Person-Centered Dental Care Through the People's Lens – A Qualitative Descriptive Study

Reenu Angeline Lysander Suthan Sam

Faculty of Dental Medicine and Oral Health Sciences

McGill University

Montreal, Quebec, Canada

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DEDICATION

First and foremost, I dedicate this thesis to the Trinity God for the strength, knowledge, wisdom, and peace. All glory to him, forever!

To my parents, Mr. Lysander Suthan Sam & Mrs. Seema Suthan, who have been a constant source of motivation, and encouragement through their prayers.

Finally, to my beloved, caring husband, Dr. Abraham Samuel Finny, his never-give-up attitude and dream of achieving big have made me who I am now.

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LIST OF ABBREVIATIONS

PCC – Person-Centered care

SAWCC – South Asian Women's Community Center

WHO – World Health Organization

IRB - Institutional Review Board

ABSTRACT

Objectives: The biomedical paternalistic approach in dentistry has been progressively replaced by a more balanced approach known as Person-centered care. Unlike other professions, there are only a few dentistry-specific person-centered models, and most were developed by researchers and dental practitioners without the input of people. Because it is important to gain people's perspective, this study aimed to understand people's expectations and preferences for their dental encounters and contribute to developing person-centered care in dentistry.

Methods: We conducted a qualitative descriptive study. It was based on one-on-one, in-depth semi-structured interviews with twelve South Asian immigrant women in Montreal, Quebec, Canada. We adopted a sampling strategy that was ‘purposive’ and, more specifically, ‘homogenous sampling,’ as described, with the goal of understanding this population in-depth and obtaining information-rich cases pertaining to our research question. The interviews were conducted on Zoom and lasted for an average of 45 minutes. The interview guide was devised using Bedos et al. Q – list of “The Montreal-Toulouse Wheel of Patient’s Expectation for dental visits”, which is based on a biopsychosocial model of dental practice. These interviews were audio-recorded, transcribed, and analyzed thematically.

Results: The participants highlighted the relevance of the “The Montreal-Toulouse Wheel of Patient’s Expectation for dental visits,” which includes four core components (Be understood; respected; provide enough time; share powers), and three components related to the clinical process (be informed and consent; be comfortable; co-construct treatment plan). This said, the participants emphasized having enough time during clinical encounters and working as a team with the dentist. Finally, the participants added the importance of having a warm and friendly relationship with the dental team to make their dental visits comfortable.

Conclusion: This study improves our understanding of what people may expect in a person-centered dental encounter and contributes to advancing person-centered care in dentistry. It could be useful to dentists and their teams interested in adopting person-centered approaches. In addition, we hope the findings will inform the public about their rights and what they could expect when consulting dental professionals.

ABSTRACT IN FRENCH

Objectifs : L'approche paternaliste biomédicale en dentisterie a été progressivement remplacée par une approche plus équilibrée connue sous le nom de soins centrés sur la personne. Contrairement à d'autres professions, il n'existe que quelques modèles centrés sur la personne spécifiques à la dentisterie, et la plupart ont été développés par des chercheurs et des praticiens dentaires sans l'apport des personnes concernées au premier chef. Comme il est important d'obtenir le point de vue des personnes, cette étude visait à comprendre les attentes et les préférences des patients en matière de soins dentaires et à contribuer au développement de soins centrés sur la personne dans le domaine dentaire.

Méthodes : Nous avons mené une étude qualitative descriptive. Elle était basée sur des entretiens semi-structurés en tête-à-tête avec douze immigrantes sud-asiatiques à Montréal, Québec, Canada. Nous avons adopté une stratégie d'échantillonnage raisonné et, plus précisément, un "échantillonnage homogène", dans le but de comprendre en profondeur cette population et d'obtenir des cas "riches en informations" en lien avec notre question de recherche. Les entretiens ont été menés sur Zoom et ont duré en moyenne 45 minutes. Le guide d'entretien a été conçu à partir de la Q-List de Bedos et al tirée de la "Montreal-Toulouse Wheel of Patient's Expectation for dental visits", qui est elle-même basée sur un modèle biopsychosocial de la pratique dentaire. Ces entretiens ont été enregistrés, transcrits et analysés thématiquement.

Résultats : Les participants ont souligné la pertinence de la "Montreal-Toulouse Wheel of Patient's Expectation for dental visits", qui comprend quatre éléments fondamentaux (être compris ; être respecté ; prévoir suffisamment de temps ; partager les pouvoirs), et trois éléments liés au processus clinique (être informé et consentir ; être à l'aise ; co-construire le plan de traitement). Ceci dit, les participants ont insisté sur le fait de disposer de suffisamment de temps lors des rencontres cliniques et de travailler en équipe avec le dentiste. Enfin, les participants ont souligné l'importance d'avoir une relation chaleureuse et amicale avec l'équipe dentaire afin de rendre leurs visites dentaires confortables.

Conclusion: Cette étude permet de mieux comprendre ce que les gens attendent d'une consultation dentaire centrée sur la personne et contribue à faire progresser les soins centrés sur la personne en dentisterie. Elle pourrait être utile aux dentistes et à leurs équipes dentaires désireux d'adopter des approches centrées sur la personne. En outre, nous espérons que les résultats informeront le public de ses droits et de ce à quoi il peut s'attendre lorsqu'il consulte des professionnels dentaires.

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CONTRIBUTION OF AUTHORS

The outline of the research project was devised by Dr. Christophe Bedos (thesis supervisor) and further refined by the co-supervisor Dr. Jean-Noel Vergnes and advisory committee member Dr. Alessandra Blaizot. Under the supervision of Dr. Christophe Bedos, the M.Sc. candidate (Reenu Angeline Lysander Suthan Sam) performed the literature review, data collection, and data analysis. With the guidance of Dr. Homa Fathi, I (Reenu Angeline) wrote all the sections in the initial draft of this thesis. I made further revisions and editing of the initial draft with Dr. Christophe Bedos. In summary, all authors provided critical feedback and helped shape the research project, analysis, and final draft of this thesis.

1. INTRODUCTION

The biomedical model of health that has historically governed healthcare education and practice has been heavily criticized in the literature over the past few decades. This model is characterized by a one-sided, doctor-centric, paternalistic doctor-patient relationship, thereby "placing the patient in a passive, dependent role with nothing to do but seek competent help and cooperate with the physician to get well. On the other hand, the physician has been granted autonomy and professional dominance"(1).

In search of a more balanced patient-doctor relationship, researchers proposed the patient- and person-centered models of practice, defined as "providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions"(2). The patient-centered care (PCC) model was first introduced by Dr. Michael Balint in the 1950s and gradually gained widespread attention in all healthcare fields(3).

This model puts the patient in the center and addresses the patient's preferences, needs, and concerns(2). Some notable aspects are understanding patients and illness, mutual respect, encouraging two-way communication, and facilitating shared decision-making(4). The literature on PCC suggests multiple benefits for this model: patient satisfaction, improved outcomes, enhanced health status, and reduced care utilization(5, 6). It can also result in greater work satisfaction for professionals and reduced levels of medical litigation(7). Currently, PCC has been adopted by various health services worldwide, namely the Institute of Medicine in the U.S., which recognizes PCC as a critical element of quality within the healthcare system(2). In 2022 WHO declared being person-centered as one of its core seven tools in its "Quality Toolkit in delivering healthcare"(8).

Dentistry started to move towards person-centered care in the 1990s. Accordingly, researchers have proposed several dentistry-specific PCC models in the literature during the past two decades. They have generally stipulated that dentists and patients should share power, understand each other, and together decide on treatment plans(9-12). According to the Association of Canadian Faculties of Dentistry (ACFD), patient-centred care is considered one of the five core competencies dentists must have mastered upon graduation(13).

Even though these models are up-and-coming, it is essential to note that they have been developed based on the literature or dental professionals' views, and they thus lack input from the patients. This could partly be the reason behind patients' dissatisfaction with dental services. A recent survey, for example, estimated that 40% of Canadians consider that dentists do not encourage shared decision-making, which sometimes results in unnecessary treatments(14). Another study from Greece showed patients' dissatisfaction with dental practitioners when provided with inadequate information on oral health care(15). A study from the USA also showed that patients often feel excluded from treatment decision-making(16).

In order to tailor the current PCC models in dentistry to the patient's needs, it is essential to understand how they perceive their past dental experiences and what their expectations are. That is why this study aims to understand people's expectations and preferences during their dental encounters in relation to person-centered dental care.

2. LITERATURE REVIEW

2.1 Doctor-patient relationship

Depending on the medical situation and socio-political climate, the doctor-patient relationship has undergone various mutations throughout the centuries (17). It all dates back to 4000 BC in ancient Egypt from a dominant priest-supplicant relationship where priests were considered healers with magic as an integral part of care(18).

Around the 5th century B.C., Greeks enlightened the world with the empiric-rational approach to science, separating medicine and religion. Their process involved realistic observation and aided in developing trial-and-error methods for human sickness(17). Representing the guidance cooperation model of Szasz and Hollender (1956)(18, 19), the doctor was in a position of power and expected the patient to obey without questioning and cooperate with his decision. However, religious and supernatural beliefs were restored during the medieval period after the fall of the Roman empire. The 'healer' role of the priest was taken up by doctors placing them in high-ranking positions.

In the early 18th century, doctors were very few and were appointed to treat politically and financially wealthy persons(18). This social scene led to a consumerist environment where the doctors acted to please patients who could afford the service(20). However, with the emergence of hospitals in the late 18th century, the role of doctors reversed. They gained the upper hand as hospitals became serving places for underprivileged people.

In the 19th century, medicine was significantly advanced, especially in the field of microbiology and surgery. One such achievement was the germ theory of disease which states that "each disease is caused by a specific germ or agent" (21). This created a massive shift in the disease perspective among physicians and has been widely accepted as 'the doctrine of specific etiology' coined by

René Dubos(22). They focused on treating the physiological dysfunctions of the body and concluded that the symptom is not the illness but an external indicator of the illness.

In the 1900s, the era of modern medicine promoted the 'biomedical model' concept (18, 23-25). This model considered that 1) the doctor's task is to repair the patient's biological disease, 2) being healthy meant being free of illness, excluding social and psychological factors, and 3) the mind and body are two separate entities(25). In addition, this model's approach to health and illness created an active-passive role in the doctor-patient relationship where the doctor, with his skill, diagnoses the disease and actively chooses the treatment plan on the patient's behalf(18, 24); meanwhile, the patient is passive and has to accept the care process. This paternalistic approach provided authority to doctors as the patient's guardians, denying patients the right to participate in their health decisions. Moreover, professional dominance and physicians' obligation to promote well-being compelled patients to obey the treatment decisions(1, 18, 24, 26).

Despite the dominance of the biomedical paternalistic model in the mid-20th century, a psychiatrist, Balint, shed light on the narrow nature of the biomedical model. He stated that "the doctor himself is the drug and also the whole atmosphere in which the drug was taken or given matters(3)." Further, Engel noted that "the behavior of the physician and the relationship between patient and physician powerfully influence the therapeutic outcome for better or worse(27)." Engel clearly assumed that the biological, psychological, and social factors were intertwined in the implication of disease, especially in chronic illness, which was clearly lacking in the biomedical model of health and disease. Further, the shortcomings, such as decreased patient treatment compliance, one-way directive doctor-to-patient communication, paved the way for a new medical model called the biopsychosocial concept of health, which further mooted the development of patient-centered medicine (17, 23, 27, 28).

Table 1: History of the doctor-patient relationship in relation to Szasz and Hollender doctor-patient relationship models and definitions

<table>
<tr><th colspan="2">Time period
(Ordered from past to current)</th><th colspan="2">Type of doctor-patient relationship based on Szasz and Hollender models (18, 19)</th></tr>
<tr><td colspan="2">Ancient Egypt
(4000 B.C. to 1000 B.C.)</td><td colspan="2">Active-passive model</td></tr>
<tr><td colspan="2">Ancient Greece
(600 B.C. to 100B.C.)</td><td colspan="2">Guidance-cooperation model</td></tr>
<tr><td colspan="2">Medieval Europe after the fall of roman empire
(Approx. 1200 to 1600 AD)</td><td colspan="2">Active-passive model</td></tr>
<tr><td colspan="2">Early 18th Century</td><td colspan="2">Mutual participation</td></tr>
<tr><td colspan="2">Late 18th century to early 20th century</td><td colspan="2">Active-passive model
Referred as the biomedical model</td></tr>
<tr><td colspan="2">Late 1900s to present day</td><td colspan="2">Currently in the process of adopting biopsychosocial perspective in treating illness and continuing research in patient centeredness</td></tr>
<tr><td>Definitions of the model</td><td>Active-passive model: Physician is in control, while patient must be completely inert</td><td>Guidance cooperation model: Physician tells the patient what to do and patient must completely cooperate/obey</td><td>Mutual participation model: Prototype of patient-centered care model. Physician helps the patient and aid in participation of the patient</td></tr>
</table>

2.2 What is Patient-centered care?

After introducing the biopsychosocial concept in medicine, several models promoting balanced therapeutic alliance, patient empowerment, and considering physical, mental, and social factors in a clinical encounter emerged in the literature. One such model which gained particular attention among healthcare professionals is the patient-centered care model. Balint laid the foundation in 1969 in her paper “The possibilities of patient-centered medicine” (29). She emphasized that physicians should try to understand the patient’s meaning of illness and view the patient as a “unique human being” to provide an overall diagnosis(29). Further, Levenstein et al. proposed “The patient-centered clinical method” based on the concept of understanding the patient and their illness (30). Their method suggested that the physician should try to enter the patient's world, to see the illness through the patient's eyes, thereby facilitating openness by allowing the patient to express their agenda in terms of expectations of the visit, feelings about their illness and associated fears; the physician's agenda is to acknowledge the patient's agenda and include his own agenda to determine the pathology and provide further treatment(30).

Later, in 1983, Gerteis, one of the leading researchers in patient-centered care, published a book called "Through the patient eyes – Understanding and Promoting Patient-centered Care," sponsored by the Picker/Commonwealth program of patient-centered care. They proposed seven primary dimensions of patient-centered care: "1) Respect for Patient's values, preferences, and expressed needs; 2) Coordination and integration of care; (3) Information, communication, and education. 4) Physical comfort; 5) Emotional support and alleviation of fear and anxiety; 6) Involvement of family and friends; 7) Transition and continuity; they later included 'access to care' as the eighth dimension(31)."

With the developing Patient-centered care framework, several researchers were trying to figure out how to adopt this approach into clinical practice. In 1995, Moira Stewart et al. described six interrelated steps to be followed in a clinical setup: (1) exploring both the disease and the illness experience; (2) understanding the whole person; (3) finding common ground; (4) incorporating prevention and health promotion; (5) enhancing the doctor-patient relationship; (6) `being realistic about the availability of time and resources(32). In a 2003 paper, she eliminated the fourth and sixth components, thus totaling four patient-centered care components (33). Despite the emergence of several definitions of patient-centered care, the definition proposed by the Institute of Medicine of the United States of America in 2001 was widely accepted. It defined patient-centered as "providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions" (34). It also identified patient-centered care as one of the six aims to be achieved in the 21st-century healthcare systems (34).

2.2.1 Components of patient-centered care

In this section, we will further discuss the various components attributed to patient-centered care. One important aspect of patient-centered care is to encourage a free flow of conversation(35, 36). Beckman and Frankel found that physicians interrupt patients within 18 seconds, followed by closed-ended, physician-centered questions(37). Smith et al. proposed that patient-centered communication (interviewing) should mainly address the patient's concerns by eliciting the biopsychosocial stories of the patient (38). According to them, the conversation should be facilitated by open-ended questions, non-verbal responses, and neutral utterances to establish a free flow of information exchange.

Another significant aspect of patient-centered care is 'shared decision-making. A longstanding relationship often facilitates this aspect (39), as the patient and the physician might have different perspectives and values. Therefore, it urges professionals to understand and respect the patient's values and find common ground in the treatment process(1, 39). Stewart et al. stated that "common ground involves mutual understanding and mutual agreement in a) defining the problem, b) identifying the goals and establishing a treatment plan, and c) identifying the roles to be assumed by both the patient and the clinician" (32). Simply put, it entails an active open discussion about the illness and treatment plans between the doctor and the patient, and empowering patients with information to help them make guided decisions on their well-being. Sometimes, shared decision-making can lead to non-treatment, which is also supported by Calderwood's "realistic medicine" approach(40). Studies show that when health professionals share power, provide precise information, and respect patients' decision, trust is established in the patient-doctor relationship(41).

Providing patients with clear information about treatment options and their benefits and consequences and avoiding complex language empowers them to think critically and provides control to make decisions(42, 43). Thus, empowerment further encourages patients to participate actively in the doctor-patient interaction. Additionally, it empowers patients with their right to seek information and take control of their own health (44, 45) by adhering to treatment plans(46, 47) and improving their health(48). Studies show that less passive interactions with clinicians were associated with more empowered people leading to more awareness of health(44), treatment benefits and their less adverse effects, less likelihood of unmet health needs, and better access to care(49, 50). Simply put, active interactions between physicians and patients create a virtuous cycle where empowered people will end up with responsive physicians, and responsive physicians will empower people who reap health benefits.

Although patient-centered medicine focuses on improving the physician's behavior, communication style, and attributes, the patient's ability to engage in a conversation with the physician to facilitate shared decision-making is far less considered(42, 51). Gertesis et al. noted that "patient passivity and lack of initiative acts as a barrier in providing Patient-centered care" (31). Therefore, it is recommended that the patients be internally motivated by themselves through various education programs (31). Research shows that externally motivated patients by health professionals to participate in the care plan increases treatment adherence to prescriptions(52, 53). In addition to the behavioral interaction, healthcare professionals should consider factors influencing patient-centeredness, such as age, gender, socio-economic status, cultural norms, language, previous clinical experience, and societal expectations(4, 54, 55).

As a result of PCC involved in addressing patients' needs and concerns, the World Health Organization (WHO) recognized person-centered care as a critical strategy for healthcare delivery in 2009(56). Moreover, in 2022, the WHO's 'Quality toolkit' added PCC as one of the seven core tools in providing quality healthcare(8).

