Perspectives of adults using free dental clinics regarding dental care: a qualitative descriptive study

Nioushah Noushi, BMSc
Division of Oral Health & Society
Faculty of Dentistry
McGill University, Montreal
July 2017

A thesis submitted to McGill University in partial fulfillment of the requirements of the degree of Master of Science, Dental Sciences.

© Nioushah Noushi, 2017

TABLE OF CONTENTS

Topic **Page number**

LIST OF TABLES

LIST OF FIGURES

ABSTRACT

Background: The dental care system in Canada is predominantly privatized. As a result, it has led to limited accessibility to dental care for low-income populations. These populations have the greatest need for dental care in our society.

The dental care system has seen a slow trend toward person-centred care (PCC) relative to other health care disciplines. Most of the research on PCC has been performed by scholars and clinicians who have tried to progress away from disease-centred care. However, the perspectives and experiences of people receiving dental care have not been considered. This omission of such perspectives is particularly true with respect to people with low incomes.

Objectives: (1) to describe the perspectives of adults using free dental clinics regarding dental care, and (2) to document their suggestions for improvements to the dental care provided.

Methods: This qualitative descriptive study includes users of a free dental clinic in Montreal, Canada that provides care to people in poverty. We adopted a maximum variation sampling strategy regarding age, sex, education level, marital status, and employment status. Our method for collecting data was in-depth, semi-structured interviews. During these interviews, we focused on participants' experiences of and perspectives about dental care. We reached data saturation after interviewing 13 participants. The interviews were transcribed verbatim, and these transcripts where then analyzed using a thematic content analysis strategy.

Results: Participants were generally satisfied with the dental care they received in both private and free dental clinics. They did not appreciate the wait times in the free dental clinic but otherwise praised its existence, as they would not have access to dental care without it.

The major barrier preventing them for accessing dental care in privatized dental clinics was the exorbitant cost of services, which made them feel excluded and marginalized. Additionally, there was a unanimous desire among them for quality time with the dentist and an exchange of sufficient and appropriate information. The participants also emphasized the importance of trust in the dentist-patient relationship, highlighting that its presence helped them feel cared for by both the clinician and the clinic.

They recommended incorporating a walk-in concept into all dental clinics, especially free dental clinics, as well as integrating a base salary for clinicians. Both recommendations would address problems with access to care for low-income populations. Participants also reported that incorporating a salary for the dentists could partly reduce the financial incentive associated with treating patients who can afford dental care.

Conclusions: Clinicians should adopt a more comprehensive approach when providing information in dental encounters with low-income populations. Taking into consideration the person's needs while sustaining shared-decision making in clinical encounters will support person-centred dental care. Thus, there will be an improvement of patients' dental care experiences and overall perspectives of dentistry.

RÉSUMÉ

Contexte: Le système de soins dentaires au Canada est principalement privatisé. En conséquence, il a permis une accessibilité limitée aux soins dentaires pour les populations à faible revenu. Ces populations ont le plus grand besoin de soins dentaires dans notre société.

Le système de soins dentaires a connu une tendance lente vers les soins centrés sur la personne (PCC) par rapport aux autres disciplines de soins de santé. La plupart des recherches sur PCC ont été réalisées par des chercheurs et des cliniciens qui ont essayé de progresser loin des soins axés sur la maladie. Cependant, les perspectives et les expériences des personnes qui reçoivent des soins dentaires n'ont pas été étudiées. Cette omission de perspectives est particulièrement vraie chez les personnes à faible revenu.

Objectifs: (1) décrire les perspectives des adultes utilisant des cliniques dentaires gratuites concernant les soins dentaires, et (2) documenter leurs suggestions d'amélioration des soins dentaires fournis.

Méthodes: Cette étude descriptive qualitative comprend les utilisateurs d'une clinique dentaire gratuite à Montréal, Canada, qui fournit des soins aux personnes en situation de pauvreté. Nous avons adopté une stratégie d'échantillonnage à variation maximale concernant l'âge, le sexe, le niveau de scolarité, l'état civil et le statut de l'emploi. Notre méthode de collecte de données était des entretiens semi-structurés et approfondis. Au cours de ces entretiens, nous nous sommes concentrés sur les expériences et les perspectives des participants en matière de soins dentaires. Nous avons atteint la saturation des données après avoir interviewé 13 participants. Les entrevues ont été transcrites textuellement, et ces transcriptions ont ensuite été analysées à l'aide d'une approche thématique.

Résultats: Les participants étaient généralement satisfaits des soins dentaires qu'ils recevaient dans les cliniques dentaires privées et gratuites. Ils n'ont pas apprécié les temps d'attente dans la clinique dentaire gratuite, mais ont par ailleurs fait l'éloge de son existence car ils n'auraient pas accès aux soins dentaires sans elle.

La principale barrière qui les empêchait d'accéder aux soins dentaires dans les cliniques dentaires privatisées était le coût exorbitant des services, ce qui les faisait sentir exclus et marginalisés. En outre, il y avait un désir unanime parmi eux pour du temps de qualité avec le dentiste et un échange d'informations suffisantes et appropriées. Les participants ont également souligné l'importance de la confiance dans la relation dentiste-patient, soulignant que sa présence les a aidés à se sentir soignés par le clinicien et la clinique.

Ils ont recommandé d'intégrer un concept sans rendez-vous dans toutes les cliniques dentaires, en particulier les cliniques dentaires gratuites, ainsi que l'intégration d'un salaire de base pour les cliniciens. Les deux recommandations porteraient sur les problèmes d'accès aux soins pour les populations à faible revenu. Les participants ont également signalé que l'incorporation d'un salaire pour les dentistes pourrait réduire partiellement l'incitation financière associée au traitement des patients qui peuvent se payer des soins dentaires.

Conclusions: Les cliniciens devraient adopter une approche plus complète lorsqu'ils fournissent des informations sur les rencontres dentaires avec des populations à faible revenu. Prendre en considération les besoins de la personne tout en soutenant la prise de décision partagée dans les rencontres cliniques soutiendra les soins dentaires centrés sur la personne. Ainsi, il y aura une amélioration des expériences de soins dentaires des patients et de leurs perspectives générales de la dentisterie.

ACKNOWLEDGEMENTS

I would like to start by thanking my supervisor, Dr. Christophe Bedos for his unwavering support and guidance throughout my master's studies. I have learned a lot about how to approach and organize all aspects of a research project. Although incredibly challenging, I greatly appreciate the invaluable experiences and knowledge I have gained as Christophe's student.

I would also like to thank the other members of my supervisory committee, Dr. Nareg Apelian for his help and advice; Dr. Jean-Noel Vergnes for his insight and positive demeanor; Dr. Charo Rodriguez for her expertise and support. This incredibly strong team helped me progress through my studies with great gusto and success. Un très grand merci à vous tous!

To Dr. Linda Furlini, it was a great pleasure to work with you on a different project and I am truly grateful for your advice and consistent support.

To Dr. Laura Stone, my time working in your lab offered me much insight into another facet of research. Thank you for giving me this opportunity.

To Dr. Paul Sweet and Dr. Jeff Myers, thank you for allowing me to recruit at the Jim Lund Dental Clinic and not only pursue my research interests but meet truly lovely people in the process. Likewise, thank you to Ms. Nicole Di Tillo for your help with recruitment. Thank you to the participants of my study for willing to share their personal experiences with me.

To the MDGSS committee members 2015-2017 and Dr. Tran, thank you for giving me a fulfilling experience in a supportive milieu. Similarly, I would like to thank the division of Oral Health & Society, as well as my fellow graduate students for providing me with a caring and thoughtful environment to pursue my studies.

Thank you to all my friends who were there for me throughout this challenging and rewarding experience.

Thank you to Ms. Maria Palumbo for your support and for always willing to answer my questions no matter how numerous they may have been.

I would also like to thank the Fondation Marcel et Jean Coutu, CREMIS, as well as the RSBO for their financial support throughout my degree.

Finally, I would like to offer my greatest gratitude to my parents and grandmother. Thank you for always being there for me because I would not have been able to accomplish any of this without you.

CONTRIBUTION OF AUTHORS

The conceptualization of this project was through the fruition of multiple meetings with my supervisor, Dr. Christophe Bedos, and my supervisory committee, Dr. Jean-Noel Vergnes, Dr. Nareg Apelian, and Dr. Charo Rodriguez. I organized all the documents for ethics approval and visited the clinic prior to recruitment to familiarize myself with the location and to acquire approval from the head clinician, Dr. Paul Sweet.

With the help of the receptionist, I recruited all the participants and interviewed them. I transcribed the interviews and coded them. Moreover, I analyzed the data and identified the emerging themes and sub-themes. I performed the literature review and wrote every section of this entire thesis. It should be noted that Dr. Christophe Bedos edited my work all throughout my MSc career. Also, I had interim meetings with my supervisory committee to review my progress and discuss about various factors pertaining to the topic.

1. Introduction

Oral health is a very important facet of general systemic health (1, 2). As a result, it is a necessity to support good oral and dental health to prevent adverse health problems. Despite the importance of dental health, it can be difficult for people to take sufficient and timely care of their teeth. Low socioeconomic status has led to limited access to dental care and therefore poor oral health in low-income populations (3). Consequently, these populations are marginalized and cannot receive the care they need. This is particularly true about populations who have low incomes and cannot afford the expensive cost of the privatized dental care system present in Quebec and Canada (3, 4). Based on their financial circumstances, these populations often resort to using free dental clinics, such as the Jim Lund Dental Clinic in Montreal.

There has been a trend toward incorporating a more patient- and person-centred approach to provide adequate and personalized health care. The concept and term patient-centred care was initially introduced by the psychoanalyst Enid Balint in 1969 (5). Many years later, the Institute of Medicine defined patient-centred care as the provision of care that is "respectful of, and responsive to, individual patient preferences, needs and values" while "ensuring that patient values guide all clinical decisions" (6).

In dentistry, patient- and person-centred care has evolved slowly, and most literature concerning the topic is based on frameworks created and improved upon by clinicians and academics (7, 8). Due in part to its relatively novel nature, patient experiences of dental care have not been considered (7, 8). Additionally, there is a significant gap regarding their perspectives about how they are receiving dental care since they have been largely excluded from the development of patient- and person-centred care approaches in dentistry (7, 8). This is

especially true concerning the experiences and perspectives of low-income populations, including those using free dental clinics, about dental care. To better understand what these frameworks should include and how they can cater to the needs of the individuals who receive care, their voices must no longer be ignored.

This research and study is important because it addresses the abovementioned gap in literature. To better understand how low-income populations experience dental care, the objectives of this study are: (1) to describe the perspectives of adults using free dental clinics regarding dental care; and (2) to document their suggestions for improvements to the dental care provided.

This MSc thesis addresses these objectives by including the following sections: 1) a literature review detailing research pertaining to the topic, 2) a methodology section describing the approaches taken to gather and analyze data; 3) a results section detailing the emerging themes, sub-themes and the quotes that support them; 4) a discussion that elaborates upon the findings and presents the implications of the research; and 5) a conclusion that summarizes the study and highlights the important concepts that emerged. There are also multiple appendices that include further information pertaining to the administrative aspects of this project.

2. Literature review

This literature review is organized into three sections, the first of which has three components, and the second of which has four components. To begin, I delve into the concept of access to care where it is important to consider the dental care system in Quebec and Canada, as well as the accessibility of care to the entire population. This first section concludes in a look at low-income populations and the free dental clinic that they may use in Montreal, Quebec. The second section addresses the concepts of patient- and person-centred care in medicine to provide a greater historical context of their origins. This section concludes with the topic of patient- and person-centred care within dentistry. The last section reviews previous research performed in dentistry taking into consideration patient perspectives and perceptions.

2.1. Access to Care

The concept of access has been approached and defined in many ways. The main definition given to access to dental care is the process of gaining an initial contact with a dentist (9). Additionally, it may include the characteristics of the provider, which can affect how services are produced and thus consumed (9). Access to care has long been a problematic facet of health care. This is particularly true for dentistry since it is an almost entirely privatized field, with 95% of all care in Canada being offered by the private dental care system (10). There have been some strides toward reducing this inequity in access, such as the implementation of subsidized and free clinics (11). However, even when present, these clinics are scarce and remain difficult to access due to their long wait times (12). This is especially an issue for low-income populations whose limited revenue cannot support the exorbitant costs of services delivered in

private dental clinics (3, 4). Thus, availability and affordability issues have a very large impact on the accessibility of dental care (4). Moreover, these barriers can vary from population to population, such as issues with accommodation for those with physical disabilities (13).

2.1.1. Dental Care Systems in Quebec and Canada

Health care in Canada functions under a universal system offering free health care to all Canadians (14). While this approach has been in place for health care, dental care has not been included in the universal Medicare system (15). There are many factors involved in the exclusion of dental care in the national Medicare system, such as a decrease of dental caries's prevalence during the time in which the health care policies were being developed and implemented (15). In addition, there was the widespread thought that dental care and oral health were a personal responsibility, therefore there was no need to implement a social and public framework by including them within Medicare (15).

Much of what is the dental public sector falls under the jurisdiction of provinces and territories, each having their own rules and laws (10, 16). As of the year 2014, only 5% of all dental care provided in Canada was through public expenditures. Most of these public dental services were offered in hospitals where some care is covered under Medicare (10). For instance, services such as local or general anesthesia, radiographs, and drainage of an abscess are among services offered free of charge for insured people in Quebec (16). In addition to dental care provided in hospitals, a few populations receive public dental care through provincial and federal programs. These populations include “military personnel, those with recognized indigenous status, social assistance recipients and their dependents, some seniors and/or those with

developmental disabilities, veterans, federal prisoners, and refugees" (10). It should be noted that 32% of Canadians do not have dental insurance, further explaining their inability to pay for their costly dental care (10). The private sector of dentistry receives 55% of all expenses through private insurances. The other 45% of private dental care is received through out-of-pocket expenses (10).

In Quebec, the Régie de l'assurance maladie (RAMQ) covers health care and by extension offers a minimal amount of dental care coverage (16). The RAMQ has some programs related to dental services. These programs offer services such as in-hospital bone grafts, drainage of an abscess, repositioning of the jaw, and removal of a cyst or tumour, among few others (16). The RAMQ does not cover costs relating to tooth extractions (16). There is a slightly greater coverage for children under the age of 10 in both hospitals and dental clinics (16). Some of the covered treatments are amalgam fillings for posterior teeth, tooth extractions, and one examination per year, among some others (16). The cost of cleanings and fluoride applications are not included. There is also some level of coverage for people receiving "last-resort financial assistance", and what is covered is based on whether they received financial assistance for less than 12 consecutive months or for at least 24 consecutive months (16). The former provides services including tooth and root extractions, and repair of a soft tissue laceration (16). The latter provides services such as repair of prostheses and replacement of prostheses following surgery (16).

2.1.2. Dental Care Access in Quebec and Canada

To further elaborate upon the complexity of the concept of access to dental care, both levels of education and income are strongly associated with visits to dental professionals; the lower the education and income levels, the less people consult a dentist (17). Largely due to the very costly dental care system present in Canada, 17% of all Canadians did not visit a dental professional in the year 2012. Additionally, 16% of all Canadians did not have the full treatment recommended due to the cost, as per a Canadian Dental Association report released in 2013 (10). Low-income populations, who may not qualify for Medicare, report visiting a dentist only in cases of emergency. Moreover, they report having poor functionality of their teeth, and a worse oral health status than those able to afford dental care (3). Similarly, people receiving social assistance are less likely to seek dental care compared to those with dental insurance (18).

By maintaining this primarily privatized approach to dental care, the accessibility of dental care for the general population is significantly reduced (14). Studies consistently show an inequality of access to dental care for low-income and underserved populations (4, 19, 20). Due to the high cost of dentistry, it can often be considered as a secondary expense that is not always a necessity (4). Additionally, the public dental benefits that are available are insufficient to meet the dental care needs of low-income populations (4) as they do not include the larger expenses, such as root canals and implants (16). As a result, populations on social assistance often acquire tertiary dental care, such as extractions, when they manage to gain access to dental care (18).

The large gap in the realm of access to dental care is thus due in part to the financial inequalities that exist in society, a gap that cannot simply be remedied by increasing dental insurance coverage (11). The isolation of dental care with regards to general health in Canada

also plays a role in the poor dental health of those who lack access. Additionally, dentistry's exclusion from Medicare affects the general health of those unable to receive the dental care they need (21). Therefore, it is important to try to identify, understand, and address the reasons why people, especially underserved populations, may not be seeking dental care in order to better address their problems (22).

2.1.3. Low-Income Populations and Stigmatization Within Dentistry

Low-income populations, such as those of low socioeconomic status or on social assistance (23, 24), are stigmatized throughout various aspects of their lives. This stigmatization is no different with regards to their dental health (22-25). One of the prevailing reasons for this stigmatization lies in the predominantly privatized system in place for dentistry in Canada (25).

Stigmatization can be experienced in numerous manners. A common pattern of stigmatization among underserved people lies in a level of misunderstanding felt between both the dentist and the patient (24). From the patient's perspective, the misunderstanding further highlights the feeling of unease and discomfort present at dental appointments (24). However, from the perspective of the dentist, the stigmatization is based on the idea that people are in poverty and lack privilege due to their own personal deficiencies (24). With this mindset, the dentist does not consider external factors that may impact the patient's socioeconomic status. (24). This may be significantly detrimental to the relationship between dentists and underserved patients because it promotes animosity, confrontation and isolation. Moreover, it may also entirely prevent the establishment of a positive and healthy dentist-patient relationship. This lack

of proper dentist-patient relationship could then have a negative impact on the patient's dental health, self-esteem, self-worth, and level of respect for the profession of dentistry (24).

2.2. Patient- and Person-Centred Care

In an increasingly consumerist society, people play a more significant role in all their life decisions (26-28). Thus, there is a trend toward a greater desire from individuals to take part in their own health care decisions (26-31). The individuality of a person is respected in patient- and person-centred care, and is the axis around which these concepts function (32). People thus feel empowered when they can play a role in their own health journey (32). Accordingly, the medical system has seen many changes over the years (33, 34), including the offering of services in ways that meet the constantly changing needs of the population (26, 31, 35, 36).

Patient-centred care in medicine has had many definitions dating to the late 1960s (37) including those by Enid Balint who coined the terms (38), Byrne and Long (39), as well as McWhinney (40). All of these definitions included humanizing the patient and understanding his or her illness through his or her own point of view and experiences (37). In the mid-1990s, the most comprehensive definition of PCC, proposed by Moïra Stewart, comprised of six interrelated components occurring during the clinical interaction: "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 patient-doctor relationship; 6) 'being realistic' about personal limitations and issues such as the availability of time and resources" (37, 41). Thus, there has been a consistent lack of a unified definition in the medical

world pertaining to patient-centred care due to the variety of definitions provided by many different researchers (37).

Patient- and person-centred care has recently been introduced to dentistry where it had been lagging as compared to medicine and other health professions (7, 42, 43). The use of the words patient and person as the initial descriptors of the concept are still not very well clarified. Thus, the concepts of patient-centred care and person-centred care are often used interchangeably (44). This uncertainty is perplexing since the terms patient and person allude to two different experiences of health care from the perspective of the person receiving care (32). For example, the word patient generally refers to a person who is sick and in need of medical attention (32). On the other hand, the word person is defined as a "human being or an individual" (32), which is an all-encompassing term that does not simply refer to the person's illness.

In health care, there has been a general movement toward the adoption of the terms person- and people-centred care in addition to patient-centred care. As a result, the person receiving care is further considered as one whole person and thus he or she is treated as such (36, 45, 46). Much of the emergence of these approaches is based on the concept of individualism in the health care field (32). In this thesis, PCC will refer to both patient- and person-centred care due to the limited body of literature available on these topics in dentistry.

2.2.1. Patient- and Person-Centred Care in Medicine

Physicians followed the biomedical model of medicine before patient- and person-centred care were introduced (37, 47, 48). According to this model, the patient was a carrier of disease

and the physician's role was to treat the disease, disregarding the complexities of the patient's experiences and how these may have impacted the disease (47). As a result, the signs and symptoms of the disease were the only factors considered in the diagnosis and in the search for an appropriate treatment. This process allowed the physician to take the patient from a state of "sick" to "normal" by curing the disease (37, 48).

The origins of PCC lie in psychiatrist George L. Engel's biopsychosocial model (47). This model addresses the missing dimensions of the biomedical model by incorporating psychological and social factors (47). Therefore, by taking a more personalized and customized approach to medicine, patient-centred care considers the biomedical, psychological, and social factors that may affect the person and his or her ailment (47). Through this approach, the physician must have the "willingness to become involved in the full range of difficulties patients bring to their doctors, and not just their biomedical problems" (37, 41). Therefore, taking a patient-centred approach requires the physician to broaden the scope of medicine by incorporating the many facets of what make a person human, including the non-medical components (37). In addition to considering the various biomedical, psychological and social factors that may influence the way a person experiences an illness, it is also important to understand what meaning he or she assigns to this experience (38). Therefore, the goal of a PCC approach is to "understand the complaints offered by the patient, and the symptoms and signs found by the doctor, not only in terms of illnesses, but also as expressions of the patient's unique individuality, his conflicts and problems" (49).

