Analysing dentist–patient communication

Frameworks, reflective writing and full model answers for the individual written assignment

Practical Class 14 · Social Medicine with Medical Ethics · Dental Medicine (English) · 2026/2027

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Why analyse communication in writing?

In classes 12 and 13 we described **how** to communicate. This lecture is about **thinking** about communication: taking one real or realistic consultation apart, explaining why it went the way it did, and proposing something better.

Writing forces precision. "The dentist should have been more empathetic" is easy to say; naming the exact moment, the sentence that closed the conversation, the mechanism and the alternative words is the skill of a reflective professional.

Reflection as a professional competence

Reflective capacity is regarded by many as an essential characteristic of professional competence, and reflection activities are now part of undergraduate, postgraduate and continuing education across health professions. A systematic review notes that the evidence for these curricular interventions remains largely theoretical (Mann et al., 2009).

Cooper & Frain list "domains for reflection in advanced clinical communication": managing one's own emotions, uncertainty, shared decision-making, responding to a complaint, candour and disclosure of error, team communication (Box 1.6, p. 4).

Mann et al., 2009, doi:10.1007/s10459-007-9090-2 · Cooper & Frain (eds), ABC of Clinical Communication, 2018, p. 4

What you should be able to do after this lecture

1. State the official task, its two options and the three assessment criteria (1 + 1 + 1 points).
2. Analyse a communication situation with several lenses: consultation process, relationship, patient perspective and emotion, information and health literacy, law and ethics, team and system.
3. Distinguish description, analysis and evaluation, and explain the mechanism by which a behaviour produced its consequences.
4. Write a reflective paragraph using Gibbs' cycle or Driscoll's "What? So what? Now what?".
5. Write an educational dialogue in which the dentist's techniques are visible and the patient is realistic.
6. Recognise and avoid the most common weaknesses before you hand in.

Resources: assignment handout (PDF) · 15-minute reading · preparation tasks.

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The official task and its place in the assessment

> *To develop and reflect on key communication skills needed in a dentist's daily clinical practice – including listening skills, clear explanation, empathy and dealing with difficult patients.*
>
> — Independent task: Communication skills of the dentist — purpose

This assignment

Module "Communicative Skills of the Dental Practitioner". Two options, one to be chosen. Up to **2 pages**. Assessed on three criteria, **1 point each, 3 points in total**.

Ongoing control

Under the department's assessment standard, social medicine has two individual assignments (scientific writing; communicative skills). The highest-rated assignments receive a combined maximum of **5 points**, added to the semester examination score. Your teacher confirms how each assignment is organised in your group.

Departmental council decision No. 24/24.09.2026: task description, individual assignments and SMME exam rules (Dental Medicine)

Option 1 · Analysis of a clinical communication situation

> *Based on the specified clinical situation in which communication with the patient is challenging (e.g. a patient with a phobia, with aggressive behaviour, language barrier, refusing treatment), analyse in detail the behaviour of the dentist. Offer an alternative approach using principles of effective communication. Volume: up to 2 pages.*
>
> — Official wording

What you deliver

An analysis of **one** situation from the case list: what the dentist did, why it was a problem, what followed, and a **concrete alternative** — what the dentist should say and do, with the named principles behind it.

Recommended headings

Context (brief) → **Problem found** → **Consequences** → **Answers to the analysis questions** → **Analysis and alternative approach** → **Reflection**. These follow the department's case sheets; they are a recommended structure, not an extra requirement.

Option 2 · Educational scenario for communication with a patient

> *Choose a dental procedure (e.g. tooth extraction, filling placement, tartar removal). Write a short script for a conversation with the patient: how you will explain what will happen, how you will respond to questions or fears, how you will convince them of the need for treatment. The script should be understandable but professional. Length: up to 2 pages (dialogue format "dentist – patient").*
>
> — Official wording

What you deliver

A dialogue in the format **Dentist: ... / Patient: ...**, with a one-line description of the patient and the setting at the top. The patient should ask at least one real question and express at least one fear or doubt.

