

Thesis

Developing an Holistic and Person-Centred Approach
to
Professional Practice and Development
Using Mentoring
with Special Reference to Dentistry

Originally submitted for examination May 2013.

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Statement of Originality

I declare that this thesis is substantially my own work.

Where reference is made to the works of others, the extent to which that work has been used is indicated and duly acknowledged in the text and references.

This thesis is within the permitted word count of 80,000 words exclusive of footnotes, figures, appendices, and reference list.

Acknowledgements

I have been fortunate to receive support from a wide range of academics, colleagues and students, many of whose individual identities and contributions are merged within the groups listed below. I acknowledge, with gratitude, their support: -

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The late Mr Mark Brennan who, whilst we were lecturing together, started the whole doctoral process with the casual observation that my work had the potential for a doctoral study.

Finally, the members of the Norwich Dental Study Group, who first met in 1987 and in whose company I learnt much of what I later came to know as the person-centred approach, and with whom I have learnt the immense value of collegial support as we have all grown professionally – in our own chosen directions.

Primary Dental Care.

The papers submitted to Primary Dental Care (PDC) contributed to my thinking approaching the thesis. In some places, significant passages have been imported (with some minor modification generally) into the thesis. The principle passages concerned are listed below:
 Holt & Ladwa 2008, pp.139-45 in Chapter 1.1pp.17-28.

Holt & Ladwa 2009(b), pp.67-73 in Chapter 2.5 pp.2-4, 113-123.

Holt & Ladwa 2009(c), pp.158-62 in Chapter 2.3 pp.73-81.

Preface

The decision to undertake this study and prepare a thesis is part of an approach to professional practice which has matured over a lifetime.

That approach itself is, in many respects, the subject of the thesis.

The approach to practice emerged in a non-rational way, like a spark struck by flint on steel, from the interaction of two forces, one intellectual and the other professional, each of which can be traced back to a trigger point early in adult life.

The intellectual trigger point, in the first undergraduate year, was the introduction to the work of Martin Buber, notably "*I and Thou*" (Buber 1937/59) with his insight into the way persons relate to each other. This was followed by a study of Paul Tillich's "*Systematic Theology*", (e.g. Tillich 1953) with its framing of concepts in language that moved away from traditional, and heavily nuanced, religious jargon and, later the study of some of the work of Teilhard de Chardin (De Chardin with his study of the formative tendency culminating in the evolution of *Homo sapiens* as a phenomenon in an emergent universe (de Chardin 1955/59). These readings provided a positive counterpoint to a strong youthful intellectual revolt against traditional religious and doctrinal concepts and language; a revolt which yet left space for an holistic view of the human which could only be acceptably described by the word "humanistic" on the understanding that that word is used in a sense that includes a recognition of the many facets of our make-up incorporating a spiritual (as distinct from religious) dimension to that human make-up and, logically therefore, to the universe itself. Anything less seemed to deny the validity of important aspects of the totality of human experience.

The professional trigger point - in 1968 - during the third year of life in general dental practice, was the rejection in a ballot by the dental profession of the Tattershall report (Tattershall et al 1964) which had been prepared to address serious issues arising from the nature of the payment system for dentists (see chapter 1). Its rejection by the profession was perceived as a preference for a system that gave the opportunity to generate ever higher income by working ever faster in a role where speed on the one hand, and quality of work (let alone relating effectively with patients as persons) on the other, were clearly diametrically opposed.

The recognition of these two trigger points - the flint of the perceived abandonment of professional values and the steel of (what would now be called) the Person-Centred Approach (PCA) with its concomitant values) left a certain sense of disillusionment with the profession (against a belief that one should feel proud to be a member of a profession) and a sense of vicarious guilt – not to mention resentment and embarrassment - when faced with challenges from friends and other individuals from the lay public who had (with what was seen as much justification in many instances) drawn their own conclusions about the affluence of dentists as a group. It was not easy to rebut such implied accusations and generalisations without running the risk of being found guilty of one of the major sins of the professional – *“bringing the profession into dispute”*.

It was not until nearly twenty-five years later that the practical opportunity presented to undertake further academic study and obtain the first of the new postgraduate diplomas available in general dental practice (MGDSRCS (Eng) reported in Chapter 1.1), benchmarking and recognising higher levels of competence and an appropriate level of knowledge of the rapidly expanding range of materials, skills and techniques becoming available to the practising dentist. This development brought together small numbers of like-minded and professionally-motivated colleagues in study groups and in specialist societies set up to support the new type of dentist with such postgraduate diplomas. This led to the establishment of a new Faculty at the Royal College of Surgeons of England dedicated to the academic growth and support of dentists in general dental practice.

Heavy involvement with the Faculty throughout its formation and early life provided a collegial environment in which the tensions of early professional life could now be addressed and a search for a better form of professional practice pursued.

That search has become the foundation of this thesis.

Introduction

With recollections of life in the UK stretching back to the end of the second world war, it is striking to observe how society has changed; how different values have emerged and become embedded in social relations and discourse; and how, with universal education and the availability of knowledge via television and internet, even the least sophisticated of the population have an understanding of the nature of our universe, as revealed by science, far beyond that previously widely prevalent.

A significant part of our increased knowledge and understanding pertains to the nature and origin of our own species and increased understanding about our nature and function as persons and social beings. Arising from this, dramatic movements are discernible in the greater store we place upon the value of persons, the value of human life, and the need to promote human flourishing: the province of the new field of Positive Psychology. In the same time period, the world's human population has grown enormously so that there are ever more serious concerns about the impact of *Homo sapiens* on our planet's finite resources.

It seems essential that, as a species in our numerous communities, we learn to live and work together to husband our planet's resources and share them equitably and prudently in order that we may survive and bequeath a viable planetary home to our progeny and succeeding generations. Such a revolution in human behaviours demands new ways of valuing, relating to, and co-operating with, each other.

Whilst such declarations of hope and intent might seem hopelessly optimistic, we have no choice if we – humankind - are to survive. No one of us, however, can solve the world's problems. We can each only strive for the good within our own sphere of life and relationships. Whilst this thesis is written, therefore, with the global context and issues in mind, it represents but one person's efforts to address these major issues within a particular context – professional healthcare, with special reference to dentistry – and it seeks to exemplify a way of being in a professional and social context which may make a viable contribution in the drive to improve peoples' lives and to achieve greater social goods within our sphere of influence than existed before us. Notwithstanding the dental context, I believe

that the model developed herein is adaptable to any profession, and represents an ideal that could be applied with great benefit and mutual advantage to human relations in general.

Specifically therefore, the Person-Centred Approach, originally developed by Carl Rogers in psychotherapy, is presented as a powerful way for people to relate in helping and in professional relationships as well as in social relationships in general. Within the professional context, the approach is presented as the *way of being* that could justify the continued designation of the status of *profession*. It is argued that those of us who lay claim to the status of “*professional*” have an obligation to model such person-centred behaviours as an exemplary *way of being* with persons not only in professional relationships, but also in society in general.

The Thesis

**Developing an Holistic and Person-Centred Approach
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Executive Summary

Section I begins by outlining the history of the dental profession, the development of regulatory and academic structures, the evolution of payment systems and the impact of those systems since the launch of the National Health Service on the way dentists work. I briefly describe the disease processes seen in the mouth and the dentist's role in their management and then discuss what, as a profession, dentists might ideally achieve for the UK population and argue that we fall far short of what is possible given our understanding of disease processes, their causes and prevention. This leads to a discussion of factors undermining and supporting the performance of dentists in which personal factors are seen as important, and mentoring a valuable resource – hitherto more widely used in medicine and surgery – for supporting dentists, improving performance, and thus serving to enhance quality assurance for the profession.

I present the problems outlined as evidence (in part, at least) of a lack of the sense of being a professional practitioner. Financial / business considerations often seem to be paramount. Whilst there is an overriding moral dimension to this issue, a major contributing factor has been the persistence of an authoritarian and paternalistic culture endemic at the time dentistry became established as a part of the medical profession based in the surgical colleges. Although the culture is changing, it has been a slow process in the surgical colleges and many current practitioners will have absorbed the culture unwittingly as undergraduates. This raises questions of power in professional relationships.

Section II begins by considering the nature of all the persons involved in professional relationships and emphasise the importance of seeing each person holistically. This involves discussing the whole person – body, mind, heart and spirit – articulating ways of viewing these aspects and considering the nature of the interactions between persons drawing on several elements of contemporary positive psychology and acknowledging, above all, the contribution of Martin Buber with his description of the “I-Thou” relationship and Teilhard de Chardin with his recognition of the “Personalising Universe”.

This leads to a consideration of the person-centred approach (PCA) developed most comprehensively by Carl Rogers and his successors in counselling but presented – by Rogers himself especially – as applicable in a wide range of social relationships, including care relationships and education. Although the concepts of the whole person and the PCA are well documented, they are virtually unknown amongst dental professionals and, I

suspect, most other professionals outside counselling and education. I suggest that the PCA is an approach suitable for wide application and that it represents a “way of being” that is appropriate – even desirable – in professional relationships as a whole and could, furthermore, be regarded as an ideal “way of being” in society in general.

The concepts of the whole person and the person-centred approach then inform a description of PCA mentoring drawing primarily on Egan’s Skilled Helper Model (SHM). Qualities, attitudes and behaviours appropriate to mentors are discussed.

Section III begins by presenting a description of a typical dentist’s working day with its pressures and preoccupations which tend to cause the dentist to take a focussed instrumental view of the interactions with the patient. The concern in this section is first to draw attention to the need for dentists to broaden their focus to embrace their own needs to be – and relate – as a whole person in the working day: not to be solely a generator of turnover. This, in turn, may be expected to include the patient more holistically in the daily transactions in the surgery. The advocacy of this reorientation towards the person implies a change in priorities or values and leads to a discussion in which caring for the person is considered a prime value in a scheme of thought in which the concept of being a self has fundamentally moral connotations. This leads to a discussion of the nature of professional practice. I suggest that care for the person of the patient is the primary value for professional practice, and that other values - albeit in support of that person - are secondary. The recognition by a patient that their interests are paramount would seem to be necessary to ensure that trust is established with the professional. On the other hand, it must not be forgotten that the professional is also a person and has needs. This draws attention to the possibility of conflicts of interest arising between the person of the professional and the person of the patient. Such conflicts lead to a discussion of altruism and the paradoxical experience that altruism generates goods for the professional.

I then present a diagrammatic “Model for Professional Practice” which is elaborated descriptively from three experiential viewpoints: the dentist, the patient and society.

I conclude by suggesting that the way of being constituting the person-centred approach embedded in this model, whilst demanding and always likely to be - to some extent - aspirational, represents a worthy calling. To choose to enter a profession with the ambition of helping others at this depth, justifies the traditional reference to a sense of vocation. I offer some reflective questions to assist a process of reviewing our professional orientation and suggest that, if professions are to continue to receive the rewards and recognition we enjoy, we must be prepared to radically review what it means to be a professional. By embodying

the person-centred approach in our professional practices, we shall be exemplifying a way of being with others that represents a good way to live (in answer to Socrates' question about "how one should live") and - as seems reasonable to expect of worthy professionals - in so doing, offers a good model for others in society to follow. To the extent that we achieve this, we shall each be able to feel that, through our professional practice, we express in our lives 'the kind of person I wish to become' in our own personal quest to live the good life.

Notes on Style.

1. Gendered Pronouns:

No significance is to be attached to the assignation of gendered pronouns (to avoid the clumsiness of his/her etc) in the thesis. The assignation of gender (e.g. between mentee and mentor) is maintained throughout any given scenario for clarity.

2. UK / American English:

Whilst UK English is used throughout, where quotations are made from American sources, the original spelling is reproduced.

Chapter 1.1

Dentistry Facing Change:

Antecedents, Professional Background.

Introduction

The role of dentistry in Britain in the early 21st century is evolving rapidly. This dissertation examines several important aspects of the profession before explaining the role of person-centred mentoring as a possible tool for facilitating the development of dental professionals and, ultimately, as a model for professional practice. In order to clarify the issues discussed, this chapter gives an overview of the way the profession of dentistry emerged and evolved over the last 160 years alongside medicine and surgery. The position of dentists in society as a group of professionals running their own businesses serving a clientèle of private fee-paying patients is explained. In most cases, dentists also enter a contractual arrangement with the local health authority²¹ to treat some patients under a payment system agreed with – or, in 2006, imposed by – Government, through National Health Service Regulations.

There are undoubtedly significant moral tensions involved in a situation where a professional serving a patient is also a businessperson who must make a profit to survive. The impact of any payment system will inevitably affect the particular conflicting imperatives and motivations that the dentist faces. Adjustments or radical changes inevitably induce a review of working practices, challenging dentists' sense of professionalism with perceived conflict between the best interests of the patient and the interests of the dentist. Individual dentists are likely to respond in varying ways to these conflicts which, for some, can become so great as to seriously affect treatment decisions and performance at work (Steele 2009 p 25). This creates a distance between a dentist's sense of what is good professional practice and what is necessary for survival. It is easy to see how changes in payment systems may significantly affect oral health outcomes for patients.

Alongside the problems arising from any particular payment system, there has been a surge over the last 50 years in scientific understanding of disease processes and the possibilities for controlling them. Developments in materials science and manufacturing technology have

²¹ Currently the Primary Care Trust – PCT.

greatly expanded the possibilities for delivering care to patients with increasing choice and complexity. Although little is made of it in the public domain, increasing scope for providing interventions which, whilst attractive to patients in terms of perceived improved outcomes (such as in cosmetics), carry with them serious risk of iatrogenic²² disease and complications which, in the long term, may seriously compromise the survival of the dentition²³ over a lifetime.

The increasing understanding of health and of disease processes, and the increasing range of treatment options available, led to the need for a vastly increased commitment by dentists to Continuing Professional Development (CPD), whether practising as a generalist or choosing to develop special interests. This resulted in the emergence of a movement within the profession to provide an *academic home* for general dentists with a structured academic *career pathway* to provide lifelong support to dentists. At the same time, increasing requirements are being laid upon dentists to maintain defined levels of CPD with the planned introduction of *revalidation* to maintain the right to practice.

I first outline the historical, social, and political milieu within which dentists work: the situation into which I advocate the introduction of mentoring as a regular part of professional life with the aim of supporting dental professionals and enhancing their performance at work. Many of the situations described lend themselves to mentoring interventions or strategies – some helping the dentist and team, and many where the dentist helps the patient.

Historical Emergence of the Dental Profession:

Legal, Regulatory and Academic Basis.

Although there is evidence of quite adventurous attempts at restorative dentistry by Etruscans nearly three thousand years ago²⁴, and evidence of the activities of tooth drawers in the middle ages, the emergence of some quite sophisticated restorative denture work in France (whence we have the word *dentist*) from the late 17th Century onwards, and the activities of the Company of Barber Surgeons (at what is now The Royal College of Surgeons) from the middle ages to the 18th century, this account will focus on key developments in the 19th and 20th centuries.

²² Disease caused by medical/dental examination or treatment.

²³ Collective noun for a person's (or animal's) teeth.

²⁴ The following early historical account draws from a book published by the British Dental Association (Hilliam 1990).

In 1858, the Royal College of Surgeons of England (RCS) was first enabled to create a Licence in Dental Surgery (LDS) though at that time few took the exam as the only schools and hospitals recognised by the RCS were in London. An attempt was made to restrict practice to *Licentiates* only by the establishment by the General Medical Council in 1879 of a *Dentists Register* following the passing of the Dentists Act 1878 which also empowered the Royal Colleges of Surgeons in Glasgow, Edinburgh and Ireland to offer LDS diplomas. Rivalries between different groups and Colleges caused this move to compulsory registration to fail despite efforts by the newly founded British Dental Association to police the profession, partly because of the apparent reluctance of the British Medical Association to get involved.

Serious concerns about the state of Dentistry eventually led to the Dentists Act 1921. A Dental Board of the United Kingdom was created to keep the register. Funds from registration fees were applied to improving dental education, research and health education. The first University degree in dental surgery (BDS) had been established (Birmingham) in 1900 and the profession finally achieved self-government in 1956 with the setting up of the General Dental Council (Hillam 1990 p.45).

Some treatment was available to people of limited means through "Approved Societies" permitted by the 1922 National Insurance Act. A dentist was under no obligation to provide treatment but, if he did, was obliged to provide all the treatment necessary to render the patient dentally fit. (Ibid p 51). When the National Health Service came into being in 1948, dental care was included in its provisions. (Ibid p.53). The authorities were surprised by the massive take up of the dental services under the NHS and the government was forced to introduce patient charges in 1951 (HC 289-1, 2008 p.11) and fee cuts to control the expenditure. A ceiling was imposed on dentists' earning above which fees were reduced by 50% from Feb 1st 1949 (Speller 1951 p.104) which was translated into a fee cut of 20% from 1st June 1949 (S.I. 1948 No 1297) and a further 10% fee cut imposed from 1st May 1950 (S.I. 1950, No 633. Pp.105, 209-10). This unilateral action was resented by the profession (British Dental Association 1950 p.19).

Academic Dentistry and Postgraduate Careers

The Faculty of Dental Surgery was established at the Royal College of Surgeons in 1947 and, apart from examining for the licentiate – LDSRCS (Eng) – which entitled a dentist to practise after registration, then focused on a Fellowship – FDSRCS (Eng) – which was an entry qualification for those who chose to go into hospital practice

doing surgery, dealing with facial fractures etc. Later, specialist qualifications were developed, for example in orthodontics²⁵. Since there was no academic career pathway in general dentistry, it was usually expected that the bright student would specialise and do their FDS (and perhaps medicine as well). This led to a hierarchical pattern where those who were able enough specialised in hospital practice (by competitive entry) and those who were not able to, went into general practice. Thus, even those who felt that their vocation was in general practice were looked down upon as the poor cousins. The resulting historical hierarchical, authoritarian and paternalistic culture still exists within the Surgical Colleges although it is becoming diluted by a (generally) more egalitarian younger generation.

Developing a Career Perspective in General Dentistry

For many years there was no specific body of knowledge that would serve as the basis for ongoing professional and career development in general dentistry. Such a development would be necessary to open up opportunities for dentists to enhance their knowledge and skills from within the general practice setting.

Whilst it had become possible during the middle of the 20th century to obtain MScs and Doctorates in specialist areas both in UK universities and overseas, these degrees were normally used as steps up to work as *specialists* often based in hospitals and dental schools, leading to senior lectureships and professorships. Some dentists would use their enhanced skills, thus developed, in the private practice environment. Dyce gives an account of his practising life attending prominent aristocrats and politicians in the West End of London (Dyce 1982) during, and following, the Second World War, having honed his skills under the guidance of L D Pankey, an American who was perhaps the first dentist to articulate a philosophy of dentistry that married the generalist aspirations of the ordinary practitioner with the desire to offer patients enhanced skills in the practice environment (Pankey & Davis 1985). Dyce (1982) reports not being able to make NHS practice work for him and was only able to offer his enhanced skills and knowledge to a privileged clientèle (pp.125-7).

General Dental Practitioners (GDPs) graduating in the mid-20th century were experienced in a comprehensive range of treatment modalities that would nowadays be considered “specialist” areas and were able to enter general practice straight from dental school, paralleling the concept of the General Medical Practitioner. Many of them made the pilgrimage to the Pankey Institute in America as well. With developments in materials and

²⁵ Dental specialty concerned with moving the natural teeth into different positions to improve aesthetics or function.

techniques the demand rose for courses offering appropriate advanced skills training in the UK. As an increasing number of clinical courses became available, so courses began to appear promoting interpersonal skills, educational skills, “*training for trainers*”, and practice management skills.

The role of the Royal College of Surgeons of England in the establishment of the first licentiate in dental surgery (1858) has been described above (pp.3-4) as has the establishment of the Faculty of Dental Surgery (FDS) 1947 (p.4). I now report the establishment of a dental faculty with a focus on developing a career in general dentistry.

First Postgraduate Qualification.

There was no postgraduate qualification in general dental practice until 1979 when a new – and, as it came to be perceived, very challenging – Membership in General Dental Surgery – MGDS or MGDSRCS(Eng) – was launched by a small group of committed and enthusiastic GDPs in London. (Similar, smaller-scale, moves occurred later in Edinburgh, Glasgow and Belfast.) To this day, less than 300 practitioners have passed that exam (out of over 40,000 practitioners currently on the Dentists Register). Most, if not all, of these diplomates were supported by peers – academics and other MGDS holders – in a traditional mentoring role (see Chapter 2.4 p.89) The syllabus for MGDS resembled the basic LDS or BDS syllabus, though the levels of understanding, competence and skills required were vastly higher. Because few dentists felt able to take on this reputedly challenging diploma, it was eventually recognised that a less daunting intermediate postgraduate diploma was required (currently known as *MJDF*). This provided the focus for the next stage in the development of general dentistry as an academic discipline.

The Faculty of General Dental Practice (UK).

The MGDS produced a cohort of academically inclined, and intensely peer-reviewed, practitioners who played a large part in establishing an *academic home* for General Dental Practice – the Faculty of General Dental Practice (UK) at the Royal College of Surgeons of England (FGDP (UK)²⁶). This Faculty was launched in 1992 and was destined to develop an academic *career pathway* for GPs.

It was against the background of these developments that the need for mentoring emerged.

²⁶At launch the Faculty name was “Faculty of General Dental Practitioners (UK)”. With the increasing level of skill and knowledge required of other members of the dental team - now referred to as “Dental Care Professionals” (DCPs) – the name was later changed and, for the first time, it became possible to become a member of a Faculty at the Royal College of

The Professional Development Pathway.

Hitherto, there has been minimal advantage for dentists in undertaking further qualifications unless they wish to register as specialists. No definite career pathway has emerged. This is changing. There is a trend towards Regional Postgraduate Deaneries requiring postgraduate qualifications in their tutors, trainers and mentors and such qualifications are necessary within the Faculty's structure.

Changes in general dental practice are occurring following the Steele report (see below p.14-15,20-1) and with the increasing part played by Dental Bodies Corporate²⁷. These developments seem likely to increase the demand for dentists holding postgraduate qualifications to be eligible for new leadership roles (including mentoring) and thus create incentives for practitioners to follow a (renamed) *professional development pathway*.

Continuing Professional Development (CPD): Regulatory Requirements.

Against the career-oriented developmental background described above, there have been regulatory changes over the years beginning with the requirement in the mid 1990s for qualifying dentists to spend a year doing *Vocational Training* (acquiring some basic clinical skills and learning the legislative obligations of dental practitioners) in a supervised environment. It is expected that this will lead to a requirement for young practitioners to be assessed for *validation* 2 years post graduation. Elements built into the Faculty academic programme have been designed to satisfy the likely requirements of validation.

For dentists in practice, there is now a requirement for the completion of specified minimum amounts of CPD over a 5-year cycle including some specific compulsory elements.

Revalidation is currently proposed to be introduced in 2014.

In the Faculty, the new development-oriented environment is thought likely to increase interest in career development in general since many colleagues may decide to meet their CPD requirements by pursuing higher qualifications (for which purpose, a modular structure to qualifications may need to be developed). This is one of the natural points in practice where mentoring is perceived to be valuable. It also leads to a later phase of this discussion (pp.25-6) where Quality Assurance issues and the need for remedial mentoring of underperforming clinicians arise.

Surgeons without holding either a medical or a dental qualification. To avoid confusion, the Faculty's current title is used throughout.

²⁷ Commercial bodies (strictly regulated) that establish (or purchase) and run a group of dental practices.

Introduction of Mentoring.

The emergence of a range of academic – and related career – options created opportunities and choices not previously available. Faced with the challenges of primary care practice already described on the one hand, and an increasing range of choices in further professional development on the other, as well as greater demands for demonstrating ongoing competence, the potential for the use of mentoring increased dramatically. This was recognised formally by the FGDP (UK) when a group was appointed in 1996 to develop an academic pathway that would lead to Fellowship of the RCS (Eng) in General Dental Practice: FFGDP (UK). Participants in this process are automatically assigned a mentor.

Politics and Payment Systems

From 1948 to 2006.

The pattern in general dental practice prior to the establishment of the National Health Service in 1948 was one where the dentist provided his (it was almost universally male in those days) accommodation, equipment and materials and treated patients under private contract. The National Health Service Regulations provided for a contractual arrangement between a local *Executive Council* and the dentist whereby the dentist agreed to provide services for (an unspecified number of) patients under NHS regulations. These regulations included a fee scale drawn up to include all *items of treatment* current at the time. The treatment provided on a *course of treatment* was listed on a standard form which the dentist submitted for payment to the *Dental Practice Board (DPB)* who duly authorised the²⁸ *Executive Council* to make a payment (on a “schedule”) to the dentist each month for services provided. This *fee per item* system of payment provided an incentive to dentists to carry out large numbers of treatments – mainly fillings and dentures - to deal with the “epidemic” of dental caries (decay) that afflicted the population following the lifting of sugar rationing after the war as well as extractions to remove teeth affected by periodontal (gum) disease of which, at the time, there was little understanding and for which little conservative treatment was attempted. The high output of dentists presented with this payment system

²⁸ The dentist provided premises, equipment, and materials, and paid the dental technician for any laboratory work such as the construction of dentures or crowns. Unlike the General Medical Practitioner, the General Dental Practitioner remained a private practitioner who had agreed to provide dental services (at her discretion only) for some patients under NHS regulations through a contract signed with his Executive Council. There was neither restriction of the dentist's freedom to continue to accept patients paying privately nor any obligation to treat any particular patient under NHS regulations. However mixing of privately-funded and NHS-funded treatments on the same course of treatment was not permitted. Having accepted a patient for treatment (other than emergency treatment) under NHS regulations, the dentist was contractually obliged to provide all the treatment necessary to secure dental fitness.

cost more than expected and early fee cuts were applied (p6 above). A system was established in which an independent *Doctors and Dentists Review Body (DDRB)* advised the government of appropriate pay levels for the next financial year – based on the projected earnings of an average practitioner with an average commitment in their working week to provision of treatments under NHS regulations. For the government, this translated to a budget for the next year (knowing the number of dental contracts in place), in effect capping the cost of dental care. If the budget set aside in the previous year had been overshot – i.e. dentists had collectively earned more than budgeted - this was effectively clawed back by a downward adjustment to the following year's fees. Given the projected earnings for the average practitioner a group of dentists provided by the British Dental Association (BDA) – effectively the dentists' trade union - forming a *Dental Rates Study Group* had the task of sharing the budget between the different items on the fee scale. This was done by assessing the times a sample of dentists took to carry out each item of treatment on the fee scale. This was further complicated by the introduction of new materials for fillings and crowns so that a vastly increased range of items of treatment was added to the fee scale over time. The result was a newly-published fee-scale each year (Tattershall et al 1964 pp.331-2).

Since the fee scales were altered regularly and dentists as a group and as individuals undoubtedly felt the need to maintain their income, changes in the fee scale provided ever more incentives to work faster (see below the observation about allocation of time) and to skew prescribing patterns in favour of treatments that were more attractive financially. Many of the more lucrative treatments had a significant aesthetic component and were easy to "sell" to patients.

The development of increasingly sophisticated equipment and materials added to the complexity of the situation:

- the introduction of improved equipment – notably the Airotor²⁹ in the 1950s – and the widespread use of local anaesthesia for operative procedures, enabled dentists to increase their output dramatically;
- the introduction of new materials – especially tooth-coloured fillings – increased the options available for conservative work on diseased teeth (though some of the early materials proved to have a short lifespan in the mouth – requiring replacement every few years);

²⁹ High speed drill driven by air turbine.

- the development of new types of crowns, and later veneers, with improved aesthetics and longevity increased the demand for these types of treatment whose provision, although subject to *prior approval*, increased greatly in frequency;
- often little regard was paid to the destructive nature of the preparation of the teeth for these restorations, with potential for precipitating the need for root canal work³⁰.

Unless very well done - requiring training, skill and, above all in this environment, the allocation of sufficient time to the task - all restorations, especially the more advanced and complex, could have a short life with further invasive treatment required to manage the failure. The cycle of repair and failure itself contributed to the treatment needs of the attending population and to the eventual loss of teeth whose structural integrity had been compromised by repeated destructive interventions. This approach has recently been critiqued by Kelleher and Holt, challenging dentists to ask themselves whether they would do the treatment they are prescribing for their own daughter (Kelleher 2010; Holt 2010(b)).

Dentists who increased their output by increasing speed or prescribing more expensive treatments naturally generated more fee income. This caused the profession to go over budget resulting in *clawback*, or a withholding of part of full increase recommended by the Doctors and Dentists Review Body the following year which was suffered by all – including those dentists who had taken more time over their treatments and who had spent time giving the patients preventive advice (see below). In effect, the most conscientious dentists were penalised year on year; it was in the nature of the averaging system that faster workers pushed down the average treatment times – and the fees derived from them - as calculated by the Dental Rates Study Group (Tattershall 1964 p.332).

The Current NHS (nGDS) Contract.

Over the years, various changes to the NHS dental contracts have occurred. The latest was imposed by government, without any piloting and at very short notice, in 2006. The House of Commons Health Select Committee observed:

“It is extraordinary that the Department did not pilot or test the UDA payment system before it was introduced in 2006.” (HC 289-1 2008 p.4.).

This contract sought to simplify the payment system by assigning different combinations of treatments *UDA*³¹ *Value* to establish three *bands* of treatment (and patient charges). This,

³⁰ Root Canal Work / Treatment (also referred to as endodontic treatment) involves management of problems arising when the fleshy pulp (popularly known as “nerve”) of a tooth becomes diseased. The usual end point is a “root-filling”.

³¹ Units of Dental Activity.

incidentally, meant that the recording of treatments by the DPB (see below) was no longer possible. The monitoring of the dental profession's output centrally by the Dental Practice Board which, during the last two decades of the 20th century, with the advent of computerisation had generated a valuable resource of information about the survival of treatments provided under the service was abandoned and dentistry moved over to *local commissioning* by Primary Care Trusts (PCTs) who had no previous knowledge or experience of dentistry and no facilities for recording or monitoring service provision. The particular impact of this change has been to remove any incentive to a dentist to do more complex treatment (even less to do more than one), an issue which will be discussed in the context of the Steele report (Steele 2009) below. The Health Select Committee observed

“...the payment system lacked sufficient incentives for the provision of preventive care and advice. In addition, the Department argued that there were too many incentives to provide complex treatment...The Department’s original goal that patient access to dental services would improve from April 2006 has not been realised...the various measures of access all indicate that the situation is deteriorating. (HC 289-1 2008 p.3).

The Department's argument (above) about incentives for complex treatment was wide of the mark.

“The number of complex treatments involving laboratory work fell by 50% during the first year of the contract. The number of root canal treatments has fallen by 45% since 2004. At the same time the number of tooth extractions has increased.” (ibid p.4.)

The Committee observed that

“The Department asked for the contract to be assessed according to its own criteria for success: patient experience, clinical quality; PCT commissioning; and dentists’ working lives” (ibid p.49 para.179.)

and concluded

“...that the contract is in fact so far failing to improve dental services measured by any of the criteria” (ibid).

The Steele Report.

Subsequently the Department commissioned an independent review of dental services in England led by Professor Jimmy Steele³² to look at the situation and produce proposals for a way forward.

The *Steele Report* was published in the late spring 2009 (Steele 2009). It highlighted many of the problems experienced by dentists, patients and PCT's and made many pertinent observations. With respect to patients, Steele emphasises that “*a healthcare system has to balance rights with responsibilities*” (p.40).

The report recommends a *Proposed Patient Pathway* which gives priority to *disease prevention and management* and removes the stress on items of treatment. Steele proposes that

“People choosing to use NHS dental services will receive a lifetime-focused oral health service, base on evidence where possible, which will

- *Help them to prevent oral disease and the damage it causes;*
- *Provide effective and prompt urgent care when required;*
- *Minimise the impact of dental diseases when they occur by providing proper assessments, treatment to manage disease and the opportunity for regular maintenance and review for those who want it;*
- *Provide treatments to maintain and restore quality of life subject to a stable oral environment being achieved, and subject to pre-set criteria for appropriate NHS care, built around long-term health gain.”* (ibid p.44).

The report, which set out a carefully timed programme for initiating pilot trials of a variety of flexible contracts to meet local needs effectively, has been broadly welcomed and the piloting process is under way. The pilot schemes include both individual practices and - significantly – one of the larger Dental Bodies Corporate which has successfully submitted proposals for an imaginative pilot study embracing the Steele philosophy.

Were the spirit of the Steele report to be embraced and applied nationally, then not only could dentists benefit from mentoring to reassess their own way forward as the structure of the dental career evolves, they would also need mentoring skills to engage, and facilitate the planning processes, with their patients.

³² Professor of Oral Health Services Research, University of Newcastle-upon-Tyne.

Oral Diseases and the Dentist's Role

Since dentistry is a healthcare profession, it is helpful to highlight for the critical reader some of the issues to do with *managing disease* and *securing oral health* and the role of the general dental practitioner.

Oral Medicine.

A very long list of systemic diseases (e.g. anaemia, diabetes) may produce signs or symptoms in the mouth allowing the dentist to be the first to spot that there is something amiss. There may be specific diseases affecting the tissues of the mouth, from small benign polyps through white patches (potentially pre-cancerous), and over 60 different types of ulceration, including syphilis, tuberculosis and oral cancers. For most of these the dentist's role is screening. Specifically in 1993 (the *Year of the Crab*³³) the World Health Organisation decided that it should be the responsibility of the world's dentists to screen patients routinely for oral cancers though dentists may also be the first to see signs of leukaemias, lymphomas and many other cancers that may first appear on X-rays of the jaws or present as remote swellings in the neck. Whilst this monitoring role can be a matter of life and death for patients and requires a sharp-eyed vigilance on the part of the dentist, by far the majority of a dentist's time is spent treating patients suffering from the ravages of dental caries (tooth decay) and periodontal (gum) diseases. That is where this account will now focus.

Dental Caries

Dental caries (decay) produces the *cavities*³⁴ (Kidd 2005 p.8) that many of us have experienced and have had "treated" by the provision of *fillings*. The decay process is caused by the release of acid on the tooth surface by bacteria as a waste product when exposed to their natural substrate – sugar. The acid dissolves some of the calcium minerals on the tooth surface. Over time – usually many months – this process causes the surface to soften (*caries*) and breakdown, producing a hole or *cavity*. "Treatment" by *filling* involves cutting out the bulk of the caries, shaping the cavity appropriately for the material being used – often needing the cutting into more tooth to create a key unless an adhesive material is being used – and then *filling* or *restoring* the contours of the tooth. Different models may be

³³ The familiar "cancer" is the Latin word for *crab* used to indicate a malignant growth because of its resemblance (if growing within soft tissue), when cut through, to the body and limbs of the crab. Hence the WHO *Year of the Crab* (1993).

³⁴ The medical term referring to the holes produced in teeth by dental "caries" (also popularly referred to as "decay"). Areas of diseased tissue in medicine generally may also be referred to as "lesions".

envisioned reflecting different ways of managing disease. I briefly discuss three models – the *surgical model*, the *medical model* and the *person-centred model*.

What is implicit in the above paragraph is a **surgical model**. A patient presents with some decayed teeth (cavities, lesions). The surgeon excises the diseased tissue from the cavities and restores them with fillings. The surgeon claims his fee. The patient has been “treated”, believes she has been good in going to the dentist and is satisfied. The Dental Reference Officer (DRO) asked to do a spot check on the dentist's work (part of the NHS monitoring arrangements) sees that there is a filling in the cavity that the dentist claims to have filled and reports back that “*treatment has been satisfactorily completed*”³⁵.

What is ignored in the above scenario is the disease process itself (mediated through bacteria thriving in an environment where the teeth are exposed to frequent sugar intakes). This is a disease of lifestyle and has not been affected in the least by the provision of the fillings. Only a change of life-style - dietary habits etc. - will achieve that. It is true that the fee scale included *giving advice* in the descriptor for the provision of the filling. However, It does not take an educationist to realise that an instruction to “*cut down on your sugar*” as the patient vacates the chair is - quite apart from not being specific enough – unlikely to lead to a significant change in lifestyle. This model portrays the passive *patient* receiving *treatment* given by the *expert* professional. When a cavity enlarges beyond a certain point, this surgical intervention usually becomes necessary to repair the tooth. A preventive **medical model** could instead be applied by the dentist treating the teeth with medicaments (fluoride varnishes, gels, etc.) or sealing vulnerable parts of the teeth. This can be done as part of a preventive strategy. It may also be followed with an early lesion which is only yet affecting the outer surface of the tooth. However, this will not work either without life-style changes. This model again portrays the patient as the passive recipient of treatment and is still putting the onus on the clinician to “treat” the patient.

Both the surgical and the medical models leave the patient with a low locus of internal control transferring to the “expert” the high external locus of control: the patient tending to put responsibility for their oral health in the hands of the dentist.

A preventive and therapeutic “**person-centred**” **model** (underlying the mentoring approach described in chapters 2.5 and 2.6) would take more time explaining the disease processes to the patient, equipping the patient with the information they need to take control of the disease process for themselves – fostering a high internal locus of control. The decay

³⁵ The DRO can only confirm that a filling has been placed. They cannot say whether it was actually necessary in the first place and they are not required to comment on quality as long as the cavity is “filled”. “Over-treatment” is the temptation of a fee per item system. By contrast, a capitation-based system – rejected by the profession in 1968 (Tattershall et al 1964) but currently represented in private practice by DENPLAN - does not entice to carry out unnecessary treatment. The temptation is to under-

process described above has been well understood for over 50 years. Whilst some calcium salts are lost from the tooth surface when exposed to acid following consumption of sugar, at an early stage *remineralisation* can occur between sugar exposures – enhanced by the presence of fluoride ions. Since *demineralisation* occurs resulting from acid production by bacteria for a period of time (20 minutes or more producing a characteristic graph of tooth surface acidity against time known as Stephan's curve after the researcher who first described it in 1944) following consumption of any sugar (Kidd 2005 pp.7-8) and *remineralisation* occurs naturally – a process enhanced by fluoride use - it is possible to conceive of a see-saw effect. If the balance on the seesaw can be altered by reducing sugar intake frequency it is possible to *arrest* the disease process or even reverse it at this early stage (*ibid*). The impact of the adjustment of sugar frequency is far more powerful than the use of fluoride. This represents a lifestyle change (control of sugar intake) on the part of the patient and needs regular reinforcement (Fejerskov O, Kidd E 2003 pp.306-8). It depends on the patient discovering their own motivation.

If the patient does not make the necessary changes, no amount of interventive treatment will stop the disease process, and any treatment that is carried out will fail because of *secondary* (recurring) *caries* or uncontrolled periodontal disease. The fee scale never provided payment for time dedicated to this crucial task. Those dentists (and there were many) who did take the time to support their patients in this way were, in effect, penalised because they were not using that time in fee-earning activity. They were probably also penalised (financially) because their patients did not keep returning in need of further fillings.

Periodontal (Gum) Diseases

Periodontal diseases – significantly affecting the 25% of the population who are susceptible - are, if anything, more time consuming, in the sense that the susceptible patient needs to play an even larger part in homecare than with caries. A high locus of internal (patient) control is essential for success. Managing periodontal diseases also seems to have been a mystery to many in the profession who have not found it as glamorous as restorative treatments. The problem here is that periodontal diseases can easily escape diagnosis until they are far advanced and they can have a devastating effect on the whole mouth (not just the individual tooth.) It would seem that there is a legacy within the thinking of the profession from the days when periodontal diseases were little understood and difficult to treat. There appears to be a reluctance to undertake treatment although the principles of treatment are straightforward

treat – “supervised neglect” – which a DRO – or another dentist consulted for a “second opinion” - could identify, as there would be untreated cavities present.)

and not intellectually challenging. (The underlying molecular science and biochemistry is complex and crucial to inform and understand research, but not for day to day treatment.) However, it has to be admitted that effective periodontal treatment is time-consuming which provides a strong deterrent in a system of payment that rewards a high throughput of patients. With periodontal diseases the critical lifestyle factor is oral hygiene – removing the disease-causing bacteria from the tooth surfaces near, and beneath, the gum – especially between the teeth. Approximately 8% of the population are highly susceptible and develop very aggressive and destructive forms of periodontal disease, which are challenging to manage. With improved knowledge of the processes involved it has become possible over the last 40 years to successfully manage even these forms of the disease with conscientious patients (Lindhe & Nyman, 1975. Axelsson & Lindhe, 1981).

Restorative Dentistry and Other Special Interests.

Reference has already been made to the filling or *restoring* of carious cavities. Such teeth have been weakened by the caries and fractures often occur later. Severely damaged teeth may be extracted or may be suitable for the provision of more complex restorations such as crowns, gold inlays or overlays, and (where some teeth are missing) bridges³⁶. This often requires preliminary root canal treatment which is often, especially with large back teeth, challenging and highly skilled work. Such *advanced restorative dentistry* attracts many dentists who wish to pursue postgraduate studies. Common areas of interest include restorative dentistry, endodontics, paedodontics, orthodontics, oral surgery, periodontics, prosthetics (false teeth), special needs dentistry and implants³⁷. These choices – and the pursuit of them – provide multiple opportunities for mentoring support.

Oral Health for the Nation

What are We Trying to Achieve?

Here I address the concept of *oral health*. Much of medicine and surgery involves rendering the patient free from disease, for example by treating an infection such as pyelitis³⁸, or by excising diseased tissue such as a tumour. In dentistry, freedom from disease could be

³⁶ A simple bridge consists of one or two crowns permanently fitted onto natural teeth carrying an artificial tooth to fill a neighbouring gap.

³⁷ An implant is fitted into the bone where a tooth is missing rather like an artificial tooth root, often made of titanium, a metal which “integrates” with the bone. A crown or bridge may then be constructed on it.

³⁸ A potentially serious kidney infection.

secured in almost all cases by the simple expedient of screening for disease (including cancer) giving preventive advice, carrying out simple periodontal treatment as required and removing troublesome teeth. The patient's *health* (defined as "freedom from disease") would be secured and their survival not impaired. For the purposes of this discussion, this will be referred to as **basic oral health**

The World Health Organisation's definition of *Health* is cast in broader terms, however.

"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." (WHO 1946).

If this broader definition is taken then psychological and social considerations come into play which, in the dental context, would lead to the justification of much of what is referred to as *restorative dentistry* and *cosmetic dentistry*. This ranges through a hierarchy of treatments as presented in Fig.1.1.1.

The cost of these treatments increases dramatically moving down the list. If the provision of these treatments is to be funded out of the public purse to provide a **standard of care** that will really provide (in favourable circumstances) "**optimum oral health**" for all, the cost is likely to be prohibitive, given government reluctance to invest more funding in dentistry.

Lower complexity /cost
1. insertion of simple fillings;
2. more complex, more aesthetic, fillings;
3. simple endodontic treatment;
4. more complex endodontic treatment (more posterior, multi-rooted treatment, older patients, and re-treatments);
5. stabilisation of advanced periodontal diseases with appropriate maintenance;
6. the provision of indirect restorations of increasing complexity, (veneers, crowns, bridges);
7. multiple or "full mouth" restorations;
8. implants.
Higher complexity /cost
Fig 1.1.1: Hierarchy of Restorative Interventions (Complexity/Cost)
<i>The costs of the treatments listed typically range from a simple filling costing £15-20 to a single implant costing £2,500 with its associated crown included.</i>

The attempt during the second half of the 20th century, through the General Dental Services, to provide dental care for all (albeit with some financial contribution from patients) was, in my view, only partially successful. It certainly provided an effective financial incentive to the dental profession to repair the damage caused by a high rate of caries in the population by “drilling and filling” and carrying out more complex restorative procedures. The manipulations of the system of payment, however, whilst increasing the output of operative treatment, failed to provide the necessary incentive to educate patients and prevent disease, especially periodontal disease which, by nature of the minimal symptoms it produces until its advanced stages, may be thought of as “the hidden disease” in the mouth. Steele (2009) recognises these difficulties.

“So long as we see value for taxpayers’ money as measured by the production of fillings, extractions, dentures or crowns, rather than improvements in oral health. It will be difficult to escape the cycle of intervention and repair that is the legacy of a different age.” (p.5)

“...there was no financial incentive to keep patients disease free. Dentists were still rewarded according to how much they drilled and filled, not how well they did it or how appropriately they made their treatment decisions.” (p.2) *“...extractions increasing and endodontic care decreasing.”* (p.34)

These difficulties point to the “*moral tensions*” which many dentists describe, succinctly expressed by a dentist quoted by Steele:

“There is a professional conflict between being a dental professional, being a businessman, and acting ethically.” (p. 25)

These tensions are the starting point for a paper by Holt published in *Primary Dental Care*. Discussing ways of resolving these tensions in different areas of practice – “*In search of the moral high ground*” (Holt,2010(a)).

Steele observes

“... for the last 60 years of NHS dentistry the financial incentive has been to do a lot of treatment often, rather than to do it to last.” (p.69).

The point here is that the provision of high quality restorations – i.e. restorations that will endure as well as being functional and (where appropriate) aesthetic, requires both skills (far beyond those acquired in undergraduate training) and – above all – time, to execute them to a high standard. Furthermore, that statement does not take account of the time needed to counsel and support patients in anticipation of operative treatment which many regard with

apprehension, nor does it take account of the considerable time required to discuss all options, alternatives, risks and benefits to a level satisfactory not only to the patient (in that they are fully empowered to participate in the decisions affecting them) but satisfactory medico-legally in an increasingly litigious civilisation.

I suggest, therefore, that it is unrealistic to expect that public funding can extend to the provision of “**optimum oral health**” for all. It is more realistic to think that public funding could provide “**basic oral health**”. Indeed, it might be realistic to think that public funding could extend to the funding of simple fillings, simple periodontal treatment and simple endodontic treatments which might be labelled “**basic oral health plus**”. Beyond that, it is reasonable to accept that public funding should be directed to areas where there are more severe levels of morbidity and more serious threats to life expectancy. For patients, further dental treatment is available as part of discretionary spending. Interestingly, Steele suggests a pyramid of need (Steele 2009 p.42) and acknowledges that not all treatments can be available as of right to all as in the statement

“It is time to bring some clarity and consistency to what NHS dentistry can and should offer to patients.” (p. 42). Referring to “...advanced, complex and expensive treatment...”

Professor Steele states that

“These services should not be seen as an automatic right for everyone, but the investments should be targeted to where risks are managed and where need and benefits are greatest.” (p.44).

Political Honesty and Professional Voice.

Historically, the view expressed above (“*that it is unrealistic to expect that public funding can extend to the provision of “optimum oral health” for all*”) has never been acknowledged by those representing patients in society (in practice the governments of the day) so that the quotation from Steele above is remarkably radical and refreshing. Relying on criteria (statistics showing numbers of courses of treatment carried out or items of service provided), governments have consistently proclaimed to the electorate the illusion that such a service was being provided. Yet dentists (*the professionals*) know – as part of their unique professional understanding – these statistics say absolutely nothing about quality of care, health gain, or patient benefit or interest. Far from serving the interests of the patient in society, they have served to demonstrate (to those who will believe such statistics) that the politicians and managers are successfully doing their jobs. Furthermore, the manipulations

effected through various funding strategies over the years have tended to skew the manner in which patient care was delivered (by rewarding dentists for “doing [items of] treatment”), creating for dentists a moral tension between what they perceived they needed to do to stay in business, and what they would really have wished, as caring clinicians, to offer.

Governments alone cannot be held to blame for this situation. In the view of this author, since rejecting the Tattershall proposals embodying a capitation-based scheme (Tattershall 1964) in 1968 the profession has signally failed to formulate a truly professional perspective on these issues. I argue that the profession needs to think deeply about its unique role as a profession and rediscover its *Voice* (Covey 2006 p.5; Peterson & Seligman 2004 p.255) so that it may articulate a professional vision based on well founded moral principles centring on its unique professional understanding of what is clinically possible and what can practically be done to yield the best outcomes within honestly stated budgetary constraints. It could be argued that that is exactly what Professor Steele has sought to do.

This leads to a discussion of the role of the profession in society – developed in chapters 3.6 and 3.7.

Significant Issues for UK Clinical Dentistry 2012.

In the years since the introduction of the National Health Service Dental Services in 1948, knowledge and understanding of dental disease and their management has increased beyond recognition with the development of some excellent new materials and treatment approaches that now mean that, with a compliant patient who will take responsibility for their own home care, it is possible, almost without exception – barring major health complications - to successfully guide the patient through life to the point where they go to their grave at an advanced age with a functional, comfortable and reasonably aesthetic dentition (Department of Health 1994 p.1). The key components of this ongoing process are:

1. Assessment and Diagnosis:

In relation to patient assessment, diagnosis and treatment planning, it has to be observed that the application of these skills is time consuming. There are guidelines for *best practice* which would involve appropriate investigation of symptoms and reaching a definitive diagnosis before discussing all the options with the patient and, with their understanding and agreement, planning and executing treatment. (FGDP (UK),2007; FGDP(UK),2009). Contrast the above with Appendix 1, scenarios I - III.

2. Strategic Planning (for Life):

The key element here is the prevention of active disease (periodontal and caries), preceded, if disease is present, by changes in lifestyle and therapeutic interventions to bring active disease under control. With disease controlled, planning of necessary restorative or prosthodontic work becomes realistic from a lifetime perspective. Mentoring a patient through this process is time consuming (though may be delegated to an appropriate DCP³⁹.

3. Quality and Longevity of Therapeutic and Restorative Work:

The quality of therapeutic and restorative work is partly a function of dentist skill and (with more complex work) advanced training. It is even more importantly, a function of the time spent in executing the work. The preparation, for example, of a tooth for a crown that will be retained in the long term requires great skill and time and is unfavourably influenced by production-line pressures.

A painful or infected tooth may often need to have “root canal treatment” in order to save it. For teeth nearer the back of the mouth whose internal anatomy is more complex, this can be very challenging, requiring great skill and – again – the expenditure of considerable time. It is almost always an option, though - as always with challenging procedures - good practice requires that, if the dentist feels unable to do the work, then the patient should be advised that it is possible and offered referral to a colleague who does this sort of treatment (FGDP (UK), 2009 pp 42-45).

4. Patient Involvement:

Patient involvement is central to the process from two perspectives:

- a. It is important that the patient is fully informed about their health/disease status and the full implications. All options are made available to them (with pros and cons for each) and they are fully involved in any decisions regarding their health and treatment. Apart from a natural respect for the person of the patient (see chapters 2.4 and 2.5) this is also a medico-legal requirement.
- b. The patient exercises the greatest influence through their daily lifestyle practices, on the maintenance of a disease-free mouth.

Here is an opportunity to improve clinicians' effectiveness through the application of mentoring skills.

³⁹ Dental Care Professional (including Hygienist, Dental Therapist (who may in addition do simple fillings), Oral Health Educator and Nurse all working on prescription from the dentist).

5. The *position* (Harré & Moghaddam 2003, pp.1-8) the dentist adopts in relation to the patient has a powerful impact on the patient's own self-efficacy (*ibid*,pp.15-27). Positioning as "*the expert*" vis à vis the passive patient is unhelpful - even "*malignant*," (*ibid* pp85-98) - and represents a way of being with the patient opposed to the stance I advocate in this thesis. This will be further discussed in later chapters.

These issues highlight the need for Quality Assurance in the provision of dental care. This is an area where mentoring is advocated as having particular relevance.

A Case for Mentoring.

Quality Control or Quality Assurance?

A recent conference of the National Clinical Assessment Service – NCAS - (a part of the National Patient Safety Agency – NPSA) used the term "*Professional Governance*" in its title to convey something of the concept of *quality assurance of medical and dental practitioners*. However, this organisation has been set up largely in response to widely publicised disasters such as the Bristol heart babies case (where there was an attempt to cover up an unusually high post-operative death rate in babies receiving cardiac surgery) (Irvine 2003 pp.121-3), Alder Hey (where children's body parts were removed post mortem without parental consent) (*ibid* p190) and the well-known Harold Shipman case (*ibid* pp.161-72). In other words its primary focus - described in its Framework Document *Back on Track* (National Clinical Assessment Service 2006a) is on practitioners who are already *underperforming*. This is analogous to the traditional industry's *quality control* department picking out the faulty components passing through on the conveyor belt.

I advocate a more widespread adoption of the *quality assurance* approach – analogous to reducing the number of faulty components on the conveyor belt in the first place (Quality Assurance website). This requires that the Professional Governance approach be used, not as a *remedial* response to problems already identified, but as a *supportive, developmental culture*. I suggest that a culture proactively supportive of practitioners at all stages of their careers using routine mentoring could do more than any amount of audit of techniques, protocols or choosing of "the latest" materials, to enhance the quality of care delivered. Furthermore, because the dentist has a leadership role in the practising environment, the quality of performance of the dentist in the team can have a profound effect on the morale and culture of the team of which he or she is a part. This in turn will influence the quality of patient care indirectly as well as the direct effect through his/her own clinical performance.

Providing a supportive culture for practitioners requires the commitment of educational bodies such as the FGDP (UK) to the provision of training of a cohort of colleagues endowed with the necessary skills and insight. These colleagues, in turn, can pass on their skills to others so that their acquisition becomes the norm. Thus, over the next generation, those skills will become as basic a requirement for the mature practitioner as a sound understanding of occlusion or periodontology.

Quality Assurance, Audit and Clinical Governance.

The use of the term *Quality Assurance (QA)* has become commonplace in industry and commerce, in healthcare generally, and in general dental practice in particular. A widely used QA tool in dental practice is audit which is nowadays seen as an essential part of Clinical Governance (CG). CG itself takes a broader view of the quality of care and service delivered by the practice overall.

The use of clinical audit is now regarded as so fundamental that it forms an essential part of the Foundation Dentist's (FD's) training in their first year in practice. It is part of, the Personal Development Portfolio for the Faculty Diploma in Restorative Dentistry (FGDP (UK), 2006). The portfolio of evidence submitted by the candidate for the Fellowship in General Dental Practice must include two full audit reports as well as evidence of the regular use of Patient Satisfaction Questionnaires (FGDP (UK), 2004).