Patient-centred care involves shared power between the physician and the patient (39), which requires a safe space of equal rights in the relationship. This is considerably different from the previously well-established paternalistic approach to medicine whereby the doctor was the

expert in the field and knew what was best for the patient based on the signs and symptoms. This approach did not consider the importance of the experiences and knowledge that a lay person could bring to the doctor-patient relationship. This exclusion was highly critiqued (37), resulting in a shift from a paternalistic approach to one of 'mutual participation' (37). This shift fosters shared decision-making and allows patients to take greater responsibility of their health through an increase in acquired information and unrestricted discussion with the physician (50).

Within patient-centred care, the therapeutic alliance between the doctor and the patient highlights the priority that is assigned to the doctor-patient relationship. Developing and maintaining this alliance is important since it can lead to positive or negative adherences to treatment plans (37). Empathy and receiving sufficient information have been identified as highly valuable to maintaining a beneficial doctor-patient relationship (37, 51). Despite the importance of the patient in the therapeutic alliance, the literature predominantly focuses on the doctor's role in providing a desired emotional setting for the patient (37).

The doctor-patient relationship is expressed as a 'behavioural interaction' between the patient and the doctor (37). Factors such as gender norms, cultural differences, age, positive or negative clinical experiences, language barriers and time limitations are the most immediate influencers of a doctor's ability to be patient-centred during a patient encounter (37). Thus, being patient-centred involves many interrelated and cumulative factors within a respectful interaction that is responsive to each patient's informed needs and preferences (44). For instance, largely uninsured or underinsured patients visiting campus clinics in Chicago identified various important behaviours and traits about their doctors that supported the provision of patient-centred care (52). These included, a positive doctor-patient relationship, good time management skills and coherent explanations of all steps of the diagnosis and treatment (52).

The doctor's own personal qualities may have an impact on the exchange between the doctor and the patient (37). Within the biomedical model, objectivity reigned supreme and any form of subjectivity pertaining to the care of the patient was considered a gap in the physician's education. In contrast, in PCC, the subjectivity of the doctor in the doctor-patient relationship is considered inevitable and an integral part of the relationship (37, 53).

Much like patient-centred care, person-centred care has been evolving without a universal definition since the late 1980s (32). Nevertheless, there are some notable definitions that help guide research, as well as practice, in medicine and dentistry. For instance, person-centred care is defined as "a holistic approach to deliver a respectful and individualized care, allowing negotiation of care and offering choice through a therapeutic relationship in which persons are empowered to be involved in health decisions through mutual trust" (32). Person-centred care maintains the personhood of the subject being considered, thereby respecting his or her individuality (32). Personhood has three dimensions: 1) within their own 'world', the person's focus is on their "need to be understood"; 2) they require a certain level of "physical and emotional security" as their 'self'; and 3) the social and material world considers their need for a sense of belonging relating to 'others' (32, 54). Rational decision-making and reflection are important facets of the concept of personhood that is at the base of person-centred care (32, 55).

In addition, person-centred care also organizes medicine and medical care through concepts like relationship building and collaboration among and between medical professionals, other health care professionals, patients and their families, and patients and their doctors (56). Through these diverse interactions, person-centred care maintains highly interrelated and interdisciplinary approaches to health care. Throughout its progressive growth, person-centred care has become a staple of quality medical care and an asset in understanding patients'

perceptions of their health care (44).

In an attempt to better unify the concept, the World Health Organization declared people-centred care as a fundamental approach in health care during its 2009 World Health Assembly (57). Furthermore, it included this strategy as part of its WHO 2014-2019 Work Program where it also focuses on integrative and universally accessible health care (57). This move further highlights the significant role of people- and person-centred care in medicine.

2.2.2. Patient- and Person-Centred Care in Dentistry

Practicing dentistry involves a detached diagnostic process that incorporates a paternalistic approach to decisions made regarding interventions and treatments (58). As a result, it has been difficult for dentistry to adopt patient- and person-centred care. The field's focus on the biomedical processes underlying the 'diseases' being 'treated' is driven by this paternalistic approach to care (7, 58). When the emphasis is on these systematic and strictly biological problems, then the person who is being treated loses part of his or her identity and role in the process of care (7, 58). The past decade has seen significant strides away from the paternalistic model within dentistry (43, 59, 60).

Due to the surgical intervention present in dental care, medical models of PCC are not easily transferrable to dentistry. Nevertheless, medical models have been used and applied to clinical practice while conceptualizing patient-centred dental care (7). Due to its relative novelty, however, PCC remains a theoretical concept framed in the realm of dentists and researchers (7, 61). To date, patient- and person-centred care in dentistry still focuses on how the clinician thinks care should be provided (7, 62).

A dental appointment entails various steps (63), from the acquisition of the appointment, time spent in the waiting room, interactions with other staff, and time spent after the actual appointment. Among these many steps, the dentist-patient relationship is often highlighted as one of the most important components from a patient- and person-centred point of view (7). Therefore, non-judgmental power-sharing (62) between the patient and the dentist addresses patient needs in addition to treating the illness (8).

Apelian et al. developed a model of person-centred dentistry with the goal of humanizing clinical dentistry. This model (Figure 1) comprises three principles: understanding, decision-making, and intervention (7). The first of the three, understanding, incorporates both the identification of the disease, as well as encourages the patient to discuss his or her experiences of illness (7). The second principle, decision-making, is central to an "equally powered relationship" through "co-authoring the treatment plan", and is "always subject to discussion, evaluation, and validation" (7). Lastly, the third principle, intervention, involves the traditional surgical procedures but also takes into consideration the "patient's own pace, previous fears, and values and accommodate the intervention to them" (7). The central concept within person-centred care in dentistry identified by Apelian et al. is the "equal-powered patient-dentist encounter" (7).

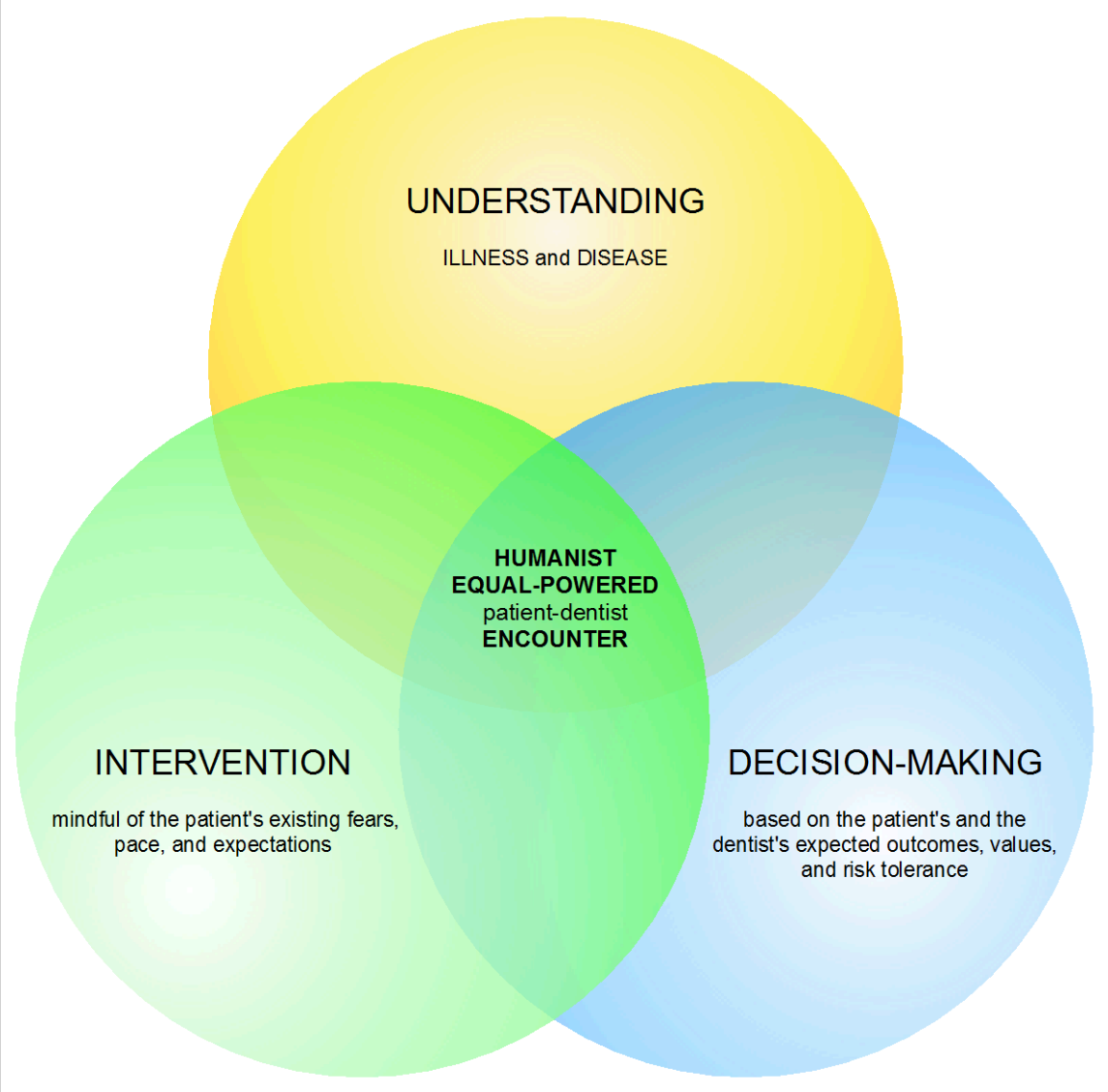

Figure 1. "Heuristic representation of the Person-Centred dental clinic model"

Narrative medicine is an approach suggested by Dr. Rita Charon that can be applied within dental schools to increase PCC among dental students, and therefore their dental practice (8). Dr. Charon, a professor at Columbia University, referred to narrative capacity as "the ability to recognize, absorb, metabolize, interpret, and be moved by stories of illness" (8, 58). Thus, it highlights the importance of skills such as empathy (8) that can lead to equal-powered dentist-patient relationships. As a result, narrative dentistry could be taught in dental schools to initiate discussions about the philosophical and biopsychosocial underpinnings of person-centred care in

dentistry. A greater patient- and person-centred approach would help dentists provide a safer environment for underserved patients, leading to a more accepting relationship between the two groups. Through this, the hope would be to improve their oral health, and other facets of their general health by extension (1, 2).

2.3. Research Pertaining to Patient Perspectives and Perceptions in Dentistry

The limited literature available regarding patient- and person-centred care in dentistry highlights its novelty in the field. Despite the patients being at the center of both concepts, their perspectives and experiences have not been sufficiently considered and addressed. As a result, there is a limited amount of knowledge available to understand their experiences of dental care and how these fit into the conceptualization of patient- and person-centred care in dentistry.

The approach of patient- and person-centred care needs to be adapted to each person by attempting to understand what he or she wants in order to feel more in control of his or her dental care (43). This is especially significant since patient-centred care has also been shown to be beneficial to the patients' outcomes and level of satisfaction with the care they receive (8). For instance, people receiving dental care valued characteristics such as empathy (64), warmth and understanding because these helped create a caring environment where they could be involved in their care (43, 65).

Oral and maxillofacial patients in the UK underlined the importance of communication and teamwork, as well as 'good interpersonal skills' when considering the social and psychological characteristics of dentist-patient interactions (66). According to these patients,

interpersonal skills include “empathy, sympathy, and emotional intelligence” (66). It should be noted that these traits or abilities complemented technical ‘hard’ skills, as well as reputation and clinical outcome (66). In another study, people with apical periodontitis also presented their preference for a patient-centred approach rather than the traditional “paternalistic approach to patient care” (67). These patients valued autonomy in their decision-making process, but also wanted collaboration with the dentist (67).

Other studies have used surveys to better identify patients’ desires, perceptions, and expectations in order to adjust their diagnostic and treatment approaches accordingly (68). However, it should be noted that the use of surveys in such contexts impedes the emergence of deep thoughts, perceptions, and experiences from patients (68). Researchers have adopted in-depth interviews (43, 69) in the hopes of learning greater details about people’s dental experiences. Still, these interviews are not sufficient to fully understand the experiences of people attending regular private dental clinics, let alone subsidized (69) or free dental clinics.

3. Purpose and Research Questions

3.1. Purpose

We are interested in what the most vulnerable and excluded people need and experience. As a result, we chose to recruit patients who use free dental clinics. Therefore, the purpose of this study is to describe the perspectives of adults using free dental clinics regarding dental care. Moreover, we also want to know their suggestions for improvements to dental care. These comments and recommendations could be addressed through curricular and practice changes at the educational and clinical levels.

3.2. Research Questions

To achieve our purpose, the following research questions guide our empirical investigation and are stated as follows:

a) What are the perspectives of adults using free dental clinics regarding dental care?

b) What are their suggestions for improvements to the dental care provided?

4. Methodology

4.1. Research Team

The team of researchers included my supervisor, Dr. Christophe Bedos, who is also a professor teaching person-centred care to the undergraduate dentistry students at McGill University. In addition, there was Dr. Nareg Apelian, who is director of the 3rd year students' clinical activities, and co-director of the clinical decision-making course in the 3rd year of the dental program. He teaches PCC with Dr. Christophe Bedos, has reflected a lot on PCC as a practitioner, and has developed a model as an academic researcher. The next member of the research team was Dr. Jean-Noel Vergnes, professor at Université Toulouse III – Paul Sabatier, where he teaches person-centred care to dentistry students. The final member of the research team was Dr. Charo Rodriguez, a professor in the Department of Family Medicine in the Faculty of Medicine at McGill University. Dr. Rodriguez is an expert in qualitative health research and management.

The entire research team was involved in determining the objective of the research, as well as the research questions and part of the interview guide. All the interviews, transcription, and most of the analysis were done solely by me. The members of the research team received all the interview report forms and the interview transcripts upon their request, neither of which had identifiable information in them. My supervisor was the main active member of the research team who discussed the analysis of the data and the rest of the thesis with me.

Reflexivity was a vital asset to possess as a researcher, especially since I was the one identifying codes and themes that would be further considered during the analysis. Consequently, I was aware of my position in the research and how my decisions and judgment could impact the

interpretations of the data (70). Personally, I believe that I had an emic perspective because I have been a patient visiting a dental clinic and have had many different experiences in such a situation. Moreover, I am not a dentist, therefore I have been the patient in all my dental appointments, which further helps me relate with the participants since they have all only been patients and not dentists. However, I believe that my perspective was also etic because I am not part of this particular group of people with low incomes who use a free dental clinic.

4.2. Research design

Qualitative research is situated in an interpretivist/constructivist paradigm. The ontology that leads to this paradigm aims to "understand the world of human experience" (71) and therefore considers that "reality is socially constructed" (72). Within this paradigm, I conducted a qualitative descriptive study as defined by Sandelowski (73, 74). This methodology is a form of naturalistic inquiry (75, 76), which allows the researcher to offer a thorough description of a phenomenon of interest (73). It also enables the participants to describe their personal experiences in a natural context (73, 75, 76). The goal of qualitative description is a contextualized and comprehensive summary of events as they were experienced, described and defined by the participants involved in the study (73). Qualitative description was appropriate for this study because it helped me obtain answers to the research questions (73). Therefore, we could acknowledge and understand the participants' perspectives of their experiences with dental care, the meaning they gave to these experiences, and why they gave those meanings to their experiences (73).

Based on the choice of methodology, we did not use a formal theoretical or conceptual framework since our purpose as researchers was to report and interpret, at a basic level, what the participants were saying in their own words (73).

4.3. Methods of Data Generation

4.3.1. Participant sampling strategy:

We recruited participants who are excluded from the privatized dental care system in Canada due to their socioeconomic status. Since they cannot afford dental care and do not have access to social assistance, they frequent a free dental clinic. Our interest in this population is also based on the fact that the dental care system needs to be adjusted to the most vulnerable populations to better respond to their needs and the challenges they face. The sampling was purposive to include people who were patients in a free dental clinic (73, 77). The use of maximum variation sampling let us explore common and unique life events that were pertinent to the perspectives of adults using free dental clinics regarding dental care (73). The criteria for the maximum variation sampling included sex, age, education level, marital status and employment status (78). The rationale behind using these dimensions was that these may be factors in differing perceptions of health care. For instance, I ensured to recruit both men and women since they can have varying experiences and perceptions with regards to their approach to health care (79-81). Moreover, there are differences between younger and aging populations (80) where increased age is associated with increased positive perceptions of health care (82, 83). Additionally, a higher educational level is associated with a decrease in positive perceptions of health care providers (82).

The sample included adults who use free dental clinics because of their economic, health and societal situations. We conducted the recruitment for the data collection of this study at the free Jim Lund Dental Clinic in Montreal (84). This dental clinic is run through McGill University's Faculty of Dentistry Service to the Community Program at the Welcome Hall Mission. We chose this clinic because it offers free dental care to low-income populations who are otherwise completely excluded from the dental care system due to their low socioeconomic status and their ineligibility for social assistance.

The Jim Lund Dental Clinic is self-described as one of "24 different community groups and agencies throughout the Montreal area, which assist disadvantaged populations […] patients include individuals who require dental care but are ineligible for Dentcaid, do not have dental insurance or cannot afford to receive treatment in private or university constraints […]" (85). This clinic was established on February 11, 2011 and is located in the Welcome Hall Mission in the St-Henri burough of Montreal (84). Patients attending this clinic are from underserved communities on the island of Montreal (86). Those who want to use the services must either be referred through one of the many partner agencies or open a file through the food bank at Welcome Hall Mission (84). Additionally, there may be referral cases through social workers if the person does not have a permanent address or is part of the Welcome Hall Mission. The services offered at the clinic are "complete dental examination, regular and deep cleaning (under local anesthetic), simple fillings, simple extractions, referrals to the Montreal General Hospital in emergency cases" (84, 87). At the clinic, there are three dental chairs being used five days a week for ten months of the year. The staff involved are: two third and fourth year dental students from McGill University, two dental hygiene students from John Abbott College, two dentists, one resident, one dental assistant (84, 87), and a receptionist.

I visited the Jim Lund Dental Clinic and discussed with the head clinician, Dr. Paul Sweet, and his staff to get better acquainted with how the dental clinic is organized. He suggested that the best way to recruit patients is to visit the clinic and speak with patients in the waiting room. During this visit, he gave me permission to recruit at the clinic and mentioned that no advertisements or pamphlets were necessary. In addition, the Associate Dean Clinical Affairs, Dr. Jeff Myers, also gave me permission to recruit patients at the clinic.

The receptionist mentioned that she has a waiting list of people who may be called to come in if there are last minute cancellations. She added that she can contact people in-house in the Welcome Hall Mission, in the rehab center on the second floor of the Welcome Hall Mission, in the reinsertion program, in the Men's Mission, or in the Food Bank Services. This allows the patients who were on the first appointment waiting list lasting generally five to six months or were scheduled for a later appointment to be seen at an earlier appointment time.

The inclusion criteria for this study were adults over the age of 18 who used the Jim Lund Dental Clinic services and who understood and spoke English and/or French. All people who could not express themselves clearly in an oral capacity or who did not fit the inclusion criteria were excluded from this study. When I attempted to recruit a participant, the receptionist introduced me to them in the waiting room as a graduate student conducting a study. During this time, I provided the potential participants with an overview of the research project by using a detailed consent form (Appendix B). If the people were interested, I arranged a time and place for the interview that suited their availabilities and preferences. I also invited the potential participants to contact me by phone or email if they required further information and/or clarifications. In certain cases, the interview took place immediately after their dental appointment in a private room at the Jim Lund Dental Clinic. If the interview was scheduled for

a later date, it either took place in a meeting room in the Faculty of Dentistry, or at a McDonald's or Tim Hortons near the participant's residence. Before starting the interview, I reviewed the consent form with them, answered all their questions, and invited them to sign the form. Once consent was acquired, the interview began.

This study reached data saturation with 13 participants in 12 interviews. It should be noted that considering the language criteria, participants being able to speak English or French, six of the interviews were conducted in English and the other six were conducted in French. Although I began every interview with one individual participant, as one of my interviews was progressing, the participant's partner also entered the room because he was taking care of their child who wanted to see the parent I was interviewing. The parent who later entered the room then joined the discussion while they both took care of their infant. Both participants had mentioned that they would partake in the study and as such I do have signed informed consent forms for each participant.

4.3.2. Methods for collecting data:

I conducted semi-structured open-ended interviews (73, 88) from September 2016 to January 2017. The rationale for using such a method was its ability to elicit stories of experience from the participants (89). Particularly, it provided the participants with the opportunity to express their experiences of dental care, while also allowing them confidentiality (88) and comfort in a private setting. The choice of individual in lieu of group interviews, such as focus groups, was due to the qualitative descriptive methodology I used in this study (73).

Additionally, individual interviews were more feasible for both the participants and myself as they were easier to organize and schedule.