Make the technique visible (optional)

Short notes in brackets naming what the dentist is doing: [ICE], [NURSE], [chunk and check], [options and costs], [teach-back], [stop signal], [safety-net]. "Convince" means **inform and motivate**, not pressure (Health Act, Arts 88 and 90).

Assessment criteria: 3 points

Criterion (official)	Points	What helps meet the criterion — guidance, not extra requirements
Clear structure and logic	1	The text follows the headings (option 1) or a consultation structure with opening, exploration, explanation, questions, decision and closing (option 2). Each argument leads to the next; the alternative follows from the problem identified.
Originality	1	Your own analysis and wording; concrete, realistic phrases a dentist could actually say; a perspective of your own rather than a general list of rules. Copied model texts or a classmate's work do not meet this criterion.
Depth of analysis / reflection	1	Names the mechanism (why the behaviour failed), uses named principles correctly (teach-back, NURSE, shared decision-making...), links to patient rights or the dental code where relevant, and reflects on limits and on what you would find difficult yourself.
Total	3	

The criteria and points are the department's. The descriptions on the right explain how this class interprets them; they do not add further requirements.

Independent task "Communication skills of the dentist", evaluation criteria

Practical arrangements

- The assignment is written **individually**, after this lecture, and handed to your teacher by the date announced in your group.
- At the top of the first page: **name, faculty number, group, date, option, and case number or procedure**.
- Up to **two pages**, typed or legibly handwritten.
- You may use the lecture materials, the handout and the textbooks; cite what you use. The text — analysis, dialogue and reflection — must be your own.
- Do not reuse the model answers in this lecture; for option 1 choose a case from the list (cases 1–5 or situations A–D).

A suggested way to work

1. Choose the option and the case or procedure.
2. Read the case twice; underline the exact words and actions of the dentist.
3. Analyse with the lenses (next section); note three mechanisms.
4. Draft the alternative as words a dentist could say.
5. Write the reflection.
6. Cut to two pages; check against the self-check list.

The handout contains the full text of every case with its analysis questions, the recommended headings, the self-check and an observation guide.

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Description, analysis, evaluation

Level	What it does	Example (course case 2)
Description	Says what happened.	"The dentist made a joke about the toothbrush and the patient did not return."
Analysis	Explains **why** it happened: the mechanism linking behaviour, perception and consequence.	"The remark was heard as contempt; it confirmed the shame that had kept him away for years, so avoidance was the predictable response."
Evaluation	Judges against a standard: principles, evidence, law, code.	"It breached the duty to respect dignity (code, Art. 11(1)) and the evidence that judgemental styles reduce motivation (Daly, p. 129)."
Alternative	Proposes better behaviour, derived from the analysis.	"Affirm the decision to come, ask permission, describe findings neutrally, elicit his goals: 'What would you like to change first?'"
Reflection	Relates the case to yourself and your future practice.	"I tend to use humour when I am nervous; I would prepare a neutral sentence for findings like these."

Most weak answers stop at description. Moving through these levels shows depth (assessed within the single one-point criterion); the alternative must grow out of the analysis.

Course case 2 · Daly et al., 2013, p. 129 · Dental code, Art. 11

Six analytical lenses

Lens	Key questions	Tools from classes 12–13
1. Consultation process	Which Calgary–Cambridge tasks were done, done badly or omitted? Was the patient's agenda elicited? Was information chunked and checked? Was the session closed with a safety-net?	Calgary–Cambridge guide, observation guide
2. Relationship	Which model was the dentist using (paternalistic, informative, interpretive, deliberative)? Did it fit the situation? How was power used?	Szasz–Hollender, Emanuel & Emanuel
3. Patient perspective and emotion	What were the patient's ideas, concerns, expectations and feelings? Were cues picked up? Was emotion addressed before information?	ICE, NURSE, BATHE
4. Information and health literacy	Was language plain? Were numbers understandable? Was understanding checked? Were written materials given?	Teach-back, natural frequencies
5. Law and ethics	Which rights and duties applied — information, consent, refusal, records, confidentiality, complaint, dignity?	Health Act Arts 86–92; dental code
6. Team and system	Did the problem arise from one person or from records, protocols, time pressure, hierarchy?	SBARR, PACE, checklists

You do not need all six lenses in two pages. Choose the two or three that explain the case best and use them in depth.

