Communication in challenging clinical situations

Eight dental scenarios analysed: evidence, recommended structure, helpful and harmful phrases, and annotated model dialogues

Practical Class 13 · Social Medicine with Medical Ethics · Dental Medicine (English) · 2026/2027

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Why a lecture on challenging situations?

Most consultations go well with the core skills from class 12. Some do not: the patient is terrified, ashamed, angry, unable to understand our language, hiding something, or facing bad news. These situations can contribute to complaints, avoidable harm and the stress dentists report.

Silverman's advice is not to invent a new set of skills for each difficult situation. Once the core tasks and skills are mastered, challenges such as anger, breaking bad news or diversity are tackled by using particular subsets of the same skills "with greater intention, intensity and awareness" (Cooper & Frain, p. 8).

How each scenario is taught today

1. **The situation** — from the department's case collection or of a type named in the official task.
2. **What the evidence and the law say** — the mechanism of the difficulty.
3. **A recommended structure** — the order of steps.
4. **Phrases that help and phrases that harm.**
5. **An annotated model dialogue** — what the dentist says and why.

The syllabus title of this class is "Role plays"; the last part of the lecture explains how simulation is used to practise exactly these situations.

Cooper & Frain (eds), ABC of Clinical Communication, 2018, p. 8 · course syllabus SMME DM, class 13

What you should be able to do after this lecture

1. Explain what makes a dental consultation difficult, using patient, clinician and context factors.
2. For each of eight situations, describe the mechanism of the difficulty and the evidence or legal duty that shapes the dentist's response.
3. Apply a recommended structure and choose phrases that help rather than harm.
4. Read and write an annotated model dialogue, naming the technique behind each move.
5. Explain how simulation, role play, observation and structured feedback are used to learn these skills.

Resources: 15-minute reading · student tasks. The analyses here are models for option 1 and option 2 of the individual written assignment (class 14), but the assignment must use your own words.

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1. **A framework for difficult situations**
2. Scenarios 1–4: the department's course cases
3. Scenarios 5–8: situation types named in the official task
4. The team and the system
5. How simulation and role play are used

What makes a situation difficult?

Source	Examples	What the dentist can influence
Patient	Fear and phobia, pain, shame, anger, mistrust, limited health literacy, a foreign language, cognitive impairment, cultural expectations, previous bad experiences.	Exploring and acknowledging; adapting language and pace; interpreters; written and visual information.
Clinician	Time pressure, fatigue, irritation, own anxiety, defensiveness after a complaint, unconscious bias, the "righting reflex".	Self-awareness, preparation, a pause before responding, asking for help; stress and burnout (class 11) worsen communication.
Relationship	Unequal power, cost and commercial pressure, a broken previous relationship, a third party (parent, interpreter, relative).	Transparency on options and costs; speaking to the patient directly; clarifying roles.
Context	Waiting times, noise, no privacy, interruptions, a hierarchy that silences the assistant, missing records.	Scheduling, safe systems (alerts, checklists), team communication.

Cooper and Frain's model of patient-centredness shows the same layers: doctor factors, patient factors, consultation-level influences (barriers, interruptions, third parties, time) and wider "shapers" such as culture, training and professional norms (Figure 1.2, p. 3). An anxious patient can transfer anxiety to the dentist, increasing tension and fatigue (Yolov, p. 88).

Cooper & Frain, p. 3 · Yolov & Yaneva (eds), 2011, p. 88

One core structure for every difficult conversation

Step	Content
1. Prepare	Facts, records, the right setting, time, an interpreter, your own state.
2. Open	Greet, introduce yourself and your role, agree the purpose.
3. Explore	What the patient knows, fears and expects (ICE); emotions first (NURSE).
4. Explain	Chunk and check, plain language, honest uncertainty, options.
5. Agree	A shared plan or a respected refusal; limits where needed.
6. Close	Summary, teach-back, safety-net, follow-up.
7. Document and reflect	Record what was said and decided; debrief the team; learn.

The ethics book's sequence for a difficult conversation

1. Prepare. 2. Establish perspective. 3. Invite information preferences. 4. Give a warning and explain. 5. Respond to emotion. 6. Plan — summarise, identify support, arrange follow-up.

Difficult consultations will not always proceed according to the dentist's agenda; flexibility is required, and reflecting afterwards builds skill and confidence (Cooper & Frain, ch. 7, p. 41).