Commonly favoured audit topics include quality of radiographs, clinical record keeping and cross infection control procedures, all of which are undoubtedly worthy and essential components in the delivery of good quality clinical care. However, Chambers (2001) reports that the majority of dentists, when asked, believe that the most important factor in the delivery of good clinical care is the dentist him - or herself. Despite this, "*the dentists themselves*", their frame of mind, the way they work, the way they perform every day, the quality of their personal clinical outcomes, their sense of *job engagement* and the quality of their interpersonal transactions, receive little assessment or audit in the practice environment. It will be noted that these areas would, in a regular commercial/industrial situation, be the concern either of managers or of Human Resources (HR) departments, appraising and supporting staff and, often, using coaching and mentoring.

NCAS has developed tools for assessing underperforming practitioners and I was recruited to the specialist group that developed a variation on the "SPRAT"⁴⁰ 360° feedback system for use with dentists (Healthcare Assessment and Training (HcaT) 2008) (See p.154 below).

⁴⁰ Sheffield Peer Review Assessment Tool.

How Can We Recognise Good “Performance” in a Dentist?

This question is not about clinical expertise or special diagnostic or technical skills. It is about the performance of a dentist who has the necessary skills and is using them to perform on a daily basis in the workplace – his or her general dental practice. Gorter, in a wide-ranging thesis on burnout (Gorter, R. 2000) suggests that there is a continuum with *engagement* at one extreme and *burnout* at the other, respectively characterised by *energy* (versus *exhaustion*), *involvement* (versus *cynicism*), and *efficacy* (versus *inefficacy*) (p.38). Brake reports work on the concept of *job engagement*. This concept is considered useful to identify the positive *engaged* state (originally defined as the *opposite of burnout* as above) characterising the motivated dentist working and coping well in the workplace, enjoying patient care, finding the work stimulating, satisfying, rewarding and fulfilling (Brake 2005 pp.90 - 92).

Whilst we might expect intuitively that dentists who feel motivated, respected and fulfilled will provide better care, very little work has been published describing the impact on clinical care of the way dentists actually practise. However, a paper studying the relationship between levels of burnout in dentists and their sensitivity to the needs of anxious patients, concluded that

“psychosocial aspects of dental practice have meaningful and often adverse associations with dentist perceptions about anxious patients.” (Moore,R. Brodsgaard,I.2001).

The implication of this conclusion is that, conversely, when the *psychosocial aspects* are favourable, the associations may be positive.

Some Factors Undermining the Quality of Dentists’ Performance.

Multiple Stressors.

When asked, a large proportion of dentists identify “*patient care*”, “*helping people*”, and “*improving oral health*” as principle attractions of the profession report Russell and Leggate in a paper which considers “*job satisfaction, career and retirement plans of dentists in general and community practice*” (Russell,E. & Leggate,M.2002). There are, however, many factors that dentists find to be impediments to the delivery of Quality Care. In the light of the literature Gorter (2000) developed a list of 112 items on a “*Dentists’ Experienced Work Stress Scale*” (pp.53-54) used in his later work. A nationwide study enumerated a wide range of stressors in general dental practice (Cooper et al.1987). A further study by Wilson et al.(1998) following similar methodology (using a “*Work Stress Inventory*”) showed that

“working constraints set by the NHS” came second only to time constraints in the form of “running behind schedule” as the perceived major source of stress. Gilmour et al. (2005), assessing career satisfaction among a group of general dental practitioners in Staffordshire found the factor that was associated with the greatest dissatisfaction was stress. The stressful nature of dentistry is also referred to in continental European papers. For example Gorter et al. in a paper looking at the relationship between “*Work Place Characteristics and Work Stress and Burnout Amongst Dutch Dentists*”, reviewing the literature conclude, “apparently dentistry is a profession with many possible stressors (Gorter et al. 1998).

I have reviewed elsewhere (Holt & Ladwa 2008) literature on stress and burnout in dentistry. Amongst stressors found to be important were “[un]certainty in the future of the organisation of dental care provision” (Humphris and Cooper 1998); time pressures (Russell and Leggate 2002), (Gorter et al 1998); especially when those pressures conflict with needs of patients (Moore & Brodsgaard, 2001); lack of Career Perspective – which is strongly related to burnout (Gorter et al 1998); and isolation – the need for support: a problem not confined to small practices as dentists often do not communicate during the working day. Other stressors reported included detrimental management pressures - reflected in “hard” management styles (Bejerot et al. 1999) and “heavy workload and poor management” where it is “*their skill rather than their time that was not being adequately used*” (Russell and Leggate 2002), a factor likely to become more significant with the increase of dental corporates with *hard* management strategies, and lack of trained support in general dental practice, all three of these latter concerns becoming increasingly common as growing numbers of practices are coming under the control of dental corporate bodies. Whilst it is the norm in the hospital environment for a practitioner to have frequent contact with colleagues, in the general dental practice environment not only is there little, but also very few dentists appear to avail themselves of opportunities to develop skills appropriate for supporting colleagues.

The reported results of these stressors included disillusion and discontent (Russell and Leggate 2002); job dissatisfaction where a disturbing proportion of dentists were unhappy with their choice of career; and one paper suggests that this unhappiness may be under-reported (Rada & Johnson-Leong 2004). More serious were reported health issues related to stress (Myers & Myers 2004) and burnout - a condition found in workers (healthcare and social workers) who engage personally with their clients/patients - which is characterised by emotional exhaustion, depersonalisation, and [a negative sense of] personal accomplishment assessed using the Maslach Burnout Inventory, described by Humphris (1998) in a review of burnout in dentists.

Supportive and Helpful Strategies:

Special Interests, Self-initiative, Career Development, Good Human Resources Support.

Practitioners who develop **special interests** (Rada & Johnson-Leong 2004), and take on teaching or leadership roles, tend to have lower stress scores and to be happier.

Interestingly, Brake et al (2001,) reporting a study where supportive interventions were made (individual and group meetings on relevant topics), found that interventions produced an improvement in burnout scores that was lost at follow-up, whereas a group of non-participating controls who took action **on their own initiative** achieved long-lasting improvements. At first this appears as if the successful group improved without support, but it is seen as significant that they took their more proactive stance (**“self-initiative”**) after declining support. They were not acting in isolation. Gorter et al (1998) recommended the promotion of *“more activities concerning satisfactory career development”*, and NCAS, listing *“Principles for Handling Performance Concerns”* (considering Doctors and Dentists) state Principle 8. *“Good human resources practice will help prevent performance problems.”* (National Clinical Assessment Service, 2006b, p.11). For General Dental Practice, this begs the questions:

1. “Who is providing the *‘good human resources practice’* when the dentist may have to act as the human resources lead whilst himself needing HR support?” and
2. “How can we promote a system for providing that much-needed support for the dentist?”

Mentoring and Coaching.

In the secondary care career pathway, in sharp contrast to the traditional primary care pattern, there is a very significant use of mentoring-type support as the early career dentist progresses up the ladder. Schrubbe (2004), discussing the use of mentoring support for students, commends it as a tool supporting professional growth and development as well as academic success. She reports its value in increasing the retention of promising graduates in the academic career pathway. Friedman et al (2004), in the American Dental Education Association President’s Commission on Mentoring, reported the success of mentoring in *“developing, nurturing, and retaining...faculty members”*. Friedman (2006) again, states that mentors *“provide leadership within the profession”* and outlines many benefits for both mentor and mentee of the relationship, pointing out its link to career development, stress management, professional goal setting, etc. Goldstein (2000) points out how, *“in the*

corporate world, coaching is now seen as an important and necessary activity...an essential part of our repertoire".

A study of a range of texts on coaching and mentoring will quickly show that there is much common ground between the two skills – to the extent that definitions overlap and even contradict each other. All agree that these are learning relationships, in which both parties develop, change and grow. In one text McDermot & Jago (2006) refer to a “*coaching approach*” (pp.2-3). A useful definition from another text (Connor & Pokora 2007) shows the relevance to the dental situation of coaching and mentoring.

“Coaching and mentoring are learning relationships which help people to take charge of their own development, to release their potential and to achieve results which they value.” (p. 6).

This emphasis on helping the client to “*release their potential*” resonates with the report by Brake et al.(2001), referred to above, that controls acting on their own initiative produced long-term successful change.

Warnock, in an editorial in the *Canadian Journal of Surgery* (Warnock 2006) commenting on an article by Macdonald (2006) published in the same issue, speaks of a “*Culture of Mentoring*” and points out that “*because learning is a lifelong process, mentorship should play some role through all stages of surgical seniority.*” Macdonald (2006) states, “*It is time to recognise and formalise the mentoring process*”. Warnock also points out that in another study (Miedzinsksil, et al.2001) lifestyle issues including personal organisation and time management were often the career development issues to address – especially for the solo practitioner. This study also highlighted “*challenges inherent in setting personal and professional goals... adapting to change and preparing for leadership*”.

Mentoring in Supportive Relationships, Peer Review, Study Groups, etc.

A Study Group can provide peer support as well as a participatory learning environment. Where access to such a group is available, this can help overcome the GDP's sense of isolation. However, it is important that the atmosphere in the group is supportive and not judgmental – something that depends on the leadership as well as on the membership of the group and requires of the leader (at least) some level of coaching / mentoring skills. A study of the impact of a Peer Review programme reported by Holt and Earp (1996) demonstrates how effective such a tool can be.

Other possible supportive relationships include counselling (perhaps often incorrectly named), buddy relationships, and co-mentoring (where two colleagues mentor each other).

Of all of them, based on experience in medicine, and early experience in dentistry, the mentoring / coaching arrangement seems to lend itself most readily to development at organisational (i.e. specifically, Faculty) level.

Medical Experience.

Mentoring has had a place in the hospital / academic environment for many years. In more recent years in some areas, GMP's have been offered mentor support. Freeman (1997) reports on such a project in which mentees benefited greatly in terms of career development and in being able to openly discuss, without judgement, many complex issues that arise in practice, improving their sense of well being. I report further work in the medical profession below.

SCOPME Report on Mentoring and After.

The Standing Committee on Postgraduate Medical and Dental Education (SCOPME) report on Mentoring (1998) describes other mentoring projects and outlines areas of concern and issues to consider in setting up mentoring programmes. It encourages further development of mentoring.

Hutton Taylor (1999), writing in the BMJ, asserts:

“What is needed is not just a handful of allocated or even fully trained mentors but an overall paradigm shift to a culture of coaching, with role models, positive constructive feedback, and good staff management principles.”

Two substantial working papers produced for the Doctors' Forum (established at the first “*Improving the Working Lives for Doctors*” Conference, 2002 to improve communication with the DoH) discuss at length the experience (Doctors Forum 2003a), and benefits (Doctors Forum 2003b), in relation to mentoring, drawing on extensive interviews with 30 career-grade doctor mentees. Doctors' experience of mentoring is reported as beneficial in a range of areas which are summarised in Figs. 1.1.2 and 1.1.3.

A joint publication by the Doctors' Forum and the DoH, produced as “*Best Practice Guidance*”, declares:

“There is now influential support for mentoring for doctors and many schemes have been started.”

(DoH 2004 p3)

Benefits of mentoring are both General and Specific :

- *can benefit patient care;*
- *can benefit relationships with colleagues and teamwork;*
- *managing change and solving problems;*
- *can improve job performance, competence and confidence;*
- *improving personal well-being;*
- *developing leadership;*
- *improving and sustaining job satisfaction;*
- *helping personal development and education;*
- *providing a greater sense of collegiality;*
- *using mentoring skills in appraisal.*

(Adapted from Doctors' Forum 2003a pp 21-36)

Fig. 1.1.2

In dentistry, Spicer (2004) reviews recent literature on mentoring from other fields (including health care), and reports experience in General Medicine, concluding that mentoring (or co-mentoring in twos or threes) in preparation of Personal Development Plans is beneficial. He describes three pilot mentoring schemes for GPs. Amongst other benefits, he highlights the flexibility of the mentoring approach, catering for varying circumstances. He expresses the view that if the experience with GPs were reproduced – which seems a reasonable expectation - then mentoring would be expected to help *“improve the standards of both those GPs that are performing well and those that are underperforming.*

An extensive study (Garret-Harris & Garvey 2005) looking at three “Case Studies” (Northern Deanery, National Blood Service and Oxford Radcliffe Hospitals) using mentoring, gives as the first of its “Key Messages”

“Mentoring is Key to the future of the NHS”.

“Mentoring has gained both recognition and validity in supporting the modernisation agenda and is already relatively widespread within the NHS (17% of the workforce).

General benefits of mentoring “*identified by interviewees*”

- *a positive response to the experience of mentoring both as mentor and mentee;*
- *the value of the time for reflection set aside from the hurly burly of professional life;*
- *the value of having someone to go to who would make you feel you were being well listened to;*
- *the value of being able to address problems and dilemmas in a risk free environment;*
- *the value of dealing with real problems during mentoring development programmes;*
- *the value of the action orientation of mentoring – finding ways of addressing real problems;*
- *the value of seeing another’s point of view and the ability to challenge one-sided views;*
- *use in appraisal;*
- *increased job satisfaction;*
- *improved problem solving;*
- *clarifying a sense of identity and purpose.*

Specific benefits “*identified by interviewees*” listed include increased confidence to:

- *take control;*
- *take action on matters that had previously been pending;*
- *manage complex job responsibilities;*
- *deal with difficult relationships;*
- *be themselves;*
- *remain in the profession;*
- *leave the profession;*
- *extend their professional roles and activities.*

(Adapted from Doctors’ Forum 2003b pp 22-24)

Fig 1.1.3

The benefits of mentoring both to the individuals and to their organisations are being demonstrated (illustrated through case studies). (op cit p.8)

Viney and Paice (2010) reporting on the London Deanery's "First Five Hundred" mentees conclude

"The first five hundred mentees have confirmed our conviction that this service is needed and appreciated by a significant number of doctors and dentists." (p.38)

Mentoring in General Dental Practice.

Currently, early career practitioners receive some mentoring type support from Vocational Trainers. Those who take MJDF (page 8 above) then experience support from Faculty Diploma Tutors.

After that, it is not until the practitioner applies for Fellowship Assessment that they will be assigned a Fellowship mentor. By this time the practitioner will probably have been qualified for 15 years or more. It can be argued that this is much too late to offer the support of a mentor because, in those 15 years, the practitioner may have drifted off the professional development pathway and lost focus and motivation altogether.

The Board of Faculty accepted (in 2008) my argument that mentoring should be available to dentists throughout their careers, opening the way to my development of a Mentoring Certificate programme. This programme is based on the Person-Centred Approach which is discussed in chapters 2.3-2.5.

Poor Performance.

This chapter began by discussing historical payment systems for dentistry in the UK, showing how the effect of the system with built-in incentives inevitably led to dentists' increasing their output of fee-generating treatments, and discouraging the holistic patient – health oriented approach. Having rejected an alternative (capitation-based) system (Tattershall 1964) in 1968, many dentists allowed this arrangement to degrade them into little more than technical operatives, executing treatments as quickly as (rather than as well as) possible, devoting inadequate attention to enlisting patients' own resources in securing and maintaining their own oral health. Manipulation and operation of the system by politicians and bureaucrats had a dehumanising effect on dentists and patients alike. The profession acquiesced in a technical/rational culture of *doing treatments* when what was

really required was a person-centred, *health-oriented* approach. Furthermore, the profession collectively, weakly connived with the successive governments of the day by allowing them to perpetuate the myth that it is possible to provide comprehensive dental care (whatever that may be) for all at the expense of the state (albeit with contributions from patients) when endless repetition of poorly executed treatments is neither affordable nor even the appropriate way to manage dental diseases. The performance of the profession, it could be argued, has been poor indeed for it failed to achieve for its “clientèle” – the UK population – what its role as a profession requires, and what, with the knowledge, techniques, and materials available, is well within its capacity.

Mentoring: A Quality Assurance Tool for Dentists

To reverse this process, it will be necessary for the profession to act decisively both individually and collectively:

- Individually by finding ways of ensuring that the dentistry we do is appropriate to the needs of individuals and the well understood principles which govern the effective management of dental diseases and
- Individually again by accepting our responsibility to contribute to the collective professional project:
- Collectively in finding our professional *Voice* and exploring ways of making sure we are *heard*.

Considering the widely varying circumstances and professional isolation of general dental practice, the most adaptable tool for supporting the quality of performance of dentists is likely to be mentoring. Within a *mentoring culture* mentoring / coaching skills may be shared and fostered, encouraging colleagues, as a matter of course, to enter regular mentoring relationships throughout their career to provide support in all areas from handling personal and stressful issues, to career development and personal and professional growth. In this way dentists of the future may be supported in taking charge of their own development, realising their full potential, and delivering to their patients the best care that they envisaged when they embarked on their careers, thereby generating the sense that within the profession of dentistry they have found a vehicle for expressing their full humanity, and have rediscovered the meaning of professionalism.

Chapter 1.2

Professional Practice and Power

Introduction

The starting point for this chapter is a profound conviction that the concept of professionalism must remain central to the dental practitioners' view of themselves, their relationship with patients, and their role as privileged members of society as a whole. This arises from the "*close relationship with the [patient] which is the foundation of true professionalism*" (Marshall 1939). Dentist-patient power relationships have often been asymmetrical to the detriment of patients, and separate the concept of being a professional from inappropriate ambitions to power and status. This raises ethical issues which lead in later chapters to a consideration of professional values and the requirement laid upon those to whom society has conceded the privileged status of "*professional*" to exemplify exceptional standards in behaviour, attitude and conduct as leaders in society (Chapters 3.7-9). This is presented as a *way of being* in relationship with people: both colleagues and patients as individuals, and society in general.

Vast changes in the world of humankind have taken place since dentistry emerged as a profession. Significantly, substantial changes have taken place in the distribution of power within society so that the social milieu in which the contemporary dentist functions is very different from that of previous generations. The concept of professionalism itself reflects a particular power attribution that might have existed 160 years ago but has undergone a radical shift in the last 50 years. Similarly, whilst an ethical orientation is implied in the concept of professionalism, in the current era the very foundation of ethics in agreed moral norms is in doubt (Macintyre 2007 p.22.) and attempts to resolve this difficulty are found unsatisfactory (Beauchamp and Childress 2001 p.2).

This analysis will consider power as it operates in professional relationships, highlighting historical changes that call for a radical revision of the traditional professional culture. The inappropriate distribution of power is seen as a key ingredient of the problems described in chapter 1.1. The intention ultimately is to encourage dentists to engage with the substance of what follows in a spirit of enquiry and dialogue, as seekers of a larger truth in the journey of professional life, by striving to find meaningful articulation for a fuller and more complete humanity, which we seek to express - and to share - with the people who are our patients

and our colleagues. In doing so, we may hope to model in our own lives the qualities, behaviours and attitudes that distinguish the humanitarian orientation of the *true professional* and the ideals of the *good society*. The term “*true professional*” is deliberately not defined here. Each professional reader is likely, on reflection, to discover within themselves, arising from their own thought and experience, a conception of how they would define such a person, whether as a true-to-life model, or as an aspirational vision. In this chapter, I prepare the ground for a formulation in later chapters of the qualities, attitudes and beliefs that may be considered representative of this “*true professional*”. To some extent, these qualities, attitudes and beliefs are aspirational. We must all of us be disappointed by our inability to live up to our own self-image at times. That is why the metaphor “*journey of professional life*” is used above, for all human beings can recover from their mistakes and their stumbles and can learn to travel more sure-footedly into the future. Inevitably, any presentation on professionalism risks provoking a negative response from the practitioner for there are tensions and paradoxes to be faced arising from the conflict of interest between our sense of altruistic commitment to our patient and to society on the one hand, and our awareness of our own needs on the other.

The Undercurrents of World Upheaval

In times of change there needs to be a radical reconsideration of what it means to be a dental professional in the 21st century, on the grounds that the social relationships that defined the way of thinking 160 years ago, when dentistry became a science-based profession⁴¹ have evolved. Whilst many – especially younger – practitioners are comfortable with this new social order, others, either through age, temperament, or cultural background, seem less so. The categories and thought-forms prevalent at the time of the foundation of the profession have inevitably tended to become fossilised in the profession’s ethos and practising philosophy and have been passed down through generations. They are long overdue for review.

A document produced after extensive consultation by the Royal Society of Medicine on medical professionalism (RCP 2005a) with its technical supplement, (RCP 2005b) presents a radical reappraisal of professionalism for doctors. This document, referred to extensively in an article in the British Dental Journal (Trathen and Gallagher 2009), and discussed in detail in Chapter 3.7, betrays a remarkable change in emphasis and, substituting the words “*dentist*” and “*dentistry*” for “*doctor*” and “*medicine*” could well be applied to the dental profession with little modification.

⁴¹ Taken as the first LDS diploma, the Royal College of Surgeons of England in 1858 (p.6 above).

The impact of the far-reaching changes mentioned above means that many dentists now in the second half of their practising lives are caught between sets of assumptions and values that were current - even dominant - in our formative years and may now find ourselves (without necessarily understanding how or why) feeling strangely out of tune with assumptions and values which seem to be creeping into our daily interpersonal transactions.

The result is to create an impression that we are losing control, torn between conflicting pressures and arguments, and deprived of an understanding of the premises on which these conflicting arguments are based. Nowhere are these changes and tensions more obvious than in the two professional areas of interest to dentists: namely healthcare and education.

Not only do these changes impact heavily on the way practitioners in healthcare and education do their work, they also have a fundamental impact on the way practitioners view themselves and the persons they deal with in their professional capacities. In other words, there has been a fundamental shift taking place in the meaning of professional practice and the way it may be conceptualised, described and experienced. This is nothing short of a complete change in worldview; *a paradigm shift* (Kuhn 1970) which has impact on the sciences of the person and relationships (Bozarth 1998 pp.89-90). In this discussion I seek to reconstruct a way of conceptualising our role as professionals viewed through the lens of this new paradigm.

Dialectical Tension between Power and Ethics

The challenge of being a professional can be presented as the striking of a balance between the power and authority accorded to the professional *qua* professional on the one hand, and the ethics of being a caring professional on the other. The resolution of this dialectical tension will be explored via a tentative articulation of values and beliefs appropriate to professional practice⁴² in chapter 3.7. Since many problems in dentistry are interpreted as arising from issues of power, this is the starting point for the discussion.

Although the work of Foucault (e.g. Foucault 2002, 2003) is often cited in discussion of power relationships (e.g. Jones and Porter 1994, Macdonald 1995), his “*declared aim is...to get rid of the subject and subjectivity*” (Foucault 2003; review inside cover). Authors consulted in the development of this thesis, who cite Foucault, include Giddens (1991), Habermas (1987), Lukes (2005), Taylor (1989), and Wilber (2000), though many others (e.g. Beck (1992), Etzioni (1996), Harré (1983, 1993), McIntyre (2007), Polanyi (1962, 1969,

⁴² See chapters 3.7-3.9.

1975, 2009, Rawls (1999), Schön (1991) and Sen (2009)) do not. Indeed, in the field of person-centred psychology, Foucault seems to be completely ignored. His discussion of the construction of the patient portrays a stage in the emergence of practices – specifically medical practices - in an era when the observer / professional was perceived as distanced from the subject/patient. The patient was depersonalised and objectified by the employment of *the gaze*. Whilst this reflects a stage in the development of knowledge about the body (or mouth) overlaid with a behaviourist veneer, it portrays, in the hands of Nettleton (1992), an approach to the dental subject which is the very antithesis of the person-centred approach. Paradoxically, Nettleton, in her Foucauldian study of dentistry (op cit.) maps out changes during the middle years of the 20th century in which, in citing the work of highly regarded dental authors such as Blinkhorn (Professor Anthony Blinkhorn, OBE a regular contributor to academic dental journals between the 1970s and the 1990s), she is able to show how the leading thinkers of the profession were really learning from psychology and the behavioural sciences and coming to regard the dental patient not just as a *set of teeth* but as a *whole person*, a perspective that seems remarkably un-Foucauldian (op. cit. p. 103). In citing Foucault's reference to "*man's being as object of positive knowledge*" (ibid p 130) she seems to be affirming Foucault's objectivist, instrumental approach.

Foucauld's concept of the 'gaze' may be useful in analysing the attention-focusing of the medical or dental attendant as they stand back and survey the symptoms and signs presenting, especially when the diagnosis or optimal treatment is not immediately obvious. It may have been useful at an historical time when medical attendants were learning to apply newly acquired knowledge '*scientifically*' to the analysis and interpretation of a patient's presenting signs and symptoms. For the contemporary student or mature clinician, the gaze is, I believe, but a stage in the learning process (albeit sometimes useful to employ self-consciously in reviewing a puzzling case) which needs to become absorbed into their engagement at all levels as a whole person (*the clinician*) with the whole person before them as *the patient*. In contrast to the language I use in chapter 3.6 (p.124 et seq.) considering *Holistic Practice*, Foucault appears to focus on the *external* aspects of processes and activities and to regard the human as an object (whether patient or attendant) manipulating or being manipulated instrumentally. He disregards the individual personal contribution made by the human agent – the internal processes that contribute to the full picture of the *whole person*. The dental project in the present century has moved on so that the focus of the profession might, with benefit to both dentists and patients, be conceived less in terms of power and control, and more in terms of personal qualities and relationships, which become the focus in later sections of this thesis. Even at organisational level, it is notable that the person-centred orientation is emerging, at least as an aspiration, in documents from UK

government sources, notably a diagram representing “*The health & care system from April 2013*” (Fig 1.2.1. available on line) which shows “*People & Communities*” at the centre of the whole organisational structure supporting “*health & care*”. Foucault portrays *power* as being embodied in organisations and many dentists are experiencing the way dental corporate bodies as systems can wield power and bring pressure to bear on practitioners and support staff. However, the pressures are ultimately applied by persons and their underlings who are also persons acting as agents and not by “*the organisation*” or “*the system*”. Foucauld’s attribution of power to organisations *qua* organisations seems to be misplaced. Observation suggests that power is wielded by persons at each level in the organisation over those below them in the hierarchy of command. Thus, although the diagram conveys a person-centred orientation – which conveys good intentions – person-centred behaviours (or the converse) are not properties of the organisation *per se* but behaviours of those working within the organisation. Since Foucault ignores this perspective on human agency and personality (Jones & Porter 1998 pp.167-77) – thus devaluing the *person* - I do not find it helpful to draw on his work further for the purpose of this analysis.

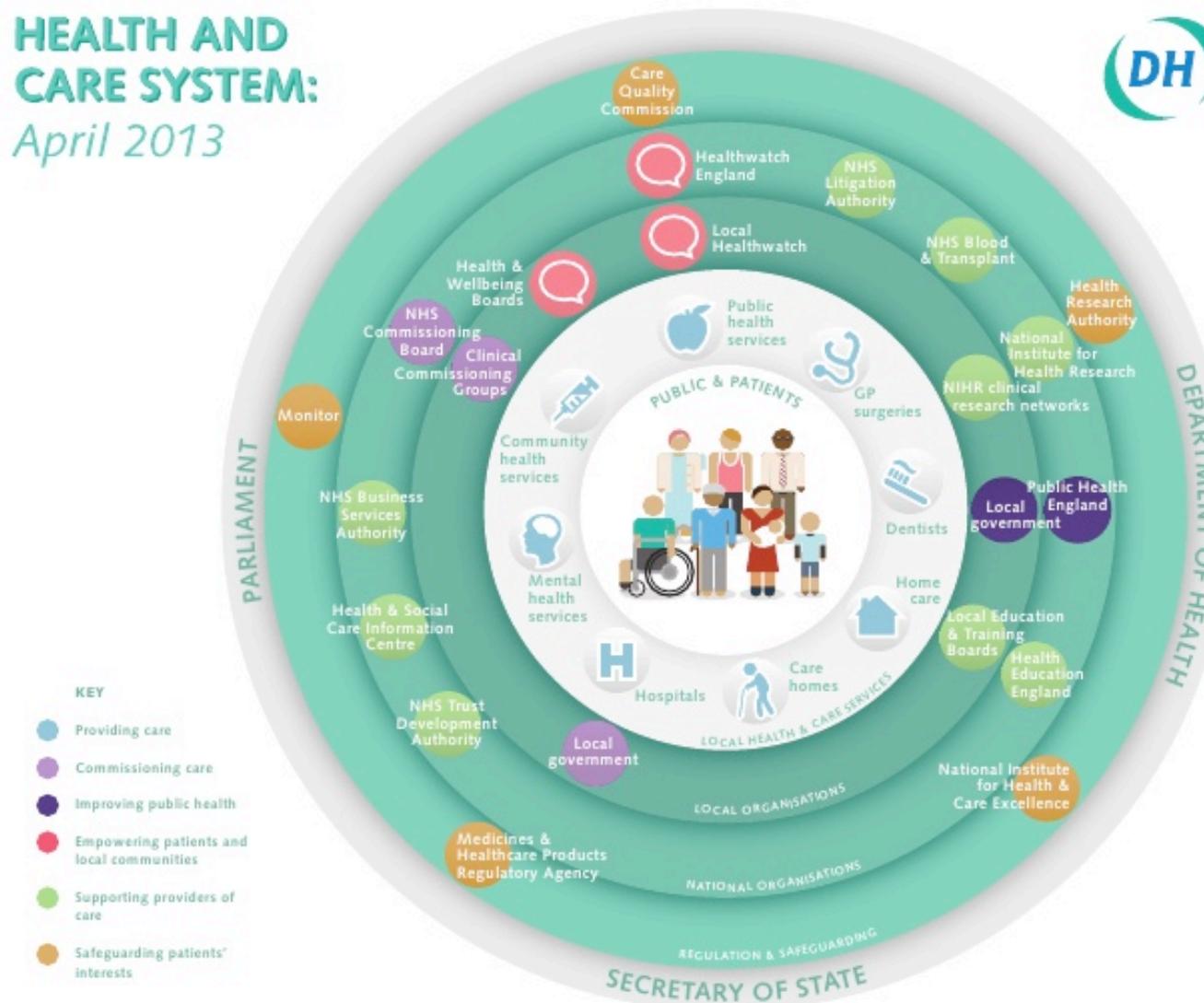
Yet issues of power have a significant impact on the way we conceive professionalism or – as I prefer - professional practice. Professional privileges both reflect, and endow, a position of **power** accorded at a time when the then current (19th century) worldview or paradigm in science - basically positivist, paternalistic and authoritarian spilling over into social constructs and hierarchy - was very different from the dominant paradigm of the postmodern era in which we have recently lived and worked: an era which is much more sceptical of claims to authority and any certainty of knowledge: an era that is much less hierarchical, and with a population much better equipped to make good use of the vastly increased access to information via the world wide web. These issues in turn raise questions about *ethics* in relation to professional practice discussed later.

Issues of Power

Power could be defined as “*the capacity for doing work*” Oxford English Reference Dictionary 1996/95 p.1134). The French word “*pouvoir*” used as a noun means *power* and when used as a verb means *to be able to* (Oxford Hatchette French Dictionary 2007 p.662). From these two starting points, the word *power* emerges in human affairs with concepts such as the “*power to decide*”, “*the power to influence*” or to be “*a powerful influence*” (in affairs or opinion), “*legislative power*”, “*controlling power*”, “*being in a powerful position to...*”, “*being in power*” (as in government), “*winning – or losing – power*” (in an election),

Fig 1.2.1

HEALTH AND CARE SYSTEM: April 2013



“controlling power”, “abusing power”, “the power of industry”, “the power of the professions”, “the power of the unions”, “brain power”, “the power of the intellect”, “the power of the church”, “the power of the universities”, “a powerful woman (or man)”, an individual or group in society being “powerless”, “powerful bankers”, “money equals power”, “power and control”, “having the power to close down a business”, “the power of advertising”, “inappropriate use of power”, “the power to decide”, “the power of self-determination” (the last two implying an element of freedom from external constraints), etc.

It is not difficult, drawing on the implications of the above phrases, to contemplate the development of the “power struggle” (which is often for a “controlling influence”): neither is it difficult, given the intellectual power concentrated in the universities and in the professions, to imagine that those wielding political power, whether elected or employed servants of government – i.e. politicians, the civil service, bureaucrats and administrators - might perceive the power of the universities and the professions as being a threat, given their *potential* (another word for power) to mount a well-structured and coherent case against policies and actions they perceive to be harmful or inappropriate (Polanyi 2009/1966 p.84). To the extent that the professions value their privileged position of power – empowering them to carry out their particular professional role - they should never forget this potential threat to their existence and autonomy

This part of the discussion assumes that by virtue of being accorded the privileged status of *profession*, the dental profession is in a position of power. This power revolves around the privileges accorded to the profession *qua* profession, including (amongst others) the exclusive right to practise within the defined boundaries appropriate to the profession, the right to determine appropriate learning and skills to earn admission to the profession (Freidson 1994 p.174), and the right to exert disciplinary processes when appropriate. The power here lies in the *exclusive* right to practise dentistry. Such power is, of course, not unique to dentistry. It is, by definition, accorded, *mutatis mutandis*⁷¹, to any recognised profession. However, considerations of power crop up in a whole range of relationships within dentistry and it is apparent that power could be used by the professional in beneficial ways (for the patient and society, often by sharing power) as well as in the pursuit of the professional’s own self-serving ends which, where it happens, may legitimately be defined as *oppression*⁷².

⁷¹ Latin: Changing that which needs to be changed,

⁷² “Keep in subservience by coercion”. Oxford English Reference Dictionary 1996.

Three Dimensions of Power

Lukes' discussion of the dimensions of power (Lukes 2005/1974) casts light on the ways power operates within the dental profession, both within the profession itself and in the relationships between dentists and patients. All three of Lukes' dimensions of power are manifest in dental professional relationships.

Thus, at the organisational level the *one dimensional view* – which simply studies actual behaviours and uses of power - may illuminate a situation where individuals within a professional body conspire to force through a decision against the view of others, an act that might be viewed as political strategy or manipulation. Such acts may ultimately have indirect effects on patients and personal observation suggests that those who adopt such strategies tend to represent a traditional, authoritarian and paternalistic mindset within the profession. The one dimensional view does not reveal what is going on beneath the surface (for example) to ensure that certain issues are – or are not – presented for discussion in the decision-making process.

The *two dimensional view* takes account of actions taken or information given in seeking to influence the decision-making process, and may be seen in situations where someone in authority (who could be a dentist, a practice manager or a paying authority) applies pressure to a dentist to achieve output/earning targets with a penalty for failure. Such pressures may cause the dentist to attempt to *find work to do, which* may well not be in the patient's interests. The dentist himself, may be seen in this two-dimensional view to be giving information – say a leaflet on the advantages of dental implants – with the objective of influencing the patient's decision-making processes in favour of the choice of implants.

The *three dimensional view* is both more subtle and, I suggest, until the present time, more prevalent in the clinical dental situation. This view does not only observe the decision taken or imposed. It looks at actions taken to promote a particular decision – such as giving a patient an implant promotional leaflet – and it also considers what was *not* done to empower the patient's decision: for example, in this case, the patient is not given leaflets or advice on alternative solutions, such as saving the teeth by delivering alternative treatment strategies and they are not given an account of the disadvantages of taking the implant option. In this third dimension, power is seen to have been exercised by keeping the disadvantages and alternative treatments *off the agenda*. The same strategy (which does not necessarily have to be a calculated Machiavellian manoeuvre) may be manifest in a meeting by what is *not* on the agenda. It is not uncommon to find that agendas at meetings are tight so that underlying issues – which determine participants' attitudes – do not receive an airing. For those whose power interests favour the status quo, there is no incentive to create time for discussions of

such matters. Some of the examples given below reflect this type of power relationship and are of grave concern for professional practice where they impinge on patients' ability to participate in a fully informed way in decisions affecting their own care.

At the time of writing (2012), the Care Quality Commission (CQC) is visiting all dental practices and a key part of their enquiries concerns information given to patients covering all options with their advantages and disadvantages.

The two situations more fully described below illustrate the way a dentist who is used to the idea of being the powerful participant in the relationship may, in taking that for granted, fails to genuinely satisfy the needs and preferences of the patient.

A. Extracting saveable teeth needing treatment.

The following factual scenario illustrates the point (With further comment Appendix 1

Scenario II

An affluent woman in her fifties was referred by her (nGDS) dentist to a private practitioner accepting referrals for all aspects of restorative dentistry and with a special interest in managing periodontal disease. The moderately advanced periodontal disease prompting the referral, with a well-motivated patient, was very manageable. In the lower jaw on the right side there were only two molars (Large chewing teeth) behind the canine, both with large-caries free cavities (extensive lost fillings). One was found on X-ray to have evidence indicating an infection meaning that the pulp of the tooth had died. Treating this endodontic problem seemed to be very feasible (to save the tooth) and both teeth would have been very readily restorable eventually with crowns. Since the referral had been for periodontal treatment only, the radiographic information was relayed back to the referring practitioner in the expectation that endodontic and restorative treatment options would be given. The patient returned to commence periodontal treatment some weeks later minus both the lower molars (i.e. edentulous⁷³ behind her lower right canine and therefore without any chewing function at all on this side of her mouth with an otherwise complete dentition), reporting that she had been told these teeth "needed to come out".

If, as seems reasonable, the patient's account – the basis of this scenario – is accepted, then she had not been made aware of the options for treating (and, almost certainly successfully, saving) these two teeth. Her regular attendance throughout life for dental care as well as her decision to undertake private treatment to manage her

⁷³ Without teeth.

periodontal problem point to her preference to keep her teeth if possible. It appears that she – a very mild-mannered woman - accepted without question the advice of the dentist (the professional with “power” in the relationship): advice which may legitimately be interpreted as against her wishes (were she suitably informed) and best interests. On the one-dimensional view of power, the patient, by virtue of being told, incorrectly, that the teeth would “*have to come out*” (i.e. they were “*not saveable*”) had been coerced or manipulated into accepting extractions which, with complete information, she would have declined. The pay-off for the person-in power - the dentist – was that they would not then need to carry out the lengthy work involved in providing root canal treatment and making two crowns – work that would, admittedly, be poorly rewarded under their NHS contract. There was also now a situation offering the prospect of selling the patient dental implants.

B. Cultivating an implant-oriented patient philosophy.

It is not uncommon in practice to meet patients who have been encouraged to think that the solution to their problems can be found in having dental implants placed. Rather than conserving and restoring saveable teeth, the patient has accepted in principle the likelihood that sooner or later they will need an implant or implants. They are, in effect, being *trained* to choose treatment options that the dentist would prefer to carry out. In a significant number of cases, such patients have been warned that they will lose teeth as a result of (inadequately or un-treated) periodontal disease and advised to have the teeth removed “*whilst there is still bone there*” to make way for implants. The careful planning and placement of implants by a well-trained operator is, undoubtedly, generally very successful and they have their place. The pay-off for the dentist is the relatively lucrative nature of implant treatment. What the patient usually does not understand is the possibility of restoring (in most cases, and usually at much lower cost) the natural teeth and they are often quite unaware that their periodontal disease is not only treatable, but makes them a relatively poor risk for implant placement. When the patient has not been given this information with a full account of risks and benefits from the various options, then in Lukes’ terms, they have been denied the information needed to make a decision, something accounted for in the three-dimensional view.

Changes in Power Relationships in Dentistry.

Several different areas warrant attention: -

1. In preparing people for practice as dentists (education and culture).

As far as *education* is concerned, the issues arising are issues relevant to the professional as an educationist – a second professional role adopted by many dental professionals who develop an interest in supporting life-long learning. The educationist who merely seeks to feed information didactically into their students (the “deficiency model”) is using a style (instructivist or behaviourist) which is now recognised as having limitations in promoting learning (Fry Ketterridge and Marshall (2009), p.64) *“Listening to a lecture is not the most effective way of learning”* (Fairclough 2008 p.85). The professional in this field, therefore, may well seek to apply principles of experiential learning (Greenhalgh 2006, pp.37-39, Fry, Ketterridge and Marshall 2009, pp.15-18) appropriate in an adult learning environment, facilitating a process of discovery of which the learner has control so that, in effect, the power in the relationship is with the learner and not with the teacher.

“Learning is facilitated when the student participates responsibly in the learning process...Independence, creativity and self-reliance are all facilitated when self-criticism and self evaluation are basic and evaluation by others is of secondary importance.” (Rogers & Coulson 1969 pp.162-3)

“There is no such thing as teaching; there is only learning.” (Epigram from Monty Roberts in Miller WR, Rollnick S. 2002, p.179).

Considering *culture*, the change in the relationship between the learner and the teacher or facilitator, insofar as it is adopted, begins to set a different cultural tone from the traditional authoritarian approach in medicine and dentistry. In a Vygotskian sense, not only are learners encouraged to learn how to think (Wink & Putney 2002 p.7), for the socio-cultural change that this embodies in the process of supporting the development of professionals (dentists and DCPs), and the relationships established in the learning environment comprise a cultural shift which is itself part of the learning process (ibid pp.60-3). The expectation is that it will serve as a model which is likely to have a significant effect on the style of relationships between these developing professional adult learners as future colleagues, and between them and their future patients, reflecting an emerging *culture* which once embraced is likely to be absorbed into the next generation of professionals as *habitus* Bourdieu (1977, 2010), Reay (2004), Leaton Gray and Whitty (2010). Increasingly, as the use of mentoring becomes more widespread, mentors working with colleagues over a professional lifetime will model this approach to education and learning.

2. In the style or model of behaviour used by the professional...

... in their daily practising life. Traditionally this model has tended to be authoritarian and directive reflecting values of authority, dominance and control, and maintaining a culture of status and hierarchy ("the dentist knows what to do": the prevailing *habitus* within the profession) which values may be seen as having a dominant influence on the way professional advancement and career progression have been perceived. Whilst there are many practitioners who reflect a more egalitarian approach - and the recruitment of a much higher proportion of women to the profession may create a gradual trend away from this authoritarian mode, especially within the general practice environment⁷⁴ - the concept of the *expert* professional still persists as an aspiration and this may be most apparent amongst those whose approaching qualification for *expert* status may cause them to feel that they want to retain this status. In other words, for some, the *status* (which in this context implies *power*) itself is sought-after and highly valued.

3. In the way the professional relates to the person...

...who is in the role of *patient*. The concept of the *expert* who is *treating* the *patient* – the latter being relatively passive and powerless in the relationship – undoubtedly still persists in dentistry so that the power is seen to belong to the dentist rather than the patient. (See 1. above.) I argue that this disadvantages patients in many ways. An approach focused on helping the patient to achieve and maintain health, rather than focused on the delivery of high-tech dentistry has been presented in chapter 1.1. The patient requesting – and receiving – more radical cosmetic work is not necessarily in control. Seduced by clever marketing, seen through Lukes' third dimension, they often have no awareness of the true risk of long-term consequences (Kelleher 2010; Kelleher et al. 2012(a), 2012(b) and 2012(c) and Holt 2010b). It also puts the dentist in the position of steering a treatment path without the full involvement of the patient who might otherwise be empowered to modulate treatment decisions in their own interest rather than follow a route responding to financial pressures on the dentist. E.g. it is more financially viable to do two crowns rather than one, making the provision of several crowns together for *cosmetic reasons* particularly attractive to the dentist. See Scenarios 1-4 in Appendix I, and paragraph 6 below. On the other hand, for the professional whose focus is on achieving goods for the patient, and finds his own goods in the satisfaction of providing the service, the *ethical character of work*

⁷⁴ In 2008 UK dental schools admitted 691 women and 508 men undergraduate students (BDJ 2008) – a change from the 1960's when women were a very small minority. In a programme awarding a prize annually in a postgraduate training scheme in East Anglia, the prize has almost without exception been awarded to a woman because of a more caring, person-centred approach rather than the more technically treatment-focused orientation of most of the men.

(Hinchliffe 200 p.538) may be discovered to carry its own reward and provide a *eudaimonic*⁷⁵ outcome for the professional that may transcend other goods.

4. In the way entrants to the profession plan, structure and experience their careers

It is understandable that to someone who has launched onto a career pathway with expectations of wielding a controlling influence in professional affairs – whether in primary or secondary care – as they progress through their career, may feel that the rules on which they based their career decisions and expectations have been re-written. To someone with deep roots in traditional sciences with their rational positivist background and the epistemological certainty and authority of the one with knowledge now seriously undermined since Heisenberg (Hilgevoord, Uffink, 2008), there is no longer this passport to unquestioned authority. On the contrary, ontological humility might be seen as more appropriate. For now, all knowledge is provisional; all truths are contingent; and all authority is open to question (Thompson 2006 pp.214-7). For whilst the developing *expert authority* has been (metaphorically) focused on their work in laboratory and clinic, others, in other branches of science (including neuroscience), the social sciences, psychology, the humanities (including art and philosophy) have been deconstructing the priorities and values of a civilisation based on incontrovertible *scientifically proven* certainties: this in the face of vast changes in the accessibility of information and increasing challenges to a traditional world order, authorities, status and - above all - privilege based on inheritance, conferred in another era by a far less egalitarian society.

To the person concerned, this might be seen as a loss of (anticipated) power or control. However, there are also ethical issues, to be discussed below, which some may see as more telling and which are crucial here.

5. In the way payment systems influence professional behaviours and...

... prescribing patterns. Note in the above sentence the term *prescribing* – redolent with the power and authority of the prescriber. This distribution of power in the dentist-patient relationship is exaggerated by payment systems and patterns of work that demand a high throughput of patients in the manner of a production line so that little opportunity may arise for communications in the surgery which might provide some opportunity to redress the power balance in favour of the patient.

6. In the political environment of dental practice dominated by...

⁷⁵ From the Greek *eudaimonia*: meaning literally “good spirit” usually translated in English as “good life” or “authentic happiness” (Seligman 2003) and the adjective *eudaimonic* refers to those things which tend towards good life outcomes/processes.

... the need of bureaucrats, managers, administrators and politicians to provide evidence of accessibility and high output in the race for value for money (which begs the question “*What is valued?*”, discussed further in chapters 3.7-3.9.), whilst disadvantaging patients indirectly in the power balance with the dentist, also seriously constrains the power of the dentist in the professional relationship with their patient provoking the professional’s resentment towards those managers (Hinchliffe p.541).

Issues of power arise on the larger scale between the profession and society: i.e. the relationship with society as a whole. In practice, the functional relationship of the profession with society is mediated from the side of society through laws, regulations, directives and guidelines put in place by central government (politicians and bureaucrats), as well as distributed tiers of government (health authorities, primary care trusts etc) and other regulatory and advisory bodies, some of which have political as well as purely contracting and administrative roles in the hierarchy of control of the healthcare professions.

The professional, it will be apparent from the above, may be seen from one perspective as the power-broker between *the system* and the patient. Facing upwards in the power/control hierarchy, the professional – ideally acting in concert with a weight of professional opinion exerted by professionals working together and speaking with one voice - articulating clearly and forcefully arguments designed to promote systemic changes that will serve the healthcare needs of patients more effectively. This has already been discussed in chapter 1.1 pp.18-21 and at greater length elsewhere considering “*A responsibility for the profession: leading patients with different needs and preferences.*” (Holt 2008 p.116) and the need for “*Political Honesty and Professional Voice*” (Holt 2010a p.141)⁷⁶.

In this role, the professional, or the profession itself, could be seen as acting as advocate (as those who have the professional knowledge and judgement to understand the impacts of various policies on oral health) on behalf of patients. The dentist, after all, may have insight into the effects of policies on the patient’s freedom to make *good choices*. Whilst this takes the concept of professionalism a step higher in the hierarchy of the community, than its conventional day-to-day expression of practice, It could be argued that the status conceded to professionals entails an obligation to carry the professional banner into the realms of social policy, articulating the unique professional vision amongst those who would impose their political values on society without due regard to informed professional opinion. It has been argued

⁷⁶ See scenario 1, appendix I.

that the dental profession has signally failed in this role of speaking as advocate for patients for decades (Holt and Ladwa 2010 pp.94-95). Part of the problem, undoubtedly, lies in reaching a profession-wide consensus as to what is needed. There are inevitably conflicting values obstructing progress in this direction reflecting the weighty ethical component⁷⁷.

7. In the Regulation of the Profession

Between professional colleagues, there is a whole range of rules and practices which define appropriate behaviour (for example the long-standing admonition to “*not bring the profession into disrepute*” (GDC 2001/97 para. 2.1). Many of these rules may be interpreted as being directive and controlling and, as in the example given, arguably not in the interests of patients. However it may reasonably be argued that it is necessary to have some clear-cut ground rules that define a profession and appropriate professional conduct: rules which have been constructed and agreed by the members of that profession over time. Whilst many of those ground rules may be seen in this present discussion as tools of power, (in that, by defining a profession - its special areas and standards of skill, knowledge and practice - they *ipso facto* exclude those who do not meet the criteria set in defining the profession, that is, the rest of society) this is an implicit, (and often explicit), part of the understanding with society that acknowledges the existence of a profession. The ethical aspect of collegial relationships that is the concern of this section relates to the nature of the hierarchy, in terms of authority, power and control, within the profession. The persistence of a culture of the *great expert* or *authority* who is revered and is beyond contradiction is a legacy from the 19th and 20th centuries and, since the GMC’s landmark judgement of 1994 (Appendix 2) reported by Irvine (2003 p.125), is inappropriate.

8. Professional Protectionism or Professional Leadership

Whilst the Bristol heart babies case (Appendix 3 and Irvine 2003 pp.121-35) received great publicity, the underlying culture of the expert who is revered and held to be beyond contradiction is by no means extinct, albeit operating in more subtle and less dramatic ways – often in styles of education or assessment⁷⁸, although it would be seen as out of keeping with the more egalitarian approach of the current era.

It is appropriate that there should be a defined career pathway to encourage and recognise the pursuit of higher levels of knowledge, skills and practice. It is

⁷⁷ to be addressed in chapters 3.7 - 3.9.

⁷⁸ See comments about “*hidden curriculum barriers*” Chapter 3.7 p.154.

appropriate – and even desirable – that those who can demonstrate a high level of competence, skills and knowledge should be appointed to higher positions along the career pathway where they may take on educational and leadership roles within the profession. However, it is not appropriate that the holders of such positions should assume an authoritarian and directive style except insofar as that is necessary to execute the tasks specific to their professional work. Even there, with the evolving conceptions of leadership (Adair J, 1998, Adair J 2003), openness and teamwork (Seward 2009 pp.117-123), it might be expected that a facilitative approach would be more appropriate than the command and control style traditionally admired in armed forces. The satire of “*All men are equal but some are more equal than others*” (Orwell 2008/1945) has been heard: yet observation suggests that there are a goodly few who would still lay claim to being “*more equal than others*”. The person-centred approach to mentoring (chapter 2.6) rejects the authoritarian approach and focuses on the mentor using her power to help the mentee to discover his own power and resources (Holt & Ladwa 2009 pp.20-1, Rogers 1995 p.115): the epitome of the *servant leader* (Covey S R. 2006 pp.298-307).

9. A culture that elevates its experts...

...runs the risk of devaluing those at the other end of the social spectrum. Within a social system that regarded the lower orders as ignorant and where medicine regarded them as patients – passively in receipt of the professional’s ministrations, from diagnosis through to treatment prescribed or carried out with the authority of the expert - persons were inevitably devalued in a way that would be regarded as wholly inappropriate (“*not politically correct*”) in contemporary society. The ethical issue here is presented as one of the fundamental approach to valuing the person - whether it be the junior professional, the postgraduate student, the ancillary professional worker (DCP) or the patient, however unprivileged their perceived social standing.

Where the professional’s power is used to assert status, authority, power over others – and indeed to abrogate power itself – this may be construed as a form of *oppression* (Freire 1996/1970) that in the twenty-first century constitutes a breach of the terms of being a professional. Conversely, when power is used to help others discover their own power, resources, talents and strengths, to take responsibility for themselves and make their own decisions, then this is the power of the farmer or gardener, nurturing, cultivating, seeking to provide good conditions for growth (or recovery) and entirely in keeping with the new paradigm: an aspect of the traditional professional virtue of *altruism*.

This, I suggest, is worthy – and, indeed, the defining feature - of a contemporary approach to being a professional.

The above nine areas of issue raise further questions about professionalism: questions which, in analogous form, must also be answered by all professions, including other healthcare professions and education, where political intrusion is perceived to compromise professional judgement, autonomy and integrity to the disadvantage of those served by the profession. Occupying - as professionals do - a privileged leadership role in society, it is incumbent upon us to give deep thought to the nature of professionalism. taking into account the contemporary understanding – and uncertainty – of our roles in society; and to consider the responsibility of humanity faced with the increasingly obvious constraints of our planetary home (Teilhard de Chardin 1959/55, Senge 2005). This, for the professions, raises questions about both ethics and morality.

Morality and Conformity

I draw a clear distinction between *compliant* conduct and behaviour and *truly ethical (and/or moral)* behaviour and conduct. *Compliant* behaviour can be defined as behaviour that is displayed out of necessity to comply with externally imposed requirements (whether justified or not) in order to avoid the consequences of non-compliance (e.g. disciplinary procedures from a professional body such as the General Dental Council or closure of the practice by an external body such as the Care Quality Commission). *Compliant* behaviour cannot be regarded as an expression of professionalism, though a practitioner with a thoroughly professional orientation might, on occasion, find themselves obliged to comply with a requirement that they believe is not actually appropriate or necessary. *Truly ethical or moral* behaviour can be defined as behaviour expressing a full sense of professional, ethical or moral commitment, which would be honoured even without outside pressure or monitoring.

Conduct and Values

Conduct, including “ethical” moral conduct (or otherwise) reflects values held and prized. Values are about what is important to us – “valued” by us (Williams 1993 p.140) - and underlie daily, minute-by-minute, decisions and choices. Such values may, on occasion come into conflict (E.g. “*I ought to go to that parent-teacher meeting tonight but I also ought to go to the rehearsal for tomorrow’s concert.*”) Conflicts may be resolved by reference to higher values (in the example given, perhaps: “*I should go to the rehearsal as I have a responsibility as a soloist to be there for others. I must make an arrangement to see my child’s teacher(s) at another time.*”) Larger issues take us to higher order values so that

values may be seen as being ranked in a hierarchy which for many may ultimately lead to values perceived as having a transcendental significance⁷⁹.

In Chapter 1.1 I pointed out that societal and political factors are contributing to the difficulties identified, and to the practising strategies adopted, by dentists in response to those factors in order to survive in the contemporary environment. This state of affairs raises ethical issues⁸⁰ concerning the relationship between the profession (both *qua* profession and at an individual level with the patient) and society. In dentistry it is a state of affairs that exists despite – or even partly because of:

- the strictures of the General Dental Council; (GDC 2001/1997; GDC 2005. And see Appendix 4);
- the admonitions of the Defence Societies⁸¹ encouraging practising strategies that will help to protect the practitioner from being sued in an increasingly litigious society;
- the terms of NHS regulations and Department of Health directives laying obligations upon practitioners;
- exhortations of academic bodies such as the Faculty of General Dental Practice (UK) to develop enhanced skills and observe ever-higher standards of practice appropriate to a modern healthcare profession.