Lens 1 in practice: the Calgary–Cambridge guide as an analysis grid

Task	Course case 1 — what happened	Effect on the patient
Initiating	The patient's question was the opening of her agenda ("Will it hurt?").	It was closed down: "no need for so many questions".
Gathering information	Her anxiety and its source were not explored (no ICE).	The dentist did not learn what she feared or expected.
Explanation and planning	No description of the procedure, the expected course, options, risks; no written consent.	She had no reference for what is normal after surgery.
Closing	No safety-net: what is normal, what is not, whom to call.	Swelling was interpreted as error; she did not call, she posted online.
Building the relationship	Reassurance without empathy; a dismissive tone.	Trust was lost at the first contact.

Using the guide this way turns impressions ("poor communication") into specific, observable omissions — exactly what the criterion **depth of analysis** rewards. The same grid can check your own option 2 dialogue.

Cooper & Frain, Figure 2.5, p. 11 · course case 1

Finding the mechanism: a chain from behaviour to consequence

Link	Course case 4 (after-care)
Behaviour	Instructions given once, orally, right after a complex extraction; no check of understanding; nothing in writing.
Perception	Stressed patient remembers little; does not grasp that smoking matters "that much".
Reaction	Smokes and eats spicy food the same day.
Consequence	Pain and inflammation; the patient has no explanation except "bad work".
Second reaction	Accusation, confrontation, a likely complaint.

Why the chain matters

Each link is a point where a different behaviour would have broken the chain: chunking and teach-back (perception), a written leaflet (reaction), a safety-net (consequence), a non-blaming response at the second visit (second reaction).

A good analysis names at least one mechanism supported by evidence: memory is poor after stress (Yolov, p. 93); patients often cannot recall advice (Daly, p. 245); teach-back improved outcomes in 19 of 20 studies (Talevski et al., 2020).

Course case 4 · Yolov & Yaneva (eds), 2011, p. 93 · Daly et al., 2013, p. 245 · Talevski et al., 2020, doi:10.1371/journal.pone.0231350

Lens 5: the legal and ethical anchors most often relevant

Provision	Use it when the case involves…
Health Act, Art. 86(1) items 7–8, 10, 12, 13	Accessible language and clear information; safety of procedures; prevention of pain; access to records.
Art. 87	Consent in general; minors (under 14: parent; 14–17: both); persons who cannot consent.
Arts 88–89	Content of information for consent; written form for surgical and higher-risk procedures.
Art. 90	Refusal: at any time, documented by signature or by dentist and witness; may be withdrawn.
Art. 92	Duty to inform; the right not to be informed; authorising another person.
Dental code, Art. 11	Dignity, non-discrimination, declining to treat when trust is absent.
Arts 12–13	Patient safety above loyalty; duty in emergencies.
Art. 15	Information before treatment, options and costs, written consent for complex or expensive treatment, every reasonable effort to resolve a threatened complaint on the spot, no unnecessary treatment.
Arts 17–18, 25	Respect for colleagues; complete records.

Quote the article only when it explains something about the case; a list of articles without a link to the dentist's behaviour adds nothing to depth.

Health Act, Arts 86–92 (consolidated 2026) · Code of Professional Ethics of Dentists

Lens 6: from individual error to system

Human-factors science studies the limitations of human performance. Analyses of serious adverse events show that human factors, and poor team communication in particular, play a significant role; contributing factors include multiple handovers, hierarchies that discourage challenge and stress responses (Cooper & Frain, p. 29).

Asking only "who was wrong?" produces blame. Asking also "what allowed this to happen?" produces prevention.