Department ethics book, ch. 4 ("A difficult conversation") · Cooper & Frain, pp. 11, 41

How to read an annotated model dialogue

A model dialogue is not a script to memorise. It shows one good way through the situation and makes the reasoning visible. In the tables that follow, the right-hand column names the technique:

Label	Meaning
ICE	Ideas, concerns, expectations explored
NURSE	Naming, understanding, respecting, supporting or exploring emotion
Chunk / check	Small block of information, then a check
Options	Alternatives, risks and costs presented
Teach-back	Patient restates in own words
Safety-net	What to watch for and whom to call
Limit	A clear boundary on behaviour

Questions to ask of any dialogue

- Where did the patient's agenda appear, and did the dentist pick it up?
- Was emotion addressed before information?
- Could the patient say in their own words what will happen?
- Was a legal or ethical duty met (consent, refusal, records, complaint)?
- What would **you** find hardest to say, and how would you prepare it?

These are also the questions behind "depth of analysis/reflection", one of the three criteria of the class 14 assignment.

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Scenario 1 · The anxious implant patient (course case 1): the theory

The situation

A 45-year-old woman, slightly anxious, asks before implant placement whether it will hurt. The dentist says: "It's okay, everything will be fine, there is no need for so many questions", and obtains no written consent. Swelling and pain follow; she believes something went wrong, stops attending and posts a negative review.

Mechanism. Anxiety is anticipation of the unknown (Yolov, p. 95). Dismissive reassurance leaves the unknown untouched and adds the message that questions are unwelcome. Without preparation, an **expected** post-operative course (swelling, pain for several days) is interpreted as a **complication or error**. The patient had no way of telling them apart.

Law and code. Implant placement is a surgical intervention: information and consent must be written (Health Act, Art. 89(1)); content per Art. 88(1); alternatives and approximate costs before treatment (code, Art. 15(1)–(3)). **Evidence:** good communication and establishing rapport are the first layer of non-pharmacological anxiety management (Armfield & Heaton, 2013); predictability and control reduce anxiety (Yolov, pp. 93, 96).

Course case 1 · Health Act, Arts 88–89 · Dental code, Art. 15 · Armfield & Heaton, 2013, doi:10.1111/adj.12118 · Yolov, pp. 93–96

Scenario 1 · Recommended structure and phrases

Phrases that harm	Phrases that help
"Everything will be fine."	"It's a good question — many people worry about that. Let me tell you exactly what you will feel."
"There is no need for so many questions."	"What else would you like to know before we decide?"
"It won't hurt at all."	"You will feel pressure but not sharp pain; if anything feels sharp, raise your hand."
"Just sign here."	"This form summarises what we discussed. Read it, and ask about anything that is unclear."

Recommended structure: invite the question → name the fear (NURSE) → explain what she will feel during and after → options and risks (written consent) → stop signal → safety-net → teach-back.

Scenario 1 · An annotated model dialogue

Speaker	Model dialogue	What the dentist is doing
Patient	Will it hurt?	
Dentist	That's an important question, and it sounds as if you're a bit worried. Has someone told you about their implant?	Welcomes question · NURSE (name) · ICE
Patient	A friend said she couldn't eat for a week.	
Dentist	No wonder you're anxious. During the procedure the area is fully numb; you'll feel pressure and vibration. Afterwards, some swelling and soreness for three to five days are expected — part of healing.	NURSE (understand) · chunk 1: sensation and expected course
Dentist	What isn't normal: swelling that keeps increasing after the third day, fever, or bleeding that doesn't stop with pressure. Then call us — here is the number.	Chunk 2: safety-net
Dentist	So that I know I explained it well: what would you expect on day two, and when would you call us?	Teach-back

Model dialogue written for this lecture · Cooper & Frain, p. 11

Scenario 2 · Long-standing caries and shame (course case 2): the theory

The situation

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

Mechanism. Shame is a powerful driver of avoidance: people who are embarrassed about their teeth delay care, which worsens the teeth and deepens the shame. A judgemental remark confirms the patient's fear of being judged. Lecturing provokes **reactance** (Burt & Eklund, p. 236). Non-verbal signals — tone, facial expression, a sigh at the radiograph — carry contempt even when the words are neutral (Yolov, p. 93; course case question 2).

Evidence and duty. Motivational interviewing elicits the patient's own reasons for change and avoids argument; in dental practice it is promising, though trials are few and heterogeneous (Kay et al., 2016). Threatening, patronising or prescriptive styles do more harm than good (Daly et al., p. 129). The code requires respect for dignity (Art. 11(1)); a dentist must not comment disrespectfully on other dentists either (Art. 18).