There is a sense in which the practitioner feels trapped. On the one hand, there are societal and (NHS) contractual pressures imposed demanding, in effect, more for less (or in less time). On the other hand, there is a desire as a professional and a human being to be able to spend more time with the patient before them. Although dentists tend to be pragmatic about such things (though it should be observed that, unfortunately, pragmatic decisions are not necessarily ethical) this, in the last analysis, becomes an issue of conscience, often placing the interests of the dentist in conflict with the interests of the patient. For the practitioner who reflects upon it, this becomes an acutely uncomfortable moral experience and a source of stress, which can lead to burnout⁸².

Consulting a standard text on medical ethics (Beauchamp & Childress 2001) does not bring the dentist much comfort. Significant systems of repute present high-sounding and demanding obligations and imperatives - the deontological approach of Kant - (op cit pp.348-355) or offer the greatest good for the greatest number - the utilitarian approach of Bentham

⁷⁹ Values are discussed further in chapter 3.7.

⁸⁰ Footnote: taking "ethics" to mean "*the rules of conduct recognised as appropriate to a particular profession or area of life*". (Oxford English Reference Dictionary 1996).

⁸¹ Footnote: Dentists are obliged to take out "Professional Indemnity cover", a specialised form of insurance offered by a few specialist companies – Defence Societies – such as the Dental Defence Union and the Dental Protection Society.

⁸² See chapter 1.1 (pp.26-8).

and Stuart Mill - (*ibid* pp.340 – 348) which begs questions about the good of the minority. A different approach with its roots in the thought of Aristotle, presents outstanding ideals as standards of excellence (*ibid* pp.43 – 49)⁸³. Current requirements (2012) embodied in technical memoranda (DoH 2009, HTM01-05) calling for compliance with an extensive list of new demands raise questions of the morality of a system which seems to have far less to do with the welfare of patients than it has to do with defensive practice designed to make it difficult for clinicians and healthcare organisations to be sued in an increasingly litigious society. Such requirements seem to be imposed with scant attention to the consequences of the inevitable increased consumption of resources upon the planet or the associated costs. Freire's concept of oppressive "*dominant élites*" resonates strongly with practitioners who feel that their professional judgement is disregarded. (Freire 1993 p.112).

Dentistry: A New Model.

In "*Risk Society: Towards a New Modernity*", Beck puts forward the interesting thesis that, because of the highly technical nature of scientific and industrial progress, the real power for change in contemporary society follows less from political acts than from acts in laboratories and industry. Some of the highest impact changes in society in recent years, such as the establishment of the ubiquitous mobile telephone (which has become embedded in society since Beck published), have emerged from rapid technological progress in electronics and other laboratories: from business, not from government policies. Beck therefore contrasts the power for change of "*politics*" compared with "*non-politics*" (Beck 1992 p.187). He discusses "*an extreme case, Medicine*" (*op. cit.* p.203) where advances in knowledge and technology are subject to the outcomes of scientific enquiry, not political action and where, as with other areas of science, understanding is in the capacity of the workers in their specialised fields.

This generalisation reflects back upon the situation in UK dentistry since 1948 where, hitherto, working practices have revolved around payment systems developed by government in negotiation with what is effectively a trade union (the British Dental Association) with the poor results reported in chapter 1.1 above. By contrast, the Steele report, also discussed in chapter 1.1 (Steele 2009), has been produced by an academic researcher with a full understanding of the clinical implications of different ways of working. In addition, on Steele's recommendation and in contrast to previous full NHS dental contracts, extensive – and recently extended - pilot studies are revolving around different ways of working with patients taking account of the health outcomes desired and achieved. The intention is that payment will be tailored to appropriate working practices rather than

⁸³ Further discussed in chapter 3.7 pp.142,169-73.

working practices responding to financial incentives that do not reflect patient goods. The monitoring of outcomes will be facilitated by the almost universal use of computerised records in contemporary dental practice. It is expected that, with the development of a new model for oral health in the hands of a practising academic working with other clinicians and largely removed from the political arena during its development, the finalised proposals may genuinely reflect the depth of specialised knowledge and understanding available to be deployed in the interests of patients in securing oral health in a state-supported system. With patients informed and enabled with respect to appropriate self-care, disease rates are likely to continue to fall and the need for complex technical intervention may be expected to fall dramatically in the next generation (Hancocks 2012). For many established practitioners, the resultant change in practising philosophy will amount to a complete paradigm shift. This will be discussed further in chapter 3.7.

Chapter 2.3

The Whole Person

Introduction

Having raised some issues of concern in part I of this thesis, I now begin in part II to describe an approach to professional practice that offers the potential to enhance the quality of dentistry in the UK, both as delivered to, and experienced by, the person at the centre of the professional activity, the patient; and as practised and experienced by, the professionals themselves, the dentists and other DCPs providing the service. This Person-Centred Approach (PCA) is applicable to relationships at all levels, between the dentist and the patient, between the dentist and a colleague or staff member (all of which may call for a mentoring style): in an educational context, both at undergraduate and – of more direct concern here – postgraduate professional level where, beyond the mere imparting of knowledge, the goal is to support changes in lifestyle and changes in modes of being as a professional. It is in these latter – and deeper – forms of learning that the approach has been used to greatest advantage in the Faculty mentoring programme.

Two factors operating in general dental practice for many decades have tended to have a depersonalising influence on practising dentists as well as patients. Firstly, by virtue of practice being linked to a fee-scale of one form or another, the practice of dentistry became focussed on the delivery of *treatments* by a skilled operator to a patient in whom *treatment needs* had been identified. Secondly, the system of paying dentists as *independent contractors* produced a strong incentive to the dentist to generate fee income by providing a high volume of treatments. (Drawing on Steele (2009), I have discussed in chapter 1.1 the disparity between treatment provision and health-gain.) Both these factors tend to encourage a production-line mentality. Superficially both dentist and patient seem to be satisfied by the arrangement. The dentist (as an individual practitioner) has some control over income responsive to hours spent at the chair-side and the speed of work production. The patient perceives that their treatment needs have been identified and met at (relatively) low cost. To the extent that the practitioner works in this mode, the patient has been ill served by *treatment* limited to operative interventions in the mouth. The dentist must, at some level, be aware of the discrepancy between what could be achieved to secure genuine and stable oral health (as is taught during the undergraduate curriculum at dental school) and what is

actually being delivered to the patient. The patient is, in short, not being treated as a *whole person* – though they do not realise it, for they know no better. The dentist is not *acting* as a whole person either in the way they interact non-holistically with the patient, or in the limited application of their professional understanding and insight to the patient's *real problem* i.e. an ongoing disease process that has not been addressed.

It is important that, at the start of this section of the thesis, the manner in which the person is conceived is articulated clearly. The view of the person here described is emphatically holistic. There are four persons to whom these considerations are relevant if the best performance is to be elicited from dental professional encounters. They are firstly *the patient*, who needs to be considered in an holistic way; secondly *the dentist* (or other dental professional), who needs to be attentive to their own needs as a whole person acting in the role of professional; thirdly *the dental educator* (who will almost invariably also be a practising dental clinician and may be in role as *mentor*), who needs to experience and communicate a sense of personal wholeness - including the being “*attentive to their own needs*” as above - to their developing professional student, colleague or “*Foundation Dentist*” supervisee; and fourthly *the corporate or government administrator* or *policy-maker*, who needs to view professionals and patients, on whom their work will impact, in holistic (rather than, for example, behavioural) terms.

Bearing in mind these four persons, the concept of *the whole person* is discussed from six perspectives:

- functioning as an integrated whole;
- the four functional dimensions of the person;
- an essentially social being;
- wholeness as health: optimising performance;
- fully functioning in community;
- in search of meaning.

Functioning as an Integrated Whole

This topic is approached from an experiential point of view, relying to a large extent on the phenomenology of Carl Rogers augmented with input from other theorists whose work in various fields enables us to build on Carl Rogers' theory of personality. A convenient entrée to the subject is provided by Stephen Covey, an author widely read and recommended on courses designed to develop leadership and business skills for small business owners such as dentists. The following quotation seems to be directly addressed as a response to the difficulties experienced by dentists and their teams in seeking to care for patients holistically under successive NHS contracts and directives from the Department of Health or as employees of dental corporate bodies. In a passage entitled "*The Whole Person Paradigm*" Covey says:

"At core there is one simple, overarching reason why so many people remain unsatisfied in their work and why most organisations fail to draw on the greater talent, ingenuity and creativity of their people and never become truly great, enduring organisations. It stems from an incomplete paradigm of who we are – our fundamental view of human nature. The fundamental reality is human beings are not things needing to be motivated and controlled; they are four dimensional – body, mind, heart and spirit." (Covey SR 2006 pp 20-1: original emphasis)

This passage - which informs the whole of Covey's writing - and the popularity of his books in general - might be interpreted as the rejection of the behaviourist paradigm of B F Skinner (summarised briefly in Stokes (2007) pp.262-3) which had so much influence earlier in the 20th century. It would seem that human beings know intuitively that we are more than a collection of unthinking reflexes.

Having referred to the human make up as being "*four dimensional*", Covey continues:

"If you study all philosophy and religion, both Western and Eastern, from the beginning of recorded history, you'll basically find the same four dimensions: the physical/economic, the mental, the social/emotional, and the spiritual. Different words are often used, but they reflect the same four universal dimensions of life. They also represent the four basic needs and motivations of all people... to live (survival), to love (relationships), to learn (growth and development) and to leave a legacy (meaning and contribution)" (Covey SR 2006 pp 21-2: original emphasis).

This way of conceiving the human make-up – experiential and functional – highlights the manner in which I treat this subject – avoiding any implication that the different elements in

the human make-up might be separate *entities* that could be dissected out and studied separately from the concept of the (ideally fully-integrated) whole person⁸⁴.

Nothing in what I say herein is intended to suggest, for example, that there is a *spirit* or *soul*, to use traditional religious language; an *ego*, an *id* or a *superego*; a *subconscious* or an *unconscious* - to use the language of the psychoanalysts - which could be considered in isolation from the rest of the whole being. The holistic – or integrated - approach articulated here is therefore monistic. I find no need for a dualistic view of the person or of the universe, for the holism expressed may be understood as reflecting the multi-dimensional reality which is our universe and of which we are each a part. It is, however, necessary to give some attention to the significance of the four different dimensions (a convenient metaphor of the whole person)⁸⁵.

Covey's words are echoed, and developed in their own way, by other authors. Handy, for example, ends a chapter entitled "*The Search for Meaning*" with a thought echoing Covey's concept of "legacy".

"The search for the best in ourselves is only the beginning. We need a purpose for these selves.

There is... the elusive question of where we are heading... [W]e all needs a taste of the sublime, to lift our hearts, to give us a hint of something bigger than ourselves and the infinite possibilities of life. The Department of Education in Britain sum it up rather well, in their official definition of spirituality: "The valuing of the non-material aspects of life and intimations of an enduring reality... [W]e can't live forever, at least in this world, and we can't take anything with us, but we can leave a bit of ourselves behind, as proof that we made a difference, to someone. That only happens, I believe, by concentrating on others, the ultimate paradox of proper selfishness... The journey is the point, not the arrival." (Handy 2002 pp108-9).

⁸⁴ The decision to use these four familiar "dimensions" in this thesis is for simplicity and accessibility in a working context - mentoring and professional practice - where an holistic view of the person is advocated. The four categories used are broadly familiar and understood. There are other approaches looking in much more detail at some aspects of the human personality, usually elaborating in much more detail on the affective and spiritual experience of the person: these drawing on both the Western and the Eastern mystical traditions and experiences. Such approaches tend to take on a more structured approach to developing a "theory" of the human make-up which is not the intention here. They are, nevertheless, very illuminating. Three authors cited elsewhere in this thesis present such approaches: John Heron in "*Feeling and Personhood*" (Heron1992); Zohar and Marshall in "*Spiritual Intelligence*" (Zohar and Marshall 2000); Ken Wilber with the integral approach summarised in "*A Theory of Everything*" (Wilber 2001) and considered in greater depth in "*Up from Eden*" where he traces the evolution of consciousness through different stages of human anthropology (Wilber 2004/1981). These approaches – Wilber's in particular – seek to develop the concept of the human experience as an expression of, and participation in, a form of planetary and universal consciousness building on the work of Teilhard de Chardin (1959/55). A more rigorous critical review of the integral approach is given in Gidley (2007) and the approach to Integral Philosophy described by McIntosh (2007).

⁸⁵ Another metaphor that could be used instead of "dimensions" is that of "facets" of the personality. That is also useful – implying different viewpoints – however; "dimensions" is preferred here since it allows greater conceptual fluidity in moving amongst or between the four components.

Handy's words – "The journey is the point, not the arrival." – warrant emphasis as this processional view of life, self-actualisation and the *good life*, becomes a recurring theme as I develop my thesis. It recurs below in our first consideration of Carl Rogers' and Maslow's contributions.

Self-Actualisation

During the middle of the 20th century, whilst behaviourism continued to exercise influence, others, here represented by Maslow and Rogers were developing an understanding of human personality based on a completely different paradigm. Rather than the Skinnerian view of all human behaviour as a reflex response to a stimulus, Maslow and Rogers had identified in their patients and subjects a tendency to what they termed *self-actualisation*. It is not clear which man used the term first as both were using it at about the same time though Maslow attributes the invention of the term to Goldstein in a paper published in 1939 reporting on work with brain-injured soldiers, where this concept was necessary "*to explain the reorganisation of the person's capacities after injury*" (Maslow 1969 p.22). In a passage which was to be echoed more than three decades later by Seligman (one of the founders of the modern Positive Psychology movement - see below, p.75 - in his inaugural address as President of the American Psychological Association, Maslow states

"[It] is as if Freud supplied to us the sick half of psychology and we must now fill it out with the healthy half. Perhaps this health psychology will give us more possibility for controlling and improving our lives and for making ourselves better people. Perhaps this will be more fruitful than asking 'how to get unsick' " (ibid p 5, original emphasis).

In a key – and very lucid - passage, Maslow makes some comments on existentialism which are relevant to this present discussion:

"To me existential psychology means essentially two main emphases. First it is a radical stress on the concept of identity and the experience of identity as a sine qua non of human nature and of any philosophy or science of human nature, I choose this concept as the basic one partly because I understand it better than terms like essence, existence, ontology and so on, and partly because I feel also that it can be worked with empirically... Secondly, it lays great stress on starting from experiential knowledge rather than from systems of concepts or abstract categories or a priories. Existentialism rests on phenomenology, i.e. it uses personal, subjective experience as the foundation upon which abstract knowledge is built. (ibid p 9. Original emphasis).

This emphasis on the individual's "*personal, subjective experience*" underpins Maslow's approach, which I share. Discussing motivation he observes:

The original criterion of motivation and the one that is still used by all human beings except behavioural psychologists is the subjective one. I am motivated when I feel desire or want or yearning or wish or lack. No objectively observable state has yet been found that correlates decently with these subjective reports, i.e. no good behavioural definition of motivation has yet been found" (Ibid p. 22).

In referring to his oft-quoted *hierarchy of needs* (e.g. Fairclough 2008 p.28) he goes on to

“...discuss some of the differences that I have observed to exist between the motivational lives of healthy people and of others, i.e. people motivated by growth needs contrasted with those motivated by basic need.

So far as motivational status is concerned, healthy people” [which might reasonably be thought to include practising UK dentists] “have sufficiently gratified their basic needs for safety, belongingness, love, respect and self-esteem so that they are motivated primarily by trends to self-actualization (defined as ongoing actualization of potentials, capacities and talents, as fulfilment of mission (or call, fate, destiny, or vocation), as a fuller knowledge of, and acceptance of, the person’s own intrinsic nature, as an unceasing trend toward unity, integration or synergy within the person” (Maslow 1968 p. 25).

This early description of the actualising tendency was refined by Maslow, Rogers and others and became fundamental to Rogers’ whole approach to dealing with persons. Starting from these concepts Rogers articulated a theory of personality and behaviour published in “*Client-Centred Therapy*” in 1951. Here Rogers (giving full acknowledgement to many prominent psychologists who had contributed to the construction of this theory – described, as was customary for Rogers, as “*tentative*”) presented a series of nineteen “*propositions*” which

“...taken as a whole...presents a theory of behaviour which attempts to account for the phenomena previously known, and also for the facts regarding personality and behaviour which have more recently been observed in therapy” (Rogers 2003/1951 p. 481).

The first seven of the propositions are reproduced in Fig. 2.3.1. These seven are selected for their relevance to mentoring in dentistry. It is interesting to note that the second proposition clearly draws on the work of Lewin – whom Rogers cites several times though not specifically in this context - on field theory (Lewin 1951 p.189).

It is apparent from this preview⁸⁶ of Rogers’ theory that (in health, at least) the person (Rogers uses the term “*organism*” to stress the holistic, comprehensive personal, total

⁸⁶ Note that Rogers was writing at a time when it was customary to use the male form of the personal pronoun exclusively.

biological, all-embracing nature of this response) is whole and integrated in responses to the environment and situations in which she finds herself. In health there is no fragmentation or dissonance. The responses to the flow of events in the environment are expressions of the totality of experience and engagement of the whole organism with those events. The person functions as an integrated whole and this necessitates consideration in due course (Chapter 3.7) of the values and meanings that underlie our motivations and which feed into our sense of morality: the very things that define us, emerging from our biological, evolutionary ontogeny, as persons and distinguish us - and set us apart from - the rest of the living world.

- 1) *Every individual exists in a continually changing world of experience of which he is the center.*
- 2) *The organism reacts to the field as it is experienced and perceived. This perceptual field is, for the individual, "reality".*
- 3) *The organism reacts as an organised whole to this phenomenal field.*
- 4) *The organism has one basic tendency and striving – to actualise, maintain, and enhance the experiencing organism.*
- 5) *Behaviour is basically the goal-directed attempt of the organism to satisfy its needs as experienced, in the field as perceived.*
- 6) *Emotion accompanies and in general facilitates such goal-directed behaviour, the kind of emotion being related to the sacking (sic) versus the consummatory aspects of the behaviour, and the intensity of the emotion being related to the perceived significance of the behaviour for the maintenance and enhancement of the organism.*
- 7) *The best vantage point for understanding behaviour is from the internal frame of reference of the individual himself (Rogers 2003/1951 pp.483-497).*

Fig. 2.3.1 Carl Rogers Propositions 1-7 (of 19)

The Four Functional Dimensions of the Person

Having emphasised the integrated wholeness of the person, I now discuss the function of these four dimensions. Enough is incorporated into this discussion to make it apparent that none of the dimensions function in isolation, but always in co-ordination – or in dispute - with

the others. Furthermore, there are many other perspectives from which to view the human organism some of which are discussed below, which can inform and enhance this four-dimensional view.

The Body: The Do-er

The body can at different times, or the same time, be the executive in action, the communicator outwards, the recipient of subtle inward messages, and the communicator of internal dissonance.

The body executes at a physical level the decisions taken by the person. If the decision is taken to shake another person's hand on parting after a conversation, it is the body through signals sent along nerve fibres to numerous muscles coordinating the project that places the hand appropriately for the gesture to be completed. However, the manner in which the manoeuvre is executed, enthusiastically, firm grip or lax, energetic or listless, eye contact or not, the nature of eye contact, hard, glaring, cordial, etc., all contribute to the experience perceived by the other. The body language is, in fact, a major part of the communication that the other is reading of our attitude towards them (including subtle inflections in our voice). Equally, on the other hand, the body may be communicating to us information. We, as a young dentist in the practice, may have picked up an inappropriately forceful handgrip in the handshake, we may notice we have "*butterflies*" as our body reminds us we are apprehensive – perhaps the friendly handshake belies the boss's intention to give us notice. Our subtle reading of the situation influences our own inner state of mind. We empathically sense cordiality – or threat – in the relationship. Focussing on what our body is saying to us through subtle sensations, to which we often pay scant attention (sometimes referred to, literally, as "*gut feelings*"), can often provide useful insight into our state of mind and into certain dissonances between the different dimensions of our personality: the focusing approach developed by Eugene Gendlin in his person-centred practice. (Gendlin 2003/1978). Perhaps we reflect how our handshake might impact on the patient we are greeting in the waiting room.

Mind: The Calculator and Thinker (Cognition)

The cognitive functions associated with mind have dominated much of human intellectual activity for 2 ½ millennia since the Ionian period and especially in the modern period, with high levels of confidence in the capacities of the human mind to enable us to understand and manipulate our universe (and each other). Within the last century, discoveries made in

quantum science (see Chapter 1.2) have precipitated a reappraisal of what the mind can do and how much - if anything - we can really "know". Although, on a day-to-day basis, the cognitive functions can serve us well, it is noteworthy that the efficiency of mental processing varies according to circumstances, especially the emotional atmosphere, the perceived presence or threat of danger sitting in the waiting-room (which can either stimulate or paralyse), not to mention the state of physical well-being. The cognitive functions involved in decision-taking are important. However they may lead to decisions that conflict at another level. *Gut feelings* might indicate a dissonance between the mind's rational decision and the choice of the heart, or sense of disillusion as we perceive a tension between expected practices and the moral orientation of the spirit.

Heart: Feeling and Emoting

The emotions have long been associated with the heart. They range from love, serenity and joy at one end of the spectrum to fear, grief, anger and hatred at the other. Egan describes "...four of the main families of emotion" as being "sad, mad, bad and glad", (Egan, 2009 p.69) - the accurate recognition of the emotion family being important in the helping situation.⁸⁷

"Recognizing key feelings, emotions, and moods (or the lack thereof) is very important for at least three reasons. First they pervade our lives. There is an emotional tone to just about everything we do. Feelings, emotions and moods pervade clients' stories, points of view, decisions, and intentions or proposals. Second, they greatly affect the quality of our lives. A bout of depression can stop us in our tracks. A client who gets out from under the burden of self-doubt breathes more freely. Third, feelings, emotions and moods are drivers of our behaviour" (ibid, p.145).

"People change when they are emotionally engaged and committed" (Goleman 2003 p.309).

Le Doux⁸⁸ presents key points to

"justify [his] belief that emotion and cognition are best thought of as separate but interacting mental functions mediated by separate but interconnecting brain systems" (Le Doux 1998 p.69).

He points out that

⁸⁷ The practices of counselling, coaching and mentoring are collectively referred to as "helping" (Egan 2009 p 4).

⁸⁸ Professor of Neural Science, New York.

“Emotions are notoriously difficult to verbalize. They operate in some psychic and neural space that is not readily accessed from consciousness” (ibid p.71).

The negative emotions – though less pleasant to experience and to observe – are viewed as having a crucial role to play in the survival of the organism through evolution, for the pessimist is more likely to wake up in the night and go out to double-check the security against marauding humans or animals out in the forest. The same personality-type may be more likely to lie awake at night worrying about a dental appointment the next day! Conversely the apparently unemotional person may be the survivor who is able to keep cool in the face of danger. For some, a rush of emotion can temporarily overwhelm them – making them delightfully responsive in circumstances calling for care and empathy but a serious disadvantage when trying to land an aeroplane in a vicious storm. For the positive emotions, Seligman reports work by Frederickson who claimed that

“[Positive] emotions have a grand purpose in evolution. They broaden our abiding intellectual, physical, and social resources, building up reserves we can draw upon when a threat or opportunity presents itself. When we are in a positive mood, people like us better, and friendship, love, and coalitions are more likely to cement... our mental set is expansive, tolerant and creative. We are open to new ideas and new experience” (Seligman 2003 p.35).

Fostering such positive emotions might be expected to facilitate the achievement of positive outcomes by a dentist when dealing with people (patients and team members) in the clinical environment. Layard, in a book devoted to “Happiness”, arguing that “[w]e are programmed to seek happiness” and that the “best society is the happiest”, argues the case for happiness as a guiding criterion for behaviour and public policy:

“[P]ublic policy should be judged by how it increases human happiness and reduces human misery. Likewise, private behaviour should aim at producing the greatest overall happiness” (Layard 2011/2005, pp.224-5).

Parts of the emotional brain are more primitive in an evolutionary sense (see Le Doux 1998), and make a contribution that is often unnoticed or ignored. In mental distress⁸⁹ this dimension of the person - which in good times has the power to enhance experience with pleasure and joy - seems to be the source of dissonance, often because even “healthy” people have adopted positions internally to win approval from, or favour with, significant others in early life. Such “*introjected*” values can cause minor or significant distress which can make its presence felt in many ways conflicting with the normal processes of life, often

⁸⁹ Person-centred therapists prefer not to “medicalise” problems by thinking of them as illness or disorder: rather they view the person as “hurting” or “being in distress”, as discussed by Sanders in Joseph and Worsley 2005 pp 21-42.

emerging as disabling “*conditions of worth*” conflicting with the individual’s true values or preferences later in life (Cooper et al. 2007 p.11). The uncomfortable “*feelings*” are often the warning sign that something needs to be addressed and brought into the open.

Spirit: Meanings, Values, Vision, Motive, Inspiration

It is not uncommon to refer to the *spirit* of some activity, or group or meeting, meaning the general significance (meaning), mood or collective feeling emerging in the occasion. We speak of a *spirited performance* or a *spirited defence* indicating energy, conviction and meaning. The word *inspired* itself, of course, comes from the same root as spirit. Many at times long for *inspiration*. Our spiritual self weighs value and significance (other than those related to basic survival); apportions value to matters of less immediate concern for survival; beauty, goodness, altruism, motivation, vocation; the allocation of value to those things that really make life worth living. (The experience of winners of large sums on the lottery would seem, as reported by both Seligman 2003 p.48; and Argyle 2001/1987 p.138, to suggest emphatically that this does not include large sums of money.)

“Inwardness is the symbol of spirit... [It] is energy, dynamism, creativeness, transcendence...freedom...Spirit introduces the qualities of wholeness, unity and design into man’s psychic and psychic-corporeal life” (Berdyaev 1939/2009 pp.33-37).

I have already touched on this briefly with a quotation from Handy (p.61 above). Things that belong in the realm of the spirit tend to take us beyond ourselves, to envision us, imbue us with energy, often to have a transcendental quality about them which transforms our view of things or the way we ascribe value. They can become the underpinning drive or motive that keeps us going, maybe in the face of difficulty, in our quest to achieve a certain goal or overcome a particular challenge. Indeed, Victor Frankl, drawing on his experiences in Nazi concentration camps reports that

“.... striving to find a meaning in one’s life is the primary motivational force in man”
(Frankl 1959 p.104).

This discussion would be incomplete without a mention of ecstatic or mystical experiences. There can be no question that, for a significant proportion of the human species, mystical experience becomes part of their “*perceptual field*” at times and, at such a moment “*is, for the individual, ‘reality’*” (Rogers 2003/1951 p 484). A view of the person that is both humanistic and holistic has no alternative but to accept the validity of this experience. Indeed, Polanyi, asserting the validity of “*tacit knowledge*” although

“modern positivism has tried to ignore it on the grounds that [it] was not accessible to objective observation,”

claims that

“the present theory of meaning assigns a firm place to the inarticulate meaning of experience and shows that it is the foundation of explicit meaning” (Polanyi 1969 p.187).

Wilber, whilst acknowledging the lack of reliable data, observes that

“[A] majority of individuals report having had at least one major spiritual or peak experience. These events are some of the most powerful motivating forces in human psychology, whether they light the face of a Mother Teresa or drive the intense fanaticism of a jihad, and no analysis of world events that ignores them can hope to succeed” (Wilber 2001 p.133).

There is, indeed, an argument that it is in such moments of experience we discover our own wholeness or centre of being – our “deep self” (Zohar & Marshall 2000 p.287). Earlier in their book on *Spiritual Intelligence*, Zohar and Marshall state

“One of the most profound insights of twentieth-century science is that wholes can be greater than the sum of their parts. The whole contains a richness, a perspective, a dimensionality not possessed by the parts. So the whole is not just a larger quantity, but has added quality too.

Here science helps us to understand the spiritual. As the concept is used in this book, to experience ‘the spiritual’ means to be in touch with some larger, deeper, richer whole that puts our present limited situation into a new perspective. It is to have a sense of ‘something beyond’, of ‘something more’ that confers added meaning and value on where we are now. That ‘something more’ may be a deeper social reality or social web of meaning. It may be an awareness of or attunement to the mythological, archetypal, or religious dimensions of our situation. It may be a sense of some more profound level of truth or beauty. And/or it may be an attunement to some deeper, cosmic sense of wholeness, a sense that our actions are part of some greater universal process” (ibid pp.18-19).

Whitmore discusses “*Transpersonal awareness*” which

“emerges in different ways at different times. At any point in adult life an individual may experience an inner awakening, a longing for life to be more deeply fulfilling and inspiring than it previously has been. This awakening is not necessarily religious by nature” (Whitmore 2004, p.6).

Later she observes

“The revival of interest in the transpersonal is triggered, on the one hand, by an increasing dissatisfaction with competitive materialism, the pursuit of immediate gratification and, on the other hand, by a conscious or unconscious search for different and higher values and activities, a longing for what is largely termed spiritual” (ibid p.129).

Wilber has much of interest and relevance to say on the emergent concepts of parts and wholes – “*holarchies*” – covering all areas of human experience and knowledge, in developing his “*Integrative*” approach to understanding our world and our experience (e.g. Wilber 2000, 2001, 2006). McIntosh (2007) and Phipps (2012) both contribute lucidly and significantly to this discussion.

It should be clear from the above that a distinction is drawn between consideration of the spiritual dimension of the human personality and the potentially contentious issues arising from the superimposition on such experiences of an overlay of religious doctrine and practice which go beyond the legitimacy of the immediate phenomenal experience. Although, for many, religious beliefs and practices are the natural way of experiencing and expressing their spiritual side, the discussion of such beliefs and practices is not part of this thesis.

An Essentially Social Being

The whole person - the subject of this chapter - cannot, in truth, be considered in isolation. We are all, as members of the species *Homo sapiens*, essentially social beings, and would not have survived beyond the first few hours of life without social support – normally initially in the family (Liedloff 1975/86, Harré 1983 pp103-7, Harré 1993 p 215). Along with all the other skills of mind and body that are learned by every person in early years, a crucial element must be the socialisation process which accompanies them. Some aspects of this will receive attention later in this chapter in relation to emotional and social intelligence⁹⁰. Ultimately, the need for systems of morality and ethics, and the concept of professionalism – all central to this thesis – arise from our living as persons in community. I now consider two key features of life as a person in community: the experience of relationship and it’s

⁹⁰ More extensive discussion of the Self and the social aspects are presented in Chapters 3.6 and 3.7.

mediation through conversational transactions (though not forgetting the very large element contributed to the latter by tone of voice and body language, as reported by Mehrabian in the 1960s). The term community here specifically includes professional developmentally– or health- focussed relationships.

Relationship: *I and Thou*, Martin Buber

The existential approach takes as its starting point a person's self-awareness: our own centre of experience from which we make sense of the world. A particular contribution of Buber is his focus on the way persons relate to each other – what is going on (to quote one of his titles) "*Between Man and Man*". He states

"The fundamental fact of human existence is man with man" (Buber 1947/1961 p.244).

The relationship between persons is the unit of being from which social living is built. Buber's famous concept is of "*I-Thou*" – the true person-to-person communication – as distinct from "*I-It*" which can reflect the relation with things or people at an impersonal and functional level. In his seminal work, *I and Thou*, Buber portrays *being* as expressed through the (metaphorical) speaking of two primary words – "*I-Thou*" and "*I-It*" (Buber 1959/1937). Buber's style is somewhat mystical and poetic and it is difficult to convey his thoughts in conventional prose without loss. His opening paragraphs are reproduced below – all emphases original:

"TO MAN THE WORLD IS TWOFOLD, in accordance with his twofold attitude.

The attitude of man is twofold, in accordance with the twofold nature of the primary words which he speaks.

The primary words are not isolated words.

The one primary word is the combination I-Thou.

The other primary word is the combination I-It;

Wherein, without a change in the primary word, one of the words He or She can replace It.

Hence the I of man is also twofold.

For the I of the primary word I-Thou is a different I from that of the primary word I-It.

"PRIMARY WORDS DO NOT SIGNIFY THINGS, but they intimate relations.

Primary words do not describe something that might exist independently of them, but being spoken they bring about existence.

Primary words are spoken from the being.

*If Thou is said, the I of the combination I-Thou is said along with it.
 If It is said. The I of the combination I-It is said along with it,
 The primary word I-Thou can only be spoken with the whole being.
 The primary word I-It can never be spoken with the whole being.*

"THERE IS NO I TAKEN IN ITSELF, but only the I of the primary word I-Thou and the I of the primary word I-It" (Op cit pp 3-4).

To someone familiar with Buber's work the writing of Carl Rogers - on whose work I draw extensively - conveys a strong sense of Buber's influence, and, indeed, not only were the two men friends: they had a public dialogue recorded at the University of Michigan in 1957 (Anderson and Cissna 1997). Rogers refers to Buber in a typical Rogerian passage:

"When the other person is transparently real and congruent, he often helps me. In those rare moments when a deep realness in one meets a realness in the other, a memorable 'I-Thou relationship', as Martin Buber would call it, occurs" (Rogers 1995/1980. p.18).

Heron in *Feeling and Personhood* describes how

"I and Thou are only known in fullness in a direct mutual relation between two people who are genuinely open and present to each other. The reality is in the relation between them and is interdependent with the wholeness of each" (Heron 1992 p.163).

Goleman in *Social Intelligence* asserts

"I-You is a unifying relationship, in which for the time being a special other is perceived as distinct from all others and is known in all her distinctive features. Such deep encounters are the moments we remember most visibly in our close relationship" (Goleman 2006 p.110).

Macmurray – writing contemporaneously with Buber - argues in his Gifford lectures that

"[T]he Self exists only in dynamic relation with the Other. [It] has its being in its relationship; and...this relationship is necessarily personal" (Macmurray 1961 p.17).

The influence of Buber persists and contemporary writers on helping discuss "working at relational depth" in a manner expressive of Buber's *I-Thou*. So Mearns writes of wanting to "offer the client....a quality of engagement that might allow him to meet me at 'relational depth'" (Mearns 2003 p.5), and, in Mearns and Thorne (2000), says

“Organised into societies, human beings tend to lose touch with their humanity and the humanity of others, yet both of these are the existential CORE of the person. I use the phrase ‘meeting at relational depth’...as secular language to describe a powerful phenomenon. It is identical to Buber’s notion of the ‘I-Thou’ relationship...” (op. cit. p.56; original emphasis).

“All real living is meeting” (Buber 1959/1937 p.11).

Transactions: “I’m OK – You’re OK”

Relations between persons are generally developed through conversation which, (as indicated above, pp.70-1) is understood to convey much more than mere verbal interchange. A helpful way of understanding a conversation – and therefore the course of the relationship at the time – is to analyse the elements of the conversation – the “*transactions*” – that are being exchanged. Transactional Analysis (TA) is a widely used – and very accessible - approach to understanding what is going on in conversation and is a valuable tool not only in the mentoring and learning situations, but in life in general. A thorough treatment of the subject is given in Stewart and Joines (2002) who give a definition of TA:

“Transactional Analysis is a theory of personality and a systematic psychotherapy for personal growth and personal change” (p. 3).

A better-known and more accessible book for general readers not planning to practice psychotherapy is Harris (1993) which is recommended to mentors and mentees as a useful source of insight into themselves and others, especially with dental patients, practice team members and colleagues. It is based on the recognition of different *ego-states* drawing on recall and replay of life positions (attitudes) often revealed by verbal clues recorded from early life as “Parent (P)”, “Adult (A)” or “Child (C)”. The use of TA in therapy is quite outside the scope of this thesis. As a way of understanding people and how we communicate, it has immense value. The TA founder’s book “*Games People Play*” provides valuable insights into strategies we adopt in relationships (Berne E .1964) and his contemporary gives insight into life scripts (Steiner C.1990/1974). Many Faculty course participants report finding TA very useful in giving insight into their own, and mentees’, thinking, behaviour, and experience. Some more information is included in appendix 5.

The particular point to draw here from TA is the fundamental belief that people are “OK” as reflected in Harris’s title and as expressed by Stewart and Joines (2002):

“The most fundamental assumption of TA is that people are OK. This means: you and I both have worth, value and dignity as people. I accept myself as me and I accept you as you. This is a statement of essence rather than behaviour” (p 6).

This expresses a foundational position articulated in the PCA (chapter 2.5) as “*unconditional positive regard*”⁹¹.

Having discussed two key elements in social living – relations and transactions – I continue the discussion in the context of optimising those relations and developing successful transactions in supporting actualisation of the fully functioning person (pp.81-2 below) – the province of the relatively new field of Positive Psychology and, it is suggested, the aspirational goal of all educational activity from kindergarten to postgraduate professional study and beyond.

Wholeness as Health: Optimising Performance

The term “*The Whole Person*” is used here to convey the concept of the person – inhabiting several dimensions – as an *integrated* whole. This reflects the person-centred stance in which each person acts reflexively from a sense of wholeness, awareness, and integration of their own dimensions whilst also addressing another person with the same awareness of the rich multi-dimensional nature of the other’s personal make-up.

There is, however, a sense in which the word *wholeness* has been used sometimes to convey recovery from illness – “*being made whole*” - and there is no doubt that much mental distress is related to conflicts and disparity between the various dimensions of the person described above and recovery emerges from re-integration of those dimensions. It is also common experience for us all to be aware at times of struggling to reconcile different preferences and priorities within ourselves, the eventual resolution of which can bring about a sense of inner peace and contentment. Although recognising some of the more serious mental illnesses known to have an organic basis (such as “*schizophrenia*”) the PCA views the medicalisation of many other conditions with a “*diagnosis*” (such as “*depression*”) as inappropriate, regarding them as representing a form of “*distress*” rather than “*illness*” (Joseph & Worsley 2005). From that premise, person-centred counsellors or psychotherapists seek to work with their clients to unravel these inner causes of distress and

⁹¹ Appendix 5 gives further information on TA.

produce resolution without the need for medical interventions; restoring wholeness or integration where before dis-integration was incapacitating the client in their social roles.

The recognition that similar strategies (mentoring and coaching) could be used to support people who are functioning in society (not “*ill*” in traditional terms), enhancing performance and focusing on “*those things that make life most worth living*” (Peterson 2006) has emerged within the relatively new field of Positive Psychology.

Positive Psychology – the Other Half of Psychology

In the rest of this section I consider several different aspects of what has come (within the last 15 years) to be known as Positive Psychology which have bearing on mentoring and provide resources both for mentors and mentees in their personal and professional development. This section is concerned with the whole person working towards achievement of their full potential in a social context. The seriousness with which professional psychologists are taking Positive Psychology may be inferred from the election in 1998 – by the largest vote in history (Seligman 2003 p 26) - of one of the leading exponents of this approach, Professor Martin Seligman, as President of the American Psychological Association. On first seeing some of the obvious references using words such as *positive* and *happiness*, the reader might wonder whether this is a soft-headed, “happy-clappy” approach - what Seligman refers to as “*happiology*” (Seligman 2003 p6). This is far from the case. Peterson (2013) refers to “*positive psychology as a scientific perspective on the human condition* (op cit p.xiv), and in an earlier work states:

“Positive psychology is the scientific study of what goes right in life, from birth to death and at all stops in between.

It is a newly christened approach in psychology that takes seriously as a subject matter those things that make life most worth living...

The most basic assumption that positive psychology urges is that human goodness and excellence are as authentic as disease, disorder, and distress” (Peterson 2006 pp.4-5).

When Seligman gave his Presidential address to the American Psychological Association he declared:

“Psychology is half-baked, literally half-baked.

We have baked the part about mental illness.

We have baked the part about repair and damage.

But the other side is unbaked.

The side of strengths, the side of what we are good at, the side... of what makes life worth living.” (Buckingham and Clifton, 2005 p.129)

From the perspective of the PCA (see chapter 2.5), Joseph and Worsley (2005) comment:

“Positive psychology aims to facilitate and not to direct; seeks optimal human functioning in terms of the organismic valuing process, and subjective as well as psychological well-being; rejects the medical model’s aspiration to be value-neutral, but rather aims to promote the “good life”, “good citizenship” and “valued subjective experience”; expresses a professional interest in the whole range of human experiencing and not just dysfunction. The person-centred practitioner might even think to themselves that there is nothing new here, but that these key commitments can be traced straight back to the writings of Carl Rogers.” (op cit, p.348).

Positive Psychology is described as having *three pillars*:

the study of *positive emotion*;

the study of the *positive traits*, foremost among these being the strengths and virtues, but also the ‘abilities’ such as intelligence and athleticism;

the study of the *positive institutions*, such as democracy, strong families, and free inquiry, that support the virtues, which in turn support the positive emotions. The positive emotions of confidence, hope and trust, for example, serve us best not when life is easy, but when life is difficult. (Adapted from Seligman 2003 p.xiii)

Focus on Well-Being, Strengths and Virtues

For the advocates of Positive Psychology, there arose the question of what could provide the basis of such a psychology, if it was not to be defined by reference to disease. Peterson (2006) reviewed well-being – or what he called “*wellness*” - and stated that

“The person in good health feels alive, exuberant, and vital and reaps all of the psychological and social benefits of feeling good” (op. cit. p.226).

He considers the concept of “*good character*” and describes the search for universally accepted character strengths (ibid pp.137-64). In a major work, Peterson and Seligman (2004) jointly described twenty four character strengths (listed in Fig. 4.3) when working with the Values in Action Institute (VIA - “*a non-profit organisation dedicated to the development of a scientific knowledge base of human strengths*” which are also summarised by Seligman (2003 pp.141-161) where they are listed under the headings shown in Fig .2.3.3.

This work may be considered as Positive Psychology's answer to traditional psychology's standard handbook "*Diagnostic and Statistical Manual of Mental Disorders*" – "*DSM IV – TR*" (American Psychiatric Association 2000).

Strengths of wisdom and knowledge;

1. Creativity
2. Curiosity
3. Love of learning
4. Open-mindedness
5. Perspective

Strengths of courage;

6. Authenticity
7. Bravery
8. Persistence
9. Zest

Strengths of humanity;

10. Kindness
11. Loving
12. Social intelligence

Strengths of justice;

13. Fairness
14. Leadership
15. Teamwork

Strengths of temperance;

16. Forgiveness, mercy
17. Modesty/humility
18. Prudence
19. Self-regulation

Strengths of transcendence.

20. Appreciation of Beauty and Excellence
21. Gratitude
22. Hope
23. Humour
24. Religiousness/spirituality

Fig. 2.3.3. VIA Classification of Character Strengths

(After Peterson and Seligman. Full list in Appendix 6)

Focus on Performance: “Flow”

Considering Strengths and Virtues involves looking at qualities and attributes of persons – *how they are*. In considering “flow”, Positive Psychology is looking at *how they perform* – a more dynamic, functional concept. The author renowned above all for his exposition of *flow*, Csikszentmihalyi (pronounced ‘cheek sent me high’) wrote

“Flow is the way people describe their state of mind when consciousness is harmoniously ordered and they want to pursue whatever they are doing for its own sake” (Csikszentmihalyi 2002, p.6).

The concept of flow can be applied to any aspect of work or in relation to performance in the overall task. The reader will doubtless recall times when they have been totally engrossed in what they are doing, totally focussed, absorbed, fully engaged, unaware of the passage of time until they have “*suddenly come out of it*” to discover that we had not noticed that time has “*flown by*”. This experience of “*flow*” might be experienced by a dentist, for example during a calm treatment session with a relaxed patient whilst building up (in effect, a mini-sculpture) a fractured tooth by adding on small pieces of carefully-selected shaded increments of adhesive filling material to restore the contours, function and aesthetic effect of the tooth. A similar experience can arise in an interactive session with colleagues in a study group or with a patient considering a range of treatment options and for many, during absorption in reading or doing a piece of writing⁹².

Neuro-Linguistic Programming (NLP)

Knight (2002) defines NLP as

“The study of our thinking, behaviour and language patterns so that we can build strategies that work for us in making decisions, building relationships, starting up a business, coaching a team of people, inspiring and motivating others, creating balance in our lives, negotiating our way through the day, and, above all, learning how to learn” (op. cit. p.3).

Although at times there seems to be an effort to cultivate a form of “*mystique*” around NLP tending to attribute expertise to the coach rather than the client, the approach provides tools which may be used with benefit by person-centred helpers for observing and understanding

⁹² I shall return to this focus on character strengths and virtues associated with professional practice in chapter 3.7.

others; for recognising the processes going on within the self; for developing strategies aimed at making those processes more effective and for improving personal effectiveness.

The use of NLP described in course assignments demonstrates that many faculty mentors find NLP a useful resource.

Solution Focus and the Strengths-Based Approach to Leadership

The traditional approach to leadership has tended to be *Boss centred*. The boss (dentist, practice manager, proprietor, etc.,) writes a job description, advertises, interviews and selects the applicant(s) considered to be the most suitable. In all probability, the successful applicant will meet the requirements of the company in some ways and have other areas where they are weak. The weaknesses may have been apparent at the outset or, more likely, become apparent some time later – perhaps in an appraisal process. The well-intentioned boss, having recognised the problem, arranges for the employee to have further training to *work on these weaknesses*. The employee, of course, keen to progress their career and develop themselves, goes along with this programme.

From the Solution Focus point of view (another manifestation of the PCA), there are several problems with this scenario. Firstly it is focussing on problems and weaknesses rather than solutions and strengths. Secondly, it assumes that the best thing to do is to make the employee a good all round performer and to build up their weaknesses to this end. Thirdly, it assumes that working on the weaknesses will actually work. It is quite possible that if the employee does have a weakness it is either because they lack the talent in this particular area or perhaps because they are simply not interested in this aspect of the work. Either way, any amount of money and effort spent on training is likely to be largely wasted (Buckingham and Clifton 2005 p.222). Finally, it is ignoring the employee's talents and strengths and the fact that building on a talented employee's strengths will be vastly more effective in improving performance than flogging their weaknesses.

Focussing on solutions is a much healthier and more motivating approach. Jackson and McKergow (2007) describe a comprehensive approach to solutions focus, offering a wide range of useful coaching tools and strategies. Whereas focussing on problems ("problem talk", op cit p23) tends to drag the employee down emotionally, focussing on solutions engages a much more positive side of the brain, hooks attention, and fires motivation. The solutions-focus approach is founded on the principle

"[F]ind what works and do more of it" (ibid p.3).

“The focus on solutions (not problems), strengths (not weaknesses), and on what’s going well (rather than what’s wrong) leads to a positive and pragmatic way of making progress” (ibid p.xv).

Connor & Pokora (2007, pp.212-34) report on a range of mentoring culture projects, based on a solutions-focused approach, involving organisations such as the Greater Manchester Police, Astra Zeneca, and Newcastle upon Tyne NHS Foundation Trust.

Goleman (2003, p.212-3) has demonstrated the value of mentoring and coaching in helping leaders develop in a company with a mentoring and coaching culture.

Team coaching using the Solution Focus approach is described by Meier (2005) and a long series of successful projects carried out using Solutions Focus is described by McKergow & Clarke (2007).

The focus on building strengths – intrinsic to the PCA - is much more likely than focussing on weaknesses to inspire job engagement because, in doing something they are good at, the employee is likely to be doing something they like, something at which they can even excel, and from which they can gain a sense of satisfaction and reward rather than frustration and tension. Buckingham and Coffman (1999), describing research carried out by the Gallup organisation into Managers’ opinions, report that one shared insight stood out:-

“People don’t change that much.

“Don’t waste time trying to put in what was left out.

Try to draw out what was left in.

That is hard enough” (op. cit, p.63).

To employees they say:

*“You succeed by finding ways to capitalise on who you are,
not by trying to fix who you aren’t” (ibid, p.184).*

In a later book Buckingham and Clifton (2005), addressing managers (or mentors), advise that *“You should focus your training time and money on educating him about his strengths and figuring out ways to build on these strengths”* (op. cit, p.222).

The “boss” in the section above was probably looking for an employee with certain skills and knowledge. Conceptually, these skills and knowledge would be seen to have been acquired as a result of having intelligence as measured by IQ. Now that it is generally understood that measures of IQ are unable to fully explain performance outcomes, Emotional Intelligence (EI) in particular (Goleman 2004), and the related Social Intelligence (SI, Goleman 2006) are now not only recognised as important elements in a person’s make up but are much more powerful determinants of success and performance in many areas. According to Goleman

(2004, pp ix-xiv, 34), for almost any job working with people in teams or groups, or working with people as customers, clients, patients, etc., emotional intelligence may be more crucial than technical expertise or knowledge in achieving success. EI represents a collection of attributes of the person that makes it of enormous importance for survival, growth, fulfilment and success in modern civilisation. Definitions are still debated and in this discussion EI is taken to explore, in the words of Terrell and Hughes

...how human beings apply their subjective, non-cognitive behavioural skills to successfully manage and improve their relationships and life conditions (Terrell and Hughes 2008 p.6).

It is put more succinctly by Goleman (2003, p 6) as "*How leaders [people] handle themselves and their relationships*". He also suggests that "*we might think of Social Intelligence as a shorthand term for being intelligent not just about relationships but also in them.*" (Goleman 2006, p 11) and devotes a book on leadership in large measure to the application of emotional and social intelligences (Goleman 2004). Whilst it is acknowledged that the rigour applied by Gardner in defining his intelligences, (see Appendix 7), participants on the Faculty Mentoring course report finding an understanding of Social and Emotional Intelligences particularly illuminating and helpful.

Fully Functioning in Community

I have discussed the way the four dimensions of the whole person work together to produce the response of a whole person to situations and events. I have illustrated the types of role the four dimensions fill – integrating with each other in multiple ways in the process. At its best, this results in the person – in whatever role they are functioning in the moment - being fully engaged and absorbed in what they are doing: - Csikszentmihalyi's "flow" (Csikszentmihalyi, M. 2002). The person who is thus fully integrated, so that what they say (body) is in harmony with what they think (mind), and embraced with something between acceptance and passion in their feelings (heart) and, above all, who expresses their deeply held values and beliefs (spirit), which move them meaningfully in the direction of achieving their vision of how life at its best should be lived at this moment: such a person is regarded in person-centred language as *congruent* in the relationship. This, apart from being a desirable state for anybody at any time in any place, embodies the state of mind ideally sought by the therapist, mentor or coach in the helping encounter: a state of wholeness: a sense in the moment of being a whole person. This concept inspires the motivations of the

Mentoring Development Team at the Faculty of General Dental Practice (UK) and is what the mentoring project sets out to facilitate in mentees: an educational programme with a deep learning objective. The person, thus fully engaged in their life, was described by Rogers as the “*Fully Functioning Person*” (Rogers 2004/1967 p.184)⁹³.

An Holistic View of the Whole Person

The title, which sounds tautological, targets a fundamental issue already hinted at earlier (p.60). That is the need to consider not only the person herself, but the environment, - physical, intellectual, emotional and (above all) spiritual - in which she is situated and obliged to function. This is reminiscent of Vygotsky’s focus on the social/cultural/historical influence on learning and development (Wink & Putney 2002 p.62).

MacIntyre, in the famous, and somewhat gloomy, closing paragraph of his book *After Virtue* saw some parallels between the decline of the Roman Empire and the state of our own civilisation some 30 years ago. He asserted:

What matters at this stage is the construction of local forms of community within which civility and the intellectual and moral life can be sustained through the new dark ages which are already upon us (MacIntyre 2007 p.263).

This view echoes the words of Tillich writing some 3 decades earlier:

Twentieth-century man has lost a meaningful world and a self which lives in meanings out of a spiritual centre. The man-created world of objects has drawn into itself him who created it and who now loses his subjectivity in it. He has sacrificed himself to his own productions (Tillich 1952 p.132-3).

In this it is possible to see that Tillich expresses the dysfunction described in chapter 1.2 above and the deep ontological uncertainty that arises from such losses. Yet Tillich finds room for hope:

But man still is aware of what he has lost or is continuously losing. He is still man enough to experience his dehumanisation as despair. He does not know a way out but he tries to save his humanity by expressing the situation as without ‘exit’. He reacts with the courage of despair, the courage to take his despair upon himself and to resist the radical threat of non-being by the courage to be as oneself (ibid).

Frankl, speaking out of his experience in concentration camps, in a passage entitled “*The Will to Meaning*”, responds with the words: “*Man, however, is able to live and even to die for*

⁹³ Discussed further in chapter 2.4 pp.98-199.

his ideals and values" (Frankl 1959 p.105) and is capable of "saying yes to life in spite of everything" (ibid p.139); echoing Tillich's "Courage is self-affirmation 'in spite of', namely in spite of non-being" (Tillich 1952 p.62).

Viewing the Whole Person, holistically, therefore, requires that we take into account the ontological uncertainty and the existential perplexity of our time, for only thus do we acknowledge and validate the context of the Whole Person's existential being. The Whole Person is not an island (to borrow from John Donne) and the uncertain intellectual and spiritual climate which we inhabit is the *milieu* in which we must seek to express ourselves as persons and within which we strive for our own actualisation as fully functioning persons. For that reason, a significant part of this thesis is devoted to considering this *milieu*, in an effort to present some moral grounding derived from our emerging understanding of our universe, our world and our own evolution.

An important implication of the holistic view of the person presented in this chapter is found in its significance for the existential approach. In the positivist view of reality where only empirical evidence counts, the spiritual and the affective dimensions are discounted and the view of humankind is two-dimensional only. In this – wholly inadequate, indeed *dehumanising* - view of *Homo sapiens*, where a two-dimensional shadow is substituted for the whole, four-dimensional, human being, the derivative existentialist and humanistic approaches are themselves wholly inadequate. They have been founded on an inadequate, restricted view of what it is to be human; a human who has been sucked dry of affect and meaning; a model of the human that is but a shadow of the whole person. The result is a view of existence that denies (what might be regarded as) the most significant and advanced components of human experience and, therefore, the key indicators of what it means to *be* human.