During the interviews, I invited the participants to talk about their experiences of dental care, how they felt about them, and what meaning they gave to these experiences. I used the research questions to build the initial interview guides in both English and French (Appendices C and D, respectively). I then adjusted them based on the participants' experiences with private clinics and the Jim Lund Dental Clinic. The interview guides were also fine-tuned after a discussion with my supervisory committee.

The interview guides included many sections, some of which I will describe in more detail below. It should be noted that I adapted the interview guide to fit the flow of each discussion by changing the order of the questions while keeping the content unchanged.

At the beginning of the interview, participants introduced themselves and talked about their personal journey. The next section was devoted to their past dental experiences, such as the time of their last dental problem and what influenced their decision to visit a dentist or not. Then, we discussed their first impression of the dental clinic they visited, their interaction with the receptionist and their interaction with other staff excluding the dentist. Afterwards, I inquired about their interaction with the dentist and how much information the dentist provided regarding their case and the required care. Finally, we discussed the process that took place at the end of the appointment, including getting a referral or follow-up if necessary. Throughout this process, I also asked the participants to describe what they would change about any aspect of the dental visit, and how they would bring about this change.

Next, we discussed the Jim Lund Dental Clinic and the participants were asked to share their experiences related to this dental clinic. They described the process of obtaining an appointment, how long it took to be accepted, and what suggestions they had to improve the care being provided at the Jim Lund Dental Clinic.

Finally, before ending the interview, I asked each participant to imagine his or her ideal dental clinic while considering all possible aspects, including the aesthetics of the clinic, the personnel, and the process of being a patient.

The interviews, which lasted between 40 minutes and two hours, were digitally audio-recorded. Following each interview, I completed an interview report form and emailed it to the supervisory committee members. This form included a preliminary description of the findings, information related to the location and time of the interview, and methodological considerations. Next, I transcribed the interview verbatim (70) and distributed the transcript to the supervisory committee members as per their request. Each transcript was password-protected and the password was sent to the team members in a separate email.

4.4. Data Analysis

4.4.1. Methods for analyzing data:

As recommended by Braun and Clarke, the data collection and data analysis took place simultaneously. The analysis was interactive since I adapted to the data collected and any new perceptions or concepts about dentistry, person-centred care, or access to dental care expressed

by the participants (73). For instance, the concept of "fee-for-service" was brought up by one of the first participants, so I decided to consider it by adding it to the interview guides.

I conducted a thematic analysis of the data, following the approach described by Braun and Clarke (70). This approach seemed pertinent because thematic analysis is an exploratory approach (96), that helps identify, analyze and report patterns, otherwise known as themes, within the data collected during the study (70). Additionally, the flexibility of thematic analysis is one of its major benefits as it offers the potential of collecting complex data that is both rich and detailed (70). During this process, I followed the 6 steps described in Figure 2.

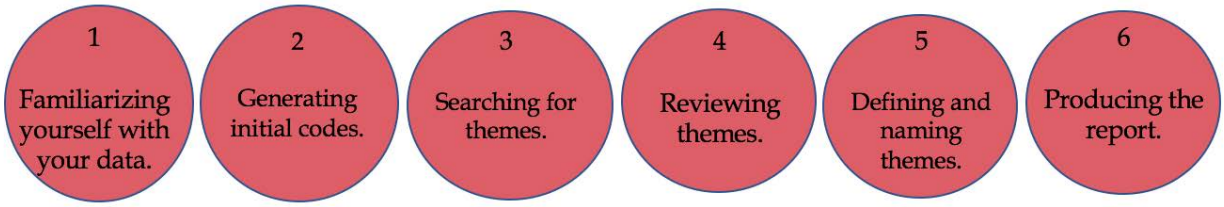

Figure 2. Steps of thematic analysis based on Braun and Clarke (70)

The first phase involved becoming familiarized with the data; this included taking notes during the interviews and completing an interview report form after each interview. I described the content of the interview prior to transcription by using these reports. During transcription, I wrote memos pertaining to certain aspects of the data that I found particularly intriguing and pertinent. Finally, I also reread the transcripts multiple times (70).

The second phase involved the generation of the initial codes by identifying facets of the data that appeared particularly interesting, and then organizing them into meaningful groups (70). I used MAXQDA Standard 12 (12.2.1; VERBI GmbH 2016) to do the initial coding of the transcripts. This step was an inductive process where I accumulated codes as I progressed, consistently adding and revising codes as I went through more transcripts. I ensured to include

inclusion and exclusion criteria for each code, as well as memos rationalizing my coding process. Once I coded all the interviews, I revisited some of the earlier transcripts to ensure that the codes were up-to-date based on the ones that emerged through the later transcripts. Ultimately, I ended up with 18 groups of codes, adding up to 63 codes in total.

Phase three initiated the search for themes among and within the codes generated in phase two. At this point, I began thinking about the relationship between the codes, the themes, and the subthemes (70).

Phase four involved reviewing the themes to identify those that would be maintained, discarded, combined or broken down. For instance, the codes 'clinician traits' and 'clinician relationship' were grouped together and later fit into sub-themes and themes (70). Despite using a software for my coding process, this phase was done predominantly on paper. Working this way helped me describe the data in detail and include a level of interpretation (70). I began by making lists and flow-charts incorporating the themes and codes I would keep and those I would discard. It should be noted that phases three and four were done concurrently.

The fifth phase entailed defining and naming the themes used to analyze the data found in the transcripts (70). These two major themes are: 'Wanting to Feel Human and Respected' and 'Feeling Excluded from the Oral Health Care System'. Using MAXQDA, I extracted relevant citations from the transcripts to illustrate the sub-themes and themes that I present in the results section of this thesis.

The sixth and final phase involves writing a report that provides the complex story of the data in a way that will convince the readers of the value of the analysis (70). Within this scope, I

am writing this thesis, and I have also produced poster and oral presentations. Additionally, I will write a scientific paper to be published in a peer-reviewed journal.

4.4.2. Trustworthiness:

Trustworthiness is defined as "characteristics of the research and its results that make it notable to readers" (89). There are evaluative criteria that have been suggested throughout the literature to address trustworthiness in qualitative research (90). These criteria include reflexivity, credibility, transferability, dependability, and confirmability (75).

Reflexivity, also known as "attending to researcher bias", is a very important concept when conducting rigorous qualitative research (90). Reflexivity refers to the "recognition that the researcher is part of the process of producing the data and their meanings, and to a conscious reflection on that process" (88). I maintained a level of reflexivity throughout the data collection and analysis by composing memos and post-interview report forms (91, 92).

Credibility, addresses "the issue of the inquirer providing assurances of the fit between respondents' views of their life ways and the inquirer's reconstruction and representation of the same" (89). The memos and post-interview report forms I completed also supported the credibility of this work. 'Member checking' or 'respondent validation' "includes techniques in which the investigator's account is compared with those of the research subjects to establish the level of correspondence between the two sets. Study participants' reactions to the analyses are then incorporated into the study findings" (93). Thus, member checking is another approach that has been reported to increase the credibility of qualitative research (93). In fact, according to

Guba and Lincoln, member checking is the most crucial and strongest available technique to ensure credibility (75, 93). However, there has been much controversy about the necessity to do member checking (93). For instance, considering the analysis process and the emergence of larger encompassing themes, it is inevitable, to a certain level, that the account produced by the researcher would differ from the individual and personal experiences of each participant (93). Furthermore, the interview process may have impacted the participants' experiences and they may have then changed their minds about their experiences (94). As a result of these issues, we omitted the use of member checking during this research project and ensured to maintain its credibility through the means addressed at the beginning of this paragraph.

Transferability concerns the "inquirer's responsibility for providing readers with sufficient information on the case studied such that readers could establish the degree of similarity between the case studied and the case to which findings might be transferred" (89). We provided contextual information about the study and the site of the fieldwork in order to increase the transferability of this empirical qualitative descriptive study (91, 92). In addition, I incorporated the breakdown of the participants including the dimensions of the maximum variation sampling to further support the transferability of the data. Therefore, "by 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" (75).

Dependability focuses on "the process of the inquiry and the inquirer's responsibility for ensuring that the process was logical, traceable and documented" (89), and is another facet that should be maintained in order to conduct good research. We tried to ensure the dependability of this work through a detailed and transparent description of the methodology, methods, and

reflexivity. Moreover, debriefing with the supervisory committee by sending them the post-interview report forms and transcripts also helped support the dependability of the research (90).

Finally, confirmability is concerned with "establishing the fact that the data and interpretations of an inquiry were not merely figments of the inquirer's imagination" (89). Much like dependability, a detailed description of the methodology, methods, and reflexivity also support the confirmability of the study (91, 92).

4.5. Research Ethics Consideration

This study was conducted per the ethical principles stated in the declaration of Helsinki (2013). We obtained ethics approval from the McGill Institutional Review Board at the Faculty of Medicine, McGill University on July 20th, 2016. If potential participants were interested, I asked them to read and then sign the consent form prior to taking part in the study. Participants were informed that their participation was completely voluntary and that they had the right to decline answering any questions. I also mentioned that they could opt out of the study at any time, all without any consequences. No compensation was provided to the participants.

Interviews were digitally audio-recorded. All participants provided permission for the recordings to take place. Several measures were taken to protect the confidentiality of the participants. I transcribed all interviews and filed them via numerical codes instead of respondent's names on my personal laptop computer. The interview materials were coded and stored directly without any names so that no individuals could be identified. Participants' names were also excluded from the post-interview reports. Signed consent forms are stored in a locked

filing cabinet in a secure central location accessible only to the principal investigators. All identifiable data is stored on McGill University's OneDrive network, which is password-secured and only accessible by Christophe Bedos and me. The data will be transferred to Dr. Christophe Bedos' OneDrive account after my graduation. All identities will be kept confidential by using pseudonyms and numbers in any presentations and/or publications. There were and still are no conflicts of interest to report.

5. Results

This results section reports the findings of the thematic analysis of the 12 interview transcripts. As previously mentioned, the codes inductively produced during the analysis are organized into two broad themes, each of which has sub-themes (Table 1). Throughout this section, I illustrate the sub-themes by providing quotes from the participants. As it is not feasible to extract one quote per participant for each sub-theme, I provide the most important and outstanding ones. It should be noted that the themes were mainly developed using the participants' experiences in private dental clinics. However, experiences at the free Jim Lund Dental Clinic were also occasionally used and discussed.

Table 1. *Major emerging themes and their sub-themes.*

Major emerging themes	**Wanting to Feel Human and Respected**	**Feeling Excluded from the Oral Health Care System**
Sub-themes	Wanting to Feel Cared for by the Clinician and the Clinic	Costing Too Much
	Wanting to Receive Quality Service	Lacking Access to Dental Care
	Wanting to Build Trust with Clinicians and the Clinic	Waiting for Care
	Wanting Sufficient and Appropriate Information	Perceiving Marginalization

Next, I also present the findings of our inquiries regarding experiences at the Jim Lund Dental Clinic, as well as participants' ideal dental clinic and ideal dentist. Following this, I include a section with the participants' suggestions for improving dental care.

5.1. Describing the sample

The participants ranged from 29 to 72 years of age (Table 2). As previously mentioned, six interviews were conducted in English and six in French, but nine participants had a mother tongue that was not English nor French. Most of them were immigrants and originated from seven countries: Russia, India, Syria, Morocco, Moldova, Cameroun and Peru. Although we did not explicitly inquire about the participants' ethnicities, they all mentioned it in the interviews to situate their experiences within their specific contexts. All quotes are presented in English. Therefore, I translated the French quotes to English, but the original versions can be found in Appendix A. A number in parentheses next to the interview number for each quote associates it with its original version in the appendix. In addition, the use of "[…]" within a quote indicates that a part of the interview was removed based on its repetitiveness or irrelevance to the topic at hand; it can also be indicative of an inaudible portion of the audio-recording.

Table 2. *Sociodemographic characteristics of participants.*

Dimensions (characteristics)	Categories	Number of participants
Sex	Female	7
	Male	6
Age (years)	18-29	1
	30-49	9
	50-69	2
	70-80	1

Marital status	Married	9
	Divorced/Widowed	3
	Single	1
Education level	High School/CEGEP	6
	Undergraduate degree	7
Employment status	Employed	4
	Unemployed	7
	Retired	2

5.2. *Major theme 1:* Wanting to Feel Human and Respected

5.2.1. *Sub-theme:* Wanting to Feel Cared for by the Clinician and the Clinic

The participants associated the feeling of being cared for to several qualities of the clinician and the clinic. These characteristics include friendliness, kindness, and the provision of sufficient and appropriate information, among others. Providing this kind of information was also associated with a clinician willing to spend time with them to ensure that they receive the care they desire.

One participant highlighted that feeling cared for by the clinician made her feel like a person, somebody worthy in the eyes of the personnel and the clinic, especially the dentist. In addition, the kind staff, and up-to-date dental equipment also contributed to this positive ambiance and feeling.

> *[…] you want friendly people too, like the receptionist and you know, you need to feel that you are being cared for, you are, you are a person and you are somebody […] –Interview #2*

Some of the participants further elaborated upon the role of the entire clinic in supporting a caring environment, and underlined the impact of the friendliness of the receptionist. As expressed below, the personnel at the Jim Lund Dental Clinic, as well as those in private clinics, can help the participant feel like a whole person.

> *Well, but that they understand that we are the Welcome Hall Mission, you know, we could maybe feel diminished depending on how they welcome us. We are people and we are worth something. You understand? – Interview #7 (1)*

Some of these sub-themes are inevitably interrelated, making for more complete and complex experiences. For instance, one participant equated the concept of feeling cared for by the clinician to the presence of trust attained with the help of detailed explanations from the clinician.

> *[…] like when they were explaining me things, I could see I could trust them more because it's, I could feel that they're caring for me. So, I believe that you explain the patients what you are doing, it's very important. – Interview #3*

Aside from these positive experiences, most participants described negative situations in which they did not really feel cared for. For example, one participant described his experience with a previous family dentist. This clinician repeatedly used shame to express his disappointment in the oral health status of his patient, thus revealing a lack of empathy. This lack of benevolence then created a space where the participant did not feel cared for and felt shame. Likewise, a careless and very busy receptionist at a private clinic also negatively impacted a participant's experience. Her commentary on this experience describes how overburdened

receptionists have become throughout the years due to their multiple roles in a clinic. This overloaded schedule creates a negative workspace, making the receptionist impersonal and inadvertently uncaring toward the patients.

> *He was very, he didn't seem, he wasn't much of a joker, right? So he was very stern, so I guess he, he kind of looked at, he had the attitude of like a military officer. He wasn't rude or anything like that, it was just the way he spoke to you, you know? You would, you would know very well when he was disappointed. So it's yeah, it's not like I was being irrational, there was, there was some rational thoughts there because he was, he'd let you know.., it was more, very much like a father figure, like he cared, he just, all the work he did when I was a kid and he would see it go away. So he was, he was pretty stern and open about his thoughts but he wasn't, he wasn't bad in any ways, just very straightforward. – Interview #4*

> *I think it was just through shame. After a while, I was just too ashamed to look down my, the guy who's been working on my teeth my whole life and for him to see what happened. – Interview #4*

> *"Receptionists once upon a time used to be very friendly people. They're not anymore cuz they're doing more than just being the receptionist. They're faxing, they have, they're serving you, they're answering phones, they're taking money, they're, you know, they're very busy. It's very impersonal now. It's like talking to a computer, they don't care about you, you're just a pain in the ass, they don't even want to be there, it doesn't pay well." –Interview #9*

Based on an experience in a private dental clinic, another participant highlighted that the person being treated is often forgotten since everything is very fast and rushed these days. Being forgotten refers to the feeling of not being cared for, which stems from the feeling of not being a priority. A lack of time creates a rushed environment in all clinics, potentially limiting the clinician's ability to consider the patient's desires. This then further supports the need for person-centred dental care.

> *Today it's fast, fast, fast, fast, fast, fast, you know? That's the problem, it's fast, fast, fast, so we forget, we forget the person sometimes. The person is important. – Interview #7 (2)*

5.2.2. *Sub-theme:* Wanting to Receive Quality Service

Since participants are excluded from the privatized dental care system, all the comments on quality service were regarding the Jim Lund Dental Clinic. The concept of quality service is not limited to the technical dental skills of the clinicians. According to the participants and their experiences, quality service also reflects the clinician's personal characteristics, such as empathy and sensitivity to the patient's needs. One participant described how the clinician treated him with empathy and was considerate when providing care. Thus, as can be seen again, there is a certain level of connectivity between these sub-themes. For instance, one would assume that if the person is feeling cared for by the clinician and the clinic, then they perceive it as receiving quality service on a non-technical level.

> *He came, he touched me in a way that even if it's not his body, and he doesn't feel anything, he knows that I feel things and he made sure that I wouldn't feel anything, that I wouldn't be hurt, ok. – Interview #12 (3)*

Another participant discussed how money can impact quality. He began by describing how private clinics provide a basic and superficial level of care and often disregard other issues since their focus is on income. Contrary to what society considers as an improvement of quality based on an increase in cost and expenses for the patient, the Jim Lund Dental Clinic's provision of free care was associated with an increase in quality of care. Since the dental students had greater amounts of time and were not working to raise money, they focused more intently on the quality of their interaction and their work.

> *So, the other places, this is the problem I see that when there's money-oriented, then the quality may not be, you know, matter. So that's why they are doing kind of a surface job and then also, they don't go in seeing the, or they don't take time in seeing other, you know, issues. – Interview #3*

So, because you're not money oriented, you are more quality oriented. But, the other dentists, and dental clinics, they might be more money-oriented than quality-oriented […] – Interview #3

5.2.3. *Sub-theme:* Wanting to Build Trust with Clinicians and the Clinic

The concept of trust was discussed with relation to the important role it played in participants' dental experiences. Although it was difficult to define and describe trust, all the participants agreed that trusting the people involved in their care was integral to having positive experiences. Some participants described the conditions of building trust as receiving information, explanations and prodding questions asked by the clinician. The two quotes below describe experiences participants had at the Jim Lund Dental Clinic. The first touches on the importance of quality service expressed through empathy, and how it can lead to building trust and thus feeling cared for by the clinician and the clinic. The interrelatedness of these sub-themes is further highlighted by the second quote that associates social interaction with building trust.

[…] he explained to me, he said 'Ok, this tooth here, I can do la, la, la. You have one big decay here, the second last tooth. Ah, you already had a root canal treatment in that place'. He saw everything that I knew I hadn't told him, the history, then I told myself 'Wow, ok, he knows, he knows what's going on. He knows what's in my my mouth', he didn't hurt me, he was polite, he didn't do anything sudden. That made me trust him […] – Interview #12 (4)

Check, well when you come back, just, when you come back from one appointment and it's weeks later, just when they ask you how you've been feeling, or just recapping on the last appointment and the time in between, I think just kinda prodding the questions, getting people to express it, that, I think that helps with it too. Yeah. Just that social interaction in general builds trust, for sure. Even if it's just checking up like "Oh, hey, you know, did the stitches come out ok?" It's just putting in my head that "Oh, he remembers exactly what he did four weeks ago, I'm not just another person laying on the bed", I guess. Yeah, that's, that's how I look at it, and I put it in the same boat as trust. – Interview #4

Other participants made further connections between sub-themes, such as the presence and expression of patience, respect, and communication to build trust. One participant also described an experience when her dentist would send a taxi to transport her to his private clinic because he acknowledged the fact that she did not have the means to pay her way to the clinic or pay upfront for her treatments. This situation showed the clinician's sensitivity to his patient's needs and he not only recognized her situation but took active steps to help her.

> *[…] That's it, respect, patience with all the patients, that's more important, […] gaining trust with the people you're going to treat, that, I think, is the most important in a good clinic. – Interview #11 (5)*

> *Trust, build trust, it took a long time, the fact that they were very patient with me, there was a time when I didn't have money to pay but like I told you, not only did they send a taxi for me, but they would say 'Ok, you need a crown, you don't have money, we trust you, you can pay 100$ a month', I don't know how else we build trust. We build trust just through communication, 'Hi, how are you?' – Interview #9*

The participant who made a connection between trust and feeling cared for also highlighted the impact of financial incentive on trust. If the patient or the person receiving care is placed at the center of the care, then the clinician is being more patient- or person-centred. Through this process, the clinician is establishing a healthy and safe environment to build trust and thus making the patient feel cared for when he or she visits a dentist.

> *First of all, you need to trust that they will do a good job, you know, they care for you. If you feel that, you know, they don't care for you, they care only about money, then you know, you know that the trust won't be that much. […] Mainly when you see that they want to help you, right? Without, with no other motive, just help you, there's no other motivation. That really builds your trust. – Interview #3*

5.2.4. *Sub-theme:* Wanting Sufficient and Appropriate Information

As previously established, communication with the clinician and receiving information

about their care are key factors for patients to have a positive dental experience. One participant said that he visits a dentist because he or she is an expert that will provide information about his dental health and the care he needs.