The term patient-centered and person-centered is often used interchangeably in the literature(57, 58). Morgan et al. decode four characteristics of person-centered care (PCC): holistic, individualized, respectful, and empowering(57). In their research paper, they also defined PCC as "a holistic (bio-psychosocial-spiritual) approach to delivering care that is respectful and individualized, allowing negotiation of care, and offering choice through a therapeutic relationship, where persons are empowered to be involved in health decisions at whatever level is desired by that individual who is receiving the care(57)." Person-centered care puts the individual in the center of care; implements a reflective and inclusive approach to provide a meaningful life for the patient (59, 60), whereas patient-centered care focuses on the patient's needs to give a functional life (60). Despite the differences, several studies show that person-centered care principles evolved from the foundation of patient-centered care(59). For the thesis, the term "person-centered care" is suitable for the research question, as it is essential to recognize the "whole individual" as a "person" rather than labeling them as a patient by their medical condition (61). The term patient-centered or person-centered would be used for the literature review purpose to prevent confusion, according to the cited article.

2.3 Person- or patient-centered care outcome in medicine

This section will discuss how person-centered care has benefitted the medical field. The benefits of person-centered care approaches are reported at three levels: Patient, healthcare professional, and organization (62).

At the patient level, increased patient satisfaction and improved health outcomes have been reported. First, patient satisfaction with the treatment seems directly related to the patient-doctor interaction. Several studies found that warm, friendly, attentive conversations with physicians increased patient satisfaction compared to dominating conversations(63-67). One such example was a study in 1984 that analyzed the interactions between family physicians and patients in the maritime provinces of Canada; Stewart et al. found that patient-centered interviews/communication were consistently associated with increased patient satisfaction and compliance with the treatment(68). Stiles et al. found that patient satisfaction was related to patient-centered conversations. The study elaborated that the open-ended conversation led the patient to express their concern in their own words (rather than in response to closed-ended questions). Furthermore, the 'feedback' exchanges, which involved the physician in getting the patient's input about the problem, increased patient satisfaction (69).

Next, adopting patient-centered approaches reported better health outcomes, especially in chronic long-term medical conditions(5, 46, 70). A study conducted in Texas found that allowing hypertensive patients to communicate their stories in their own words during their clinical visit and providing clear explanations about the disease and treatment process reduced their blood pressure levels (71). Further, the Headache Study Group of the University of Western Ontario found that the treating physician who completely understood the patient's view of illness and satisfied the patient with their visit had a better clinical prognosis of reduced headache (72).

At the professional level, practicing patient-centeredness provided increased satisfaction and reduced the number of medical litigations (7). A survey of 200 patients from 20 hospitals found that hospitals adhering to a patient-centered approach had fewer unexpected deaths and complications(73). In addition, adopting patient-centered care has significantly reduced care utilization and costs (74-76).

2.4 Person- or patient-centered care in dentistry

Despite the widespread adoption of person-centered or patient-centered care as a core value in modern medicine, practicing patient/person-centered dentistry is complex and challenging. In the medical field, an initial visit often includes a discussion about the symptoms of the disease, leading to a diagnosis and treatment plan. In contrast, a dental visit includes a "therapeutic intervention process, often surgical, within the initial encounter associated with pain, anxiety, and financial considerations" and only focuses on "treating the disease" related to the biomedical paternalistic approach(9, 77). Thus, the existing medical models could not be implemented directly in dentistry. Hence, researchers raised their voices over the lack of custom-tailored patient-centered care model in dentistry(78, 79). This led to new research articles on patient-centered care in dentistry.

In 2013, despite continued research advancements, a systematic review of 'patient-centered care in dentistry' identified only three research papers describing the key features of patient-centered care within dentistry (77). In contrast, other dental research papers reported outcomes or opinions not customized to evidence-based dental research. It should also be noted that none of the three identified research papers did not include the opinion of dental patients. Instead, they recruited dental care professionals and staff to describe the key features of person-centered care.

In 2014, Nareg Apelian et al. developed a "person-centered dental model" conceptualized on a humanistic evidence-based approach(9). They identified three principles, namely understanding (both illness and disease, patient as a whole person), decision making (through a balanced, equally powered relationship), and intervention (involving traditional treatment procedures guided by patient's values and considerations) along with the core concept of "humanist equal powered patient-dentist encounter"(9). Building on this PCC model, the same team promoted social dentistry(80) and proposed a more comprehensive framework, the Montreal-Toulouse Biopsychosocial model for dentistry; it includes three different levels – individual, community, and societal(11). This framework guides the dentist to be person-centered at the individual level and present upstream interventions at the community and societal levels(11).

In order to improve the practical application of patient-centered care in day-to-day clinical practice, Scambler et al. elaborated a "practical hierarchy of patient-centeredness" built on four foundations 1) exploring disease and its context, 2) the patient as a whole person, 3) doctor-patient relationship ethos, and 4) reaching common ground and sharing responsibility, which is followed by explaining a series of stages to turn a good practice into patient-centered practice based on decision-making (81). In addition, this study encourages "open, unambiguous communication in dental consultations"(81).

Further, Lee et al. recently introduced a new person-centered model describing the role and responsibilities of three key players: the person or primary caretaker, provider or coach, and care designer. The actions of the above-mentioned key players, also known as "change agents," influence the delivery of person-centered care. In addition, care designers identified as "entities and systems" (including hospitals and clinics, community organizations, insurance providers, and the government body) are the active, competent player required for building the infrastructure and context in which "the most meaningful and efficient way" of person-provider interaction takes place(82).

In 2016, Scambler et al. conducted a systematic review to explore the definition of patient-centered care in the dental literature(12). They highlighted the lack of a universal definition of PCC in dentistry, which could be translated into practice(12). Furthermore, unlike medical professions, clinical outcomes relating to patient and person-centered interventions in dental settings remain understudied in dentistry(12, 83). Currently, the dental literature on PCC is focused on creating awareness for practicing dentists to learn the art of PCC and integrating PCC into the dental school curriculum for graduating dental students to practice PCC(83). In fact, the Association of Canadian Faculties of Dentistry (ACFD) incorporated being patient-centered as one of the five competencies to be possessed by graduating dentists to pass their dental university education(13).

2.5 Patient perspectives of person-centered care in dentistry

Several studies in medicine show that ‘patient perception of patient centeredness’ is a strong indicator of measuring health outcomes and the efficiency of health care(32). However, limited literature addresses the patient perspective of person-centered dental care(84). Indeed, Mills et al., in their systematic review, confirmed the need for future research to understand the patient perspective to improve the understanding of PCC such that it could be generalizable to dental practice(85).

Even though there are a few promising patient and person-centered care models in dentistry, these models portray different person-centered expectations of researchers, educators, and dental professionals, not of the patients(86). Hence, Bedos et al. proposed a tool for what people could expect in a person-centered dental encounter. The tool is known as “The Montreal-Toulouse Wheel of Patient’s Expectations for dental visits” (Figure 1) (described in the methods section)(87). However, we do not know if it corresponds to patients’ expectations because it is developed by dental researchers, educators, and professionals without the direct input of the patient. In the current process of PCC in dentistry, it is essential to understand and consider the perspectives of the people who use or would like to use dental services. As person-centered care revolves around patients’ needs and preferences, it is imperative to explore their expectations, as the healthcare consumer is ultimately the patient. Therefore, a unique investigation of the patient perspective of person-centered care is necessary to improve and inform person-centered dental services.

3. OBJECTIVE

This study aims to understand people's expectations and preferences during their dental encounters in relation to person-centered dental care. Unlike other professions, most dentistry models of person-centered care were developed based on clinicians' opinions and experiences without the contribution of people. Hence, addressing the research gap of what people could expect in person-centered dental encounters is essential. The goal of this research is to contribute to the advancement of person-centered care in dentistry. Further, we hope this study will help empower people about what they could expect in person-centered dental encounters.

RESEARCH QUESTION

To achieve our objective, we proposed the following research question to guide our investigation, which will be answered in the result section of our thesis: **What are people's expectations about their clinical encounters with dentists?**

4. METHODS

4.1 Research team

The research team includes my supervisor, Dr. Christophe Bedos, professor in the faculty of dental medicine and oral health sciences at McGill University, Montreal, Canada. One of his main research interests focuses on person-centered care in dentistry, and he teaches social dentistry to both graduate and undergraduate dental students at McGill University. The second member of the research team is my co-supervisor Dr. Jean-Noel Vergnes, a professor at Université Toulouse III – Paul Sabatier, who teaches person-centered care to dentistry students in France. The third member of the research team is Dr. Alessandra Blaizot, a professor in the faculty of dentistry at the Université de Lille, France. Dr. Blaizot's research on person-centered care in dentistry mainly aligns with our study.

During the first phase of the research project, Dr. Bedos and I decided to create an advisory committee that could help us in various aspects of our study. We discussed and contacted Dr. Jean-Noel Vergnes and Dr. Alessandra Blaizot to set up a meeting. I presented the initial research proposal at the meeting. This led to discussions about the research goals, sampling strategies, and interview guide, which ultimately shaped and refined the research project. I am grateful that all of them accepted as my advisory committee members. Dr. Bedos was the leading member of the committee who helped me in all stages of the research process, including data analysis and drafting of this thesis.

4.2 Qualitative design

We adopted a qualitative descriptive study, which is appropriate for exploring a phenomenon of interest that is less known(88). This methodology assumes a naturalistic inquiry in which the participants can share their personal experiences in their own words. It permits the researcher to observe and analyze behaviors and examine patterns(88-90). Moreover, qualitative research design produces a comprehensive portrait of the phenomenon of interest by reviewing the associations of those patterns obtained from the diverse perspectives of the participants (88, 90). Therefore, this design is suited for this study to capture and understand people's views of person-centered dental care(88, 90).

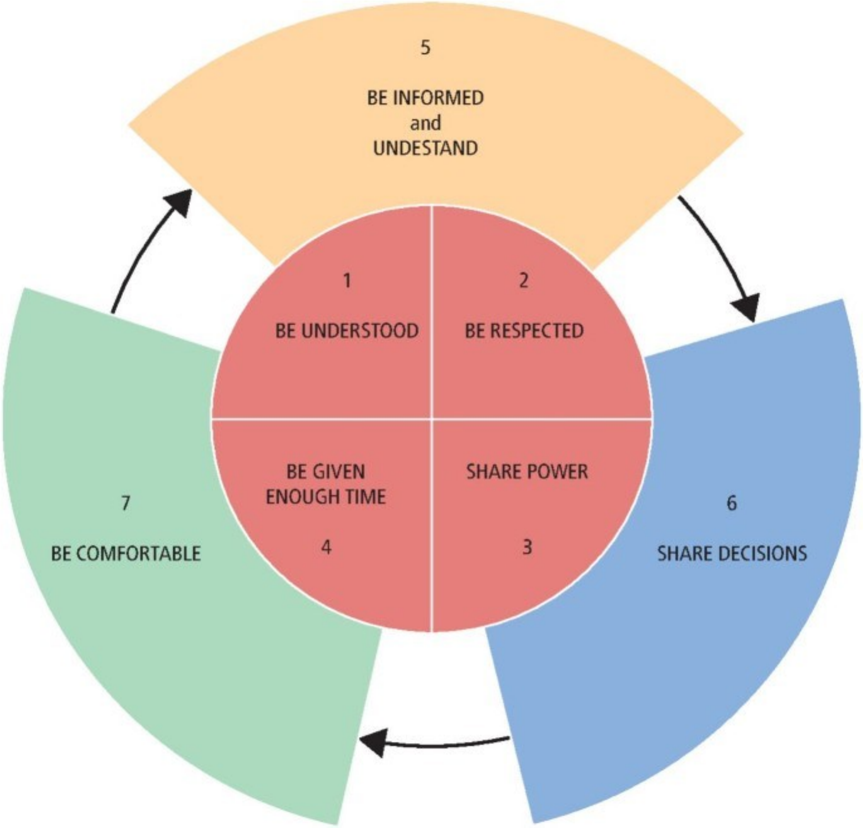

Figure 1: The Montreal- Toulouse Wheel of Patient's Expectation for dental visits' by Bedos et al.(84)

The conceptual framework used in this study is adapted from Bedos et al. 'The Montreal- Toulouse Wheel of Patient's Expectation for dental visits', which is based on the biopsychosocial model of dentistry(87). It is a tool that guides patients on what they could expect in person-centered dental encounters and promotes healthy relationships with dental professionals. Also, it acts as a guide to dentists who are interested in implementing PCC in their practice and empowering their patients to actively participate in the decision-making process(87).

This wheel consists of four core expectations: 1. Be understood by the dental professional (about people's unique illness experiences and social determinant aspects of people's health); 2. Be respected by the dental professional (on people's individuality and social, cultural, or economic backgrounds and also respect people's views on health and illness); 3. Share power and partner with a dental professional (by addressing the commonalities and differences to promote trust);

4. Be given enough time (to engage with dental professionals to exchange their perspectives and co-construct the treatment plan)(87).

The remaining three expectations revolve around the clinical care process: 5. Be informed and understand (the diseases, their causes, and the treatment process); 6. Engage and promote shared decisions in the decision-making process with the dentist (and even co-construct the treatment plan). 7. Be comfortable during dental visits (including clinical procedures and the whole care process)(87).

Based on the wheel, Bedos et al. developed a Q-list (Appendix A), which could act as a guide to help people reflect on their needs, expectations, and relationship with the dentist(87). Furthermore, this wheel and Q-list encourage people to break the barrier of patient passivity by raising their voices, concerns, and opinions for an equitable dentist-patient relationship, thereby promoting advancement in person-centered dentistry.

4.3 South Asian Women Community Centre (SAWCC)

To fill the research gap obtained from the "objectified knowledge" (i.e., Person-centered dental care models developed by researchers and dentists without the input of patients), we adopted the feminist sociological perspective to understand the "insider's knowledge" (i.e., the people's real expectation of person-centered dental care with dental visits)(91, 92). The second reason to take a feminist standpoint is to recover the silenced voices like minority groups, refugees, disabled people, etc. (91). The third reason is patient empowerment, a process through which one gains control to take decisions and actions over their health through knowledge, which aligns with one of our main goals to empower people's rights and access to dental services(93, 94).

Dr. Bedos and I were searching for potential recruitment sites in Montreal open for research. We came across the South Asian Women's Community Centre, known as SAWCC. Established in 1981 in Montreal, the Centre's goal is to create awareness of social issues and empower women, which we found well suited for our study(95). I went to the office and talked with one of their representatives in January 2020. She was highly interested and asked me to send the research proposal along with the research ethics approval form. I sent the required documents at the end of February 2020, and the board members of SAWCC reviewed them. Initially, we wanted to adopt a participatory approach involving the representatives of the South Asian Women Community Centre. Unfortunately, we could not do so due to the COVID-19 pandemic and time constraints. I received my IRB approval from SAWCC in May 2020.

4.4 Data collection

A qualitative study can rely on various data collection methods, such as interviews, focus groups, direct observations and fieldwork, and written communications. We planned to conduct one-to-one, open-ended, semi-structured interviews with a sample of women who were part of the SAWCC. This open-ended interview allows the participants to freely share their experiences, opinions, feelings, and knowledge(90).

The interview guide (Appendix B) was devised using the 'Montreal-Toulouse Wheel of Patient's Expectations for dental visits' based on the Montreal-Toulouse biopsychosocial model of dental practice(87). We incorporated the Bedos et al. Q-list (Appendix A) for people about what to expect during person-centered dental visits(87). The research team members significantly contributed to editing, refining, and simplifying the interview guide.

To facilitate the interview process, the research guide was divided into five sections: introduction, experiences with dental visits, definition of an ideal dentist, person-centered care (addressing the seven components of Montreal-Toulouse Wheel of Patient's Expectations for dental visits), and a few questions about the participant's socio-demographic status. All the questions except those in the last section were open-ended and could be followed by probing questions.

The interview guide opened with a self-introduction question, which served as an ice breaker to start the conversation and helped me understand the participants more naturally. The second section included questions about their past dental experiences, from the illness stage or the cause of the visit to the booking of the appointment and the interaction with the dentist. In addition, it included questions about what made the dental experience good or could have made it better. It was followed by a third section enquiring about their vision of an ideal dentist and dental office. Next, the fourth section of the interview guide had seven subsections. It dealt with four core components (be understood; respected; provide enough time; share powers) and three components related to the clinical process (be informed and consent; be comfortable; co-construct treatment plan)(87). The questions of each subsection were designed to capture each participant's point of view on person-centered care in dentistry. The interview's closing part included social demographic questions such as age, level of education, and country of origin. (Table 4 in the results section).

4.4.1 Sampling

Our sampling strategy was purposive and, more specifically, homogenous sampling, as described by Patton[3]. This sampling strategy was used to obtain in-depth data and information-rich cases from the particular subgroup on the research question (90).

The three inclusion criteria were as follows: The participants should 1) be at least 18 years of age, 2) be able to speak English, and 3) have consulted a dentist in the last 2 years.

As this study adopted the feminist sociological perspective, I narrowed our search only to SAWCC representatives and its users, who were women. Further, I recruited participants who had used dental services or visited the dentist in recent years so that they could remember their experience of dental visits and provide rich information about their dental services. They also needed to speak English as it is the language, I am comfortable speaking.

4.4.2 Recruitment

I recruited participants from the South Asian Women's Community Centre (SAWCC). Due to the surge in the COVID-19 pandemic in 2020, the SAWCC in-person office was closed. This made recruitment a great challenge, thus allowing me to seek different approaches.

I was allowed to introduce myself and describe the research project to SAWCC members at SAWCC's annual meeting in 2020. Moreover, invitation e-mails (Appendix D) were sent to all

SAWCC members. These e-mail messages included my research project, its aims, duration and medium of the interview, with an attached pamphlet and my contact information. Further, I used the snowball sampling technique by asking recruited participants to refer to a family or friend who might be best suited for this study(90). This technique helped me get information-rich cases.