Course case 3 — individual	**Course case 3 — system**
The dentist did not record the allergy.	No mandatory allergy field or visible alert.
The assistant prescribed by protocol.	A protocol without a contraindication check; unclear prescribing roles.
Nobody questioned the prescription.	A hierarchy in which the assistant does not speak up; no readback.

A strong option 1 answer proposes changes on both levels: what this dentist should say and do, and what the clinic should change.

Cooper & Frain, ch. 5, pp. 29–31 · course case 3

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What reflection is — and is not

- **Reflection** is the deliberate examination of experience in order to learn from it and change future practice.
- Schön distinguished **reflection-in-action** (thinking while doing: noticing the patient's silence and changing course) from **reflection-on-action** (thinking afterwards about what happened and why).
- Reflection links three things: what happened, what you felt and thought, and what theory and evidence say.

Not reflection	Reflection
"Communication is very important."	"I realised that I tend to explain before I ask; with an anxious patient that means she stops listening."
A summary of the case.	What the case means for **my** practice.
"The dentist was rude."	"In a hurry I might also say something careless; I would prepare a neutral sentence."
Self-criticism without a plan.	A specific action for next time.

Reflection belongs to the criterion **depth of analysis/reflection**. A short, honest, specific paragraph is worth more than a long general one.

Schön DA. The Reflective Practitioner, 1983 · Mann et al., 2009, doi:10.1007/s10459-007-9090-2

Gibbs' reflective cycle (1988)

Stage	Guiding question
1. Description	What happened?
2. Feelings	What was I thinking and feeling?
3. Evaluation	What was good and bad about the experience?
4. Analysis	What sense can I make of it? What does the theory say?
5. Conclusion	What else could I have done?
6. Action plan	If it arose again, what would I do?

A short example (role play, class 13, scenario 7)

(1) As the dentist I met the angry patient in the waiting room. **(2)** I felt attacked and my first impulse was to explain that it was not my fault. **(3)** When I said "there was an emergency" first, he got louder; when I acknowledged his waiting, he calmed down. **(4)** This fits the advice to acknowledge emotion before explanation (NURSE; Cooper & Frain, pp. 41–43). **(5)** I could have moved him to a quiet room at once. **(6)** Next time I will open with acknowledgement and a private space, and give the explanation in one sentence afterwards.

Gibbs G. Learning by Doing: a guide to teaching and learning methods. Oxford: FEU, 1988 · Cooper & Frain, pp. 41–43

Driscoll: What? So what? Now what?

Question	Prompts
What?	What happened? What did I see, say and do? What did the patient say and do?
So what?	What did I feel? Why did it matter? What does it show about my skills, the patient's needs, the law or the system? What does the literature say?
Now what?	What will I do differently? What do I need to learn or practise? How will I know it worked?

Driscoll's model, based on Borton's three questions, is short and suits a final paragraph of a two-page assignment. Gibbs' cycle suits a longer reflective account.

Example (option 2, writing the dialogue)

What? Writing my root canal dialogue, I noticed I had made the patient agree immediately.

So what? Real patients rarely do; I avoided the hardest part — the objection about cost — because I am not sure how to talk about money without sounding like a salesman. The code requires information on approximate costs before treatment (Art. 15(1)).

Now what? I rewrote the dialogue with a cost objection and practised a neutral sentence: "Here are the costs of each option, including leaving it."

Driscoll J. Practising Clinical Supervision: a reflective approach, 2nd ed., 2007 · Dental code, Art. 15(1)

Other reflective frameworks and how to choose

Framework	Core idea	Best used for
Kolb's learning cycle (1984)	Concrete experience → reflective observation → abstract conceptualisation → active experimentation.	Understanding how practice and theory alternate in learning a skill.
Gibbs (1988)	Six stages, adding feelings, evaluation and an action plan to Kolb.	A full reflective account of one event.
Borton / Driscoll; Rolfe et al. (2001)	What? So what? Now what?	A concise reflection at the end of an analysis.
Schön (1983)	Reflection-in-action and reflection-on-action.	Explaining what a practitioner does in the moment.
Calgary–Cambridge / ALOBA feedback	Agenda-led, outcome-based analysis of an observed consultation.	Turning observation of a consultation into specific learning.