The holistic multi-dimensional view of humankind has, however, the potential to transform our perception of reality and its meaning. The multidimensional view of *Homo sapiens* opens the way to a multidimensional view of the universe. A fuller humanity leads to a fuller – and more satisfactory - humanism⁹⁴. A more rounded view of human existence leads to a more holistic, more complete, existentialism on the grounds, as Teilhard de Chardin has shown, that *Homo sapiens* exists as an emergent product of the – only apparently, as he recognised (Teilhard de Chardin 1959 pp.290-1) – inert inorganic realm. This recognition provides the opportunity to find a resting place in "Man's Search for Meaning" (Frankl 1959).

In Search of Meaning.

In this chapter I have presented some strands of contemporary thought that converge on the focus and care of the individual person – the *I-Thou* relationship - whether that relationship be with a patient, a colleague, a staff member, a student, or a mentee. The person-centred approach pioneered by Carl Rogers reflects a shift in thinking which may, in time, come to be regarded as the beginning of the era in which the central importance and value of persons is recognised. Whilst larger issues in the world may seem to be remote from dental practices, the culture change that is under way must inevitably involve – and may be assisted by - dentists and our teams. To the extent that we achieve the fully engaged state we may find that not only we, but also our patients, are helped in our collective and personal quests for, and discovery of, the *Good Life* (Csikszentmihalyi 1997 pp.1-5).

Underlying these issues, however, there remains the challenge to update our worldview in the light of the contemporary understanding of the emergence of humanity in the universe (to which I return below). This, it is proposed, offers hope of re-establishing a sense of meaning and its offshoot, a sense of moral direction – the most pressing task for humankind - “...*this striving to find meaning in one's life is the primary motivational force in man*” (Frankl 1959 p.104). Such a grounding can underpin the concept of the *Good Life*, and enable professionals, as whole persons seeking to live a moral life with due commitment to appropriate ethical norms, to rediscover their sense of vocation. Professionals making such a rediscovery, may be enabled to discover once more their *Voice* (Covey 2006 pp 3-10) and learn to articulate persuasively, and with the power that only comes from a strong moral commitment, the way of being together in community which rates moral worth, human values and, above all, the whole person, ahead of dehumanising, exploitative, impersonal, narcissistic and oppressive social, managerial and bureaucratic forces.

Emergent Ontological and Epistemological Perspectives

At this stage it is necessary to clarify assumptions that I am making about the nature of our reality in the context of our 21st century cosmology. Here I will set out what must be a very simplistic account of the ontological and epistemological assumptions underlying this thesis. Drawing on Teilhard de Chardin (1959/55) I highlight two perspectives on our experience of our world – *Inner* and *Outer*, regarding what Teilhard refers to as the *Within* and the *Without* of things.

The *Outer* perspective describes much of what happens and may be observed in the world of affairs, from getting up in the morning and taking the children to school, to politics,

⁹⁴ This line of thought is developed further in Chapter 3.6.

business and the activities in science and technology: all those things that can be seen, described and measured in time and space. Above all it dominates empirical science. The great achievements of the scientific method with its ability to classify phenomena and things – an inductive approach pioneered by Aristotle – has enabled *Homo sapiens* to understand “how things work” and thence to learn to manipulate things both in the living and the inanimate worlds. This approach of empirical science has revolutionised human life in the developed world and has dominated our thinking about “how things are” if only because of its obvious success and power in enabling us to control (at least some of) the things around us. This approach can even be used – up to a point – to describe observed human behaviours. The *Outer* is a third person perspective. It may also be called “objective”.

By contrast, the *Inner* perspective is essentially private, first person and ‘subjective’. To the extent that it experiences consciousness – and we are usually thinking of specimens of the species *Homo sapiens* in discussing this – the organism experiences an *Inner* world. This *Inner* experiencing world is not directly accessible to any other organism or person. My experience is not directly accessible to the other, nor the other’s to me. I may choose to relay it to you via verbal signals, gestures or other sounds and you may be able to gain some understanding by reading my body language or by empathic understanding. However, for you, there is always only that third person perspective. I cannot have access to the immediacy of your *Inner* personal experience, nor you to mine. Yet, for each of us, that *Inner* experience is the most real: the most intimate core of our life-awareness. Whatever happens around us in the *Outer* world only becomes “known” to us as it enters our own *Inner* experiencing world.

The *Inner* and *Outer* are two perspectives on a single integral reality: a non-dual universe⁹⁵.

From the world of empirical science, has come the recognition of *emergent* processes at work in the universe over aeons of time from the moment of the “big bang”. At each stage in the process a step in increasing organisation, coalescence (unity) and complexity is achieved. Each stage is complete in itself – a *holon* - leading to the concept of hierarchies of *holons* - “*holarchies*” - which may be exemplified by a sequence such as: --- sub-atomic particles: atoms: molecules: --- etc. (Wilber 2000 pp. 41-7, 66-8). The key recognition, famously articulated by Teilhard de Chardin (1959/55) describing his work in palaeontology and anthropology (for the emergent process is seen very clearly in biology), came from his recognition that, for the phenomena that we recognise as *mind*, *consciousness* and *spirit* –

⁹⁵ For a lucid exposition of the Integral approach see McIntosh (2007).

all a part of the *Inner* experience above – to emerge in the later stages of evolution, there must be an *inwardness* to all things which Teilhard recognises as a tendency to unite - “*the affinity of being with being*” – what in the context of personhood is recognised as

“*love...a general property of all life and as such...embraces in its varieties and degrees, all the forms successively adopted by organised matter...If there was no internal propensity to unite, even at a prodigiously rudimentary level – indeed in the molecule itself – it would be physically impossible for love to appear higher up, with us, in ‘hominised’ form...[T]o be certain of its presence in ourselves, we should assume its presence at least in inchoate form, in everything that is*” (op.cit.p.290).

This led Teilhard to conceive the universe as “*an irreversibly personalising universe*”. There is an *inwardness and an outwardness* to all things. It is only in the most recent life forms, and specifically, the species *Homo sapiens* that the *inwardness* emerges with fuller expression and it is interpreted as the fullest (to date) manifestation of the *formative tendency* recognised to be at work in the universe.

If this emergent process is interpreted as humankind being the lead shoot producing the actualisation or *flowering* of the personalising universe in the *human spirit*, (for we often define a plant by its flower) it is but a small step to the recognition of *Homo sapiens* as holding a key to our understanding of the *telos* of the universe as a whole⁹⁶. Not only may the emergence of these properties or qualities of *spirit* in the species be seen as defining *Homo sapiens*: the qualities that emerge in the movements of the human spirit are what *define* humankind and therefore point to the *essence* of man and woman. They also define the direction that has been followed in the emergent processes at work in the universe which direction points forward in the guise of promoting *human flourishing*. This brings us full circle to the thought of Aristotle’s teacher, Plato, with his focus on the essences: *of transcendence - something that surpasses empirical reality* (Tillich 1968 p.6). Whilst the differing emphases of Plato and Aristotle have been debated for over two millennia, and could now be reconsidered in the light of a completely different – non-dual - cosmology from that pertaining in their lifetimes, it would appear that, as in any genuine dialogue, there is something to be valued from both sides. We can learn most about our selves and our universe by surveying it from above - top down - like Plato, as well as by viewing it inductively and empirically, bottom-upwards with Aristotle (ibid pp.110-11).

The outcomes for this thesis arising from taking this *emergent, Integral* (McIntosh 2007) view of a *personalising universe* are threefold: First it draws attention to the complexity of the

⁹⁶ I use the word *telos* here in its Greek meaning as “end”, preferring to avoid “purpose” as misleadingly anthropomorphic, and thinking more in terms of the “*end towards which the formative tendency appears to tend*”.

human make-up, underpinning the need to think with Teilhard of the person as a *Whole* or as he puts it in his preface emphasising that his study is of "*man solely as a phenomenon*", but also "*the whole phenomenon of man*" (Teilhard de Chardin 1959/55 p.31: original emphasis). Second it highlights the preciousness and value of the person, and therefore of human life and flourishing. Third, and as a consequence of the second, it offers an approach to ethics (Chapter 3.7) based on the valuing of personal qualities on the one hand, and on what, on the other hand, might be seen as an *existential imperative* – perhaps even an Archimedean point (Williams 1993 p.32) - emerging from a recognition of the challenges apparent for our species in seeking to ensure the survival of our planet. Addressing these person-centred issues further is the task for part 3 (chapters 3.6 – 3.9) of this dissertation.

In this chapter, I have sought to give expression to the fullness of the whole person by presenting a view of the person functioning as a whole, integrating four functional dimensions: essentially social in nature and so fully functioning in community; in whom health may be seen as optimising function in an holistic manner as described by positive psychology.

Not least I have drawn attention to the need to develop a sense of meaning; a sense of transcendence; of being part of something larger than ourselves with a contribution to make that lifts us beyond the limitations of our own finitude. In seeking that, we need to reflect on the nature of our consciousness and the reality of which we are a part as increasingly revealed by contemporary thinking, whilst looking beyond the limitations of the empirical approach alone for understanding the multifaceted nature of human personhood and that which "...can become a matter of ultimate concern for us" (Tillich 1953 p.15).

Whilst I have drawn on the broad brush-strokes of Teilhard de Chardin in his deep consideration of the unique position of *Homo sapiens* in the emergence of our planet, I have also drawn attention to the thought of Martin Buber whose seminal work "*I and Thou*" gives profound insight to the nature of relations between persons. In contrast to the purity and mystical nature of Buber's work is the practical application of Buber's insights to relations between persons in the therapeutic, educational, and other contexts by his friend Carl Rogers: an exemplary juxtaposition of pure knowledge and applied science. The relatively small contribution made by Rogers in this chapter provides a bridge from a theoretical perspective to the practical application of his person-centred approach developed more than 60 years ago in both counselling and education (Rogers & Coulson 1969) which now dominates chapters 2.4 and 2.5.

Chapter 2.4

The Person-Centred Approach

Introduction: Two Approaches to Mentoring

– Different “*Ways of Being*”

It is essential to be quite clear about the approach to mentoring under consideration. It reflects a whole philosophy, an ontological perspective, a social orientation, a valuing of persons, an approach to adult learning and, for the mentor – preferably also for the dental professional being mentored – a whole personal orientation or “*way of being*”. This is likely to influence the orientation of the professional *vis à vis* society in general and patients, colleagues and students in particular. The choice of approach has a fundamental impact on every aspect of the preparation given to future mentors.

The two frequently encountered approaches to mentoring are summarised in Fig 2.4.1. It would be misrepresenting mentoring if the two approaches outlined below were simply described as two alternative techniques. The first, traditional, approach reflects the hierarchical, authoritarian, paternalistic, directive approach to working, professional and educational relationships (see Chapter 1.2): an approach that may have some application in a close supervisory situation where, surgical skills (for example) are being taught (and therefore not strictly a mentoring relationship) but an approach that is not considered helpful when (as is likely as a matter of habit) it is projected into the professional-patient relationship much of the time. By contrast the PCA lends itself to a more egalitarian, more respectful, empathic, holistic, caring and facilitative approach to others. As such it is the approach adopted in the Faculty mentoring project – a *way of being* that is consistent with the needs of patients and the emerging values of the 21st century.

It is from the concept of *different ways of being* that the theoretical *positioning* for the study emerges. It is necessary to consider and articulate the specific relationships achieved in this approach to mentoring. Feedback from participants in the faculty mentoring course indicates that this has a significant influence on the nature and depth of the learning achieved by each participant in the mentoring experience (mentor and mentee).

Throughout my thesis I articulate, and discuss, the change in worldview - or *paradigm shift* - implicit in this shift from “Authoritarian - Directive” to “Person-Centred - Facilitative” practice. I observe that this change may be seen as reflecting other fundamental changes in society at large.

a. “Trusted Adviser and Friend”

- Gives advice;
- Tells the mentee what to do;
- Usually directive / prescriptive;
- Experienced:
- The “Expert”.

Historical origin in Greek mythology, the story of Odysseus and his son Telemachus and the appointment by Odysseus of a respected courtier (Mentor, actually the goddess Athena in disguise) as a trusted adviser and friend to prepare Telemachus for kingship whilst Odysseus was absent (Herman & Mandell 2004, p.10).

b. Person-Centred Approach (PCA) - “Ask: Don’t Tell”

- Mentor’s mantra: “Ask: Don’t Tell”
- Mentee is the expert (on their own self). Mentor facilitates;
- Focus on mentee’s Potential and Resources;
- Accompanies mentee on their “journey”;
- Respect and Empathy toward mentee.

Historical origin Carl Rogers’ (1902-1987) development of (what later became known as) the “Person-Centred Approach” in counselling initially (Rogers 1995), though he was quick to recognise that the approach was applicable in education, business, the family and other contexts including group work. The philosopher Martin Buber was a significant influence (as a friend) on Rogers’ thinking and his influence has remained apparent in the approach to this day (Buber 1959). Levinas (1996) has built on Buber’s thinking with his consideration of the “other”.

Fig 2.4.1. Two Approaches to Mentoring.

Mentoring or Coaching?

Within the PCA, the difference between mentoring and coaching (which still seems important to some) becomes relatively insignificant. Moving away from the traditional managerial model of coaching towards the PCA reduces the differences to the point where the mentor may feel that she is at different times performing each of the functions. Connor and Pokora (2007) discuss the distinction and report that some suggest that coaching tends to focus on specific short-term issues (pp.11-14), though when delivering their training course, they observe that it often seems that when the course is paid for by the NHS it is called "mentoring" and when it is paid for by a commercial company it is called "coaching".

One author succinctly sums up the difference in the words

"Coaching is about your job; mentoring is about your career"

(Harvard Business Essentials 2004 p.78).

Gallwey in "*The Inner Game of Tennis*" (1974) presents a very succinct approach which is meaningful in the mentoring situation especially if the execution of clinical tasks by the dentists is viewed as "*performance*". Within the context of dental practice, I find the separation of the two aspects seems rather artificial. I do not pursue this debate further as it appears to have no practical consequence.

The Emergence of the Person-Centred Approach

The intellectual and clinical background to the emergence of the PCA was the practice of psychotherapy and psychiatric social work in the 19th and early part of the 20th centuries. The structure of society was hierarchical, authoritarian and paternalistic. The authoritarian structure was evident in schools; the authority of the church carried weight not only socially but intellectually. Professionals such as doctors were experts in their own field. The patients were categorised according to their *illness* and the doctors, no matter how considerate or benign, treated them according to the wisdom of the day in respect of the *diagnosis* (the *medical model*). In schools, pupils were treated as empty vessels to be filled with knowledge by the teacher - the "*deficiency mode*" (Mearns & Thorne 2000 p.33). In education, thinkers like John Dewey (Dewey 1956/1902) were articulating a different approach – the beginnings of the changes to take place - but they were yet to make impact. Many dentists in practice today, therefore, were taught in a didactic deficiency mode. It is understandable that their default position when in an educational role (whether with colleagues or patients) should be modelled on the example of their own teachers.

The Person-Centred Approach (PCA) was developed by a Psychotherapist, Carl Rogers (1902 – 1987), trained (in Chicago) in the then current approach to therapy using the medical model in a world dominated by Freud, Jung and Adler where he (Rogers) was the *expert* analysing, diagnosing, prescribing and treating the patient. Having entered practice in 1926 Rogers describes an encounter in the early 1930s where he realised that this whole *directive* approach was not working: that the person in the room (the mother of the *difficult* child patient) who was the *expert* (on her own problems) was the *patient* and that, furthermore, she, the patient, had within her the resources she needed to deal with those problems (Rogers 1995/1980 pp 36-7). From this experience, and others similar, emerged Rogers' *non-directive* approach, supported by extensive research and published papers. By 1951 Rogers was describing this approach as *Client-Centred Therapy* (Rogers 2003/1951) to stress the egalitarian nature of the relationship. No longer was the *patient* the passive recipient of the *expert's treatment*. Now the client was the *expert*, and the therapist was facilitating: partners together in the process. As time went by, Rogers realised that the approach was applicable in many areas beyond the counselling room. In a paper presented in Hawaii in 1972 he observed that

“[The] philosophy of interpersonal relations that I have helped to formulate, and which is contained in this paper, is applicable to all situations involving persons. I believe it is applicable to therapy, to marriage, to parent and child, to teacher and student, to persons with high status and those with low status, to persons of one race relating to persons of another. I am even brash enough to believe it could be effective in situations now dominated by the exercise of raw power – in politics, for example, especially in our dealings with other nations” (“My philosophy of Interpersonal Relationships” in Rogers 1995/1980 p.45).

I take that statement as validation of the adoption of this approach in professional practice and, specifically in mentoring.

From the 1960s onwards, Rogers reduced his clinical commitment and increasingly sought to work in areas such as education, with groups. In the years leading up to his death he did, in fact, take his work into the international political arena

His book “*Freedom to Learn*” (Rogers & Coulson 1969) clearly articulates his application of the approach in education – a significant influence in the emergence of the *Learner-Centred* approach – picking up where Dewey (Dewey 1956/1902) and others had left off earlier. I reported Rogers' friendship with the existentialist philosopher Martin Buber and his “*I-Thou*” (Buber 1959/37; Buber 1961/47) above (Chapter 2.3 p.71). Whilst Rogers moved away from psychotherapy, many co-workers continued his work in this field and much of the published

work on the PCA comes from the field of counselling and psychotherapy. For that reason, many references given include counselling and/or psychotherapy in their titles. In what follows, I relate the key principles of the PCA to mentoring in dentistry before extending the discussion to its broader application to the practice of dentistry in general and the development of an holistic and person-centred model for professional practice which may be used to support and promote professional growth and development.

Five Key Concepts in the Person-Centred Approach to Mentoring

The first three of the five key concepts discussed – “The Actualising Tendency”; “The Mentee is Resourceful”; “The Whole Person” - may all be seen as assumptions underlying the PCA. These assumptions apply to persons in general and specifically, in this context, to the mentee and the mentor. The remaining two key concepts – “BE-ing: not DO-ing” and “Ask: Don’t Tell” – refer to the manner in which the mentor works with the mentee.

The Actualising Tendency

The *actualising tendency* is one of two foundation blocks of the PCA recognised by Rogers. It is a characteristic – and the sole motivational force (Mearns & Thorne 2007 p.28) - of all living things. The second foundation block is the *formative tendency* seen in the universe as a whole (Rogers 1995/1980 p.114). The former, I suggest, may be conceived as the flowering of the latter in an emergent universe. (McGrath 2011 p.230-1 Wilber 2000/1995 p.xiv)

Writing of the actualising tendency, Rogers says.

“The organism has one basic tendency and striving – to actualize, maintain, and enhance the experiencing organism...We are speaking of the tendency of the organism to move in the direction of maturation, as maturation is defined for each species...This involves self-actualization... A directional term... The organism actualizes itself in the greater differentiation of organs and of function...growth... reproduction...greater independence or self-responsibility...in the direction of ... an increasing self-government ...self-regulation, and autonomy, and away from heteronymous (sic) control or control by external forces. Finally, the self-actualization of the organism appears to be in the direction of socialization, broadly defined”
 (Rogers 1951 p.487).

Parts of this passage from Rogers causes some mentoring course participants concern as Rogers seems to be suggesting an approach that is “*based on individualism... egocentric and egotistical*” (as addressed by Mearns & Thorne 2000 p.80). It is helpful to remember the therapeutic context (“*Client-Centred Therapy*”) in which Rogers was writing where many patients were seen as labouring under the burden of introjected values from significant others in their early lives, *conditions of worth* (Cooper et al.2007 p.11) which imposed *heteronomous control* and impaired their ability to take healthy control of their own lives (and which few of us, if any, may be fortunate enough to avoid altogether). Rogers was not advocating a narcissistic free-for-all. The balance is provided by the last sentence of the citation where Rogers observes the tendency for “*self-actualization... to be in the direction of socialization*”. Indeed, it has been interesting to observe the changes in dentists’ lives ensuing from our participation in the mentoring programme. Data have been collected (with participants’ permission on a signed consent form) in several ways. Sources useful for this discussion were the two assignments prepared by course delegates: one consisting of reflective case studies, and one a reflective essay on an agreed topic. The majority of assignments express pleasure and a sense of reward when they perceive the effectiveness of their work with mentees, helping them to discover their own way through difficulties and challenges. In addition to applying their mentoring skills in their work and home environments, more than 10%, far from becoming self-centred and narcissistic, have changed their careers in the direction of deeper social engagement: supporting colleagues in educational roles (including mentoring) supporting “*practitioners in difficulty*”, or taking on roles in support of practices preparing for inspections by external bodies such as the Care Quality Commission, or serving as advisers to Primary Care Trusts. Their post-course feedback often includes the term ‘*life-changing*’. These colleagues illustrate “*the urge towards creativity, learning, and the enhancement of the person*” and the tendency “*to grow and develop as a unified whole towards greater maturity and higher levels of functioning* [and]... *to develop in a way that makes best use of all [their] potential*” (Merry 2002 p.21). Addressing the above concern about the actualising tendency, Mearns & Thorne stress that

“*the actualising tendency is not ‘good’ or ‘bad’ – it is an amoral concept... a basic biological concept – a ‘growth tendency’ similar to that which is embodied in many living entities but also distinctive in that it carries the potential for social expression. It is a fundamental drive within us to make the most we can of our living process and much of that living process is social in nature*” (Mearns & Thorne 2000 pp.181-2: original emphasis).

It is easy to reify the concept of “*actualisation*” which has led some authors to prefer speaking of the “*tendency to actualise*”, so helping to avoid the mistake of conceiving of

“actualisation” as a desirable or achieved end-state (Embleton Tudor et al. 2004 p.27).

“*There is no such thing as an ‘actualized’ person. Actualization is a process, not an outcome*” (Bohart in Cooper et al. 2007, p.54).

The Mentee is Resourceful

This second key concept was given expression by Rogers from his observations over many years of the response of clients to the creation of appropriate conditions (see below) for growth, development and (in therapy) healing.

“Individuals have within themselves vast resources for self-understanding and for altering their self-concepts, basic attitudes, and self-directed behaviour; these resources can be tapped if a climate of facilitative psychological attitudes can be provided” (Rogers 1995/1980 p.115).

From this recognition, Rogers came to stress that the client could be trusted to have the necessary resources for growth or healing. Kirschenbaum and Henderson state:

“Practice, theory and research make it clear that the person-centred approach is built on a basic trust in the person” (Kirschenbaum & Henderson 1990 p.136).

This observation had revolutionary consequences in helping for it turned the client/therapist relationship on its head. Now the client was the expert in the relationship. Only the client knew what was right or what was best for them. Now the therapist’s role was to accompany the client on their journey of self-discovery, growth and healing. The medical model – with the therapist *expert* making a *diagnosis* and prescribing *treatment* recommended for the *illness* of that recognised diagnostic group of *patients* – was no longer appropriate. The focus was now on the uniqueness of the individual. This is a hard lesson for dentists to learn. The power issues are analogous to those described in Chapter 1.2 as existing in medicine and surgery. For professionals such as dentists accustomed to being the *expert*, losing our expert status – and *being in control* – is often uncomfortable. The natural instinct of a caring professional is to want to *help* the mentee – to *do* something. The same temptation faces the practitioner who becomes involved in postgraduate education. This second key concept, firmly states the case for the “*potentiality*”, rather than the “*deficiency*” model, in supporting learning. To the dentist who is used to being “*the one who knows*”, “*the expert*” and “*giving advice*”, being asked, as the mentor, to believe in the resourcefulness of the mentee demands a significant reorientation. Dentists are adept at making a quick diagnosis, spotting the problem and offering the solution. In the PCA mentoring relationship, that mindset is discarded in favour of attention to the mentee’s perception of their own needs, concerns, resources, strengths and preferences. The challenge, it would seem, with the assumption that “*the mentee is resourceful*” is, for the mentor, to learn to trust it and to believe in the

importance of the mentee developing their internal *locus of control*. Some course participants have even objected to this change in orientation at the beginning. However, the concept is introduced early in the course, before the first of a series of “*skills practice*” sessions. It has been striking how rapidly course participants change their thinking. The reason appears to relate to our own experiences when, in the practice session, we take on the role of mentee considering some genuine “*issue*” that we have been asked to present to our “mentor” in the sessions. The discovery of the power of our (albeit novice) mentor’s questioning provokes a radical reassessment because, at that moment, we discover that we are resourceful in the role of mentee. Two comments made in course feedback sessions: “*Nobody’s ever listened to me like that before*”; and “*I’ve never been asked questions like that before*”; exemplify this moment of discovery.

The Whole Person

This third key concept is of paramount importance and has been discussed at length in Chapter 2.3. Whether the discussion refers to the mentor, the mentee, a student, client, patient, team member or colleague, the holistic view of the person is assumed throughout my thesis.

BE-ing: not DO-ing

At the beginning of this study, I imagined I was looking for the most effective interventions (questions) to facilitate desirable change in our mentees, thus betraying my own habitual resort to the technique-based, formulaic approach to problem-solving typical of dentists. As I explored the qualities, behaviours and attitudes that PCA authors discussed in the helping relationship, I realised that Rogers had long ago answered my question. Taken together, Rogers’ approach was not based on a formula or any particular *magic bullet*. Rather it was built on a particular type of relating with the mentee which is summed up best in one of Rogers’ titles – a particular *Way of Being* (Rogers C 1995/1980). It is this way of being that enables the mentor to create the “*climate of facilitative psychological attitudes*” cited above (ibid p.115). The answer to my question was not about what we DO but about the way we ARE with our mentees and has become the fourth key concept I describe. Rogers described this famously in his statement of the *six necessary and sufficient conditions* for growth, development and change⁹⁷ (Fig. 2.4.2).

⁹⁷ Convention adopted with quotations from the literature on the person-centred approach and mentoring, throughout this thesis: most such sources are from the field of therapy or counselling which is where the impetus has existed to promote research and debate. Since the approach is the same for all “helping”: practices (mentoring, coaching and counselling) using the PCA I substitute words such as “client” by [mentee] and words such as “therapist” by [mentor], unless my own context refers to counselling or therapy. In a similar manner I substitute words such as “therapy” and “coaching” by “helping” or “mentoring”.

“Six Necessary and Sufficient Conditions”
for Growth, Development and Change.

The role of the PCA mentor, practitioner educator or facilitator is to provide favourable conditions for growth, development, change, etc. Rogers published a theoretical statement (Rogers 1957) in which he set out “*Six necessary and sufficient conditions for...change*”. Of these, although all six are considered important, “*three core conditions*” have received

1. *Two persons are in psychological contact.*
2. *The first – the client – is in a state of incongruence.*
3. The second – the counsellor – is **congruent** or integrated in the relationship.
4. *The counsellor experiences **unconditional positive** regard in the relationship.*
5. *The counsellor experiences an **empathic understanding** of the client’s internal frame of reference and endeavours to communicate this experience to the client.*
6. *The communication to the client of the counsellor’s empathic understanding and positive regard is to a minimal degree achieved.*

(Rogers 1957).

Fig. 2.4.2

Six Necessary and Sufficient Conditions.

the most attention and discussion in the PCA literature (though there has also recently been more emphasis on condition 6). I now briefly review all six conditions for mentors before further discussing the three core conditions.

1. *Two persons are in psychological contact.*

This condition might seem more relevant in psychotherapy where, in an extreme case, there may be no psychological contact between the client and the counsellor⁹⁸. Without psychological contact no progress can be made. In the developmental situation of mentoring, there is likely to be some contact – even though it be expressed as reluctance by a mentee who has been ordered to seek remedial mentoring because of a performance problem.

⁹⁸ See Mearns & Cooper 2005 pp38-112 for an insightful account of a patient where ‘contact’ seemed not to be present initially.

2. *The first – the mentee – is in a state of incongruence. [discrepancy or need]*

Whilst “distress” might characterise the neediness of a client presenting for counselling, in mentoring the incongruence or neediness may range from difficulties in managing staff relationships in the practice to the high performer who wishes to consider the best way to progress their professional development to the next stage. The “discrepancy” is between where they are now and the direction in which they wish to develop or grow.

3. *The second – the mentor – is congruent or integrated*

This condition expresses the mentor’s state – an integrated state of “genuineness” or “realness” *in the relationship*: fully present for the mentee in the here and now: a core condition discussed below.

4. *The mentor experiences unconditional positive regard in the relationship.*

Again this condition is about the counsellor’s experience *in the relationship*: a core condition: see below.

5. *The mentor experiences an empathic understanding of the client’s internal frame of reference and endeavours to communicate this experience to the client: a core condition: see below.*

6. *The communication to the client of the mentor’s empathic understanding and positive regard is to a minimal degree achieved.*

Some contemporary authors suggest that this condition has been under-stated. The perception of being empathically understood – even to a minimal degree - appears to be a powerful force for change in the mentee. Merry (2002) states that

“[I]t will be noted that the core conditions must be perceived by the [mentee], and it follows that the [mentor’s] experience of them must be expressed” (Op cit p.54).

Embleton Tudor et al.(2004) point out that Rogers referred to this as the “assumed condition” (op. cit. p.45). Rogers himself, (writing in 1958) in discussing this condition, states:

“[T]he [mentee] perceives himself as being fully received ...he senses that he is psychologically received, just as he is, by the [mentor]. There is implied in this term the concept of being understood, empathically, and the concept of acceptance. It is also well to point out that it is the [mentee’s] experience of this condition which makes it optimal, not merely the experience of it in the [mentor].

In all that I shall say, then, about the process of change, I shall assume as a constant an optimal and maximum condition of being received" (Rogers 2004/1961 pp.130-1).

For the mentor, reflecting back feelings to the mentee as part of the mentor's empathic response in the conversation serves to communicate to the mentee the sense of being received.

The Three Core Conditions in Mentoring.

There is an extensive literature on these core conditions. They represent an interesting change of mindset for the practising clinician. Bozarth (1998) suggests that the three core conditions are but three aspects of the same condition. It is, nevertheless, helpful to discuss the three aspects separately.

Congruence.

For a typical dentist, working to a tight appointment schedule, focussing on diagnosing and treating clinical problems or executing treatments against the clock, to be fully congruent in the mentoring relationship (without one eye on the clock, or a part of the mind distracted by preoccupation with the next task for the day) represents a significant challenge. Mentoring sessions planned in advance, in an appropriate place for comfort, privacy, with protected time and no fear of interruption, are much easier to manage. As new mentors, especially, we need to cultivate a strategy in which we give ourselves time to focus, not only on our mentee, but on our own inner preoccupations, thoughts and feelings as we prepare for the session. It is these latter that are the focus of the term *congruence* for it is essential that we bring our whole self awarely into the encounter: that we be "*dependably real*" (Rogers 2004/1961 p.50), "*without front or façade*" (op.cit.p.61), and fully present for our mentee. Extraneous, irrelevant matters need to be set aside and any feelings or concerns relating to the person we are mentoring held in awareness and used openly and honestly to inform our own conduct and contributions in the session. Such feelings, for example, may be present if my mentee is a practitioner "*in difficulty*" who has been referred for "*remedial support*" and it is important to be honest with myself about the presence of those feelings. The immediate reaction on reading these remarks is that this is an impossible demand for we are all but human...etc. However, even Rogers made it clear that his own writing in this vein was "*to describe the way I would like to be*" (ibid pp.50-1). Cornelius-White, in a helpful chapter, drawing on Rogers, discusses congruence in terms of matching between *experience at gut level, awareness, and communication* (with the mentee), linking these aspects with *organismic integration, presence and interconnectedness* (Cooper et al.2007 pp.168-9). The evidence is that, though I may fall short, my mentee is capable of discerning the honest

attempt and this is sufficient. It seems to be important that I “*be sensitively aware of and acceptant toward my own feelings*” for it is then likely “*that I can form a helping relationship toward another*” (Rogers 2004/1961 p.51).

Unconditional Positive Regard (UPR).

By contrast with congruence which is about the mentor’s internal state – how I relate to my self – unconditional positive regard, sometimes referred to as *acceptance* or *respect* – is about how I relate with my mentee: an attitude on my part as mentor, of respect, valuing and prizing the person, *trusting* the mentee’s resources in dealing with their own issues and growth. UPR is *not* about “*approving of*” everything the mentee says, does, or has done. Rather, UPR expresses my belief that my mentee – and *only* my mentee - has the resources and the capacity to work through the issue under consideration. My role as mentor is to help them discover, choose and pursue their own options, resources, solutions and strategies.

This is a mindset that is a complete reversal of the typical relationship a dentist has traditionally cultivated with a patient. It is therefore remarkable – and very gratifying – that mentoring course delegates so quickly embrace this different *way of being* with their mentees. (This also raises a question about whether there is a better *way of being* with my patient to which I return later.)

Empathy

It follows from the unconditional positive regard in which I hold my mentee that I must be acutely attentive to all the signals available from them conveying clues about their inner world – thoughts, feelings, values and beliefs. This attentiveness to the mentee’s inner world is expressed in the core condition of empathy. Empathy – a perceptive understanding of my mentee’s world from their internal reference: a sensing of my mentee’s own perspective, is not just about hearing the spoken word: more about picking up non-verbal signals which may, of course, conflict with the spoken message. Empathic understanding comprises a powerful component in the mentor’s *way of being*, requiring a similar sensitivity (to my mentee’s inner world) to that sensitivity to my own inner world expressed by “*congruence*”. It is possible to communicate understanding to the mentee and I observed above that the perception by the mentee that they are received empathically is an important part of the mentoring experience. Rogers observed that

“the more psychologically mature and integrated the therapist is, the more helpful is the relationships that he or she provides... the outstanding characteristic of the therapist was his empathy... Empathy is clearly related to positive outcome... The

evidence...indicates that the more sensitively understanding is the therapist or teacher, the more likely are constructive learning and change to take place...Empathy dissolves alienation...the recipient feels valued, cared for, accepted as the person he or she is" (Rogers 1995/80 pp.148-52 original emphasis).

The Three Core Conditions with a Patient.

At the commencement of the above discussion of the core conditions in mentoring, I drew a contrast between the attitudes embodied in the relationship of the dentist as mentor with a mentee and the commonly habitual attitude of the dentist as clinician, expert and surgeon. I have highlighted (chapter 1.1) the way in which payment systems have encouraged the adoption of a technical operative approach to dental practice which conflicts - I argue – with a proper health focus appropriate to a healthcare professional in what really needs a refocus as a *people profession*. The issue now is whether there is potential for developing a better “*way of being*” with my patient.

The focus on the diagnostic and technical skills of the dentist - the passive role of the patient who may have little insight into alternative strategies for managing the oral health problems they experience; the need of the dentist to efficiently solve the diagnostic conundrum (and there are many of those) and quickly move on to providing a solution – to cope with the day's patient list and to generate income; the desire of the patient to contain costs, all conspire in the direction of the delivery of a “*quick fix*” without reflection on the overall direction which might be preferred for long-term oral health. These considerations, I observe, constrain the power to act and to choose on the parts both of the dentist and the patient¹²⁹. With the planned introduction of a new contract following the Steele report (Steele 2009) there is an opportunity to encourage a trend towards a person-centred approach. (I prefer “*person-centred*” to “*patient-centred*” since a) the term “*patient*” implies the passivity of someone being operated upon and b) both clinician and patient are persons and a complete re-evaluation of the role of each is required.)

A person-centred approach to dental practice would see the dentist – or a suitably trained dental care professional - acting initially in a mentoring role.

Congruence

The outworkings of congruence may be seen in the first instance as commitment of sufficient time to thoroughly elicit and investigate presenting symptoms, to carry out a sufficiently comprehensive examination as to be able to share with the patient - at least in a preliminary way – the long-term consequences of different solutions and the realistic alternatives, given

¹²⁹ See discussion of Power in chapter 1.2 – ref Lukes(2005).

the current oral health status. The dentist, by so doing has moved from the role of technical operative to the – surely more professionally satisfying and congruent – role of healthcare professional: employing the whole of their *persona* and approaching the orientation learnt in dental school reflecting the desire to care for people referred to above (Chapter 1.1 pp.23-4).

Unconditional Positive Regard

By providing the patient with a balanced account of the nature of the overall problem and context, the patient is now being trusted to employ their own resources to enter an intelligent discussion and to make their own decision as to how they wish to proceed.

Empathy

All sorts of signals may be picked up by the attentive clinician. At one end of the spectrum there is the natural reluctance to face operative treatment, driven by fear of (imagined) pain; there is concern about costs; there is often concern about treatments failing (“*my friend had a root canal but she still had to have the tooth out*”); and there may be concern about maintaining appearance and comfort whilst longer treatments progress through various stages – to name but a few. Giving patients “space” to ask questions and being attentive to unspoken signals exemplifies the application of a model for professional practice, using the person-centred approach, which I develop in chapter 3.8.

Ask: Don’t tell

The mantra “Ask: *Don’t tell*” (Greene & Grant, 2003 p95) is introduced right at the beginning of the faculty mentoring course and is the fifth key principle presented. There is a popular conception of counselling occasionally presented with the counsellor incessantly asking questions. This is a caricature which misses the point. In the first instance, a session with a counsellor or mentor is *not* an interrogation. Questions must be used (albeit judiciously) just because it is my mentee who is resourceful and knowledgeable in the relationship and, as a mentor, I wish to relate to my mentee as an equal and I trust their perceptions. They are the authority on their own self and their needs (Bozarth 1998 p 6) and I help them explore their own inner world. The *primary locus of change* is in my mentee (not in me as the outside expert). My role - exercised by the use of appropriate questions (see examples appendix 9), reflecting back and encouraging clarifications - is “*to help [my mentee] develop a deeper insight into his or her own feelings and attitudes*” (Cooper et al (Eds) 2007 p 67). In my role as mentor therefore, I seek consciously, to avoid “*all control over, or decision making for, the [mentee]*” (Rogers 1977 p 14). What I take care not to do is take control away from [my mentee]; interpret, guide, or manipulate them]; to give them unsolicited advice, attempt to

change the direction of the session or the experience of my mentee; or make something happen that will satisfy an agenda other than my mentee's¹³⁰.

It is, therefore, the attitudinal qualities of the practitioner, and their recognition by the client, which are crucial in creating an effective environment for growth and change. The mentoring relationship is not primarily about techniques. It is not about what the practitioner does. It is a *way of being*. This way of being is challenging and calls for psychological integration and maturity on the part of the mentor (Rogers 1995/80 p148).

It is the central argument of my thesis, that this person-centred approach – this *way of being* with a patient, quite apart from its value in mentoring professional colleagues -provides the basis for a contemporary approach to professional practice that is appropriate in healthcare both in a clinical context with a patient and in the educational role with colleagues that healthcare workers undertake.

The Fully Functioning Person Revisited

In discussing the concept of the actualising tendency I emphasised that, in the PCA, actualisation is conceived as a process, not an objective or endpoint – hence the term “*the tendency to actualise*” is offered as an alternative. As long as there is life, actualisation – in the moment and in the context – is ongoing. Just as an oak tree never becomes fully actualised because each year fresh buds break out and further growth occurs – maybe in a particular direction in response to competition from a neighbouring tree – so the human, so long as there is life left in him, is growing and responding to his (physical and social) environment. The tendency is toward *full functioning* in the context and in the moment, a term which Maslow described as an “*excellent phrase*” (Maslow 1968 p 138). Holding to the ethical perspective of this present discussion, the relevance here is of the professional working to be fully functioning with colleagues and with patients: a **fully functioning person** living their way of being, as a person, as a professional, and (sometimes) as a mentor, in the moment.

To continue the discussion of the *Fully Functioning Person* begun in chapter 2.3 p.78, I refer to Rogers' paper, *A Therapist's View of the Good Life*, in which he outlined what he perceived as the three defining characteristics of the Fully Functioning Person, (as he observed in clients restored to health as they emerged from successful counselling/therapy in this context):

¹³⁰ Adapted from Natiello 2001 p 46.

1. ***“Increasing Openness to Experience:*** *In the first place, the process seems to involve an increasing openness to experience...It is the polar opposite of defensiveness...a movement away from the pole of defensiveness toward the pole of openness to experience. The individual is becoming more able to listen to himself, to experience what is going on within himself. He is more open to his feelings of fear and discouragement and pain. He is also more open to his feelings of courage, and tenderness, and awe. He is free to live his feelings subjectively, as they exist in him, and also free to be aware of these feelings. He is more able fully to live the experiences of his organism rather than shutting them out of awareness.*
2. ***“Increasingly Existential Living:*** *A second characteristic of the process which, for me, is the good life, is that it involves an increasing tendency to live fully in each moment...the self and personality emerge from experience, rather than experience being translated or twisted to fit preconceived self-structure. It means that one becomes a participant in and an observer of the ongoing process of organismic experience rather than being [under the] control of it. It is this tendency toward existential living which appears to me very evident in people who are involved in the process of the good life...To open one’s spirit to what is going on now, and to discover in that present process whatever structure it appears to have – this to me is one of the qualities of the good life, the mature life, as I see clients approach it.*
3. ***Increasing Trust in His Organism:*** *as a means of arriving at the most satisfying behaviour in each existential situation...let me try to explain...in choosing what course of action to take, many people rely upon guiding principles, a code of action laid down by some group or institution, upon the judgement of others...or upon the way they have behaved in some similar situation. Yet as I observe the clients whose experiences in living have taught me so much, I find that increasingly such individuals are able to trust their total organismic reaction to a new situation because they discover to an ever-increasing degree that if they are open to their experience, doing what ‘feels right’ proves to be a competent and trustworthy guide to behaviour which is truly satisfying¹³¹.*

¹³¹ Adapted from *A View of the Good Life* in Rogers 2004/1961 pp 187-91.

Conclusion

In this chapter I have moved from contemplating the whole person – albeit as a social being – to contemplating a particular way for persons to relate or work together. This approach places the distinctively human person at the focus of attention. This is a two-edged sword for, not only does it acknowledge the full humanity of the person being addressed (the mentee) but, by behaving in this way - by adopting this attitude - the mentor is asserting and affirming her own full humanity. Literally, she is behaving as a fully functioning human being. This is the full converse of the “*dehumanisation*” that Freire highlighted in oppressive relationships (Freire 1996/70 pp25-32).

This form of being and relating differs dramatically from the forms of relating underlying the problems in dental professional practice highlighted in chapters 1.1-1.2. The truth is that we are living in a time of change and there are many professionals who hold a much more self-effacing – and other-prizing - view of their role in society, reflecting the social evolution taking place highlighted in chapter 1.2. Such practitioners value the quality of the relationships they establish with patients and colleagues alike so that, for many, *professionalism* might now be thought of, not so much as a *status*, but more as a *way of being with people*¹³². In this middle section of the thesis focussing on mentoring, the way of being of the PCA becomes central for it is evident that the power of this way of being in the helping situation is what makes the encounter between mentor and mentee effective. It is the nature of that mentoring encounter that is the subject of the next chapter.

¹³² Discussed further in section 3.

Chapter 2.5

The Mentoring Relationship

Introduction

In this chapter I describe the manner in which the mentoring encounter proceeds and the wide range of qualities, attitudes and behaviours which the mentor can contribute to the mentoring relationship. This will inform the proposal in chapter 3.8 of a model for professional practice based on the PCA as applied in mentoring. There is no intention of competing with the excellent texts available to support the practical learning of person-centred helping, such as Connor and Pokora (2012) or Egan (2010). However I do draw on the experiences of participants on the Faculty mentoring course as revealed in their course assignments or recorded by course facilitators making notes of key points arising in reflective 'debrief' sessions¹³³. The mentoring relationship may be either short- or long-term: from a single meeting to occasional meetings over a period of years. The parties to the relationship hold each other in mutual regard as whole persons as discussed in Chapter 2.3. I describe the unit of mentoring activity as the *mentoring encounter*. This is the principle focus of the chapter which includes a brief description of a framework (or model) which the mentor may employ to aid awareness of "where we are" in the conversation.

The Parties to the Relationship

There are two parties involved in the mentoring relationship: the mentor and the mentee. Although the mentor has the responsibility – and has been prepared – for making the process a success, the mentee can contribute significantly to the achievement of the greatest benefit for both parties by being in an open, receptive and creative frame of mind and by following through on the decisions taken in the encounter.

The mentee¹³⁴, if she has not encountered the person-centred approach previously, may be surprised to discover that the mentor does not *give advice* with the intention of solving her problems for her. The approach requires the full engagement of the mentee in the process. It is therefore helpful, right at the outset (or even prior to the encounter), for the mentor to

¹³³ All Faculty mentoring course participants were invited – and agreed to sign consents to their work being used anonymously in this way. Facilitators made notes of key points and the notes from the groups were collated to create a summary.

¹³⁴ In order to simplify the description to follow, it is imagined that the mentee is female and the mentor male.

briefly explain his approach so that the mentee is aware that she will be helped to explore her own understanding in order to discover the best way forward for herself. Experience in the Faculty mentor development programme has shown that many participants arrive expecting to be “trained to give advice” effectively. Advice is commonly expected by new mentees though, once they have experienced the impact of the PCA, they engage fully and appreciatively in the process.

The mentor has responsibilities including making clear the “rules of the game” – which may sometimes be helped with a written contract – including, above all, confidentiality; gently but firmly adopting a facilitative, not directive, stance; sensitive and thoughtful questioning; helping the mentee to explore her own ideas, and discover her own resources; and, above all, observing and listening, actively and empathically, to spoken and non-verbal messages and meanings.

Connor and Pokora (2007) give a comprehensive definition of PCA Mentoring:

“Coaching and mentoring are learning relationships which help people to take charge of their own development, to release their potential and to achieve results which they value” (op.cit.p.6).

This definition, reflecting the Rogerian approach which underlies the Faculty project and this thesis, clearly emphasises the appropriate *relational* nature of the process. Its use of the word *potential* highlights the perceived power distribution in this approach: a matter of particular significance here in the light of comments made in chapters 1.2 and 3.9 concerning power in professional relationships. This definition is about *helping* people to take charge and release *their* potential (alias ‘power’). It would be easy for the mentor to become the powerful person in the relationship given his familiarity with the process. As an antidote to this, participants on the Faculty course are encouraged to think in terms of *using their power to help the mentee to discover her own power*. Egan devotes the first three chapters of his comprehensive text to aspects of *helping* (Egan 2010).

The Mentoring Encounter

Although the mentoring encounter is frequently planned for a specific time and place this does not have to be so. One text, (McDermott and Jago, 2006) which gives a very clear exposition of the flexible coaching approach from the perspective of NLP, states:

“There are many ways of coaching. You may be formally coaching one of your people during a one-hour session but you might also be using a coaching approach during breakfast with your children” (ibid p 11).

To this could be added *“You might be discussing the most appropriate treatment option with your 9 o’clock patient”*.

The approach is so flexible that it is perfectly feasible for a brief, informal, mentoring encounter to take place in a corridor between two people hurrying off to their next meeting. Anecdotally, mentors and mentees report that these impromptu encounters are often the *“most useful”*. All that is required to qualify this as a mentoring encounter is the application of *“Ask: Don’t tell”* (Greene & Grant 2003 p.95). A key part for the learning mentor’s understanding of the process is the realisation that the principle role for the mentor (or coach) is to ask questions and listen.

“Coaching works by asking, not telling” (McDermott and Jago, 2006 p.21).

“The primary skill of coaching is not to think you know the solutions but to elicit them from the real expert – your client. So often people assume that if you can just get the other person to take your advice and do as you tell them, problems will be resolved. But how often do people really take others’ advice? And would it have been the best solution anyway?” (ibid p.11).

In a very lucid book on solution focused coaching, Greene and Grant (2003), under the headline *“Ask, Don’t Tell”* state:

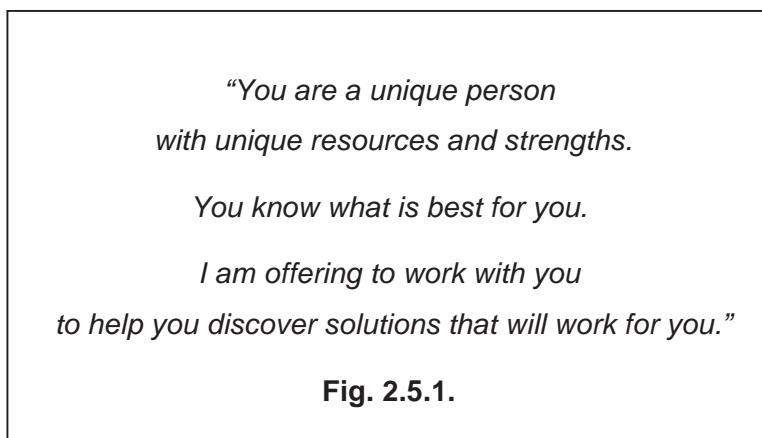
“Coaching is about asking questions. Many people today find themselves managing specialists whose knowledge far exceeds their own. They can’t tell them what to do, not least because they don’t and can’t know” (op cit p.95).

The above citations about the “coaching approach” translate without alteration to mentoring. In our mentoring language, the “coaching approach” becomes the “mentoring style” and the mantra *“Ask: don’t tell”* applies to both. The above quotations from McDermott and Jago, and from Greene and Grant, illustrate several insights into the contemporary approach to coaching and mentoring. Fundamental to the approach is that *“The mentee knows best”*. The mentor understands that the mentee is the expert. She is the one who must decide where she wants to go in life. She is the one who knows what professional areas interest her. She knows what will motivate and enthuse her. She is the one who has access to her own inner resources and strengths (the full extent of which she may yet have to discover). She is the one who knows her preferred learning styles. She is the one who knows best the nature of the challenges – and the best solution - for *her* at this particular time. The mentor’s

task is to help the mentee to discover within herself the answers to the questions that need to be answered in establishing the way forward for her professional and personal development. Any one of us, on reflection, can recognise that we are much more likely to act on an idea that we have produced ourselves than on something that we have been told to do by another party. When we have ourselves conceived an idea or solution, we have *ownership* of it and are much more likely to follow it through than if it were given to us as a solution by somebody else. Indeed, any solution thought up and offered by the mentor may be fine for them – but completely inappropriate for the mentee. The mentor does not need to know the answers to the questions that the mentee needs to answer (and, indeed, often *cannot* know them). Consequently, the mentor does not need necessarily to be an expert in the technical field of the mentee, nor even senior to the mentee in their occupational roles.

The mentee is respected on the basis that she is resourceful and has within herself the knowledge to deal with the challenges that face her, and the talents and strengths that she needs. She may not, at the outset, be aware of these resources or this knowledge. For this reason, “*coaching engages them in self-exploration, self-discovery and self-determination*” (McDermott & Jago 2006 p 21). The solution that she discovers for herself will be right for her whereas the solution proposed - or imposed - by the mentor would probably only be right for the mentor.

The mentor’s approach can be summarised as in Fig 2.5.1:



During de-brief sessions following skills practice, Faculty course participants expressed amazement both at the power of being at the receiving end of “Ask: don’t tell” and at the

realisation that they had not themselves come anywhere near using this approach in their previous (pre-course) experience. Three comments made early in the work of Cohort 1 were:

“I’ve never been involved in a conversation like that before.”

“No-one has ever listened to me like that before.”

And a revealing moment of self-discovery...

“I have never really listened to anybody like that before.”

These and similar comments have recurred with subsequent cohort participants.

Using a Model or Framework.

It is helpful for the mentor to have a suitable structure or *model* in mind to guide the conversation with the mentee. This can help guide a full series of mentoring sessions over some months or a single telephone conversation. Indeed, it is possible to have a series of mentoring sessions following a framework whilst an individual session in the series might in itself follow a framework or model also.

One of the most authoritative, most quoted, and most extensively referenced books on the subject describes the “*Skilled Helper Model*” (SHM), a framework for the application of “*helping*” skills which may be seen as the equivalent of an industry standard (Egan 2010). This model consists of *three stages* each with *three tasks*. It also includes an “*Action Arrow*” and initially proved difficult to remember (compare with the easily remembered GROW model below). For this reason, having decided that the SHM would be used in the Faculty programme (Fig.2.5.2), an acronym inspired by the GROW model was developed – “YUGROW–D3” – (Fig.2.5.3) as an *aide memoire* for student mentors as they become familiar with the stages of the model.

The diagrams of the *Skilled Helper Model* and “YUGROW” are reproduced below for reference and will be explicated in the text.

The YUGROW diagram has been tabulated (see Appendix 8) to create useful *aides memoires* as course participants learn the model.

Fig.2.5.4 outlines the function of each task in the Skilled Helper (YUGROW – D3) Model.

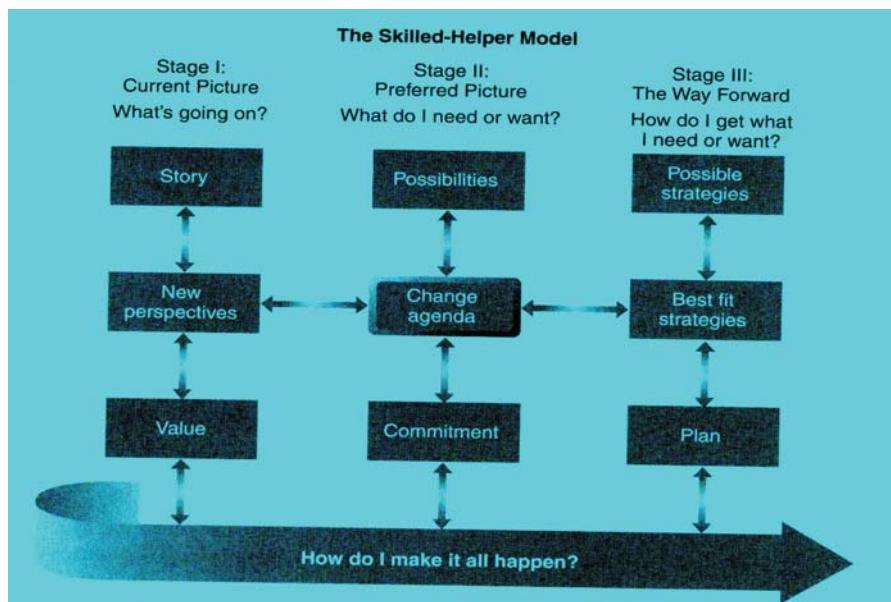


Fig. 2.5.2

- The Skilled Helper Model. From EGAN. *The Skilled Helper, International Edition, 9E*. © 2010 Wadsworth, a part of Cengage Learning, Inc. All rights reserved. Reproduced by permission.

