudent patient** standard: disclose what a reasonable person in the patient's position would consider significant, and what this particular patient would find important (ethics practical class 2). A small risk of altered lip sensation matters more to a professional wind musician.

Consent is a continuing process of understanding and agreement. The signature records the conversation; it does not replace it.

Health Act, Arts 88–89 · Dental code, Art. 15 · Department ethics book, ch. 2 and practical class 2

Course case 1 revisited: what the implant patient should have heard

Element	Content of a good consent conversation
Diagnosis and aim	Why an implant is proposed and what it will replace.
Nature of treatment	Stages, number of visits, local anaesthesia, healing time.
Alternatives	Bridge, removable denture, leaving the gap — with advantages, disadvantages and costs (code, Art. 15(1)).
Expected course	Swelling and discomfort for several days are expected; how to manage them.
Risks	Infection, bleeding, nerve injury, failure to integrate — honestly, without minimising or frightening, using the figures from the evidence.
Warning signs	What is **not** normal and whom to contact, including out of hours (safety-netting).
Questions and time	"What questions do you have?" — not "There is no need for so many questions."
Record	Written information and consent (Art. 89(1)); what was discussed, questions asked and the decision.

The first analysis question of the case — which techniques help anxious patients — is answered by NURSE, a stop signal, honest descriptions of sensation and a predictable plan. A prepared patient interprets expected swelling as healing, not as error.

Health Act, Arts 88–89 · Dental code, Art. 15 · course case 1

Capacity, minors and supported decisions

Decision-making capacity

A functional ability to make a particular decision at a particular time: to **understand** the information, **retain** it long enough, **use or weigh** it, and **communicate** a choice. An unwise choice does not prove incapacity. Support comes first: treat pain, choose a good time, use hearing aids, an interpreter, pictures, short chunks, a trusted supporter (ethics book, ch. 2).

For persons with mental disorders and established inability to consent, consent is given by the persons designated under Art. 162(3) (Health Act, Art. 87(7)); for higher-risk methods, additional safeguards apply (Art. 89(3)).

Children and adolescents in Bulgarian law

- **Under 14**: consent is given by a parent or guardian (Art. 87(4)).
- **14–17**: the minor's consent **and** that of a parent or curator (Art. 87(2)).
- **From 16**: parental consent is not required for health consultations, preventive examinations and tests specified by ordinance (Art. 87(3)).

A child who cannot consent can still be informed honestly and asked for **assent**; passive compliance is not assent.

Health Act, Arts 87, 89 · Department ethics book, ch. 2 (capacity table; minors table)

Refusal and the right not to know

Refusal (Health Act, Art. 90)

A capable patient may refuse proposed care, or its continuation, at any time (90(1)). The refusal is certified in the records with the patient's signature (90(2)); if the patient cannot or will not sign, by the treating dentist and a witness (90(3)). The patient may withdraw the refusal at any time (90(5)). Where a refusal threatens life, the head of the healthcare establishment may decide on life-saving treatment (90(4)); the emergency exception to written consent is a separate rule (89(2)).

Communicate: explore the reason (fear, cost, mistrust, misinformation, culture); explain the consequences of not treating (Art. 88(1), item 4); offer alternatives, a second opinion (Art. 86(1), item 4) or time.

The right not to be informed (Art. 92(2)–(4))

A patient may refuse to be informed about the disease and its prognosis, and about the planned activities and their risks, unless their condition endangers the health of others. The decision is recorded in writing; the patient may authorise another person in writing to be informed instead.

A useful phrase

"It is your decision, and I will respect it. I want to be sure you have what you need to decide. If you change your mind, we can start whenever you are ready."

Health Act, Arts 86, 88–90, 92 · Department ethics book, ch. 2

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Health literacy and oral health literacy

- **Health literacy** (Ratzan and Parker, 2000): an individual's capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions.
- **Oral health literacy** (NIDCR working group): the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate **oral** health decisions.
- Newer definitions add that health literacy is not only an individual skill: it depends on the demands and complexity of the health system, and it should link informed decisions with action (Burt & Eklund, p. 247).