> *Because it is very important for me to know what is happening with my […], I go to the dentist as an expert, a specialist, I find if there are problems, I need to know right away. Maybe some confidence, the instructions are very important for me […] – Interview #8 (6)*

It was important for the participants to receive information from their clinician in an environment that supported this exchange. Such a setting would not rush the clinical encounter, and it would ensure that the patient has adequate opportunity to ask questions. As an example, one participant described his previous experiences with dentists in private clinics who were not person-focused and made him feel like a burden on their time.

> *[…] the other dentists, the focus they have, what they have is that, it just on a surface level, just like they want to do, make it quick as much as possible and then let you go, you know? And you also feel kind of not, because you see that, you know, you are taking their time, when you feel that, if you have, I have questions or the thing you want just, you know, take time. – Interview #3*

Another participant further built on the importance of step-by-step explanations of the care being provided in the process of building trust. He shared his experiences and general opinion on the impact that the clinician can have on reassuring the patient by simply opening-up to them and having a conversation.

> *I think it's important. Just, I guess, just sort of at a base level because, you know, that person is doing work on your mouth that could cause serious complications or it… So it's nice to know that, you know, you've been with somebody who, even if you have a feeling you can trust, like somebody who guides you through the steps that they're doing, I think that helps with the trust too, even if, even if they've never worked on your teeth before. I think if they just open up to you a bit, and that, that helps with the trust also. So I think it's an important factor cuz otherwise you'd just be feeling uneasy and [pause] I don't think that's ever a good thing. But, trust being very important, yeah, for sure. – Interview #4*

Some participants agreed that visiting a dentist and receiving options of treatments supports the concept of shared decision-making between the clinician and the patient. For instance, it is possible that the option recommended by the clinician is not feasible for the patient due to financial or time restrictions. Thus, as described in the literature, shared decision-making is a central part of patient- and person-centred care since it puts the clinician and the person receiving care at the same level of power (7). This sustains the significance of each of their roles in the dentist-patient relationship regardless of whether it is a private or free dental clinic.

> *[…] together is better. To sit down and then say, because first you always have 'How much will it cost?', you will decide what you will do, ok, you will decide the price as well [laughter]. That is one thing, you know, but to come 'Look, you have this, this, and this possibility', let's say. 'You have the choice between repairing the tooth with paste and then it's dried and it becomes hard, paff, it's done. I can do you a nice job with that, or we extract the tooth and we do […] an implant'. – Interview #12 (7)*

> *I like the idea of making my own decisions but also, there's somebody, I'd like this, I'd like the opinion of somebody who knows a lot better too, or from a professional standpoint. – Interview #4*

> *[…] He will explain all the options and the priority, he will say 'This is the first, first option that will be practical', but otherwise I, otherwise there will be other options, I find that this is logical in parallel with the situation of the person, how he will react. That is to say that he will choose but he will think about the other one as well. That is how he will find if, because what we need in life are options that suit us. – Interview #6 (8)*

Participants emphasized the need to get appropriate information about their dental care in layman's terms since technical terminology and jargon is not informative to them. Therefore, professionals must be aware of the way they provide information in order to ensure that it is understood by the patients.

> *By somebody sticking something in my mouth and going '10 inches, eight, three, two, one [said in a robotic voice]', and talking to a dental hygienist means nothing to me. By him saying to me 'You have periodontal', means nothing to me. – Interview # 9*

He explained to me, some nurse, some doctors, some dentist, they don't explain what it is. If it is decay, they don't explain what is decay means, they, they don't explain because we are not student. So, they didn't explain. – Interview #2

5.3. *Major theme 2:* Feeling Excluded from the Oral Health Care System

5.3.1. *Sub-theme:* Costing Too much

Many participants highlighted how difficult it was for them to afford dental care due to the privatized dental care system. One participant described her inability to afford dental care and identified it as the reason she had to have several teeth extracted over the years.

[…] I cannot afford dental care, it's really too expensive, I can't. Even today, I can't afford, everything they told me for treatments of teeth, dental crowns, I can't do it. So, I prefer, I would have wanted to keep all my teeth but no I am forced to extract them, yeah. – Interview #10 (9)

Many participants associated having money with receiving better treatment, both with respect to the quality of the dental care provided, as well as their overall experience at the clinic. For instance, one participant described the difference in how she was treated during various points in her life when she had money to pay for treatments and when she went to work and had insurance. She said that she received better service when she could pay for her dental care out-of-pocket. In contrast, she stated that the quality of the service decreased when she started to work and became insured.

Ok, when I had money, I got better service. When I didn't have my insurance, when I didn't have money, well when I went back to work. 'Cuz first I had money, everything's good, then you get insurance, things get good but not as good as cash, you know? – Interview #9

Some participants believed that the fee-for-service approach currently in place in dentistry incentivizes the clinicians to schedule more patients. Participants mentioned that

booking multiple appointments in a short time leads to decreased time with each patient, which then reduces trust and quality of care. Thus, the sub-themes of the two major themes also have a certain level of connectivity. One example was a participant who described the loss of the human side of dentistry when clinicians in private clinics were more money-oriented. She associated this dehumanization to the high cost of the fee-for-service approach of the dental care system.

> *But this is sure but money, money, money, so that's what I find deplorable, it's money before the person. – Interview #7 (10)*

Participants described the value they place on money based on its scarcity and how this impacts their ability to prioritize dental care. One participant identified the fact that dental care is not an expense that he plans for, especially considering all the other, more vital, life expenses such as food and housing. Another participant explained how difficult it is for him to earn money these days and how large portions of what he earns is already taken away by the government through taxes, leaving very little with which he can live his life.

> *[…] dental care it's, it's lot of money, right, lot of expenses and people actually, you know, don't plan to spend so much money on the dental care. They, they have so many bills to pay for, you know, and all that, rent, you know, there are so many things that, this is something that they don't prepare for. – Interview #3*

> *I also don't believe that such hard earned, you know, it's so hard to earn money nowadays. We're all the working poor, you know, there's only a few people that make a lot of money and the people who even work in hospitals, who have insurance, they're just the working poor because by the time they get their paycheck, half of it has gone to insurance, half of it has gone to Quebec government, Canadian, you know? – Interview #9*

All but one participant directly agreed that dentistry is too expensive in Canada. The one who disagreed is an outlier since he initially stated that dentistry is not expensive in Canada and that it depends on the care you are receiving. He particularly compared the costs to those in the United States to support his point of view. However, he later contradicted himself by stating that

a treatment costing him 800 dollars would be expensive.

> *It depends on what, and from what I can tell you it's even worse in the United States, so it's like 'Is it expensive in Canada?', no, not that much. – Interview #12 (11)*

> *Then I tell myself, that I could not get to a hospital since I have a low income, I have seven children, I arrive, I want to have something like that done, 'Ah, it's a surgery, it will cost 800', 800 is huge for me, you know? [laughter] Then yeah, ok, then you try, you know, the dentist tells you all that and you go 'Ouf', ok, well it's 800 for this, it's 300 for the other thing, then let's say it's a tooth decay, I don't know how much it cost, luckily, I only have one. – Interview #12 (12)*

5.3.2. *Sub-theme:* Lacking Access to Dental Care

All the participants expressed their lack of access to dental care. Lack of access to dental care is not always limited to financial barriers, although this was the factor most mentioned by the participants. Some participants had not visited a dentist in two to eight years, others had only visited a few times since they began frequenting the free Jim Lund Dental Clinic. This reality of their lives was described by one participant as the reason he tries to take very good care of his teeth. He stated that he acknowledges his lack of access and understands that he would not be able to afford any treatments if he suddenly needs care.

> *I try to take care because I know that, a more important factor is that I do not have access to dental care, I must ensure that I don't fall into situations, cases where I can't afford. When it's serious, it's even more expensive […] I have problems accessing dental care because I don't really have social assistance, I am not covered. – Interview #6 (13)*

Despite all their praise for the free services at the Jim Lund Dental Clinic, it was beyond their understanding that even when they have access to some level of dental care, there are still limitations to the coverage being offered. These limitations increase their inability to access dental care that is not offered at the free clinic and is too expensive at private clinics.

I hope that it will, that we will get easier access to the services because actually, it's like really strange. It's free and in the same time, it's inaccessible. - Interview #1

And there they don't do this kind of treatment, I don't understand why it's that, I don't understand why when they want to help people there are still levels of care. Normally, they have to, if they want to help, they have to take care of everything, I don't understand why they still put limits. When we don't have the means to have one of them […] a dental crown is in the thousands and more dollars, so it comes back a bit to the same thing. – Interview #10 (14)

5.3.3. *Sub-theme:* Waiting for Care

The concepts of time and waiting with regards to dental care were broad. Participants associated waiting with time spent getting an appointment at the free Jim Lund Dental Clinic, and time waiting to be seen for a scheduled appointment at any clinic. Additionally, participants also described the time spent with the clinician during the clinical encounter. Most of the participants' comments and experiences pertaining to waiting to get an appointment were about the free clinic since many of them did not have access to private clinics. As per the way the Jim Lund Dental Clinic functions, all the participants had to wait at least six to eight months before receiving their first appointment to see a clinician.

[…] I signed up for an appointment but it's a long wait, because it's since, after six months they called me to see me. – Interview #11 (15)

However, the wait time to get the first appointment occasionally took much longer as some participants stated that they had to wait one year prior to receiving a call. One participant even mentioned that she had forgotten about the clinic by the time they had contacted her.

I made an appointment and I waited maybe one year roughly. I came here and the doctor made my file, he looked at what was happening and he said that I need to repair something and like that I'm continuing to repair my teeth here. – Interview #8 (16)

It's after one year that they called me because I was really discouraged, fortunately for me that the pain had passed, my toothaches really calmed down, I took Tylenols, it calmed my pain for one year. They called me, I didn't even remember anymore when they called me. – Interview #10 (17)

Time management was identified as being very important to one of the participants as he was thankful for the smartphone to ensure that he does not waste his time. This same participant also suggested that it is important to know how long the wait will be to organize his schedule since he works and has a family. These are not specific to the free clinic but to all dental clinics.

[...] thank God for the, for the smart phones that you don't feel that you are wasting time, I mean, I'm able to, you know, keep myself occupied so I don't waste time, whatever waiting. So there's no waiting for me, like you know? So, in that sense, waiting like longer doesn't, you know, make me a thing, as long as I'm prepared. – Interview #3

[...] you need to be informed about approximately how long you need to wait, then you can organize yourself well because I'm a family person, I'm also working in a church, so I need, you know. – Interview #3

Explaining the dental care process and the treatment options to a patient may take time. However, one participant mentioned that it is not about spending more time to address these parts of her care, but rather to focus on the quality of the information that is provided. This quote underlines the interrelatedness between time and receiving or providing sufficient and appropriate information. Thus, a longer appointment time is not an issue if the time is used appropriately by the clinician and the patient.

Longer means like not repeating the same question again and again and again. – Interview #2

One of the participants who had a more positive outlook on the wait times reported that he had previously spent hours in the waiting room before being seen by a dentist at a private clinic. He then mentioned that once he had obtained his first appointment at the Jim Lund Dental Clinic, he did not have to wait as long as he had at some private clinics. This participant

ultimately stated that waiting is relatively acceptable since he sets aside a significant amount of time when he has dental appointments.

> *I have already spent hours at the dentist's [laugher] and here [referring to the Jim Lund Dental Clinic] it didn't take an hour, that's guaranteed. […] Listen, when I make an appointment with the dentist, I have time, ok? […] I don't care about time because it doesn't take me half a week, ok. – Interview #12 (18)*

Another participant expressed that receiving free dental care at the Jim Lund Dental Clinic is a unique service offered in Montreal. He acknowledged that the high demand for these services and the limited resources available are partly responsible for the long wait times. This participant also said that he is calm and does not mind waiting because of his peaceful mindset. The underlying point is in the first sentence of the quote where the participant states that as long as he receives good care, he does not mind waiting before an appointment. This participant's experiences and comments further highlight the connectivity between receiving quality service and waiting for dental care.

> *If I knew I was getting good, good care and I was happy to be there, and I knew I was gonna get all the details I ever needed, then it wouldn't bother me at all. […] It doesn't, it personally doesn't bother me, I think it's, given my situation… I, I mean I'm, I'm more or less a patient person anyways but being somebody who's had the issue for so many years, like it was definitely worth the four or five months waiting time initially but after that, I've gotten appointments a week from, away from each other and the longest wait was the last one to the one before that but I think that because the office was closed for a month so everybody needs a vacation. So, no, I haven't had issues with that. Cuz I understand, the waiting time, it's kind of what happens when you have a unique service. – Interview #4*

5.3.4. *Sub-theme:* Perceiving Marginalization

To marginalize someone or a population is "to relegate to an unimportant or powerless position within a society or group" (95). The lack of access to dental care, largely due to

financial barriers, experienced by the participants in this study is further supported by their feelings and perceptions of being marginalized within the field of dentistry.

The service provided by the clinicians in private dental clinics, as per the experiences of one of the participants, was dependent on her method of payment for her care. According to her, whether she had money, insurance or a welfare card, not only was she treated differently, but she was viewed differently as well. Similarly, she shared that she was often entirely blamed for the state of her oral health when she was on welfare.

> *So, when you pay cash, hey, you know the treatment you get? I learned that. My in-laws have all their teeth, how come? Money talks. They'll help you, they'll help you, yeah, they'll put you little temporary things, they'll make you feel good, you just have to go back again next year because the filling came out, or they'll say 'Oh, you must have eaten something', and it pulled out or maybe, there's always, there's always an excuse. But I don't believe it anymore, I'm sorry, I don't. […] And then when it was like, 'Can I make two post-dated cheques came up', I was not a priority anymore in that clinic and I kind of like felt bad 'cuz I deposited a lot of money in that clinic. – Interview #9*

While visiting a private clinician with whom his whole family was involved, another participant was refused care because he forgot his welfare card. This could partly be due to the clinician in question who was not empathetic or sensitive to this patient's situation and needs. However, it is also a sign of marginalization since the participant said that the clinician explicitly stated that his reason for refusing to provide care was that he forgot his welfare card and could not afford to pay for his treatment out-of-pocket.

> *Except once, he, I was his client, so I had an abscess and I really had a lot of pain, and I forgot my card, my blue card, so in that moment, he didn't want, he didn't want to accept me. So, it's, I found that it's really, it's not human. – Interview #6 (19)*

Comparably, another participant described her experience and personal interaction with a private clinician. She said that her perception of how the clinician treated her was very poor and that she felt like she received subpar services. She equated this treatment to her status as a refugee.

> *We were still refugees at that time and I felt like [pause] it's difficult to explain. Like third grade of person. Like something that doesn't deserve to be treated well. […] The way she, she took, the way she touched, the way she offered her services. Like not looking for the best, like, the best solution. Just what is simpler and like cheaper and she didn't give time to think. – Interview #1*

In another capacity, one participant said that his private clinician used shaming tactics to convey disappointment in the state of his dental health. He mentioned that this was one of the reasons he stopped visiting this clinic. Thus, the participant was further excluded from his already limited access to dental care.

> *I felt I, I couldn't be the same way, you know, I'd get that look, you know like, 'Oh I haven't seen you in, you know, ten years', and I could just, I could just hear his voice just saying oh like you know 'This used to be all good and now…' like shaming in a sense. 'Cuz I know he would be straight forward like that, he wouldn't say it to hurt you but it's just, he's a very observant person and he would just, be observing everything he'd seen and that makes it hard. – Interview #4*

5.4. Appreciating the Free Service at the Jim Lund Dental Clinic

Due to the exclusion of the participants in this study from the privatized dental care system, a large part of their experiences took place at the free Jim Lund Dental Clinic. All the participants agreed that the free services offered at this clinic were highly appreciated. They also identified this clinic as one of, if not the only option they had to receive dental care. Although their appreciation could be almost directly linked to the free services being offered at this clinic, they also highlighted a few other aspects that led to their gratitude. These include the clinicians' traits, the general setup of the clinic, as well as the staff members. Therefore, it seems that there are a broad set of factors, other than the cost of a clinic, that impact the satisfaction of its patients.

[…] I find this amazing, I find this really… I am very happy because I could not have had any care, since I do not have sufficient income to pay for the dental care that I need. – Interview #7 (20)

[…] It's a really great idea, it's this really that saves us here because if I there were no free clinics [laughter], frankly I would be dead because the pain really paralyzed me [laughter]. It's really them who, who saved us. They are a little really, for us, it's a blessing to have community stuff […] – Interview #10 (21)

A clinician providing person-centred care needs to be empathetic and sensitive to the person's needs. Therefore, it is important for a dental clinic to consider all the different circumstances that led to the state of the person's oral and dental health. Once these facets are addressed, there is a greater opportunity to treat a person's dental ailments as well as help them maintain healthy oral health care. Thus, in addition to the free dental clinic being the only resource for dental care for some, one participant described his appreciation to the clinic for helping him address other issues he had previously ignored.

[…] so, for me it just feels like, if not for Jim Lund, I feel like I would probably have never gotten any care done because I didn't feel like it was affordable enough. […] Some people just can't afford it and they're just stuck in such a rut, so free clinic at least gives them something. If you're getting this done, you can work your way back up, contribute back, you know, maybe go back to school, do something that's, kind of, I guess kinda like I'm doing, it's help. It's, you know, service like welfare and free clinic, it's helping me just take care of all the bad stuff that I've just let go and I wouldn't have been able to do it if it wasn't free. – Interview #4

A free dental clinic such as the Jim Lund Dental Clinic helps low-income people receive dental care since they struggle to pay their way through life and as a result do not prioritize dentistry. This references the idea that money is scarce for people living in poverty and thus addresses the high cost of dentistry as well as the helping nature of the Jim Lund Dental Clinic.

Really great because that means your motive is to help out people, that's why you have that. So, that really make the people come, feel secure and we make them cared for because there are so many people out there, they see the tooth health as an option when it

comes to money, you know, they rather not have any cleaning done or not have the teeth, tooth cared for and then they are running into even bigger problem in the future I believe by losing their teeth and you know, and all that. – Interview #3

5.5. Participants' Suggestions to Improve Dental Care

The participants in this study had many suggestions on how to improve dental care. Some of these recommendations were based on their experiences, while others were ideas they wanted to share. These recommendations refer to the Jim Lund Dental Clinic as well as private dental clinics. I used the various sections presented in the results to organize the suggestions the participants conveyed in the interviews. However, it should be noted that the participants did not provide recommendations that fit into all the major themes and sub-themes in this thesis.

The participants provided suggestions on how to improve the negative experiences of not feeling cared for by the clinician or the clinic. When given a choice between a one-hour wait time and a one-hour appointment with an attentive clinician, or a 30-minute wait time and appointment time with a less attentive clinician, one participant stated that longer wait and appointment times would make her feel more comfortable and human.

[…] I would prefer the longer one. […] More comfortable, more like reassured and feeling like I'm treated as a human being, not just a piece of something that need to be fixed, that, this human way is very important. – Interview #1

When discussing stress associated with dental appointments, providing sufficient information was one approach suggested to help de-stress the patient. As expressed by one participant, talking can be helpful, even though he acknowledged that adding this to the care process may cause the clinician to be more nervous.

Yeah, by talking. I understand that it would be more stressful for them because they have

to concentrate on the work and, like, but by talking to patient I think it would distract him from this stress, like make it less scary. And even more, talk what you are about to do. Tell that "I will do that, I will, you will feel that, maybe, maybe" Just explain, just prepare person what to expect. - Interview #1

Reflecting on the costs associated with maintaining good dental and oral health, some participants provided innovative suggestions on how to improve the oral health care system. These recommendations aim to create more affordable dental care for those who have low incomes and cannot pay for their care. In addition to adding dentistry into the RAMQ public system, one participant suggested an intricate approach to payments based on a person's annual income. This would therefore incorporate various income brackets on which dental care costs would be based.

But if it was a fixed hourly rate depending on the person's income […] Yeah, yeah. So it's […] 'Like, you, you're a student, and you're paying so and so, but maybe you have a bursary but you, you only work part-time and you clear about 6000 [$] a year', but you're a student and you do need, you need the work done too so they could just accommodate more towards, towards what you're paying. Percentages, I don't know, but you pay, you pay half as much as the guy making 12,000 [$] let's say. – Interview #4

Moreover, a hybrid of public and private practices was also suggested where each clinic could provide both free and paid dental care. The change in approach would come in the form of a fixed salary provided by the government to pay for those patients who cannot pay for themselves. The dentist would then have both a steady base salary and could make more money through payments by the patients who are insured or can pay out-of-pocket. Similarly, another participant suggested that some private dental clinics should also offer a certain amount of free dental care to those who need it based on their low incomes.