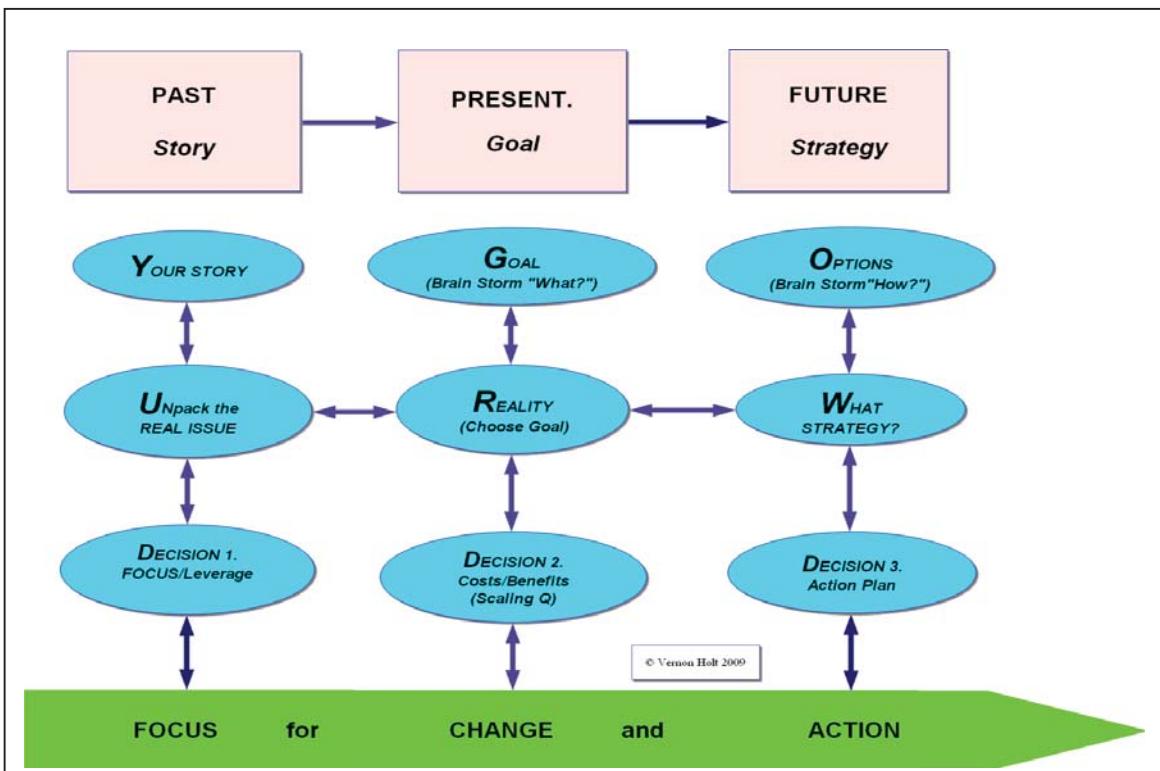


Fig 2.5.3. YUGROW D3 DIAGRAM

The Skilled Helper Model (SHM).

The model is described sequentially. Whilst the SHM has three stages 1, 2, and 3, each of which has three tasks (a, b, and c), the third, (c)-task in each stage may be thought of as a decision (YUGROW “D”) or commitment to move forward in a particular direction: hence 1c (D1), 2c (D2), 3c (D3).

In **Stage 1**, the focus is on “*What is going on?*” “*What has brought you here?*”: Your issue?

Task 1a (Y) is about Your issue?

Task 1b (U) is about Unpacking your issue. This important stage often reveals underlying issues that need to be addressed.

Task 1c (D1) is about Deciding which issue you deal with now – the one that will make a difference: the *leverage point*.

In **Stage 2**, the focus is on your “*Ideal outcome?*” “*Possibilities?*”

What Goal?”

Task 2a (G) is about “blue sky thinking” Perhaps a brainstorm: thinking of all the possible Goals: “*just one more?*”

Task 2b (R) is about choosing from the goals thought up: one that would motivate you, be Realistic and have impact just now.

Task 2c (D2) is about Deciding after balancing costs and benefits (perhaps using force-field analysis), impact on others and availability of support, to go ahead with *this* goal.

In **Stage 3**, the focus is on your “*How will you get there?*” “*Strategies?*”

What Options?”

Task 3a (O) is about Options available for achieving the chosen goal. “*How are you going to do this?*” An “options – how?” brain storm is often both helpful and enjoyable here.

Task 3b (W) is about What option you are going to choose; considering strategy; what fits your values best; ensuring resources needed are available; considering possible obstacles – other people affected – time scales, support.

Task 3c (D3) is about Deciding about when you are going to start. Milestones, key steps, timescale, contingencies? WHO? WHAT? WHEN? “*What do you need to do first? When are you going to do it? How can I provide ongoing support?*”

Fig 2.5.4. Summary of SHM Tasks Using YUGROW-D3 Acronym

A simpler model to remember and use on a day to day basis in an uncomplicated situation is the “GROW” model, often attributed to Whitmore (Whitmore 1999/1992) and described, with variations also, by (Greene & Grant 2004):

Goal

Reality

Options

Wrap-up

Many other authors produce frameworks, e.g. Solutions Circle (Meier D 2005). A contemporary author who provides courses for some Postgraduate NHS Deaneries simply proposes “Beginnings. Middles and Endings” (Rogers 2008).

All these frameworks broadly identify the mentee’s issue or concern, contemplate the preferred ideal (“blue-sky thinking”) and then set goals and plan strategies. The relative complexity of the SHM allows the consideration in valuable detail of the various stages and processes involved during the mentor’s learning stages. It also helps the mentor to remain aware of *where they* are in the model and what ground has been covered so far with the mentee.

A significant part of the preparation of mentors consists of learning to use a suitable model though it is always emphasised that the model is not intended to constrict or dictate the line of conversation, which may not follow the model sequence exactly - or even at all. Rather, it is to help the mentor to ensure that all important issues are covered. The mentee drives the direction of the conversation: not the model - nor the mentor! Egan himself makes this point in a citation given on p.117 below. The process is mentee–driven; NOT model-driven.

Although learning mentors are expected to give evidence of understanding and using the SHM in their early case studies, they are encouraged to make flexible use of the model in their later assignments.

Mentoring Resources

Having already discussed the *way of being* with a mentee in considering the person-centred-approach (Chapter 2.4), it is natural that this discussion should begin with personal resources of the mentor himself including his behaviours. The behaviours are taken to include the choices of questions asked as well as the introduction of particular aids to learning (such as SWOT analysis), generation of ideas (such as brainstorming), and decision-making (such as force field analysis), etc.

The mentor's contribution to the relationship is considered under three headings: qualities, attitudes and behaviours. It is convenient to describe qualities, attitudes, and behaviours separately. However, there is inevitably overlap between these areas and, furthermore, qualities will influence attitudes which, in turn, will influence behaviours. The reverse is also true.

An endless debate could also consider what aspects are qualities and what are attitudes or behaviours. For example is "empathy" a quality, an attitude or a behaviour? The allocation under these headings is for discursive convenience, not to make a doctrinal point. There is also a brief discussion of unhelpful mentor positions.

Mentor Qualities

It would be possible to draw up a long list of desirable qualities in a mentor. Connor and Pokora give an excellent list (Connor & Pokora 2007 p.47). In this section, I shall discuss five qualities in particular which, it may be argued, embrace all others. They are empathy, honesty, congruence (or integrity), self-sufficiency and patience.

Empathy is mentioned in Chapter 2.4 as one of Rogers' *core conditions* and is perhaps the most powerful mentor quality to encourage or cultivate whilst also the most challenging to acquire. Empathy is the sensing and the responding to the experiencing and perceptions of the other (Mearns and Thorne 2007 p.67) and lies at the heart of any caring relationship. It is often described as *being in the other person's shoes* and refers to experiencing the other's life as they experience it (Connor & Pokora 2007 p.39) from their internal frame of reference (Fig. 2.4.2 and comments pp.93-4). It calls for intense listening to what the mentee is saying, seeking to enter their inner world. Rogers reports receiving advice in his early career that '*the most effective approach was to listen for the feelings, the emotions, whose patterns could be discerned through the [mentee's] words* (Rogers 1995 pp.137/8)." He also reports the suggestion '*that the best response was to 'reflect' these feelings back to the [mentee]* (ibid)." Many writers expand on this subject, including Connor & Pokora (2007 pp.39-40), a complete chapter in Rogers (1995/1980 pp.137-163), Egan (2010 pp.131-6,227-33), an excellent chapter from Freire in Cooper et al (2007) pp.194-206; a very profound chapter from Mearns & Thorne (2007 pp.67-94), and a perspective illuminated by neuroscience from Goleman (2006 pp.106-110). Rogers reports at length his research findings that an empathic approach is associated with a successful outcome to therapy and states unequivocally that "*Empathy is clearly related to positive outcome*" (Rogers 1995/1980 p.150). Since mentoring is considered here as an educational, developmental process, it is noteworthy that Rogers later emphasises the positive impact on learning for the *whole person* when the teacher "*has a sensitive awareness of how the process of education and learning seems to the student,*

then...the likelihood that significant learning will take place is increased" (op.cit.pp.272/3: original emphasis). Empathy is a quality that the mentor could with great benefit cultivate assiduously, and reflect upon deeply.

Honesty is a core value in the mentoring relationship. The mentee trusts the mentor to be open and honest in several ways. Firstly, the mentoring relationship is established to serve the best interests of the mentee. Honesty requires that the mentor be true to this intention. The mentor's role is to support the mentee, not to satisfy his or her own desire for status, influence or authority. Secondly, in helping the mentee to work towards their personal goals, it is important that the mentor accurately reflects back to the mentee information about aspects of their work, performance or attitudes that are inadequate or unhelpful. This, on occasion, may be a matter of skilfully giving feedback, on some written coursework, on strategies for dealing with staff in the practice, etc. The mentor is being trusted by the mentee to be honest. Avoiding giving negative feedback (*"keeping 'mum' so as not to hurt anybody's feelings"*) represents a failure on the part of the mentor. The skilful and balanced giving of feedback constitutes an important component of mentor training and is a facilitating tool for mentor honesty. Thirdly, in the mentoring conversations, the mentor may well become aware of an area where the mentee would benefit from addressing performance issues say, perhaps, in order to improve working relationships within the practice. Bearing in mind the comments above (p.99) on *"Ask, don't tell"*, honesty requires that the mentor seeks – or even creates - an opportunity to ask the mentee questions that may lead them to self-examination and new insight.

As a core condition *congruence* has been discussed in Chapter 2.4. *Integrity* is a word that is often used as a synonym for *honesty*. In the Helping professions, however, the word has a much deeper meaning relating to its implication of *being integrated* and is often referred to as "congruence". Whereas *honesty* has been described above as a feature of the mentor's relationship with the mentee, *integrity* is more about the mentor being honest with his own self; being *true to himself*, being focussed throughout his being – mind (thoughts), heart (feelings), body (actions) and spirit (values, meaning, purpose) - on the *good life* outcome for the mentee (Rogers 2004/1967 pp.184-96). Egan (2007) describes this quality as *genuineness* and states that *"[g]enuine people are at home with themselves and therefore can comfortably be themselves in all their interactions"* (op.cit.p.56). Rogers also uses the words "*realness*" (Rogers 1995/1980 p.115) and "*transparently real*" (Rogers 2004/1967 pp.33,50-1) to describe this quality of congruence. The evidence is that clients or mentees sense the incongruence, no matter how carefully concealed, in their counsellor or mentor and this has a negative influence on the outcome of the relationship. By contrast, when congruence is achieved, the relationship flourishes (Rogers 2004/1967.p.61). Congruence,

or integrity therefore, represents an essential quality in the mentor and is discussed extensively in Mearns & Thorne (2000,pp.119-152).

Self-sufficiency as a quality embraces several elements. *Self-efficacy* has been defined as “*beliefs in one’s capabilities to organise and execute the courses of action required to manage prospective situations*” (Bandura 1977,p.2). *Psychological maturity* has nothing to do with chronological age, but rather a state of inner balance, resilience and stability that enables the mentor to give themselves empathically to their mentee without being swamped or taken over by the mentee’s issues and feelings (Rogers 2004/1967 p.56). A further aspect of self-sufficiency is *resourcefulness*, which, in the mentoring relationship, combines a level of natural ability to draw imaginatively on different strategies for considering issues and inventing solutions, with training in mentoring approaches and techniques. From this, it will be seen that *self-sufficiency* is not just about having the strength and resources; it also includes a sense of “*I can do it*”. That is not, however, to say that the mentor is “*out on their own*”. It is essential that any mentoring programme provides for mentoring support to be available to every mentor so that they always have a colleague to whom they can turn.

Patience is a quality that reflects both the mentor’s maturity (self-sufficiency) and their congruence in the sense that patience is a form of respect for, and engagement with, the mentee on the mentee’s home ground. The mentee has to make progress in a direction of their own choosing, in a manner that meets their own needs and styles (of learning etc.) and at a pace within their own capacity to make adjustments (in concepts, vision or direction) and carry out tasks (changing behaviours, learning new skills, physically developing practice, etc.). Patience might be required on the part of the mentor especially in the mentoring conversation. The respect for the mentee embodied in the *Ask, don’t tell* approach means that the impatient or inexperienced mentor has to resist the temptation to tell the mentee what they should do, provide the answers (as perceived by the mentor), or otherwise force the pace. In the mentoring conversation, the mentor needs to be able to allow for silence - even long silence – recognising the “*power of silence*” whilst the mentee reflects on an answer to a question raised during the conversation. Indeed, such periods of silence can be amongst the most fruitful parts of the conversation (Berg & Szabo 2005 p.74-5).

Mentor Attitudes

A range of attitudes helps to define the PCA mentor.

As a core condition, *unconditional positive regard* (UPR) has been discussed in Chapter 2.4 p.98. The single word often used to convey this attitude of unconditional positive regard is “*respect*” (Egan 2007,p.53), (Merry 2002 pp.80,137). The mentor’s support is unconditional.

The relationship is founded on respect for the dignity of the mentee. Respect means accepting and affirming the person as they are. UPR embodies the acceptance that the relationship is to support the mentee. It is their life: their career. The goals must be their goals. The decisions must be their decisions. The values agenda must be their agenda (Egan 2007 p.54; Connor & Pokora 2007 pp.38-9). Mearns & Thorne 2007 in a complete chapter emphasise the attitudinal nature of UPR (pp.95-117).

Being *non-judgmental* does not mean that the mentor has to approve of everything the mentee says or does. Indeed in a remedial situation, the mentee may be facing disciplinary hearings for alleged unprofessional behaviour. The mentor's role is to seek to see the situation from the mentee's perspective (empathically). Gentle and skilful challenges may be necessary and the mentee may be helped to learn to challenge their own positions (Egan 2007 pp.159-82). On the debrief session following the first skills practice session of one Faculty mentoring course, it transpired that two participants had presented issues for mentoring which turned out in session to go much deeper than the usual "medium weight" issues selected. I expressed surprise (and pleasure) that they had felt able to "go so deep so early on" and in a group situation. When asked what had made them feel comfortable going this deep so early, two reasons were given: firstly the facilitator opening the course had emphasised confidentiality – "*Nothing that is said here goes outside*"; and secondly she had stressed that part of the mentoring approach means that we "...do not sit in judgment". As a result these two participants '...felt safe'.

Humility is presented as an important feature of the mentor. This does represent a significant shift from traditional attitudes in a surgical college (see chapter 1.2) and experience to date would suggest that those who feel drawn to the mentoring course tend to be colleagues with a naturally more person-centred approach. There have been exceptions however, for whom the experience has been challenging and described as "*life-changing*". In recent years, the perceived role of a good leader has changed (Adair 2003) so that their role is more to support and facilitate the work of their followers, and the leader is seen more as a servant of the led. Bearing in mind that mentoring is in its nature a leadership activity, the role of the leader (the mentor) in supporting and helping the led (the mentee) implies the humility of the new "*servant leader*" (Covey 2006 p.298). For the mentor there is the enormous sense of privilege in being allowed to share a level of intimacy with the mentee, their thoughts, their goals, their hopes and their vision.

Self-Observation (self-monitoring) is presented as an essential element of reflective practice. The mentor needs to have a heightened awareness of the impact of their words, their behaviours and their reactions on the mentee. This reflexive self-awareness is a significant part of the mentor's inner mental processes as the mentoring conversation unfolds.

Mentee Focus embodies the “*person-centred approach*” inherited early from psychotherapy when the applicability of this approach to all normal situations from child rearing to education - which includes what is now known as mentoring and coaching (Rogers 1995/1980 pp.308-10) - was recognised. The approach continues to the present day in counselling (e.g. Mearns & Thorne 2007), and underlies all the various approaches to mentoring, and coaching (Connor & Pokora 2007 pp.38-9) including NLP, Solution focus, the SIMPLE approach, Brief Coaching, and the Skilled Helper.

A key attitude for the mentor arises from the perception that the mentee is talented and resourceful. In Chapter 2.4 p.89 it was emphasised that the whole approach to mentoring and coaching is based on the belief that

“Individuals have within themselves vast resources of self understanding and for altering their self-concepts, basic attitudes and self-directed behaviour” (Rogers 1995/1980 p.115).

As a part of this, the mentor recognises that the mentee knows herself best. It is fundamental to the mentoring approach that the mentee sets the agenda as they alone know what excites them, what inspires them and what personal resources they can draw upon in pursuit of their goals. McDermott & Jago (2005) state that

“[Mentoring] works from the empowering premise that we have the resources we need within us – but that often we would benefit from some outside assistance to help us access them” (op.cit.p.15).

Berg & Szabo (2005) urge us to

“...find out what is important to the client because this is where the client’s energy is and this is what the client is investing in changing. When we follow what is important to clients, it means they are more likely to be invested in making necessary changes to achieve their goals” (op.cit.p.26).



Fig 2.5.4. Problem vs. Solution Focus.

The PCA is focused on the resources and solutions of the mentee so that a solution focus is implicit. In contrast, to problem focus, which tends to draw attention to what is wrong and the past, solution focus lifts the mentee's vision to what might be. Fig 2.5.4 contrasts the two approaches. Fig 2.5.5 summarises mentor attitudes.

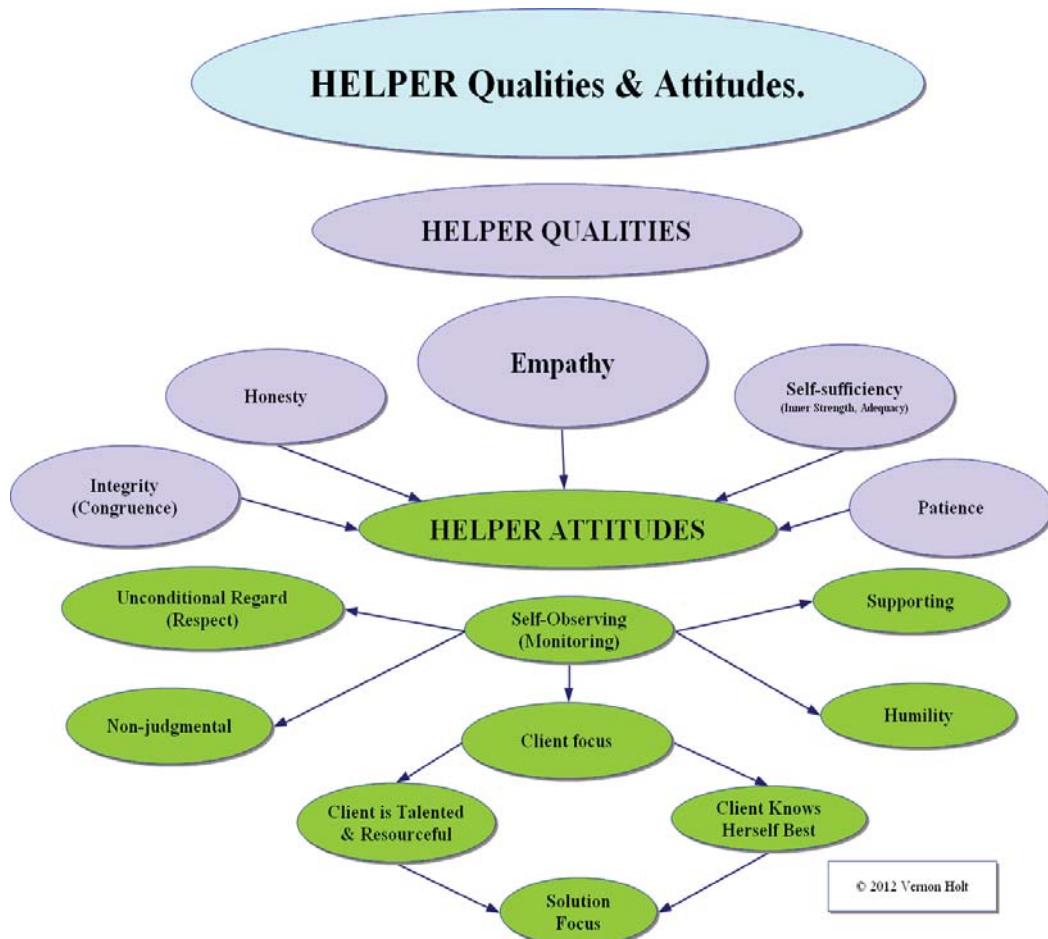


Fig. 2.5.5. Summary of Mentor Qualities and Attitudes.

Mentor Behaviours

There is a vast array of tools and approaches available to mentors and the more experienced mentor is likely to have developed a wider range of options. Some key foundation behaviours are briefly discussed below with indications of sources of further information.

Establishing rapport is about facilitating communication by ensuring the mentee is comfortable and relaxed. It may include choice of dress, choice of vocabulary, careful arrangement of seating positions, and taking an interest in the mentee and their affairs as a way of easing into a deeper conversation. According to O'Connor and Lages (2004), “*In order to build rapport it is important to respect the mentee's beliefs and values*” (op.cit.p.48). McDermott & Jago (2002) state that *[b]eing in rapport [with someone] is not the same as agreeing with them. You can disagree with someone but still have rapport with them*” (op.cit.p.70). Knight (2002) gives a very useful chapter on rapport pp.286-307 and Goleman (2006) asserts that “*[p]eople in helping professions must work hard to ensure that the ingredients of rapport operate during their professional encounters. Their detachment needs to be balanced with sufficient empathy to allow at least a bit of I-You feeling to bloom*” (op.cit.p.112).

Demonstrating warmth is a way of communicating to the mentee that they are accepted and valued. Personal styles will influence how this is done. Maintaining eye contact, genuinely smiling or laughing at humorous remarks, showing genuine interest in the mentee, arise naturally from sincere caring for the mentee and are included in a list of approaches listed by Mearns and Thorne in a helpful passage on warmth (Mearns & Thorne 2007/1988 pp.106-110).

Active Listening is addressed by Egan (2007) in a powerful section (pp.78-93). He asserts that

“*Full listening means listening actively, listening accurately, and listening for meaning. Listening is not merely a skill. It is a rich metaphor for the helping relationship itself...not a state of mind. It's not something that 'just happens'. It's an activity. In other words, effective listening requires work*” (op.cit.pp.78).

Another way of putting this is to say that active listening takes effort. Egan also refers to *empathic listening* for, as observed on p.110 above, the process of empathy begins with listening for underlying feelings.

Demonstrating empathy is a key behaviour discussed above under *Mentor Qualities*; pp.107-109.

Building up trust emerges from the establishment of rapport. As trust becomes established, greater openness and effectiveness in the mentoring relationship will follow. Two specific elements already mentioned (p.114) underlying trust are the assurance the mentee has of complete confidentiality and the sense that the mentor is not judgemental.

The mentor always *encourages the mentee to provide the agenda* for the mentoring relationship. The mentoring arrangement exists to support the mentee and to help her achieve personal growth. She is the client or the “customer”. The inventor of the “Skilled Helper Model” himself asserts:

“Helpers need to become radically client-centred. Client-centred helping means that the needs of the client, not the models and methods of the helper, constitute the starting point and guide for helping. Therefore, flexibility is essential. In the end, helping is about solutions, results, outcomes, and impact, rather than process (Egan 2007 p.46).”

The mentor *assists the mentee explore her own thinking*. Skilful and carefully considered questioning is the basic tool of the mentor in helping the mentee to move forward in life. O'Connor & Lages (2004) give a useful chapter on “*Questions are the answer*” (pp.75-93). Some samples of question types as used on the Faculty course are shown in appendix 9.

The mentor *supports the mentee in setting and pursuing choices and goals*. With the benefit of training, the mentor can assist the mentee to clarify their goals and to develop their own strategies for achieving them (Egan 2010 pp.354-396). E.g. having timed stages in a process of change can help the mentee focus and maintain momentum.

Providing follow-up is another key part of the mentor's role. This is a part of their *being with* the mentee on her journey and this on-going support and interest from the mentor is an important part of the on-going mentoring relationship. The mentor can play an important role in ensuring that the mentee maintains their motivation and that they have access to any resources they need. Zachary (2000 pp.117-143) discusses on-going support as a “*Nurturing*” activity.

Sharing experience is only occasionally appropriate. Although generally inappropriate, there will be occasions when a mentee may be so helped. This may perhaps be most useful when the mentor is in a position to identify with the mentee over a shared difficulty – e.g. mastering a technique, overcoming shyness, apprehension about public speaking, etc. Egan counsels helpers to use self-disclosure carefully and reports that research into self-disclosure has produced conflicting results concerning its benefits (ibid pp.234-7).

The mentor needs to be *prepared to challenge* (if appropriate). Respectfully challenging the mentee who is out of line with “good practice”, or who lacks insight into the impact of their behaviours is a necessary skill to acquire. The ideal is to help the mentee learn how to challenge herself (Egan 2010 p.252-260).

Giving constructive feedback is an important skill. In a learning situation, the mentor who fails to give feedback on his mentee’s efforts is failing to support the mentee appropriately. Where feedback is required, the mentor needs to carefully prepare the ground so that the mentee is ready to receive it. Feedback that is balanced - both positive and negative - is preferable to all negative. Covey states that

“Giving negative feedback is one of the most difficult communications there is. It is also one of the most needed. So many people have serious blind spots they never come to grips with because no one knows how to give them feedback” (Covey 2006, pp.177-8).

A very practical insight to feedback is given by Zachary (2000 pp.30-143) and Goleman (2002) stresses the value of candid feedback in the business environment (op.cit.pp.168-71).

Keeping promises is fundamental to being a good mentor not only because this is a manifestation of integrity (see above) but also because keeping promises builds trust. Furthermore, in this way the mentor is modelling best behaviour and it is safest to assume that the mentee may regard the mentor as a model.

The mentor enjoys their rewards. Whilst mentoring has its challenges and is a role that demands of its practitioners their very best, it seems inappropriate to discuss mentor qualities and attitudes without mentioning the enormous inherent rewards for the mentor. The dentist who undertakes mentoring is likely to be a natural carer who finds professional and personal satisfaction in supporting a colleague in their personal and professional growth. Above all, there is satisfaction for the mentor: a sense of pride – almost parental in quality – in watching the growth and success of the mentee. It is impossible to put a price on this sense of pride and satisfaction. In addition, it is inevitable that in a living and dynamic personal relationship with the mentee, the mentor too will be forever learning and gaining new insights. The “learning relationship” features two learners. This is so central to the process that the enjoyment of these rewards itself becomes one of the qualities of the mentor and supports his on-going motivation.

Unhelpful Mentor Positions

The traditional view of mentoring referred to in chapter 2.4 above has led, on occasion, to mentors assuming unhelpful roles which need to be discarded in the current model. There

are many professionals currently in mentoring roles who have emerged from the earlier culture. As recently as 1998 a report on mentoring produced by the Standing Committee on Postgraduate Medical and Dental Education (SCOPME) defined mentoring as:

“The process whereby an experienced, highly regarded, empathic person (the mentor), guides another individual (the mentee) in the development and re-examination of their own ideas, learning, and personal and professional development. The mentor who often, but not necessarily, works in the same organisation or field as the mentee, achieves this by listening and talking in confidence to the mentee”.

In this definition, it is clear that the “*expert*” in the relationship is still the mentor who “*guides*” the mentee. Whilst there is evidence in this definition of late 20th century influence, (a mention of “*empathic*”, the mentee’s “*own ideas*” and “*listening*”) it is still essentially the old authoritarian model based on the concept of the “*Trusted adviser and friend*” and reflecting the historical professional values that were presented as problematical in chapter 1.2 above. It follows, therefore, that there persists in the medical and surgical colleges a widespread acceptance of the traditional model of mentoring so that new arrivals on the Faculty mentoring course are sometimes quite taken aback by the dramatic change in emphasis from that they had anticipated. Significant adjustments in attitude are called for and the following attitudes and roles are highlighted as those to be discarded:

“*Expert*”, “*Authority Figure*”, “*Instructor*”, “*Adviser*”, “*Senior*”, “*Superior*”.

These positions are inappropriate since they place the mentor, not the mentee, at the centre of the process. Egan (2007) says, “*Don’t tell clients what to do. Don’t try to take over their lives. Let clients make their own decisions*” (op.cit.p.171).

The Mentee’s Contribution

This chapter would not be complete without a brief consideration of the contribution the mentee can make to the process.

The mentee can help by being open to the mentoring process; expecting to develop, change and grow from the experience; and not expecting their mentor to “*solve the problem for them*”. The mentor’s role is to help the mentee to discover their own goals and resources, not to give them advice. There is little point in going through this process however, unless the mentee acts on the decisions taken in the mentoring encounter.

In fact, the most helpful mind-set from the mentee may be that of someone who positively invites feedback and, when it is given (and it can be hard for the mentor to give for fear of

causing offence), to receive it appreciatively acknowledging the mentor's effort and risk-taking. The mentor will have been trained to give feedback on "the behaviour, not the person". The mentee who can receive the feedback in this spirit will be well placed to gain the most from it. By gratefully acknowledging the mentor's contribution in giving feedback, the mentee can reinforce the learning relationship so that they can both benefit from it even more as time goes by. The mentor may also invite feedback from the mentee for the relationship works both ways.

Conclusion

Feedback from the faculty mentoring team suggests that every encounter brings benefit to the mentor as well as the mentee. Both mentor and mentee can contribute significantly to the success of the mentoring relationship. Whilst the mentor may be perceived as having the greatest responsibility (and, of course, training) both people can creatively influence the process so that it becomes not only an effective learning experience for both but also a source of inspiration and motivation to develop their selves and their professional lives to the benefit of the patients they both serve.

Chapter 3.6

Holistic Practice

Introduction

Stating the intention of my thesis, I suggested that

[B]y striving to find meaningful articulation for the fuller and more complete humanity, which we seek to express - and to share - with the persons who are our patients and our colleagues...we may hope to model in our own lives the qualities, behaviours and attitudes that distinguish the humanitarian orientation of the true professional. (chapter 1.2, pp.37-8 above)

In this chapter, focussing primarily on the individual professional person, I address the *“meaningful articulation for the fuller and more complete humanity which we seek to express and to share.”* In Chapter 3.7, focussing primarily on the professional collective, I address *“the qualities, behaviours and attitudes that distinguish the humanitarian orientation of the true professional.”*

The objective for the two chapters is to develop an holistic sense of the relationships involved, the way this may inform the application of the PCA in professional practice and development, and the potential for wider health and social gains in professional practice.

The focus is now on that *“fuller and more complete humanity”*. The objective is *“to find meaningful articulation for”* those subtle and intangible aspects of our nature which are so easily submerged under the busyness of everyday life. To begin, I reflect this busyness by presenting a picture of a typical dentist’s working day with its heavy component of cognitive and instrumental empirical elements.

The remainder of the chapter seeks to articulate a more holistic view of the person-who-is-the-dentist (as well as the patient and other staff): seeking ways of expressing the deeper things that are going on – mostly out of awareness – which constitute a more holistic view of the self and of the person in this small social (professionally-oriented) group. In Chapter 2.3 I briefly discussed the spiritual dimension of the *“Whole Person”* (pp.68-70) and later asserted *“...the need to consider not only the person herself, but the environment, - physical, intellectual, emotional and (above all) spiritual - in which she is situated and obliged to function.”* (p.82) This is the *“lifespace”* of Lewin (1997/51 pp.210,188-9), the *“perceptual*

field" of Rogers (2003/1951 p.484), the "*lifeworld*" of Welton (1995). In the dental professional's experience, the dimension¹³⁵ that tends to dominate our lifespan is the mind (cognition) subject to the demands of rational empiricism. Whilst this dimension is the starting point for this discussion, my objective is to move the focus to the spiritual dimension of our nature – the dimension that deals with values, meanings and evaluations of significance. Whilst body and heart (affect) are fully recognised for their significance in our functional make-up. It is the dimension of spirit that provides the counter-balance - the dialectical polar opposite - to the insistent claims to authority made by the rational mind. The discussion thus requires a consideration of the complex nature of *The Self*, defining the core of our humanity.

I aim to find ways of *articulating* some of the concepts which are accessible to us for, as both Vygotsky (Wink & Putney 2002) and Polanyi (2009/1966) make clear, without a vocabulary to frame ideas, we cannot fully apprehend them. Even less can we share them and incorporate them into our collegial discourse.

From Rational Empiricism to the Spiritual: Asserting our Humanity

The Rational Empirical Day

After exchanging greetings with other team members, the *day list* awaits the dentist on arrival at the practice each morning. Depending on the type of practice, the patient base and practice policy regarding time allocation to different treatments, appointment lengths will vary. Planned work of a more complicated nature – root canal work, crown or bridge work, multiple fillings, advanced gum treatments, surgery, implants, etc. – may be allocated as long as 2 hours or more in a few cases though $\frac{1}{2}$ to $1\frac{1}{2}$ hours would be more common. Less complex treatments, fillings, scaling, denture work, extractions, fitting of crown work may be between $\frac{1}{4}$ and $\frac{1}{2}$ hour. Routine examinations may be as little as 10 minutes. and, for some practitioners, $\frac{1}{2}$ hour. A private practice will generally be giving longer appointments than NHS (which is partly what the patient is paying for). A well-organised appointment book may have "emergency slots" incorporated which may already be filled or double- or treble- booked. More often than not, perusal of the list will reveal a patient who is very nervous and takes a long time to actually open their mouth; or a patient who always wants everything to be explained again; or a patient who gags as soon as you look at them

¹³⁵ Out of the four dimensions of the person: see chapter 2.3, pp.60-1 above.

or another who always gets angry if they are kept waiting; or a combination of any of the above. The probability is that the day will consist of an assortment of tasks, personality and treatment types, and appointment lengths. Somehow, amongst all this, it might be deemed nice to exchange pleasantries with the patient but see Appendix 1 Scenario V.

Whatever the payment system, in the allotted time it is mandatory to check or confirm the patient's medical status (and record any changes reported), to enquire after, and respond to, any *presenting complaint* (such as "*a piece has broken off another tooth and is cutting my tongue*"), to be sure the patient understands what is to be done today and consents to it – including the costs involved. It would be nice to think that the patient can be made comfortable and relaxed with a few friendly words before work begins. Finally, everything done and all advice/discussion must be recorded. On many occasions the appointment proceeds uneventfully so that the planned treatment is carried out in the allotted time. On others, symptoms or mishaps such as a filling breaking complicate the appointment. Pain symptoms, in particular, sometimes with an obvious explanation quickly confirmed, can also be difficult to diagnose, especially in a mouth that has already received quite a lot of treatment so that many teeth are filled or crowned. Meanwhile, the clock is ticking and that patient who does not like being kept waiting has arrived. Although dentists become adept at executing operative tasks efficiently there is a constant awareness of moving (and vulnerable) lips and tongue, the patient cringing because they think it is going to hurt (sometimes understandably based on a previous "bad experience"), or the patient needs to swallow or rinse. The shorter the appointment (in general) the harder it is to achieve a relaxed comfortable relationship with the patient subjected to the on-going procedure. It is not often possible to go onto "automatic pilot" as one might do carrying out a similar task on a workbench.

To the extent that dentists are surgeons using operative interventions to treat the problems and conditions that present to us, we are working under the laws of empiricism. In diagnosing problems we seek evidence to enable us to develop a more complete picture of the presenting conditions (signs, symptoms, special tests). Even at this stage, our empirical approach runs into difficulties. The evidence is confusing. Pain, for example can be referred to a site other than the site of pathology and may, as elsewhere in the body, be of functional or psychogenic origin. Even the most experienced of us, after the most careful investigations, can be left unsure of the cause of symptoms. Conversely, we meet colleagues who seem to have an uncanny diagnostic skill. Have they simply organised and reviewed their accumulated experience more effectively or have they really been gifted with some sort of deeper, perhaps empathic, insight?

Having established a (perhaps provisional) diagnosis we draw on empirical evidence to offer remedial treatment for pain or disease, or enumerate a range of options for the restoration of damaged or missing tooth tissue, all with pros and cons. In dentistry, the acronym *EBD* can only stand for one thing – *Evidence-Based Dentistry*. (The authoritative *British Dental Journal* includes a substantial supplement entitled *EBD* every three months.) Unfortunately, accumulated “evidence” tends to change – not unlike other areas of science – and very frequently, attempts to satisfy the strictest criteria for the quality of evidence by reference to a series of Randomised Clinical Trials (RCTs) are frustrated by either the adjudged quality, or the scarcity, of RCTs. A further complication arises when research studies are published showing that a particular (new) material or technique is superior to others. Naturally the researchers are proud of their work and receive credit for it – “ $P = 0.001$ ” being the hallmark we aim to achieve. Quite often, however, the *statistically* significant improvement is of such a small order that either it is not *clinically* significant, or it could be lost in practice due to the material’s relative unfamiliarity in the hands of the operator. A further confounding factor could arise from the need to produce results (and – for the manufacturer of a new product – the marketing advantage) quickly, whereas the true value – or weakness - of a material or technique may, in some circumstances, not be confirmed until it has been in reliable service for 10 or 20 years. (See Appendix 1: Scenario VI).

I stated in Chapter 1.1 p.26 “*Chambers (2001) reports that the majority of dentists, when asked, believe that the most important factor in the delivery of good clinical care is the dentist him - or herself*” rather than the latest materials or equipment. This part of the discussion is intended to convey the primary – empirical, technical, rational – approach that comes to dominate that dentist’s minute-by-minute thinking during the course of the daily clinical sessions. It is not an attack on the rational–empirical approach *per se*. It is, however, intended to show how easy it is for the dentist to become immersed in the problems of the moment and finding solutions for them. With all else squeezed out by the pressures of an overloaded appointment book, these empirical processes come to dominate our day. They can also dominate the way we conceive ourselves simply because they easily overwhelm other inner processes and phenomena. We then easily conflate what we *do* with who we *are*. At the end of the working day, the process continues as we rush to the shops, to the family, to social, or other professional, activities. What we *do* dominates what we *are*. It is not that we deny other aspects of our being. It is simply that they become swamped by the daily tsunami of preoccupation: the busyness of our rational and instrumental world-of-affairs: the backdrop to our need to generate income to cover our commitments and perceived needs.

Dentists are great “doers”. The working structure strongly favours the quick fix for the presenting problem. (See Appendix 1 Scenario I) Such an environment and such preoccupations are not conducive to lateral thinking or to an empathic awareness of the patient lying there with their mouth open, often suffering great anxieties and wondering...¹³⁶

Dental professionals are certainly not unique in this respect. Discussions with members of healthcare and other learned professions draw out sharing that they too become caught up in a similar fashion in what may be seen as a contemporary lifestyle shared by the majority of the working population (including home and family carers).

Rediscovering the Whole Person

Beneath this surface of preoccupation and busyness, other aspects of our being are easily submerged, ignored, or forgotten. Consequently we come to regard them as *deeper*, a metaphor which can easily make them seem relatively difficult to access. Assagioli, writing in the field of Transpersonal Psychology, observes that were a Plato or Marcus Aurelius to appear “*among present-day humanity*”, and were he

“...to examine the human condition...carefully...He would soon notice that, though man has acquired an impressive degree of power over nature, his knowledge of and control over his inner being is very limited” and, despite his enormous scientific accomplishments, “...is largely ignorant of what is going on in the depths of his unconscious and is unable to reach up to the luminous superconscious levels, and to become aware of his true Self” (Assagioli 2007/1974 p.3).¹³⁷

Yet many of us will sometimes protest that “*I need some time for myself*” and, if the current demand for various forms of counselling, psychotherapy - not to mention mentoring and coaching - are anything to go by, many of us feel that we need help to access these deeper areas recognising, perhaps, that they need to be integrated into our life. Indeed, a helpful way of conceiving the person-centred approach to mentoring and coaching is as a process where one person helps another to integrate what they *do* with those deeper processes which define who they *are*. The successful outcome will result in what the person *does* becoming an expression, moment-by-moment of who they *are*: demonstrating congruence achieved by a process of integration (chapter 2.5 pp.114-5).

¹³⁶ It was striking in a group of dentists practising the use of the Skilled Helper Model – described in Chapter 2.5 – that at the point when the mentor is helping the mentee to consider a wide range of possibilities from which to choose a “Goal” (Stage 2a), the mentors had a strong tendency to slide straight into the next “How to achieve it...” stage (3a).

¹³⁷ Assagioli uses the expression “*in the depths of his unconscious*” as though “*his unconscious*” were an entity. I prefer to follow Rogers and use the expression “*out of awareness*”.

This discussion is not, however, restricted to the professional in their professional role. It embraces the patient (student or client) as well. I had not been qualified long when I observed that I never had any teeth walk into my surgery without a person attached. Yet the whole system seemed to focus on rewarding me for doing treatment to those teeth. That was all I was ever paid for. There was no financial reward for spending time on that person - (including giving preventive advice - the first step to achieving health as distinct from repairing the damage caused by on-going disease).

Furthermore, in the mid-1960s it felt that not only the patient, but also the dentist, was devalued and ignored as not relevant by *the system*. If anything, colleagues report, the current contract (2012) seems even worse (HC 289-1 2008 p.3, cited on p.13 Chapter 1.1 above). There were depths to the dentist's own experience, as well as to the experience of the patient, that were not recognised by the system. This discomfiture appeared to challenge the very nature of professionalism which itself was perceived in an authoritarian and (I would now say) élitist, somewhat paternalistic, hierarchical way, and not, in general, in a way reflective of the *I-Thou* approach of Buber (1959/37).

Although there were many other fine minds thinking more deeply – some cited herein - their thinking had not yet diffused through academia, into society at large, and into the thinking of the dentist in the high street – nor, on the whole, have they yet. These deep strands of thought, that in their origins transcend the millennia to the time of Plato and before, have leap-frogged the era of modernity, rationalism, positivism and behaviourism, and have surfaced again to challenge the one-eyed view of the world provided by empiricism. They challenge us, above all – to look again at the too-often-neglected, ignored, or just unseen – richness and depth of the human make-up which – I argue – consists of far more than the flat two-dimensional reality that is recognised by the instruments of empiricism. In our time there is an increasing literature (e.g. McIntosh 2007) emerging, acknowledging and exploring this richness and depth.

It is not the empirical approach itself that is the issue here. The issue is the inadequacy of the empirical *alone* to explain our world or the full depth of our human nature. The danger arises when the empirical approach becomes an –‘ism – a kind of cognitive fundamentalism. Empiricism gives us less than half the picture (see below and Wilber 2000) and denies the existence of the other half. During an era dominated by empiricism, there has been a failure to recognise the reality of those aspects of our being and experience not accessible to the scrutiny of the empirical approach. Now, and increasingly in the writings of thinkers of the 20th and 21st centuries, such as Buber, Berdyaev, Macmurray, Teilhard de Chardin, Rogers, Taylor, Tillich, Polanyi and Wilber there is a recognition that there is more to know about ourselves and about our Selves. When empiricism has spoken, in effect, half the story still

remains to be told. Bergson(1998) gives clarity to this dichotomy by opposing “*materiality*” to “*spirituality*” (op.cit.p.201).

Wilber's Integral Approach to Knowledge and Consciousness

Wilber traces the emergence of different levels of knowledge and consciousness over millennia (Wilber 2004/1981) and writes extensively and persuasively – though rather polemically - on the manner in which stages identified emerging in anthropology are also experienced by each of us in our own ontogeny (Wilber 2000/1995).

The core of Wilber's theory is represented in a diagram showing four quadrants of which a simplified version is given in Fig.3.6.1 to facilitate the present discussion¹³⁸.

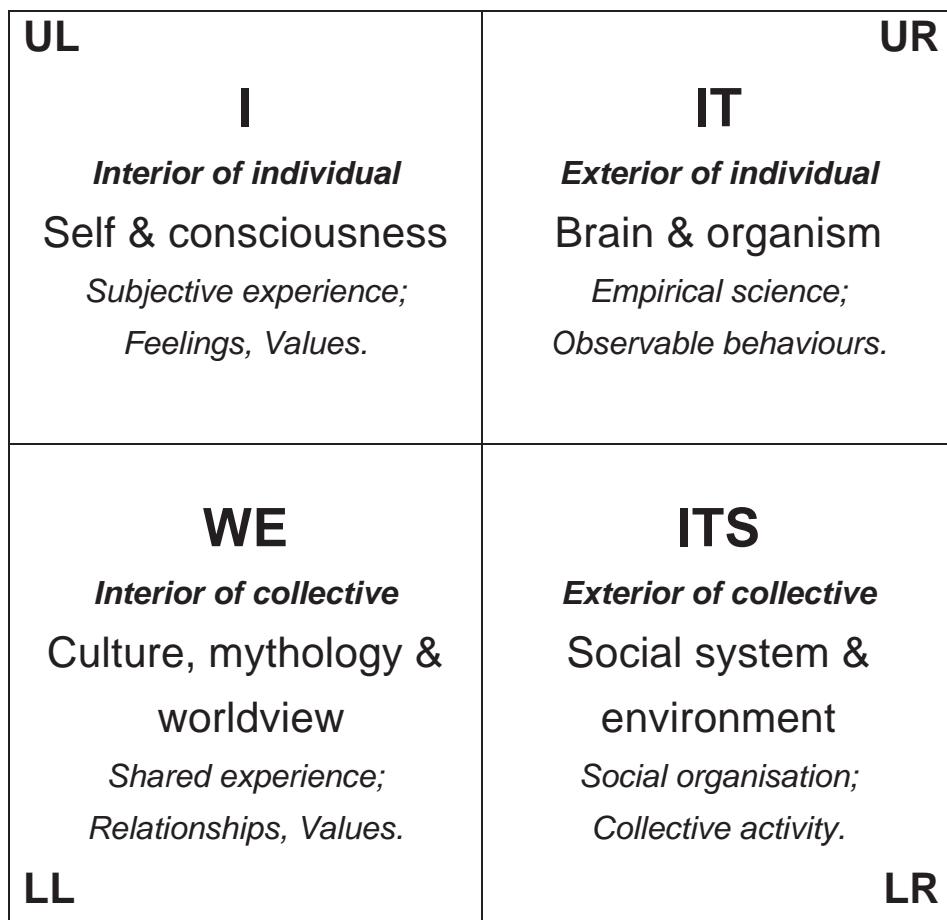


Fig 3.6.1. Wilber's Four Quadrants.

Adapted from diagram and text (Wilber 2006 pp.223-7.)

The right hand and left hand quadrants reflect Teilhard de Chardin's "*law of complexity and consciousness*", articulated in his "*The Phenomenon of Man*" (Chardin 1959)¹³⁹ summed up by Wilber as "*the greater the exterior complexity of material form, the greater the degree of interior consciousness that can be enacted within that form*" (Wilber 2006 pp.227-8).

Wilber's left hand quadrants represent the *interior* of things and the right the *exterior*. The upper quadrants represent the *individual* (I / It) and the lower quadrants represent the *multiple / social collective* (We / Its). Empirical, positivist science takes place in UR and to some extent LR, where the exterior of things (and behaviours) may be observed and measured. Empiricism did not recognise UL – a quadrant which includes all aspects of individual spirituality, experience and meaning – or LL - the quadrant that represents group experience and relations. The content of neither is accessible to direct empirical treatment. Wilber claims that in the premodern period, the left quadrants were dominant; though the mythologies, frozen at a low level, were such that emerging empirical science easily "*threw them out*". The result was that "*the baby was thrown with the bathwater*" (ibid p.226). Not only were the current (and rather primitive) mythologies discarded but mythic consciousness as a whole was trampled before the cognitive advance of the modern period in North Western Europe creating a tension between faith and reason which, though beyond the scope of this thesis, still remains to be resolved.

What I draw from Wilber for this present discussion is access to his visual representation of the problems I have articulated, and holistic ways of viewing them.

- a. The education and training of dentists (on the whole, including psychology) and their function in the surgery on a typical day as outlined at the beginning of this chapter take place in the right hand quadrants (principally UR) where they are dealing with the *exterior* of things whether it be empirical science or rules and protocols for appropriate performance in their role as dentist.
- b. When practising dentists do gather to discuss or learn further how to deal with current issues or advances, most of the time this takes place in UR or, if they are working on protocols and policy issues, in LR – almost always the *exterior*. Even discussion of ethics is traced back to Kant, Bentham and Aristotle and focuses on objectives and rules based on some sort of rational argument (though, one might argue, from questionable premises). See, for example the widely respected authority on biomedical ethics, Beauchamp & Childress (2001) and further discussion in chapter 3.7).

¹³⁸ A lucid account drawing on other leading writers on the rapidly developing Integral approach, including a discussion of a simplified Wilber diagram, is given in McIntosh 2007.

¹³⁹ A greatly shortened account of his theories is given by Chardin in "*Man's Place in Nature*" Chardin T D. 1956/71.

- c. Working on patients in UR is fundamentally impersonal: instrumental.
- d. That is not to say that it is impossible to be empathically sensitive to a patient's state of mind during procedures nor that truly personal (*I-Thou*) contact cannot also be made even in brief conversation in UL. Indeed, this is the ideal I promote. It is, however, helpful to be aware of the distinction.
- e. Working with colleagues as mentees - or working with patients - using the Person-Centred Approach (PCA) - takes place in UL. This is challenging in the surgery (c, d, above) where time pressures tend to dominate. In a mentoring situation, time is usually set aside, though even here, for the mentor in *practising mode*, it is difficult to switch out of the problem-solving mind-set and follow the PCA rule, "Ask: don't tell" (p.101 above).
- f. I propose that the PCA may form an essential component of a relationship that can claim to be *professional* so that professionals (not just *dental* professionals) need to be mindful of working in quadrant UL. UL is where *I-Thou* occurs. UR is *I-it*.
- g. A broader, more holistic, view of human nature sees the person (including "myself") as functioning in more than just one quadrant (UR). The left hand quadrants, and UL especially, are the meeting place for genuine interpersonal contact.

Valuing the Whole Person as a Basis for Professional Life and Action

The significance of this broader, more holistic, view of human nature for our concept of professionalism – especially in the caring professions and education - is central to my argument. In this chapter and the next, the Whole Person remains the focus. I consider the Whole Person in relation with others, taking a holistic view, not only of the person herself, but of the social, and world context in which we seek to *express and share our full and complete humanity*. In this context – social, cultural and philosophical - which constitutes the basis of our experience with other whole persons. We have no choice – whether we have thought it through or not - but to put our trust in *something* which becomes our *deepest value* – our basis for life and action. Although only the religious seem generally to use the word "*faith*" to describe this, it is a basic ontological position, a set of assumptions which become the pole towards which our personal compass points as the determinant of our course in the journey of life: our *deepest value*: *what matters most to us*. The choice of deep value that we each make has major implications for how we regard our *selves*, and ultimately how we frame our sense of morality out of which springs our sense of professionalism. From that emerges our ability, as professionals, to project into our communities the sensing of values

and meaning that enables us, on occasion at least, to transcend the routine, the mundane and the merely empirical, and share with our patients, students, and clients a more complete vision of what it is to be human and what it means to be a professional, occupying a particular position in social space, as a part of a wider caring and learning community.

The view each of us holds of the implications of what it means to “*be human*” must almost inevitably influence our value priorities. Whilst the rational side of our nature – the side that deals with the empirical world in Wilber’s UR quadrant – might be seen as well-developed (indeed cultivated to a very high degree), the focus of this thesis is on the *whole* of the *person* participating in the rational processes. This increasing focus on the holistic view of our nature seems to be a feature of our time. Assagioli observes:

“People are moving towards an integrated form of spirituality which includes the whole human being, without any water-tight compartments, any opposition between heart and mind, between body and soul, between inner and outer life – a spirituality which extends to social life (we can call this spiritual psychosynthesis) (Assagioli 2007 p195, original emphasis).

In the remainder of this chapter I look at our sense of self (personhood and identity): the importance of values - both as part of our sense of self and as a grounding for our professional practice - and the essential role for our sense of self (of being human, indeed) played in our (social) life of relationships with others. In other words, in this section, I am considering the aspects of our make-up broadly signified by the term “*spiritual*” (bearing in mind the distinction I drew between “*the spiritual*” and “*religion*”. Chapter 2.3 p.70).

In some ways this thesis is a response to Tillich’s observation reported in Chapter 2.4 p.86

“Twentieth-century man has lost a meaningful world and a self which lives in meanings out of a spiritual centre” (Tillich 1952 p.132-3).

My focus is on that “*spiritual centre*” whose functioning is represented at the level of the individual interior in Wilber’s UL quadrant and the social/group interior in quadrant LL. In referring to our functioning at this level, it is not uncommon to use the metaphor of *depth* which is employed in a wide range of literature prepared for practitioners developing their helping skills.

The metaphor of *depth* finds two general applications in this context:

- i. the *depth* of self-knowledge or insight which might relate to “*getting to the root of the problem*” and

- ii. in referring to the spiritual dimension of our awareness of *being*: a sense of significance and meaning that may emerge from a tacit (Polanyi 1969 pp 138-58) ontological perception that we are part of something greater than ourselves.