Interested potential participants contacted me through phone or e-mail. During our phone conversations, I provided further explanations about the project, described its ethical principles, clearly explained the process of interviews, and responded to any questions people had about their participation. For the participants who were still interested and met the inclusion criteria, a time for an interview was arranged.

4.4.3 Interviews

I conducted one-on-one in-depth semi-structured interviews after obtaining approval from McGill's Institutional Review Board of Medicine (IRB) and from the South Asian Women's Community Centre. Due to the COVID-19 pandemic, the Department of Public health strongly recommended restricting all in-person meetings for the data collection to reduce further disease transmission. Hence, I conducted the "virtual interview" through the Zoom application licensed by McGill IT services.

Once the date and time of the interview were set, I sent out the zoom invitation link and the consent form (Appendix - C). This consent form was agreed upon by the Institutional Review Board (IRB) of McGill University's Faculty of Medicine. The participant sent the signed consent form before the interview. On the interview day, the participant and I greeted each other through the Zoom platform. Then, I requested the participant to reread the consent form and reminded the participant's right not to respond to uncomfortable questions and to stop or pause the interview at any time. I invited the participant to share their experiences and express their expectations about past and future dental visits. At the end of the interview, I thanked the participant for their time and contribution to this study.

Initially, as a novice researcher, I was nervous about probing questions to the participants who were older and more knowledgeable. With the help of Dr. Bedos and peer discussions, I overcame it in the latter part of the data collection process. Probing helped me manage the flow of conversation, stay on topic, ask for clarification when in doubt, and elaborate on the answers with examples(96). I tried to be very polite throughout the interview by showing that I understood the conversation with a nod of the head or words like "I understand." At the end of specific questions, I summarized the discussion to improve the clarity of the content. I listened to the participant's long answers without interrupting to unravel the "why" questions. I also made sure to ask more specific questions in areas where answers were vague or not understandable.

In total, I interviewed twelve participants from June 2020 to August 2021. The interviews were in English and lasted for an average of 45 minutes. After the 12th interview, I stopped data collection as it reached data saturation; saturation indicates that additional data does not improve or change the study findings and instead replicates what was said in previous interviews(90, 97).

4.5 Data Analysis

All the interviews were audio-video recorded using the Zoom recording feature or a phone recorder upon the consent of the participants. After each interview, I filled out an interview report form (summary of each discussion), which included a description of the interviews and notes to improve my interview probing skills and address the topics in-depth in the later interviews. I would meet with Dr. Bedos to discuss the interview and the emerging codes. With this in mind, I transcribed interviews verbatim, omitting participants' names and identities for confidentiality purposes. I used punctuation marks and symbols in the transcripts (see table 2 below) to enable me and the other team members to understand the nuances of talk, such as pause, intonation, and non-verbal noises, which provide better context of participants' feelings and emotions.

Table 2: Symbols used in transcripts

……	Indicating when the participant did not complete the sentence, moved to a different topic, or pause in the conversation.
( )	Indicating nonverbal gestures, emotions, or actions of the participant
[ ]	Indicating words that I added to make the text more coherent
Capital letters like XXX	Indicating names of people and places mentioned in the interview, replaced with the original text for privacy and confidentiality reasons.
(…..)	Indicating omitted words that are unclear or unable to hear the audio properly.

I started conducting a thematic content analysis of the transcripts simultaneously with the data collection. Green describes thematic content analysis as "a method aiming to provide a 'map' of the content and topics across the data set and a way of summarizing the variation and regularities within the data"(98). Moreover, the flexibility of the thematic analysis is one of its advantages in obtaining a rich, thick description of the given data set(99). I followed the six steps of Braun and Clarke's analytic approach to conducting the thematic analysis(99, 100).

Phase1: Familiarizing myself with the data

In this phase, I immersed myself with the data, which involved listening to interviews, and "repetitive reading" of notes and interviews. Transcribing is a time-consuming process that facilitates close active reading and improves interpretative skills to analyze the data(100). The interview report form consisting of socio-demographic information, notes on the topic covered, and the interview context helped me familiarize myself with the data in the later phases(98).

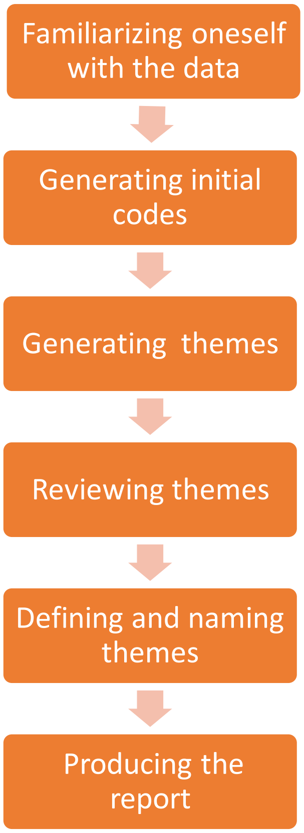

Figure 2: Six phases of thematic analysis by Braun & Clarke(96)

Phase 2: Generating initial codes

After acquainting myself with the data, I organized it into meaningful groups called codes. Generally, codes are attached to "an individual chunk of data which has been identified within and extracted from the data item"(100). For this process, I used the MAXQDA 2020 version 20.4.1 to create initial codes and write down memos. Initially, I started with the theory-driven (deductive) coding approach based on the "Montreal-Toulouse Wheel of Patient's Expectations for dental visits"(87, 100). Later, I re-coded using the data-driven (inductive) coding approach to develop codes without trying to fit into the preexisting theoretical framework. At the end of this phase, I had around 800 initial codes.

Phase 3: Generating themes

During this phase, I carefully reviewed and analyzed the assigned codes. Green defines Themes as "recurrent concepts which can be used to summarize and organize the range of topics, views, experiences or beliefs voiced by participants"(98). Then, I collated the different codes to see how different codes, if combined, share any meanings when put together to form potential main themes and sorted specific codes under subthemes. For example, codes like 'communication', 'being understood as a person', 'encourage to ask questions' were collated to form the first major theme as 'Participants considered that two-way communication was essential to be understood.' At this stage, I had also codes that did not fit any prospective themes and labeled them miscellaneous to review in the next phase.

Phase 4: Reviewing potential themes

In this iterative phase, I redefined my themes using Braun & Clarke's method[13]. The first level, called reviewing, involves the focused reading all codes under a particular theme to achieve a coherent pattern. I organized the themes and codes to see if they contribute to the overall story of data by internal homogeneity within themes(90). The second level, refining the themes, is similar to phase one but corresponds to the entire data by observing the external heterogeneity among themes(90). I had to repeat the two levels, which led me to restructure codes and themes until the themes provided an appropriate representation of the data. For instance, initially, I had eight potential themes. After careful reviewing, I found that two themes – 'hospitality of dental team' and 'being comfortable' were overlapping. Therefore, I combined both themes, which resulted in total of seven final themes.

Phase5: Defining and naming themes

This phase was an ongoing process, redefining each theme and establishing definitions and names for each theme. This led to the development of the following seven themes discussed in the results section of the thesis (Table 4). Even though this phase sounded simple, it required deep analysis of the theme to make the name concise and informative(101). In addition, I identified multiple extracts from the data pool to make a vivid argument for each theme to write the results.

Phase 6: Producing the report

This final phase involved writing a report that provides a concise, coherent narrative of the data to the readers(100). Therefore, I am presenting my findings in the results section of this thesis and through oral and poster presentations. Furthermore, I will write a scholarly article in the hope of publishing it in a peer-reviewed journal.

4.6 Trustworthiness

Trustworthiness is "the quality of an investigation and its findings that made it noteworthy to audiences" (102). As Lincoln and Guba suggested, we used different evaluative criteria, such as credibility, transferability, dependability, and confirmability, to address the trustworthiness of our qualitative research (89).

Credibility is defined as the "extent to which a research account is believable and appropriate, with particular reference to the level of agreement between participants and the researcher"(102). There are different strategies to ensure the credibility of our research(103). One such strategy is known as “*peer debriefing*”(89). After each interview, I completed an interview-report form noting down the preliminary findings of the interview. Then, I met with my supervisor to reflect on my thoughts and debriefed with various aspects of the interview, including the participants' experiences and expectations, challenges faced, and solutions recommended by the participants in their dental encounters. This strategy helped me to identify and improve the interview skills by probing questions to obtain thick description of data.

Another important strategy used is “*prolonged engagement*,” as described by Lincoln and Guba(89). I visited the community center before the COVID-19 pandemic. I attended their general meetings, which provided me an opportunity to observe the social and cultural setting and also develop a relationship with the community center. In addition, I spent more time with data by transcribing the interviews myself, reading the transcripts frequently, and further coding and analyzing the data.

The next criterion used to evaluate the trustworthiness of the research is ***transferability***. It is “describing a phenomenon in sufficient detail, one can begin to evaluate the extent to which the conclusions drawn are transferable to other times, settings, situations, and people”(89). Therefore, we provided detailed information on the context of the study and included the socio-demographic data of the participants to further support the transferability of the study(104).

The third and fourth criteria are ***dependability*** and ***confirmability***. Dependability focusses on “the process of the inquiry, and the inquirer’s responsibility for ensuring that the process was logical, traceable and documented,” and confirmability stresses “establishing the fact that the data and interpretations of an inquiry were not merely figments of the inquirer’s imagination”(102). We tried to ensure both the third and fourth criteria are supported through the detailed description of the methodology and obtaining thick descriptive data for the study(104, 105).

As a qualitative researcher, it is important to describe my role in this study. I played different roles in this study: a dentist, a patient, and a researcher. My background as a dentist from India serving people of different communities helped me show empathy toward participants. In addition, it aided in a better understanding of the dental terminology used during conversations with participants. Next, my role as a patient allowed me to easily connect with the participants about their dental encounters. This is because, during the course of this study, I encountered some health issues that led me to gain varied experience in the health care system in Montreal, Canada. These various experiences, including the biomedical paternalistic approach and person-centered approach, enabled me to better differentiate both approaches and could well relate the outcome and barriers, such as lack of time and communication barriers faced by the participants in their dental visits. Like the participants of this study, being a woman from a South Asian background also allowed me to better understand their culture, beliefs, and health practices. Finally, as a researcher, I developed deep conversations with participants by probing and being open to hearing their perspectives without prejudging or stereotyping. This said, my biomedical background in dentistry and firsthand experience as a patient, combined with the lens of a researcher, allowed and influenced me to analyze the data very sensitively. Further, a better understanding of my different roles in this study enabled and encouraged me to bring out the people's perspectives of person-centered dental care from a better point of view.

4.7 Ethical considerations

Dr. Bedos and I obtained approval for all phases of the study from the South Asian Women's Community Centre (SAWCC) and McGill Institutional Review Board (IRB) at the Faculty of Medicine (Appendix E&F). The IRB study number for this research project is A05-B33-20B (20-05-042). Steps were taken to ensure that the participants in this study have been dealt with high ethical standards.

Before the interview, I provided the participants with a McGill IRB-approved consent form which included a summary of the research project, study method, potential risks and benefits of participation, strategies to secure and protect the confidential information, and contact information of the research team and a McGill IRB representative. On the day of the interview, the participants were invited to reread the consent form and ask questions regarding the research. In addition, I obtained audio consent for digitally recording the interviews. The recorded interviews were initially stored on the password-secured personal computer and later transferred to my McGill OneDrive cloud space secured by 2FA authentication.

Each participant received compensation of $20 cash for participating in the study. This compensation was provided to cover the participants' costs related to their participation (such as the internet fee for the "virtual interview").

Several measures were taken to maintain information confidentiality, including participants' names, personal identities, and interview responses. I replaced the participants' names with numbers in transcribed interview material and interview report forms to protect the participants' privacy. As per the McGill IRB guidelines(106), all-digital recordings, consent forms, and compensation acknowledgment receipts are stored in my password-secured McGill University's OneDrive account. Records have been made accessible to the research team only. After graduation, I will transfer all the research materials to my Dr. Bedos OneDrive account, which will eventually be destroyed after seven years per the University policy.

5. RESULTS

5.1 Sample description

The participants were women aged from 26 to 83 years old (Table 3). All were Canadian immigrants from Asian countries, mostly from India and Pakistan, and were involved in the South Asian Women's Community Centre, Montreal. Established in 1981, the center primarily addresses social issues and strives for women's empowerment. The participants all had a high level of education and had completed a university degree.

Table 3: Socio-demographic characteristics of the participants

Characteristics	**Categories**	**Number of participants**
Age (years)	18-29	1
	30-49	2
	50-69	4
	70-89	5
Highest level of education	Bachelors	3
	Masters / Ph. D	9
Country of origin	India	5
	Pakistan	4
	Bangladesh	1
	Singapore	1
	Iran	1
Employment status	Student	1
	Employed	6
	Retired	5
Marital status	Married	7
	Divorced/Widowed	2
	Single	3
Nature of last dental visit	Regular check-up	12
	Emergency	0

5.2 Findings

We categorized the findings into seven themes that mirror the components of the Montreal Toulouse wheel of patients' expectations in dental visits (Table 4). Although interconnected, participants found each component essential throughout the dental visits. In the next paragraphs, we will describe each of these themes and enrich our descriptions with quotes that illustrate participants' experiences and expectations related to dental visits. Hereafter, the individuals who were interviewed in this study will be referred as "participants". Note that "(…)" in the quotes meant omitted words that were unclear or unable to hear the audio properly(98).

Table 4: Themes related to participant's experience and expectations from person-centered dental visits

❖ Participants considered that two-way communication was essential to be understood.
❖ Participants suggested that being respected was the basis for an egalitarian therapeutic relationship and had to be applied throughout the care process.
❖ Participants felt better-taken care of when the dentists spent enough time with them.
❖ Sharing power was difficult for participants due to the imbalance and hierarchy in the dentist-patient relationship.
❖ Participants recognized communication barriers in being informed and understanding the care process.
❖ Participants felt empowered when dentists shared the decision-making process with them.
❖ A hospitable dental environment favors a comfortable dental visit.

5.2.1 Theme 1: Participants considered that two-way communication was essential to be understood.

Participants strongly believed communication was the key to any dentist-patient relationship. In addition, this section will discuss their expectations and real-life experiences on the aspect of being understood by their dentists.

Why did they feel it was essential?

According to the participants, one of the main aspects of the dentist-patient relationship was being perceived as human beings and understood as a whole person. They explained that they felt valued and appreciated when the dentist tried to understand them as a whole person, including their mood, their habits, and their availability for appointments.

> *(…) because when they understand us as a person, then they'd understand as a patient. So, most of them, they ask questions and when patient is replying, so, they try to understand- what is? or and, understand and try to reply as I find. (…) Because sometimes if they don't understand their patient, then they cannot give a good service. So that's why, I find that the patient should be understood by doctor. (P6 transcript, Pos. 54-56)*
>
> *Anybody should understand everybody else as a person, not just the dentist! But, my dentist understands me as a person. My hygienist understands me. My dentist knows that…I hate having X-rays. He knows my idiosyncrasies as well, as I said. He always dealt with me as a person. And really, I wouldn't be with him for 35 years if I didn't have a good relationship with him! (P2 transcript, Pos. 51)*

To be understood as a whole person, participants strongly emphasized on the term "Communication". According to them, healthy communication with the dentist and being welcomed to express concerns and fears helped them develop trust. It also gave them confidence that the dentists would give them personalized and effective care.

> *I think to make patient comfortable, if you communicate and you know that, you have you have been taken care of properly. This person has feeling for you… feeling that you know how I'm*

> *feeling, and that protect me or taking care of me. I will put more trust on that. (P7 transcript, Pos. 30)*
>
> *I feel that I am going to a place where I can express myself… I can discuss my concerns and I can get better information and knowledge. So, I have that trust. The trust that I have developed over the years… it's almost five years now. And, even if the dentist tells me that I think you should do things this way. Sometimes, I don't even question cause it benefited me. (P1 transcript, Pos. 135-136)*
>
> *like a lot of healthcare interaction – there has to be certain element of trust and if you want to, you know… to ensure that you are giving the patient the most-the best…the most effective treatment. The patients should feel comfortable sharing any concerns or fears or issues with you. (P3 transcript, Pos. 51)*

In addition, participants felt more comfortable when the dentist tried to understand not only their reason for the visit but also to know more about their life in general, such as their lifestyle, dietary habits, their moods, work, and hobbies. Further, they believed these regular conversations provided critical information that would aid the dentist treating them better.

> *Having good bedside manner. Like "Hello! How are you?" Asking them like "you feeling okay?" "are you comfortable with dentist?" because it's, you know, specifically saying "how are you usually with dental appointments?", you know, I think we should know, or like "anything that would make you feel better?". Just being really open with communicating, so that the patient feels more comfortable sharing, how they're feeling. (P11 transcript, Pos. 127)*
>
> *The more knowledge they have about my life I think. I'm not saying you have to reveal all your private life to them. But to generally to know that you eat well and sleep well, you know you're enjoying life. It helps them to understand you better as a person and that could be happening with your teeth. (P8 transcript, Pos. 31)*

Despite being transparent about their personal lives and concerns, some participants felt uncomfortable and awkward answering in-depth questions about some aspects of their life, such as their financial status, fearing this could impede them to receive the highest quality of care. Thus, they emphasized that dentists should not be too intrusive in understanding them but communicate within reason.

> *I mean expectations though like, it's it's hard to say that every dentist must know everything about the patient. And you know, but within…within reason. (P3 transcript, Pos. 120)*

> *I think that if the relationship between patient and like health, health care professional is. It goes like through financial things. It's not good. It's not good….so maybe no! I, (…) I believe that's not good. I know that's expensive. but it will affect the service, I think that maybe it will affect the service. Not quality wise. Maybe they has no like eager to see me again, you know. (P10 transcript, Pos. 68)*

What were their expectations of being understood?

Participants listed three main expectations discussing how regular dentist–patient conversations should be. The first expectation was "Communication," which, according to them, should be two-way. They argued that the patient should not be a passive recipient of the information but instead participate and contribute to the whole care process.