Course case 2 · Kay et al., 2016, doi:10.1038/sj.bdj.2016.952 · Burt & Eklund, 7th ed., p. 236 · Daly et al., 2013, p. 129 · Dental code, Arts 11, 18

Scenario 2 · Recommended structure and phrases

Phrases that harm	Phrases that help
"You haven't seen a toothbrush in ages."	"It's good that you came in — that's the hardest step."
"How could you let it get this bad?"	"May I tell you what I see?"
"You must floss every day, otherwise you'll lose them."	"What would you like to change first?"
"Your teeth are a disaster."	"Most of this can be repaired if we start soon."

Recommended structure: affirm the decision to come → ask permission to give findings → describe neutrally → elicit his goals (change talk) → one achievable step (SMART) → schedule the next visit.

Scenario 2 · An annotated model dialogue

Speaker	Model dialogue	What the dentist is doing
Dentist	Thank you for coming in. Many people put off the dentist for years; what made you decide to come now?	Affirmation · open question · ICE
Patient	I've got a job interview next month and I hate my smile.	Change talk
Dentist	So your smile matters for the interview. May I tell you what I see? There are several cavities; most can be repaired, and a few need attention soon.	Reflection · permission · neutral findings
Patient	I know I should brush more. I'm just tired in the evenings.	
Dentist	You'd like to look after your teeth, but evenings are hard. What would make brushing before bed realistic for you?	Double-sided reflection · elicit
Patient	Maybe keep a toothbrush by the bed and do it before I lie down.	
Dentist	That's a practical plan. Shall we start with the two front fillings before the interview, and check how the evening brushing goes in two weeks?	SMART goal · shared plan

Model dialogue written for this lecture · Miller & Rollnick, 2009, doi:10.1017/S1352465809005128

Scenario 3 · After-care instructions and blame (course case 4): the theory

The situation

After a complex extraction the dentist explains orally only: no smoking, no hard or spicy food, no rinsing for 24 hours. The patient smokes and eats spicy food the same day; two days later he has pain and inflammation and accuses the dentist of "poor-quality work".

Mechanism. Instructions given once, orally, immediately after a stressful procedure are poorly remembered (Yolov, p. 93; Daly et al., p. 245). Without teach-back nobody knew what he had understood. When an outcome is bad, patients look for a cause; if they were never told what is normal and what raises risk, the dentist becomes the obvious explanation.

Clinically, assess before attributing cause: pain two days after an extraction may be dry socket (alveolar osteitis), normal post-operative inflammation or infection. Smoking is a risk factor for dry socket, not proof of what happened in this patient.

Written instructions complement speech: the patient can reread them at home, show them to a relative, and they document what was advised. Burt & Eklund list printed instructions, underlining key points and phone follow-up among recommended techniques (Table 22.2, p. 251). **Complaint duty:** make every reasonable effort to resolve the problem on the spot (code, Art. 15(4)).

Responding to blame (course case question 3): do not counter-accuse. Treat first; then review the instructions together as information for the future, not as evidence against the patient.

Course case 4 · Talevski et al., 2020, doi:10.1371/journal.pone.0231350 · Burt & Eklund, p. 251 · Dental code, Art. 15(4)

Scenario 3 · Recommended structure and phrases (second visit)

Phrases that harm	Phrases that help
"It's your own fault — you smoked."	"You're in pain, so let's look at it first and make it better."
"My work was perfect."	"Can you tell me what the first day was like — eating, smoking, rinsing?"
"I told you not to."	"Smoking makes this kind of problem more likely; it doesn't mean anyone is to blame."

Recommended structure: part A — instructions in two or three chunks + written leaflet + teach-back; part B — acknowledge pain → assess and treat → explore what happened without blame → explain → agree a plan → document.

Scenario 3 · An annotated model dialogue (second visit)

Speaker	Model dialogue	What the dentist is doing
Patient	You botched it. It's worse than before.	
Dentist	I can see you're in a lot of pain, and that's the first thing I want to deal with. Let me look.	NURSE (name) · priority to pain
Dentist	The blood clot in the socket has broken down and the bone is exposed, which fits a dry socket; there are no signs of a spreading infection. It is painful but treatable; I'll clean it and place a soothing dressing now.	Plain explanation · immediate plan
Dentist	To understand why it happened: how did the first day go — did you manage without cigarettes?	Open, non-judgemental question
Patient	I had a few. Nobody said it mattered that much.	
Dentist	Thank you for telling me. Smoking makes dry socket more likely; I should have given you the instructions in writing too. Here they are now. Please tell me in your own words what you'll do at home — and which point will be hardest?	Affirmation · shared responsibility · written info · teach-back · barriers
Dentist	If the pain hasn't eased by tomorrow evening, or you get a fever, call us; we'll see you on Friday either way.	Safety-net · follow-up

Model dialogue written for this lecture · Dental code, Art. 15(4)

Scenario 4 · The undisclosed anticoagulant (course case 5): the theory

The situation

A 60-year-old woman taking an anticoagulant and two antihypertensives does not mention them at the initial examination, fearing that her extraction would be postponed again. Profuse bleeding occurs during the extraction.