Three types (Nutbeam)

1. **Functional** — basic reading and writing skills for everyday situations (reading the label on mouthwash).
2. **Interactive** — cognitive and social skills to extract meaning from different forms of communication and apply new information (asking the dentist the right questions).
3. **Critical** — analysing information and using it to take action, including in the community (judging a "natural whitening" post on social media).

Health literacy is an **outcome** of effective health education, which is one part of health promotion (Ottawa Charter) (p. 247).

Burt & Eklund, 7th ed., ch. 22 (Kohli & Schwarz), pp. 247–248 · Sørensen et al., 2012, doi:10.1186/1471-2458-12-80

Limited health literacy is common — and most common in Bulgaria

European Health Literacy Survey (HLS-EU)

Eight countries, 1,000 respondents each (8,000 in total), 2011. **47.6%** of respondents had limited (inadequate or problematic) health literacy and about 12% inadequate. The share of limited health literacy ranged from **28.7% in the Netherlands to 62.1% in Bulgaria**; inadequate health literacy from 1.8% to **26.9% (Bulgaria)**. Financial deprivation, low social status, low education and old age were associated with higher proportions — a **social gradient**.

Consequences in dentistry

- In the USA, 44% of adults with below-basic health literacy had a dental visit in the past year, against 77% of those with proficient health literacy (Burt & Eklund, p. 249).
- Low health literacy is associated with more emergency care, less preventive care, missed appointments and poorer oral health (p. 249).
- In 150 dental-school patients, limited oral health literacy was associated with poorer periodontal status (Baskaradoss, 2018; cross-sectional).

In a Bulgarian dental surgery, assume that a large share of patients will struggle with written forms, numbers and technical words — and design every explanation accordingly.

Sørensen et al., 2015, doi:10.1093/eurpub/ckv043 · Burt & Eklund, p. 249 · Baskaradoss, 2018, doi:10.1186/s12903-018-0640-1

Recognising limited health literacy

A case from the textbook (Burt & Eklund, Box 22.1, p. 250)

A 35-year-old man returns after two years with deep "notches" worn into the proximal surfaces of almost all his teeth. Asked about it, he says: "Well, you told me to use a see-sawing motion with the dental floss for 10 seconds on each tooth." The instruction was followed exactly — and understood wrongly.

Warning signs: forms left incomplete or filled in by a companion; "I forgot my glasses"; not knowing the names of one's medicines; missed appointments; nodding without questions.

Three screening questions (Chew et al., in Burt & Eklund, p. 251)

1. "How often do you have someone help you read hospital materials?"
2. "How often do you have problems learning about your medical condition because of difficulty understanding written information?"
3. "How confident are you filling out forms by yourself?"

Formal oral health literacy instruments include REALD-30 (word recognition), TOFHLiD (reading comprehension and numeracy) and HeLD; most are biased towards word recognition rather than decisions and use of services (p. 249).

Burt & Eklund, 7th ed., pp. 249–251

“Universal precautions”: explain so that everyone understands

Technique	How (Burt & Eklund, Table 22.2)
Understandable language	Simple words; speak slowly; **two or three concepts at a time**; draw or use pictures.
Teach-back	Ask the patient to repeat the instructions or to say what they will do at home.
Help understanding	Underline key points in printed material; read instructions aloud; follow up by phone.
Patient-friendly materials	Models, radiographs, photographs, short videos, leaflets.
Patient-friendly environment	Ask how the patient learns best; use an interpreter.

Judging written materials (Daly et al., Box 10.4, p. 131)

Funding source and conflicts of interest; development process; objectives; target audience; scientific content and sources; presentation quality; appeal; equal opportunities and diversity; **understandability** (jargon, dense text, plain language); practical focus.

Ask Me 3 encourages patients to ask: What is my main problem? What do I need to do? Why is it important for me to do this? (p. 251). A good explanation answers all three without being asked.

Because limited health literacy is not visible, plain language and teach-back are used with patient, not only with those who “seem” to need them.