Thus: -

- a. In a key work on counselling, Gendlin (2003/1978) describes a process he calls "*focusing*" which his team discovered was something "...*successful patients* [and presumably successful mentees] *do inside themselves*" (op cit. p4): something that anybody can do to increase their awareness of their own deep processes and feelings in which they focus on a "*felt sense*" referring to "*that edge of awareness between the known and the unknown*".
- b. Mearns & Thorne (2007) stress the value of using a deep level of empathy to help the client [mentee] (if they are ready) "*to explore underlying feelings ...commonly referred to as depth reflection*" (Op.cit.p.71: original emphasis). Mearns & Thorne take the distinction between dealing superficially – "*meeting presentational aspects of the self*" and meeting "*the more fundamental, existential self, extremely seriously*". In the person-centred approach they recognise "*relational depth*" (op.cit.pp.63-4) described in the words of Mearns & Cooper (2005) as

"A state of contact and engagement between two people, in which each person is fully real with the other, and able to understand and value the other's experiences at a high level (Op.cit.p.xii)... A feeling of profound contact and engagement with the client, in which one simultaneously experiences high and consistent levels of empathy and acceptance towards the other and relates to them in a highly transparent way. In this relationship, the [mentee] is experienced as acknowledging one's empathy, acceptance and congruence in that moment" (ibid p.36).

What is described here is a depth of contact that, I believe, cannot simply be taught on a course and practised self-consciously – for being *self- conscious* must be its very antithesis. It occurs when both in the relationship have opened at a deep level to the other – attentiveness/receptiveness in the one and open-ness in the other – reciprocally. On those special occasions when it *does* happen, in my own experience, it is received as a surprise.

- c. John Whitmore, writing about transpersonal psychology, refers to

“A deeper sense of the will, the experience of meaning, purpose, and direction, personal responsibility, and placing others before self” (Whitmore J. 2009/1992 p.205).

This sentence (from a text on coaching) conveys a sense of awareness in the [mentoring] relationship which seems to arise for many mentors. Although it need not be overplayed, it also conveys an underlying sense of depth and commitment which I suggest is necessary to sustain the *true professional* which I discuss in chapters 3.7-3.9.

- d. Diane Whitmore writing about the transpersonal dimension in counselling, comments that

“In our culture and in our psychology, it is difficult to talk about the transpersonal dimension. Our spiritual lives have become as embarrassing to us as sex was to the Victorians...we are reluctant to admit the existence of the non-rational and of spiritual values...The inadequacies inherent in our language and the difficulty of communicating the true nature of transpersonal experience have added to this... [P]eople seeking a better quality of life see counselling also as a means of addressing their deeper needs – for meaning and purpose, for fulfilling an inner longing, a divine homesickness for a better depth and quality of life” (Whitmore D. 2004 p.123.original emphasis).

It has been interesting to receive feedback from trained mentors – as well as that relayed from some of their mentees - reporting that the impact of their experiences as mentees has resulted in their sense of experiencing this *“better depth and quality of life”*.

The Self

There seems to be a widespread shared understanding that there is something unique¹⁴⁰ about being a *person*. We become angry when we feel *“I was just treated like a thing”* or *“I didn’t feel like I was being treated as a person at all.”* We are pleased when we experience that *“They really cared for me as a person.”* The mentoring experience of the mentee has often been described in feedback sessions as *“I really felt I was being listened to as a person.”* However, defining the nature of this core part of us: the part that distinguishes us as a *person* (as seen by the rest of the world); the part that gives us our *identity* (what I

experience as my *Self*) - is remarkably challenging (Greenfield 2000; 2011). At one time, the concept of the *soul* that animates the body and departs at death – *vitalism* – provided an explanation. This theory seems less plausible in the face of increasing knowledge of anatomy and neuroscience which still leaves the question unanswered. The evolutionary emergence of *mind* as a phenomenon arising from increasing complexity in biological systems has been summarised by, amongst many others, Varela et al ((1993) and McGrath (2011 pp.230-33) who draws on the seminal work of Teilhard de Chardin (1959/55), who, in turn, benefitted from the pivotal work of Darwin (1859) and the geologist Lyell (1830-33). Contemporary writers mentioned include Wilber (2000), McIntosh(2007) and Phipps(2011).

The concept of mind or consciousness as a process rather than an entity located in space encourages a phenomenological approach to our conceiving and understanding of it. This inevitably means that learnings about the inner workings which these words signify must, in the first instance, be based on introspection – albeit shared introspection. Charles Taylor in *Sources of the Self* refers to

“[M]odern inwardness, the sense of ourselves as beings with inner depths, and the connected notion that we are ‘selves” (Taylor 1989 p.x).

Taylor points out that this distinctively modern sense of self is not, and has not been, universal in human civilisations¹⁴⁰. Alternative senses may be seen as being equally valid, though different; as having something to offer currently not part of our experience; or a part of an evolutionary process from which our current sense of self has emerged (ibid pp.111-115). Harré (1983), discussing the “*emergence of personal being*” (op.cit.p.ix), argues, along side others, that our self is not, as commonly held,

“...a tabula rasa.... an empty vessel into whom first his mother and then the other adults who form his social milieu pour an increasing amount of social competence. Richards (1974) and others.... have proposed that a child should be imagined as a component of a synthetic but complete social individual – the mother-child dyad.... Careful studies of the way mothers speak to infants, suggest that much of the mother’s speech serves to complete the infant by attributing intentions, wants and plans to it. She does for her child what that child cannot presently do for itself, so that it is always part of a fully competent social individual [the dyad]” (Harré 1983 pp.214-5).

This process is referred to as “*socio-psychological symbiosis*” (ibid pp.104-6). I suggest later that processes that are not wholly dissimilar contribute to the development of professional

¹⁴⁰ By contrast with the rest of the living world.

¹⁴¹ See Jaynes 1982, *The Origin of Consciousness in the Breakdown of the Bicameral Mind*.

behaviours and *habitus*. In Chapter 3.7, p.145) I cite Harré further in considering social and moral aspects of being a professional.

Harré discusses the uses of models to describe phenomena “as if...” (ibid p.96-7). Many writers (e.g. Heron 1992, Wilber 2006, 2004/1981, Zohar & Marshall, 2000), have proposed theories of the person in which models of mind are presented and discussed. There is a rapidly growing literature in this field which takes us into realms of Transpersonal Psychology (Assagioli 2007), philosophy and spirituality (e.g. Wilber 2,000) beyond the scope of this thesis. In what follows, whilst referring to some of this literature at times, I focus on inner experiencing (phenomenology) centred on professional practice and relationships whilst striving to convey some sense of the depths that remain to be explored, both within this subject and within ourselves. Throughout, I hold that these inner depths constitute a part of the “*life space [which] includes the person and the psychological environment*” (Lewin 1997/51 p.188) in the context of which we act as professional agents both as dentists and as mentors.

The Person

The origin of the word “person” – derived from the Greek word “*persona*”, is helpful here. “*The persona was the mask worn by actors to represent the identity that they were representing on stage.*” (Vesey 2011 p.36). Those (this author included) who have experience of portraying different characters on a public stage know very well the experience of being one moment back-stage exchanging comments with fellow actors and then, on cue, in the blink of an eye, stepping right out on stage with a different posture, different gait, mannerisms and facial expressions to the extent, perhaps, that even by a member of the audience who knows them personally, they are not recognised. This is identical to the transformations described by George Orwell and Monica Dickens respectively, relayed by Goffman, describing the *maître d'hôtel* insulting a poorly performing apprentice waiter before “*sailing across...the dining-room...graceful as a swan*” and the waitresses relaxing busily in the kitchen of the hotel before suddenly changing totally, putting on their public faces with a “*tense expression of hauteur*” as they “*glide off again*” to the restaurant bearing plates of food for the guests (Goffman 1959 pp.123-4). The “*presentation of self in everyday life*” is a key and legitimate - even healthy - part of our function in different roles for it can serve to be protective as well as conveying appropriate messages relating to status and competence in professional and social relationships. Such an approach can be used, for example, for “*keeping social distance*” (ibid p.75). Whilst this can be a protective strategy for the professional at times, it could become a barrier to *person-centred practice* which is founded

at least on openness if not always on (psychological) intimacy. The point here, however, is to recognise that the subject of this section is the person, actor, or *Self* *behind* the “*persona*”. We are interested in the person who remains when the *persona* - the mask - has been taken away and the performance or act has ended. Subjectively, we may, with insight, be able to refer to this person as “*the real me*”. Yet who – or what – *is* this *real me*?

Some Helpful Contributions from Neuroscience and from Counselling.

The manner in which the phenomena we refer to as consciousness and mind, and the sense of self that comes with them emerge, remains to be explained. Greenfield (2000) describes numerous “*neural correlates of consciousness*” yet cannot say, “*...and then consciousness happens*” (op.cit.p.180). Whilst recognising that consciousness is related to the activities of highly complex neural networks in the brain, contemporary scientists also recognise that understanding the phenomena requires consideration of our subjective experience. Echoing the discussion above concerning Wilber’s four quadrants describing interior *and* exterior experience, Varela et al (1991) stress the need to see our bodies as comprising both an “*outer and an inner, biological and phenomenological*” (op.cit.xv). They point out the paradox that, in our present world, science is so dominant that “*we give it the authority to explain even when it denies what is most immediate and direct - our everyday, immediate experience*” so that “*most people*” would accept the scientific account of matter and space as occupied by atomic particles whilst treating our own inner experience as “*less profound and true*” (ibid p.12). Greenfield, on the other hand, employing the metaphor of *depth* used earlier (pp.135-6 above), states that “*A deeper consciousness is one where the world around you is...a world laden with personal meaning*” (Greenfield 2000 p.182).

Even if scientists could now explain how our sense of self arises in our brains, whilst it might influence some habits of mind (such as meditation, for example, to which Varela et al give considerable weight) it would be unlikely to change the way we go about our lives on a daily basis. The remainder of this chapter, therefore, will consider the question of *self* from a phenomenological point of view, making the common-sense assumption that the *Self* of which I am aware now is the same *Self* I recall experiencing yesterday and the *Self* I shall (*d.v.*) experience being tomorrow.

Whitmore (2004) refers to “*a centre of life, a place where we feel whole and complete...that lies within ourselves*” (op.cit.p.128) and states that “*The Self can be described as a person’s most authentic identity, the deepest experience of Being (p.14). [It] is the point of synthesis*

of our whole being, of individuality and universality, or our connection with the larger whole of human existence" (ibid).

Rogers (1951) with greater precision, states that

"The self-concept or self-structure, may be thought of as an organized configuration of perceptions of the self which are admissible to awareness. It is composed of such elements as the perceptions of one's characteristics and abilities; the percepts and concepts of the self in relation to others and to the environment, the value qualities which are perceived as associated with experiences and objects; and goals and ideals which are perceived as having positive or negative valence (op.cit.p. 136).

Mearns & Thorne (2007), writing in the Rogers tradition, observe that "*[f]rom our experience of our clients their existential process contains a rich mixture of self-experiences, self-assumptions, hopes, fears, fantasies, terrors, experiences in relation to others, assumptions about others and deeply-held values*" (op.cit.p.39). Whilst in the mentoring context, it is to be hoped that not many mentees will present with "*fears [and] terrors*" this experience would seem to be replicated in the context of mentoring in dentistry.

The Self as Essentially Moral

The above quotations state or imply a moral (valuing) dimension to the Self. Harré, writing from the standpoint of Social Psychology, states that "*the very idea of a person is bound up with the possibility of that person taking moral action. This in itself is bound up with the idea of action in the interests not only of oneself but of others*" (Harré 1993 p.38). He points out that "*an identity crisis is prompted by the question 'What sort of person am I?' not by the question 'Who am I?'* (ibid p.2). Similarly, Taylor, announcing his intention to "*explore various facets of what I will call the 'modern identity'*," finds that "*selfhood and morality turn out to be inextricably intertwined themes*" (Taylor 1983 p.3).

Translating this into the world of work, the implications for the person working in the role of dentist with another who is in the role of patient are reciprocal.

As the patient attending this dentist for the first time I present myself, an intelligent, aware, moral being capable, under expert guidance, if necessary, of making my own choices about treatment needs and options, expecting to be accorded respect – as from one intelligent moral being towards another - in the professional relationship I am entering. I am here because I wish to ensure that I maintain a healthy mouth through seeking regular support from a registered professional. A moral being myself, I shall be looking for signs of a moral orientation in the practitioner I am

consulting: treating me with the respect appropriate to another person. I shall be somewhat wary, looking for signs of the dentist's attitude towards me as a person; checking my background; sensitive to my frame of mind, responding to any concerns I have; making appropriate enquiries concerning my general health status as well as any possible oral or dental needs; and displaying an appropriate level of interest or concern in relation to any problems I report or questions I ask. I shall appreciate being treated as a whole person – not just a mouth – so that the dentist may talk me through the unfamiliar process, inform me of what has been observed, check that I am comfortable or give me a break from time to time. When the examination is complete I shall appreciate being treated like an intelligent person – advised of the state of my mouth; given a report of what the dentist has found in language I can understand and an explanation of any possible problems found with a discussion of options (with pros and cons) for managing those problems. I shall be noticing body language, tone of voice, posture, eye contact and choice of words. If these are manifest in appropriate ways, then I shall feel I have been examined by a whole person who is treating me as a whole person. When the process is completed (which might take more than a single visit, of course) I shall have formulated a sense of whether the dentist is really attentive to (caring for) my needs; whether the main thrust of the appointment(s) has been the attainment of my good as the patient.

As the dentist in the relationship, much of what goes on through the appointment(s) may be fairly automatic – the examination routine, for example, which involves a routine head and neck and oral cancer screen as well as a periodontal screening and I always tell the patient what I am doing next and sharing any relevant observations. I seek to BE with them in a way that does not set me apart as “the expert” looking down and “operating” (DO-ing) on them but rather as a friend familiar with the terrain and exploring with them the best route. I want them to feel that there is a routine in progress with appropriate relevant information being recorded of which they will receive a copy so that, if the unfamiliar environment has made them forgetful, they can refresh their memory later. However, despite the routine, I am always aware that I am not a technician just performing on a plaster model on a workbench. This person has not put a model on the table in front of me, but a (very significant) part of their body. This evokes a certain sense of reverence (not usually mentioned in texts on medical ethics) which is, perhaps, a facet of “respect” or “unconditional positive regard”. I am obliged to check through a medical history with the new patient so that there is an opportunity to make contact on more general human issues related to home, work and health-related practices so that I feel I am getting to know the person

before I get to know the mouth. This is of reciprocal benefit, for the patient is also beginning to meet me as a person, face-to-face with eye contact and I want to be a whole person with them too. When the initial examination is completed, I sit in front of the patient – if anything slightly lower than they so that they do not feel dominated – report on what I have seen and evaluate it before discussing options for managing any concerns – ranging from “keep it under observation for now”, through appointments for preventive advice and routine restorative work, to arranging urgent appointments for management of serious painful or unsightly problems. Almost every “problem” presents a wide range of options for management and time or financial considerations may dictate prioritisation. The plans are managed so far as is possible around the life of the person who is the patient, taking a lifetime perspective on the impact of interventions. From my point of view as the dentist-caring, the choices and timings are governed so far as is possible by the patient’s perception as the cared-for (Noddings 2003/1984 p.9) of the best way to meet their total need.

In the above account, I have maintained an awareness of the *inwardness* of each person, mindful of the inner depths that characterise our Self as human. The whole transaction is seen, from the dentist’s point of view, as the warp and weft of a fundamentally moral process. The warp may be seen as the basic dental professional obligations in expressing goods such as integrity, temperance, wisdom, trustworthiness and competence (to be discussed in chapter 3.8) and the weft as the deployment of social goods such as congruence, unconditional positive regard and empathy, coloured with caring and humour, upholding the dignity of the patient in promoting life as meaningful and fulfilling (Taylor 1989 pp.3-4). All these (and many more) are contributing to the process of the good life for the patient (see chapter 3.7). The focus of my professionalism, after technical competence, is my *way of being* with the patient. In this I seek to show respect for life and integrity, and to promote well-being and flourishing (Ibid p.4). I find the exercise of this intuitive morality reflects a depth and complexity in human affairs which significantly helps to define each of us as a human Self.

These moral positions are key to the definition of “*Who I am*” so that who I am reflects my judgements on what is good or bad; what is worth doing and what is not: what has meaning and importance for me. Taylor states that “*The full definition of someone’s identity... usually involves not only his stand on moral and spiritual matters but also some reference to a defining community*” (ibid p.36). I find this makes sense, for the kind of person I am reflects my (metaphorical) incarnation as a dentist within the community. This relates both to patients who consult me – without whom I would not be a dentist – and the defining community of colleagues within the profession as a whole within which I share concerns,

ideas and professional projects. It is to this community that I look for *mentoring* support when I have a concern that impels me to “*talk about it with certain special partner(s), who know me, or have wisdom, or with whom I have an affinity*” (*ibid*). We all need another suitable person with whom to talk over these deep issues in order to clarify what we feel.

Whilst the last point clearly has a bearing on the value of mentoring (and others will have bearing on a discussion to follow on professionalism and values which, as presented by Taylor, are functions of the Self) the point to draw upon here is the recognition that each of us meets our Self in that reflexive process that entails exploring our “*inwardness*” – those “*inner depths*” where our own moral evaluations take place, where we judge what is good or bad, weigh values and seek meaning.

Holistic Practice

I opened this chapter with an account of the daily empirical and functional focus of the dentist – exemplifying not only other professions but many – maybe most - contemporary lives. I observed that “*Beneath the surface of preoccupation and busyness, other aspects of our being are easily submerged, ignored, or forgotten*” (p.124 above). I now complete the task of the chapter by focusing on what is going on “*beneath the surface*”. Our attention moves to maintaining awareness of our whole Self, and addressing our colleague or patient as a whole Self. The exercise of *mindfulness* is briefly discussed in chapter 3.9.

Here, the focus is on that inner space where our consciousness generates its thoughts, ideas, creative productions, syntheses, moral evaluations, judgments, meanings, artistic creations: that secret inner chamber where the flame of consciousness generates the sense of grounding in a larger reality – what some might call a spiritual grounding – the transpersonal Self (Assagioli 2007/1974 pp.113-15, Wilber 2000, pp.343-5, 710-716) - in the essence of being, “*the essence of life*” (Vesey 2011 p.135) the Ground of Being, or our Ultimate Concern (Tillich 1953 pp.14, 227, Huxley 2009/1945 p.38). These phenomena and experiences are beyond the direct inspection, measurement and validation of empirical science although Lewin (1997/51) acknowledges the importance of taking account of the “*totality of the existing facts*”; that we “*have to deal in psychology, too, with a manifold, the interrelations of which cannot be represented without the concept of space... treated, at least for the time being, as a psychological space. It is everywhere accepted that this 'life space' includes the person and the psychological environment*” (op.cit.pp.187-8).

Yet, paradoxically, it is this inner space, harbouring and illuminated by the inner flame of consciousness, that has generated the concepts and rules of empiricism. It is from this space - to which we have immediate and direct access; of which we have *direct* knowledge – which our power arises to manipulate the empirical world – remotely, and *only indirectly* as it were, through our senses, limbs, and the ratiocinations of our reasoning minds. Through those senses and tools, we have only indirect, second-hand, third person, access, to those phenomena that are the objects of empirical enquiry. Yet we have habitually accorded to the findings of this indirect, remote, form of inquiry the authority to declare our *direct inner* experience invalid! The information we have received back through our senses - our remote sensors – we have processed *rationally* and then used it to cast doubt on our own inner reality – the reality that promoted the investigations in the first place. We have come close to losing our Selves. To speak metaphorically and colloquially, the boot should be on the other foot. Our consciousness is a given. It is the empirical world that is remote and subject to construction and interpretation by our consciousness. It is consciousness that we meet first-hand. In the words of Searle:

"[C]onsciousness only exists as experienced, or enjoyed... it has a first person ontology, whereas mountains and molecules and tectonic plates have an objective ontology, a third person ontology" (Blackmore 2005 p199).

The empirical is remote, second-hand and third person. If we are to doubt anything it is logically the empirical.

In practice, however, we concede that – on the whole – there is an internal consistency in the claims of empiricism. Different investigators repeat our experiments and (frequently) confirm our results. It is *AS IF* that world out there were real. If we allow empiricism its *AS IF* then we have reason to expect the same concession from empiricism, namely the recognition that our inner experience has - *at least* - an equal validity, for it is anterior - in Rousseau's sense: "*anterior to reason*" (Delaney 2009 p.41) - to the *AS IF* of empiricism.

In this chapter we see dental professionals straddling the divide between the empirical and the spiritual. Technically, we must work with the empirical on the basis of the evidence available. At the same time, if we strive to maintain an awareness of the inwardness and (spiritual) depth, both of ourselves and our patient, living those inner phenomena: the flame of consciousness, burning, illuminating, warming, generating creatively in our inner space, defining our humanity; we may yet find ways to assert our professionalism as whole persons, invoking the dimension of our nature that has the resources to heal and nourish our selves, to nourish others, and help us together to improve life and address the needs of our overstretched planet.

In the mentoring relationship, no matter what the position of the mentee on these deeper matters, the mentor must meet her at the level she prefers (an expression of unconditional positive regard). Whatever the position of the mentor, he is committed to consider his mentee holistically, mindful of the dimensions that are – or could be – meaningful to her. This is part of the professionalism of the mentor: mindful of working with the Whole Person. He is working with her holistically: no part of the human make-up is excluded from the encounter. There is no licence to impose discussion of these (deep, sensitive and highly personal) issues on the mentee. However, in discussion with other professional colleagues, with mentees and – especially – those who have attended the Faculty Certificate Course in Mentoring to develop their mentoring skills, it becomes apparent that many eagerly take up the opportunity to delve deeper into these matters. What is desirable in the mentor, therefore, is that they are aware of the potential for deeper exploration and able to gently offer the opening.

“Metaphorically, the person-centred [mentor] wants to ‘knock on the [mentee’s] door’ at a deeper level of his experiencing but she does not want to knock the door down”
(Mearns & Thorne 2007 p 73).

Ways of creating openings and opportunities for such exploration are not difficult to find. Most frequently, this can be achieved by referring to values, professional values and meaning. There does seem, in conversation with colleagues, to be a real yearning to discover meaning in our existence. I have taken that as a validation of my enquiries. Values and meaning are considered in the next chapter in the context of a discussion of Professional Practice: reflecting on the professional Self in community.

Chapter 3.7

Professional Practice

Values, Ethics & Meaning

Introduction

Whilst chapter 3.6 focused on the Self – albeit always as part of a community – this chapter focuses on the community in which the professional's being is actualised and expressed. I suggest that, to warrant ongoing recognition by society as a profession, members of a skilled community are honour-bound to take up a particular moral position *vis à vis* society and the individuals in society whom they serve. This moral position reflects a certain set of values – holistic and person-centred - that stem from our essential nature as persons in a personalising universe, and our existential need for caring assistance.

“Human beings are fully persons only as members of social groups. Each person is a social being, equipped” - as Harré points out - *“with a dual identity and recognised as such by others who are also persons”* (Harré 1993 p.12). The dual identity is evident in two sharply different modes of psychological functioning. In the first, *“when no other persons are present, we function as nodes or centres of perception, action and memory in relation only to ourselves”*. In the other *“our selves are greatly diminished, and exist only as nodes in a network of relations with others”* (ibid p.5). Important in this context, and continuing the theme of the previous chapter, Harré emphasises that *“[t]he self is a location, not a substance or an attribute. The sense of self is the sense of being located at a point in space, of having a perspective in time and of having a variety of positions in local moral orders”* (ibid p.4). Chapter 3.6 (p.133) refers to *“socio-psychological symbiosis”* as a key component of the early social development of the child. The process continues throughout life however, since *“social encounters are the context within which “most psychological phenomena are created and have their primal being”* (Harré 1993 p.95), which includes professional development in collegial contexts. Harré asserts the clear link between social being and morality for *“it would be impossible for an individual to attain true moral stature if it were not attained through the exercise of responsibility to and for others”* (ibid p.38).

In this chapter, I relate the concept of *responsibility to and for others* (often manifest as “*caring*”) to the experience of being part of a professional community. Whilst each of us, at different times, participate in different communities: e.g. family, work, leisure interests, and the broader national – and, ultimately, world - community, I focus here specifically on the communities defined by our roles and status as *professionals* and the relationship between those professional communities and the broader communities in which we live. In doing that, I pursue the emphasis already laid in chapter 3.6 on the moral aspects of our identity, not just as individuals but also now as a professional community. I suggest that, if the concept of *professionalism* is to continue to serve a useful purpose it must incorporate a fundamentally moral foundation such that our individual identity as a *professional* is validated (or not), at least in part, by our *moral position* and that, conversely, (for better or for worse) the standing of our (professional) community is defined by our collective moral contributions. In short, I suggest that for a group of persons to claim to be a profession is not only to claim a particular level of expertise in a specialised and personally significant field of learning, but also – and more importantly - to declare a particular *moral position*. In chapter 3.8 I present a model based on experiences generated in a person-centred - therefore moral - position. Evidence of that morality may be revealed by our qualities, behaviours, and attitudes which in turn reflect our deeply held values and beliefs about *what is good for me to do* which, in turn, distinguish that moral position which, I suggest, *is the humanitarian orientation of the true professional*. Later in this chapter, I enumerate some person-centred values that the dental profession can enact in society and suggest how the morality of that *humanitarian orientation* might be supported by a particular ethic inspiring relations in dental practice.

Qualities, Behaviours and Attitudes – Values in Action

Since behaviours and attitudes arise from fundamental decisions - not necessarily conscious: possibly imposed as “*conditions of worth*” (Cooper et al 2007,p.11) and now forgotten - about what is really important to each of us: i.e. what it is that we *value* as right and good; and since personal qualities (such as trustworthiness) are recognised and attributed on the basis of discerned behaviours and attitudes (for there is a common understanding that “*actions speak louder than words*”), values as demonstrated through behaviour provide important clues to patients and others as to our moral orientation.

Congruence or Genuineness: Transparency vs. Deception

The quality of congruence (or *genuineness*)¹⁴² plays an important part in this discussion for, if declared *values* are not reflected in perceived *qualities, attitudes* and *behaviours*, then *trust* – a key component of any professional relationship - will not be established, or will be lost. Harré, acknowledging his debt to the writings of Thorstein Veblen (1899), makes

“... a broad distinction between those aspects of social activity that are directed to material and biological ends, which I shall call ‘practical aspects of joint action’, realised as a practical order, and those directed to such ends as the presentation of self as valuable and worthy of respect, which I shall call ‘expressive aspects of joint action’, realised as an expressive order... The expressive aspects of an activity usually appear in the way the practical side of the activity is carried out; and would often be described in adverbs of action: ‘She typed the letter resentfully’ and the like.”

(Harré 1993 p.25: emphasis added)

This distinction between the “*practical order*” and the “*expressive order*” draws attention to potential conflicts in the moral space – *incongruence* - between practice and expression, particularly relevant in dentistry where there is a very significant practical component. It is not unknown in everyday life for a worker to convincingly recommend and carry out a procedure (e.g.) to resolve a house maintenance problem, speaking nonsense but with great authority as if they had great knowledge – commonly referred to as “*B.S.*” Later, when the workman has left, it becomes apparent the job was “botched”. The professional equivalent might be work poorly executed in a confident and charming manner so that the patient or client is thoroughly at ease and impressed and, unless the poor quality – or inappropriate nature – of the work comes to light if seen by another qualified professional – perhaps when it goes wrong – the patient may be quite unaware (and then, importantly for this current discussion, the professional who sees the poor work is under a professional restriction to avoid criticising his colleague!). More insidious, yet just as damaging, is the failure in healthcare of a clinician to divulge a particular treatment option which, whilst it might well be in the patient’s best interest and the option they would choose if fully informed, is inconvenient or not so profitable for the clinician¹⁴³. In all these cases, the practical activity falls short of what is required to meet its ostensible end whilst the expressive performance, although inspiring confidence, is deceiving the client or patient.

This highlights the importance of *congruence*. Here the congruence is required between the practical and expressive content of an action: the *whole person* experiencing inner consistency. When workers or professionals do display this congruence, it is often referred

¹⁴² Discussed in chapters 2.4 pp.97-8,100, and 2.5 p.114

to as *integrity*. Because of the potential for either good or harm to *the other* ("*beneficence*" and "*maleficence*" in texts on ethics) the presence or absence of *congruence* takes on a moral aspect, with a bearing on the nature of professionalism and trust and the living of the *good life*.

Achieving Goods for Both Patient and Dentist

In this discussion, I follow Williams' approach which begins with "Socrates' question" - "*How should one live?*" (Williams 2011/1985 p.5). This approach is interpreted as part of an answer to Taylor's plea for a broader approach to morality (Taylor 1983 p.3), reasserting in the words of Higgins (2010a p.212), "*the priority of the good and the ethical importance of the shape of a life as a whole, with the recovery of ancient conceptions of social, historical, spiritual and aesthetic questions into ethics*". Williams points out that for both Plato and Aristotle the *good* is about pursuing "*a certain kind of life*" or being a "*certain sort of person*" (ibid p.38), conveyed by the Greek word *eudaimonia*, which describes "*the shape of a whole life*" and may be translated as "*well-being*" (ibid) or "*flourishing*" (Higgins 2010a. p.212). Although Socrates' question is a general one – how should *one* live? – it invites also another, radically personal, question - what shall *I* do? (Williams 2011/1985 p.23). A particularly relevant and interesting observation (for this discussion) from Williams is that Socrates' question leads to another question - how should *anybody* live – "*which seems to ask for the conditions of the good life – the right life, perhaps, for human beings as such*" (ibid p.22). Higgins, discussing Williams, urges that the ethical reflection, rather than asking '*What is the right thing to do in this situation?*'..."*is better represented by questions such as: 'Who do I hope to become? What is worthy of my time and effort?' and 'What is the best sort of life I can live?'*" (Higgins 2010a p.213). Whilst this appears to invite an egotistical response, Williams points out that neither Plato nor Aristotle regarded *selfish satisfactions* as the desired outcome of the ethical life. Rather, they suggest that it is in the person's rational interest to behave ethically on the basis of "*how he will be if he is a person with that sort of character*" (Williams 2011/1985 p.32). Thus, "*[e]ven when one is reflecting about other-regarding virtues...it is still his own well-being that the agent in Socratic reflection will be considering*" (ibid p.50), so that "*the role of work in the practitioner's own quest to lead a flourishing life*" (Higgins 2010b p.237) is an important part of any conception of professional ethics, and "*understanding internal goods, which are goods for the practitioner, helps show how the eudaimonia of the practitioner is a central concern of professional ethics*" (ibid p.238). This articulates in more formal language the sense of satisfaction and fulfilment that may accompany the completion of a particular procedure in clinical practice: a sense that

¹⁴³ Some discussion of this in relation to 'power' is given in chapter 1.2 pp.45-47.

may relate to the technical quality of the work done or the achievement of the outcome in a manner that ensured the comfort and relaxation of an erstwhile apprehensive patient – or both. This approach to ethics recognises the coincidence of the goods for the patient and for the dentist – mutually advantageous - which might be seen as an ideal to be aimed at by practitioners themselves and by administrators, managers and negotiators from the profession with influence on the clinical practising environment¹⁴⁴. To the extent that the goods (or “interests”) of the dentist and the patient are coincident, the achievement of a satisfactory outcome for the patient may be expected. To the extent that their interests are *not* coincident, there is a likelihood of a greater tension within the dentist between achieving a good outcome for the patient and protecting his own interests, resulting in a possible loss of congruence. The resolution of this tension is likely to reflect the values of the dentist and his prioritisation between those values which, in turn, reflects his moral orientation and gives life meaning. The impact is the same upon any observer whether the action is carried out unthinkingly as a matter of habit - which itself may have developed as childhood modelling of parental behaviours or as a result of professional socialisation/modelling – or whether it is carried out mindfully and deliberately¹⁴⁵.

Values

Values vary in their significance: some may, and others may not, perhaps according to context, have a moral significance. Some of us, for example, like a curry meal – and some do not. That is a preference – a value judgement that carries no moral significance in itself. However, if a host prepares a curry meal for a guest knowing that the guest strongly dislikes curry, this immediately becomes a moral issue for the guest. The host has allowed his own valuing of curry as desirable to override what his guest might reasonably expect to be his caring obligation to value – and respect – her likes or preferences. Indeed, she might interpret her host’s lack of respect for her tastes as a moral shortcoming on his part. Insofar as her host’s decision affects her experience of goods for better or for worse, it contains a moral component and might be interpreted as harmful (in terms of the guest’s personal well-being) rather than benign. The greater the impact upon her – if the host knew the guest would develop an allergic reaction to one of the curry ingredients, for example – then the weightier the moral component. Equally, the less control the guest could have over the situation – then the greater the host’s obligation to her so that his failure to disclose to the guest all the ingredients when she was known to have allergies, for example, highlights a greater moral failure. It is issues such as these: those that carry moral significance - and

¹⁴⁴ This *eudaimonic* outcome for the practitioner is discussed further in chapters 3.8-9.

¹⁴⁵ I return to ‘mindfulness’ in chapter 3.9.

there are real parallels in dentistry¹⁴⁶ - that are important for this discussion and important for how individuals are viewed as professionals.

It is possible to create a list of values. Because absolutely anything could be valued by somebody, the list could be infinitely long. I therefore consider below two values particularly pertinent to the PCA.

Two Primary Values and Their Anti-values

It is helpful to recognise that anything that might be valued has a polar opposite. One person, for example, values peace and tranquillity: another values being surrounded by noise and incessant lively activity. In the right situation, either pole may be chosen without being regarded as “*morally wrong*”. There are some values however, where one pole is undoubtedly generally agreed as being *morally good* – for example, universal respect for human life (though this may, admittedly, be interpreted differently by different communities). There is, in general (Taylor 1989 pp.4-9), a revulsion against the polar opposite – disregard for life. To put it succinctly, therefore, we can say we value some values (here referred to as “*primary values*”) more than others (“*secondary or lower order values*”). Some values are, we might say, more fundamental and that fundamental nature has a weightier *moral quality*.

I assume, in the following discussion, that attitudes underlie behaviours, and human qualities are a summation of attitudes and behaviours that define a person – the moral understanding of the self discussed in chapter 3.6. In short, I assume that values (“*what is important to me right now: what I need right now*”) drive behaviour and, conversely, behaviour reveals values genuinely held and operating in the moment (though not necessarily *awarely* considered and held).

Values may be helpfully considered paired with their antonym or *anti-value*. “*Caring*”, for example, has the anti-value of “*Indifference (Not Caring)*¹⁴⁷”. This dialectical approach is used here as it helps to focus on the degree to which a value is espoused. The polar opposites represent extremes of value held. Behaviours will reflect the value position on the continuum between these extremes that indicate the person’s level of care or indifference.

Value: Care (Caring)

¹⁴⁶ See case study in Fig .3.7.2, and Scenarios in Appendix 1

¹⁴⁷ The values and their comments are given in normal text and the antivalues and their comments are distinguished in italics in this section.

“Care is probably the most deeply fundamental value” (Held 2006 p.17). I take Care to be the fundamental value; the biological and existential necessity for survival of species and planetary ecosystem. Giving and receiving care constitutes the foundation of personal relations in which, when either giving or receiving care, we emerge – out of mere potential – to full actualisation as *persons*. Given our existence as a species displaying personhood, this is the moral value to which, I suggest, all other values are subsidiary and from which all other moral values are derived. As the foundation of Care Ethics – “*the basic moral value*” (Held 2006 p.134) - it takes account of variation, complexity and subtlety operating in a dialectic with other values to permit fine discrimination and a variety of solutions to subtly different dilemmas.

In the dental professional context, the value of Care requires provision for the whole person’s comfort and mood; the creation of atmosphere and humour; empathic awareness of the person’s world; solicitous enquiry as to comfort at appropriate times during the session. This is the “*I-Thou*” of Buber (Buber 1959/37); the “*responsibility for the other*” of Levinas (Levinas 1996 p.158). Care also extends to availability for support out of hours (if necessary via a reliable on-call rota).

Antivalue: Indifference

The antivalue does not accept the responsibility to enter caring or may take the easy way out - “Go by the book.” or “Just do it!”

Binary Value: The Person Cared-for

The *Person* is also a fundamental value. The *Person* provides the primary focus of Care. Care needs the *Person* as its object. Taken with Care, the two together might be seen as the *binary primary value*, for Care without an object is meaningless. Caring - or not caring - derives its significance as the fundamental *moral* value from its potential to affect the *one-cared-for* for the good or for the bad.

The *Person* is the one I meet in the relationship at this particular moment. In a dental professional relationship this will often be conceived - and rightly – as the person who is in the role of patient. However there are others, the nurse assisting, the hygienist, the receptionist, the practice manager and numerous others at different times, on different days, in different contexts; the colleague, the mentee, the tutee, sometimes even the examinee. All these and others are valued and all are worthy of care. That is not all.

The professional: the dentist him- or her-self, is also a person. I will only be able to give unconditional positive regard to the other to the extent that I experience unconditional

positive **self-regard** or **self-acceptance** (Kirschenbaum 1990 p.19). That is the challenge: to be fully present in the relationship.

This *binary value*, I suggest, comes before, and modulates, all the others

Antivalue: Exploitation; Manipulation; Oppression

The antivalue does not value or respect the person for themselves but merely for what they can yield when used, dominated, manipulated or controlled.

Care for Self and Care for Other (Altruism)

Before considering further the value and power of “*Caring*” as a *primary value* that serves as a *discriminator* when *secondary* values may appear to be in conflict, I draw attention to a further dialectic related to the nature of *Caring*, key to the concept of “*altruism*” often regarded as a feature of being a professional (RCP 2005 pp.19-20).

Within each person *Caring* may be applied in two directions (modes), which are also polar opposites. These two poles are inwardly-directed and outwardly-directed caring: caring for the self and caring for the other. Caring for the self has been validated by the biblical golden rule “...*love your neighbour as yourself*” (Bible: Matthew 19.19), and is explicitly endorsed in contemporary culture by the frequent practice of concluding a conversation or meeting with the exhortation “*Take Care (of yourself)*”. It is necessary for each of us to act from the self. Buber’s primary word “*I-Thou*” starts with the “*I*”.

I therefore seek to elucidate the manner in which *Care* may be applied via two parallel dialectics: to discriminate between secondary values that reflect degrees of caring on the one hand, and to resolve a tension between caring-for-self and caring-for-other on the other. In short: how do we discriminate between different degrees, different forms, and different modes (self- and other-) of caring? The evidence before us tells us that when human beings in groups (from two upwards) live their lives based on attitudes of caring, (respect, empathy, support etc.), society works well. The evidence before us also tells us that when self-assertion, self-interest and self-indulgence hold sway, society does not function well. The implication of this observation is that caring-for-other is the desirable default, or aspirational orientation. Because the *self* is a person, as the *other* is a person, so both are equally deserving of care. In general, there is a natural tendency to default to caring-for-self. There are times – moments of *altruism* - when caring-for-other is given precedence as a temporary disadvantage to the self (e.g. a financial sacrifice in giving a sum of money to a Disasters Emergency Committee appeal). There are times when the sacrifice demanded of the self is greater (e.g. the dentist advising a patient against a lucrative form of treatment that,

professionally, the dentist perceives to be harmful to the patient's best interests for long-term dental health). This advice, if it is given frequently as a matter of good practice by the dentist, is likely to lead to his long-term financial disadvantage. (At deeper levels there may be other advantages such as professional reputation or self-respect for the dentist though these advantages are less obvious and less tangible in the heat of the moment.) Taking the argument to its limit there are rare occasions where a person is faced with risking their life to save another – perhaps jumping into a river to save someone in difficulty or, on the battle field, taking risks to save an injured comrade. The virtuous nature of such risk-taking or sacrifice is honoured by society as *heroism*: taking the caring-for-other to an extreme that may cause the fatal loss of the self. Although it is hard to *demand* that the rescuer risks – or sacrifices – his life, the failure to do so nevertheless, if recognised or reported, may incur accusations of cowardice.

Caring for Other and Altruism

In summary, I find the value of *Care* has a *dual role*:

1. The first role of *Care* is as a primary value in itself. In conversations with colleagues a key reason for choosing dentistry as a career frequently elicits the wish to *care* for people. Dentists in general value being part of a healthcare profession. We shall see *Care* in this role frequently in what follows.
2. The second role for *Care* – as a “*primary, or first-order, value*” - is as a discriminator or criterion which guides us in sifting other competing “*secondary, or second-order, values*”.

In both of these roles, “*Care*” is more completely categorised as “*Care for the Other*”. When “*Care for the Other*” is chosen in spite of disadvantage to the “*one-caring*” (Noddings 2003/1984), then this is called “*Altruism*”. However, note the comment above (pp.148-9) about goods – a *eudaimonic* outcome - for the practitioner.

An illustrative range of values and antivalues is included **in** Appendix 10.

When there is a discrepancy between enacted values (even though enacted unthinkingly or unawarely) and professed or espoused values then, on the basis of the common wisdom that “*actions speak louder than words*”, an observer is likely to attribute more credence to the values manifest - or implied in – action, than to the professed values.

Defining Professional Practice

In the remainder of my thesis, I maintain that it is values held and manifest in behaviour – ultimately disclosing a *moral position* – that define *professional practice*. However, in formal discussion concerning the nature of professionalism and what defines a profession, the moral criterion articulated above tends to be submerged beneath other, more readily defined, empirical criteria. Before returning to consider values pertinent particularly to dental professionals, I now review some literature discussing what makes a profession in general, and the state of dentistry as a profession in particular.

What Makes a Profession?

In this section I continue to explore what I consider the core issue for the professions including dentistry: the fundamentally *moral* nature of being a professional.

I begin by briefly considering identifying features of a profession drawing on Macdonald 1995 and Freidson (1994). I then review some literature discussing professionalism in the dental context. After commenting on these contributions, I consider and contrast the above with two other recent approaches to defining medical professionalism - one a significant document produced by the Royal College of Physicians of London - and comment on them, highlighting what I perceive as a clear trend in thinking.

I then return to values in relation to professional ethics – drawing on positions taken by some other professions, within and without healthcare. I suggest that the professions in general, and the medical professions in particular, have to work continuously to demonstrate that we care sufficiently and consistently enough to be *trusted* to live up to these values if society is to be persuaded that the *concept of professionalism* – a relatively recent development in human history - remains useful and valid.

Bernstein observes that

“The modern concept of a professional is absent from eighteenth century English (e.g. is not to be found in Dr. Samuel Johnson’s Dictionary 1755 and later eds.) emerging in the early nineteenth century initially in Percival’s Medical Ethics (1803).”

In that book Percival

“... offer[s] the concept of an occupational role, that of physicians and/or surgeons, whose obligations--because they entail duties of service to others--transcend that of mere employee, and whose prerogatives are justified by an implicit social contract which makes their position a “public trust” (Percival’s words).”

Percival's work eventually led to

"the concept of being a professional (and the correlative notion of unprofessional conduct) gradually displac[ing] the older conception of the physician as gentleman bound by precepts of gentlemanly honor" (Bernstein M. 2011).

The lesson I draw from that account is that our modern concept of professionalism is only approximately 200 years old and emerged at a point in history when privilege and hierarchical values dominated Anglo-Saxon social realities in a way that is rapidly becoming discredited in contemporary society¹⁴⁸. If the concept of professionalism is to survive, I argue that the status and privilege it confers will have to be earned and the nature of the professional commitment it requires subject to continual review and renewal in the light of contemporary, and evolving, humanitarian and societal values and realities. A major purpose of this thesis is to respond to those evolving values and realities and contribute to that ongoing process of review and renewal.

The Concept of Professionalism

Bernstein above refers to "*the older conception of the physician as gentleman*", reflecting the historically common practice for the younger sons of the landed gentry, by-passed in the handing down of the estate to their eldest brother, to choose to enter one of the professions¹⁴⁹. This quirk of the English system may have done much to foster the emergence of the concept of the profession, which has not happened in the non-English-speaking world generally. Macdonald, discussing the sociology of the professions, discusses various theoretical approaches, and '*traits*' identified for defining professionalism, including the concept of the "*gentlemanly values*" cited above.

Mastery of (extensive and complex or esoteric) knowledge in a special field constitutes a widely recognised feature of any profession (Macdonald 1995 pp.134-5, 157-185)¹⁵⁰. In contemporary society a significant proportion of the population acquire extensive and (often) complex knowledge outside recognised professions. The further distinction for professions is added that the application of the knowledge and skill itself requires a level of knowledge only acquired with lengthy training to acquire the skills of discrimination and judgment such that "*there would be grave danger to the public if there were no control over those who offer their services*" (Freidson 1994 p.174).

¹⁴⁸ Discussed in Chapter 1.2 above.

¹⁴⁹ Traditionally Medicine, the Church, Law or the Army.

¹⁵⁰ And see discussion of Freidson below.

Some professions notably the law and medicine - have come to wield considerable power within society (Macdonald 1995 pp.4-6) in addition to the power that is inherent in the *autonomy* traditionally accorded the professions in terms of self governance, including defining and delivering the required learning and training for entry to the profession, and self-regulation including disciplinary procedures. Initially, these powers protected the professions from outside interference and supervision, though failures in self-regulation, notably in medicine since a cluster of serious failures in the late 1980's (see chapter 1.1 p.25, Appendix 3, and Irvine 2003 pp.121-35), have been followed by government-led changes to both the General Medical Council and the General Dental Council securing a weighty lay influence in both regulatory bodies.

Freidson's Professional Model

Freidson (1994 pp.173-8) in his highly regarded review of professionalism, presents an "*Ideal-Typical Model*" (he also refers to it as the "*professional model*") of a profession – a model that

"revolves around the central principle that the members of a specialized occupation control their own work. By control, I mean that the members of the occupation determine the content of the work they do ...controlling the goals, terms, and conditions of work as well as the criteria by which it can be legitimately evaluated."
...In the professional model, both individual customers and executives or managers (who are corporate or organizational consumers of labour) are excluded from such control (Op cit p.173, original emphasis).

Acknowledging the work of many others, Freidson offers the following defining elements:

1. *"An identifiable group... organised ...to establish a corporate identity.*
2. *[T]he body of knowledge and skill ascribed to the occupation is of such a special character as to warrant privilege.*
3. *The occupation as a corporate body is organized in such a way as to be able to control itself without abusing its privilege ... [and] ...must display institutional arrangements that make self-regulation plausible. Such arrangements include:*
4. *Members of professions are able to develop a deep life-long commitment to, and identification with, their work.*
5. *[S]ome will experiment, innovate and do research.*
6. *[T]o protect the integrity of their profession and its work, they will monitor and correct each other's work and discipline or even expel deviants if necessary.*

7. *Collegiality is a central element of the professional model, distinguishing professionalism from both the unfettered individualistic competition among workers in a free market and the formal hierarchies of rational-legal bureaucracy.*

Freidson states that the above (which I have tabulated for ease of reference)

“....are advanced as a model of the elements that together allow people to control their own highly specialized work in the spirit of service to others and the advancement of their discipline. (ibid p.175)

8. *[A]n additional activity of some importance ...encouraged by professionalism ... [is]...intellectual innovation... [often associated with] members of the profession who serve in the special role of teaching [ibid p.176].*
9. *[T]he [professional] collectivity provides a general shelter within which highly critical modes of thought can develop well past what is conventionally accepted...It can make an important contribution to the possibility of developing a more humane, richer, and effectively functioning society”¹⁵¹ [ibid p.178].*

Commentary on Freidson Extract

This extract lists the principle concepts generally accepted as defining a profession. It is undoubtedly authoritative and represents a traditional view - see Wilber's UR quadrant (Chapter 3.6 p.126) – viewing the profession as an entity from an external, rational empirical, or positivist viewpoint.

I regard this exterior view as seriously limiting and suggest that an interior, experiential view can better support both engagement and motivation. In this thesis, I develop a model focusing on the experience of being a professional, seen from the inside – Wilber's UL (“I, interior”) and LL (“We, interior”) quadrants (ibid).

A Selective Review of Professionalism in Dental Literature.

There has been a surge of interest in medical and dental professionalism and ethics reflected in medical and dental Journals published in English worldwide in the last 20 years. Medline searches were made for articles from 2,000 onwards on “*Professionalism in Dentistry*”, and for review articles on “*Professionalism*”. Papers are selected on the basis of their perceived relevance to this discussion and spread across different world centres¹⁵².

¹⁵¹ NOTE: I refer back to this paragraph 9 several times below.

¹⁵² I indicate the base from which each citation emerges, where identifiable.

Many papers reflect the traditional points of view outlined above from authors such as Macdonald (1995) and Freidson (1994) (though Freidson's approach seems to have been evolving gently). Increasingly, however (though by no means universally), authors recognise that traditional approaches need to be reviewed to look beneath the empirically measurable actions which can be described and governed by rules. Deeper issues of attitude, motivation, moral sense and interpersonal relationships are increasingly mentioned with some authors explicitly discussing what is going on "inside" the mind of the professional. In this brief selection, the worldwide spread of interest is apparent, and citations are selected either because they offer a distinctive perspective or helpful turn of phrase or idea to the debate; or because they offer a more comprehensive, or more radical, change in position.

Welie (Canada), writing a short 3-part paper asking whether dentistry is a profession seeks to define, and set out the hallmarks of, professionalism. He observes that dictionary definitions of professionalism "suggest unusually high levels of expertise and skilfulness, virtuousness and trustworthiness, as well as class and market value" and "[f]requently identified hallmarks include a skill based on theoretical knowledge, obtained through extended and standardised education, demonstrated competence, high level of organization, codification of behaviour and altruism". Welie argues that to enter into a social contract with the public, an occupation must provide a good or service that is not easily available and meets a need arising from "existential vulnerability...the combination of a significant human need that must be relieved and complete dependency on experts for that relief." Welie bases his concept of a profession on the literal meaning of the word "profess" - "public avowal" and the offering of a "public good". He offers the definition "a collective of expert service providers who have jointly and publicly committed to always give priority to the existential needs and interests of the public to do so." He admits that there is extensive evidence that the professions initially emerged "first and foremost to protect their own interests" (Welie J V M 2004a and 2004b)¹⁵³ and like several other authors quotes Bertolami's (USA) assertion that when the interests of physicians and dentists conflict with the interests of their patients, practitioners "can be reliably counted on to place themselves first" (Bertolami 2003).

Yeager (USA), reviewing the internationally produced "Charter of Medical Professionalism" (Medical Professionalism Project 2002), points out that it is only since the advent of antibiotics (1942) that doctors have been able to cure disease (as distinct from supporting the patient as diseases ran their course) and observes that, far from making the doctor equipped with this new power more remote and paternalistic, has produced a significant change in professional-patient relationships as the patients themselves have become better

¹⁵³ A pattern modeled, perhaps on the earlier Guilds.

informed. The charter states 3 principles of “*Primacy of... Patient Welfare...Patient Autonomy...Social Justice*” (Op.cit.). The latter principle envisions the “*elimination of unfair distribution of healthcare*” which Yeager observes is not even mentioned in the American Dental Association’s Code of Ethics. “*Emphasis is significantly altered with the shifting of the usual central role of the practitioner to the primacy of the patient and the stressing of the professional’s obligation to society*” (Yeager 2002). (Note: this and further citations from *J Am Coll Dent* are all taken from a section of the journal dedicated to the American Society for Dental Ethics.)

Writing from a sociological perspective, Martimianakis et al (2009) (Toronto) examine the manner in which professions construct themselves and function in society and observe that some sociologists “*...focus on how professionalism is experienced, not only by professionals themselves, but also by patients, families, other health professionals and society at large*” (Op.cit.), exactly the approach adopted in the next chapter of this thesis.

A substantial paper by Cruess and Cruess (2008) (Montreal), argues that the two concepts of *professionalism* and the *social contract* provide a sound foundation for the professions’ relationship with society. Through an epigram consisting of the Oxford dictionary of Philosophy (1996) definition of a social *contract* they suggest that it is helpful to think and behave “*as if*” a contract had been formed. They then discuss expectations and obligations from both sides in this contract. Their paper, describes the relationship between society and the profession in objective, empirical, contractualist terms drawing on Rawls (1999), a traditional view typical of the right hand quadrants of Wilber’s diagram. They do themselves present a diagram of the relationship between the profession, patients and society. Unlike the diagram presented in the next chapter of this thesis, however, they are focussing on externally observable *relationships* between the parties and not on the *experiences* of the parties involved. Nevertheless, it is necessary to have observable behaviours and relationships for presentation in educational contexts and to provide some measurable components for student and practitioner assessments.

Some further papers reviewed below, show trends towards a more diversified approach to conceptualising, teaching, and assessing professionalism.

Rule (2010) (Maryland, USA) “*...draw[s] a distinction between professional ethics and professionalism in that the former is essentially a theoretical enterprise, whereas professionalism is a matter of practice – in other words, a particular set of behaviours.*” I shall express a slightly different view shortly though I find Rule’s definition progressive compared with many others: “*...the cluster of commitments and behaviours shared by the members of a profession, through which they exhibit the values, principles and norms they*

hold in common as members of their profession.” This definition begins to point towards the dentist’s inner world of values and principles. The thrust of Rule’s argument is to encourage practitioners to seek to reverse what he perceives as dentistry’s “*disconnectedness (or isolation)*”, to seek connection or involvement – “*...connectedness*”. He quotes Hershey (1994) as stating that what is needed is “*A willingness to be connected – a willingness to go beyond the isolation of narrowly interpreting one’s professional role in order to be connected to the concerns of other individuals and to the overall well-being of society*”. He advocates seeking “*connectedness in ...four different realms...With Patients...With the Profession...With the Community....With Society at Large*” (Op.cit.). This paper speaks well to the UK situation where significant dental professional bodies frequently have difficulty finding colleagues willing to take office in running professional groups, though, from the tone of Rule’s paper, it may be that UK dentists are more involved at a societal level – at least in non-dental activities.

A valuable paper led by a New Zealand clinician (Wilkinson et al 2009) considers the multidimensional aspects of professionalism as represented by various sources and matches clusters of components of professionalism with clusters of assessment tools. In drawing up a definition of professionalism, the authors identified themes and subthemes to which they matched assessment tools (where suitable tools were deemed to be available). The themes and subthemes derived from Wilkinson’s literature review are reproduced in Appendix 11.

Interestingly, in the UK at about the same time that this paper was being prepared, The Network of Expertise group of NCAS¹⁵⁴ were developing assessment tools looking at a similar range of themes. As did these authors, we found a wide range of assessment tools necessary, including “360 degree feedback”¹⁵⁵. It is striking how significantly this list of themes and subthemes varies in its expression of professional qualities and behaviours from traditionally accepted descriptions such as Freidman’s. In the language of this thesis, the approach has become more holistic and it is acknowledging the existence of an inwardness to the professional’s experience, which is portrayed in Wilber’s left hand quadrants and whose validity or even authenticity would be denied by positivism. It is also evident that these subthemes describe areas that lend themselves naturally to mentor support both during training and within practice.