Why patients withhold information: fear of postponement or refusal; shame (alcohol, drugs, psychiatric medicines); the belief that medicines from "another doctor" are irrelevant to the teeth; not knowing the names of their medicines (limited health literacy); a hurried, form-based history that does not invite disclosure.

What helps: **normalising** ("many people take..."), explaining the **rationale** for the question (a Calgary–Cambridge skill, Cooper & Frain, p. 11), asking specific rather than general questions ("blood thinners such as warfarin or apixaban?" rather than "any medicines?"), and reassuring that disclosure usually allows safe treatment rather than refusal.

Clinical safety: for many patients on anticoagulants, simple extractions can be carried out without stopping the medicine, using local haemostatic measures and planning according to current guidance; the decision is the dentist's, if necessary with the prescribing doctor, and the patient must **never** stop an anticoagulant on her own. This is exactly why the information must reach the dentist before the procedure.

System: a written medical history updated at each course of treatment, a verbal check before every invasive procedure, a visible alert in the record, and complete documentation (code, Art. 25(1)); patient safety and the safety of procedures are patient rights (Health Act, Art. 86(1), item 10).

Course case 5 · Cooper & Frain, pp. 11, 44 · Dental code, Art. 25 · Health Act, Art. 86(1)

Scenario 4 · Recommended structure and phrases

Phrases that harm	Phrases that help
"Any medicines? No? Fine."	"I ask everyone about medicines because some affect bleeding and healing."
"Why didn't you tell me before?!"	"Many people take blood thinners or blood-pressure tablets — do you take any, including from other doctors?"
"If you take blood thinners, I can't do anything for you."	"Thank you for telling me — this lets me do it safely."

Recommended structure: explain why you ask → normalise → specific questions → thank for disclosure → explain the plan → document and set an alert.

Scenario 4 · An annotated model dialogue

Speaker	Model dialogue	What the dentist is doing
Dentist	Before we take the tooth out, I need to ask about medicines, because some affect bleeding and healing. Many people your age take tablets for blood pressure or to thin the blood. Do you take any, from any doctor?	Rationale · normalising · specific question
Patient	Will you send me away again if I say yes?	Concern revealed
Dentist	It sounds as if that has happened before and was frustrating. In most cases knowing about your medicines doesn't mean we can't treat you — it means we can plan it safely.	NURSE · honest reassurance
Patient	I take apixaban, and two tablets for blood pressure.	
Dentist	Thank you, that's really helpful. Please don't stop any of them on your own. I'll plan the extraction for this, use stitches and a pack to control bleeding, and I'll explain exactly what to do at home.	Affirmation · plan · safety
Dentist	I'm adding this to your record so that everyone in the team sees it at every visit.	Documentation · team safety

Model dialogue written for this lecture

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Scenario 5 · A child, an anxious parent and a first filling: the theory

The situation

A 6-year-old needs a small filling. The parent, visibly nervous, keeps saying: "It won't hurt, don't cry like last time." The child is curious but afraid of "the needle".

Mechanism. The paediatric consultation is **triadic**: the child, the parent and the dentist each have an agenda, and unless the dentist involves both parties, information remains hidden and someone is left dissatisfied (Cooper & Frain, pp. 41–42). Parental anxiety is transmitted to the child; well-meant parental phrases ("it won't hurt", "don't cry") introduce the very ideas of pain and crying and are promises the dentist cannot keep. Children may see the visit as punishment; first visits shape lifelong attitudes (Yolov, p. 89).

Prevalence: about a quarter of children and adolescents have dental fear and anxiety; preschoolers 36.5%, schoolchildren 25.8% (Grisolia et al., 2021).

Techniques: tell–show–do; positive, specific praise; distraction; modelling; clear, calm instructions; honest answers to the child's questions in non-threatening words; a defined role for the parent (Yolov, p. 89; Roberts et al., 2010).

Law: for a child under 14, informed consent is given by a parent or guardian (Health Act, Art. 87(4)). Ethically, the child is still informed in an age-appropriate way and their assent is sought; resistance is a signal to explore, not to overpower (ethics book, ch. 2).