Burt & Eklund, pp. 250–251 · Daly et al., 2013, p. 131

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Dental fear, anxiety and phobia

- **Fear** is a reaction to a real, present stimulus (the needle, the drill); **anxiety** is apprehension about something anticipated or unknown. Both are shaped by past experience, observing others' reactions and rumours (Yolov, p. 95).
- **Dental phobia** is an overwhelming, persistent fear that makes treatment impossible or very difficult; it can occur at any age and in either sex, and its development is multifactorial — past experiences, observation of others, pain sensitivity and individual factors (p. 96).
- Reactions are **emotional** (tension, unease), **vegetative** (pallor, sweating, tachycardia, changes in blood pressure) and **psychomotor** (anxious face, agitation or freezing) (p. 95). The more anxious the patient, the lower the pain threshold (p. 88).

Four types of dental phobia (Moore, Brødsgaard & Birn, 1991; Yolov, p. 96)

1. Fear of specific painful or unpleasant stimuli (needle, drill, sounds, smells).
2. Fear of a bodily reaction (allergy to the anaesthetic, fainting, panic attack).
3. Generalised anxiety or multiple phobias.
4. Distrust of dental personnel, linked to social fears.

The type matters: the first responds to desensitisation and control, the fourth to trust built over time.

Yolov, pp. 88, 94–96

How common is dental fear, and how is it measured?

Adults (Silveira et al., 2021)

31 population-based studies, 72,577 adults; 28 studies at high risk of bias. Pooled prevalence: dental fear and anxiety **15.3%** (95% CI 10.2–21.2), high **12.4%** (9.5–15.6), severe **3.3%** (0.9–7.1). Higher in women and younger adults.

Children and adolescents (Grisolia et al., 2021)

50 studies, none of high methodological quality. Overall **23.9%** (20.4–27.3): preschoolers 36.5%, schoolchildren 25.8%, adolescents 13.3%. The scale used influenced the estimate.

Measurement: Corah's Dental Anxiety Scale (1969) was the first widely used instrument. The **Modified Dental Anxiety Scale (MDAS)** has five questions (tomorrow's visit, waiting room, drilling, scaling, injection), each scored 1–5, total 5–25; a score of 19 or more indicates high dental anxiety. In a UK population sample of 1,000 adults, 11.6% scored at or above it (Humphris et al., 2009). Armfield and Heaton estimate that about one person in seven is highly anxious about dental treatment (2013). A screening score supports a conversation; it is not a diagnosis of specific phobia.

doi:10.1016/j.jdent.2021.103632 · doi:10.1111/ipd.12712 · doi:10.1186/1472-6831-9-20 · Corah, 1969, doi:10.1177/00220345690480041801 · Armfield & Heaton, 2013, doi:10.1111/adj.12118

Communicating with and managing the anxious adult

Principle	What to do
Identify and ask	"How do you feel about dental treatment?" Ask what exactly is frightening: needle, sound, gagging, loss of control, past pain, embarrassment. Use the MDAS if helpful.
Give control	Stop signal, explanation before each step, breaks, tell–show–do with adults too.
Predictability	Honest description of sensations; no false promises.
Pace and plan	Start with simple, non-invasive visits where possible; build trust step by step (phased treatment).
Psychological techniques	Relaxation and controlled breathing, distraction, cognitive restructuring of catastrophic beliefs, systematic desensitisation; hypnosis and CBT need specialist training.
Refer when needed	Severe anxiety or phobia may need psychological treatment or sedation services.

Feldbau's four rules (Yolov, p. 97)

1. Assess the level of anxiety and stress carefully by questioning.
2. Choose methods of pain and anxiety control on the basis of the patient's health and psychological profile.
3. Use medicines as an aid, not as **the** method of control.
4. Relaxation techniques (progressive muscle relaxation, abdominal breathing) help.

A review of 22 RCTs in adults found the strongest evidence for CBT, including one-session formats (Gordon et al., 2013). Approaches must be individualised; one method for everyone fails (Yolov, p. 97).