¹⁵⁴ The National Clinical Assessment Service, an arm of the NPSA, National Patient Safety Agency which aims to support and assess, Doctors, Dentists and Pharmacists identified as underperforming.

¹⁵⁵ An assessment process which draws on many different sources including other members of the healthcare and administrative teams, assessments of the clinician’s work practices, record keeping, feedback from patients, continuing professional development record, etc.

Another team from New Zealand begins by pointing out the shift in the definition of professionalism from the “social structures of medicine...to represent the expected behaviours and attributes of practitioners...and...a more patient-centred approach” (Wearn et al 2010 p.1). They report a change from “defining what we are to defining how we practice” and point out that the “culture’ of medicine then becomes the biggest influence” – described in part by “peer and senior pressure and role modelling in the development of professional identity: elements of what has become known as the ‘hidden curriculum’ ”. They cite evidence of the importance of the ‘hidden curriculum’ and report two American medical students publishing a paper in which they “identify the key barriers to successful professionalism education [as] being the unprofessional conduct of those that the students learn from” (ibid p.2). They conclude their paper by reiterating that “in modern times when considering professionalism we think of the activities and behaviours of the professional. In medicine, the common themes are; altruism, a code of ethics, societal responsibility and humanistic values...The current understanding [is] that professional expertise includes and emphasises attitudes as much as knowledge and skills” (ibid p.7).

Four further papers highlight person-centred and holistic concepts in their discussions of professionalism. Schwartz and Bohay (2011) (Ontario) refer to “empathy...values [which] include compassionate patient-centred care” and they observe “At the core of clinical practice is the interpersonal interaction between dentist and patient. The expanding role of dentists in treating the whole patient includes the ability to connect the emotional and behavioural health of dental patients... [improving]...overall health and well-being.” They stress the value of the “humanistic approach to education...in which real learning occurs when the whole person, not just the intellect, is engaged in growth and development. The emotions, the social being, the mind and the skills needed for a career are all focuses...” (Op cit.pp.174-5). Zijlstra-Shaw et al (2012) (UK) seek to “explain the importance of professionalism... based on traditional values... augmented with an increased emphasis on reflection” and quote Weil’s definition given above. They point out that “professionalism has been described as a meta-skill” (Op.cit.128-9). Masella (2007) (USA) states that “[t]he most important mission of dental education is development of student professionalism.” In this paper, “[t]op-down, rule-based professionalism is contrasted with its experience-based, mentor-mediated, socially driven counterpart” and (quoting Sullivan)... “Professional education is above all a shaping of the person (Op.cit.p.205).” In a thoughtful, and relatively early, paper Arnold (2006) (USA) states “We will have truly achieved our goal if our graduates, our colleagues, and we ourselves internalise the principles of professionalism, embracing them as our own (Op.cit.p.211).” Earlier she states – drawing on Wilber (2001) - that “the very nature of assessing professionalism requires us to make noncontent-oriented

judgements about learners' and colleagues' behaviour. Assessment of professionalism requires us to consider the inner world of a human being, but we prefer to deal with the outer world of observable behaviour" (Op.cit.p.206).

The focus and tone of these papers demonstrate an increasing recognition of the importance of thinking about dentistry in an holistic and person-centred way.

The American Board of Internal Medicine: *Medical Professionalism*

The American Board of Internal Medicine describes medical professionalism as
"constituting those attitudes and behaviors that serve to maintain patient interest above physician self-interest" (ABIM 2002 p.243).

Commentary on ABIM Description

The couching of that description in terms of "attitudes and behaviours" is relevant in our present context for whilst "behaviours" are observable and therefore belong in Wilber's UR quadrant, they, along with "attitudes" which may *not* be observed in UR but in quadrants UL and LL – reflect individual and collective inner experience respectively. The assertion of "patient interest above physician self-interest" relates to the discussion of "care for self and care for other (altruism)" above (pp.152-4).

The Royal College of Physicians of London (RCP)

I reproduce below (with commentary) major extracts from the RCP report (RCP 2005a) which presents a radically revised approach to professional practice. The report was produced by a high level working party after lengthy profession-wide consultation and was accompanied by a technical supplement (RCP 2005b) in which evidence submitted is reproduced.

(NOTE: in the citations below from the RCP report I reproduce their use of italicised and bold text etc. and retain the original paragraph numbers.)

Doctors in Society: Medical Professionalism in a Changing World

The Working Party informed the early stages of their enquiry by referring to the Oxford English Dictionary definition of a profession:

“An occupation whose core element is work based upon the mastery of a complex body of knowledge and skills. It is a vocation in which knowledge of some department of science or the practice of an art founded upon it is used in the service of others. Its members profess a commitment to competence, integrity and morality, altruism and the promotion of the public good within their domain. These commitments form the basis of a social contract between a profession and society, which in return grants the profession the right to autonomy in practice and the privilege of self-regulation. Professions and their members are accountable to those serviced and to society” (RCP 2005a, para.2.3)

Commentary on Dictionary Definition

This definition, whilst preserving some of the external (Wilber’s UR quadrant) perspective, also – reflecting the times - subtly moves towards a UL and LL perspective in referring to “...vocation...art...service...profess a commitment... (and possibly) social contract”, all of which are part of the professionals’ – and society’s inner experience.

At the end of their deliberations, which followed wide consultation, the Working Party produced a report offering both a **definition** and a **description** of medical professionalism.

The RCP Definition:

2.5. “Medical professionalism signifies a set of values, behaviours and relationships that underpins the trust that the public has in doctors.”

The Description of medical professionalism sets out these values, behaviours and relationships in clearer terms.”

2.6. “Medicine is a vocation in which a doctor’s knowledge, clinical skills, and judgment are put in the service of protecting and restoring human well-being. This purpose is realised through a partnership between patient and doctor, one based on mutual respect, individuality, and appropriate accountability.”

In their day-to-day practice, doctors are committed to:

- ***integrity***
- ***compassion***
- ***altruism***
- ***continuous improvement***

- **excellence**
- **working in partnership with members of the wider healthcare team.**

These values, which underpin the science and practice of medicine, form the basis of a moral contract between the medical profession and society. Each party has a duty to work to strengthen the system of healthcare on which our collective human dignity depends.”

They state in 2.7. “... [T]he words we have selected aim to map out a substantially new conceptual geography (a collection of qualities or dimensions) for medical professionalism – one that lays out the values that inform the behaviours and relationships of doctors. These values create the basis for a modern healthcare system.”

“Securing trust is the most important purpose of medical professionalism. Trust – and so professionalism - operates at two levels:”

- *In the doctor providing care (individual professionalism)*
- *In the system where that care is given (institutional professionalism)*” (para.2.8).

Commentary on RCP Report.

The substance of this report (substituting “dentistry” for “medicine” and “dentist” for “doctor”) could be applied with minimal alteration to dentistry. The focus announced above is on values.

Both the definition and the description, incorporating concepts such as human well-being, collective human dignity, values, relationships, a *moral* contract, integrity, compassion, vocation and altruism belong largely in Wilber’s UL and LL quadrants – inner individual and collective perspectives – and, thereby fully justify the claim below to map out a “substantially new conceptual geography”. This represents a highly significant shift towards a more person-centred approach. In so doing it also fulfils the requirement of the last of Freidson’s “Defining Elements” (para 9. p.13 above) in that it may be seen to *make an important contribution to the possibility of developing a more humane, richer, and effectively functioning society*. I observe also that this document is progressive and visionary, demonstrating the *leadership* potential of professionals by using their collective influence to nudge society further along a road that has already begun to open up in the last century. Not only are the doctors reflecting a perceptible social trend, they are embracing it and giving it

an influential and powerful thrust forward by embedding a new social philosophy in such a significant document in such a socially influential profession, consistent with Freidson (para 9.p.153 above).

I take issue with one element only in this report: I prefer that we *earn* or *deserve* trust and find this choice of the words “*Securing trust*” (para 2.8) surprising and incongruous though I agree with the stated importance of trust. I refer to “*Securing trust*” below (pp.176-7). The bullet points referring to *individual professionalism* and *institutional professionalism* match the perspectives represented above by Wilber’s UL and LL quadrants respectively.

I comment briefly below, from the perspective of this thesis, on the 6 bullet points making up the “**description**” above.

Integrity has been discussed in chapter 3.6 p.141 in relation to mentoring and I treat it as a near synonym for inner congruence or genuineness. Whilst this also applies in the professional relationship, insofar as the professional is relating with the patient/client using a *mentoring approach* (illustrated in chapter 3.8 pp.11813-5) the more widely used meaning of integrity as *honesty* is also required to complete the function of the word in the RCP report.

Compassion is a term less commonly used in the dental context as fewer patients present who are frankly “poorly”. However, it most certainly has a place in determining the dentist’s response to a situation where a patient presents with severe pain needing urgent relief, or a patient is consumed by overwhelming apprehension¹⁵⁶.

Altruism seems to appear on any list of qualities of a professional (see pp.153-5 above).

Integrity, Compassion and Altruism all relate to the character of the practitioner. In an ideal world, dental schools would select future dentists using criteria including the assessment of character, and include such assessments in both undergraduate and postgraduate assessments. This is problematic: Pellegrino and Thomasma, writing in 1993, state that “*Unfortunately, there is no reliable way to assess an applicant’s character*” (p 180) and, although reflective writing is included in professional portfolios (Cavanagh et al 2011, pp 25-35) this, in itself, does not ensure that the philosophy expounded is integrated into practice. However, literature reviewed above (pp. 15-20) includes authors who now believe suitable assessment tools can be developed.

Continuous improvement in a civilisation where knowledge, techniques and procedures are continuously evolving, is an inevitable requirement for good professional practice. It is interesting that the RCP choose the word “*improvement*” rather than “*education*” or “*updating*”. The word “*improvement*” begs the question of what is actually an improvement –

¹⁵⁶ In Chapters 1.1 and 1.2 I refer to inadequacies commonly observed in responding to patient needs.

or even whether something is actually “*wrong and needing improvement*”. Unfortunately the concept is often equated (by patients and clients as well as professionals who wish to promote themselves as “*using the latest techniques and materials*”) with “*keeping up to date*” which, in a world where the “*latest*” often falls quickly into disfavour, draws attention to the need for a secure evidence base to justify change. Regulatory requirements ensure that dental professionals expose themselves to at least a minimum amount of CPD. Since, however, it is not possible to demonstrate improvements in practice from mere attendance at CPD events, there are moves afoot to introduce *revalidation* every few years. The use of *the latest* material can be seen and recorded – Wilber’s UR quadrant – but the appropriateness of the decision to trust this new material is a judgment call that belongs in Wilber’s UL quadrant and requires an acceptance of uncertainty and risk.

Excellence. Whilst it is inconceivable that the concept of “*excellence*” should be omitted from this list, it is open to misinterpretation, exploitation and misuse. To the extent that it implies the execution of a necessary and agreed task, procedure or operation to an excellent standard, there can be no argument. Such excellence can be assessed or measured (Wilber’s URQ). To the extent that it is applied to a concept such as “*dental care*” it becomes extremely problematic. The promotional strap line used by the Faculty of General Dental Practice, “*Promoting Excellence in Dentistry*”, suffers from this ambiguity reflecting, perhaps, a significant divergence of interests within the membership. The example of providing implants to a patient with periodontal disease mentioned in Chapter 1.2 pp.46-7 illustrates the case. Many would argue that in most cases (with the patient’s consent and involvement), the periodontal disease could be managed successfully avoiding the extraction of teeth and avoiding the provision of implants in a patient who is a poor risk for implants. Many would, however, extract the teeth saying this is “*inevitable*” (which in most cases it is not) and then provide implants. This is a much more expensive option for the patient and a much more lucrative option for the dentist. Assuming the implants and restorations are well done, a colleague seeing the completed work could truthfully describe it as technically “*excellent*”. A colleague taking a more conservative and preservationist approach, knowing the details of the decision-making process, might well deem it highly inappropriate and disastrous rather than excellent. Excellence in the attitudes, decisions and judgements made by a clinician (Wilber’s ULQ) cannot be assessed in retrospect or measured by any regulator or inspector (a URQ activity) unless subject to a full clinical review with access to all pre-operative radiographs, models, etc. and an in-depth interview with the patient. Much impressive-looking dentistry is done in the name of aesthetics or cosmetics which is ill-advised if the long-term objective is to keep a functional natural dentition for the full life-span (Kelleher 2010; Holt 2010b; Kelleher et al 2012a, 2012b, 2012c). Whilst it is possible to confirm by

inspection that clinical work (often referred to colloquially between colleagues as “*the carpentry*”) is of a high standard, the appropriateness of the decision to provide this particular restorative work – bearing in mind the potential for *harm* from such interventions from a lifetime “*cradle-to-the-grave*” health perspective cannot so easily be assessed.

Working in partnership with members of the wider healthcare team. Within a hospital environment or a large practice the concept of *Teamwork* plays a dominant role. It is a fact, however, that many professionals tend to behave as stars and do not readily become good team players. A comprehensive discussion of this is given in “*First Among Equals: How to Manage a Group of Professionals*” (McKenna & Maister 2005) and I discuss issues of power in Chapter 1.2 above.

It is notable – and, perhaps, not coincidental - that contemporary statements pertaining to professionalism in professions related to medicine referred to below, reflect a very similar trend towards consideration of values, attitudes and beliefs with an holistic focus on the patient (person-centred) and an emphasis on the patient’s autonomy and contribution in decision-making. Most bodies (including the General Medical Council and the British Dental Association) declare their own organisational values. Some also include statements about values for their members. In the discussion below, I have sought to identify some such “*Standards*”, “*Values*” or “*Principles*” (all of which may be seen to embody *values*) which are promoted by my sources as appropriate to the various groups of practitioners.

The General Medical Council (GMC).

Before looking at other professions, it is worth first taking a look at the General Medical Council’s advice on “Good Medical Practice”: Doctor patient partnership (GMC 2012).

They refer to

“*Relationships based on openness, trust and good communication [enabling the doctor] to work in partnership with [their] patients to address their individual needs and state that*

“*To fulfil your role in the doctor-patient partnership you must:*

- a. *Be polite, considerate and honest*
- b. *Treat patients with dignity*
- c. *Treat each patient as an individual*
- d. *Respect patients’ privacy and right to confidentiality*
- e. *Support patients in caring for themselves to improve and maintain their health*

f. *Encourage patients who have knowledge about their condition to use this when they are making decisions about their care.”*

This is accompanied by extensive and helpful explanation. With the possible exception of injunction e, all these injunctions belong in Wilber's UR quadrant. It would be possible to obey them all without relating at an UL quadrant (“interior”) level at all.

The General Dental Council (GDC)

The GDC publishes “*Standards for Dental Professionals*” which consists of the six *Principles* reproduced in Fig 3.7.1 below -

Fig 3.7.1

“The Principles of Practice in Dentistry

There are six principles around which the guidance is built. These should be at the centre of everything you do as a healthcare professional. They are:

1. *put patients' interests first and act to protect them,*
2. *respect patients' dignity and choices,*
3. *protect the confidentiality of patients' information,*
4. *co-operate with other members of the dental team and other healthcare colleagues in the interests of patients,*
5. *maintain your professional knowledge and competence, and*
6. *be trustworthy.”*

From: *Standards for Dental Professionals* (GDC 2006)

There are also explanatory notes. As with the GMC “*Good Medical Practice*” above, the principles are couched in traditional directive terms. Neither makes any reference to either the dental professional's, or the patient's, experience of being in a healing or helping, supportive relationship. This may be contrasted, for example, with the simple definition of Occupational Therapy given in their “*Code of Ethics and Professional Conduct*”:

Occupational Therapy enables people to achieve health, well-being and life satisfaction through participation in occupation. (BAOT/COT 2011 p.4)

The patient's experiences of the trio of "*health, well being and life satisfaction*" belong in Wilber's UL ("I – inner") quadrant. The simple device of shifting from detached injunctions or directives, (which may, in any case, be derived from the more holistic form of statement) to using experiential terms, immediately gives an entrée to the *inwardness* of the relationships and experiences, whilst still including the pragmatic action-focused need for rules.

I do not argue that *all* such statements should avoid the form of injunction or directive. To attempt that would be contrived in the extreme. However, the example of the "*Code of Ethics for Social Work: Values and Ethical Principles*" shows the change in impact that can be made with references to the need to "*respect, uphold and defend each person's physical, psychological, emotional and spiritual integrity and wellbeing*"... by reference to "*values and life choices*",..."*compassion, empathy and care*",..."*the duty to respect a child's wishes and feelings*",..."*development of positive policies, procedures and practices which are anti-oppressive and empowering*". The difference in tone of the document is striking (BASW 2012: part reproduced in appendix 12 alongside some other similar statements). The key words used in the RCP report (above) which generate this shift in tone include "*values, mutual respect, individual responsibility, relationships, integrity, compassion, altruism, moral, moral contract, art (of medicine), well-being, patient-centred, holistic, happiness, well-being, passion, vocation, kindness, humility, attitudes*". In presenting a model for professional practice in the next chapter, I seek to express it largely in terms of the *inwardness* of the professional encounter experience for all parties involved.

A Range of Dental Professional Values in Person-Centred Terms

Having introduced the binary value of *The Person* and *Caring* in a dialogical style, I now list and describe a range of additional values more specifically oriented towards dentistry.

- 1) **Value: Congruence:** It is essential, above all, that the dentist is congruent within their relationship with their patient. This is much more than "getting on with the patient". It requires that the dentist has resolved within his own being the tension between his own interests (making the practice earn a fair income) and the interests and needs of his patient: securing health; conserving tooth tissue; encouraging the patient to work from a life-time perspective in planning their oral health pathway into the future (Holt 2010a). Without this congruence, there will be an unresolved conflict within the dentist which will lead either to disadvantage for the patient or stress, further inner conflict, and perhaps breakdown for the dentist (*ibid*).

2) **Value: Respect:** With congruence addressed, the dentist is unencumbered and able to show respect (unconditional positive regard) for the WHOLE patient, to establish comfort and rapport through friendly greeting and parting; with conversation when appropriate at other times to keep contact with “the person” behind the mouth, seeking to enhance a sense of well-being even within the dreaded professional encounter.

The choices for the way forward will always be subject to the patient’s *autonomy*, upholding their right to self-determination and their human dignity, including *confidentiality*. The congruent dentist wants to ensure that the patient is fully aware of all options, their advantages and disadvantages in both short and long-term, and she will either undertake the work required if it is within her competence, or offer appropriate referral. She will tailor sessions in the practice to the patient’s overall needs, taking account of social and family circumstances as well as the level of challenge she empathically senses the patient will experience during any operative treatment.

3) **Value: Relationship:** Relationship is a key component of human *being* and an inevitable component of every professional encounter. Although the ongoing relationship with a long-standing patient is, in itself very satisfying, this value points (hopefully) to something more substantial within that relationship: namely a deeper side to it, reflecting the wholeness of the two (often three including the nurse) persons involved. This is more likely to happen, it would seem, over a greater expanse of time as the clinician and patient “*get to know each other*”. Over the years, a patient and dentist may spend many hours together and there are numerous opportunities between stages in procedures when a few words can be exchanged. Significant life events, happy, threatening and sad, “*problems at home*”, loss of loved ones, all come through the consulting room from time to time. They need airing – and sometimes that is the most important part of the appointment – acknowledging the wholeness of the person in distress - and this constitutes perhaps the greatest reward for the general dental practitioner for, unlike the specialist who may only see the patient for two short encounters, there is an ongoing relationship with the patient and at times it falls to the dentist to be the one who can offer support at that moment, even if it is only a sympathetic ear. At that moment the dentist is a part of the patient’s network of support in their community.

4) **Value: Calling, Vocation:** The concept of “calling” or vocation seems a little unfashionable. However, for the true professional, it can convey a sense of mission, of having an obligation to respond; of being part of something bigger than ourselves;

a sense of being called upon; that is lacking from the more popular term “career”. Yet for many in dentistry, the practice of such a profession dealing with patients’ intimate sensitivities and personal concerns, can flower into a sense of vocation “*almost as if I have been called*” to this work. For many of these, the sense of vocation causes them to become involved in supporting colleagues through mentoring and other forms of education and support. The sense of being part of a larger scheme of things, which *vocation* implies, is something to be valued most highly for the inner sense of personal commitment and personal reward that it can bring.

- 5) **Value: Health:** Routine and careful screening for all forms of disease affecting the mouth and adjacent tissues. Offering to support (where appropriate) lifestyle changes to achieve stability in disease processes (usually caries and periodontal) in the mouth as well as related risks such as smoking, excessive consumption of alcohol and betel nut chewing. Where possible, offering treatments that minimise the risk of harm consequent on operative interventions.
- 6) **Value: Lifetime Perspective (Teeth for Life):** Patients need teeth for life. Even long-standing regular patients seem to expect that they will eventually lose their teeth. Indeed many of them will unless this value – and indeed the full possibility of keeping *teeth for life* - is conveyed to them by their professional advisers so that they are equipped to ask the right questions when involved in planning their dental futures.
- 7) **Value: Tooth Tissue:** This value focuses on the irreplaceable nature of natural tooth tissue and the risk of iatrogenic damage and long term pulpal degeneration following extensive tooth preparation. “*Would you do it to your daughter?*” (Kelleher 2010; Holt 2010b).
- 8) **Value: Appearance:** This issue may cause conflict with value 6: tooth tissue. This area can also bring the patient’s interests and the dentist’s into conflict unless the dentist has thoroughly resolved these issues as in value 1): congruence. In this discussion, full information to the patient about long-term risks of elective operative intervention is important. This is a judgement call that belongs, first and foremost, to the patient, who needs to be well advised of the 20% risk of (initially invisible) serious longer-term consequences of seeking a quick cosmetic makeover now.
- 9) **Value: Family:** Patients have families and seeing the patient (where appropriate) as a part of a family unit – and communicating this awareness - is part of overall respect - caring for the Whole Person, for the Whole Person IS their relationships as well – a social being. “*No man is an island...*”

10) **Value: Social:** As well as being a part of a family, many patients have social roles that are meaningful to them, possibly relevant to dental discussions, and often a means of conversing them out of tension and psychological discomfort in the surgery: part of the Whole Person again. Remembering social events and enquiring about them contributes to the sense of being cared for as a whole person.

11) **Value: Quality:** Quality of caring is of prime value. This may mean the patient needs more time, a system that recognises and supports the professional appropriately (with a system of payment designed to reward the professional for meeting this need appropriately) is important if the dentist herself is not to feel undervalued and not respected. Quality may also refer to the actual operative treatment carried out by the dentist – whether (for example) the tooth is well prepared to ensure a long-lasting crown and the shaping and fit of the crown are of a high standard. This places an obligation upon the reflective practitioner to identify training needs to enhance relevant skills.

12) **Value: Technical Skills:** According to the type of dentistry the dentist is undertaking, from basic care, to restorative and prosthetic work to more advanced forms or even specialist skills levels, technical excellence is valued and a system that respects the professional, seeks to reward excellence appropriately. It was stated in chapter 1.2 that clinicians demonstrating high levels of competence might reasonably be rewarded with appropriate promotion within the team in some environments. In other environments the appropriate recognition and reward may appropriately be financial. Note, however, that there is a strong tendency to equate high “Standards” with technical excellence. This happens both with dentists and with patients who are impressed by technical skills and achievements. However, when we refocus on *health and prevention* it becomes apparent that the highest standard of excellence would be achieved by preventing and controlling disease in the first place. Technical excellence is only required (barring accidents) when the health agenda has failed to achieve its goals.

13) **Value: Fair Recompense:** It is entirely appropriate that a system of values should include the valuing of fair recompense for professional commitment. Whilst Kennedy’s Bible-based dictum “*Much is asked of those to whom much is given*” might, to the committed professional, be seen to deserve moral precedence, the demands of the PCA rebound upon the professional and society in reverse order, for the professionals themselves deserve Unconditional Positive Regard (respect), and a society that does not respect its professionals in all ways – not merely financially –

should not be surprised if there is difficulty recruiting and retaining professionals of high calibre and with high levels of ongoing professional commitment.

14) **Value: Communication / Openness and Transparency:** This value honours the patient's need to be informed about his health status and prognosis, the options available, relevant costs, needs for referral etc. All records are the patient's and he has full access to them on request. (Note: the deliberate avoidance of any reference to the patient's "rights" in this paper. The information belongs to the patient. Period. Respect makes it available as a matter of course. This is not a rule. It is a person-to-person attitude based on respect (values *Care & Respect*) for the *other*.)

15) **Value: Leadership:** As a clinician in a practice, even where the dentist is an associate, there is often opportunity using the PCA to influence other team members helpfully so that they can discover new opportunities for being their best and, in turn, supporting their patients and colleagues. One person can often do much to influence mood and performance in a team as well as promoting values and beliefs. In some environments the promotion to leading roles is a way of showing that leadership qualities are valued as well as making good use of available talent.

For the appointed leader, the concept of the *servant leader* belongs to the person-centred approach. (Covey et al. 2003) Leadership involves responsibility.

16) **Value: Responsibility with Power.** Whilst there is no suggestion in this paper that a professional should not enjoy some privilege and influence (and, indeed, it has been stated earlier that it is "*appropriate – and even desirable – that those who can demonstrate a high level of competence, skills and knowledge should be appointed to higher positions along the career pathway where they may take on educational and leadership roles within the profession*" (Chaper 1.2), the reasons for desiring that power (as a career ambition, for example) and the use to which the advantages conferred by power are put – decisions which might be based on (unconsciously perceived) self-need rather than long-term patient-benefit, for example - need to be carefully evaluated and reflected upon by the professional who wishes to be worthy of the privilege.

17) **Value: Development, Personal Growth:** Ongoing professional development appropriate to professional skills, interests and needs of patients. The direction of development will naturally reflect personal interests as well as patient needs. For some, this will entail becoming involved in research, and for many it will mean becoming involved in education supporting *others'* development and growth: from being a mentor or a vocational trainer through to becoming a tutor in general dental

practice or specialist areas; perhaps, in those roles, running study groups, action learning sets and other facilitative learning activities including those designed to support the growth of DCPs. Contributing to professional journals promotes growth in both the author and the readership.

18) **Value: Collegiality:** The group of colleagues acquired at the moment of acceptance into a profession can be a source of constant support, inspiration and learning. Conversely, I too may support colleagues, whether it be as a mentor, educator, *confidante* or just a fellow traveller. This is an enormous source of support and comfort which colleagues forego to their detriment and to the detriment of their profession and patients.

19) **Value: The world:** Taking a global view of dentistry, the global impact of policies and strategies on the ecosystem (Senge 2005). Having a Voice and helping others to find theirs (Holt & Ladwa 2008). This might also lead to active involvement in dental organisations. Through bodies such as the FGDP (UK) there are opportunities to support and promote professional development in third world countries.

20) **Value: Presence:** This value sums up the whole of the dentist's Way of Being with the "other". This value includes all the others and expresses the dentist seeking to be "**fully present**": the "**fully functioning person**", living her "*way of being*" with her patient in the moment throughout the encounter. (Natiello 2001 p46). There is also an opportunity here for the practitioner to consider how they "present themselves" (Goffman 1959) before their patients. A buoyant, encouraging and supportive encounter at a personal level, seeking to make the patient "feel good about themselves" and empowering them to make their own contribution at home to their ongoing oral health, is a contribution towards a positive *way of being* with the Whole Person, *habitus* that can inspire: inspire confidence, and inspire self-confidence.

21) **Value: Being a Professional:** Several lists of "*professional values*" rather oddly include "*professionalism*" itself. However, the status of *professional* is, I suggest, something to be prized: something of great value whose possession can itself reflexively perpetuate and reinforce the professional attitudes and behaviours which it acknowledges.

22) **Value: Responsibility:** This value is closely tied to collegiality for it includes – apart from my responsibility for my own actions as a professional, and supporting younger

colleagues in their professional development - being willing to support a colleague, or even whistleblower, when they are in difficulties and perhaps putting patients at risk.

More happily, as a professional, each of us has a responsibility to share in the work of continuous review and development – perhaps through research and education and assessment - of the profession and the way it serves the community. Ongoing changes in the light of developments in knowledge and – perhaps even more critical in the present time – in responding in collaboration with other professions, to political and social pressures that risk encroaching upon our ability as professionals to give our patients, clients or students, the best that we are able to offer them.

22) **Value: Being Trustworthy.** The knowledge that “*I am trusted*” carries its own enormous reward for the professional. It is, however, far more important for the patient to know that I am trustworthy for that will greatly reduce the anxiety in anticipation of an appointment and help to foster trust in the profession at a societal level which may reasonably be expected to reduce the mental obstacles to seeking necessary oral healthcare and without which the profession could hardly claim to deserve its status. I need to help my patient “*to believe that the results of [my] intended actions will be appropriate from [their] point of view*” (Misztal 1996 p.24). “*Trust demands two basic conditions, that I will incorporate my patient’s interests into my own, and that I am capable of the actions required*” (Kohn 2008 p.59). It is incumbent upon me to be consistent in meeting the needs of my patient. There is no short cut. “*Trust grows out of trustworthiness*” (Covey et al 2003 p.203).

These values inform the Model for Professional Practice presented in the next chapter.

An Ethical Approach to Person-Centred Professional Practice.

Current discussions of professional ethics rely on one of three broad approaches:

- the application of (*prima facie*) *principles* – the approach espoused and adopted by the most widely cited authors on medical ethics, Beauchamp & Childress (2001) who also incorporate “*rules*” into this group whilst acknowledging that rules may be more specific and prescriptive than principles;
- the deontological (duties-based) approach usually drawing on Kant’s categorical imperative or Bentham’s greatest happiness;
- the virtues-based approach whose history is traced back to Plato and Aristotle.

(Pellegrino & Thomasma 1993 pp.4-9)

A fourth approach which is relevant here in view of the moral stance of this thesis is

- an axiological (values-based) approach.

Earlier in my thesis, I have expressed serious concerns over the residual authoritarian, directive approaches in clinical practice and education, and more generally in society. I have therefore sought to highlight more holistic approaches visualised through my (very simplified) version of Wilber's diagram (p.130) as drawing on the *exterior* (or outwardly-oriented) aspects of our experience and knowledge (represented by Wilber's UR and LR quadrants), and approaches drawing on the *interior* (or inwardly-oriented) aspects of our experience and knowledge (represented by UL and LL quadrants). Viewed through this lens, I note that the principles-based and duties-based approaches sit firmly in the UR and LR quadrants. They call for the engagement of the mind but not – at least, not *necessarily* – the heart or spirit. They therefore, in their formulation leave the *whole person* out of the equation. On that basis, I find them inadequate in the narrowness of their perspective when considered from a broad humanistic point of view. The right hand quadrants do not account for *meaning* in actions or events beyond cause and effect. That is not to say that they have no value in dentistry. Indeed, I suspect that the difficulty moral philosophers and ethicists have in choosing between these approaches may be, at least in part, because, given the diversity of human personality, character-types, and cultural backgrounds, not to mention the different stages of (moral) development and competence within any professional population, the search for a “*one size fits all*” solution to this ongoing question may not be realistic. On that basis, I suggest that all these views can contribute something to a formulation of an ethical approach to dental practice.

I use, as an example for discussing these different approaches, the hypothetical *Case Study at Fig 3.7.2.*

Fig. 3.7.2
Hypothetical Case Study

An adult patient in their early twenties presenting with six upper front teeth that are sound (no cavities or fillings) but which have some congenital discolouration and irregularity ("My teeth are crooked and I don't like those brown marks") and a friend or relative has made comments that have provoked a visit to the dentist to "get some crowns made" to improve appearance. Superficially – without any real reflection – this is a great opportunity for the dentist. Six sound teeth will be easy to work on and the crowning of several teeth together is, financially, a very attractive proposition. The patient will have received what they requested. Everybody will be happy: beneficence all round: or so it would seem.

However, on average, approximately one in five "virgin" teeth cut down to prepare them for crowns will die (that is the pulp will die) and the risk is greater in young adults than older people. (The teeth that are more prominent and therefore have to be cut back the most to "straighten" them will be at greatest risk.) Whether it causes pain or not, when discovered any dead or dying tooth will need root canal treatment which will weaken the tooth setting the tooth on a cycle of failure (e.g. fracture) and ever more desperate attempts at repair. The provision of the six crowns requested risks setting the patient up for future complications that could cause the loss of a tooth or teeth and require ever more complex, destructive and expensive interventions to try to restore the losses or damage. With that knowledge of risk, and knowing that, very often, simple less invasive measures that *reduce* the offending irregularity without completely eliminating it and others that can mask discoloured areas of tooth are often all that is required to produce a happy patient. It can be argued that, despite the apparent *beneficence* delivered in acceding to the patient's request for six crowns for cosmetic reasons, the dentist concerned is open to the accusation of *maleficence* unless he has really made sure that the patient *fully* understands the risks and their serious potential consequences, as well as the possibility of using alternative (less damaging and much less expensive) strategies and have genuinely failed in their attempt to encourage the patient to try out the simpler, less damaging and risky alternative before proceeding to the crown option.

Four Principles

Four *principles* are usually recognised in medical ethics: non-maleficence, beneficence, autonomy and justice. The juxtaposition of maleficence and beneficence is interesting in dentistry for there are some occasions – which I have illustrated above – where a favoured treatment choice might be interpreted as delivering both as will be discussed below. The third (*autonomy*) and fourth (*justice*) both represent the impact of more contemporary thinking, moving away from the authoritarian and paternalistic model for professional practice: autonomy asserting the importance of the patient's involvement in receiving all information and participating in selection of appropriate treatment options – *informed consent* and *confidentiality* - and the fourth *justice*, which perhaps becomes most relevant in discussing inequalities in the availability of healthcare¹⁵⁷. As guidelines for those to whom the patient's *good* is not readily discernible, the principles have some value, though experience of the last 50 years suggests that they need radical interpretation in the dental context backed up by strong supervision or monitoring of performance.

In managing the scenario below, I observe that the *principles* have not, over more than half a century, been effective in guiding dentists away from the potential harm present in carrying out *any* destructive procedure. The risk of harm will always be present and must be balanced realistically – by the *patient* - against the benefits: a risk which may be regarded all the more seriously when the intervention is *elective* – as for cosmetic reasons - rather than *therapeutic*. I have referred to the dangers of such treatments above pp.168-9.

Duties

Since duties tend to be articulated in terms of the principles and impose very similar obligations – to adhere to the principles, in effect – their impact over the last half-century also seems to have had little or no impact on the kind of scenario set out above. To the extent that there has been a growing awareness in recent years of the longer term consequences of aggressive restorative dentistry there has been an increasing emphasis – from medico-legal advisers generally, rather than moral philosophers – on the importance of obtaining patients' consent. More recently this has been extended to include *fully informed* consent which relates not only to the procedure undertaken with its risks and benefits but to all the possible alternatives with *their* risks and benefits also. With the recent creation of the Care Quality Commission (CQC) armed with the right to visit all

¹⁵⁷ It is interesting to observe the shift between Rawls' (1999/71) "A Theory of Justice" in which Rawls places his discussion in the context of the structuring of (impersonal) institutions, and his pupil, Sen, who in his "The Idea of Justice" (2009) emphasizes

practices as a routine, there is a real prospect that all practitioners (not just the enthusiasts who offer themselves for higher level diploma and degree assessments) will have no choice but to comply with this requirement to fully inform patients and obtain and keep appropriate signed consents.

Virtues

The virtues are generally defined as traits or dispositions which incline the person to choose - i.e. to *want* - to do the *good thing*. The concept of *virtue* is not satisfied if the actor only *does* the good thing. The virtuous person will do the good thing because they *want* to – it enables them to actualise congruently with their concept of their own moral self. Consequently, the virtuous activity arises from the whole person – both the cognitive side *knowing* what is right to do and the feeling, meaningful side perceiving what is *good* in a way that transcends rules and duties and can see beyond them – even sometimes to realise that on *this* occasion, the rule does not meet the need. The virtuous person will generally not need the principles or the duties to guide them; being at a higher level of moral development, they will know – often intuitively rather than rationally – what is *good to do* in this situation (Beauchamp & Childress 2001 p.29). “*Virtue is a habitual disposition to act well*” (Pellegrino & Thomasma 1993 p.5). Four “*Cardinal Virtues*” are recognised: “*fortitude, temperance, justice and wisdom*”, though the list accumulated for their treatise on “*Character Strengths and Virtues*” by Peterson & Seligman (2004) describes 24 strengths (some of which, such as *prudence* are described elsewhere as virtues) grouped under seven *virtues* See Fig 2.3.3 p.74.

A Values-based (Axiological) Approach

The nature of the values chosen to support this approach is important. The context however, is twofold: first, the person-centred approach, where, as articulated above, the **person** is the prime value and second, an ethic based on **care** which is directed towards the person as the complementary half of the prime *binary* value.

The impact here is similar to the consideration of the virtue-based ethic. The difference is that, if there is not for the virtuous person an intuitive answer, then the Care ethic gives a prime value to guide their deliberations. Lower order values are consequential upon this position – some articulated above and others presented in a dialogical style in Appendix 7. If the position is accepted that the fundamental orientation of the true professional tends towards the good of the *other* – usually here for the *patient* though it could be a mentee or

the importance of considering justice at a personal level, taking account of concepts such as impact on human lives, freedom, capability and happiness .

student - then values that tend towards the good of the *other* will follow to the extent that I recognise that, in society, my good is served by serving the good of the *other* (Levinas 1996 p.158). “*My good as a man is one and the same as the good of those others with whom I am bound up in human community*” (MacIntyre 2007 p.22). Ultimately, this is the moral position of the “*true professional*” referred to early in the thesis: the recognition that we *must* care each for the other: that we have accepted this as our particular *calling*. From this caring emerge subordinate values concerned with preserving goods in society and – especially at this time in our history – collaborating with each other to achieve what must become the major challenge for our species over the next century: namely adjusting our needs as a species to the finite ecosystem of our planet on which we all depend for our survival and for further generations. This will, I suggest in dentistry, broaden out our discussion of *maleficence* to include harm done to our planet (and therefore our fellow inhabitants) by the extravagant use of non-renewable or non-recyclable materials and equipment: a topic beyond further discussion here.

A Framework to Support a Model for Professional Practice.

I opened this chapter with the idea of the *self*, seen in holistic, moral terms, now contributing to, and functioning, as part of a moral community – a profession.

In considering the nature of professional practice, I have drawn attention to changes occurring over the last 160 years, and still ongoing, in the way healthcare and other professionals see themselves and how they relate to their clientèle or patients. In considering a contemporary view of professional practice: reflecting changing social values during the latter half of the 20th century; informed by the experience of applying the person-centred approach in mentoring, I have discussed the role of the dental professional – which constitutes the reason for having a dental profession at all - and discussed a list of values relevant to an holistic and person-centred ethic for professional dental practice in this evolving – and increasingly patient-focused - climate.

The description of the contribution that the dental profession can make in society, together with an ethical approach supported by a framework of underpinning values, now provide the basis for the presentation of an holistic and person-centred model for professional practice.

Chapter 3.8

An Holistic and Person-Centred Model for Professional Practice:

Introduction to the Model

In drawing up the model¹⁵⁸, I focus primarily on the inwardness of the *experience* of professional practice rather than its organisation or institutions, except insofar as these are pointers to, or reflective of, the experiencing of the performers in the professional drama as it unfolds, or facilitative of, or hindrances to, the sharing by all the interested parties of a good professional experience. The model considers the experience of the professional activity (primarily here the professional *dental* activity) from three perspectives:

1. The dentist¹⁵⁹;
2. The patient (client);
3. Society generally, (a collective made up of individuals who, in many cases will have some experience from time to time of dental – professional - care) expressed through the voice of “*Krites*” (Greek “Judge”).

¹⁵⁸ Although this presentation of the model illustrates relationships in dental practice, it could easily be written, *mutatis mutandis*, for any profession.

1. The dentist (professional):

Drawing on the discussion in earlier chapters, I present a proposed ideal dentist experience in delivering care using an holistic and person-centred approach. It is incumbent upon the dentist – the professional in the encounter – to set the relational agenda, and that is where the discussion commences.

2. The patient (client):

The professional encounter is a relationship between the professional (here dentist) and the client (here patient). Although the contribution and experience of the dentist – the provider of the professional service - is considered first, the experience of the patient – the person to whom the service is rendered; the consumer for whom the relationship is brought into being - is the one who expects to be served and who expects to benefit from the professional transaction. Their experience is the one by which the adequacy of the transaction may be judged by themselves and by society.

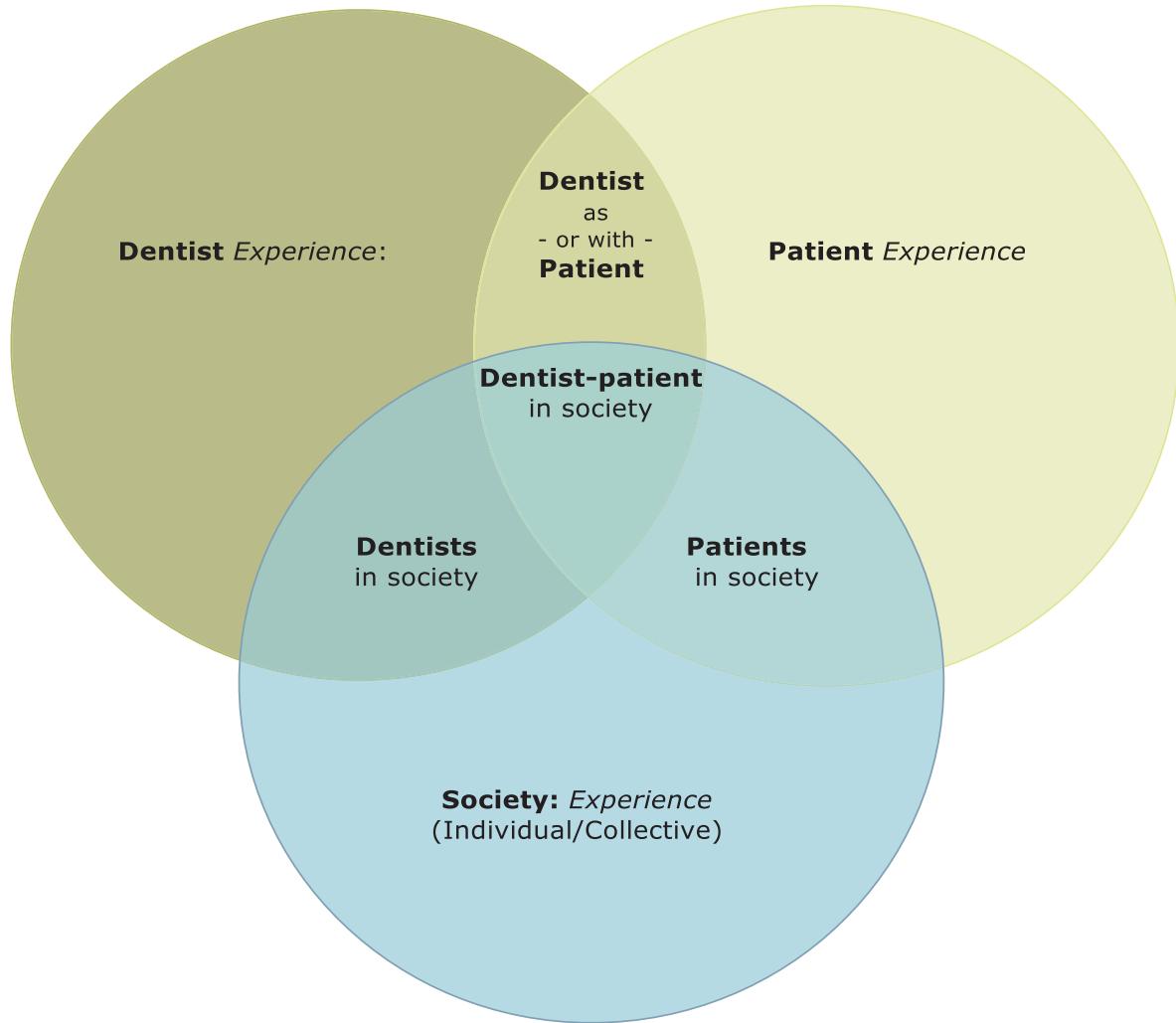
3. Society (individual /collective):

Because the nature of the dentist's work is such that it is classed in society as a professional role, society – and the individuals who make up society and who (mostly) seek the professional services of dentists from time to time - have a vested interest in the nature and quality of the experience that they have, and may expect to have, in the professional dental relationship. To the extent that the experience of most members of society inspires trust the profession may hope to retain its status. To the extent that the profession fails to inspire trust, the future of the profession's status is imperilled.

¹⁵⁹ The word 'dentist' is used throughout for simplicity. It is not intended thereby to exclude other dental care professionals (DCPs) from the discussion, for their experiencing will – according to their particular role - - have much in common with the

A Model for Professional Practice - 3 Experiential Perspectives - Basic Diagram

1. Dentist: (Professional)



2. Patient: (Client)

3. Society (Individual / Collective)

Fig 3.8.1. Basic Diagram of Model

Insights gained from crossing boundaries:

The three groups above are not clearly defined and many individuals have experience across the boundaries implied in the discussion and illustrated in the drawing of the model (Fig 3.8.1.). Thus:-:

Dentists have, from time to time, experience as patients and, on a daily basis, experience *with* patients.

Patients are also members of society and may adopt a societal perspective on cultural and professional political agendas.

Dentists are also themselves members of society and may engage with a professional perspective on social, cultural and political agendas.

Dentist-who-are-also-patients, and drawing empathically on the experiences of the patients they are with, have a uniquely multi-faceted perspective on the issues - including political agendas - to do with the functioning of their particular profession in society. Taking a wider view, they may develop a perspective on the balances and relationships between society and professions in general.

Three Experiential Perspectives.

As the Model for Professional Practice represents three perspectives on the relationships involved in this social phenomenon, I adopt the voice of each in turn. The professional – the **dentist** in this illustration – is the key character in the encounter. He has the power to influence the plot - bring the story to a satisfactory conclusion given the facts presented at the start. He is the professional presence – both an individual practitioner and a representative of the profession - embodying the profession and its unique area of expertise, and its values, in service to the patient. The perspective from the dentist's experiential viewpoint is examined first.

Whilst the dentist is the key character in the drama, the **patient** is the focus of the story. The patient and her presenting oral health status are the *raison d'être* for the story. The patient has a perceived need of the special area of expertise embodied by the dentist. Her experience of the dentist's response to that need and the outcome(s) that he helps her to achieve is itself the story. Her experience is, to a large extent, dependent on the extent she is encouraged to participate in the development of the plot of the story. The perspective from the patient's experiential viewpoint is examined second.

The story unfolds in the ubiquitous presence of another key character. This character goes by the name of “**Krites**” – appointed as the voice of society - and may appear in the drama in many guises, both collective and individual. Crucially, society has an unspoken contract with the dentist, entrusting him – and his professional colleagues – with a particular type of monopoly of his area of work: a monopoly deemed necessary because of the extent of knowledge and skill required for practice in this area of work, the fateful (Giddens 1991 pp112-4) nature of the work, and the consequences of its inadequate execution. Society sometimes appears rather amorphous and indifferent, and at other times appears as an individual or group in various guises of regulation, purchaser of services, or wielder of disciplinary powers. There is a curiously incestuous relationship between the dentist, the patient, and society. Both the dentist and the patient are themselves members of that society. The perspective from society's collective and individual experiential viewpoint is examined third.

All the voices when speaking are represented in italics within inverted commas.

1. Dentist Experience

The account from the dentist's perspective describes an idealised (though not unrealistic) PCA-based view of the dentist's experience of *Being a Dentist*. Our dentist says that...

“**As a dentist...**

- “**I experience a sense of living professional values.** (See chapter 3.7,pp. 149-54).

A part of my reason for choosing dentistry was a desire to help people. I enjoyed working with my hands and wanted to use my manual skills in a caring way with people.

“My enjoyment of the practical skills of dentistry stimulates me to undertake further training in areas of special interest that appeal to me. Sometimes, having acquired these enhanced skills, I find myself looking for opportunities to use them. I seek to remind myself that the skills are for use only when it is in the patient's (not my) best interests and after they have had all other options – and all their pros and cons – explained to them.

“In a similar way I find myself attracted to some areas of practice that tend to be more lucrative. I remind myself that, out of respect for my patients and their needs, and as an expression of my commitment as a professional to serving patients' interests – rather than my own – in prescribing treatments, these treatment modalities must only

be applied in practice when it is clinically appropriate – i.e. a suitably healthy oral environment has been established - and when these options have been chosen by my fully-informed patient.

*“That means that sometimes I either do not provide certain treatment, or I provide a treatment that is less financially rewarding for me, because I know in my heart this is in my patient’s best interests as they perceive them. This I understand to be a part of what the word **altruism** signifies and, although I am sometimes conscious of a sense of sacrifice, I also experience a sense of human community with my patients and a sense of inner comfort: of being at peace with myself and - maybe something that transcends my own selfish interests - that I am truly practising by the values that I know are most important, not only for me, but for the ideal human society to which I aspire and to which I wish to make a contribution.”*

- *“I experience collegial mentoring support. My enjoyment of working with people has been enhanced enormously by my own experience of being mentored using the PCA which I have found enormously empowering for myself, rewarding to use in support of colleagues and adaptable to use its elements (embodied in the titles below) in supporting patients as they work with me through the strategies and options they have for maintaining their own oral health.*
- *“I experience the Person-Centred Approach as a way of being with people (my patients and fellow team members). All the sets of teeth that walk into my practice have a person attached. This I remember at all times. I am not treating teeth! I am helping a person. I need the person on my side before I treat the teeth. Much more important: the person in the chair needs me on their side! It is my responsibility to help her to feel this.*

“I also remember that I can only be there for my patient if my team are there for my patient also, carrying out the multiplicity of tasks and duties that collectively provide for my patient not only good care but a good experience. I seek to involve them with the patient and make the patient aware of the ongoing support the team are giving me to secure the best possible outcome and experience. This sometimes means that, between patients, when my nurse is very busy preparing the surgery, I go and make a cup of coffee for us both. (It used to be the other way round.) I am comfortable with the concept of the “servant leader” (Covey 2003 pp251-6).”

- *“I experience a sense of respect for the other person (patient, team member, or colleague) (Ch 2.4 p.98, Ch.2.5 p.116). This is a key component of the PCA. At the most basic level, respect means always making sure my patient knows what I am*

about to do, what to expect, what they will hear or feel. It also means that handling them (literally) is done with due warning and extreme gentleness and consideration – as I would wish if someone were handling my mouth, lips, cheeks, tongue. Respect means that I value their perspective as much as my own. Indeed, where their own needs and preferences are concerned, their perspective takes precedence. I value them as I value myself. My professional status does not mark me out as superior to them. Their perspective is as valid as my own. I have an obligation - to value their perspective above my own where their own life and interests are concerned. This is hard. I often feel that I know a better way. But that is my way, not theirs; and they are my patients and I the servant. When I come to terms with this then...

- ***"I experience congruence.*** Congruence (Ch 2.4 p.94-97; Ch 2.5 p.112-3;) seems like a kind of freedom when it comes. It is a freedom from tension between different parts (body, mind, heart and spirit) trying to pull me in different directions. When the "felt sense" (Gendlin 2003/1978) of the body, the rational appreciation of what is most appropriate, the positive affect of knowing "this is the best way for this patient", and the deep sense that this way forward reflects personal, professional, and even transcendental, values to which I am committed, then there is a sense of being genuine and whole in the moment – which ultimately far outweighs any financial reward."
- ***"I experience empathy.*** Empathy is about my ability (hopefully) to pick up an inarticulate sense of what my patient (team member or colleague) is feeling giving me a sense of "how it is for them". When it happens, I often feel the empathic sense reflected back – a kind of resonant connection that enriches the transaction in a way that transcends the (often) relatively inconsequential issue under discussion. The person who feels empathically understood responds with more openness, greater frankness, and increasing trust in a situation which, for most people, is underscored with a certain level of anxiety if not actual fear."
- ***"I experience being part of a caring relationship.*** Because dentistry is a healthCare profession; because my practice is inspired by an ethic of Care, and because I consider Care- (or Caring-) for-Other as the most profound value, reflecting the deepest reality discernible to me in my universe – sometimes referred to as unconditional positive regard, non-possessive love, agape, brotherly love, caritas (charity), - then the experience of a truly caring relationship comes as a kind of fulfilment or ultimate job satisfaction. It feels, indeed, as the most fulfilling "actualisation of self" – when I am most fully myself, most fully in connection with another – the cared-for (Noddings 1986) or, indeed, someone else (team-member)

sharing the caring with me. A dimension to this experience not elaborated upon much in books on Care Ethics is the sense of wholeness and community shared amongst the team (two or more) sharing in this experience of Caring together.”

- *“I Experience my own ‘Presentation of Self’ (Goffman 1959) as a crucial part of my engagement with my patient: egalitarian, smart, competent and professional without being formal; relaxed and attentive, empathic, light-humoured, caring, well-informed yet trusting them and their own perceptions and preferences; offering my ‘I’ to their ‘Thou’. Part of this ‘Presentation’ I achieve by including my nurse in the relationship as an equal in the process of creating a buoyant mood; I seek to position (Harré & Moghaddam 2003 pp.3-8) myself as “one–caring” (Noddings (1986 pp16-18), so that the patient feels comfortable. The (usually) unspoken message is: ‘We are both here to help you have a good experience.’ ”*

2. Patient Experience

Speaking from this perspective I adopt the voice of a hypothetical patient and his experience of *Being a Patient*. Our patient is assumed to have recollections of dentistry practised using a traditional, more authoritarian model and says that...

“As a patient...

I have noticed significant changes in recent years. My early experiences were very mixed. Sometimes I would be lying on my back in the chair looking at the ceiling before the dentist even spoke to me. When he did speak to me he seemed to be more interested in selling me white fillings or implants or something than in answering any questions I had.