> *Ask your background! Ask your background! Ask her that certain things: did you see any dentist before? have you been going to the dentist every year? you know all these things, my teeth are crooked- "how come you did not have braces?" or "what was the reason that you did not?" And whatever… It is not like… "just lie down, put your feet there, your head there," and you know, put the light on you and start your surgery. (…) I think that communication. They definitely have sympathy. They feel little bit…. Yeah… talk to… talk to…. Communicate. Communicate is not just, you know, you come and your job will be done and you go. This is not only with the dentists, but with all the doctors. That is a profession fashion everybody is so busy. So, it's like… create a friendly atmosphere… then even if I have fear, and by talking to me. (P7 transcript, Pos. 24-26)*

Their second expectation was that the dentist asked open-ended questions and avoided unidirectional talk aiming at collecting biomedical information. They expected the dentist to initiate and facilitate the conversation, inviting patients to share their backgrounds and express their concerns or fears.

> *He can ask for example, "what are your concerns", you know, that is not something that people often ask, you know. "Do you have any fears", for example, "do you have you had some experiences", because you see a dental experience can be very very harrowing…[distressing] a bad dental experience. so, so those are concerns that they can ask. And they can also ask something*

> *like, "do you have any questions that you'd like to ask me", so they don't ask you those questions. (P9 transcript, Pos. 28)*

Their third and last expectation was that the dentist would understand their illness by listening and being receptive to their cues. With listening considered a crucial skill to be possessed by the dentist, participants also preferred to be uninterrupted by the dentist during the conversation. That would encourage them to express their concerns and questions while being comfortable in the discussion.

> *Listen to each other... they absolutely do, I have to say. Then they attend to what your needs are… I can't see it just being anything other than what I already have, you know (....) because I think anytime, we know what is… the situation of our bodies, our teeth and things like that, you know. I think that people who are attending to us... they need to listen which they do because formulating something on outside opinion… I mean they are… the dentist is expert of this area, but I can tell them things about myself that they wouldn't know, you know. It's very important for the listening you know, a friendly environment setting you at ease. (P8 transcript, Pos. 25-27)*
>
> *What I'm saying is that if a person is comfortable, person will ask questions. And if you are not comfortable, you are scared, (…) So, then you will not ask. But yes there should be communication, asking questions and there should be a room to ask questions. (P7 transcript, Pos. 87)*

Based on participants' experiences, were the aspects of being understood reflected in the current dental settings?

Participants expressed opinions grounded in their past dental experiences, in which they believed they were not fully understood by dentists. More importantly, they highlighted dentists' lack of interest in understanding them, involving what they do for a living, where they come from, and their culture. In addition, according to participants, the dentist should enquire about any specific details about them, especially dental-related fears, that might aid them in receiving quality care.

Several participants reported that the dental hygienists communicated and understood them better than the dentist. Consequently, they felt more comfortable sharing their concerns with the dental hygienist, as highlighted by a participant who even approached the dental hygienist/assistant for a second opinion on a treatment plan. She explained that the dentist generally confirmed the findings of the dental hygienist and provided the treatment plan while the patient had to passively listen, with no room to start a conversation with the dentist.

> *Because he saw me for five minutes. You know, after the dental hygienist does her stuff, the dentist comes, checks things for five minutes and then goes away. And she (dental hygienist) tells that 'well, you know you need this and it's going to take you two hours, and she's the one who told me'. (P9 transcript, Pos. 81)*
>
> *Dentist also explains. (...) the doctor checks me… she sees and everything. But the hygienist is the one who communicates with me on an extensive level! (P1 transcript, Pos. 59)*
>
> *It is like a doctor-patient relationship. I trust her[dentist], and when something she recommends, I agree with it. And then, I ask my hygienist also -"what do you think?". That makes… that makes me… gives me more reassurance. (P1 transcript, Pos. 61-62)*

In summary, participants strongly believed communication was key in understanding the patient as a whole person; they therefore encouraged the dentist to ask open-ended questions, actively listen to their needs and concerns, and give them the confidence that the dentist would take good care of them. However, they deplored the reality being dentists not interested in understanding them and found that dental hygienists communicate better than dentists.

5.2.2 Theme 2: Participants suggested that being respected was the basis for an egalitarian therapeutic relationship and had to be applied throughout the care process.

With respect being the foundation of any human relationship, participants anticipated the same in their relationship with the dentist. According to them, respect meant something of high value, not demonstrated as a separate entity; instead, they felt that it should be implied in the dentist's actions in every step of the treatment process. In this section, we will show the participants' views on respect and what it meant for them.

What did the term "being respected" mean for participants?

Firstly, participants highlighted the term "mutual respect," which involved the patient respecting the dentist's view and knowledge and following their advice to improve oral health. In addition, they felt that the dentist should reciprocate it by welcoming patients to express their concerns and respecting them as a person.

> *I think that regardless of profession or, regardless of the interaction or whatever it is. Anytime you are interacting with the person, you should always be respectful, but I think especially in this scenario as dentists and with patients. The dentist should be respectful (P11 transcript, Pos. 53)*
>
> *I always think respect is very important because if you do not have respect, I do not think you could have a good relationship with anyone. You know, I mean, that is one of the first steps to putting in a good relationship. So, you know, I mean you can...people should feel free…should not be intimidated to express their views and if the dentist has a different opinion, I think that dentist should express their views also. Because sometimes, as lay people, we may not have… you know, we could do with… information that someone who is working as a dentist as that could help us in the care of our teeth and prolonging ...you know, the health of.... dental health of anyone, you know. So, it's a mutual thing. You respect and dentist respects, you know. (P8 transcript, Pos. 43-44)*
>
> *Doctor has the right to do say something good to good or bad to me, which I deserve, and I'm a person, as a patient I have the duty to respect the doctor and listen to them. This is my relationship with a doctor and the patient to me. (P12 transcript, Pos. 72)*

Next, some participants articulated that respecting meant actively listening to the patient's concerns without interruption. They argued that vital pieces of information, such as their change in medical and dental conditions, might go unnoticed when dentists tried to stop them from making complete statements and interrupt by saying, "I know." Thus, participants emphasized that dentists should respect them by paying attention to what the patients communicate without interrupting during their dental encounters.

> *I go to a dentist, and I start to talk about my problem. for example, they listen and then I want to give more, more, like, more like explanation. Some, sometimes they say, 'I know, I know', and they drop me. So, I feel okay. Maybe if I was, if I could tell that thing may be, you know, we are ready,*

> *we don't know, you know with a look… you know what's the problem, but for us, it's, it's not that much clear. So, we want just to give more details to you also. So yes, listening, listening is… good listening is what is the most respectful thing that we can, I can expect from my dentist. (P10 transcript, Pos. 38)*
>
> *"I think that's definitely true! and I think it's true of any health profession… is making sure that you are respectful towards your patients. And that you know you understand them, and you treat them as partners in your decision making, and it shouldn't be like a one way--that just the dentist tells you what to do! But I think respect them-- also in the sense that, make sure you're listening to what they want. (P4 transcript, Pos. 51)*

In addition to listening to them, participants considered acknowledging the patient's views equally important as understanding them. They expressed that the dentist should listen to them keenly, be receptive to their cues and recognize their values and opinions even if they were wrong. Later, according to participants, the dentist should attempt to help the patient realize their wrong misconceptions, which should be persuasive rather than directive.

> *"It is important because you're giving the person that he… that person is also human with thoughts, with information and with knowledge. Once you acknowledge that and then you bring your point of look, "what you said it's right but my experience says…if we go to like this…it will be more beneficial". It is just putting the same thing in a different way. (P1 transcript, Pos. 133)*

In times of conflict of views, participants suggested that the dentist had to be non-judgmental and explain to them clearly the importance of their stand in an encouraging, respectful tone. They expressed that explaining their reasons would help them modify and also strengthen their good oral health practices. For instance, the importance of daily flossing could be conveyed politely to a patient who does not floss regularly, not by putting them to shame. Moreover, they believed there would be no room for judgment in a respectful, healthy interactive patient-dentist relationship.

> *I expect them to remain not judgmental. And… and I think that if there ever is a conflict, I think it's important for both sides to state their views. and maybe you know, it's a matter of… maybe I didn't express myself clearly enough or I didn't express what my concerns were of why I can't do… you know… certain procedure or why I'm not in favor of it… and the same with the dentist as well. And*

> *I think that goes back to the respect thing that maybe… you know it's possible even you don't explain properly. (P4 transcript, Pos. 55)*

What were the participants' experiences on being respected at their dentist's office?

Participants felt that they were being respected at their primary dental office, even though some stated they felt disrespected in certain circumstances. For instance, as said by participants, dentists may dismiss patients based on various factors, including age, gender, ethnicity, and insurance coverage. A participant even described that a fellow patient in her dental office was dismissed from treatments based on her insurance coverage. She added that patients could sense when the dentist avoids engaging in a conversation, oversees the treatment superficially, and looks down on less insurance coverage or non–insured patients. Further, this dismissive nature of the dentist made them feel ignored and obstructed from their rights to access high-quality dental care compared with a patient with good dental insurance.

> *Your financial status, your age, your color, the kind of clothes you wear, you know. For example, if there is a woman who was wearing… you know, maybe a hijab or, or a niqab or something you know their, their attitude towards her… And again, you know, if she is somebody who is working here or let's say for the government and has good money… making good money, it would be very different, you know, and sometimes even if you are from the same country, you know, let's say Egypt, you may be from the same country. But your, your approach to someone who is not as well off as your [rich]patient. It is going to be different. So, sometimes it is color. Sometimes, it is not color… (P9 transcript, Pos. 35)*

When disrespected, participants noted that they would lose confidence in the dentist and the care they provide. As a result, they found it uncomfortable to continue the relationship with the dentist and would stop going to the current dental office. Consequently, participants had to move on to find a new dental office. They added that searching for a new dentist again, establishing dental care with a better dental office, and transferring files from their previous dental office to the new one was a hassle and complicated.

> *If I go through that situation [disrespected]. Maybe for that time, I just keep my mouth like closed. But I never go back to that. As I told you, I don't want to go back to that office again. (P10 transcript, Pos. 87)*

> *"So, if I'm not happy with this dentist. Obviously, I will find another one. when I go to another one, They will first visit, they will take extra money for opening my file, my X-ray and everything. So, I don't want to go again and again and again to two different dentists. So, I want to go speak with my one doctor where all access, and all the reports are preserved, and I go for the next time. I need to pay this much because I don't need to reopen the file. And because within the doctors, there is no communication, it is not that my doctor gave this is a treatment, ; another other doctor can see that. no, whenever you go to the new Clinic, they will say, we have to find out what is your dental situation. So, we have to get this x ray and this and that, then we'll start the treatment. So, this is the double way I'm punished. I mean, mentally, finding out and economically (P12 transcript, Pos. 48)"*

To conclude, "Being Respected" implied different meanings among participants. For some participants, respect denoted active listening without interruptions; for others, it meant acknowledging patient values and being non-judgmental. Some also described respect as being non-dismissive to patients irrespective of socio-economic factors. Overall, participants considered that respect was vital for any long-lasting relationship and should be applied throughout the dental care process.

5.2.3 Theme 3: Participants felt better-taken care of when the dentist spent enough time with them.

Participants related that sufficient time spent with the dentist by both listening to their concerns and answering their queries benefited their whole health in general. They categorized their dental consultation into three phases, namely the *examination phase* where the dentist examined and evaluated the oral cavity, the *discussion phase* where the dentist engaged in conversation with the patient and explained the diagnoses and its related treatment process, and *the treatment decision phase* where the patient was given time to decide to proceed with further treatment or not. In this section, we will describe participants' views when the dentist spends time based on the abovementioned three phases of the care process and followed by their dental experiences.

> *(...) as I told you that if my doctor gives me a little more time and talk about my health issues, properly then I would be very benefited out of it. (P12 transcript, Pos. 106)*

What do they feel about spending time with the dentist at different stages of the care process?

First, in the *examination phase,* during a regular consultation, according to participants, the dental hygienist usually welcomed the patient, examined the patient, took appropriate radiographs, and jotted downs her findings. Then, the dentist would enter and examine the patient's oral cavity. They felt they were being thoroughly examined when the dentist would take the time to examine them, look at the radiographs and confirms the findings of the dental hygienist. This thorough examination by the dentist, according to participants, gave them satisfaction and provided fulfillment of the purpose of the visit.

> *But I think what I would like is for them to spend a little bit more time maybe and be a little bit more… but we're just… so you feel like they're being more thorough. Even though I understand like it's a dentist they know what they're doing, I get it. Maybe they only, they probably only do need to look at your mouth for a few seconds and you know, they know what's going on, but it would just be more reassuring if they spent a little bit more time, or if they encouraged you to ask questions and things like that too… because like for someone like me, one I don't like going to the dentist I'm also just generally kind of shy, so I didn't know how to express that like, 'I'm not reassured by what you're telling me', so I think it would have been nicer if he was like, 'let me explain why, you know, this is happening or like what exactly is going on in your with your teeth'. (P11 transcript, Pos. 16-17)*

Secondly, in the *discussion phase,* participants felt comfortable and relaxed_when the dentist tried to spend time with them, engaging in conversations after the initial examination. As said by participants, this dialogue exchange might include discussing their reason for the visit; and the dentist explaining treatment procedures, welcoming their questions, and describing treatment steps during the procedure. At the same time, they did not want to feel rushed or not given enough attention by the dentist.

> *They are very attentive, they listen, never make me feel rushed and the next appointment is meeting. So, they are always…I have not had that experience… but I do feel that every person comes to see the dentist should be given sufficient time to express; to not feel rushed or pressure and get the attention that is required. (P8 transcript, Pos. 77-78)*

> *I think it would be good to get a little more time with the doctor like how the previous appointment went and how about this appointment and what do you have any special concern, or do you need any, any. Do you have any question said can I help you in these regards. So, I think they are charging like lots of money for my [one hour appointment]. But this is the way it is. (P12 transcript, Pos. 26)*

Thirdly, after treatment discussions with the dentist, in the *treatment decision phase,* participants believed having enough time to examine the treatment options and decide was essential, particularly in the case of complex dental treatments like orthodontic treatment or comprehensive treatment procedures. Participants explained their need to discuss treatment plans and options with their family and friends and do some research on the subject. Further, they elaborated that their research helped them compare the cost of the provided treatment options, and more importantly, it gave them more insight into their oral health problem and the need to address it.

> *I will definitely want to come back yeah if they tried to make, tell me to like make the decision right away. I'll never be able to, especially for something like braces, it is obviously longer commitment more complicated and all. Yeah, I would say that I want time to think about this, and to do some research as well. (P11 transcript, Pos. 107)*

> *Like in my case, when I say my tooth broke and they filled in….my first molar, I think. And for the front teeth, definitely she gave me an opinion that you can do this…you can do that. And I took my time…let me think about it… because it was sometimes money is also involved. Some time you see…. that you have the time… you will… sometimes you see that it is necessary to do it, you know all these things. So, I asked her to give me time and then I will come back on my next appointment for my teeth and then I'll let you know. (P7 transcript, Pos. 71)*

Did the dentist spend enough time with patients based on the participants' experiences?

Many participants echoed that dentists usually did not spend enough time with them, especially during the treatment discussion phase. They appreciated, when it occurred, dentists' attempts to spend time with them, which made them feel taken care of and accounted for what they were billed. On the opposite, they were dissatisfied when the dentist tried to speed things up, even though they understood that dentists were busy when they could see other patients in the waiting room.

> *I suppose, normal dentists, they should give time. But then regular dentists, they don't have enough time because they just, like… how assembly line work... you know... work with one patient, then the next, and the next. They try to go very fast. It is so expensive, and they don't give time. That is really sad! (P6 transcript, Pos. 95)*
>
> *Sometimes we you, we asked them like what it is the best toothpaste for me. What kind of toothbrush should I use or are like filling, like a dental filling like, how much is the cost? Or at least five more minutes maybe, maybe good for a patient, that's what I'm saying that, maybe. Yeah, because sometimes the hygiene is only quietly sitting there. Her job is done, and the doctor comes in three minutes, and that's all. 285$ for 15 minutes! It hurts me! Yeah, that is the situation. (P12 transcript, Pos. 31)*
>
> *I never talked about that, because, you know, the visit time with a dentist is not that much longer, and also, you don't have any opportunity to opportunity to talk with the dentist, you can't talk, only the dentist can talk (laughs). (P10 transcript, Pos. 60)*

As recognized by the participants, dental hygienists spent more time with them than dentists. They appreciated their presence and were closely attached to them to the point that, sometimes, they decided on their dental visit or treatment based on the availability or opinions of the dental hygienist. They credited their dental hygienist, as they were the first person in the dental office to gain trust from the patient; due to their warm, friendly nature and the role of an ice-breaker in a conversation.

> *The dentist hygienist was the one who spent time with me…showing diagrams. She brought all those dental…small… small things they shown. So, the dental hygienist was the extraordinary person" (P1 transcript, Pos. 59)*
>
> *I feel like the hygienist spent [time] like. Let's see if I have one hour appointment or 45 minutes. Doctors come for three minutes and check the X-ray, check the mouth and, and this is the doctors' duty. And so, where is the time for asking questions? I don't know! because doctors is only there for three minutes, check everything. (….) So, they have very short time for the patient. First of all, I'm not blaming them back. They have very short time. The hygienist at the end of the day, obviously she's very tired and things like that but some of them are very kind, very nice, very well behaved and they gave us time and talk to me or they tell me 'okay. this is the small thing you can do for floss, you can go to the jean-Coutu [pharmacy] you can buy this or this is the special toothpaste you need to use or something like that'. They are kind (P12 transcript, Pos. 23-24)"*

In brief, participants expected their dentist to spend enough time with them at different phases of the care process: examination, discussion, and treatment decision phases. When given enough time, they felt they were being thoroughly examined at the examination phase, given enough attention at the discussion phase, and gained insight into problems at the treatment plan decision phase. Overall, they felt they were better cared for when they spent enough time with the dentist.

5.2.4 Theme 4: Sharing power was difficult for participants due to the imbalance and hierarchy in the dentist-patient relationship.

Interestingly, participants, who were socially engaged and vocal about women's rights, found it somewhat unrealistic to share equal power with the dentist. They believed there was always a hierarchy or an imbalance in the dentist-patient relationship, which could not be avoided. In this section, we will discuss the two main reasons explaining their inability to share power and their proposed solution.