But I think that with a salary it has to be like this, for example, there are some services like here [referring to the Jim Lund Dental Clinic], we can provide services for people who need help and that is a guarantee of the state, and one must do the particular service at the same time […]. That way, the doctors can have some money since the clinic pays

him because he works with paying individuals, and also the state, the government has to pay the salary since he works here with people who do not pay, who are not rich. – Interview #8 (22)

They should have a base and then have in addition to the base, have a surplus as they want, the number of patients they want to have, but at least I think they should introduce a bit like the other doctors, they should be part of the RAMQ [Régie de l'assurance maladie du Québec]. – Interview #10 (23)

[…] maybe the private clinics could also offer free services. That way, so I think, because I've seen many people here who have problems with their teeth, many, many. But all these people who have problems, I think, are people who don't have money, who are socially vulnerable, for example. No work, maybe they work seasonally, they work a few months, a few months they don't work. – Interview #8 (24)

Participants thought that it was difficult to make appointments at the free dental clinic and that it can be challenging to cancel or reschedule dental appointments. As a result, they recommended the use of reservation-style applications for smartphones. For instance, something similar to those used for restaurants was suggested where the patient could see which appointment times are available and could sign up for one according to his or her schedule.

"Yeah, appointment on the net. Appointment for the emergency, when you have a very, very hard thing, you need a doctor. […]like ok, they have like available slots you can take that slot and if it, like according to your needs and their, you know, their capabilities." – Interview #5

The lack of walk-in dental clinics was identified as another gap in access to dental care. These clinics could help patients with emergencies who cannot or do not want to go to the hospital. Additionally, it may help with scheduling issues and address last-minute cancellations. Thus, incorporating a walk-in clinic into dental clinics, including the Jim Lund Dental Clinic, was recommended. Participants said that it could be once or twice a week for part of the day or the entire day.

If there are times without appointments, it would be a good thing because there are moments when you have a lot of pain, if there were times of no appointments, we would

> *really be relieved. Because when you have a pain crisis, even if you show up there [referring to the Jim Lund Dental Clinic], we can't accept you because you don't have an appointment. If there really was a walk-in section, that would really be perfect. – Interview #10 (25*)

To address perceptions and feelings of marginalization, one participant suggested that clinicians should pay attention to the level of professionalism in their interactions with patients. She underlined that it's important for the clinician to understand that the patients are not there to be a burden on them but rather because they are in pain. Participants expressed that clinicians' biases against low-income populations are propagated by society's stigmatization of this community. This population's marginalization can then negatively impact the clinicians' professionalism.

> *If we are there, it's not because we came to bother, it's because we are really in pain. I only want to say to have a concern for professionalism. – Interview #10 (26)*

Finally, the participants also discussed some suggestions to improve the care they received at the free Jim Lund Dental Clinic. They mentioned the importance of increasing the coverage offered at this clinic. One participant proposed the incorporation of an affordable subsidized coverage plan for treatments such as orthodontics. Therefore, this highlights the fact that a free service is not without its limitations and that the users will not necessarily be completely satisfied with all the aspects of the services they receive.

> *[…] expand the care, you know. It's still a, you know, increasing, ok, you're limited to this, there is no aesthetic, it's certain that at some point there will be a doctor who will have to practice aesthetics, maybe he will practice here, I don't know. It's a suggestion, yes, but is it a gap? No, it's not a gap, you know, I mean, sometimes you have to accept what they give you and that's it. To say, ok, is there a possibility that you could give, for instance, cosmetic care at 50 percent with a lower charge, that wouldn't be too bad either, you know. – Interview #12 (27)*

5.6. The Ideal Dental Clinic and Dentist

The concepts of an ideal dental clinic and an ideal dentist were occasionally difficult for the participants to think about and describe. Nevertheless, some participants described what they would consider aesthetically ideal for the clinic. They identified flowers and a television as distractions that would make them feel more comfortable. Additionally, participants also talked about how the clinic should be more accommodating to children. One participant was very detailed in her desires for a child-friendly clinic that included games and a television.

> *It would be, it would be pleasant to find myself in.., like cozy place, accommodating with flowers and some greens. Nice paint like [pause] light colours. Uhh [pause] some kind of distraction like maybe a TV of something. By the way, it's, it would be like [pause] less, it could make the appointment less scary […] – Interview #1*

> *[…] for children, I think it could be more fun, it's more games, a television, to bring trust and all that. – Interview #11 (28)*

At times, the participants' conceptualizations of the ideal dental clinic also referred to the ideal clinician and staff. Those who described the ideal dentist identified laughter, communication and being friendly as important traits that help increase the ability to work in teams and promote shared decision-making.

> *But in any case, really the cleanliness, that the staff be human and welcoming, that's what I want to know that they take the time to explain to us, that's my ideal clinic – Interview #12 (29)*

> *With regards to personality, more of, that they give you more confidence, and also are laughing [laughter], friendly, they, while they do your dental care, they talk to you, they tell you 'It's going well? Is it good? Do you have any pain?', all that, communication, that's it. – Interview #11 (30)*

> *Teamwork, I would expect a lot of teamwork. I would expect everybody to know exactly what was going on and that I was part of the decision too, like I was there too, involved too instead of them making a decision and coming and saying 'Well this is what we're gonna do and this is the date that you come in'. Then they only make team decisions like that when it's a big, big, big unfortunate situation, yeah. – Interview #9*

Lastly, one participant combined these facets by describing the aesthetics of the clinic and the personality traits of the receptionist that contribute to the positive experiences taking place at the free Jim Lund Dental Clinic. According to her, it is ideal to have a warm welcome in an office that does not feel like a doctor's office or a hospital. The warm welcome is related to a kind and cheerful receptionist who can make the person smile despite his or her pain. She mentioned that white walls should be avoided since they can increase a person's level of stress, whereas well-decorated walls can help instill trust.

> *[…] my ideal dentist, I would have liked[laughter], how would I imagine this? A welcome a little like the Welcome Hall Mission [where the Jim Lund Dental Clinic is located], it doesn't really feel like being at the doctor's office. How to say, an environment that has nothing to do with the hospital, yes, like it builds trust, it destresses first when you enter. There is nothing that, there are no white walls for example, it's decorated well, yes. It gives you confidence because if you go to a dentist and you enter, it's all white, the walls white, and I don't know [laughter], it's stressful, it's frightening, you tell yourself 'Oh my God, where do I [laughter], it's frightening', it's stressful, you're not relaxed when you go receive care. So, I imagine a very warm location, with flowers, with a receptionist, with a very welcoming secretary like at Welcome Hall Mission, really, yes. Someone who really, who makes us smile when we arrive despite our pain, you can still smile, yeah. And then a dentist who, and then also a room, a room for providing care with really advanced machines like there. – Interview #10 (31)*

6. Discussion

The aim of this study was to understand the experiences of adults using a free dental clinic in Montreal, Canada regarding dental care. In addition, we wanted to learn about their suggestions on how to improve the care they received. We found a wide range of information about their experiences with dental care, which were described in the results section. The participants were generally satisfied with the care they received in private and free dental clinics although they were unhappy with the predominantly privatized approach to dentistry. This privatization makes dentistry too expensive for them, which negatively impacts their access to dental care. The participants expressed a desire for more quality time with the clinician that would involve sufficient and appropriate information about their oral and dental health. This information would help the participants become more informed about their dental care, and would thus support shared decision-making with their clinician. Participants identified trust as imperative to sustaining a positive and healthy dentist-patient relationship. They also wanted to be treated with kindness and as a whole person in lieu of strictly being treated for their dental ailments.

6.1. Experiences of Dental Care

As mentioned in the introduction to this section, the participants discussed various facets of their dental care experiences. Participants highlighted the desire to feel cared for by the clinician, which was often associated with being treated as a human being who is more than his or her dental ailments. Similarly, Raja et al. reported the importance for dentists to consider their patients' overall health and other medical issues since these may also be impacting their oral

health (69). The same study supports the need to feel cared for because people often feel dehumanized if they perceive that they are not "seen as an entire human being in oral health settings" (69). Dehumanization of patients in dental settings was also associated with "financial difficulties, minority status, and an inability to pay for optimal treatment" (69). This further validates the population considered in this study.

A clinician adopting a humanized approach to dental care sustains the development of trust within a dentist-patient relationship (7). When further discussing trust, the participants identified communication, receiving information, respect and patience as major factors in establishing trust with the clinician. These traits also support feeling cared for by the clinician and the clinic. As reported by Mills et al., a caring clinician is central to feeling cared for as a patient (43). Additionally, the authors found that kindness is an important trait to possess for a clinician to provide more person-centred care (43). Mills et al. also reported that the level of trust is "predicated by familiarity, attitude, continuity of care" (43).

Our study demonstrates that people want more from their dentists than just dental care and dental information. As a result, the idea of conversation is not limited to discussions about dental care, but also includes casual conversations about life. Thus, people receiving care would also like to build better rapport with their dentists by talking about their everyday personal lives, how their families are, etc. Mills et al. support the relationship between rapport and trust by finding that some patients used "engagement, rapport and shared values or beliefs" as a way of choosing a dentist (43). Moreover, Raja et al. also discussed the importance of empathy and rapport, and their role in the dentist-patient relationship (69).

Our participants stated that the amount of information provided by the clinician is

insignificant if it is full of technical jargon. Thus, this perspective further emphasizes the role of information in a dentist-patient relationship. Raja et al. also conveyed the desire for more easily understandable information through their participants wanting a limit to the use of technical jargon (43, 69). Our participants wanted enough information about their dental care in terms they could understand so that they could make informed decisions that were shared with their clinicians. Apelian et al. demonstrated the significance of equal-powered shared decision-making as a principle of person-centred dentistry (7). Therefore, it is important to note that patients, such as our participants, want such interactions and clinicians should be made aware of this desire.

Participants discussed the concept of quality service without being incited to do so, and they did not only take into consideration the clinical or technical skills of the dentist when doing so. The focus was also on the traits or soft skills the clinician should possess, and the most common was empathy toward patients. Empathy plays a significant role in the provision of person-centred health and dental care (96). Mills et al. previously reported that patients greatly value an empathetic approach to dental care (43). However, in the same Mills et al. study, the authors classified empathy as part of the clinician's attitude while providing care and did not directly associate it with quality service. Additionally, Karydis et al. supported the importance of an empathetic clinician, especially pertaining to the creation and maintenance of a good dentist-patient relationship (64).

Another emerging trait pertaining to the provision of quality service was the clinician's sensitivity toward the patient. This trait was specifically identified while discussing experiences of dental care at the Jim Lund Dental Clinic. Wallace et al. demonstrated that sensitivity is strongly associated with empathy since it is considered as the clinician's ability to understand and be aware of what the patient may need in addition to his or her clinical needs (4). These traits

are well related with the process of instilling trust, which was the most important and unanimously agreed upon factor involved in having a positive dental care experience.

In the predominantly privatized dental care system present in Quebec and Canada, dental care is a very costly expense. For our participants, saving money for possible future dental emergencies or expenses is not feasible. As a result, if the clinician's concentration is on money as opposed to the person's needs, the care being provided is dehumanizing rather than person-centred. Raja et al. similarly underlined the negative impact that cost and focus on money can have on the provision of person-centred care (52, 69). In line with the high costs, difficulty accessing dental care as a person with a low income is an issue that has been demonstrated countless times (4, 19, 20). Our participants reported a significant decrease in the number of dental clinic visits since encountering financial difficulties. This experience thus supports the lack of access to dental care in a low-income population.

Additionally, the fact that our participants had to visit a free dental clinic and were willing to wait four to six months to do so further highlights their inability to access privatized dental care. Thus, considering the high cost and limited accessibility of dental care, the concept of a free dental clinic was largely appreciated by our participants. Even though they may not have had other options, our participants did not shy away from critiquing and commenting on the service they received. For instance, they cited problems with the types of care not offered at the free Jim Lund Dental Clinic that are also excluded from the RAMQ coverage (16, 84, 87). Therefore, even though they had access to that clinic, they still could not receive some of the care they greatly needed, such as crowns (16, 84, 87).

This gap in dental care is not explicitly the clinic's fault since they have limited resources

as a university-run free dental clinic. The gap in dental care coverage falls under the jurisdiction of the privatized dental care system present in this country and is perpetuated by certain clinicians who are reluctant to offer care to underserved populations for reasons such as issues with levels of respect due to missed appointments (4).

The exclusion of low-income populations from the privatized dental care system has led to instances of overt marginalization in the perspective of our participants. Raja et al. (69) reported cases when the clinician did not offer person-centred care or was not being 'human'. The fear of being shamed based on oral health status could also be a barrier to accessing dental care along with other life events like getting a job (97). Accordingly, our participants stated that clinicians should ensure that they do not inadvertently treat their patients in a condescending manner. Similarly, our participants mentioned that clinicians should understand that they are seeking care because they are in pain and have real dental problems.

A common obstacle to providing more attentive and person-centred care from the perspective of the clinician is the thought that they would have to spend too much time to do so (98, 99). From the patient's perspective, however, our study has shown that although patients do not necessarily enjoy waiting for a long time, there are situations where a longer appointment or waiting time is not a big problem. For instance, receiving assurance that an appointment would provide sufficient and appropriate information with a kind and empathetic clinician could justify longer wait times.

6.2. Study Contributions

This study fills in the knowledge and research gaps pertaining to the dental experiences of people with low incomes. More specifically, it increases the knowledge available about their perspectives of dental care and person-centred care in dentistry. Simultaneously, their commentary on access to dental care will hopefully help improve some of the problems they face when trying to access dental care. As a result, this study contributes to the theoretical approach behind person-centred care in dentistry by providing the patient's perspective of dental care. It also complements the current clinician- and academic-led framework that was developed by Apelian et al (7).

Particularly, the results of this study add a more global component to Apelian et al.'s clinical model of "person-centred dentistry" (7). The three principles within this model are understanding, decision-making and interview. These three meet and provide the ideal setting for a "humanist equal-powered patient-dentist encounter". The findings of this study add a larger scope to the patient-dentist encounter by providing the perceptions of patients who are receiving dental care while highlighting the importance of an empathetic clinician who sustains a trusting dentist-patient relationship.

We used the sub-themes and themes that emerged during the analysis to incorporate other concepts that can be considered within each of the three principles in Apelian et al's model. For the first principle, understanding, we have added conversing with the patient about their dental health, as well as other life events. Next, for the second principle, decision-making, we incorporated the importance of providing sufficient and appropriate information. Both new additions will help instill and sustain trust within the dentist-patient relationship. Lastly, we integrated the importance of maintaining a supportive environment that ensures the patient feels

cared for by the clinician and the clinic. The previously mentioned and established trust will help create such an environment and vice-versa. Therefore, we added the lived experiences of low-income people as a reference point for improved provision of care. However, during clinical encounters, patients' experiences should be considered within their personal contexts since they have their own needs and desires with regards to dental care. Since the knowledge created through this project touches on many facets of dental care, the following adaptation of Apelian et al.'s model was created (Figure 3).

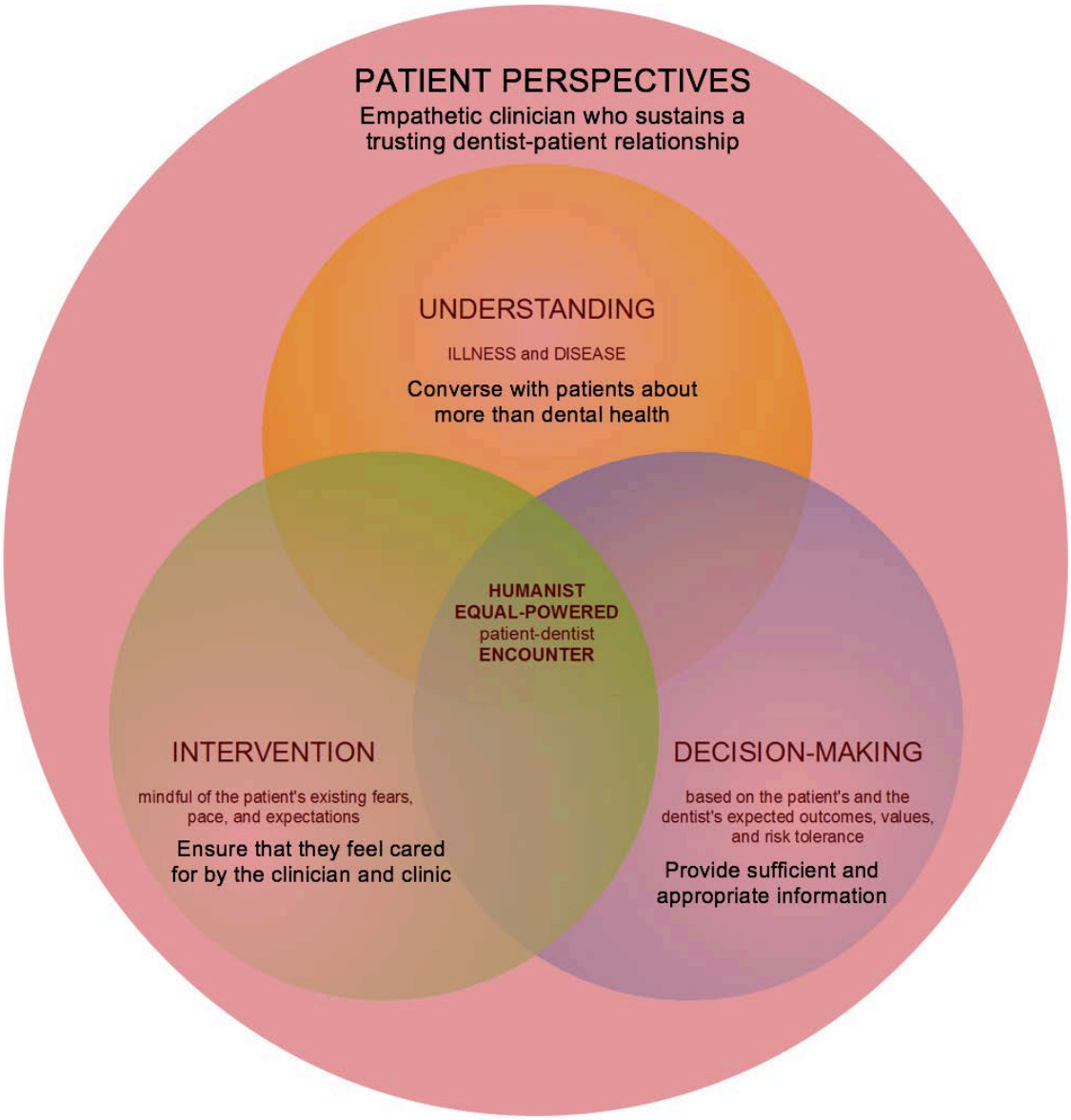

Figure 3. Enriched model of clinical person-centred dental care adapted from Apelian et al.

The in-depth knowledge that has emerged through the discussions and interviews with adults using a free dental clinic, as well as the above-adapted model of clinical person-centred dentistry, will help current and future dentists become better at how they interact, treat, and understand their patients. For instance, teaching this model in more dental schools and in continuing education classes for current dentists could help clinicians understand the different facets of a dentist-patient encounter. Currently, Apelian et al's model is being taught at McGill University, as well as at the Université Toulouse III – Paul Sabatier. The findings of this study and the adapted PCC framework presented can complement and illustrate the different aspects of dentist-patient encounters, including patient expectations. People will thus have a greater chance of receiving the type of dental care they want based on their needs. Although there may be some resistance from the dental profession due to various barriers impeding clinicians from offering such person-centred dental care, providing current and future dentists with greater amounts of resources is a step in the right direction.

6.3. Study Limitations and Strengths

6.3.1. *Limitations*

The first limitation of this study lies in the difficulty to generalize the findings. However, transferability of the results can be considered if the population to which it is being transferred is similar to the population used in this study. Since we recruited in Montreal, Quebec, the social, economic and political contexts of this city, as well as the demographics of the population attending the free dental clinic must be considered prior to trying to transfer its results to different contexts. Therefore, it was important to describe the various contextual characteristics

of the participants who were recruited. As an example, the varied ethnicities of the participants may be a limitation pertaining to the transferability of the results of this project. However, Quebec, and especially Montreal is a very multicultural and diverse society, and as such, the varied number of ethnicities is an integral part of the community. Nevertheless, this element needs to be considered when transferring these findings.

Another limitation could lie in the participants who were mostly immigrants and may not have been able to convey their true experiences of dental care if English or French was not their first language. This is also true in my role as interviewer as I may not have been able to understand the exact meanings they gave their experiences based on the interview transcripts. Additionally, the previous experiences of the participants may have positively or negatively impacted their experiences of dental care in Montréal. For example, one participant described her previous experiences in her country of origin where they had a more public dental care system. Therefore, when she first visited a private dental clinic in Montreal, she had specific expectations that were not met by the privatized dental care system in place in Canada. Likewise, another participant also described her experiences in her own country and how she was surprised that dental care is not included in the Canadian public health care system. Nevertheless, the participants' different experiences outside Montreal have given them a wider range of experiences and perspectives leading to a greater spectrum of suggestions to improve the dental care being provided.

A third limitation of this study could stem from the benefits that a participatory action approach may have provided the overall findings. Since we were looking at the perspectives and experiences of people regarding dental care, it would have been even more enriching to involve them from the beginning steps of the conception of this project. For instance, it could have been

beneficial to consult them with regards to the research questions and interview guides. These consultations would have helped us understand if our approach was the most appropriate to learn about their experiences with dental care. To address this limitation, we included open-ended questions at the end of the interview to allow the participants to discuss anything else they wanted to share pertaining to the topic at hand.