In the assignment you do not need to name a model, but using one keeps the reflection structured. Mixing models in a single paragraph usually makes it confusing.

Kolb DA, 1984 · Gibbs G, 1988 · Rolfe G, Freshwater D, Jasper M, 2001 · Schön DA, 1983 · Cooper & Frain, p. 65

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Model answer, option 1 · The situation (not on the case list)

Example situation

A 40-year-old man with acute pulpitis in a lower molar demands antibiotics "like last time" and refuses to have the tooth opened today. The dentist, behind schedule, prescribes amoxicillin without explanation and says: "Fine, take these and we'll see." No decision is recorded. Four days later the patient returns as an emergency with severe pain, saying: "Your tablets didn't work."

Why this example

It is deliberately **not** on the case list, so that it cannot be copied. It contains the typical elements: an expectation, a fear, time pressure, a legal duty and a team or system dimension.

Clinical background used in the analysis

A Cochrane review found no evidence that antibiotics relieve the pain of irreversible pulpitis (one small trial, low-certainty evidence); the established treatment is removal of the inflamed pulp or extraction, with analgesics for pain (Agnihotry et al., 2019).

Agnihotry et al., Cochrane 2019, doi:10.1002/14651858.CD004969.pub5

Model answer, option 1 · Problem found and consequences

Problem found

The dentist replaced communication with a prescription. The patient's **expectation** — that antibiotics cure toothache — was neither explored nor corrected (no ICE), and his **reason for refusing** the definitive treatment remained unknown. Information required for a valid decision was not given: diagnosis, the nature of the proposed treatment, alternatives, the consequences of refusal (Health Act, Art. 88(1)). The refusal was not documented (Art. 90(2)). The dentist neither guided nor informed: this was not even the **informative** model (which requires full information) but uncritical acquiescence to a demand, without informed decision-making.

Consequences

- **Patient**: continuing pain; adverse effects of an unnecessary antibiotic; a reinforced false belief; a likely emergency return.
- **Dentist and clinic**: a second, harder visit; a patient who now trusts antibiotics more than the dentist ("your tablets didn't work"); no record to show what was offered.
- **Society**: unnecessary antibiotic use contributes to antimicrobial resistance.
- **Relationship**: the patient concludes that the dentist "gave the wrong tablets".

Health Act, Arts 88, 90 · Agnihotry et al., 2019 · Emanuel & Emanuel, 1992, doi:10.1001/jama.1992.03480160079038

Model answer, option 1 · Analysis: why it went wrong

Lens	Analysis
Process (Calgary–Cambridge)	The agenda ("antibiotics like last time") was heard but not explored; no information was gathered about his fear; explanation and planning were skipped; there was no closing or safety-net.
Patient perspective	His **idea** was that infection causes the pain and antibiotics kill infection; his likely **concern** was pain during treatment; his **expectation** was a quick, painless solution. All three were plausible from a lay perspective and could have been addressed in a minute.
Emotion	Fear of pain was probably the real reason for refusal. Without acknowledging it (NURSE), information alone would not have changed his mind.
Information and health literacy	"We'll see" is not information. No plain explanation of pulpitis, no check of understanding.
Law and ethics	Information and consent duties (Art. 88), refusal documentation (Art. 90), no unnecessary treatment (code, Art. 15(5)); non-maleficence (an antibiotic without indication); respect for autonomy requires an **informed** refusal, not just acceptance of a demand.
System	Running behind schedule with no emergency slot made the shortcut tempting; time pressure is a predictable system problem.