> *But we generally know that, when it comes to things like medicine and all that, there's a power imbalance and it's based on all kinds of things. It's based on hierarchies of knowledge, hierarchies of status. In some cases, it could also be gender. (...) There is a power imbalance, no matter what you say! (P3 transcript, Pos. 59-60)*

What were the challenges the participants faced in sharing power with the dentist?

First, participants identified dentists' professional knowledge of oral health as one of the hindering reasons for sharing power in achieving a more balanced patient-dentist relationship. They reasoned that they lacked oral health knowledge and were not specialists in dentistry. Thereby, they sought professionals - the dentist who specializes in the oral cavity and its related problems. This difference in knowledge between the dentist and the patients, according to participants, made it difficult for them to have the upper hand in power. Even though considering dentists' knowledge as a barrier to sharing power, participants expected their dentists to be more knowledgeable and up-to-date with treatment procedures.

> *I think, I think it will be, if it matters, as you know, when you as a professional, you have spent lots of, you know, the days of your life to to achieve the ability to diagnose to, you know, to treat. So, (...) I can expect that I have the same level of power as you... In the matter of like oral oral health or so. Personally, I can't, I can't think that I should have the same power of, you know, because I don't have... you have extra [knowledge] than me. (P10 transcript, Pos. 102)*
>
> *The dentist has the power over you! You... you are not... you are there because you want his services, and he is the person in power. It's the same as any doctor-patient relationship. There's no equality. That person is in power because they have the knowledge and they are there to treat you; you are not there to treat them. (P2 transcript, Pos. 77)*

Second, participants perceived that some personal aspects of the patients might influence their relationship with the dentist and prevent a balanced relationship in terms of power. Participants notably mentioned that patients' age, gender, socio-economic situation, ethnic group, language, immigration status, or religion were "invisible factors" that, knowingly or unknowingly, could create a power hierarchy between the patient and the dentist and lead to an unbalanced relationship.

> *"In my case, I think as a woman with woman dentist, the gender aspect of the power imbalance is not there. But I think you have a female patient and a male dentist, then the gender aspect- power balance could come in and sometimes even, race might come in, right. So, that the white person knows better and if you're a Brown person or a black person, you know. Also, the cultures we come from right." (P3 transcript, Pos. 59-60)*
>
> *"I mean you know race and gender were very important. when I first came here and they still are. But I find that dismissiveness and discrimination exists, even in the people of color. So, you can have a dentist who is a person of color, but he or she can be dismissive, and you may not call it racism, but you would call it discrimination" (P9 transcript, Pos. 154)*

What was recommended by the participants to overcome the difficulty in sharing power?

To overcome the challenges mentioned earlier, several participants expressed the idea of collaborating as a team with the dentist. The team, according to them, involved exchanging clear information, being involved in the treatment plan, and the dentist assisting them in making the best treatment decisions. They elaborated that they wanted to be a team player and have "informed control," not "full control." Some participants suggested that dentists should take into account patients' abovementioned challenges and vulnerabilities in sharing power, encouraging the patient to be involved in the team.

> *At the end of the day, it's for your own health, and you know we have to be mindful of and then take control of our health too. But I think it's great to work as a team, because because… that has not been my experience in the past with other dentists. Obviously, not the 1st dentist I've seen. but I know previously it was more like they would just tell you what to do…. without you know having the opportunity to ask questions or to bring things up. (P4 transcript, Pos. 63)*
>
> *It is good to work as a team but personally… for personally… I will really rely on the professional expertise of the dentist. Because I'm not a dentist. But I understand with the basics. But to understand the complexity of the dental treatment, I definitely rely on the dentist and once the dentist explains things very clearly with transparency in it. It helps me to make my decision. So, it's a very balanced relationship that the dentist is giving you information and he leaves that option*

> *of making the decision on you depending on the information you get. So, you feel powerful as well. Yes, I am the one who is taking the decision to go for this treatment and not this! You feel powerful too. (P1 transcript, Pos. 143)*

To sum up, participants recognized difficulties in sharing power owing to two factors, namely dentists' professional knowledge and patients' personal characteristics. They suggested that the dentist could encourage the patient to work together as a team and provide "informed control" to achieve a balanced dentist-patient relationship.

5.2.5 Theme 5: Participants recognized communication barriers in being informed and understanding the care process.

Several participants echoed "Being informed and understand" as one of the vital aspects of the "Montreal-Toulouse Wheel of Patient's Expectations for dental visits". This section will describe participants' views about the importance of being well-informed, the barriers encountered in the process, and suggestions to overcome them.

Why do they feel being informed is vital?

Most importantly, participants considered "being informed" as their right in the care process. This was because, according to them, they relied entirely on the information provided by the dentist to help them decide on treatment plans and improve their oral health, information that they considered highly credible since the dentist is the expert.

> *Because we are lay people and we don't understand terminology and impact that situation can have on our health.... and dentist should take the time to explain what is.. what it is…what could be done for it… and then WE will draw conclusions, you know. (P8 transcript, Pos. 81)*

What were the barriers identified by the participants from their dental encounters?

Based on their experience, participants considered they were usually not well informed about the care process; they mentioned several communication barriers related to their lack of language fluency since they were all immigrants, but also the dentist's use of dental jargon. They explained that they faced these communication barriers when the dentist overlooked the knowledge gap that existed between patients and dentists and, thereby, failed to understand that their level of understanding played a vital role in being informed.

> *I think it's that the way… they are delivering the information or the way they're doing the information should really be tailored… to their patient and to the client that they're serving at the moment. (…) Depending on their background, your level of comfort, even in terms of the language, you know for some people… English or French may not be their first language. So, if you're using very technical or very difficult words, people might not understand. So, be whether the complexity of the language, whether it's your use of like you know dental jargon, like just being mindful… I think it's very important. (P4 transcript, Pos. 83)*

According to participants, the abovementioned communication barriers created a stressful situation when they were deprived of clear information about the disease and the treatment. Furthermore, not understanding the treatment plan clearly put them in a confusing situation; accepting a treatment plan without questioning and trusting the dentist blindly created anxiety, with the potential consequence to avoid further treatments.

> *I think it is stressful because, you know, health issues can be stressful and dental dental care is expensive as well. So it's stressful in both ways, it reduces trust between dentist and patient as well, because it's like are you trying to just not tell me something… (P11 transcript, Pos. 88)*
>
> *Because My expectation is not fulfilled in that regard, let's see if I asked these questions and obviously, before going to the doctor I had to prepare myself like what is my questions. And, obviously, if it is not answered properly then I would not be happy! (P12 transcript, Pos. 110)*
>
> *If that is not properly explained, So, what happened is that… patient will see… in in this real life…. in in many many situations that I can imagine…. that you when you don't understand…I went to the dentist, for example, and I don't understand. I said I fully give myself to the doctor to treat me,*

> *then you don't ask questions… you don't make any decision. ….it is like so it depends on. (P7 transcript, Pos. 101)*

What are the participants' expectations for being informed?

To prevent patients from being adequately informed and put in a stressful situation, participants suggested that the dentist consider adopting the four strategies described below. The dentist should:

1. Explain the cause of the problem and treatment options.

2. Avoid complex dental terms (jargon) and break down complex words into simple layperson terms.

3. Paraphrase and customize the information based on the patient's level of understanding.

4. Ensure the patient understands and should be willing to answer the questions without hesitation.

> *We have to have 100%... each other has to understand what is going to do… what will he do… how will he do… what will be the consequences… that has to be explained to me properly. (P5 transcript, Pos. 96)*
>
> *Simple talk will be much better. For those who really knows these terms, it is good! But, if doctor telling me all those professional medical terms… I don't know what they're talking about. It is no use talking to me, no use giving me that, because I'm not understanding anything. Maybe, I will… I will…I get very upset that I don't understand or maybe I'll get scared that the doctor gave me so big… big… big words or maybe I am dying. (P7 transcript, Pos. 81)*
>
> *It is very important!. If somebody don't understand, I think that dentists in their own will right away understand this person is not understanding. To start something like a procedure or treatment, I think it's very important the person or patient are very clear about it. Because they can come back and say why did you do that? So, to keep that trust and working relationship, it's very important that dentist should understand that my vision to understanding or not. (P1 transcript, Pos. 206)*
>
> *I think it's important for the dentist to make sure that the patients understand what it is. So, even whether that's through repetition; whether that's through maybe using more gestures- like sometimes in the dentist you know will explain stuff to me… like you know… he might be using more gestures to explain why this is, where the muscle is; or just making it more visual. So, it's a little bit easier to understand. (P4 transcript, Pos. 95)*

Additionally, participants recommended dentists to incorporate dental videos or show radiographs on a screen to inform the patient about the causes of the disease and the treatment. They welcomed the dentist to convey the information verbally, show videos or diagrams (non-verbal), and then do the treatment. Moreover, participants suggested that dentists could recommend videos explaining the treatment procedures and take short courses on improving and maintaining good oral health (for example, brushing and flossing videos) after consultations.

> *I see that they they give us…. they show me the screen… you know their computer screen or sometimes they use paper to show exactly what is happening, that happened to sometime. And I like that. Because when you explain by paper and then that is more understandable, and using simpler terms. (P6 transcript, Pos. 124-125)*
>
> *This whole new system. of, you know, the mold and the 3d printer and all. This is something that he could explain graphically, you know, he could have a kind of a… in a laptop or something that he could talk to patients about which would be really really good. (P9 transcript, Pos. 101)*

To sum-up, participants related to being informed as their basic patient's right to know about their health condition and recommended dentists clearly explain the treatment plan, use simple words, rephrase the information based on patient's level of understanding, and be welcoming to explain their queries.

5.2.6 Theme 6: Participants felt empowered when dentists shared the decision-making process with them.

Participants had diverse views on co-constructing the treatment plan. In this section, we will explore the participants' ideas on how the decision on the treatment plan should be made and what it meant for them.

What was the participants' stand on the "decision-making process" related to dental treatments?

As discussed in theme number 3, most participants encouraged a "partnership" to make an "informed decision" on the treatment plan. This partnership, according to them, involved dentists a) sharing information on treatment/options and the need to address the problem (and being honest about previously failed treatment procedures), and b) laying out treatment options with the pros and cons of each treatment and its costs before proceeding with the treatment. They even mentioned that they wanted the dentist not just to explain to them the various treatment options, but also to recommend the best treatment plan with appropriate reasons for suggesting it. Instead of the dentist choosing the treatment plan for them, they strongly emphasized that the "decision-making" authority be given to the patient to make an "informed decision" on the treatment plan.

> *Be very honest about things! be open. Be open, honest you know when you're giving different treatment options, give them the information, the honest information that people need to make that decision. (P9 transcript, Pos. 179)*
>
> *I would want to clearly know the pros and cons of each and likes, but especially if there's a price difference, I don't know specifically Why is one more expensive than the other? Is it like is it long is it going to be better or worse? long term? is it just aesthetic reasons, you know, is that health reasons specifically? So, I would want to know all of the pros and cons of each so that I can make an informed decision informed decision. (P11 transcript, Pos. 94)*
>
> *Doctor's position is to tell the patient what is wrong; then say that you have these these option; and tell us what option you want to take; and then this is patient decision. (P7 transcript, Pos. 77)*

Nonetheless, in the decision-making process, some participants implied that they relied entirely on the dentist's professional expertise and the trust developed in their relationship. Despite leaning towards the paternalistic approach of expecting the dentist to choose the best treatment for them, they wished to be fully informed of the treatment plan.

> *I like to be informed and the pros and cons – because there are always side effects, things I don't know about dental things but it's not too much. But it's good to investigate both, you know. And if the pros are weighted heavier than the cons…I think, you know, you go with the decision to go with*

> *the procedure or whatever the dentist saying you know. Because they are well informed!" (P8 transcript, Pos. 95)*
>
> *Dentist will start to explain about the problem. Clearly, and then. Okay, this is the patient that's been decided. 'I want, I want to do that… oh I don't want to do that', but normally what happens is that, you know, as a patient they accept! they trust, that they're professionals. (P10 transcript, Pos. 114-115)*

How did they feel when "shared decision making" was practiced?

Participants felt empowered when they were given the authority to choose the treatment plan. According to them, empowerment with the information made them feel respected and included in the team. It also motivated them to take control and improve their oral health.

> *I think that way you're empowering… you're… you're empowering people to be decision makers in their own health. and you are… and I think the more you empower people, the better their relationship also is. and it will make people and it could make people take a more active interest also in their own oral hygiene, in their own oral health as well. (P4 transcript, Pos. 53)*
>
> *But, you know when the dentist used to tell me everything. Then I used to feel empowered because I used to feel, I have some choices to make. But if the dentist is not going to give you any choice. You don't really feel empowered. You just feel empowered based on what control you have over what you have. (P9 transcript, Pos. 120)*

In summary, several participants invited dentists to build an "informed partnership" in the decision-making process because they felt empowered by the information they received, which gave them the opportunity and the authority to plan the treatment. However, some participants seemed comfortable trusting and depending on the dentist to make health decisions.

5.2.7 Theme 7: A hospitable dental environment favors a comfortable dental visit.

This last and final section will present participants' expectations of the dental environment as it is essential in making the patient comfortable. In addition, this section will discuss the importance of being comfortable and provide two essential components, as suggested by participants, which are mainly responsible for a comfortable dental visit.

Why do they want their dental visits to be comfortable?

As most dental procedures are considered stressful, participants underlined that making them comfortable should be instilled in every aspect of dental visits. They believed that comfortableness could help them open up and clearly express their fears, insecurities, needs, and concerns to the dentist. It would also allow them to feel more relaxed during procedures leading to efficient dental care.

What was suggested by them to keep them comfortable?

Participants explained that being comfortable depended on the dental team's hospitality and mentioned two major components that made them comfortable: *physical and human*. With respect to the *physical component,* participants expected the dental clinic to be clean and tidy. Some preferred soothing music during treatment procedures and decorations in the dental office waiting area, which made them feel more relaxed.

> *Well, the atmosphere, the reception, the waiting time, those things are the ones that make you feel comfortable or irritated… (P2 transcript, Pos. 117)*
>
> *When we enter it to an office, you know, the appearance is very important. However, every version, if it's clean… you'll feel that, 'okay I am, I am in a good place', you know. Actually, I don't want to seem superficial but really it matters to me, how they are. The look… for example, they are clean, they know everything, their appearance is good. Also, clothing are good." (P10 transcript, Pos. 26)*

In relation to the *human componen*t, participants described two basic skill sets required for the dentist: professional and interpersonal. With respect to being professional, participants insisted that their dentist be knowledgeable and up to date with current scientific trends and technology advancements. Plus, they also expected dentists to be honest, accept and acknowledge mistakes if needed, and refer to other specialties in case of complex treatments.

> *The best thing I like about him is that he up to date with everything. You know, whatever his… I know he gets his upgrade… you know to go away and get courses and things like that. Everybody should know what they're doing. (P2 transcript, Pos. 41)*
>
> *And then, and most important things is professional, like being professional, and yes, this is the most important thing, and also how they behave, how they how they treat their patients, you know, for example, with respect, explain everything. (P10 transcript, Pos. 26)*

Next, with respect to interpersonal skills, participants highlighted that the nature of the dentist was mainly responsible for making them comfortable. They used various terms to describe these skills, such as friendly, polite, patient, warm, sensitive, or kind. As an example, they explained that a little smile and a friendly attitude were important to make their visits more comfortable and contribute to building a long-lasting relationship. Some suggested that future dentists be trained to develop such skills in dental school. In addition, the dentist should be encouraged to work with underprivileged people, as said by a participant, it would help the dentist treat the patient with empathy and help them adopt the person-centered model over the business-centered model in their clinics.

> *Very professional but very friendly! You always feel at ease, you know. And since I've been with this dentist from 1988, it is a long-standing relationship It's a professional relationship, but there is also some personal elements in this relationship with this dentist. (P3 transcript, Pos. 24)*
>
> *The dentist, you know look at this and hit all of these points, but still be like very cold, but the patient right and then that'll make the whole visit really uncomfortable if they're just like, you know, blank face, no friendly demeanor, very cold, like you would feel really awkward, it's been an instance like that. So I think definitely to be really friendly, helps, and adds on to number seven*

> *or eight to be comfortable during procedures, you're not going to be comfortable with through with someone who's not nice to you. (P11 transcript, Pos. 133)*
>
> *I trust in the knowledge of the dentist. the staff is always friendly, profession able… sorry… friendly and professional. They're very approachable. (P4 transcript, Pos. 121)*

Overall, participants implied that the dentist was responsible for setting a friendly tone in the dental clinic, thereby influencing the dental hygienist and receptionist to be more person-centered. They further noted that dental hygienists and receptionists should be warm, welcoming, and accommodating to their needs, such as scheduling appointments based on the patient's availability and taking care of kids when a parent is in a dental operating room.

> *I think the dentist… it's her practice… her practice, and so she sets a certain tone. I think that filters down to the hygienist… to the receptionist, etcetera… that tone of friendly, informality, relaxed, etc., but very professional at the same time! So, I think that too, to a large extent has influenced. (P3 transcript, Pos. 35)*
>
> *I mean, if you're not comfortable, to begin with, then you're not going to be comfortable to say anything right it's hard to speak up. So, I think it's on the dentist to make the place comfortable. (P11 transcript, Pos. 113)*

Finally, participants concluded that the whole dental team should provide a comfortable environment, including the receptionist, dental hygienists, dental assistants, and most importantly, the dentist. Therefore, they expected a safe, hospitable environment where they could open up and express their fears, needs, and concerns to get high-quality dental care.

6. DISCUSSION

6.1 Summary

This study aimed to understand what people may expect from a person-centered dentist during dental visits. The participants recognized the “Montreal-Toulouse Wheel of Expectation for dental visits” developed by Bedos et al. (87) as a good description of what they expected from dentists. The wheel included four core components (1. be understood; 2. be respected; 3. provide enough time; 4. share power) and three components related to the clinical process (5. be informed and understand; 6. co-construct treatment plan; 7. be comfortable during procedures) (87). In addition, participants described their challenges to have their expectations fulfilled and proposed solutions to overcome them.