Lastly, another limitation is the restricted experience participants had with private dental care in Montreal. This limited experience was largely due to the high cost of dental care and their inability to afford the care they needed prior to visiting the free dental clinic. Due to the nature of the free dental clinic we used for recruitment and the population they aim to serve, this was a very difficult limitation to overcome.

6.3.2. *Strengths*

Despite the difficulty of generalizing these findings, there may be similarities in the experiences of our multicultural participants and patients in other contexts. Raja et al. reported a similar robustness of themes and perceptions pertaining to the various ethnic groups present in their study (69). This could increase the strength and rigor of our study since we had more diverse demographics than Raja et al.

Our goal was to speak with people who were the recipients of free dental care and whose voices had so often been ignored. The participants appreciated the opportunity to be involved and they assured me that it was a relief to be able to talk about their positive and negative experiences with dental care.

6.4. Directions for Future Research

Future research should consider the experiences of people using private dental clinics in Montreal, Quebec to understand whether their perceptions of dentistry and the ideal dentist differ from those who use a free dental clinic. This new project should also compare the differences between people's experiences based on the geographical location of their dental clinic. For instance, future researchers should compare experiences in different cities or different neighbourhoods in the same city. These projects would help further enrich the PCC model in dentistry from the perspective of people with varying experiences of dental care.

Also, other investigations should be carried out in regions with different approaches to dental care to further enrich the PCC model in dentistry. For instance, how do people's perceptions differ in countries where there are very different oral health care systems? Additionally, further studies should address the differences, gaps and discrepancies between student, dentist and patient perceptions of PCC.

6.5. Knowledge Translation Plan

Our goal is to share these findings with the Faculty of Dentistry at McGill University through the positions of my supervisor, Dr. Christophe Bedos, as well as one of the members of my supervisory committee, Dr. Nareg Apelian. The former teaches person-centred care to the dentistry students at McGill University. The latter is directly responsible for the dentistry students' clinical approach education at McGill University. This will increase future dentists' awareness of the needs and desires of low-income populations regarding dental care.

Moreover, to better ensure a cohesive and person-centred approach to dental care in clinics, a summarizing report of the findings and implications of the adapted model can be shared with current dentists. This report would include sections detailing how receptionists, dental hygienists and dental assistants could also be involved in providing person-centred care. Furthermore, we could partner with dental hygienists and write a document in their professional journals, while also working with dental hygienist schools to incorporate such information into their curriculum. Thus, there could eventually be an increase of person-centred care in all dental clinics, which could improve patient experiences with dental care.

To further widen the spectrum of people with access to these findings, I will share a report with all funding bodies. I have already presented these findings in five different research events. The first was an oral presentation at the McGill University Faculty of Dentistry 12th Annual Research Day on April 6th, 2017 for which I won the first prize for oral presentations. Next, I had an oral presentation at CREMIS for their Colloque Appréhender, documenter et répondre aux inégalités sociales et à leurs effets - Perspectives de jeunes chercheur(es) on May 4th, 2017. I have presented a poster at the 85th Congrès de l'ACFAS on May 10th, 2017. During this same conference, I also had a three-minute oral presentation as part of the Colloque 85e ACFAS – Comment les Facultés de médecine dentaire travaillent avec la profession dentaire, les gouvernements et la communauté pour améliorer l'accès aux soins dentaires on May 12th, 2017. Moreover, I had another poster presentation within the scope of the RSBO Journée Scientifique on May 26th, 2017 in Montreal, Quebec. Lastly, I will be presenting a poster at the 2nd International Congress on Whole Person Care in October 2017 in Montreal, Quebec. In addition, we will submit the findings of this study to a peer-reviewed scientific journal to further broaden the widespread knowledge translation and dissemination of this research.

7. Conclusion

In this study, we wanted to understand the perspectives of adults using free dental clinics about dentistry. To acquire this knowledge, I conducted semi-structured in-depth interviews with 13 participants recruited at the free Jim Lund Dental Clinic in Montreal, Quebec. These interviews were done in the context of a qualitative descriptive study. Additionally, I asked about their suggestions for improving the provision of dental care based on their previous experiences.

While analyzing the results of this study, two major themes emerged pertaining to adults using free dental clinics and their experiences with dental care. The first major theme was 'Wanting to Feel Human and Respected' and it included four sub-themes as follows: 'Wanting to Feel Cared for by the Clinician and the Clinic'; 'Wanting to Receive Quality Service'; 'Wanting to Build Trust with the Clinicians and the Clinic'; and 'Wanting Sufficient and Appropriate Information'. The second major theme that emerged from the thematic analysis of this study was 'Feeling Excluded from the Oral Health Care System' and it included four sub-themes as follows: 'Costing Too Much'; 'Lacking Access to Dental Care'; 'Waiting for Care'; and 'Perceiving Marginalization'.

The participants expressed their desire to feel cared for through the receipt of quality service and adequate amounts of appropriate information about their dental care. With this information, they could then make more informed and educated shared decisions about their dental care and oral health with the help of their clinician. To receive this level and type of care from their dentist, participants identified the ideal clinician as someone who is empathetic and sensitive to their personal needs. Moreover, this clinician should consider how people's life experiences may impact their dental health and what they want from their dental care.

Based on the participants' low access to dental care in our predominantly privatized dental care system, they appreciated the free service they received at the Jim Lund Dental Clinic. However, their appreciation did not prevent them from identifying certain gaps that exist within the service. Nevertheless, they understand that it is not the clinic's direct responsibility but rather the system that does not provide them with sufficient funds and resources. This population's exclusion from the private dental care system then creates further feelings of marginalization.

The concept of time was discussed in three main ways, the first of which was related to waiting to get an appointment. This was an issue with the free dental clinic due to their limited resources. The second facet of time was related to waiting to be seen by the clinician when they had an appointment. The participants were not significantly bothered by waiting for a longer time if they knew that the clinician would be a caring, empathetic and informative person who was there to address their needs. The last facet of time was the actual time spent with the clinician. Much like the impact of longer wait times before an appointment, a longer appointment time was appreciated if they received appropriate and sufficient information about their dental care from a thoughtful clinician.

The participants had many suggestions to address issues with access to dental care. For instance, incorporating a walk-in clinic in both free and private dental clinics was one of the suggestions to improve people's experiences of dental care. Other recommendations included increasing public coverage of dental care to provide a greater range of treatments and care to those in need. Additionally, implementing a base salary for clinicians was recommended by some of the participants.

In sum, people need clinicians who adopt a comprehensive approach when providing

information. This and other findings of this study could improve patients' experiences through a more person-centred approach to dental care that considers their needs, their difficulty accessing care, and sustains shared decision-making.

8. References:

1. Hollister M, Weintraub J. The association of oral status with systemic health, quality of life, and economic productivity. J Dent Educ. 1993;57(12):901-12.
2. Rhodus N. Oral health and systemic health. Minnesota Medicine. 2005;88(8):46-8.
3. Quinonez C, Figueiredo R. Sorry Doctor, I Can't Afford the Root Canal, I Have a Job: Canadian Dental Care Policy and the Working Poor. Canadian Journal of Public Health. 2010;101(5):481-5.
4. Wallace BB, Macentee MI. Access to dental care for low-income adults: perceptions of affordability, availability and acceptability. J Community Health. 2012;37(1):32-9.
5. Balint E. The possibilities of patient-centered medicine. . J R Coll Gen Pract. 1969;17:269-76.
6. Institute of Medicine. Crossing the Quality Chasm: A New Health System for the 21st Century. 2001.
7. Apelian NV, J-N.; Bedos, C. Humanizing Clinical Dentistry Through a Person-Centred Model. The International Journal of Whole Person Care. 2014;1(2):30-50.
8. Vergnes JN, Apelian N, Bedos C. What about narrative dentistry? J Am Dent Assoc. 2015;146(6):398-401.
9. Levesque J, Harris M, Russell G. Patient-centred access to health care: conceptualising access at the interface of health systems and populations. International Journal for Equity in Health. 2013;12(18).
10. Canadian Dental Association Inc. Laws, Regulations and Guidelines in Health Care 2017 [Available from: https://www.cda-adc.ca/en/services/internationallytrained/laws/.
11. Duncan L, Bonner A. Effects of Income and Dental Insurance Coverage on Need for Dental Care in Canada. J Can Dent Assoc. 2014;80:e6.
12. McGill University Faculty of Dentistry. Patients & Community Montreal, QC2017 [Available from: https://www.mcgill.ca/dentistry/patientscommunity.
13. Rashid-Kandvani F, Nicolau B, Bedos C. Access to Dental Services for People Using a Wheelchair. American Journal of Public Health. 2015:e1–e6.
14. Msefer-Laroussi S. Analyse du systeme de couverture des services dentaires au Quebec. [Ph.D. dissertation]. Montréal: Université de Montréal; 2007.
15. Quinonez C. Why was dental care excluded from Canadian Medicare. NCOHR Working Papers Series 2013;1(1):1-5.
16. Régie de l'assurance maladie Québec. Health Insurance - Dental Services 2017 [Available from: http://www.ramq.gouv.qc.ca/en/citizens/health-insurance/healthcare/Pages/dental-services.aspx.
17. Leake J. Why Do We Need an Oral Health Care Policy in Canada. J Can Dent Assoc 2006;72(4):317.
18. Sweet M, Damiano P, Rivera E, Kuthy RA, Heller K. A comparison of dental services received by Medicaid and privately insured adult populations. JADA. 2005;136:93-100.
19. Muirhead V, Quinonez C, Figueiredo R, Locker D. Oral health disparities and food insecurity in working poor Canadians. Community Dent Oral Epidemiol. 2009;37(4):294-304.
20. Quinonez C, Locker D. Canadian Opinions on Publicly Finances Dental Care. Canadian Journal of Public Health. 2007;98(6):495-88.
21. Main P, Leake J, Burman D. Oral Health Care in Canada — A View from the Trenches. J Can Dent Assoc 2006;72(4):319.

22. McQuistan MR, Kuthy RA, Qian F, Riniker-Pins KJ, Heller KE. Dentists' treatment of underserved populations following participation in community-based clinical rotations as dental students. J Public Health Dent. 2010;70(4):276-84.
23. Emami EW, J.; Galarneau, C.; Bedos, Christophe. Oral health and access to dental care: a qualitative exploration in rural Quebec. Canadian Journal of Rural Medicine. 2014;19(2):63-70.
24. Loignon C, Landry A, Allison P, Richard L, Bedos C. How do dentists perceive poverty and people on social assistance? A qualitative study conducted in Montreal, Canada. J Dent Educ. 2012;76(5):545-52.
25. Reis CR, C.; Macaulay, AC.; Bedos, Christophe. Dental Students' Perceptions of and Attitutes About Poverty: A Canadian Participatory Case Study. J Dent Educ. 2014;78(12):1604-14.
26. Woolf SC EH, R.; Sheridan, SL.; Braddock, CH.; Kaplan, RM.; Krist, A.; O'Connor, AM.; Tunis, S. . Promoting Informed Choice: Transforming Health Care To Dispense Knowledge for Decision Making. . Ann Intern Med. 2005;143:293-300.
27. Fang HM NR, J.; Zeckhauser, R. Demanding Customers: Consumerist Patients and Quality of Care. The BE Journal of Economic Analysis & Policy. 2011;11(1):1-49.
28. Zeckhauser RS B. Consumerism in Health Care: Challenges and Opportunities. Virtual Mentor. 2013;15(11):988-92.
29. Longtin YS HL, LL.; Sheridan, SE.; Donaldson, L.; Pittet, D. . Patient Participation: Current Knowledge and Applicability to Patient Safety. Mayo Clin Proc. 2010;85(1):53-62.
30. Vahdat S, Hamzehgardeshi L, Hessam S, Hamzehgardeshi Z. Patient involvement in health care decision making: a review. Iran Red Crescent Med J. 2014;16(1):e12454.
31. Dixon-Fyle SG SP, T.; Spatharou, A. . Changing patient behavior: the next frontier in healthcare value. Health International. 2012;12:64-73.
32. Slater L. Person-centredness: A concept analysis. Contemporary Nurse. 2014;23(1):135-44.
33. Academy of Medical Royal Colleges. Changing care, improving quality - Reframing the debate on reconfiguration. The NHS Confederation. ; 2013.
34. Al-Abri R. Managing Change in Healthcare. Oman Medical Journal 2007;22(3):9-10.
35. Little PE HW, I.; Warner, G.; Moore, M.; Gould, C.; Ferrier, K.; Payne S. . Preferences of patients for patient centred approach to consultation in primary care: observational study. BMJ. 2001;322:1-7.
36. Association. CM. Health Care Transformation in Canada. Canada: Canadian Medical Association; 2010.
37. Mead N, Bower P. Patient-centredness: a conceptual framework and review of the empirical literature. Social Science & Medicine. 2000;51:1087-110.
38. Balint M. The doctor, his patient and the illness. London: Pitman Medical; 1964.
39. Byrne P, Long B. Doctors Talking to Patients. London: HMSO; 1976.
40. McWhinney I. The need for a transformed clinical method. Communicating with medical patients. London: Sage; 1989.
41. Stewart M, Brown J, Weston W, McWhinney I, McWilliam C, Freeman T. Patient-centred medicine: transforming the clinical method. London: Sage; 1995.
42. Scambler SL, E.; Zoitopoulos, L.; Gallagher, JE. . Professional attitudes towards disability in special care dentistry. Journal of Disability and Oral Health. 2011;12(2):51-8.
43. Mills I, Frost J, Kay E, Moles DR. Person-centred care in dentistry--the patients' perspective. Br Dent J. 2015;218(7):407-12; discussion 13.

44. Zhao J, Gao S, Wang J, Liu X, Hao Y. Differentiation between two healthcare concepts: Person-centered and patient-centered care. International Journal of Nursing Sciences. 2016;3(4):398-402.
45. Green A. Why the disease-based model of medicine fails our patients. Culture and Medicine 2002;176:141-3.
46. van der Eijk M, Nijhuis FA, Faber MJ, Bloem BR. Moving from physician-centered care towards patient-centered care for Parkinson's disease patients. Parkinsonism Relat Disord. 2013;19(11):923-7.
47. Engel G. The Clinical Application of the Biopsychosocial Model Am J Psychiatry 1980;137(5):535-44.
48. Neighbour R. The inner consultation. Lancaster: MTP Press; 1987.
49. Henbest R, Stewart M. Patient-centredness in the Consultation. 1: A Method for Measurement. Family Practice. 1989;6(4):249-53.
50. Grol R, De Maeseneer J, Whitfield M, Mokkink H. Disease-Centred Versus PatientCentred Attitudes- Comparison of General Practitioners in Belgium, Britain and The Netherlands. Family Practice. 1990;7(2):100-3.
51. Rogers C. On becoming a person: a therapist's view of psychotherapy. London: Constable; 1967.
52. Raja S, Hasnain M, Vadakumchery T, Hamad J, Shah R, Hoersch M. Identifying elements of patient-centered care in underserved populations: a qualitative study of patient perspectives. PLoS One. 2015;10(5):e0126708.
53. Balint E, Courtenay M, Elder A, Hull S, Julian P. The doctor, the patient and the group: Balint revisited. London: Routledge; 1993.
54. Barker P. The tidal model: the lived-experience in person-centredmental health nursing care. Nursing Philosophy. 2001;2:213-23.
55. Ford P, McCormack B. Keeping the person in the centre of nursing. Nursing Standard. 2000;14(46):40-4.
56. Cloninger C, Salvador-Carulla L, Kirmayer L, Schwartz M, Appleyard J, Goodwin N, et al. A Time for Action on Health Inequities- Foundations of the 2014 Geneva Declaration on Person- and People-centered Integrated Health Care for All. Int J Pers Cent Med. 2014;4(3):69-89.
57. Mezzich J, Appleyard J, Ghebrehiwet T. Interdisciplinary Collaboration and the Construction of Person Centered Medicine The International Journal of Person Centered Medicine 2014;4(3):149-55.
58. Charon R. Narrative Medicine: A Model for Empathy,Reflection, Profession, and Trust. JAMA. 2001;286(15):1897-902.
59. Mills I, Frost J, Cooper C, Moles DR, Kay E. Patient-centred care in general dental practice--a systematic review of the literature. BMC Oral Health. 2014;14:64.
60. Mills I, Frost J, Moles DR, Kay E. Patient-centred care in general dental practice: sound sense or soundbite? Br Dent J. 2013;215(2):81-5.
61. Department of Health. Dental Quality and Outcomes Framework. 2011.
62. Scambler S, Asimakopoulou K. A model of patient-centred care - turning good care into patient-centred care. Br Dent J. 2014;217(5):225-8.
63. Bedos C, Brodeur J-M, Boucheron L, Richard L, Benigeri M, Olivier M, et al. The dental care pathway of welfare recipients in Quebec. Social Science & Medicine. 2003;57(11):2089-99.

64. Karydis A, Komboli-Kodovazeniti M, Hatzigeorgiou D, Panis V. Expectations and perceptions of Greek patients regarding the quality of dental health care. Int J Qual Health Care. 2001;13(5):409-16.
65. Chapple HS, S.; Caress, A-L.; Kay, EJ. Exploring dental patients' preferred roles in treatment decision-making — a novel approach. Br Dent J. 2003;194(6):321-7.
66. Abu-Serriah M, Dhariwal D, Martin G. Reputation of Oral and Maxillofacial Surgery in the UK: the patients' perspective. Br J Oral Maxillofac Surg. 2015;53(4):321-5.
67. Azarpazhooh A, Dao T, Ungar WJ, Chaudry F, Figueiredo R, Krahn M, et al. Clinical decision making for a tooth with apical periodontitis: the patients' preferred level of participation. J Endod. 2014;40(6):784-9.
68. Riley JL, 3rd, Gordan VV, Hudak-Boss SE, Fellows JL, Rindal DB, Gilbert GH, et al. Concordance between patient satisfaction and the dentist's view: findings from The National Dental Practice-Based Research Network. J Am Dent Assoc. 2014;145(4):355-62.
69. Raja S, Shah R, Hamad J, Van Kanegan M, Kupershmidt A, Kruthoff M. Patients' Perceptions of Dehumanization of Patients in Dental School Settings: Implications for Clinic Management and Curriculum Planning. J Dent Educ. 2015;79(10):1201-7.
70. Braun VC, V. Using thematic analysis in psychology. Qualitative Research in Psychology. 2006;3:77-101.
71. Cohen L, Manion L. Research methods in education. Fourth ed. London: Routledge; 1994.
72. Mertens D. Research methods in education and psychology: Integrating diversity with quantitative and qualitative approaches. . Second ed. Thousand Oaks: Sage; 2005.
73. Sandelowski M. Focus on Research Methods Whatever Happened to Qualitative Description? Research in Nursing & Health. 2000;23:334-40.
74. Sandelowski M. What's in a name? Qualitative description revisited. Res Nurs Health. 2010;33(1):77-84.
75. Lincoln Y, Guba E. Naturalistic inquiry. Beverly Hill, CA: Sage; 1985.
76. Willems E. Toward an explicit rationale for naturalistic research methods. Human Development. 1967;10:138-54.
77. Patton M. Qualitative evaluation and research methods. 2nd ed. Newbury Park, CA: Sage; 1990.
78. Minelli L, Pigini C, Chiavarini M, Bartolucci F. Employment status and perceived health condition- longitudinal data from Italy. BMC Public Health. 2014;14:946.
79. Kaur M, Sodhi S, Kaur P, Singh J, Kumar R. Gender Differences in Health Care Seeking Behaviour of Tuberculosis Patients in Chandigarh. Indian J Tuberc. 2013;60:217-22.
80. Elliott MN, Lehrman WG, Beckett MK, Goldstein E, Hambarsoomian K, Giordano LA. Gender differences in patients' perceptions of inpatient care. Health Serv Res. 2012;47(4):1482-501.
81. Gil-Lacruz M, Gil-Lacruz A. Health Perception and Health Care Access- Sex Differences in Behaviors and Attitudes. The American Journal of Economics and Sociology. 2010;69(2):783-801.
82. Singh H, Haqq E, Mustapha N. Patients' perception and satisfaction with health care professionals at primary care facilities in Trinidad and Tobago. Bulletin of the World Health Organization. 1999;77(4):356-60.
83. DeVoe J, Wallace L, Fryer G. Patient Age Influences Perceptions About Health Care Communication. Health Services Research. 2009;41(2):126-33.