Model answer, option 1 · The alternative approach

Speaker	Dialogue	Technique
Dentist	What did the antibiotics do for you last time? And what worries you about opening the tooth today?	ICE
Patient	The pain went away. And the last time someone drilled a bad tooth, it hurt terribly.	Concern revealed
Dentist	That makes sense — if it hurt last time, you'd want to avoid it. Today I would numb the tooth and check that it is numb before I start, and you can raise your hand at any time and I'll stop.	NURSE · control
Dentist	The pain comes from the inflamed nerve inside the tooth. Antibiotics are not the treatment for this kind of inflammation and won't take this pain away; painkillers can ease it, but only treating the inside of the tooth deals with the cause.	Chunk 1: plain explanation
Dentist	There are three options: start root canal treatment today, take the tooth out, or wait with painkillers only — which usually means more pain and possibly an abscess. Here are the costs of each.	Chunk 2: options and costs
Dentist	So that I know I explained it clearly — why won't the antibiotics help this time, and what are your choices?	Teach-back
Dentist (if he still refuses)	It's your decision and I respect it. Please sign here that we discussed it; here is a painkiller plan, and here is the earliest appointment. If the swelling spreads or you have a fever, come at once.	Art. 90 · safety-net

Model answer written for this lecture · Health Act, Arts 88, 90

Model answer, option 1 · Reflection and why the answer scores

Reflection (Driscoll)

What? I analysed a dentist who gave in to a demand for antibiotics. **So what?** I can imagine doing the same: when a patient is in pain and I am late, saying yes feels kind and saves time. The analysis shows it was neither kind nor efficient — it postponed the pain and the conflict. **Now what?** I will prepare one sentence in advance: "I understand you want the pain to stop today; antibiotics won't do that, treating the tooth will, and painkillers can help meanwhile." I also think clinics need a short emergency slot so that this conversation is possible.

Criterion	How the model meets it
Structure and logic	Problem → consequences → analysis with lenses → alternative that answers each problem → reflection.
Originality	A concrete, realistic alternative in the dentist's own words; a personal reflection and a system suggestion.
Depth	Mechanism (unexplored expectation and fear), named principles applied, evidence (Cochrane review), law (Arts 88, 90; code 15(5)), limits acknowledged.

Length: the full text of this model is about one and a half pages. It is in the handout; do not reuse it.

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Building an educational dialogue

Ingredients of a strong dialogue

1. **Patient and setting** in one line: age, procedure, emotional state.
2. **Opening**: greeting, introduction, purpose.
3. **Exploration**: what the patient knows, fears and expects.
4. **Explanation**: what will happen, in chunks, in plain words.
5. **A real question and a real fear or objection** — and how it is handled.
6. **Options, risks and costs**; the decision is the patient's.
7. **Consent** (written where the law requires it).
8. **Closing**: summary, after-care, safety-net, teach-back.

What makes dialogues weak

- A perfectly compliant patient who says "OK, doctor" to everything.
- Monologues of the dentist with no pauses or checks.
- Jargon ("we'll do an obturation after extirpation").
- "Convincing" by fear ("you'll lose all your teeth").
- No mention of alternatives or cost.
- Ending without after-care or what to do if something goes wrong.

You may label techniques in brackets; it makes the depth visible to the assessor.

Model answer, option 2 · Root canal treatment (part 1)

Patient and setting: a 35-year-old teacher with a painful upper premolar, anxious after hearing stories about root canal treatment; first consultation.

Speaker	Dialogue	Technique
Dentist	Good morning, Ms Dimitrova. I'm Dr Petrov, one of the dentists here. You said on the phone the tooth has been hurting for three days — tell me about it.	Introduction · open question
Patient	It throbs, especially at night. I'm scared it needs a root canal. Everyone says it's the worst thing at the dentist.	Fear
Dentist	That's a very common fear, and it's understandable if that's what you've heard. Before we decide anything, may I examine the tooth and take one small X-ray?	NURSE · permission
Dentist	Your symptoms and the tests I've just done show that the nerve inside the tooth is inflamed and is unlikely to settle by itself; the X-ray shows the tooth and the bone around it. That's why it throbs at night.	Chunk 1: diagnosis in plain words
Patient	So it is a root canal?	
Dentist	That's one option. There are three: clean and seal the inside of the tooth and later protect it with a crown; take the tooth out; or leave it, which usually means more pain and an abscess. May I go through each, including costs?	Options · permission · choice talk
Patient	Why not just take it out? It's cheaper.	Objection
Dentist	That's a reasonable option and it's your choice. Keeping your own tooth avoids a gap, which might later need a bridge or an implant. What matters most to you — keeping the tooth, cost, the number of visits?	Respect · balanced information · decision talk