Yolov, pp. 96–97 · Armfield & Heaton, 2013 · Gordon et al., 2013, doi:10.1016/j.janxdis.2013.04.002 · Appukuttan, 2016, doi:10.2147/CCIDE.S63626

Children and parents: a triadic consultation

Communicating with the child

- Young children may give procedures a "magical" quality or see the visit as punishment; parents should not threaten children with the dentist. The **first visits** leave a lasting attitude (Yolov, p. 89).
- **Tell–show–do**: explain in words suited to age, demonstrate on a finger or a model, then do.
- Specific, frequent praise; clear, firm instructions when behaviour endangers treatment; a calm, moderately loud voice.
- **Modelling**: films of other children coping helped fearful children (Melamed and Siegel, in Yolov, p. 89).
- Answer the child's questions honestly, in non-threatening words.

The parent

In the triadic consultation each party has a hidden agenda: the child's fears, the parent's worries ("Is it something serious?"), the clinician's time pressure (Cooper & Frain, Figure 7.1, p. 42). Speak to the child directly, let them describe symptoms in their own words, and involve them in decisions to the extent of their understanding (p. 41).

Agree the plan with the parent first; ask how the child usually copes; give the parent a role (calm presence, holding a hand). Parental anxiety is transmitted to the child. Consent: Health Act, Art. 87(4) — but the child is still informed and asked to cooperate.

Yolov, p. 89 · Cooper & Frain, ch. 7, pp. 41–42 · Roberts et al., 2010, doi:10.1007/BF03262738 · Grisolia et al., 2021

Adolescents: autonomy, confidentiality and its limits

Young people want to be listened to, respected and involved, and are moving from reliance on carers towards responsibility for their own health. Give them time to be seen **alone** for at least part of the consultation, to uncover a hidden agenda (Cooper & Frain, p. 44).

HEADSSS (Home, Education, Activities, Drugs, Sex, Self-harm and self-image, Safety) is a framework for difficult questions; "normalising" helps: "Many young people try smoking or vaping at this age — is that something your friends do? What about you?" (pp. 44–45).

Dental relevance

Smoking and vaping, energy drinks, eating disorders (enamel erosion), sports trauma, piercings, appearance concerns in orthodontics, signs of neglect or abuse.

Legal frame

At 14–17, the adolescent's consent and a parent's are needed (Art. 87(2)); from 16, not for specified consultations and preventive examinations (Art. 87(3)). Explain **confidentiality and its limits** at the start, especially where safeguarding concerns may arise (Cooper & Frain, p. 44).

Cooper & Frain, ch. 7, pp. 44–46 (Boxes 7.4–7.5) · Health Act, Art. 87(2)–(3)

Older people, dementia and disability

Older patients (Yolov, p. 90; Daly, ch. 16)

Dental needs rise with age while attendance falls: poorer general health, reduced mobility, sensory loss, depression, cognitive impairment, dementia or Parkinson's disease can reduce self-care and attendance. Daly et al. describe barriers in residential care and call for oral health to be part of every health and social care assessment (pp. 181–183).

Communication: good light, face the patient, check hearing aids and glasses, speak slowly without shouting, one idea at a time, written summaries in large print; involve carers **with the patient's consent**; in dementia, short sentences, familiar routines, calm tone and attention to non-verbal signs of pain.

People with disabilities and learning disabilities

Some depend on family, carers or support workers for self-care and access to services (Daly, p. 175). Address the person first; adapt the format (pictures, easy-read leaflets, extra time, a get-to-know visit); agree yes/no signals. Disability alone does not mean incapacity. Where a person has a legal guardian, the guardian consents (Health Act, Art. 87(4)); for persons with mental disorders and established inability to consent, consent is given by the persons designated under Art. 162(3) (Art. 87(7)); emergencies follow Art. 89(2).

Seldom-heard groups include people with sensory impairment or learning disability, carers, asylum-seekers and minorities (Cooper & Frain, Box 7.8, p. 47).

Yolov, p. 90 · Daly et al., 2013, ch. 16, pp. 175–183 · Cooper & Frain, p. 47 · Health Act, Art. 87(7)

Language barriers: understanding is a patient right

Working with an interpreter (Cooper & Frain, Box 7.2, p. 43)

- Use a trained interpreter for history, consent and bad news; brief them: translate everything, without own interpretation; confidentiality.
- Speak to and look at the **patient**, not the interpreter; speak slowly rather than loudly; short segments with pauses.
- Watch for signs of poor interpretation (a long explanation rendered in one sentence).
- Do not confuse a language barrier with poor cognition — and remember that interpretation does not guarantee understanding: use teach-back.