84. Welcome Hall Mission. Jim Lund Dental Clinic Montreal, QC2017 [Available from: https://welcomehallmission.com/services/jim-lund-dental-clinic/.
85. McGill University Faculty of Dentistry. Target Audience Montreal, QC2016 [Available from: https://www.mcgill.ca/dentistry/alumni/newsletter/community/audience.
86. McGill University. Mobile Outreach Clinics - Faculty of Dentistry Montréal, QC2015 [Website describing the McGill Dentistry Outreach Program]. Available from: https://www.mcgill.ca/dentistry/patients/outreach - about.
87. McGill University Faculty of Dentistry. Jim Lund Dental Clinic Montreal, QC2017 [Available from: https://www.mcgill.ca/dentistry/patientscommunity/jim-lund.
88. Green JM, Thorogood N. Qualitative Methods for Health Research. 3rd ed. Silverman D, editor. London: Sage; 2014. 342 p.
89. Schwandt T. The SAGE Dictionary of Qualitative Inquiry. 4 ed. Thousand Oaks, CA: SAGE Publications, Inc.; 2015. 332 p.
90. Cohen DC, BF. Evaluative Criteria for Qualitative Research in Health Care: Controversies and Recommendations. Annals of Family Medicine. 2008;6(4):331-9.
91. Shenton A. Strategies for ensuring trustworthiness in qualitative research projects. Education for Information. 2004;22:63-75.
92. Miles M, Huberman A. Qualitative Data Analysis. Second ed. Thousand Oaks, California: Sage; 1994.
93. Mays N, Pope C. Qualitative research in health care Assessing quality in qualitative research. BMJ. 2000;320:50-2.
94. Angen M. Evaluating Interpretive Inquiry: Reviewing the Validity Debate and Opening the Dialogue. QUALITATIVE HEALTH RESEARCH. 2000;10(2):378-95.
95. Merriam-Webster Dictionnary. Marginalize 2017 [Available from: https://www.merriam-webster.com/dictionary/marginalize.
96. Dwamena F, Holmes-Rovner M, Gaulden CM, Jorgenson S, Sadigh G, Sikorskii A, et al. Interventions for providers to promote a patient-centred approach in clinical consultations. Cochrane Database Syst Rev. 2012;12:CD003267.
97. Bedos C, Levine A, Brodeur JM. How people on social assistance perceive, experience, and improve oral health. J Dent Res. 2009;88(7):653-7.
98. Rabe P, Holmén A, Sjögren P. Attitudes, awareness and perceptions on evidence based dentistry and scientific publications among dental professionals in the county of Halland, Sweden: a questionnaire survey. Swed Dent J. 2007;31(3):113–20.
99. Iqbal A, Glenny A-M. General dental practitioners' knowledge of and attitudes towards evidence based practice. Br Dent J. 2002;193(10):587–91; discussion 3.

Appendices

Appendix A. Original French Quotes in Results Section Compared to Translated English Quotes

	Français	English
1	« Bon, mais qu'ils comprennent qu'on est à Mission Bon Accueil, tu sais, on pourrait peut-être se sentir diminuée dépendant de leur façon de nous accueillir. On est des personnes et on vaut la peine. Tu comprends? » – Entrevue #7	"Well, but that they understand that we are the Welcome Hall Mission, you know, we could maybe feel diminished depending on how they welcome us. We are people and we are worth something. You understand?" – Interview #7
2	« Aujourd'hui c'est vite, vite, vite, vite, vite, vite tu sais? C'est ça le problème, c'est vite, vite, vite, fait qu'on oublie, on oublie la personne un peu là des fois. La personne est importante. » – Entrevue #7	"Today it's fast, fast, fast, fast, fast, fast, you know? That's the problem, it's fast, fast, fast, so we forget, we forget the person sometimes. The person is important". – Interview #7
3	« Il est arrivé, il m'a touché d'une manière que même si c'est pas son corps, puis il sent rien, il sait que moi je sens de quoi puis il l'a fait pour pas que je sente de quoi, pour pas que j'ai mal, ok. » – Entrevue #12	"He came, he touched me in a way that even if it's not his body, and he doesn't feel anything, he knows that I feel things and he made sure that I wouldn't feel anything, that I wouldn't be hurt, ok." – Interview #12
4	« […] il m'expliquait, il m'a dit « Ok, cette dent-là, je peux le faire la, la, la. Vous avez une grosse carie là, l'avant-dernière dent. Ah, vous avez déjà eu un traitement de canal à cette place-là ». Il voit toute qu'est-ce que moi je savais je lui avais pas dit l'historique, là je me dis « Wow, ok, il sait, il sait qu'est-ce qui se passe. Il sait qu'est-ce qu'il y a dans ma bouche », il m'a pas faite mal, il était poli, il a pas rien fait de brusque. Ça c'est de la confiance, là […] » – Entrevue #12	"[…] he explained to me, he said 'Ok, this tooth here, I can do la, la, la. You have one big decay here, the second last tooth. Ah, you already had a root canal treatment in that place'. He saw everything that I knew I hadn't told him, the history, then I told myself 'Wow, ok, he knows, he knows what's going on. He knows what's in my mouth', he didn't hurt me, he was polite, he didn't do anything sudden. That made me trust him […]" – Interview #12
5	« […] C'est ça, le respect, la patience avec tous les patients, c'est plus important, […] acquérir la confiance avec les personnes que tu vas traiter, ça c'est, je pense que c'est plus important de une bonne clinique. » – Entrevue #11	[…] That's it, respect, patience with all the patients, that's more important, […] gaining trust with the people you're going to treat, that, I think, is the most important in a good clinic. – Interview #11
6	« Parce que c'est très important pour moi de savoir qu'est-ce qui ce passe avec ma, je viens chez le dentiste comme un expert, un spécialiste, je trouve si il y a des problèmes, je	"Because it is very important for me to know what is happening with my, I go to the dentist as an expert, a specialist, I find if there are problems, I need to know right

	dois savoir tout de suite. Peut-être quelque confiance, les instructions pour moi c'est très important […] » – Entrevue #8	away. Maybe some confidence, the instructions are very important for me […]" – Interview #8
7	« […] ensemble c'est mieux. De s'asseoir avec puis dire, parce que premièrement t'as toujours « Combien ça va coûter? », tu vas prendre la décision de ce que tu vas faire, ok, tu vas décider du prix aussi [rire]. Ça c'est une affaire, tsé, mais d'arriver 'Regarde, t'as tel, tel, tel possibilité', mettons, 'T'as le choix entre je te fais une réparation de dent avec la pâte puis on fait sécher ça, ça devient dur, *paff*, c'est fini. Je peux te faire une belle job avec ça, ou on arrache la dent puis on fait […] un implant.' » – Entrevue #12	"[…] together is better. To sit down and then say, because first you always have 'How much will it cost?', you will decide what you will do, ok, you will decide the price as well [laughter]. That is one thing, you know, but to come 'Look, you have this, this, and this possibility', let's say. 'You have the choice between repairing the tooth with paste and then it's dried and it becomes hard, paff, it's done. I can do you a nice job with that, or we extract the tooth and we do […] an implant'." – Interview #12
8	« […] lui il va expliquer toutes les options et la priorité, il va dire « ça c'est la première, première option qui va être pratique », mais sinon moi je, sinon il y aura d'autres options, moi je trouve que ça c'est logique en parallèle à la situation de la personne, comment il va réagir. C'est-à-dire il va choisir ça mais il va penser à l'autre aussi. Ça c'est comment il va trouver, si, parce que nous on a besoin dans la vie, c'est des options qui nous conviennent. » – Entrevue #6	"[…] He will explain all the options and the priority, he will say 'This is the first, first option that will be practical', but otherwise I, otherwise there will be other options, I find that this is logical in parallel with the situation of the person, how he will react. That is to say that he will choose but he will think about the other one as well. That is how he will find if, because what we need in life are options that suit us." – Interview #6
9	« […] je peux pas me payer les soins dentaires, c'est vraiment trop cher, je peux pas. Même aujourd'hui, je peux pas me payer, tout ce qu'ils m'ont dit traitement de dents, traitements de couronnes là, je peux pas le faire. Donc, je préfère, moi j'avais voulu garder toutes mes dents mais là je suis obligé de les arracher, ouais. » – Entrevue #10	"[…] I cannot afford dental care, it's really too expensive, I can't. Even today, I can't afford, everything they told me for treatments of teeth, dental crowns, I can't do it. So, I prefer, I would have wanted to keep all my teeth but no I am forced to extract them, yeah." – Interview #10
10	« Mais là c'est sure mais *money, money, money*, fait que c'est ça que je trouve déplorable, c'est l'argent avant la personne » – Entrevue #7	"But this is sure but money, money, money, so that's what I find deplorable, it's money before the person." – Interview #7
11	« Ça dépend pour quoi puis je peux vous dire qu'aux États-Unis c'est encore pire fait que c'est comme, « C'est tu cher au Canada? », non, pas tant que ça. » – Entrevue #12	"It depends on what, and from what I can tell you it's even worse in the United States, so it's like 'Is it expensive in Canada?', no, not that much." – Interview #12
12	« Là je me dis, que je pourrais pas arriver dans un hopital parce que moi je suis bas salarié, j'ai sept enfants, j'arrive, je veux faire faire quelque chose comme ça là, « Ah c'est	"Then I tell myself, that I could not get to a hospital since I have a low income, I have seven children, I arrive, I want to have something like that done, 'Ah, it's a surgery,

	une chirurgie, ça va couter 800 », 800 là, c'est énorme pour moi là, tsé? [rire] Là ouais, ok, là tu, t'essaye, tsé le dentiste te dit ça puis tu fais « Ouf », ok, là c'est 800 ça, c'est 300 l'autre affaire, là c'est mettons une carie, je sais pas combien ça coûte, une chance j'en ai rien qu'une. » – Entrevue #12	it will cost 800', 800 is huge for me, you know? [laughter] Then yeah, ok, then you try, you know, the dentist tells you all that and you go 'Ouf', ok, well it's 800 for this, it's 300 for the other thing, then let's say it's a tooth decay, I don't know how much it cost, luckily, I only have one." – Interview #12
13	« J'essaye de prendre soins parce que moi je sais que, aussi c'est, aussi un facteur c'est plus important c'est j'ai pas accès aux soins dentaires, je dois veiller à ce que je peux pas tomber dans des situations, des cas ou je peux pas avoir des moyens pour c'est ça grave, ça grave, c'est encore plus cher. […] j'ai des problèmes à l'accès aux soins dentaires parce que moi je suis pas vraiment à l'aide social, je suis pas couvert. » – Entrevue #6	"I try to take care because I know that, a more important factor is that I do not have access to dental care, I must ensure that I don't fall into situations, cases where I can't afford. When it's serious, it's even more expensive […] I have problems accessing dental care because I don't really have social assistance, I am not covered." – Interview #6
14	« Et là eux ils font pas ce genre de traitement, je comprends pas pourquoi c'est ça, je comprends pas pourquoi quand ils veulent aider les gens encore il y a des niveaux de soins. Normalement, ils doivent, si ils veulent aider, ils doivent prendre tout en charge, je comprends pas pourquoi on met encore des limites. Quand nous on a pas des moyens pour faire une des, un traitement de couronne c'est dans les mille et plus de dollars donc ça revient un peu à la même chose. » – Entrevue #10	"And there they don't do this kind of treatment, I don't understand why it's that, I don't understand why when they want to help people there are still levels of care. Normally, they have to, if they want to help, they have to take care of everything, I don't understand why they still put limits. When we don't have the means to have one of them […] a dental crown is in the thousands and more dollars, so it comes back a bit to the same thing." – Interview #10
15	« […] je me suis inscris pour un rendez-vous mais c'est long l'attente aussi, parce que c'est depuis, après six mois on m'a appelé mais pour me voir. » – Entrevue #11	"[…] I signed up for an appointment but it's a long wait, because it's since, after six months they called me to see me." – Interview #11
16	« J'ai pris un rendez-vous et j'ai attendu un an peut-être à peu près. Je suis venu ici et le médecin a fait mon dossier, il a regardé ce qui se passe et il a dit que j'ai besoin de réparer quelque chose et comme ça je continue de réparer mes dents ici. » – Entrevue #8	"I made an appointment and I waited maybe one year roughly. I came here and the doctor made my file, he looked at what was happening and he said that I need to repair something and like that I'm continuing to repair my teeth here." – Interview #8
17	« C'est après un an qu'ils m'ont appelé parce que là j'étais vraiment découragée, heureusement pour moi que le mal est passé, mes douleurs de dents se sont vraiment calmé, j'ai pris des Tylenols là, c'est ça qui a calmé mon mal durant un an. Ils m'ont appelé, je me	"It's after one year that they called me because I was really discouraged, fortunately for me that the pain had passed, my toothaches really calmed down, I took Tylenols, it calmed my pain for one year. They called me, I didn't even remember

	rappelais même plus quand ils m'ont appelé. » – Entrevue #10	anymore when they called me." – Interview #10
18	« J'ai déjà passé des heures chez des dentistes [rire] puis ici [Jim Lund] ça a pas pris une heure, c'est garantie. [..] Écoute, quand je prends un rendez-vous au dentiste, j'ai du temps, ok? […] le temps je m'en fous, parce que ça me prend pas une demie semaine, ok. » – Entrevue #12	"I have already spent hours at the dentist's [laugher] and here [referring to the Jim Lund Dental Clinic] it didn't take an hour, that's guaranteed. […] Listen, when I make an appointment with the dentist, I have time, ok? […] I don't care about time because it doesn't take me half a week, ok." – Interview #12
19	« Sauf une fois, lui, moi c'est un client de lui, donc j'avais comme un abcès et j'avais vraiment beaucoup de douleur et moi j'ai oublié mon, ma carte, la carte bleue, donc en ce moment lui il ne veut pas, il n'a pas voulu m'accepter. Donc, c'est, j'ai trouvé que ça c'est vraiment, c'est pas humain. » – Entrevue #6	"Except once, he, I was his client, so I had an abscess and I really had a lot of pain, and I forgot my card, my blue card, so in that moment, he didn't want, he didn't want to accept me. So, it's, I found that it's really, it's not human." – Interview #6
20	« […] je trouve ça extraordinaire, je trouve ça vraiment… Je suis très heureuse parce que j'aurais pas pu avoir de soins, puisque j'ai pas suffisamment de revenu pour payer des soins dentaires qu'il me faut. » – Entrevue #7	"[…] I find this amazing, I find this really… I am very happy because I could not have had any care, since I do not have sufficient income to pay for the dental care that I need." – Interview #7
21	« […] c'est vraiment une bonne idée, c'est ça vraiment qui nous sauve ici parce que si y'avait pas ces cliniques gratuites [rire], franchement moi je serais morte parce que la douleur m'a tellement tétanisé là [rire]. C'est eux vraiment qui, qui nous ont sauvés quoi. Ils sont un peu, vraiment, pour nous là, c'est une bénédiction d'avoir des trucs communautaires […] » – Entrevue #10	"[…] It's a really great idea, it's this really that saves us here because if I there were no free clinics [laughter], frankly I would be dead because the pain really paralyzed me [laughter]. It's really them who, who saved us. They are a little really, for us, it's a blessing to have community stuff […]" – Interview #10
22	« Mais je pense que comme salarié il faut faire comme ça, par exemple, il y a quelques services comme ici, on peut prêter les services pour les personnes qui ont besoin de l'aide et ça c'est une garantie de l'état et on doit faire le service particulier en même temps. […] comme ça les médecins il peut avoir un peu d'argent comme la clinique paye lui parce qu'il travaille avec les personnes qui payent et particuliers, et aussi l'état, le gouvernement doit payer le salaire parce qu'il travaille ici avec les personnes qui payent pas, qui sont pas riches. » – Entrevue #8	"But I think that with a salary it has to be like this, for example, there are some services like here [referring to the Jim Lund Dental Clinic], we can provide services for people who need help and that is a guarantee of the state, and one must do the particular service at the same time […]. That way, the doctors can have some money since the clinic pays him because he works with paying individuals, and also the state, the government has to pay the salary since he works here with people who do not pay, who are not rich." – Interview #8

23	« Il devrait avoir une base et puis avoir au dessus de cette base, avoir le surplus comme ils veulent, le nombre de patients qu'ils veulent recevoir, mais au moins je crois qu'on devrait les introduire un peu comme les autres médecins là. Ils devraient faire partie de la RAMQ. » – Entrevue #10	"They should have a base and then have in addition to the base, have a surplus as they want, the number of patients they want to have, but at least I think they should introduce a bit like the other doctors, they should be part of the RAMQ [Régie de l'assurance maladie du Québec]." – Interview #10
24	« […] peut-être les cliniques privées ils peut aussi apporter des services gratuits. Comme ça, comme ça je pense, parce que j'ai vu beaucoup de gens ici qui a des problèmes avec les dents, beaucoup, beaucoup. Mais toutes les gens qui ont des problèmes, je pense, sont personnes qui pas d'argent, qui sont sociales vulnérables, par exemple. Pas de travaille, ils travaillent peut-être saisonniers, quelques mois ils travaillent, quelques mois pas travaillent. » – Entrevue #8	"[…] maybe the private clinics could also offer free services. That way, so I think, because I've seen many people here who have problems with their teeth, many, many. But all these people who have problems, I think, are people who don't have money, who are socially vulnerable, for example. No work, maybe they work seasonally, they work a few months, a few months they don't work." – Interview #8
25	« S'il y a des moments sans rendez-vous, ça serait vraiment une bonne chose parce que là il y a des moments où on a des crises de douleurs là, s'il y avait des moments de sans rendez-vous, on devrait vraiment être soulagé. Parce que là, quand on a des crises de douleurs, même si tu présentes là-bas, on peut pas te recevoir parce que tu as pas de rendez-vous. S'il y avait vraiment une section de sans rendez-vous, ça allait vraiment être parfait. » – Entrevue #10	"If there are times without appointments, it would be a good thing because there are moments when you have a lot of pain, if there were times of no appointments, we would really be relieved. Because when you have a pain crisis, even if you show up there [referring to the Jim Lund Dental Clinic], we can't accept you because you don't have an appointment. If there really was a walk-in section, that would really be perfect." – Interview #10
26	« Si on est là, c'est pas parce que on est venu déranger, c'est parce qu'on a vraiment mal. Je peux seulement lui dire d'avoir le souci du professionnalisme, quoi. » – Entrevue #10	"If we are there, it's not because we came to bother, it's because we are really in pain. I only want to say to have a concern for professionalism." – Interview #10
27	« […] élargir les soins tsé. C'est encore une, tsé élargir, bon, t'es limité à ça, il y a pas d'esthétique, c'est sure qu'à un moment donné il y en a un médecin qui va falloir qu'il se pratique à faire de l'esthétique, il va peut-être pratiquer ici, je sais pas, tsé. C'est une suggestion, oui, mais est-ce que c'est une lacune? Non, c'est pas une lacune, tsé je veux dire, des fois il faut que t'accepte qu'est-ce qui se donne là, puis c'est ça là. Dire, ok est-ce qu'il y a une possibilité vous pouvez donner, mettons, un soin esthétique à 50	"[…] expand the care, you know. It's still a, you know, increasing, ok, you're limited to this, there is no aesthetic, it's certain that at some point there will be a doctor who will have to practice aesthetics, maybe he will practice here, I don't know. It's a suggestion, yes, but is it a gap? No, it's not a gap, you know, I mean, sometimes you have to accept what they give you and that's it. To say, ok, is there a possibility that you could give, for instance, cosmetic care at 50 percent with a lower charge, that wouldn't

	pourcent avec un plus bas de charge, ça serait pas pire ça aussi, tsé. » – Entrevue #12	be too bad either, you know." – Interview #12
28	« […] pour les enfants, je pense que c'est plus ludique, c'est plus de jeux, la télévision, pour faire la confiance et tout ça. » – Interview #11	"[…] for children, I think it could be more fun, it's more games, a television, to bring trust and all that." – Interview #11
29	« Mais en tout cas, vraiment la propreté, le personnel qui soit humain puis accueillant, c'est ce que je veux savoir pour qu'ils prennent le temps de nous expliquer, c'est ma clinique idéale. » – Entrevue #12	"But in any case, really the cleanliness, that the staff be human and welcoming, that's what I want to know that they take the time to explain to us, that's my ideal clinic." – Interview #12
30	« […] par rapport à la personnalité, plus de, qu'ils te donnent plus de confiance, et aussi sont riants [rire], amical, on te, que, pendant que on te fait tous les soins de dents, on que te parle, que te dit « Ça va bien? C'est bien? Tu as des douleurs? » tout ça, la communication, c'est ça. » – Entrevue #11	"With regards to personality, more of, that they give you more confidence, and also are laughing [laughter], friendly, they, while they do your dental care, they talk to you, they tell you 'It's going well? Is it good? Do you have any pain?', all that, communication, that's it." – Interview #11
31	« […] mon dentiste idéale, j'aurais voulu [rire], j'imaginerais ça comment? Un accueil un peu comme la Mission Bon Accueil, ça fait pas trop chez le médecin. Comment dire, un environnement qui n'a rien à voir avec l'hôpital, oui, comme ça met en confiance, ça déstresse d'abord quand tu entres. Il y a rien qui, il y a pas des murs blancs par exemple, c'est bien décoré, oui. Ça te met en confiance parce que si tu t'en vas chez un dentiste et puis tu entre, c'est tout carrelé de blanc là, les murs blancs, et puis je sais pas quoi [rire], ça stresse, ça fait peur, tu te dis « Oh mon dieu, où je [rire] ça fait peur, quoi », ça stresse, tu es pas détendu quand tu vas recevoir tes soins. Donc, j'imagine un lieu vraiment chaleureux, avec des fleurs, avec une réceptionniste, avec une secrétaire vraiment accueillante comme à Mission Bon Accueil vraiment oui. Quelqu'un qui vraiment, qui nous met le sourire quand on arrive malgré ta douleur, tu peux quand même sourire là, ouais. Et puis aussi un dentiste qui, et puis la salle aussi, la salle des soins avec des machines vraiment développés comme là-bas. » – Entrevue #10	"[…] my ideal dentist, I would have liked[laughter], how would I imagine this? A welcome a little like the Welcome Hall Mission [where the Jim Lund Dental Clinic is located], it doesn't really feel like being at the doctor's office. How to say, an environment that has nothing to do with the hospital, yes, like it builds trust, it destresses first when you enter. There is nothing that, there are no white walls for example, it's decorated well, yes. It gives you confidence because if you go to a dentist and you enter, it's all white, the walls white, and I don't know [laughter], it's stressful, it's frightening, you tell yourself 'Oh my God, where do I [laughter], it's frightening', it's stressful, you're not relaxed when you go receive care. So, I imagine a very warm location, with flowers, with a receptionist, with a very welcoming secretary like at Welcome Hall Mission, really, yes. Someone who really, who makes us smile when we arrive despite our pain, you can still smile, yeah. And then a dentist who, and then also a room, a room for providing care with really advanced machines like there." – Interview #10

Appendix B. Consent Form

Faculty of Dentistry
McGill University,
2001 Ave McGill College,
Montreal, QC H3A 1G1

INFORMATION AND CONSENT FORM

Title of Research Project:
Perspectives of adults using free dental clinics regarding dental care: a qualitative descriptive study

Researchers:
Principal investigator: Dr. Christophe Bedos, McGill University, Faculty of Dentistry, Department of Oral Health and Society
Student investigator: Nioushah Noushi, McGill University, Faculty of Dentistry, Department of Oral Health and Society
Co-researchers:
Dr. Nareg Apelian, McGill University, Faculty of Dentistry, Department of Oral Health and Society
Dr. Jean-Noel Vergnes, McGill University, Faculty of Dentistry, Department of Oral Health and Society
Dr. Charo Rodríguez, McGill University, Faculty of Medicine, Department of Family Medicine

Introduction:
You are invited to take part in a research project. Before you decide to take part in this study, take some time to review the information in this consent form, which describes the purpose of this study and what you will be asked to do. If you have any questions about the information in this form or need additional clarification, please discuss the study with one of the researchers. You may also want to discuss your participation choice with your friends and family. Participation in this study is voluntary. It is your decision whether or not you take part in this study. If you decide to take part in this study, 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:
The purpose of this study is to understand the perspective of adults receiving dental services at the Jim Lund Dental Clinic regarding dental care. Moreover, we would like to explore your suggestions for improvements to the dental care provided.