Model answer, option 2 · Root canal treatment (part 2)

Speaker	Dialogue	Technique
Patient	I'd like to keep it, if it doesn't hurt too much.	
Dentist	Today it is usually no more uncomfortable than a filling, because the tooth is numbed and I check that before I start. You'll feel pressure and hear the instruments. If anything feels sharp, raise your left hand and I'll stop immediately.	Honest sensation · stop signal
Dentist	It takes two visits of about an hour. Afterwards the tooth may be tender for a few days; an ordinary painkiller is enough for most people.	Chunk 2: course · expected effects
Dentist	The risks are small but real: sometimes the canals are difficult and you'd need a specialist, and occasionally a tooth still has to come out later. Here is the written information and the consent form — please read it and ask me anything.	Risks · written consent (Art. 89; code 15(3))
Dentist	So that I know I explained it clearly: what will happen at the first visit, and what would you do if it's very sore tonight?	Teach-back
Patient	You numb it, clean the inside, and put a temporary filling. If it's very sore, I take the painkiller, and if my face swells I call you.	
Dentist	Exactly. If the swelling spreads or you have a fever, call us that day — here's the number. See you on Thursday.	Safety-net · closing

Model answer written for this lecture · Health Act, Arts 88–89 · Dental code, Art. 15

Model answer, option 2 · Commentary

Element	Where it appears
Opening and agenda	Introduction with name and role (Art. 92(1), item 5); open question.
Exploration	Fear named and acknowledged before information.
Explanation	Two short chunks; no jargon; the X-ray used visually.
Options	Three options including no treatment; costs offered.
Objection	Cost raised by the patient; respected, balanced information.
Consent	Risks stated honestly; written information and consent.
Closing	Teach-back, safety-net, next appointment.

Why this scores

Structure follows a real consultation. **Originality** lies in the realistic patient, the specific phrases and the handling of the cost objection. **Depth** shows in the labelled techniques and in the legal elements built naturally into the conversation.

A short reflective note after the dialogue (three or four sentences) is recommended: which part was hardest to write and why. You may choose any procedure, including root canal treatment, but the dialogue must be your own.

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Frequent weaknesses and how to avoid them

Weakness	Better
Retelling the case instead of analysing it	Keep the context to two or three lines; spend the space on why and what instead.
A list of general rules ("be empathetic, listen actively")	Show the rule in action: the exact sentence and its effect on this patient.
Blaming only the patient or only the dentist	Look at the system too: records, team, time, written materials.
Naming techniques without applying them	"Using NURSE, the dentist could say: ..."
Quoting law without linking it to behaviour	"Because the refusal was not documented (Art. 90(2)), the dentist cannot show..."
A perfect, compliant patient in option 2	A realistic fear, question or objection, and how it is handled.
"Convincing" by pressure or fear	Inform, give options and respect the decision (Health Act, Arts 88 and 90).
Technical jargon in the dialogue	Plain language, with necessary terms explained.
No reflection, or reflection as self-criticism only	A specific insight and a specific action.
Copying a model text or a classmate	Your own case analysis and wording; originality is one third of the mark.

Weak and strong sentences

Weak	Strong
"The dentist did not communicate well."	"The dentist closed the patient's only question with 'there is no need for so many questions', so her fear was never explored."
"Empathy is very important in dentistry."	"A naming statement — 'It sounds as if you're worried about the pain' — would have taken five seconds and opened the conversation."
"The patient should have followed the instructions."	"The instructions were given once, orally, after a stressful procedure; without teach-back or a leaflet, forgetting was predictable."
"According to the law, consent is needed."	"Because implant surgery is a surgical intervention, information and consent had to be written (Art. 89(1)); a form alone would still not have replaced the explanation."
"In the future I will be a better communicator."	"I will prepare one sentence for anxious patients and use teach-back after every set of after-care instructions."