Cooper & Frain, ch. 7, pp. 41–42 · Yolov, p. 89 · Grisolia et al., 2021, doi:10.1111/ipd.12712 · Roberts et al., 2010, doi:10.1007/BF03262738 · Health Act, Art. 87(4)

Scenario 5 · Recommended structure and phrases

Phrases that harm	Phrases that help
"Don't cry, it won't hurt."	"I'm going to show you everything before I do it."
"If you don't sit still, I'll have to hold you."	"You can raise your hand like this if you want me to stop."
"This is a big needle."	"First I'll make your tooth sleepy so it won't hurt; you may still feel me pushing. Tell me if anything hurts."
Talking only to the parent about the child.	"Mum, could you hold Ana's hand and breathe slowly with her?"

Recommended structure: agree the plan with the parent first → greet the child at eye level → tell–show–do → praise specifically → give the parent a calm role → summary for both.

Scenario 5 · An annotated model dialogue

Speaker	Model dialogue	What the dentist is doing
Dentist (to parent, before)	Many parents are nervous here; children notice. Could you be her calm helper — hold her hand and breathe slowly with her? I'll explain everything to her myself.	Agreeing the parent's role
Dentist (to child)	Hi Ana. This is Mr Thirsty — he drinks the water. Let me show you on your finger... tickles, doesn't it?	Tell–show–do
Child	Is there a needle?	
Dentist	Good question. I'll put some sleepy medicine next to the tooth so it won't hurt; you might feel a little pinch for a second, and later some pushing. If anything hurts, tell me. If you want me to stop, raise your hand like this.	Honest, age-appropriate · stop signal
Dentist	You kept your mouth wide open the whole time — that was really brave and really helpful.	Specific praise

Model dialogue written for this lecture · Roberts et al., 2010

Scenario 6 · Toothache and a language barrier: the theory

The situation

An adult visitor with severe toothache speaks little English and no Bulgarian. A 12-year-old relative offers to interpret. A telephone interpreting service is available. A pain history, a diagnosis, options and informed consent are needed.

Mechanism. A child interpreter lacks vocabulary for medical concepts, may omit or soften information, is placed in an inappropriate role and may hear things a child should not; the patient may not ask what she really wants to know. Nodding is not understanding, and a signature on a form the patient cannot read is not informed consent (ethics book, ch. 2).

Evidence: professional interpreters are associated with fewer communication errors, better comprehension and outcomes and higher satisfaction than ad hoc interpreters (28 studies; Karliner et al., 2007). Cooper & Frain list children under 18 and family members among those to avoid as interpreters (p. 43).

Law: the patient has the right to information in accessible language and to clear and accessible information about her condition and treatment (Health Act, Art. 86(1), items 7–8); consent requires information about diagnosis, options, risks and the consequences of refusal (Art. 88). In an emergency, communicate as well as possible and record how information was given.

Practical tools: telephone or video interpreting; pictures, a pain scale with faces, a model of the jaw; translated after-care sheets; teach-back through the interpreter; the interpreter's identity recorded.

Karliner et al., 2007, doi:10.1111/j.1475-6773.2006.00629.x · Cooper & Frain, Box 7.2, p. 43 · Health Act, Arts 86, 88 · Department ethics book, ch. 2

Scenario 6 · Recommended structure and phrases

Phrases that harm	Phrases that help
"Tell your aunt she needs the tooth out."	"Thank you for helping — I'll call an interpreter so you can just keep her company."
Speaking louder and faster.	Short sentences, one idea at a time, looking at the patient.
"Sign here." (form in Bulgarian)	"The interpreter will read the form to you; ask anything."
"Do you understand?" (nod)	"Please tell me, through the interpreter, what you will do tonight."

Recommended structure: thank the child, but call a trained interpreter → brief the interpreter → speak to the patient in short segments → pictures and models → teach-back → translated written instructions → document.

Scenario 6 · An annotated model dialogue

Speaker	Model dialogue	What the dentist is doing
Dentist (to interpreter)	Please translate everything exactly, in the first person, and tell me if you think something isn't understood.	Briefing
Dentist (to patient)	I am Dr Petrova, the dentist. Where is the pain? Can you point to it? … How strong, from this face to this face?	Introduction · pictures · pain scale
Dentist	The nerve in this tooth is infected. There are two options: clean and fill the inside of the tooth over two visits, or take the tooth out today.	Chunk · options
Dentist	What questions do you have about either option?	Inviting questions
Dentist	So that I know the interpreter and I explained clearly: what will you do tonight if it bleeds?	Teach-back through interpreter
Dentist (note)	Information given via telephone interpreter no. 214; consent obtained; written instructions in the patient's language.	Documentation

Model dialogue written for this lecture · Cooper & Frain, p. 43

Scenario 7 · An angry patient in the waiting area: the theory

The situation

A patient with acute pain has waited 90 minutes past the appointment because an emergency was treated first; nobody has told him why. He is shouting at reception that the clinic "doesn't care".