Avoid where possible

Family members or friends; **children under 18**; untrained volunteers; other patients; internet translation for important information (p. 43). An interpreter from the same close community may inhibit disclosure; one may soften bad news.

A systematic review of 28 studies found that professional interpreters were associated with fewer communication errors, better comprehension and outcomes, and higher satisfaction than ad hoc interpreters (Karliner et al., 2007). Health Act, Art. 86(1), items 7–8: accessible language and clear information. In an emergency, communicate as well as possible and record how information was given.

Cooper & Frain, ch. 7, p. 43 · Karliner et al., 2007, doi:10.1111/j.1475-6773.2006.00629.x · Health Act, Art. 86

Culture, typologies and the danger of labels

Cultural competence (Nathe, ch. 11, p. 147)

Transcultural communication is the ability to interpret and transmit information to someone from a different culture. Beware the **cultural blind-spot syndrome**: assuming that a patient who looks and behaves like you has no cultural differences. Develop sensitivity by examining your own beliefs and biases and learning the patient's belief system.

Cooper & Frain describe a woman recently arrived from India whose rocking and chanting were diagnosed as psychosis; they were prayers for her unborn child (p. 51). Culture shapes eye contact, touch, who decides and how pain is expressed — ask, do not assume.

Patient typology in the Bulgarian literature (Yolov, pp. 87–88)

Patients with **preconceived** views (closed, suspicious); "**difficult**" patients (do not follow advice, very anxious, including phobic); **pretentious** patients (demand inappropriate treatment — answer firmly and professionally); **aggressive** patients (often in pain or with neglected disease — stay calm, invite specific complaints); **burdened** patients (feel disfigured; need tact, warmth, unconditional positive regard); **supportive** patients (punctual, cooperative).

A typology helps anticipate needs; used as a label it becomes a self-fulfilling prophecy. Describe the behaviour, not the person.

Nathe, 2017, p. 147 · Cooper & Frain, p. 51 · Yolov, pp. 87–88

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Anger and conflict: understand before you respond

Anger usually covers another feeling: pain, fear, exhaustion, helplessness, feeling ignored or blamed (Cooper & Frain, pp. 41–43, 51). In Cooper and Frain's case, a mother of a child with mouth ulcers became hostile because she felt accused of neglect and was in pain herself.

Recommended approach (pp. 41–43)

Non-threatening body language · acknowledge the concern and show empathy · an open question: "You seem very angry — why is that?" ("remember it is the mother who is angry, not you") · acknowledge the limits of treatment honestly · acknowledge what the person did right · summarise and allow time for questions.

Conflict styles (Borisova & Veder, p. 169): the **rational** type stays calm and keeps long-term goals; the **strong** type flares up quickly but forgets quickly; the **harmonious** type avoids conflict at almost any cost.

A checklist for conflict conversations (pp. 170–171)

Show understanding for emotional outbursts; plan the conversation; stay calm so that the other can "let off steam"; propose a solution; find a friendly word to close; take the first step to restore the relationship; apologise for any sharp words of your own.

Cooper & Frain, ch. 7, pp. 41–43; ch. 8, p. 51 · Borisova & Veder, pp. 168–171

The aggressive patient: safety first, then de-escalation

Step	Practice
Protect safety	Keep a clear exit, put instruments away, do not stay alone with a threatening person; call colleagues or security.
Lower the temperature	Calm voice, open posture, sit if possible; let the patient speak; avoid arguing or correcting at once; do not take the tone personally (Yolov, p. 88).
Acknowledge	"You have been waiting in pain for an hour; I can see why you are angry." Acknowledging is not admitting fault.
Set limits	"I want to help you, and I can do that if we speak without shouting." State clearly what is not acceptable.
Offer a way forward	What can be done now (pain relief, a time), and by whom.
Afterwards	Record the incident, debrief the team, review causes such as waiting times and information at reception.