Before you hand in: self-check

1. Name, faculty number, group, date, option and case or procedure are at the top.
2. The text is at most two pages.
3. Option 1: problem, consequences and alternative are clear, and the case's analysis questions are addressed.
4. Option 2: it is a dialogue in which the patient has a real fear or objection, and the dentist explains, offers options and closes safely.
5. The alternative or the dialogue contains words a dentist could actually say.
6. At least one mechanism is explained, not only described.
7. Principles are applied, not only listed; legal or ethical duties are linked to behaviour where relevant.
8. Your own reflection is visible (recommended: a closing paragraph).
9. Sources you used are named.

This is a recommended self-check, not a list of additional criteria. The official criteria are structure and logic, originality, and depth of analysis/reflection.

CONTENTS

1. The official assignment
2. How to analyse a communication case
3. Reflective writing
4. A full model answer for option 1
5. A full model answer for option 2
6. Avoiding common mistakes
7. **Case list for option 1**

The department's five cases

No.	Title	Situation in brief
1	Lack of informed consent and psychological preparation	Anxious implant patient; questions dismissed, no written consent; marked swelling and pain; lost trust, negative posts online.
2	Unprofessional tone and lack of empathy	28-year-old with long-standing caries: "Looks like you haven't seen a toothbrush in a long time!"; humiliated, does not return.
3	Lack of active listening; error in team communication	Allergy reported but not recorded; assistant prescribes a penicillin antibiotic by "standard protocol"; allergic reaction and complaint.
4	Post-operative instructions not followed	Oral instructions only after a complex extraction; patient smokes and eats spicy food; inflammation; blames the dentist.
5	Health information withheld by the patient	60-year-old on anticoagulants and antihypertensives does not report them, fearing postponement; profuse bleeding at extraction.

Full texts and the three analysis questions for each case are in the handout. Class 13 analysed cases 1, 2, 4 and 5 and case 3 in the team section; your written analysis must go beyond those slides in your own words.

Department of Social Medicine and Public Health, case collection for the communication-skills task, 2026/2027

Additional situations of the types named in the official task

No.	Type	Situation
A	Dental phobia	A 34-year-old has avoided dentists for 10 years. At the first injection she starts crying; the dentist says: "Come on, you are an adult", and continues. She does not return.
B	Aggressive behaviour	A patient waited 80 minutes in pain without explanation and shouts at reception. The dentist comes out and says loudly: "If you can't behave, leave." He files a complaint.
C	Language barrier	A patient with limited English needs an extraction. Her 11-year-old son interprets, including the risks; she signs a Bulgarian consent form she cannot read; after-care is given orally to the son.
D	Refusal of treatment	A patient refuses root canal treatment on a symptomatic molar because of cost. The dentist answers: "Then don't come back crying when it hurts", and does not record the refusal. Three weeks later: facial swelling.

Situations A–D are teaching cases written for this course. Analysis questions for each: (1) What did the dentist do, and why was it a problem? (2) What were or could be the consequences for the patient, the dentist and the clinic? (3) What should the dentist have said and done instead, and on which principles is your alternative based?

Review

1. What are the three official criteria, and how many points does each carry?
2. What is the difference between describing and analysing a communication failure?
3. Name the six analytical lenses and choose the two most useful for course case 5.
4. What are the six stages of Gibbs' cycle? What are Driscoll's three questions?
5. What must a strong option 2 dialogue contain besides an explanation of the procedure?
6. Why does a list of Health Act articles not by itself show depth?

A good analysis is specific, explains a mechanism, proposes words a dentist could actually say, and shows what you yourself have learned.

Sources

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Good luck with your analysis!