The findings provided a more patient-oriented description of each component and incorporated the challenges faced by people in dental encounters. For instance, the power struggle between patients and dental professionals due to the added layer of professionalism and the “invisible factors” such as the patient’s age, gender, socio-economic situation, ethnic group, language, immigration status, or religion prevented them from having a balanced relationship. Considering these challenges, participants suggested some practices to overcome them. For example, they suggested that patients could make an “informed decision” when the dentist shares information and help them understand by avoiding dental jargon. More specifically, they felt empowered when they could decide for themselves rather than the dentist choosing for them. Overall, besides the challenges and solutions mentioned, they emphasized that “Be comfortable during procedures” was an essential element they sought in their dental visit, which was dependent on the hospitality of the dental team.

6.2 Understanding person-centered care based on the participants' view and experiences in dental settings

As mentioned in the above summary, participants discussed various facets of being person-centered based on their experiences of previous dental visits. First, participants expressed their desire to be ***understood as a whole person***. As a result, they felt valued and appreciated when seen as individuals. Our findings are echoed in the work of Noushi et al. of underprivileged people in Montreal wanting to be valued as individuals (107). Also, Mills et al., who interviewed dental patients in the United Kingdom about PCC, reported that they appreciate when the dentist tries to understand them and show support (84).

To be understood, participants of this study considered 'communication' as essential and a key factor in delivering person-centered care (108). Further, this study briefly describes ***three features of dentist-patient communication***: 1. Two-way conversation between dentists and patients; 2. asking open-ended questions to facilitate patients' expression; and 3. active listening to patients' perceived needs. Our study participants also suggested that the dentist should engage in conversations not only to collect biomedical information but also to participate in casual discussions about patients' life, hobbies, and habits and provide quality care.

Further, Karydis et al. work on the dentist selection criteria sought by patients, pointed out that "effective communication with empathy and making an effort to understand their needs" was mainly responsible for patient satisfaction (15). On the opposite, Rajas et al., in their study involving patients who attended campus dental clinics, found that people may feel dehumanized if they perceive that they are not "seen as an entire human being in oral health settings"(109). These authors also stated that the dehumanization of patients in dental settings was associated with "financial difficulties, minority status, and an inability to pay for optimal treatment" (109). This further supports our participants' experiences of being disrespected and feeling dismissed by the dentist.

Another important aspect of our study is the difficulty faced by patients in sharing power with the dentist, despite the participants’ close association with movements raising awareness of women’s equal rights. They elaborated that it was mainly due to the “invisible factors” - differences between providers and patients regarding socio-economic status and ethnicity. Haque et al. states that these differences could cause dehumanization in medical settings(110). Hence, our study suggests that dentists should be mindful of “invisible factors” in order to provide humanized person-centered care and share power. Besides, Mills et al., in their holistic assessment of the person-centered approach, noticed a significant shift in the power balance within dental consultations with enhanced patient awareness of their rights and access to medical knowledge (108). Remarkably, to overcome the barriers, our participants were willing to take an active role by working together as a team, thereby having “informed control” to achieve a balanced dentist-patient relationship.

To achieve an “informed control,” participants discussed the importance of being clearly informed of the treatment process. Being provided with enough information, they felt empowered to make an “informed decision” in a shared decision-making process. However, like the studies of Noushi et al. and Raja et al. (107, 109), the participants found that communication barriers, such as the use of technical jargon, might be one of the reasons that could prevent patients from being fully involved in the care process. Further, our findings show that the different linguistic backgrounds between patients and providers added an extra-layer of difficulty, hampering the exchange of information, thereby creating a stressful environment for the patient on whether to deliberately accept the decision made by the dentist or avoid it. Suurmond et al. also points out that in an intercultural patient-provider encounter, not only linguistics differences, but also patients’ ideas on health and illness based on their attachment to the former culture might impede or influence the shared decision-making process (111). Therefore, with Canada being a land of immigrants, it is recommended that dental education recognize the barriers to communication and focus on improving the skills by assessing the situation, avoiding the influence of stereotyping, and acknowledging the "invisible factors" in an intercultural dental setting (111). It is further suggested that working in underserved communities might help dentists gain perspective on the challenges faced by those populations (109, 112) and aid in delivering humanized, person-centered dental care.

This said, our findings are also consistent with Nowak et al., who showed that some people preferred the dentist to decide their treatment plan and were not interested in a shared decision-making process (113). This approach of leaning towards the biomedical model of care indicates that patients may not want to take an active role and prefer trusting the expert's knowledge in planning treatment. The literature shows that a patient's preference to be inactive should be supported as a part of shared-decision making process. It is suggested that the dentist understand the patient's concerns, explain the treatment process clearly rather than proceeding with uniformed treatment plan (113, 114). On the other hand, the dentist could explore different ways to make the patient feel included and might discuss the shared decision-making process and its associated benefits.

Finally, most importantly, our findings show that sometimes a dental visit can be a distressing experience; hence, being comfortable during a dental visit was considered indispensable by the participants. In terms of providing a comfortable environment, they relied heavily on the social skills of the dental team. They elaborated that dentists should be warm and friendly to build trusting relationships. They also believed the dentists were responsible for setting the tone of the environment on whether to be person-centered or business-centered. Mills et al. also mentioned that the "attitude of the dental professional has a profound influence on the willingness of the patient to engage and share information about their dental, social or medical history" (108). Even our participants confirm they can only open up about their fears, concerns, and needs in a safe environment when the dentist is welcoming. Therefore, according to participants, being hospitable to provide a comfortable environment is deemed necessary to offer person-centered dental care.

Moreover, the findings suggest that "being comfortable cannot be a separate entity; rather, it should be part of each and every component of the "Montreal-Toulouse Wheel of Patient's Expectation for dental visits" and be applied throughout the entire care process. Hence, we created the following modified version of the "Montreal-Toulouse wheel of Patient's Expectation for dental visits" (Figure 3).

Figure 3: Modified version of the "Montreal-Toulouse Wheel of Patients' Expectation for dental visits"

We believe this model would help the dental academic community incorporate it into the dental curricula and further encourage dentists to adopt the person-centered care approach. In addition to the current educational curriculum focusing only on communication skills, it must consider every component of the "Montreal-Toulouse Wheel of Patient's Expectation for dental visits" essential and continue to encourage the dentist to address the patient's perceived needs and concerns, which is being person-centered.

6.3 Limitations of the study

Firstly, the findings of this qualitative study cannot be generalized. It is important to remind that we recruited participants selectively from an empowered South Asian Women Community group, mainly immigrants settled in Montreal, Canada. Thus, we invite the readers to carefully assess the similarities and differences between our context (the social, economic, and cultural contexts of the South Asian population in a western country) and theirs before transferring our findings.

Secondly, most participants, being immigrants, had neither English nor French as their first language. This might have hindered them from fully expressing their thoughts and experiences during their interviews, even though they seemed fluent in English. Nonetheless, the participants' dental experiences in and out of Canada provided a broad picture of people's expectations and preferences in improving person-centered dental care.

Thirdly, I recruited only women in our interviews. As one of the main goals of this study is to help people empower and express their rights, interviewing people striving for their rights and empowerment, which was the goal of the community organization we partnered with, was found more suitable for collecting in-depth, rich data.

Due to the COVID-19 pandemic and public health regulations prohibiting in-person meetings, all 12 interviews were conducted through Zoom – an online platform. I ensured the interviews were conducted in a private room and recorded on the interviewer's computer. Despite technical issues such as unstable internet connection and unclear audio, I ensured this virtual setting did not affect our data collection process by further probing unclear answers. Moreover, the participants welcomed the idea of virtual interviews as they could be accustomed to their availabilities and felt comfortable and safe sharing their experiences in their own familiar surroundings.

Lastly, another limitation of this study is the relatively small sample size. However, a small number of participants is not uncommon for qualitative descriptive studies (97). Furthermore, we stopped recruiting participants after 12 interviews as we had reached saturation, point at which additional data did not improve or change our study findings and instead replicated what was said in previous interviews. In fact, Guest et al. confirm that “small” sample sizes are enough to “understand common perceptions and experiences of relatively homogeneous individuals.” (97)

6.4 Strengths of the study

Despite some limitations, we adopted a pertinent qualitative descriptive approach to gain deep insights into the people’s actual expectations (rather than what was previously assumed by dental professionals/researchers) in a dental encounter. Further, some participants, during interviews, got enlightened about their rights of what they could expect from the dentist when reflecting on their own dental experiences, thus encouraging them to be more vocal to the dentist about providing person-centered care. In addition, participants welcomed this type of study, which enabled them to express their thoughts and concerns freely in their own words, which is lacking in quantitative approaches.

6.5 Knowledge translation

We hope that this study will inform and influence the future practice of dentistry and support dentists who are willing to adopt a person-centered approach. We will inform dental educators and researchers about this model through an article we will submit to a scientific journal.

Our team consisting of my supervisor, Dr. Christophe Bedos, and co-supervisor, Dr. Jean- Noel Vergnes, will share the findings of this study with dental students through their academic positions at McGill University and Université Paul Sabatier – Toulouse III (France). This will help create awareness among future dentists to understand and recognize patients' needs and expectations and further encourage them to adopt person-centered approaches. In addition, we could improve the dental curriculum at McGill University by developing person-centered care training modules with case scenarios based on the seven components of the "Montreal-Toulouse Wheel of Patient's Expectations of Dental visits". Furthermore, we could extend this training program available to licensed dentists through the McGill University Continuing Dental Education program. It also needs to be mentioned that the findings of this study were presented by Reenu Angeline at the McGill Dentistry Annual Research Day in April 2020 and at the International Association of Dental Research conference in July 2021.

Finally, we hope the findings will inform the public about their rights and what they could expect when consulting dental professionals.

6.6 Directions for future research

Future research could consider exploring the expectations of different communities, gender, and age groups. For instance, researchers could include men, native indigenous people, refugees, and other geo-based communities to widen our understanding of person-centered care in dentistry. Furthermore, new studies could compare the expectations of people based on different geographic locations, including different countries. Most importantly, we welcome dentists and patients to evaluate and customize the "Montreal-Toulouse Wheel of Patient's Expectation for dental visits" depending on patients' needs, concerns, and the health culture of the community.

7. CONCLUSION

With person-centered care models becoming more popular in the medical field, there are only a few models in dentistry. Moreover, these models were proposed by dental professionals, researchers, and educators without patients' input. Hence, we did not know if they corresponded to patients' expectations in providing person-centered care. To address this research gap, we conducted a qualitative descriptive study in which elicited people's perspectives of person-centered dental care and tried to understand their needs and expectations about dental visits.

We described seven themes that mirrored the components of the "Montreal-Toulouse Wheel of Patients' Expectations in dental visits". Participants emphasized that communication was key to being understood as a whole person, and respect was the basis of the relationship. However, based on their previous experiences with the dentist, they felt they were often dismissed from receiving dental care based on factors like their ability to pay, insurance coverage, skin tone, and origin. They also mentioned their difficulties in sharing power with dentists and the communication barriers that prevented them from fully understanding the treatment process. Besides, the participants emphasized wanting enough time during clinical encounters and working as a team with the dentist. Finally, participants said being hospitable and having a warm and friendly relationship with the whole dental team translated to making their dental visits more comfortable.

To conclude, this study improves our understanding of what people may expect in a person-centered dental encounter and contributes to advancing person-centered care in dentistry. In addition, our findings contribute to a refinement of the existing models and framework of person-centered care in dentistry.

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9. COPYRIGHT

Figure 1: The Montreal- Toulouse Wheel of Patient's Expectations for dental visits is obtained from the article What should people expect from person-centred dental visits? The Montreal-Toulouse Wheel of expectations by Bedos et al. and reproduced with permission from springer nature.

Appendix A – Q-List for people about what to expect during person-centred dental visits is obtained from the article What should people expect from person-centred dental visits? The Montreal-Toulouse Wheel of expectations by Bedos et al. and reproduced with permission from springer nature.

10. APPENDICES

10.1 Appendix A: Q-List for people about what to expect during person-centred dental visits

10.2 Appendix B: The interview guide

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10.4 Appendix D: Recruitment invite email and advertisement

10.5 Appendix E: The McGill initial IRB approval

10.6 Appendix F: The McGill IRB approval for the continuation of the study

10.1 Appendix A: Bedos et al. Q-List for people about what to expect during person-centred dental visits(87)

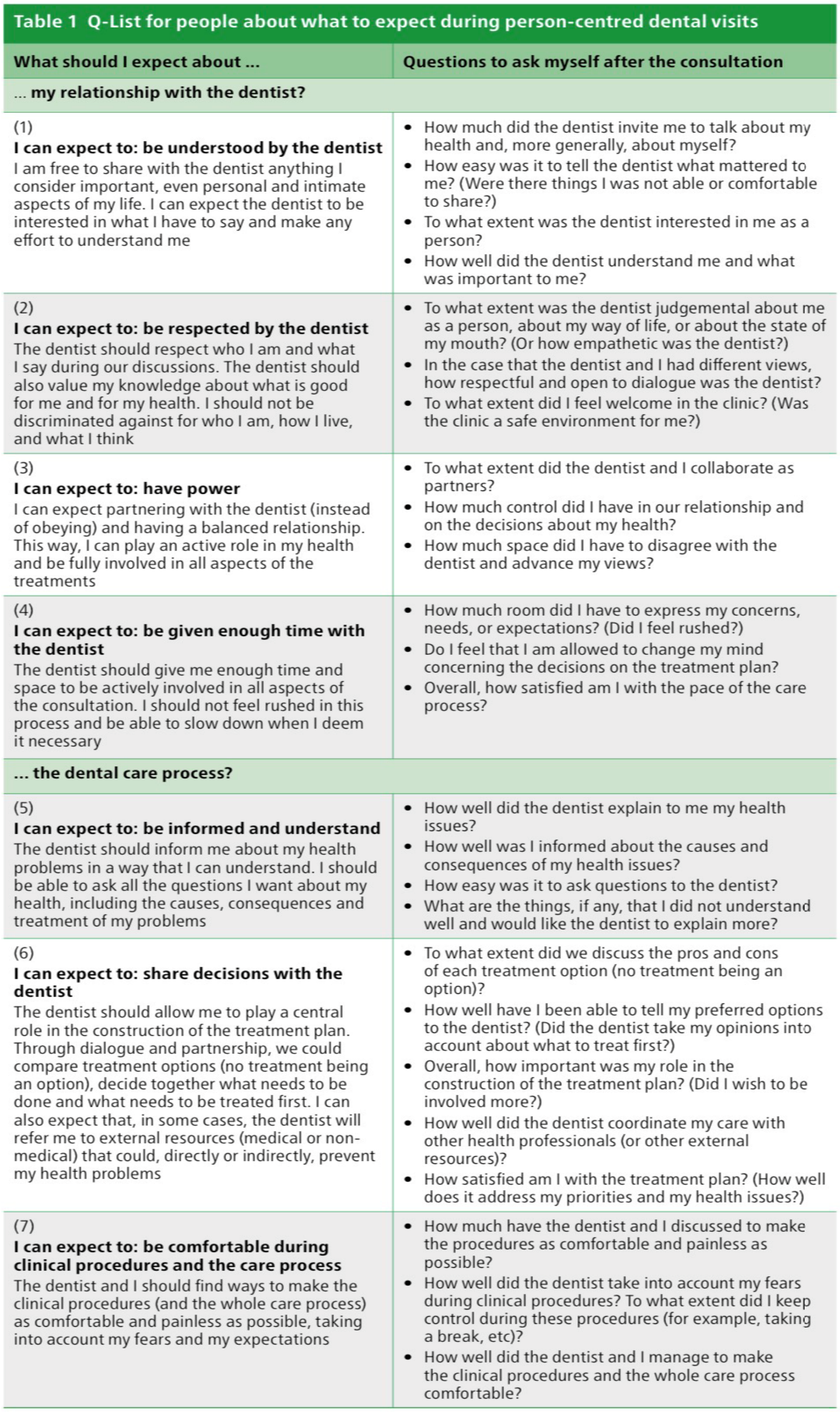


Table 1 Q-List for people about what to expect during person-centred dental visits

What should I expect about ...	Questions to ask myself after the consultation
... my relationship with the dentist?	
(1) **I can expect to: be understood by the dentist** I am free to share with the dentist anything I consider important, even personal and intimate aspects of my life. I can expect the dentist to be interested in what I have to say and make any effort to understand me	• How much did the dentist invite me to talk about my health and, more generally, about myself? • How easy was it to tell the dentist what mattered to me? (Were there things I was not able or comfortable to share?) • To what extent was the dentist interested in me as a person? • How well did the dentist understand me and what was important to me?
(2) **I can expect to: be respected by the dentist** The dentist should respect who I am and what I say during our discussions. The dentist should also value my knowledge about what is good for me and for my health. I should not be discriminated against for who I am, how I live, and what I think	• To what extent was the dentist judgemental about me as a person, about my way of life, or about the state of my mouth? (Or how empathetic was the dentist?) • In the case that the dentist and I had different views, how respectful and open to dialogue was the dentist? • To what extent did I feel welcome in the clinic? (Was the clinic a safe environment for me?)
(3) **I can expect to: have power** I can expect partnering with the dentist (instead of obeying) and having a balanced relationship. This way, I can play an active role in my health and be fully involved in all aspects of the treatments	• To what extent did the dentist and I collaborate as partners? • How much control did I have in our relationship and on the decisions about my health? • How much space did I have to disagree with the dentist and advance my views?
(4) **I can expect to: be given enough time with the dentist** The dentist should give me enough time and space to be actively involved in all aspects of the consultation. I should not feel rushed in this process and be able to slow down when I deem it necessary	• How much room did I have to express my concerns, needs, or expectations? (Did I feel rushed?) • Do I feel that I am allowed to change my mind concerning the decisions on the treatment plan? • Overall, how satisfied am I with the pace of the care process?
... the dental care process?	
(5) **I can expect to: be informed and understand** The dentist should inform me about my health problems in a way that I can understand. I should be able to ask all the questions I want about my health, including the causes, consequences and treatment of my problems	• How well did the dentist explain to me my health issues? • How well was I informed about the causes and consequences of my health issues? • How easy was it to ask questions to the dentist? • What are the things, if any, that I did not understand well and would like the dentist to explain more?
(6) **I can expect to: share decisions with the dentist** The dentist should allow me to play a central role in the construction of the treatment plan. Through dialogue and partnership, we could compare treatment options (no treatment being an option), decide together what needs to be done and what needs to be treated first. I can also expect that, in some cases, the dentist will refer me to external resources (medical or non-medical) that could, directly or indirectly, prevent my health problems	• To what extent did we discuss the pros and cons of each treatment option (no treatment being an option)? • How well have I been able to tell my preferred options to the dentist? (Did the dentist take my opinions into account about what to treat first?) • Overall, how important was my role in the construction of the treatment plan? (Did I wish to be involved more?) • How well did the dentist coordinate my care with other health professionals (or other external resources)? • How satisfied am I with the treatment plan? (How well does it address my priorities and my health issues?)
(7) **I can expect to: be comfortable during clinical procedures and the care process** The dentist and I should find ways to make the clinical procedures (and the whole care process) as comfortable and painless as possible, taking into account my fears and my expectations	• How much have the dentist and I discussed to make the procedures as comfortable and painless as possible? • How well did the dentist take into account my fears during clinical procedures? To what extent did I keep control during these procedures (for example, taking a break, etc)? • How well did the dentist and I manage to make the clinical procedures and the whole care process comfortable?