Study procedures:
Your participation is completely voluntary. If you agree to take part in this study, you will be asked to take part in an individual interview with Ms. Nioushah Noushi. The interview will take around an hour and a half to complete, and will be scheduled at a time convenient for you. The interview will either take place in a quiet room in the Jim Lund Dental Clinic, Welcome Hall Mission, or at the Faculty of Dentistry, McGill Dentistry. Ms. Noushi will ask questions about your past and current experiences with dentistry and dental care, mostly within, but not limited to, the Jim Lund Dental Clinic. Ms. Noushi will also read you three different situations of dental care and get your opinions regarding these stories. The interview will be digitally audio-recorded with your permission. If you opt out of the recording, you can still take part in the study. If this is the case, the interviewer will document the interview with hand-written or typed notes. The recordings will be transcribed by the same person who conducted the interviews (Nioushah Noushi). You have the choice to stop the interview at any time or take a break if needed. You can also refuse to answer any question asked by the interviewer. Furthermore, you may decide to withdraw from this study at any time without any negative consequences.

Possible risks:
There is little expected discomfort or risk associated with the interview, mainly because the purpose is simply for you to talk with the researcher. However, some of the questions or discussions during the interview may cause you discomfort or emotional upset.

Possible benefits:
You are unlikely to directly benefit from your participation in this study. The researchers hope that the information gained from this study will provide greater insight into the perceptions of populations using free dental clinics regarding dentistry and how this may improve approaches in the field.

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 any particular individual. The typed material will not contain any names. All the identifiable data will be stored on McGill University's OneDrive network, which is password-secured and only accessible by Nioushah Noushi; access will be granted to supervisor Dr. Christophe Bedos. The data will be transferred to Dr. Christophe Bedos' OneDrive account after Nioushah Noushi's graduation, and eventually be destroyed after seven years as per University policy. Any printed material or drawings, including consent forms, will be stored in a locked filing cabinet in a secure central location accessible only to the principal investigator. The findings of this study will be published in a thesis, 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. 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:
You will not receive compensation for taking part in the study.

Contact Information for questions about the study:
- Nioushah Noushi: Student, McGill University, Faculty of Dentistry, 2001 Ave McGill College, Montreal, QC, H3A 1G1. Tel: (416) 450-2855. Email: nioushah.noushi@mail.mcgill.ca
- 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.bedos@mcgill.ca

Contact Information for questions about 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, QC H3G 1Y6. Tel: (514) 398-8302. Email: ilde.lepore@mcgill.ca

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

I agree to be interviewed ☐ YES _____ ☐ NO _____

I agree to be audio-recorded ☐ 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 person who obtained consent: ……

Appendix C. Interview Guide (English)

INTERVIEW GUIDE:

Hello,
I would like to thank you for having taken the time to participate in this interview for a research project regarding dental care. It is very important to us because we want to improve the dental care system and your opinions matter to us and will help us with this goal.

1) Introduction/personal history
    a. Can you please tell me a bit about yourself?

2) Experience with dental care process
    a. Can you please tell me about your experience of dental care in Montreal?
        i. Follow-up: Dental care in general? (Private practice? Another setup?)
    b. When was the last time you had a dental problem?
        i. What were the symptoms?
        ii. Did you go to the dentist for it?
        iii. What affected your decision to visit or not visit?
        iv. When was the last time you went to the dentist?
        v. What was your experience like?
    c. Can you please describe how you found the dentist and then acquired the dental appointment?
        i. How did you feel about this?
        ii. Who decided about the date of the appointment?
        iii. How much later did they give you the appointment?
        iv. Was the delay acceptable?
        v. Did you have to do anything else/anything special to get the appointment?
        vi. What would you change? How?
    d. Can you please describe what your first impression was of the dental clinic?
        i. Had you been there before?
        ii. How did you feel about this?
        iii. What would you change? How?
    e. Can you please describe your interaction with the receptionist?
        i. How did you feel about this?
        ii. What would you change? How?
    f. Can you please describe your interaction with other staff? Who were they?
        i. How did you feel about this?
        ii. What would you change? How?
    g. Can you please describe your interaction with the dentist?
        i. How did you feel about this?
        ii. How was the relationship?
        iii. What would you change? How?
    h. How do you feel about the amount of information you were given by the dentist regarding your care?
    i. Can you please describe the process after you were seen by the dentist?

i. Who did you interact with?
ii. How did you feel about this?
iii. What would you change? How?
iv. Were you given a referral or a follow-up appointment?

j. What was positive about this process?
    i. How would you ensure this happens all the time? Can it be taught?
k. What was negative about this process?
    i. How would you ensure this doesn't happen? What would you change? How?

3) Past experiences with dental care
    a. Thinking back to all your experiences, can you please describe positive aspects of these experiences?
        i. In which ways were they positive?
    b. Thinking back to all your experiences, can you please describe negative aspects of these experiences?
        i. In which ways were they negative?
    c. How does the positive compare to the negative?

4) Health care/suggestions/trust/fee for service/free clinics
    a. Can you tell me about your experiences of health care in general?
        i. Could you describe positive experiences?
        ii. Could you describe negative experiences?
        iii. How would you change it?
        iv. Why?
    b. Do you have any suggestions for improvements in the provision of dental care in general?
        i. <u>Follow-up:</u> How should these changes be achieved?
        ii. <u>Follow-up:</u> For dental care at other settings?
    c. What are your perceptions about the "fee for service" approach of health and dental care?
        i. <u>Follow-up:</u> How do you think this impacts the care/treatment you receive?
        ii. <u>Follow-up:</u> How would you change this?
        iii. <u>Follow-up:</u> Why?
    d. Do you think that trust is important in providing the type of care you desire?
        i. Why?
        ii. How would you build this trust?
    e. How do you feel about free clinics?
        i. How do you feel about needing to consult free clinics?
    f. Do you feel different when you visit a doctor's office compared to when you visit a dentist's office? Is this the same at Jim Lund?
        i. Why do you feel different? How do you feel different?
        ii. How would you change things in order to feel the same in a dentist's office as you do in a doctor's office and vice-versa?

5) Clinician-patient interaction
    a. Present two situations [(a) ask them which they would prefer; (b) ask them which they would prefer if the first makes them wait in the waiting room for one hour and the other doesn't make them wait more than 30 minutes]:
        i. One-hour long appointment where the dentist is very attentive and PCC.
        ii. 30-minute appointment where the dentist is less attentive and PCC. (same level of care but doesn't talk much about care provided or what patient thinks/wants)
        iii. WHICH HAVE YOU EXPERIENCED MOST OFTEN?
    b. Three more situations but working through Emmanuel
        i. Parent/child relationship where clinician tells patient what should/must do.
        ii. Parent/adolescent relationship where clinician gives patient information and helps in decision-making.
        iii. Adult/adult relationship where clinician informs patient and patient is solely responsible for decision-making.
            1. Which do you prefer?
            2. Why?
            3. Is this what you have experienced?
            4. What would you change?
            5. How?
6) Jim Lund:
    a. What has led you to use the services offered at Jim Lund Dental Clinic?
    b. Can you tell me how long you have been a patient at the Jim Lund Dental Clinic?
        i. How did you find out about it?
        ii. What happened that you started coming here?
    c. Can you please tell me about your experience at Jim Lund Dental Clinic?
            1. <u>Possible follow-up:</u> What about the entrance door (being locked)?
            2. How do you feel about the fact that the students may not have the same experiences as a dentist?
            3. *If being treated by a dentist, have you previously been treated by students at Jim Lund? If so, what's the difference? If you haven't, would you mind? Which do you prefer?*
            4. How did you get an appointment?
            5. What was your purpose for getting an appointment?
    d. What suggestions do you have for improvements in the provision of dental care at Jim Lund Dental Clinic?

Now I would like to ask you a couple of more precise questions about yourself and I would like you to know that you do not have to answer any of these questions if you do not want to do so.

7) 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?
    1. Follow-up: If yes, what do you do?
    2. Follow-up: If no, how long have you been unemployed?
        a. Follow-up: Are you currently looking for work?

8) Do you have any comments or questions? Anything you want to add about what we've discussed?

9) How did you find the experience of the interview?

10) Could you now think about your ideal dental clinic? Think about every aspect and detail possible. How would you like to get an appointment? What does the reception area look like? How is the receptionist? How does the dentist greet you? How is your interaction with the dentist before treatment begins? How is your interaction with the dentist during the treatment? How is your interaction with the dentist after the treatment? What does the actual room look like? How would you like to get a follow-up? What about the competencies of the people you encounter, how do they act? How about the equipment?

11) Does the Jim Lund Clinic fit into this? How would you improve it to fit your ideal clinic?

This is the end of the interview. Thank you again for participating in this interview.

If you would like to add anything in the future, something you think of later, please feel free to contact me.

Also, would it me ok for me to contact you if I have any other questions?

Appendix D. Interview Guide (French)

GUIDE D'ENTREVUE :

Bonjour,
J'aimerais vous remercier pour avoir pris le temps de participer dans cette entrevue pour un projet de recherche à propos des soins dentaires. C'est très important pour nous parce qu'on veut améliorer le système de soins dentaires et vos opinions comptent pour nous et nous aideront à atteindre cet objectif.

1) Introduction/histoire personnelle
    a. Pouvez-vous parler un peu à propos de vous-même ?

2) Expérience avec les soins dentaires
    a. Pouvez-vous, s'il vous plait, parler à propos de votre expérience avec les soins dentaires à Montréal ?
        i. Suivi : Les soins dentaires en général ? (Pratique privée ? Autre ?)
    b. À quand remonte la dernière fois que vous avez eu un problème dentaire?
        i. Quels étaient les symptômes?
        ii. Êtes-vous allé au dentiste pour ceux-ci?
        iii. Qu'est-ce qui a influencé votre décision de visiter ou de ne pas visiter un dentiste?
        iv. À quand remonte la dernière fois que vous avez visité un dentiste?
        v. Comment a été votre expérience?
    c. Pouvez-vous s'il vous plaît décrire comment vous avez trouvé un dentiste et ensuite obtenu un rendez-vous dentaire?
        i. Comment vous êtes-vous senti à ce sujet?
        ii. Qui a choisi la date du rendez-vous?
        iii. Est-ce qu'il y avait un long délai?
        iv. Est-ce que ce délai était acceptable?
        v. Deviez-vous faire autre chose pour obtenir le rendez-vous?
        vi. Que changeriez-vous à propos de ce processus? Comment?
    d. Pouvez-vous décrire votre première impression de la clinique dentaire?
        i. Y aviez-vous déjà été?
        ii. Comment vous sentiez-vous à propos de la clinique?
        iii. Que changeriez-vous? Comment?
    e. Pouvez-vous décrire votre interaction avec la secrétaire?
        i. Comment vous sentiez-vous à propos de ceci?
        ii. Que changeriez-vous? Comment?
    f. Pouvez-vous décrire votre interaction avec les autres membres du personnel? Qui étaient-ils?
        i. Comment vous sentiez-vous à propos de ceci?
        ii. Que changeriez-vous? Comment?
    g. Pouvez-vous décrire votre interaction avec le dentiste?
        i. Comment vous sentiez-vous à propos de ceci?
        ii. Comment a été la relation?

iii. Que changeriez-vous? Comment?

h. Que pensez-vous de la quantité d'information que vous avez reçue du dentiste concernant vos soins?
i. Pouvez-vous décrire le processus après avoir été vu par le dentiste?
    i. Avec qui avez-vous interagi?
    ii. Comment vous sentiez-vous à propos de ceci?
    iii. Que changeriez-vous? Comment?
    iv. Avez-vous reçu un rendez-vous de suivi?
j. Qu'est-ce qui a été positif à propos de ce processus?
    i. Comment vous assureriez-vous que cela arrive tout le temps? Peut-on l'enseigner?
k. Qu'est-ce qui a été négatif à propos de ce processus?
    i. Comment vous assureriez-vous que cela n'arrive plus? Que changeriez-vous? Comment?

3) Expériences avec les soins dentaires
    a. En réfléchissant à toutes vos expériences, pouvez-vous décrire les aspects positifs de ces expériences?
        i. De quelle manière étaient-ils positifs?
    b. En réfléchissant à toutes vos expériences, pouvez-vous décrire les aspects négatifs de ces expériences?
        i. De quelles manières étaient-elles négatives?
    c. Comment le positif se compare-t-il au négatif?

4) Soins de santé / suggestions / confiance / frais de service / cliniques gratuites
    a. Pouvez-vous me parler de vos expériences en matière de soins de santé en général?
        i. Pouvez-vous décrire les expériences positives?
        ii. Pouvez-vous décrire les expériences négatives?
        iii. Comment les changeriez-vous?
        iv. Pourquoi?
    b. Avez-vous des suggestions pour améliorer la prestation des soins dentaires en général?
        i. <u>Suivi:</u> Comment ces changements devraient-ils être réalisés?
        ii. <u>Suivi:</u> Pour les soins dentaires à d'autres endroits?
    c. Quelles sont vos perceptions au sujet de l'approche « frais pour service » de la santé et des soins dentaires?
        i. <u>Suivi:</u> Comment pensez-vous que cela affecte les soins et le traitement que vous recevez?
        ii. <u>Suivi:</u> Comment changeriez-vous cela?
        iii. <u>Suivi:</u> Pourquoi?
    d. Pensez-vous que la confiance est importante dans la prestation du type de soins que vous désirez?
        i. Pourquoi?
        ii. Comment établiriez-vous cette confiance?
    e. Que pensez-vous des cliniques gratuites?

i. Que pensez-vous du fait que vous avez besoin de consulter des cliniques gratuites?

f. Vous sentez-vous différent lorsque vous visitez le médecin par rapport à quand vous visitez le dentiste? Est-ce la même chose à Jim Lund?
   i. Pourquoi vous sentez-vous différent? Comment vous sentez-vous différent?
   ii. Comment changeriez-vous les choses pour ressentir la même chose chez le dentiste que chez le médecin et vice-versa?

5) Interaction clinicien-patient
   a. Présenter deux situations [(A) leur demander ce qu'ils préfèrent; (B) leur demander ce qu'ils préféreraient si le premier les fait attendre dans la salle d'attente pendant une heure et l'autre ne les fait pas attendre plus de 30 minutes]:
      i. Un rendez-vous d'une heure où le dentiste est très attentif et PCC.
      ii. Un rendez-vous de 30 minutes où le dentiste est moins attentif et PCC. (Même niveau de soins, mais ne parle pas beaucoup des soins fournis ou ce que le patient pense / veut)
      iii. LEQUEL AVEZ-VOUS VÉCU LE PLUS SOUVENT?
   b. Trois autres situations mais en travaillant à travers Emmanuel
      i. La relation parent / enfant où le clinicien dit au patient ce qu'il devrait / doit faire.
      ii. La relation parent / adolescent où le clinicien donne l'information au patient et l'aide avec la prise de décision.
      iii. La relation adulte / adulte où le clinicien informe le patient et le patient est seule responsable de la prise de décision.
         1. Lequel préférez-vous?
         2. Pourquoi?
         3. Est-ce ce que c'est celui que vous avez vécu?
         4. Que changeriez-vous?
         5. Comment?

6) Jim Lund :
   a. Qu'est-ce qui vous a amené à utiliser les services offerts à la clinique dentaire Jim Lund?
   b. Pouvez-vous me dire combien de temps vous avez été patient à la clinique dentaire Jim Lund?
      i. Comment l'avez-vous connu?
      ii. Qu'est-il arrivé que vous avez commencé à venir ici?
   c. Pouvez-vous me parler de votre expérience à la clinique dentaire Jim Lund?
         1. <u>Suivi possible:</u> Que pensez-vous de la porte d'entrée qui est verrouillée?
         2. Comment vous sentez-vous à propos du fait que les étudiants peuvent ne pas avoir les mêmes expériences qu'un dentiste?
         3. *Si vous avez été traité par un dentiste, avez-vous déjà été traité par des étudiants à Jim Lund? Si oui, quelle est la différence? Si ceci n'est pas le cas, cela vous dérangerait-il? Lequel préférez-vous?*

4. Comment avez-vous obtenu un rendez-vous?
5. Quel était votre but pour obtenir un rendez-vous?

d. Quelles suggestions avez-vous pour améliorer la prestation des soins dentaires à la clinique dentaire Jim Lund?

Maintenant j'aimerais vous demander quelques questions plus précises à propos de vous et j'aimerais que vous sachiez que vous ne devez pas répondre à ces questions si vous ne voulez pas le faire.

7) Questions sociodémographiques :
   a. Quel âge avez-vous ?
   b. Où habitez-vous ?
   c. Quel est votre état civil ?
      i. Avez-vous des enfants ?
   d. Quel est votre plus haut niveau de scolarité ?
   e. Quel est votre situation d'emploi ? Travaillez-vous présentement ?
      i. <u>Suivit :</u> Si oui, quel est votre emploi ?
      ii. <u>Suivit :</u> Si non, ça fait combien de temps que vous êtes sans emploi ou retraité(e) ?
         1. <u>Suivit :</u> Êtes-vous présentement à la recherche d'emploi ?

8) Avez-vous des commentaires ou des questions ? Quelque chose que vous aimeriez ajouter ou discuter ?

9) Comment avez-vous passé l'expérience de l'entrevue ?

10) Pourriez-vous maintenant imaginer votre clinique dentaire idéale ? Pensez à propos de chaque aspect et détail possible. Comment voudriez-vous obtenir un rendez-vous ? De quoi a l'air la salle d'attente ? Comment est-ce que le dentiste vous rencontre ? Comment est votre interaction avec le dentiste avant le début du traitement ? Comment est votre interaction avec le dentiste durant le traitement ? Comment est votre interaction avec le dentiste après le traitement ? De quoi a l'air la chambre où prend place le traitement ? Comment voudriez-vous obtenir un rendez-vous de suivi ? Et les compétences des personnes que vous rencontrez, comment agissent-ils ? Et l'équipement ?

11) Est-ce que la clinique Jim Lund ressemble à ceci ? Que feriez-vous pour l'améliorer pour qu'elle soit comme votre clinique idéale ?

Ceci marque la fin de l'entrevue. Merci encore pour avoir participé à cette entrevue.

Si vous aimeriez ajouter quelque chose dans le future, quelque chose qui vous vient plus tard, s'il vous plait n'hésitez pas à me contacter.

De plus, pourrais-je vous contacter si j'ai d'autres questions ?