The code allows a dentist to decline to treat when the necessary trust is absent (Art. 11(3)), but the duty to assist in an emergency remains (Art. 13). Violence is never part of the job.

Yolov, p. 88 · Cooper & Frain, pp. 41–43 · Dental code, Arts 11, 13

Complaints: listen, acknowledge, resolve

A constructive response

Listen without interrupting; thank the patient for raising it; apologise for the experience; establish the facts from the records; explain what happened in plain language; agree what will be done and when; follow up. Distinguish an **expected effect**, a **complication** and an **error** — and say which it was.

What makes it worse

Defensiveness, blaming the patient, jargon, delay, discussing the case with others, editing records afterwards, or disparaging the previous dentist (Arts 17–18).

> *If a patient or the patient's legal representative states that he or she intends to file a complaint against a dentist, the dentist must make every reasonable effort to resolve the problem on the spot.*
>
> — Code of Professional Ethics of Dentists, Art. 15(4) (teaching translation)

Course case 4: assess first — pain two days after an extraction may be dry socket, normal post-operative inflammation or infection; smoking is a risk factor, not proof of cause. Treat, then review the instructions together, without accusation. Responding to a complaint is one of the domains of advanced communication that professionals should reflect on (Cooper & Frain, Box 1.6, p. 4).

Breaking bad news: SPIKES for a suspicious oral lesion

Step	Dental application
Setting	Patient upright, mask off, privacy, enough time; ask whether they want someone with them.
Perception	"What have you noticed about this area? What did you think it might be?"
Invitation	"Would you like me to explain everything I see, or the main points now?" A patient may decline information on the disease and prognosis or on planned activities and their risks, unless their condition endangers others; the decision is recorded in writing (Health Act, Art. 92(2)–(3)). Declining information is not refusing referral (Art. 90).
Knowledge	Warning shot, then plain words: "I cannot tell what this is from the examination alone. It needs prompt specialist assessment and possibly a small tissue test (biopsy)."
Emotions / empathy	Pause; respond with NURSE; tolerate silence — silence after bad news is not a failure of communication (ethics book, ch. 4).
Strategy and summary	Concrete referral, timescale, written information, how results will be communicated, follow-up contact.

Bad news in dentistry also includes a hopeless tooth, a failed implant, the need for full dentures or an unexpected cost; its weight depends on what the person expected and values. Never give a diagnosis before it exists, and never hide the need for urgent investigation. Protocols are memory aids, not scripts (ethics book, ch. 4).

Baile et al., 2000, doi:10.1634/theoncologist.5-4-302 · Cooper & Frain, Figure 9.2, p. 56 · Department ethics book, ch. 4

When something goes wrong: disclosure and apology

What patients want (Gallagher et al., 2003)

Thirteen focus groups with 52 patients and 46 physicians. Patients wanted disclosure of **all harmful errors**: what happened, why, how the consequences will be mitigated and how recurrence will be prevented — and emotional support including an **apology**. Physicians disclosed the adverse event but often avoided saying that an error occurred, why, or how recurrence would be prevented; they feared that an apology creates liability.

A structure for disclosure

1. Prepare: facts, a private setting, the right people.
2. Say what happened, in plain words, without speculation or blame.
3. Apologise sincerely: "I am sorry this happened."
4. Explain what will be done now for the patient.
5. Explain what will be done so that it does not happen again.
6. Document and report through the clinic's procedures; offer follow-up.

Patient safety stands above personal and professional loyalty (dental code, Art. 12(1)). Concealing an error enlarges both the harm and the loss of trust (ethics book, ch. 3). Borisova and Veder note that people forgive unintentional mistakes but not bad intentions or pride; a sincere apology strengthens the relationship (p. 168). Professionals involved in errors also need support (Gallagher et al., 2003).

Gallagher et al., 2003, doi:10.1001/jama.289.8.1001 · Dental code, Art. 12 · Department ethics book, ch. 3 · Borisova & Veder, p. 168

Withheld information: build safety for disclosure (course case 5)

Course case 5

A 60-year-old woman taking anticoagulants and antihypertensives does not mention them, fearing that her extraction will be postponed. Profuse bleeding follows.