Mechanism. Anger usually covers another feeling — pain, fear, exhaustion, feeling ignored (Cooper & Frain, pp. 41–43). Aggressive dental patients are often in pain or have neglected disease; the dentist should stay calm, not take the tone personally and invite the specific complaint (Yolov, p. 88). Telling someone to "calm down" or arguing escalates; so does an audience.

Conflict styles: some people flare up and calm quickly, others stay rational, others avoid conflict; let the other "let off steam", then propose a solution (Borisova & Veder, pp. 169–171).

Safety first: a clear exit, instruments away, not alone with a threatening person, colleagues or security called if needed. Acknowledging is not admitting fault.

Code: a dentist may decline to treat when the necessary trust is absent (Art. 11(3)), but must help a patient in an emergency who cannot reach their own dentist (Art. 13). Afterwards: record the incident, debrief the team, and fix the cause — here, the failure to inform waiting patients about the delay.

Cooper & Frain, pp. 41–43 · Yolov, p. 88 · Borisova & Veder, pp. 169–171 · Dental code, Arts 11(3), 13

Scenario 7 · Recommended structure and phrases

Phrases that harm	Phrases that help
"Calm down!"	"I can see you're in pain and you've waited a long time."
"If you can't behave, leave."	"Let's talk in here, where it's quieter."
"It's not my fault, there was an emergency."	"I want to help you, and I can do that if we talk without shouting."
"Everyone has to wait."	"I can see you in ten minutes, and here is something for the pain now."

Recommended structure: safety → move to a private space → listen without interrupting → acknowledge (NURSE) → explain briefly → set a limit if needed → concrete way forward → follow up and fix the system.

Scenario 7 · An annotated model dialogue

Speaker	Model dialogue	What the dentist is doing
Dentist	Mr Ivanov? I'm Dr Georgiev. Would you come with me where it's quieter, so you can tell me what's happened?	Introduction · private space
Patient	I've been here an hour and a half with this tooth and nobody cares!	
Dentist	You've been in pain all night and waited ninety minutes without anyone explaining — I'd be angry too. I'm sorry nobody told you.	NURSE (understand) · apology for the experience
Dentist	We had an emergency that couldn't wait. I can't change the last hour, but I can see you in ten minutes, and I'd like to check whether you can take a painkiller now.	Brief explanation · way forward
Patient (raising voice)	Ten more minutes?!	
Dentist	I want to help you, and I can do that if we talk without shouting. Ten minutes, and I'll come for you myself.	Limit · commitment

Model dialogue written for this lecture · Cooper & Frain, pp. 41–43

Scenario 8 · A suspicious lesion and a refusal: the theory

The situation

During a routine check-up of a 58-year-old smoker, the dentist finds a persistent white-red patch on the lateral border of the tongue. It cannot be diagnosed by examination alone and needs prompt specialist assessment and possibly a biopsy. The patient, whose brother died of cancer, says: "I don't want to know, I won't go to any hospital."

Mechanism. Bad news is information that significantly changes a person's view of their future; its weight depends on what they expect and fear (ethics book, ch. 4). Fear may produce avoidance — not wanting to know — which is different from an informed refusal. The dentist must neither give a diagnosis that does not yet exist nor hide the need for urgent investigation.

SPIKES (setting, perception, invitation, knowledge, emotions, strategy and summary) structures the conversation; NURSE handles the emotion; silence is allowed (Baile et al., 2000; Cooper & Frain, p. 56).

Law: the patient may refuse to be informed about the disease and prognosis and about planned activities and their risks, unless the condition endangers others; the decision is recorded in writing; she may authorise another person in writing to be informed (Health Act, Art. 92(2)–(4)). A capable patient may also refuse referral or treatment; the refusal is certified with her signature or, if she will not sign, the dentist's and a witness's (Art. 90). She can withdraw a refusal at any time (Art. 90(5)).

Ethics: a wish not to know details does not remove the duty to make the **need for referral** clear.