10.2 Appendix B: The interview guide

(Virtual interview)

Hello, my name is Reenu Lysander and I am a graduate student at McGill University, Faculty of Dentistry. I would like to thank you for reading and signing the consent form and also for taking the time to meet and discuss with me online today. As you know, my goal is to know what people think about dental visits and what they expect from the dentist. I need to confirm a few things with you before we get started. I know you have read the consent form and agreed to participate in the interview;(the share screen feature of the Zoom software will be used to display and explain the consent form briefly) yet, if you have any questions regarding the research or the interview, please feel free to ask me. I will be happy to explain it to you.

(In- person interview)

Hello, my name is Reenu and I am a graduate student at McGill University, Faculty of Dentistry. I would like to thank you for taking the time to meet and discuss with me. Please make yourself comfortable.

As you know, my goal is to know what people think about dental visits and what they expect from the dentist. I need to confirm a few things with you before we get started. I know you have agreed to participate in the interview, but can you please take some time to read this consent form and acknowledge it, if you agree? If you have any questions regarding the research or the interview, please feel free to ask me, I will be happy to explain it to you.

1. <u>Introduction</u>

   Could you introduce yourself and tell me a little about who you are?

2. <u>Experience with the dental visits</u>

   Thank you for sharing this with me. Now I would like to know more about your experiences with dentists.

   - ➢ Could you please share with me your last experience at a dental office?
     - i. When was the last time you consulted a dentist?
     - ii. Could you tell me what happened? Was it a regular checkup? Or an emergency? How did you book a dental appointment?
     - iii. Could you describe your visit at the dental office?
   - ➢ What was your experience like?
     - i. How was your relationship with this dentist?
     - ii. What are the things that the dentist and the staff did well, according to you?
     - iii. What are the things that the dentist and the staff did not do well, or could have done better?

    iv. Could you imagine what this dentist – or the staff – could have done differently to make your experience good? (or very good)

3. Ideal Dentist
    i. Could you tell me what would be an ideal relationship with a dentist? How do want to customize your dental visits? [probe: how would it work in a dental clinic in this perfect world? What would be a perfect encounter?]
    ii. What are the qualities a dentist should have for this perfect relationship?
    iii. According to you, what would be the qualities of this ideal dentist?
    iv. What would you expect from this ideal dentist?

4. Person – Centered care

- BE UNDERSTOOD

Some people say that dentists should try to understand their patients…

    i. What is your point of view on this: Do you think that the dentist should understand you well as a person?
        a. Follow up: If yes, what do you generally think that the dentist needs to understand and why do you think it is important to be understood?
        b. Follow up: If no, why do you think so?
    ii. In your previous visits,
        a. Did the dentist was welcoming you to express your concerns and expectations? If so, to what extent?
        b. Were you free or comfortable to share your views to the doctor?
        c. Were there any important things that you felt uncomfortable to share?

- BE RESPECTED

I have heard people say that dentists should respect their patient as a person

    i. What is your thought on this: Do you think that the dentist should respect your views? (knowledge, feelings, expectations, opinions etc.)
        a. Follow up: If yes,
            - How?
            - Why do you think it is important to be respected?
        b. Follow up: If no, why do you think so?
    ii. In your previous visits,
        a. How respectful was the dentist about you ande your life in general?
        b. In case of conflict of views between you and your dentist, Do you expect your dentist to be judgmental? If yes or no, why so?

- SHARE POWER

Some people also say that the patient and the dentist should share equal powers

i. What is your opinion on this: do you think that the dentists and their patients should work as a team? [what kind of team should they make according to you?]
ii. How much control would you like to have on the decisions about your dental health?
iii. In your previous visits,
    - Did you and the dentist work as a team?
        a. Follow up: If yes,
            - Did you like it?
            - How was the experience to work as a team?
            - Did you find the dentist dominating controlling your health decisions?
            - Did you feel compelled to agree on dentist view?
            - Did you feel uncomfortable to disagree to dentists' opinions?
        b. Follow up: If no,
            - Did you like it?
            - Did you feel compelled to agree on dentist view?
            - Did you feel uncomfortable to disagree to dentists' voice?

➢ HAVE ENOUGH TIME

Some people feel that dentists do not give enough time and space to the patients…

i. Could you share your views on this: How much time would you like to need to talk to the dentists about your concerns, needs, or expectations?
ii. In your previous visits,
    - Did the dentist give you enough time to reflect on the various treatment options and decide? How much tim?
        a. Follow up: If yes,
            - Could you share your experience?
        b. Follow up: If no,
            - Why do you think so?
            - Did you feel rushed or slowed down on deciding treatment plans?

    - Do you feel that you are allowed to change your mind concerning the decisions on the treatment plan?

➢ BE INFORMED AND UNDERSTAND

Most of the people say that dentist should inform the health problems in a way that a patient can understand.

i. What is your point of view on this: Do you think it is important that the dentist clearly explains the diagnosis and its causes in simple terms? If so, why?

ii. Do you think that the dentist should be welcoming to answer the patient question?
iii. In your previous visits,
    - How clearly did the dentist informed the health problem to you?
    - Did the dentist clearly explain you about the cause of your health problems? If so, how (by verbal or model)?
    - In case you didn't understand what the dentist said, do you feel easy to ask the dentist to explain it to you again?

- CO-CONSTRUCT THE TREATMENT PLAN
  They are people who also say that the patient and the dentist need to decide together about the treatment.

i. According to you, how should you and the dentist decide about the dental treatment? (various treatment options, including the pros and cons of each of them?)
ii. In your previous visits,
    - Was it comfortable to ask questions about the treatment options and share your preferences?
    - How important was your role (and your input) in the co-construction of the treatment plan? (Do you think you could have been involved more?)
    - Were you satisfied with the treatment plan? (i.e. does it address your health problems and priorities?)

- BE COMFORTABLE DURING PROCEDURES
  Some people feel that the dental visits should be comfortable and approachable.

i. According to you, what would make you at ease during dental procedure? (is it the welcoming nature of the dental clinic, relaxing sound or understandable conversation with dentist)
ii. In previous visits,
    - How much have you and dentist discussed to make the dental procedures as comfortable and painless as possible?
    - Did the dentist consider your fears and expectations about the procedures into account? Did the dentist give you control during the treatment? (e.g. taking a break)
    - How successful have we been to make the dental procedures comfortable?

5. The closing part of the interview:

We are almost towards the end of the interview. Shall we continue?

- Thinking back of all your experiences, can you please describe positive aspects of these experiences?
- Thinking back of all your experiences, can you please describe negative aspects of these experiences?
- What would like you to improve or expect from the dental visits?
- According to you, what is heath and illness?

6. Now I would like to ask you a couple of more precise questions about yourself. And as I said before, you do not have to answer to these questions if you do not want to do so.

   - Socio-demographic questions:
     a. How old are you?
     b. Where do you live?
     c. What is your marital status?
        i. Do you have kids?
     d. What is your highest level of education?
     e. Are you currently employed?
        i. Follow-up: If yes, what do you do?
        ii. Follow-up: If no, how long have you been unemployed? Follow-up: Are you currently looking for work?
     f. Could you tell me when did you immigrate to Canada?
     g. What is your country of origin?
     h. What is your mother tongue?

7. Do you have any comments or questions about this research? Anything you want to add to what we've discussed?

8. How did you find the experience of the interview?

9. Would it be ok to contact you in the next days or weeks if I have any other questions?

   This is the end of the interview. If you would like to add anything in the future, something you think of later, please feel free to contact me.
   Thank you once again for participating in this interview.

10.3 Appendix C: The consent form

INFORMATION AND CONSENT FORM

Faculty of Dentistry

McGill University
2001 McGill college ave, Rm 529
Montreal, QC, CANADA H3A 1G1

Tel. # (514) 398-7203 Ext.0129
Fax # (514) 398-8242
E-mail: christophe.bedos@mcgill.ca

Faculté de médecine dentaire

Université McGill
2001, av. McGill college, bureau 529
Montréal, QC, CANADA H3A 1G1

Title of Research Project:
Person-centered dental care through people's lens – a qualitative descriptive study

Researchers:

- Principal Investigator: Dr. Christophe Bedos, Associate Professor, McGill University, Faculty of Dentistry, Division of Oral Health and Society
- Student Investigator: Reenu Angeline Lysander Suthan Sam, McGill University, Faculty of Dentistry, Division of Oral Health and Society
- Co-researcher: Dr. Jean-Noel Vergnes, Adjunct Professor, McGill University, Faculty of Dentistry, Division of Oral Health and Society

Introduction:
We invite you to take part in our research project. Before you make a decision please read this consent form carefully: it describes the purpose of this study, the nature of your participation and highlights your rights. If you have any additional questions, please discuss with one of our researchers. You can also discuss with your friends and family members to get their advice. Participation in this study is voluntary. You can withdraw your consent at any time. If you decide to take part in this study, you will be asked to sign this consent form. You will receive a copy of this consent form to keep.

Purpose of the Research:
We want to better understand people's expectations and preferences with respect to visiting a dental clinic.

Study procedures
Your participation is voluntary. If you agree to participate, we will ask you to take part in a face-to-face interview with Ms. Reenu Angeline Lysander Suthan Sam. She expects to interview approximately 12 to 15 woman that are part of the South Asian Women (SAW) community. If the COVID – 19 crisis resolves, the interview could take place either in a quiet room at SAWCC center, or in a public place of your choice, as long as it is quiet and allows a confidential discussion. If an interview "in-person' is not possible, we will propose to organize a "virtual" interview; it will

take place through Zoom/Skype application, while both student investigator and participant sitting in a quiet room.

During this interview, the discussions will be informal; they will be conducted in English and last between 30 minutes and 1 hour. The interviewer, Ms. Reenu Angeline Lysander Suthan Sam She will digitally record the interview with your permission and transcribe it later. If you opt out of the recording, you can still take part in the study and Reenu will document the interview with hand-written or typed notes. During this interview, you will have the choice to stop the discussion at any time or take a break whenever needed. You have the right to refuse to answer any question.

Possible risks:

There is a little or no risk associated with the interview, mainly because your participation simply consists of talking with Reenu Angeline Lysander Suthan Sam. However, some of the questions or subjects during the interview might be uncomfortable for you to respond to or cause discomfort. If this happens, Reenu will offer you to pause or stop the interview. You could also withdraw your decision to participate at any point, before or during the interview. In case of emergency, the researcher will also provide contact information of mental health care services to the participants and accompany the participants there, if needed.

Possible benefits:

You are unlikely to directly benefit from your participation in this study. The researchers nevertheless hope that the information gained from this study will influence the future practice of dentistry and support dentists willing to adopt a person-centered approach.

Confidentiality:

All information you provide—including your identifying data, your health information, and the responses you give during the interview—will be considered completely confidential. This pledge of confidentiality means that the interview materials will be coded and stored in such a way as to make it impossible to associate them directly with you.

The transcribed interviews will not contain any names (all names will be removed in order to make them anonymous). All the identifiable data will be stored on McGill University's OneDrive network, which is password-secured and only accessible by Reenu Angeline Lysander Suthan Sam; access will be granted to her supervisor, Dr. Christophe Bedos. The data will be transferred to Dr. Christophe Bedos' OneDrive account after Reenu Angeline Lysander Suthan Sam's graduation, and eventually be destroyed after seven years as per University policy. Any printed material, including consent forms, transcripts, etc. will be stored in a locked filing cabinet in a secure central location accessible only to the principal investigator, Dr. Christophe Bedos.

The findings of this study will be published in a Master's thesis written by Ms. Reenu Angeline Lysander Suthan Sam, as well as in scientific journals and conference materials. You might be quoted in these; however, we will make sure that these quotations will be anonymous. Consequently, the readers will not be able to identify anyone - whether it is you or the people that you may mention during the interview. All names will be erased, and any information that would allow readers to recognize anyone's identity will be removed.

A representative of the McGill Institutional Review Board, or a person designated by this Board, may access the study data to verify the ethical conduct of this study.

Compensation:
Each participant will receive compensation of $20 cash for taking part in the study. This compensation could cover participants' cost related to their participation (such as transportation or internet fee in the case of a "virtual interview").

Contact Information for questions about the study:
-Reenu Angeline Lysander Suthan Sam: MSc Dental Science Student, McGill University, Faculty of Dentistry, 2001 Ave McGill College, Montreal, QC, H3A 1G1. Tel: 514 702 3762.
Email: reenu.lysandersuthansam@mail.mcgill.ca
- Dr. Christophe Bedos: Associate Professor, McGill University, Faculty of Dentistry, 2001 Ave McGill College, Montreal, QC, H3A 1G1. Tel: 514-398-7203 ext. 0129#
Email: christophe.bedos1@mcgill.ca

Contact information for questions about the rights of research participants:
If you have any questions or concerns regarding your rights or welfare as a participant in this study, you can contact:

Ms. Ilde Lepore: Ethics Officer for the McGill Institutional Review Board, McGill University, Faculty of Medicine, McIntyre Building, #633-3655 Promenade Sir William Osler, Montreal, Quebec H3G 1Y6.
Tel: (514) 398-8302.
Email: ilde.lepore@mcgill.ca

CONSENT:

Please mark your choice of yes or no on the line next to your answer.

I agree to be interviewed ☐ YES ☐ NO

I agree to be digitally recorded via Zoom/Skype ☐ YES ☐ NO

I have read the information in this consent form. I am aware of the purpose of this study and what I am asked to do. I have asked my questions, and my questions have been answered. I was given enough time to make a decision. I am free to withdraw from this study at any time. I was informed that my name will not appear on any publications associated with this study. I do not give up any of my legal rights by signing this consent form. I will be given a copy of this signed consent form.

Name of the participant: ………………………………………. Date: ………………………

Signature of the participant: ……………………………………

Person who obtained consent: …………………………………. Date: ………………………

Signature of the person who obtained consent: ………………………………

10.4 Appendix D: Recruitment invite email and advertisement

Dear ……….,

Make your voice heard with South Asian Women Community Centre (SAWCC)! We are conducting virtual Zoom / in – person interviews as part of a study at McGill University. Our goal is to know what people think about dental visits and what they expect from the dentist. Your participation will influence the adoption of person-centered dentistry.

The participants should:

- Be at least 18 years old
- Speak English
- Have consulted a dentist in the last 2 years

Interview duration: 30 mins to 1 hour
Compensation: 20 $ (cash/cheque/e- transfer).

If you are willing to participate, kindly reply to this email (reenu.lysandersuthansam@mail.mcgill.ca) or contact Reenu +1 (514)-702-3762. We will get in touch in with you for further details and explanations.

In case you have any questions or concerns, please do not hesitate to contact us at the same email address. We look forward to hearing from you.