Ask so that honesty feels safe:

"Many people take blood thinners or blood-pressure tablets. Which medicines do you take, including those from other doctors?"

"Knowing this does not usually mean we cannot treat you; it lets us do it safely."

Normalising statements make a sensitive answer easier, as in HEADSSS (Cooper & Frain, p. 44). Explaining the rationale for the question is itself a Calgary–Cambridge skill (p. 11).

Make it a system, not luck:

Written medical history updated at each course of treatment; verbal check before every invasive procedure; bring the medicines or a list; documented in the record (code, Art. 25(1)); a visible alert in the electronic record.

Patients rarely conceal information out of malice; they conceal it out of fear. Non-judgemental questions and a predictable routine protect both sides.

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Team communication and speaking up

Ineffective communication within and between teams contributes to a large share of clinical errors (Cooper & Frain, p. 4). Human-factors training teaches:

- **State the obvious** — what is obvious to you may not be obvious to others.
- **Avoid "problematic pronouns"** ("he", "it", "that one"): "the **upper left** first molar, tooth 26".
- **Readback**: repeat back key information ("Articaine with adrenaline, one cartridge — correct?").
- **Red flags**: confusion, conflicting information, departure from standard procedure, unease — a cue to stop and talk (Box 5.2, p. 30).

PACE: raising a concern in graded steps (Box 5.3, p. 31)

Probe: "Do you know that the patient reported a penicillin allergy?"
Alert: "I'm worried about this prescription. Can we check the record?"
Challenge: "Please stop before we hand it to the patient."
Emergency: "STOP!"

In the Elaine Bromiley case, nurses prepared a tracheostomy kit and alerted intensive care, but felt unable to press their concerns, and their signals were not acted on; hierarchy made assertiveness difficult (p. 31). Speaking up and listening to concerns both matter. In the dental surgery, the assistant must feel able to speak to the dentist.

Cooper & Frain, ch. 5 (Cracknell & Cooper), pp. 29–31

SBAR(R): structured handover (course case 3)

Course case 3

A patient reports a penicillin allergy. The dentist is in a hurry and does not record it. At the next visit an assistant, following a "standard protocol", issues a prescription for a penicillin-containing antibiotic. The patient has an allergic reaction and files a complaint.

SBARR	**Handover of a concern within the team**
Situation	"Mr P. is in for a dental infection today and reports a penicillin allergy."
Background	"He had a rash and swelling after amoxicillin; it is now in his record and on the alert screen."
Assessment	"The penicillin-based antibiotic in our standard protocol must not be given to him."
Recommendation	"Please check with me before any prescription. I will decide whether an antibiotic is indicated at all and, if it is, choose a suitable agent."
Readback	Assistant: "So: no penicillin for Mr P., and I'll ask you before any prescription."

Listening is not just hearing: it ends with documentation and transmission. A "standard protocol" never overrides a recorded contraindication. SBARR has been shown to improve the effectiveness of communication and to take less time (Cooper & Frain, Figure 6.3, p. 39).

Haig et al., 2006, doi:10.1016/S1553-7250(06)32022-3 · Cooper & Frain, p. 39 · Dental code, Art. 25

Checklists and “time out”: preventing wrong-tooth errors

The WHO Surgical Safety Checklist requires the team to introduce themselves by name and role, confirm the patient’s identity, the procedure, the site and consent, and verbalise known allergies and anticipated critical events.

In eight pilot hospitals, implementation was followed by a fall in major in-patient complications from **11% to 7%** and in in-patient deaths after major surgery from **1.5% to 0.8%** (Haynes et al., 2009; before–after study, Cooper & Frain, p. 34).

A dental time-out before an extraction

- Who is the patient? (name and date of birth, not “the 10 o’clock”)
- Which tooth? (FDI number, checked against the radiograph and referral; the patient points to it)
- What procedure, and was consent obtained?
- Allergies, anticoagulants, medical alerts?
- Equipment and emergency drugs ready?

A checklist reduces reliance on memory and flattens hierarchy: it gives everyone permission to speak.