Baile et al., 2000, doi:10.1634/theoncologist.5-4-302 · Back et al., 2005, doi:10.3322/canjclin.55.3.164 · Health Act, Arts 90, 92 · Department ethics book, ch. 4

Scenario 8 · Recommended structure and phrases

Phrases that harm	Phrases that help
"It's probably nothing."	"I can't tell what this is by looking; that's why it needs a specialist."
"This looks like cancer."	"Would you like me to explain everything now, or the main points?"
"If you don't go, you'll die like your brother."	"After what happened to your brother, of course this is frightening."
"Fine, it's your choice." (and nothing more)	"You don't have to hear all the details today. Can we agree on the next small step?"

Recommended structure: SPIKES → acknowledge the fear (NURSE) → separate "not wanting details" from "not going" → make the next step concrete and small → offer support (someone to accompany) → document → follow up.

Scenario 8 · An annotated model dialogue

Speaker	Model dialogue	What the dentist is doing
Dentist	I've found an area on the side of your tongue that I'd like to talk about. Would you like to sit up?	Setting · warning shot
Dentist	Have you noticed it yourself? What did you think it might be?	Perception
Patient	My brother died of cancer. I don't want to know. I won't go to any hospital.	
Dentist	After losing your brother, of course this is frightening. (pause) You don't have to hear details you don't want. What I do need you to know is that I can't tell what this is by looking, and that it needs to be checked by a specialist soon.	NURSE · respects limits of information · essential message
Dentist	What would make going for that check possible for you? Could someone come with you?	Explore · support
Patient	Maybe my daughter.	
Dentist	I'll write the referral now and call you on Monday to see how it went. If you decide not to go, I'll respect that, but I'll ask you to sign that we talked about it.	Strategy · follow-up · Art. 90 documentation

Model dialogue written for this lecture · SPIKES (Baile et al., 2000)

CONTENTS

1. A framework for difficult situations
2. Scenarios 1–4: the department's course cases
3. Scenarios 5–8: situation types named in the official task
4. **The team and the system**
5. How simulation and role play are used

Course case 3 as a worked analysis: allergy, protocol and the team

The situation

A patient tells the dentist he is allergic to penicillin. The dentist, in a hurry, does not record it. At the next visit an assistant, following a "standard protocol", issues a prescription for a penicillin-containing antibiotic. Allergic reaction, complaint, loss of trust.

Analysis question	Model answer (summary)
How can effective exchange of information be ensured in a team?	Single shared record with a visible allergy alert; structured handover (SBARR) with readback; explicit roles — who may prescribe; a short daily briefing; a culture in which the assistant can ask "Has the allergy been checked?" (PACE).
Which strategies would have prevented the incident?	Listening that ends in documentation ("listening is not just hearing"); a verbal allergy check before every prescription; protocols that require checking contraindications; avoiding problematic pronouns and assumptions; the dentist deciding whether an antibiotic is indicated at all.
Why is documentation part of professional responsibility?	The record carries information between people and visits; it is the basis for safe care, continuity and accountability (code, Art. 25(1)); "if it isn't written, it is taken as not done" (Cooper & Frain, p. 35).

Afterwards: treat, disclose and apologise, report, change the system; patient safety comes before loyalty (code, Art. 12(1)).

Course case 3 · Cooper & Frain, ch. 5–6, pp. 29–39 · Haig et al., 2006, doi:10.1016/S1553-7250(06)32022-3 · Gallagher et al., 2003, doi:10.1001/jama.289.8.1001

What the eight scenarios have in common

Scenario	Core emotion or barrier	Key technique	Legal or ethical anchor
1 Anxious implant patient	Fear of the unknown	NURSE, preparation, safety-net	Arts 88–89; code 15
2 Long-standing caries	Shame	MI, elicit–provide–elicit	Code 11(1)
3 After-care and blame	Forgetting, anger	Teach-back, written info, complaint handling	Code 15(4)
4 Withheld anticoagulant	Fear of postponement	Normalising, rationale	Art. 86(1)(10); code 25
5 Child and parent	Child's fear, parental anxiety	Tell–show–do, parent's role	Art. 87(4); assent
6 Language barrier	Not understanding	Professional interpreter, pictures	Art. 86(1)(7–8)
7 Angry patient	Pain, feeling ignored	Safety, acknowledge, limits	Code 11(3), 13
8 Lesion and refusal	Fear of cancer	SPIKES, NURSE, small next step	Arts 90, 92
Case 3 Team	Haste, hierarchy	SBARR, readback, PACE	Code 12, 25

In almost every scenario the decisive move is the same: notice the emotion or barrier, address it first, and only then explain.