With thanks,
Reenu

PERSON-CENTERED DENTAL CARE THROUGH THE PEOPLE'S LENS – A QUALITATIVE DESCRIPTIVE STUDY

We are looking for participants in a study conducted at McGill.
We want hear to what people think about dental visits

The participation consists of an informal discussion with Reenu

The discussion could be in person or on-line
It will last less than an hour

You will be compensated 20$ for your participation

To participate, you should
- Be at least 18 years old
- Speak English
- Have consulted a dentist in the last 2 years

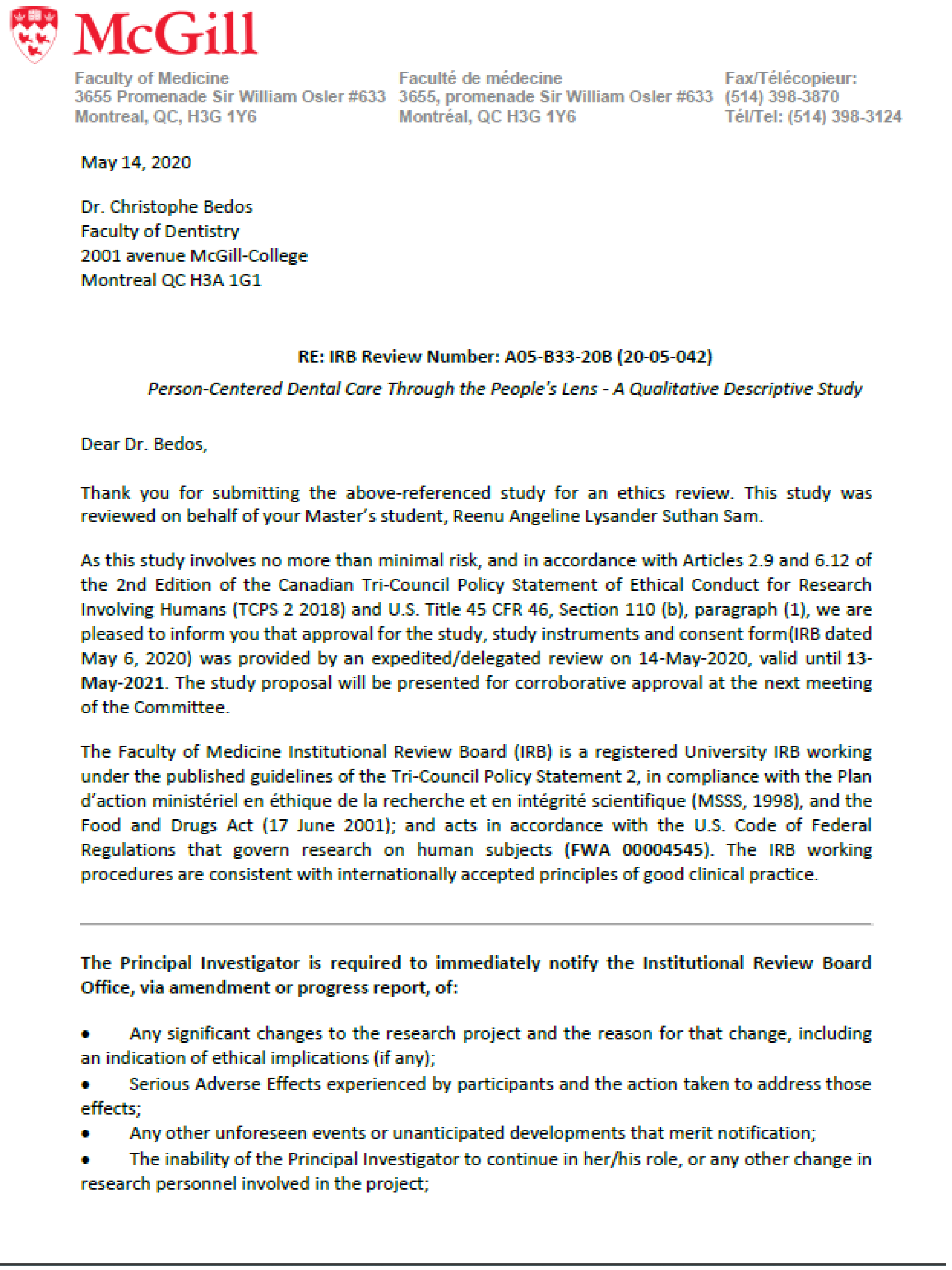
If you are interested, please contact:

Reenu +1 (514)-702-3762 or

reenu.lysandersuthansam@mail.mcgill.ca

This project is supervised by Dr. Christophe Bedos (christophe.bedos1@mcgill.ca) at McGill University, Faculty of Dentistry.

10.5 Appendix E: The McGill initial IRB approval



McGill

Faculty of Medicine
3655 Promenade Sir William Osler #633
Montreal, QC, H3G 1Y6

Faculté de médecine
3655, promenade Sir William Osler #633
Montréal, QC H3G 1Y6

Fax/Télécopieur:
(514) 398-3870
Tél/Tel: (514) 398-3124

May 14, 2020

Dr. Christophe Bedos
Faculty of Dentistry
2001 avenue McGill-College
Montreal QC H3A 1G1

RE: IRB Review Number: A05-B33-20B (20-05-042)

Person-Centered Dental Care Through the People's Lens - A Qualitative Descriptive Study

Dear Dr. Bedos,

Thank you for submitting the above-referenced study for an ethics review. This study was reviewed on behalf of your Master's student, Reenu Angeline Lysander Suthan Sam.

As this study involves no more than minimal risk, and in accordance with Articles 2.9 and 6.12 of the 2nd Edition of the Canadian Tri-Council Policy Statement of Ethical Conduct for Research Involving Humans (TCPS 2 2018) and U.S. Title 45 CFR 46, Section 110 (b), paragraph (1), we are pleased to inform you that approval for the study, study instruments and consent form(IRB dated May 6, 2020) was provided by an expedited/delegated review on 14-May-2020, valid until 13-May-2021. The study proposal will be presented for corroborative approval at the next meeting of the Committee.

The Faculty of Medicine Institutional Review Board (IRB) is a registered University IRB working under the published guidelines of the Tri-Council Policy Statement 2, in compliance with the Plan d'action ministériel en éthique de la recherche et en intégrité scientifique (MSSS, 1998), and the Food and Drugs Act (17 June 2001); and acts in accordance with the U.S. Code of Federal Regulations that govern research on human subjects (**FWA 00004545**). The IRB working procedures are consistent with internationally accepted principles of good clinical practice.

The Principal Investigator is required to immediately notify the Institutional Review Board Office, via amendment or progress report, of:

- Any significant changes to the research project and the reason for that change, including an indication of ethical implications (if any);
- Serious Adverse Effects experienced by participants and the action taken to address those effects;
- Any other unforeseen events or unanticipated developments that merit notification;
- The inability of the Principal Investigator to continue in her/his role, or any other change in research personnel involved in the project;

- A delay of more than 12 months in the commencement of the research project, and;
- Termination or closure of the research project.

The Principal Investigator is required to submit an annual progress report (continuing review application) on the anniversary of the date of the initial approval (or see the date of expiration).

The Faculty of Medicine IRB may conduct an audit of the research project at any time.

If the research project involves multiple study sites, the Principal Investigator is required to report all IRB approvals and approved study documents to the appropriate Research Ethics Office (REO) or delegated authority for the participating study sites. Appropriate authorization from each study site must be obtained before the study recruitment and/or testing can begin at that site. Research funds linked to this research project may be withheld and/or the study data may be revoked if the Principal Investigator fails to comply with this requirement. A copy of the study site authorization should be submitted the IRB Office.

It is the Principal Investigator's responsibility to ensure that all researchers associated with this project are aware of the conditions of approval and which documents have been approved.

The McGill IRB wishes you and your colleagues every success in your research.

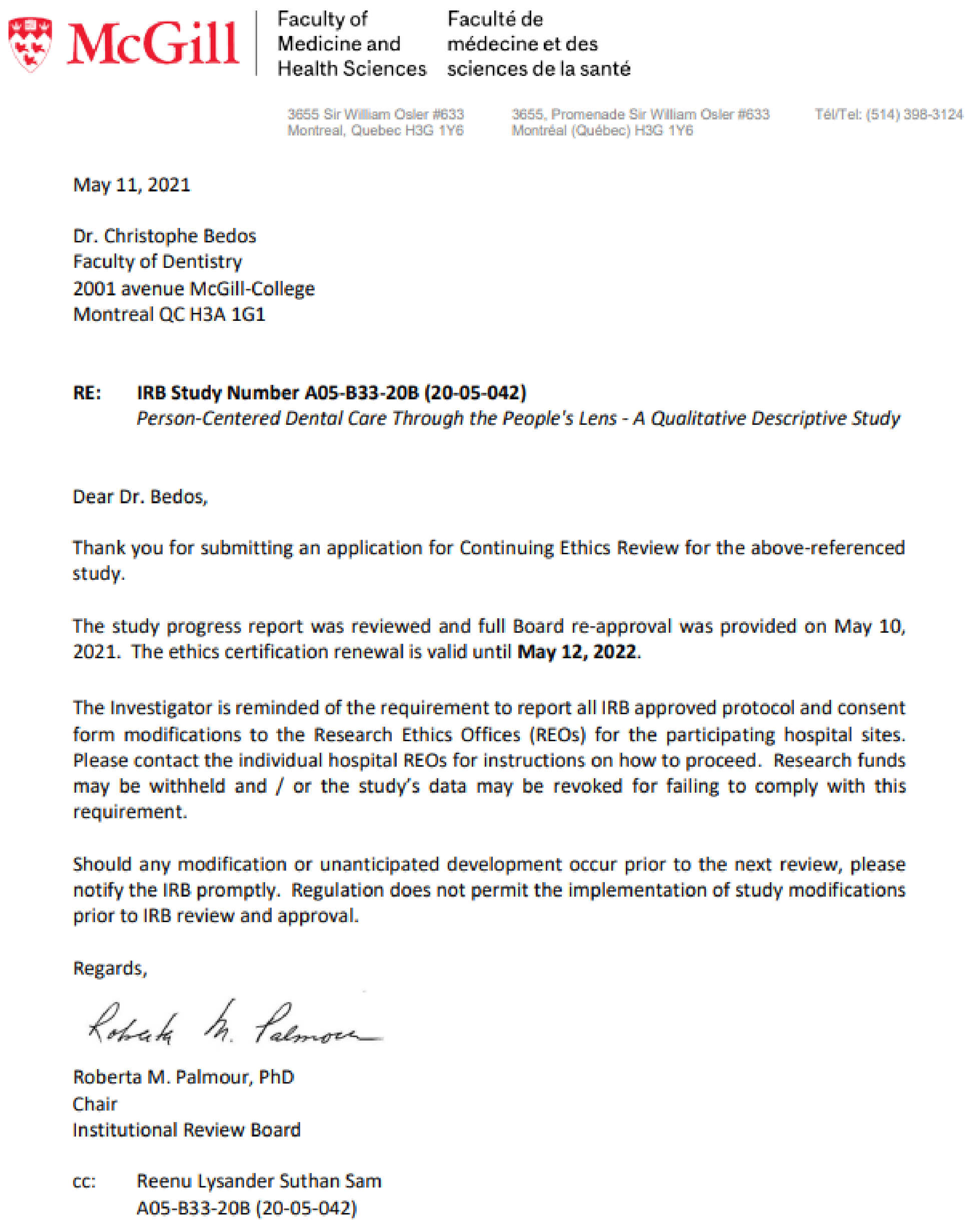
Sincerely,

Roberta M. Palmour

Roberta Palmour, PhD
Chair
Institutional Review Board

cc: Reenu Lysander Suthan Sam
Dr. S. Baillet, Associate Dean, Research
A05-B33-20B (20-05-042)

10.6 Appendix F: The McGill IRB approval for continuation of study



McGill | Faculty of Medicine and Health Sciences | Faculté de médecine et des sciences de la santé

3655 Sir William Osler #633
Montreal, Quebec H3G 1Y6

3655, Promenade Sir William Osler #633
Montréal (Québec) H3G 1Y6

Tél/Tel: (514) 398-3124

May 11, 2021

Dr. Christophe Bedos
Faculty of Dentistry
2001 avenue McGill-College
Montreal QC H3A 1G1

RE: IRB Study Number A05-B33-20B (20-05-042)
Person-Centered Dental Care Through the People's Lens - A Qualitative Descriptive Study

Dear Dr. Bedos,

Thank you for submitting an application for Continuing Ethics Review for the above-referenced study.

The study progress report was reviewed and full Board re-approval was provided on May 10, 2021. The ethics certification renewal is valid until **May 12, 2022**.

The Investigator is reminded of the requirement to report all IRB approved protocol and consent form modifications to the Research Ethics Offices (REOs) for the participating hospital sites. Please contact the individual hospital REOs for instructions on how to proceed. Research funds may be withheld and / or the study's data may be revoked for failing to comply with this requirement.

Should any modification or unanticipated development occur prior to the next review, please notify the IRB promptly. Regulation does not permit the implementation of study modifications prior to IRB review and approval.

Regards,

Roberta M. Palmour

Roberta M. Palmour, PhD
Chair
Institutional Review Board

cc: Reenu Lysander Suthan Sam
A05-B33-20B (20-05-042)

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3655 Sir William Osler #633
Montreal, Quebec H3G 1Y6

3655, Promenade Sir William Osler #633
Montréal (Québec) H3G 1Y6

Tél/Tel: (514) 398-3124

May 10, 2022

Dr. Christophe Bedos
Faculty of Dental Medicine and Oral Health Sciences
2001 avenue McGill-College
Montreal, QC H3A 1G1

RE: IRB Study Number A05-B33-20B (20-05-042)
Person-Centered Dental Care Through the People's Lens - A Qualitative Descriptive Study

Dear Dr. Bedos,

Thank you for submitting a Continuing Review Form to extend the above-referenced study's ethics oversight for one more year.

The study progress was reviewed and Full Board re-approval was provided on May 9, 2022. The ethics certification renewal is valid from **May 12, 2022 to May 11, 2023**. The status of your renewal submission including documents can be accessed on eRAP https://infoed.is.mcgill.ca

Investigators are reminded of the requirement to report all McGill IRB approved study documents to the Research Ethics Offices (REOs) of participating study sites, if applicable. Please contact the individual REOs for instructions on how to proceed. Research funds may be withheld and / or the study's data may be revoked for failing to comply with this requirement.

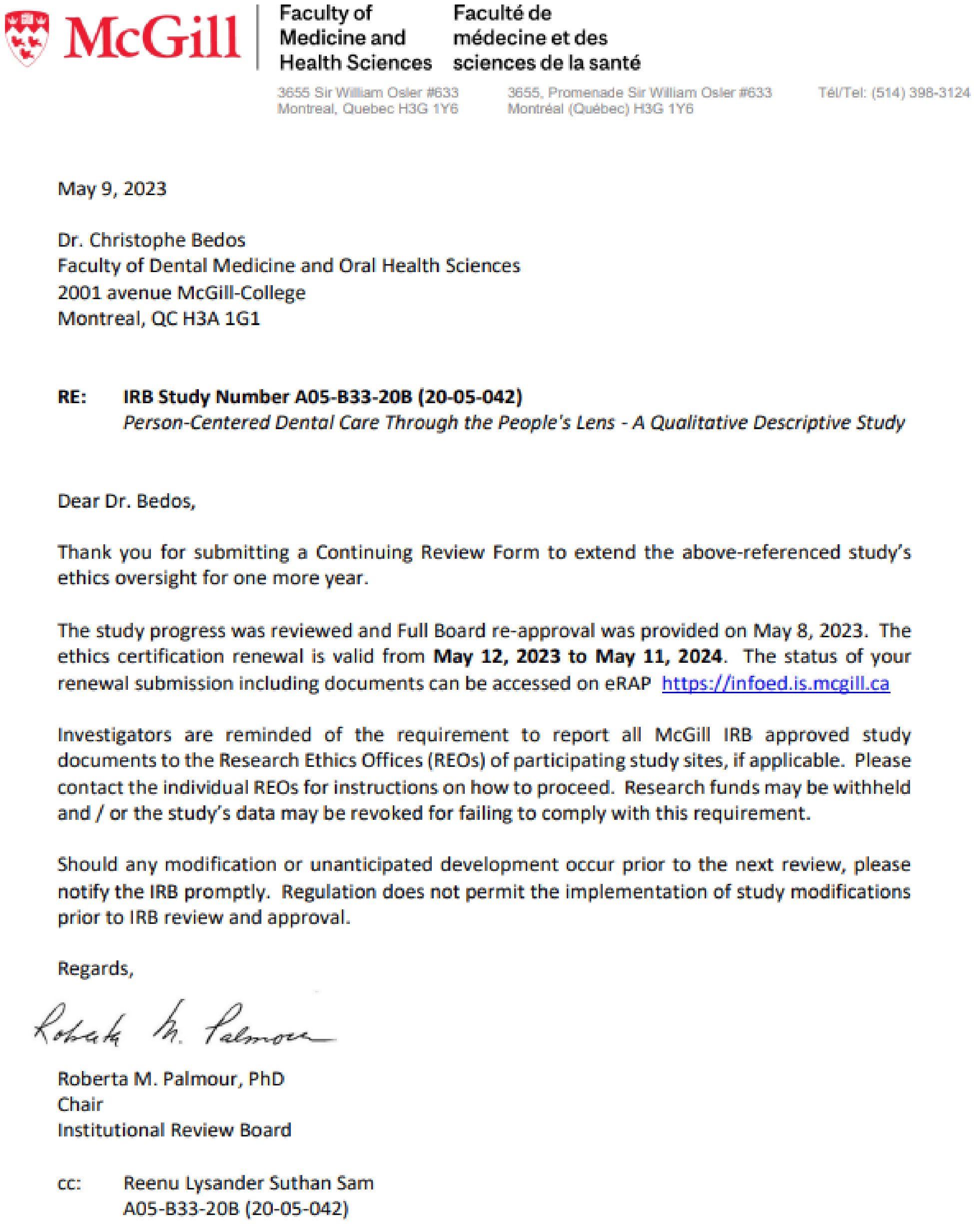
Should any modification or unanticipated development occur prior to the next review, please notify the IRB promptly. Regulation does not permit the implementation of study modifications prior to IRB review and approval.

Regards,

Roberta M. Palmour

Roberta M. Palmour, PhD
Chair
Institutional Review Board

cc: Reenu Lysander Suthan Sam
A05-B33-20B (20-05-042)



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3655 Sir William Osler #633
Montreal, Quebec H3G 1Y6

3655, Promenade Sir William Osler #633
Montréal (Québec) H3G 1Y6

Tél/Tel: (514) 398-3124

May 9, 2023

Dr. Christophe Bedos
Faculty of Dental Medicine and Oral Health Sciences
2001 avenue McGill-College
Montreal, QC H3A 1G1

RE: IRB Study Number A05-B33-20B (20-05-042)
Person-Centered Dental Care Through the People's Lens - A Qualitative Descriptive Study

Dear Dr. Bedos,

Thank you for submitting a Continuing Review Form to extend the above-referenced study's ethics oversight for one more year.

The study progress was reviewed and Full Board re-approval was provided on May 8, 2023. The ethics certification renewal is valid from **May 12, 2023 to May 11, 2024**. The status of your renewal submission including documents can be accessed on eRAP https://infoed.is.mcgill.ca

Investigators are reminded of the requirement to report all McGill IRB approved study documents to the Research Ethics Offices (REOs) of participating study sites, if applicable. Please contact the individual REOs for instructions on how to proceed. Research funds may be withheld and / or the study's data may be revoked for failing to comply with this requirement.

Should any modification or unanticipated development occur prior to the next review, please notify the IRB promptly. Regulation does not permit the implementation of study modifications prior to IRB review and approval.

Regards,

Roberta M. Palmour

Roberta M. Palmour, PhD
Chair
Institutional Review Board

cc: Reenu Lysander Suthan Sam
A05-B33-20B (20-05-042)