Haynes et al., 2009, doi:10.1056/NEJMsa0810119 · Cooper & Frain, ch. 5, pp. 33–34

The record as communication — and confidentiality

Good record-keeping (Cooper & Frain, ch. 6, pp. 35, 38)

Accurate, concise, legible, contemporaneous, signed, dated and timed. Identify the patient on every page. Record findings, diagnoses, plans and **what information was given to the patient**. Corrections: a single line through the error, dated and signed — never remove or obliterate entries. Never use pejorative terms. Avoid ambiguous abbreviations.

In Bulgaria the record must contain the refusal of treatment with signatures (Health Act, Art. 90(2)–(3)) and a decision not to be informed (Art. 92(3)); the dental code requires complete documentation (Art. 25). Patients have the right of access to their records (Art. 86(1), item 13).

Confidentiality in everyday communication

Confidentiality covers the fact that a person attended, appointments, images and prescriptions, not only diagnoses (ethics book, ch. 3). Typical breaches: talking about a patient in the corridor or waiting room; a computer screen visible to others; calling out a diagnosis at reception; a clinical photograph in a group chat; telling a relative without the patient's permission. Share within the team what is needed for care — the minimum necessary.

Cooper & Frain, ch. 6, pp. 35–40 (Boxes 6.2, Figure 6.2) · Department ethics book, ch. 3 · Health Act, Arts 86, 90, 92 · Dental code, Art. 25

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A phrase bank: what to avoid and what to prefer

Avoid	Prefer
"Don't worry, it won't hurt."	"You will feel pressure. If anything feels sharp, raise your hand and I will stop."
"There is no need for so many questions."	"Good question. What else would you like to know?"
"Do you understand?"	"Can you tell me in your own words what you will do tonight?"
"You haven't brushed for ages."	"There are several cavities. Let's look at what would make cleaning easier for you."
"Who did this terrible filling?"	"This filling needs replacing; let me explain why."
"You must have this done."	"I recommend this because...; the other options are...; what matters most to you?"
"It reduces the risk by 50%."	"Without it about 2 in 100 people...; with it about 1 in 100." (with the real figures)
"Calm down!"	"I can see you are upset. Tell me what happened."
"Your son can translate."	"I'll call an interpreter so that you can ask me everything directly."

Synthesis of the sources cited in this lecture; dental code, Arts 11, 15, 18

Communication skills can be learned

A Cochrane review of 76 studies concluded that communication training **may** improve medical students' overall communication skills and empathy compared with no training. Benefits appeared in expert-rated assessments but not consistently in simulated-patient ratings; effect sizes varied and most evidence was of low quality.

System-wide, relationship-centred training has a measurable effect on patient satisfaction, and short training (under 10 hours) can be as successful as longer courses (Cooper & Frain, p. 4). Skills do not improve automatically with experience; they need observation, feedback and reflection.

How this course continues

Class 13 analyses challenging clinical situations in depth — anxiety and consent, shame and motivation, after-care and blame, withheld information, children, language barriers, aggression, bad news and refusal — with worked model dialogues.

Class 14 teaches how to analyse a dentist–patient communication in writing, with full model analyses for both options of the individual assignment.

Gilligan et al., Cochrane 2021, doi:10.1002/14651858.CD012418.pub2 · Cooper & Frain, p. 4

Review questions

1. Name the elements of the communication process and three types of barrier, with a dental example of each.
2. Compare the Szasz–Hollender and Emanuel models. Which fits a capable adult choosing between an implant and a bridge?
3. List the five tasks and two threads of the Calgary–Cambridge guide.
4. What do ICE, NURSE, SPIKES, BATHE and SBARR stand for?
5. Why is teach-back better than "Do you understand?"
6. Explain the difference between relative and absolute risk with an example.
7. What proportion of Bulgarian respondents in HLS-EU had limited health literacy, and what follows for practice?
8. What does the Health Act require for consent to a surgical dental procedure, and how is a refusal documented?
9. Describe tell–show–do and the role of the parent.
10. What do patients want after a harmful error?

Patients judge dental care by what they understand and how they were treated. Communication is the part of care they can always see.

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Thank you for your attention!