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Why simulation is used to learn communication

Simulated patients have been used since the 1960s; well-trained simulated patients are as effective as real patients in being interviewed. They allow students to learn under safe supervision, where mistakes can be made and reflection undertaken (Cooper & Frain, p. 65). Peer role play is a cheaper alternative; both work best combined with feedback and repeated practice (Lane & Rollnick, 2007).

A Cochrane review of 76 studies found that communication training **may** improve medical students' communication skills and empathy, mainly in expert-rated assessments; most evidence was of low quality (Gilligan et al., 2021).

What makes simulation useful

- observing, practising, giving and receiving feedback in a non-threatening environment;
- the chance to **rehearse and re-run** a difficult moment;
- feedback from patients, peers and teachers;
- seeing one's own development over time (Cooper & Frain, ch. 10, pp. 61–62).

Role play is practice, not assessment: in this course it is not graded.

Cooper & Frain, ch. 10 (Frain & Abdalla), pp. 61–67 · Lane & Rollnick, 2007, doi:10.1016/j.pec.2007.02.011 · Gilligan et al., 2021, doi:10.1002/14651858.CD012418.pub2

Roles, ground rules and observation

Three roles

Dentist — plans the aim and two techniques, then conducts the conversation.

Patient — builds the character from a card and reacts realistically to what the dentist actually does.

Observer — keeps time and records **exact phrases** on an observation guide based on the Calgary–Cambridge guide (Cooper & Frain, Box 10.3, p. 64).

Ground rules: everything is fiction; what happens in the role stays in the room; anyone may call "time out"; play realistically, not to win; step out of role explicitly at the end. Confidentiality, mutual respect and teamwork are stated at the start (p. 65).

Observation guide (extract)	No	Partly	Yes
Greets, introduces self and role, clarifies the reason			
Open questions; lets the patient finish			
Explores ideas, concerns, expectations			
Responds to emotion before information			
Chunks, plain language, no jargon			
Options, risks, costs; involves the patient			
Checks understanding (teach-back)			
Non-verbal: eye level, tone, pace			
Closes: summary, safety-net, documentation			

Cooper & Frain, pp. 64–65 · Kurtz et al., 2003, doi:10.1097/00001888-200308000-00011

Feedback and debriefing

Agenda-led, outcome-based analysis (ALOBA)

Feedback starts from the learner's own agenda ("What would you like help with?") and the outcomes both parties wanted; it is detailed, specific and non-judgemental, uses the observation guide, and offers alternatives that can be rehearsed (Kurtz, Silverman & Draper; Cooper & Frain, p. 65).

A sequence for the trio

1. The dentist says what went well and what they would change. 2. The patient says how it felt — which sentence helped, which closed the conversation. 3. The observer gives two strengths and one suggestion, each with an exact phrase. 4. The dentist names one thing to try next time.

Debriefing with good judgement

Rudolph and colleagues propose **advocacy with inquiry**: state what you observed and your view, then ask genuinely about the other person's reasoning — "I noticed you explained the risks before asking what worried her; I wondered whether she was still listening. What were you thinking at that point?" A debrief moves through **reactions → analysis → summary**.

The value of a role play lies in the debrief: what was done, what effect it had, and what to do differently.

Cooper & Frain, p. 65 · Rudolph et al., 2006, doi:10.1097/01266021-200600110-00006

Common pitfalls seen in dental role plays

Pitfall	Better alternative
Starting with the technical explanation	Ask first: what does the patient know, fear and expect?
Reassurance that dismisses (“Don’t worry”)	Name the emotion, then give honest, specific information.
A monologue of ten risks	Chunk and check; ask what matters most to the patient.
Arguing with an angry patient	Acknowledge, set limits, offer a way forward.
“Do you understand?”	Teach-back: “Tell me in your own words...”
Ignoring the silent party (child, interpreter’s client)	Speak to the patient directly, every time.
Pressure to accept treatment	Inform, give options, respect the decision; document a refusal.
Forgetting the record	Consent, refusal, allergies and what was explained belong in the documentation.

Review and discussion

1. Which four layers of factors make a consultation difficult? Give a dental example of each.
2. Why does "It won't hurt" increase rather than reduce anxiety in the long run?
3. In scenario 3, how would you answer the patient's accusation without blaming him?
4. Why is a 12-year-old relative an inappropriate interpreter for consent?
5. What is the difference between "I don't want to know" and "I refuse referral", legally and ethically?
6. Which of the eight scenarios would be hardest for you, and which sentence would you prepare in advance?
7. What makes feedback after a role play useful rather than hurtful?

Difficult conversations become manageable when they become predictable: a structure, a few prepared sentences, and the habit of addressing emotion before information.

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Thank you for your attention!