- *“I experience a strong sense of respect coming from the dentist nowadays. She seems to take more time finding out about my lifestyle and what I really need from her. She has spent much more time and trouble discussing the reasons for my dental problems – talking about lifestyle issues and helping me to find methods of cleaning the awkward corners in my mouth so that my teeth and gums are much healthier than they used to be. Although I still need to visit her regularly to keep on top of things, she has helped me to understand much better what I can do to help myself between times with sensible diet and careful cleaning. I feel I understand much more now and feel more in control.*
- *“I experience a sense of being listened to and understood now better than ever before. I feel comfortable with this because, after all, it is my mouth and my life and I*

am the patient. I feel I deserve that much. This gives me much more confidence that my dentist will help me make choices that are really in my best interests. Another thing I notice is that...

- *“I experience a sense of being involved in a dialogue before reaching decisions about how we address problems in my mouth. In the past the dentist told me what would have to be done – “a filling” or “it will have to come out” – and got on with it as fast as he could. Now I realise I lost some teeth that did not really have to come out. I am surprised at the options open to me. I had never really understood that it is perfectly possible to keep my own teeth for life – or enough of them to manage without false teeth - Ugh! – even though I have left it rather late before I learnt what I needed to do to achieve this.*
- *“I experience a sense of being cared for. This is partly because I do now feel more involved in decisions about my mouth so that more care is being taken to make sure that I receive what I prefer but it is also because the dentist – not just her nurse – frequently checks that I am comfortable and always makes sure that I know how to let them know if I need a break at any time. They also seem to take the trouble to remember personal details such as my work or where I like to go on holiday, or other interests that I have. I feel nowadays as if I am much more of a “person” to them rather than a set of bad teeth. Although she often makes suggestions to improve my cleaning, she always makes me feel that she can see the effort I am putting in so she does not make me feel small or stupid. That makes me feel I really want to do even better. This is quite subtle really and as a result...*
- *“I now realise that the focus is on having a healthy mouth, not just on having treatment. I had never realised until she told me that the holes in my teeth were signs of a disease active in my mouth and just filling the holes or taking out the teeth did not stop the disease. This health focus has helped me to understand what I can do for myself - and even how I can monitor it for myself. I feel empowered by this and I think everybody needs to know this. The effect of all this is that...*
- *“I feel I can really trust my dentist because I sense that she really cares about my health; I know she will always make sure that I have all the information I need to choose what is really best for me in the long term; that it will be my choice and not hers. I feel this because she is so open with me about things. I feel she is really working with me for my health – not just “doing a job” or earning a fat fee but - really working to meet my needs and preferences.”*

1:2. Dentist with – or as – Patient

"As the dentist, I strive to be sensitive to the feelings of my patient. He may "put a brave face on it", yet the sweaty forehead belies his good cheer. If I am attentive to their unspoken messages, body language and sensed mood, my patients teach me what I need to know. As a dentist who must, on occasion, reverse my role and become "patient" I have a unique opportunity to experience directly what a patient may experience...the..."

- **"Caring Relation:** I learn from my colleague: the establishment of rapport; the solicitous enquiry – general and dental histories; the friendly warning of events ("tipping the chair back now"); careful and gentle examination and manipulations of my physical person; checking my comfort; the respect implied in a careful explanation of findings and a relaxed, unpressured discussion of options, choices and priorities. The insight, always valuable, can be salutary.

When I add this to what I learn from being with my own patients – whose sensitivities and preferred comforts may vary from my own – I learn to adjust my own 'performance' in response to others' needs, preferences, and moods. Always these experiences call for ...

- **"Reflection,** for a constant self-monitoring helps me to avoid stagnation, provokes constant self-awareness as an agent for better or for worse, and provides me with positive – as well as formative - feedback. Sometimes, reflection calls for...
- **"Action,** because I recognise a need to enhance skills or knowledge; or because I need to make adjustments in practice amenities, services or protocols in response to identified needs. Sometimes, this may point to the need for political action (see 1:2:3. below)."
- **"As Mentor":** Sometimes as I am discussing options and strategies for their care with my patient, I find myself slipping into "mentoring mode". I found it so helpful when I first experienced mentoring that I instinctively draw on the mentoring experiences and skills to support my patient (as I do in other social roles). Many of the older patients comment that a modern dental visit is a completely different experience."

1:3. Dentists' Involvement in Society

As citizens – members of society – dentists may engage in any of the activities common in society including social, cultural - sporting, musical, dramatic, artistic, academic –

activities; and political activities, both within the profession and at large. It is common, with their talents, gifts, skills and education, for professionals to emerge in leading roles in such areas.

- **Social, cultural and political agendas: Dentist's experience.**

“As a person with interests, energy and talents, I enjoy participating in a wide range of social activities. Some people seem surprised that a dentist enjoys doing normal things. Most appreciate the contributions I am able to make and I feel that this helps the image of my profession in the eyes of others.

Some of my colleagues engage in political activities in the community / society at large. I choose to become engaged in academic and political activities within the profession which puts me in a position, with others, to seek to influence the way dentistry develops in the future.”

- **Social, cultural and political agendas: Society's experience.**

“As a member of society, I see a dentist involved in political discussions as a concerned member of our community, actively involved in efforts to improve the lives of people, and working through professional organisations to improve the way dental care is delivered in our country. I appreciate the concern she expresses that things should be improved for ordinary people like me.”

2:3. Patients' Experience

The experience of each patient is individual and unique. When experiences are positive, people tell their friends and relatives. When experiences are negative, it is reported that people spread the news much more (Customer Service Facts 2012). These experiences are shared and the totality of the collective experience reflects on the profession - for good or bad. Good experiences may be expected to improve a profession's image and poor experiences the converse. The sum total of these experiences of the profession...

- **informs society's political agenda...**

...and feeds into the adjudication of Krites. (See p.186 below.)

“When I have a good experience at the dentist I feel well-served - that I have been treated by a caring professional who deserves their professional status. I respect – even admire – them and feel grateful. I share this with friends and relatives and we say how fortunate we are to have a good caring professional in our community.

When I have a poor experience – or hear that my friend or relative has had a poor experience, then I feel exploited and used, not cared-for - that we have been “taken advantage of” and I resent the professional status that the dentist enjoys. I share this with my friends and relatives and we wonder why we accord such privileged status to people who do not appear to care for us but are more interested in funding their expensive-looking, flashy life-style.”

1:2:3. Dentist-patient in Society

- **Reflection**

“Reflecting as a patient given my insight as an informed dentist, I am aware of a myriad things that could have been done differently that would have detracted from my comfort or undermined my confidence. I reflect on experiences that patients transferring to my care sometimes report from their personal dental histories. I am embarrassed: I do not want to be “tarred with the same brush”. I – and very many of my respected colleagues - want to see a more consistent level of good dental experience and a better level of oral health - for all members of our society. I am aware - as a dentist myself - of the pressures to generate income, especially in the NHS. Dentists are generally running their own businesses or part of a corporate business, either of which would disappear if not financially viable. I know that the payment system in place gives little scope for changing practice and that the incentives built in to the system are to “do treatment”, not to “help the patient to become healthy” or to “give the patient a good experience.” This makes me want to find ways of exerting...

- **political influence.**

“For changes to take place in the way dental care is delivered, I know amendment of the Dentists Act (The Dentists Act 1984) is required. Significant influence on the government – if possible at all, is likely to come through academic bodies (Royal Colleges and Universities) rather than bodies perceived as politically orientated trade union style, such as the British Dental Association. I know that such academic bodies are more likely to be listened to when articulating ideas for improving the delivery of care. As a professional, I seek to support the work of such bodies, promoting standards of care and the programmes of postgraduate education that they offer.”

3. Society (Individual/Collective) Experience

Introducing “*Krites*”.

The portrayal of society's perspective is more complex as it conveys a blend of varying individual perspectives combining to give voice to a range of views varying from unanimous to highly fragmented. In this section I speak with the voice of an (hypothetical) individual, “*Krites*”, [Greek, “*Judge*”] entrusted with the task of representing the societal “*We*” in assessing the profession's performance *qua profession* using this model, as if the profession had applied for confirmation of the status “profession”. Thus *Krites* is representing Society's collective voice to the profession.

Krites observes that society – and the professions – are evolving. He therefore comments both on the residual “**Traditional Model**” and on the proposed holistic and person-centred “**Model for Professional Practice**”.

Model for Professional Practice:

The Voice of *Krites*.

- Profession – seen to be engaging with society

Krites says:

“To the extent that I see you:

- working with our populations – from the most privileged to the most disadvantaged – to help inform and educate our people, so that they know what is possible to achieve for them if they wish to take ownership of their own health;
- then working (with government where necessary) to secure good oral health for all those wishing for it and maintaining healthy mouths and natural dentitions, supported, above all by ongoing educational and preventive programmes;

... I shall judge

that you are using your unique mix of skills and knowledge for the benefit of your fellow beings in society and I shall deem you worthy of the continuing accolade “profession”.

Traditional Model:

Profession set their own terms. Gentleman practitioner.

“To the extent that I see you:

- asserting – or hanging on to – status and privilege just because you are members of “a profession”;

I shall suspect

that you wish to set yourselves apart from society. This is not what I expect to see.

• **Exemplifying PCA in society**

Krites says: “*To the extent that you:*

- seek to ascertain your patients’ agendas;
- ensure that they understand the problems (diagnoses etc) that need to be addressed;
- ensure that they fully understand the range of options open to them with their advantages, drawbacks and lifetime risks, including referral options for work requiring special skills, cost implications (immediate and longer-term);
- are patient-centred – not treatment-centred;

then...

...I shall judge

that you are person-centred and altruistic and I shall deem you worthy of the continuing accolade “profession”.

• **Professional service: not privilege and protectionism**

Krites says: “*To the extent that I see you:*

- working with government to devise systems of payment to dentists that incentivise working with patients to produce health – rather than to “do treatment” – to generate income;
- undertaking training to enhance your interpersonal – as well as technical and clinical – skills;
- working together to improve information to patients so that they may better assess the quality of care being offered to them;
- working together to improve patients’ involvement in

Male values: Dominant, Authoritarian.

“To the extent that I see you:

- taking control of the treatment agenda;
- prescribing treatments that suit your own agenda (clinical or fiscal), pandering to the patients’ wants without their full awareness of potential consequences;

To that extent

I shall deem you as self-serving, exploiting your professional status and not deserving of its continuance.

Privilege: Professional ranking expression of status.

“To the extent that I see you:

- expecting people to accept your authoritative “expert” decisions about their care on the basis that you are a Fellow of some illustrious Royal College;

I shall deem your behaviour as oppressive

decisions being taken about their own care;

- *adopting a “dialogic approach to problem solving” (Cunningham 2008 p95), working together to improve patients’ involvement in decisions being taken about their own care;*
- *displaying humility in your approach to managing issues with patients;*
- *displaying reflective integrity in your approach to managing issues with patients;*
- *each one, individually taking steps to genuinely enhance your professional knowledge, skills and attitudes out of a desire to “be a better practitioner”, (rather than to tick the CPD boxes);*

... I shall judge

that you are genuinely focussed on caring for – and seeking to serve - the people who entrust their care to you and I shall deem you worthy of the continuing accolade “profession”.

• Promotion of professional values

Krites says:

“To the extent that:

- *I see each one of you valuing, and caring for, the person in front of you; presenting your congruent self empathically to your patient; demonstrating Unconditional Positive Regard;*
- *I see you adopting positions and strategies in society that work for the common good including promoting awareness of planetary issues;*

...I shall judge

that you are modelling a way of being with people and in the world appropriate for someone claiming the continuing accolade “profession”.

and out of keeping with a contemporary view of professional practice.

“To the extent that I see you:

- *making changes in the direction of empowering patients only in response to external pressures,*

I shall doubt the sincerity of your professional claims.

Values of service, honour, integrity, hierarchy, power, influence and control.

- *Whilst I applaud traditional values of service, integrity and honour, to the extent that they are associated also with traditional values of hierarchy, power, influence and control,*

...I shall judge that your claim to professional status is compromised by values out of tune with contemporary

• **Reflecting societal values and concerns**

Krites says:

"Insofar as society is always evolving and changing - and in the present early 21st century there are many "hot" issues at stake - I should expect to see you engaging with these issues and adopting personal and professional positions on them. Insofar as (over-)regulation, litigiousness, and planetary issues have a major impact on professional practice, I should expect to see you engaging deeply and constructively with them.

To the extent that:

➤ *you are engaging with the evolution in human values – more egalitarian, more respectful and empowering of the individual, but also seeking to build a sense of community, where the individual limits their self-interest for the common good;*

... I shall judge

that you are genuinely engaging appropriately in contemporary culture and thought: leading by example as is appropriate for those who wish to be viewed as members of a learned profession".

society.

Population "looked up to" experts and authority figures in professions.

Insofar as you expect to be "looked up to" just because you are a member of a traditional "profession", I shall take the view that you are out of touch and unworthy of that title.

Such respect must be deserved.

• Respect for, and trust in, the profession

Krites says: *“As I consider your application...*

- *...to retain your status as a profession, the issue of trust looms large in my thinking. It is not a question of the extent to which you are trusted by your patients (clients,) for such trust – or lack of it – could be misplaced. It is a question of trustworthiness. Are you as a profession worthy of trust? Have you earned trust? Do you deserve to be trusted?*
- *Underpinning your patients' trust in you is your General Dental Council GDC) which has in recent years changed very significantly from being entirely under your control with your own Presidents to a Council in which your own interest is greatly weakened and there is a heavy lay influence (including the chairman).*
- *I note that the GDC seems to adopt a two-pronged “carrot and stick” approach. The stick – the disciplinary aspect - it appears, is being used liberally (and rather poorly) whilst the carrot - the moves reinforcing lifelong professional development through establishing regular revalidation requirements - seems to be repeatedly put back for financial reasons.*
- *I note that the work of the GDC has escalated dramatically in recent years⁸² and that a significant part of its work is dealing with cases of fraud involving dentists and their paymaster (usually the NHS) as well as “poor treatment”. Both criminal behaviour and poor treatment are wholly inconsistent with professional practice and I need to see that these patterns of behaviour are being rigorously addressed.*
- *I note that the Dental Faculties in the Royal Colleges in the UK have, in recent years, developed postgraduate courses and qualifications to underpin dentists' CPD and lifelong learning to the extent that there is now in place a “Professional Development Pathway” which could readily be structured in a*

**Authoritarian,
hierarchical, class
culture...**

**expects respect and trust
based on hierarchy as of
right.**

To the extent that you cling to your professional status on the basis of inherited privilege or the presumption of lifetime assignation of status or superiority, I shall deem you to be out of step with the currently evolving worldview and values, and I shall conclude that society no longer has need of your kind of professional status in the contemporary world.

⁸² The numbers of “Interim Order” cases rose from 8 in 2002 to 214 in 2010; and the number of scheduled hearing days rose from 54 in 2002 to 582 in 2010. (Data supplied by the GDC (Hearings Team).

manner that could fit into a lifelong revalidation programme. However, I also note that these qualifications themselves are not subject to revalidation except for those who progress up the pathway towards Fellowship at which level again, there is no ongoing revalidation.

To the extent that I see:

- *you are committed to eliminating criminal elements in your midst;*
- *you demonstrate that you are maintaining knowledge and skill levels throughout your careers;*
- *you are working to put in place appropriate professional development pathways to sustain a lifetime in practice so that your least ambitious members are demonstrating that they are keeping up with current practice;*

I shall judge that

you are maintaining your competence levels as is appropriate for those who wish to be viewed as members of a learned profession".

• Altruism:

Krites says: *"There are many times when you will be confronted with treatment options which are more lucrative for you versus others that may be less destructive or invasive for your patient.*

I wonder how faithful you are to your calling to put your patient's interests first - above your own;

To the extent that you demonstrate altruism ...

- *...in your practising, then I shall judge that you are worthy of the ongoing status of a learned profession".*

Krites' pertinent questions (above) challenge our claim to be professional. He might well ask us:

"What is the Value in maintaining the concept of professionalism in the 21st century?"

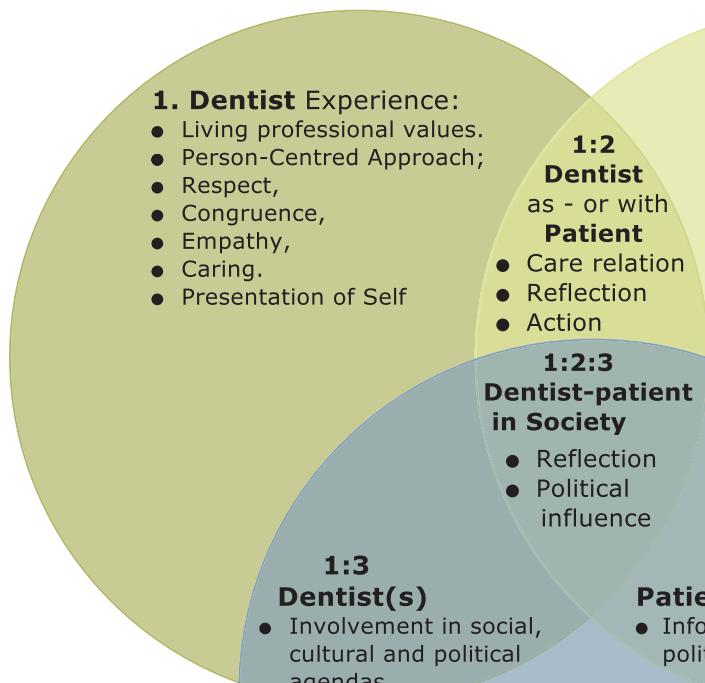
We are challenged to respond to...

A High Calling

1. In an ideal world, every person would perform every task, fulfil every role and meet every responsibility to the utmost limit of their ability. This is not an ideal world and human frailty means that the achievement by anybody of that ideal with absolute consistency is highly improbable.
2. There are some areas of activity where we feel a need for a particularly high level of caring, probity, honesty, altruism, integrity - in short trustworthiness – because those activities are particularly intimate or fateful (Giddens 1991) in their nature and significance. These are the areas that have become the province of the “professions” (see chapter 3.7.).
3. For the recognition of these groups as *professions* to be of value to society, it follows that a particularly high level of conduct must be displayed by the members of those professions.
4. Society needs to be able to place this level of trust: the professions need to demonstrate this level of trustworthiness.
5. If the professions fail then both professions and society are the losers.
6. The answer can only lie in the hands of the professions ourselves for only we have the insight necessary to evaluate the profile of the *true professional*: one who is true to her calling in terms not only of competence but of moral commitment. Only we can have the full insight into the nature of our specialised *competence* and the particular, unique tensions of a moral nature that must be appropriately resolved to warrant society’s trust.
7. Whilst civilisation managed for millennia without recognised *professions* in the modern sense, the nature and extent of the knowledge involved has increased dramatically so that most of the time a non-specialist cannot know the right questions to ask; cannot know the right answers to seek; cannot make adequately informed judgements between different answers.
8. Indeed, it might be considered that in our modern and highly complex society we all must rely much more than ever before on the trustworthiness of the many others on whom we depend. In a more complex society a high standard of morality would seem to be more important than ever.
9. In this the professions are merely required to lead the way. We are the head of the arrow.
10. To the extent that the above provides an answer, it invokes what might be called a *societal imperative*. This is our **vocation**.

A Model for Professional Practice - 3 Experiential Perspectives.

1. Dentist: (Professional)



2. Patient: (Client)

2. Patient Experience

- Respected
- Listened to and Understood
- Involved - Dialogue
- Cared-for
- Health Focus
- Trusts caring professional

**1:3
Dentist(s)**

- Involvement in social, cultural and political agendas

**1:2:3
Dentist-patient
in Society**

- Reflection
- Political influence

2:3

Patients' experience

- Informs society's political agenda

3. Society (Individual/Collective) Experience

- Profession - engaging with society
- Exemplifying PCA in society
- Professional service: not privilege
- Promotion of professional values
- Respect for, & trust in, profession
- Reflecting Societal Values
- Altruism

3. Society: (Individual / Collective)

Fig 3.8.2. A Model for Professional Practice.

A Way of Being for the Professions and for Society.

The Value of the Model

What I have outlined above is a very demanding – and admittedly often aspirational – model of how we might wish all professional practitioners could be in our vocation.

I suggest that each professional, as part of our contract with society, has a responsibility to practice the highest order *Way of Being* with people as an example and a model. Failure to achieve that, I suggest, seriously undermines our claim to being *professionals*.

Kirklin and Richardson in their book on *Medical Humanities*, echoing de Chardin, referred to earlier, quote Einstein:

"A human being is part of the whole that we call the universe, a part limited in time and space. He experiences himself, his thoughts and feelings, as something separated from the rest – a kind of optical illusion of his consciousness. This illusion is a prison for us, restricting us to our personal desires and to affection for only the few people nearest us. Our task must be to free ourselves from this prison by widening our circle of comparison to embrace all living beings and all of nature." (Kirklin & Richardson 2001 p.24.)

The offering of mentoring by one professional to another is, at its best, a collegial act aimed at offering support to help the mentee address the live issues in their life at this moment and to assess their options in the light of their own values, priorities and meanings. It may be construed as one person working (*connecting*) with another to help them consider the deeper meanings in their own life at this point in time as they make that onward journey to a better acquaintance with, and understanding of, the depth of the wonder which is their own self and the way that they would connect with others. Their *positioning* (Harré & Moghaddam 2003) as a *Skilled Helper* (Egan 2010) exemplifies a *Way of Being* (Rogers 1995/80) from which society might take inspiration.

The professional employing a mentoring style to help their patient or client to a deeper self understanding: to the next step on their road of actualisation, can know that they are engaged in a work in society that enriches not only the mentee, but their contacts as well; and, as well as contributing directly to the *good life* process in society, are also modelling a way of being with people which is itself arguably the best hope for humanity's survival on this planet.

Chapter 3.9

Developing Professional Practice:

A Reflective Agenda for Change

Embracing Change

The “*Model for Professional Practice*” represents an idealised account of how dental practice might be experienced by the professional, the patient and society. The question now is about how such an ideal may be translated into practice. To colleagues who have undergone preparation for mentoring using the PCA, the approach to practice here advocated will seem natural and even obvious. There will undoubtedly be others whose natural orientation is to a greater or lesser degree person-centred (even though they have probably never heard of Carl Rogers). For such colleagues, some tools, such as questions for self-assessment, may be helpful in promoting self-development in a PCA direction. Although the model represents an ideal, many colleagues *do*, despite apparent difficulties, manage to run their practices in ways that come close to this ideal. We might wish, however, that this should be seen more often. If professionals feel they are unable to serve their public properly because of the terms of service with which they must comply, it would seem to be essential for the profession to work collectively to guide change to make the ideal more achievable. The history of the last 65 years - since the establishment of the NHS General Dental Services⁸³ -- would seem to suggest that, as a large group, dentists have been unable to create conditions for change. Where change has occurred, notable individuals have led it. Margaret Seward, now Dame of the British Empire (Seward 2010) led the development and launch of *Teamwork* in dental practice, which provided structured learning for dental nurses nationwide: producing a new generation of nurses able to take responsible roles in an increasingly technical and demanding clinical environment. Important developments were the launching of Denplan and BUPA DentalCover – two schemes in the private sector which demonstrated another way of funding dental care – capitation – under the umbrella of an organisation which has proved capable of supporting dentists in developing the quality of their care. A huge impact resulted from the gathering together of a small number of dentists in the late 1970s to develop the MGDSRCS(Eng.)⁸⁴, the first postgraduate examination in general dentistry which over the next 20 years produced a cohort of enthusiasts who had taken their knowledge and their clinical practice to a new level,

⁸³ Outlined in chapter 1.1 pp.10-14

⁸⁴ Member in General Dental Surgery of the Royal College of Surgeons of England.

equipping them to develop and launch a Faculty of General Dental Practice able to work alongside the Faculty of Dental Surgery at the Royal College of Surgeons developing *Standards* for dental practice (SAMS)⁸⁵ and postgraduate diplomas to mark stages in practitioners' ongoing professional development at the end of the 20th century and into the 21st.

In contrast, Chief Dental Officers are influential at government level, though do not seem themselves to have been powerful agents for change – more often, it seems, mouthpieces for the Government to the profession and the public. However, the choice of Professor Steele, a Professor of *Oral Health Services Research*, to prepare a report (Steele 2009) planned to lead to a new contract in 2014 seems to have been particularly well-advised. For the first time, as discussed in chapter 1.1 pp.14-24, proposals have been drawn up for a system of dental care in the NHS which focuses on achieving *health* first. It would appear that it has fallen to Professor Steele to be "*the right person in the right place at the right time*" representing our profession as the agent for change which, by now, many in the profession will be glad to see. Dentists working under NHS regulations are therefore facing a very significant change in working in two years' time. New graduates already recognise that they will be working in a way that is more consistent with their undergraduate training. The bigger change may be for older practitioners who have ingrained a completely different – fee-generating, treatment-oriented - way of thinking and working and who are now going to need to radically rethink their patient care philosophy.

The focus on *health* rather than *treatment* is crucial and relevant to this project. Whereas *treatment* depends on the ministrations of the dentist (necessitating a visit to the dentist for every intervention), achieving and maintaining *health* is a function of life-style patterns – diet and oral hygiene - which, in contrast to treatment visits to the dentist, depend for their success on the daily commitment of the patient to a suitable regime at home. There will, of course, be a need for suitable education of patients to change their understanding and priorities, and this will call for support from the dentist and other team members such as hygienists and oral health educators. Active disease and tooth wear or breakdown will still need appropriate (though increasingly less invasive) restorative work, once disease processes are brought under control. All this will require of the dentist and team good mentoring skills. By definition the process will be more patient-focused – i.e. person-centred.

It also seems likely that making this change could be helpfully facilitated for many dentists themselves by having mentoring support.

Other changes are likely to provide for more advanced treatments to be provided by dentists with specific contracts (likely therefore to require demonstration of higher levels of expertise) which will put greater emphasis on quality rather than output. (This is already happening in

⁸⁵ *Self-Assessment Manual and Standards*: Developed and published by the Advisory Board in General Dental Practice, London, The Royal College of Surgeons of England 1991, as part of the preparation for the launch of the Faculty of General Dental Practice in 1992: superseded in 1996 by *Standards in Dentistry ("SiD")* which includes an online component to facilitate updating with rapidly changing regulations.

some health authorities with minor oral surgery, for example.) Advanced restorative work will only be funded when stable health is achieved, and ongoing health maintenance will remain a priority. These changes therefore place a greater emphasis on the patient's contribution to their own welfare – patient-focused or *person-centred*.

Responsibilities: Not Rights

The changes in dentistry appear to mirror changes in other aspects of healthcare and other areas too where expectations, often articulated in the language of *rights*, are changing. Although doubts may be expressed about the nature of *rights* in any absolute sense, insofar as society declares rights, this may be seen as a collective declaration of felt *responsibility* that in society we owe this level of care each to the *other*. Such language has become much more audible over the last half century so that the person-centred mentoring approach to professional practice would seem to be consistent with other changes in society in general and healthcare in particular. Such changes include:

- statements on professional values, widely available on their websites, from several other professional groups – exemplified by doctors, nurses, physiotherapists, occupational therapists, social workers and professional educators, all of which show a very significant shift in emphasis towards a more holistic and person-centred approach⁸⁶.
- an increasing tendency, as in the RCS(Eng.), to have lay groups involved in advising professionals;
- an increasing demand for better patient information and participation in decision-making leading to *informed consent*;
- a discernible trend over the last half-century to seek far more consultation on planned political changes;
- emergence of different ways of delivering care – such as through dental *access centres*: recognising that different persons have different needs;
- the views expressed by Royalty in a recent Guest Editorial of the *Journal of the Royal Society of Medicine* suggesting “*that it might be beneficial to develop truly integrated systems of providing health and care. That is not simply to treat the symptoms of disease, but actively to create health and to put the patient at the heart of this process by incorporating those core human elements of mind, body and spirit*” (HRH the Prince of Wales, 2012 pp.496-8).
- changes in the way policy is represented by government, exemplified by the recently published diagram of the “*Health and Care System: April 2013*” which places “*Public and*

⁸⁶ As does an increasing volume of literature – reviewed briefly in Chapter 3.7, pp.158-162.

Patients" at the centre of a series of concentric circles representing various bodies and agencies involved (Fig.1.2.1,)⁸⁷.

These changes reflect a significant shift in values in society and the symbolism of Fig.1.2.1 projects a major shift, both in philosophy and in will, within recent years. It is hard to resist the conclusion that the influence of individuals such as Maslow, Buber, Rogers, and Vygotsky is discernible in the social changes and at government level. Changes described and advocated in this thesis are consistent with these trends and, as such, will enable the dental profession to make its own contribution to a way of living in society that values each person as an individual and values the richness and diversity of individuality itself.

Perspectives on Professional Practice: Self - Examination

In this thesis, the focus has been on the personal, humanistic and existential aspects of being a professional in contrast to many approaches that tend to focus on the empirical and technical aspects involved in *delivering treatment* as if they alone define dental practice.

In the person-centred mentoring spirit, it is now time to review some of the perspectives that have been employed in developing the present argument. These perspectives are presented as *helpful ways for each professional to think about professional practice*: as a framework for moral enquiry or of *truth searching* (Bottery 1998, p.67): a framework for *reflection* (Schön 1991/83 & 1987) about *how we are* as practitioners *with our patients*, as distinct from *what we are doing to them*. I have argued (Chapter 3.7) that such moral enquiry is at the core of our sense of *being a professional* and that just such a moral perspective lies at the heart of our sense of *vocation*: being *called to serve*. In a world where so much is changing over such short time-scales it is necessary that we continuously reinvent ourselves and redefine the *raison d'être* of our profession. Nettleton's sociological review of dentistry portrays a profession undergoing accelerating change (Nettleton 1992). The paradigms of yesteryear are history and evidence has been presented in chapter 3.7 (pp.158-162) that the self-perceptions and expectations of our contemporaries are rapidly changing. In truth, in the field of oral health, only visionary oral health professionals can know just how much change may be reasonably expected. It is the professionals, who have the specialised knowledge that can be used to enhance our performance. With a radically new NHS contract rapidly approaching, engaging in an ongoing internal or collegial conversation in an effort the better to understand and redefine the dental professional's role in the 21st century, post-Steele, is an opportunity to reinvent ourselves as a profession. It is going to be necessary for many practitioners to redefine our role as healthcare

⁸⁷ Also available online at healthandcare.dh.gov.uk/system-overview-diagram/

workers and to refine the way we are with our patients as we seek to enhance the goods they receive from us. In so doing, we have an opportunity to rediscover our sense of *vocation*.

For many discovering - or *re*-discovering - unconditional positive *self*-regard may be a valuable step. Earlier, compromises were indicated which dentists often have to make between what they could – or would really prefer to – do for their patient but for the constraints of the payment system within which they work (chapter 1.1, pp.23-28). On reflection, many of us may recall decisions we have taken that we would not have taken had the patient been our mother or our daughter. These discoveries can reveal an uncomfortable disjunction between the kind of dentist we had hoped in our undergraduate days we should become, and the reality in which we now find ourselves: for, on many occasions, in our practice we are expressing qualities, values and priorities which conflict with those that define the kind of person we wish to be.

The challenge – in the interests of becoming better professionals and, indeed, better persons – is to reflect with humility on the attitudes and behaviours that characterise our *way of being* as professionals and how they compare with those that would reflect the type of professional person we wish to become. To the extent that the two sets of values are incongruent, we have work to do if we are to be comfortable with ourselves. For many of us, rather than a conscious and malevolent decision, the incongruent values and priorities have been absorbed as assumptions from the family and the social and professional culture in which we grew up and experienced our early professional development. It is unlikely that dentists will be able to offer others (mentees, colleagues or patients) *unconditional positive regard* if we are not comfortable with ourselves. It is appropriate, therefore, to recall that one of our requirements when relating to a mentee is *unconditional positive regard*. If I owe that to my mentee, then I owe the same consideration to myself – unconditional positive *self*-regard. A useful question for reflection might be:

“To what extent does my clinical practice reflect my deeply held values and beliefs and show the kind of person I really want to be?”

Inward reflection on this basis can be helpfully illuminated by Transactional Analysis (chapter 2.3, pp.73-4 and appendix 5), identifying the “recordings” that contributed to my own Parent, Adult, and Child ego-states. Once identified, I can bring my Adult to bear on them and, if I so decide, reduce their influence. A high proportion of the participants in the Faculty Mentoring course find T/A illuminating both for self-understanding and for understanding others.

Reflection on how we use or exploit *power* in professional relationships can be illuminating. As a professional, each one of us is *empowered*, by virtue of our training, knowledge and skill, to serve our clientèle in our particular field – here dentistry. To serve my patient, however, I must put my *knowledge* and my *skill* at their disposal. *That is the leverage point*⁸⁸ for my power. The

⁸⁸ See Task 1c, Skilled Helper Model Chapter 2.5, p.111)

decision as to which treatment option (if any) should be selected rests with my patient. To dictate a solution: *“The tooth will have to be taken out.”*; to give slanted information that will tend to produce a particular choice (extraction): *“It could be root-filled but that is a lengthy and difficult job and can be very painful”*; or to withhold information that might result in an alternative decision such as *“If necessary, modern local anaesthetics are very effective. Although it takes a while to do, it can be very relaxed and people sometimes even doze off while I am doing it”* is, I would argue, an inappropriate use of my power⁸⁹. The use or misuse of power is helpfully illuminated by the concept of *positioning* (Harré & Moghaddam 2003,pp.1-9). The dentist above, telling the patient *“The tooth will have to be taken out.”* Is taking up the position of *expert*. At the same time, the patient is positioned by the dentist as *incompetent* to take a decision or as *not interested* in considering alternatives. It is worth each of us reflecting on the extent this strategy of positioning is used in our own clinical practice for it deprives the patient of their rightful *autonomy* and, thereby, fails to accord them appropriate *respect*. Such *positioning* which harms the patient by depriving them of their rightful autonomy has been described as *malignant positioning* by Sabat in relation to a patient suffering from Alzheimer’s disease who, on the basis of such positioning was deemed *incompetent* and conveniently (for the family) moved into a “home” against his own preferences (*ibid* pp.85-97). This represents a more extreme case. However, I argue that the moral issues are exactly the same as the patient having a tooth extracted that they would have chosen to conserve if they were in possession of full information. It is noticeable that issues related to positioning can arise within the practice team and, especially perhaps, in larger groups of practices such as Dental Bodies Corporate. The concept of *positioning* is a valuable tool to illuminate what is “going on” in relationships at many levels. Positioning can also be employed as a means to dominance – often perceived by others as *arrogance* – at an organisational level in political structures, faculties, colleges, and other professional bodies. Recently the challenges facing the two dental faculties at the RCS (Eng.) have been addressed, both with respect to their mutual positioning in their relationship and with respect to their perceived positioning (as “*superior - not in touch with our world*”) in the eyes of general practitioners who may, thereby, feel somewhat distanced from a source of professional and academic support (Holt 2012). The example, referred to in chapter 1.1,p.25, of the Bristol heart babies case, arose because of an out-dated *positioning* of the consultant surgeon as *beyond criticism*, and of the whistle-blower as *acting unprofessionally* (Irvine 2003). This episode constituted a salutary lesson for the medical profession from which much has, undoubtedly, been learned and subsequently embodied in the RCP report discussed in chapter 3.7,pp.163-8.

⁸⁹ These three alternatives correspond to Lukes' three dimensions of power discussed in chapter 1.2 pp.44-5.

This brief discussion of *power* and *positioning* which has focused on negative issues (which I interpret as being at the root of many concerns in professional practice) is concluded by suggesting that dental professionals could usefully take a positive step by asking themselves a question:

“What can I do to conduct myself so that colleagues, team members and patients know that, when they come to me to discuss an issue, I shall accord them the respect they deserve, and position myself as a ‘servant leader’ rather than ‘the one who has all the answers?’”

To view my patient in a holistic way – as a whole person - is, I suggest, *the* crucial step into person-centred practice. The revering of the *whole* person as a centre of thoughts, feelings and values - like myself - makes it much more likely that my *I* will recognise their *Thou* and avoid falling into the trap of instrumental treatment of the *other*. A person so viewed is valued as one able – and entitled - to contribute intelligently to decisions concerning their own dental future, displaying a “*tendency to actualise as fully as possible in any given environment*” (Tudor & Worrall 2006,p.88). It is from this valuing position that the *person-centred approach* is derived.

In adopting the PCA in professional practice, the second of the three core conditions - *unconditional positive regard* - implies a valuing of the patient as *worthy of respect*. The holistic valuing of the person is one of *wholeness* and *competence*. That is a fundamental relational position I adopt as a clinician. This, in the language just used above, is a *position* from which I acknowledge the competence and the freedom of my patient to take the *power* of decision over their own dental future and, in my relationship with them, I *position* them thus. Perhaps the question for the clinician to consider here is not so much about how far I go in giving the patient the control – or not: rather I might ask myself:

“To what extent do I really believe in – and act on my belief in - my patient’s competence? “How genuine is my attitude of unconditional positive regard?”

The third of the three core conditions, *empathy - putting ourselves in the other’s shoes* - involves an attitude of mind which enables us to identify with our patient and enter their world of experience. Given the fulfilment of the condition of unconditional positive regard, empathic understanding heightens our ability to respond accurately to how the patient is feeling in the moment. Perhaps the question to ask here is:

“How far am I prepared to go to really be tuned in to my patient and their feelings?”

The first of the three core conditions – *congruence* – tests the *genuineness* of our positive regard and the extent to which we have resolved any conflicts between the interests of our patient and our own self-interest. Perhaps the question to ask here is:

“How do I resolve the tension between serving my patient’s best interests and serving my own needs to make a living and find job-satisfaction?”

Being a Professional

Resolving this tension between what is in my patient’s best interests and my own perceived interests is, perhaps, the key to being comfortable in a professional orientation toward my patient. The key defining element in being a professional is the *way of being* with my patient: according them *unconditional positive regard* as a whole person. Perhaps the question to ask ourselves here is:

“How closely do my inner mental processes and feelings in the professional encounter accord with those I would wish for in someone caring for me?”

That question raises the issue of the nature of the *inner mental processes and feelings that I should wish for in someone caring for me*. I have highlighted (Chapter 3.8,pp.183-5) the professional’s orientation that engages the patient in the decision-making processes and involves them in their own preventive care. A further focus of a health-oriented dentist’s state of mind is on the quality of clinical work produced – which depends to a significant degree on time taken as well as on operative skills. The longevity of restorative work is likely to be determined by the time and care taken in preparing a tooth (driven by mental processes and states identified in Wilber’s UL quadrant, chapter 3.6,p.130 which, once the restoration is placed is not amenable to inspection by a dental reference officer (a process that belongs in Wilber’s UR quadrant). Work such as crown-work is constructed on a prepared model which may be inspected, but this only occurs normally in postgraduate assessments for higher diplomas. Longevity is not merely a matter of convenience (the patient does not want repeated procedures), for the preparation of a tooth for repeat restorations invariably destroys more tooth tissue and increases the risk of pulp death, further compromising the tooth. There are therefore three elements contributing to the professional care for the dental patient:

- the deployment of human communication and relational skills informing and involving the patient holistically in preventive and decision-making processes;
- the application of a mindful, self-critical mind-set in guiding decisions and in carrying out operative procedures to ensure that the maximum amount of tooth tissue is conserved and preparations designed. and work finished to a standard, calculated to achieve maximum possible longevity;
- the acquisition and deployment of a high level of operative skills to underpin the mental processes and facilitate the delivery of high quality restorative work.

The third of these elements tends (alongside cross-infection control issues) to dominate current discussions about *“High Standards in Dentistry”*. All three elements - altruistic in intent - are

ideally put at the disposal of the patient in the professional relationship. How effectively that is achieved is a function of the professional's *way of being* with her patient, and the importance – and level of prioritisation – that she attaches to these aspects of her professional service.

Altruism

The final element in this part of the discussion requires a consideration of how we frame this desire for altruistic professional practice as an ideal towards which we target our professional development. From the PCA perspective, it is clear that it is incumbent upon each professional to adopt a *way of being* with the patient or client - based on congruence, unconditional positive regard, and empathic understanding – that makes the professional open to their needs and places their goods first – and, above all, before the professional's own goods – in the encounter. It is not possible to impose, demand, or regulate for, such a mind-set. It can only be framed as an ideal towards which professionals target their own personal and professional development. The extent to which, as professionals we are each able to embody and enact such values will reflect how we perceive ourselves. This is a critical part of our *first person, inner experience* as professionals (Wilber's UL quadrant). To the extent that we perceive ourselves in an holistic way so we shall attribute similar dimensions and qualities to others including our patients. That, in turn, will influence how patients perceive us as professionals, for they also have empathic skills to inform their own evaluations of the kind of people we are, including our altruistic (or contrary) orientation.

Imminent Changes in Dentistry.

The implementation of the Steele report (chapter 1.1 pp.14,19-22) is currently expected to take effect in 2014 after the extended pilot schemes have been evaluated. Only limited information is available though it is known that methods of assessing and recording the oral health status of patients are being evaluated as are approaches to addressing health problems identified, using a team approach involving dentists and dental care professionals such as hygienists. To the majority of dentists (i.e. those working within the NHS and not involved in the pilots) it is evident that a very substantial upheaval in working practices is looming, with the need for dentists to develop team-working to a much greater degree and to approach patients from a more patient-centred position. This change, even for those for whom such a change may seem welcome in theory, seems likely to find many dentists, their teams and their practices ill-equipped, for these changes represent nothing short of a paradigm shift in the day-to-day delivery of care. The whole *telos* of dental practice – including its public perception - needs to change and, most challenging of all, in terms of work-practices, patients themselves will need to be engaged in the new approach to securing their oral health. The traditional treatment-focussed *modus operandi* will be replaced by a patient-focused approach, guiding patients through lifestyle changes

necessary to secure oral health and, only when stability has been established, carrying out – or, more likely, referring on to a different, more highly-skilled contract-holder for - more complex restorative work. Professor Steele's model closely matches the “**basic oral health plus**” model outlined in chapter 1.1,pp.19-21, with criteria added based on effective disease control (prevention and stability) limiting access to more complex restorative treatment at public expense. Assuming that the legislation, when it is drawn up, follows this pattern, then Professor Steele has created a framework providing an opportunity for dentists to reinvent themselves and rediscover their professional role. The expectation would then be that the dental teams that engage most effectively with the persons who are their patients, equipping them with the knowledge and skills to secure and maintain their own oral health, would be beginning to work a professional model, which is both holistic and person-centred in its delivery. The closer dentists and their teams come to creating Rogers' *core conditions* – *congruence* (genuineness), *unconditional positive regard* (respect), and *empathy* (empathic understanding): the closer we come to engaging at the level of Buber's *I-Thou*, then the closer we shall approach the ideal presented in the *model for professional practice* above (chapter 3.8). To the extent that dentists chose their profession out of a sense of *vocation*: a desire to help people as part of the broader healthcare professions, then the new contract provides an opportunity to realise that calling and to develop afresh as a healthcare professional.

Developing Professional Practice

Not all dentists work under NHS regulations and many who do also see patients under private contract. Some dentists taking private patients will have already absorbed, and be practising, an holistic and person-centred approach to practice as, no doubt, will a proportion of dentists with NHS contracts, though the latter will be doing so *in spite of* the system rather than because the system offers inducements for so doing. Many dentists in private, or predominantly private, practice may still be operating a treatment-focussed rather than health-focussed approach to practice. They will not be directly affected by a change in NHS contract and there may be little reason for them to change their practising philosophy. The likelihood is that Regional Dental Deans will be encouraged to provide appropriate postgraduate courses to prepare dentists for changes. However, since the detailed nature of any new contract remains completely unknown at this time, and the lead-in time for planning postgraduate courses is many months, always assuming that appropriately trained or skilled course leaders are available, the prospect looms of little opportunity to prepare dentists in advance of the introduction of any new contract. Those practices already equipped with ‘prevention’ units and suitable support staff will be better

equipped than others. The submission of suitable articles to dental journals at the appropriate time, may also offer a means of supporting colleagues.

Overall, however, regardless of NHS changes, there remains the desire to maintain the impetus in the change of perspective (demonstrated in sources cited in chapter 3.7,pp.158-62) towards a more person-centred approach, considering the inner experiences of the professional (in delivering education and assessments at undergraduate and postgraduate levels) and the patient (in delivering care).

There will be those dentists who will argue that in focussing on offering *cosmetic dentistry*, despite the hazards described above⁹⁰, they are meeting patients' demands. Many practitioners who seek to ensure that patients seeking such treatments are fully aware of the very likely, and serious, long-term consequences for the survival of their dentitions into old age – not to mention on-going costs of managing the problems emerging in the damaged teeth – find that a very high proportion of patients given appropriate counselling either choose simpler and less radical measures, or decide to accept their current situation. Kelleher et al's three excellent recent papers (Kelleher et al 2012a, 2012b, & 2012c) have, in effect, provided the legal profession with all the information they need to seriously challenge in court any dentist providing such treatment without the most detailed and explicit evidence that the patient, now suffering "*complications*", was fully informed as to potential risks and alternative treatments before proceeding.

There may also be some professionals who object to the PCA on the basis that it is too 'friendly' and that the dentist needs to stand back and be more "impersonal and detached" in carrying out operative procedures. There are, undoubtedly, dentists for whom this may be a genuine problem. It would be interesting to explore with such colleagues whether mentoring would help them to 'cope' with the kind of dual role implied. There are, however, also some patients who, themselves, seem to be more comfortable with a more formal approach from their professional adviser. For both parties, the solution may be provided by patients locating a dentist with a 'style' that suits them.

Notwithstanding the above comment, it is important to reiterate that the holistic and person-centred approach advocated here is presented as much more than a particular 'style of practice'. It is a *way of being* between a patient and her healthcare worker that is humanistic in the two senses that it seeks to address the whole person: and that it adopts a very broad humanism that takes account of all the four dimensions of the person, even though, for much of the time, the relationship may be straightforward at a fairly superficial 'day-to-day' level of contact (which does not, however, preclude the full *I-Thou* relationship, transient though it may be). For most patients, personal experience suggests, the bridging of the gap of *impersonality* in

⁹⁰ Chapter 3.7 p.37 Fig. 3.7.2.

a friendly and personal way, does more than anything else to help them successfully and happily negotiate procedures that give rise to anxiety in anticipation.

It would be interesting, indeed, to study a group of dentists, some of whom preferred the relatively impersonal and “instrumental” approach to practice. It may be that their orientation is much more focussed on the empirical, or even avowedly positivist, and denying the importance, or even reality, of the aspects of personality portrayed and functioning in the left hand quadrants of Wilber’s diagram and which are integral to my whole argument. There is a vast ontological and epistemological gap between the holders of such views and the perspective upon which this thesis is based for I have presented a particular view of what it means to be human. The view presented is fundamentally existential, seeking to develop a synthesis of the Platonic and Aristotelian approaches to reality, for their different emphases may be seen, not as incompatibles concerning the nature of our universe, but rather as different perspectives supplied by different facets of the human make-up. I advocate an holistic view that incorporates the differing viewpoints as polar opposites in a dialectical sense so that our individual experiences, between different persons and within each of us at different times may illuminate different aspects of our reality, the whole weaving together to produce an ever-evolving synthesis. Although further exploration of this is outwith the scope of this thesis, Teilhard de Chardin’s emergent understanding of the non-dual universe (chapter 2.3 pp.84-7) does afford a perspective that provides space for both the Platonic and the Aristotelian viewpoints.

The On-going Value of the Concept of Professionalism.

This thesis began from a sense of dissatisfaction with the performance of the dental profession in meeting the needs of the UK population. The publication of a report, the production of which was led by a distinguished and visionary member of the dental profession (Steele 2009), demonstrates a level of reflection and self-critique within the profession that increases hope that the profession as a *whole*, notwithstanding the dissatisfactions expressed in chapters 1.1 and 1.2, has within its collective soul the capacity and the will to reflect critically upon its performance to date and to devise a way forward which will better serve the interests of our patients. This is not a way of working that typifies all trades or businesses. Few of us will not have had the experience of being confronted by a sales person who is trying to sell us something we do not want or which might be positively damaging to us. For years we have been confronted by advertisements promoting the smoking of cigarettes which, by common agreement, is bad for us (the very antithesis of promoting *human flourishing*) and it is not the tobacco companies that have imposed advertising restrictions upon themselves, but the state. For all its faults, the dental profession is taking up Professor Steele’s lead and working to make

the changes proposed effective in the interests of patients. Whilst there were some serious cases of misconduct revealed in medicine with the Bristol heart babies case and others at about the same time (chapter 1.1 p.25), the response of the medical profession was to produce a report on medical professionalism which radically reframes the roles of the profession in society and the relationships involved (RCP 2006a), and gives evidence of great concern and deep soul-searching at all levels of the profession from those in the House of Lords to young medical students not yet entering practice (RCP 2006b).

Whilst the non-English-speaking world seems to manage without the concept of *professionalism*, there are some areas of human affairs which, because of their personal intimacy and/or *fateful or consequential* nature (Giddens 1991 pp.112-4,127-8), prompt persons to seek expert help upon which it is important they can rely. Medicine (broadly the professions committed to care for persons' health), the church, the law and the university assist with physical and spiritual well being; matters to do with property, and the training of the mind. With such sensitive areas, the need to *trust* the agent consulted is important. The *professing* of a commitment to put the interests of the patient, client or student first sets the professions apart. Since the promotion of the patient's *good* – or the causing of *harm* - is a *moral* issue, I have presented the claim to *professionalism* as the declaration of a *moral position* (chapter 3.7,p.146). Whilst individuals within professions fall short from time to time, and probably all, on reflection, from time to time reproach themselves for not '*doing (or caring) better*', the overall commitment of a professional body to this high moral calling is reflected in its internal ability as a community to self-examine, self-reproach and to self-adjust when failings are identified. No claim is made to infallibility or unfailing virtue. The ambition is aretaic⁹¹: a declaration of intent to strive for excellence (which must be defined specifically by each profession, as I seek to do for dentistry in chapter 1.1 above) and the objective is to work for human well-being and human flourishing. Whilst there are many in various trades and services who individually follow a similar path to excellence of service, they are not members of a group *professing* the same level of expertise or *moral commitment* in a *fateful* area of human affairs. It may be that, in time, society - ever becoming more complex - may find value in expecting a similar aretaic and moral commitment from other areas of service or care where learning is becoming ever more complex and esoteric. If the concept of professionalism has value, it would be unsurprising if society discovered it could, with benefit, be of wider application in years to come.

Mindfulness and a *Eudaimonic* Experience for Professionals.

The technique of practising *mindfulness* – sometimes referred to as *spiritual awareness* or *enlightenment*⁹² - has been increasingly invoked in recent years. Whilst it may have roots in all the major religious traditions of the world, many members of the healthcare professions are

⁹¹ Based on virtue or excellence.

finding it helpful to facilitate their maintaining focus on the fundamental values (*caring* etc.) which they wish to uphold in their practising lives in relations both with their patients and with their colleagues, and in their own inner state as they go about their lives. A team in Canada recommend the practice as a means to “*improve attentiveness, self-awareness, acceptance, wisdom and self-care in dentistry*” and help “*foster commitment to a common set of professional values such as altruism, compassion, and community service*” (Lovas et al. 2008, p.998). These authors advocate encouraging students - it could be practitioners – to

“*discuss in small groups how the aspiration (the good life) and obligation (the right thing to do) aspects of ethics, like self-care and patient-care, are actually interdependent.*

Instead of seeing it as a burdensome ‘should list’, we recommend reframing professional morality as a vital prerequisite for enjoying a truly high quality of life” (*ibid*, p. 1003).

Emphasising educational strategies focussing on “*underlying values and motives*” (once more highlighting processes described in Wilber’s UL quadrant), they report a study involving patients and colleagues who “*showed preference for health care professionals who manifest personal congruence, i.e. Internal values and external behaviour match*” (*ibid*): the first of Rogers’ core conditions.

Conclusion: Altruism as Vocation

I conclude by returning to the discussion based on work of Williams and Higgins (chapter 3.7, pp.145) where it was recognised that a good (*good life* or *eudaimonic*) outcome for the patient/client may also be a good (*eudaimonic* or *good life*) outcome for the professional even when the professional has (on a superficial view) subordinated her own interests to those of her patient. The superficial view fails to take account of the inner experience and self-evaluation of the professional for, if she views herself as “*one who cares in this way:*” or as “*one who wants to be seen (or known) by others (or, indeed, by her own reflexive self) as being ‘the sort of person who acts this way’*”, then the self-denying, altruistic act more than compensates for the superficial ‘disadvantage’ the professional has suffered, by its fulfilment of her own sense of personal morality: her own inner *telos*: her sense of “*the kind of person I wish to be*”. In this way the professional’s altruistic behaviour delivers her goods beyond price and authenticates her own ‘*good life*’ process as a person who enjoys inner congruence: a *eudaimonic* outcome indeed. Continuing the series of questions presented for the professional above, I offer three further questions for the reflective practitioner:

⁹² See Cohen (2011) for an excellent contemporary exposition.

“What, at the deepest level, considering the kind of person I want to be - and the kind of person I want to be known to be - are the values that drive my professional relationships and work with my patients/clients?”

“To what extent do I feel I am true to those values in my daily practice?”

“How do I feel about that?”

It is reasonable to hope that those claiming the privileged status of *professional* constantly review and refine their *professionalism* by reference to questions such as these.

THE END

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Appendix 1: Scenarios.

Five illustrative scenarios are given in this appendix below. All are factual and known to the author either via the dentist or via the patient.

Appendix 1. Scenario I. Diagnosis and Treatment Planning: Referred to Ch 1 p.23

Day 1. The patient presented as an emergency in a busy treatment session complaining of pain initiated by hot and cold referred to the back teeth in the lower jaw on the right. The dentist took a quick look; saw several teeth with moderate size fillings, one of which had a chip missing. He replaced the filling and sent the patient away.

Day 2. The patient represented with symptoms unchanged. The dentist looked again and noticed another filling that appeared to have a “leaky margin”. Under local anaesthetic the “faulty” filling was removed and replaced.

Day 3. The patient presented again with the symptoms worsening. This time the dentist decided to carry out a “special test”, i.e. test the teeth by placing a small piece of iced cotton wool against the teeth. Whilst other teeth reacted mildly to this test, a third tooth reacted very severely to the cold. A further “special test” – an x-ray - revealed decay underneath another filling on a third tooth previously not seen to have any fault. The tooth was extracted.

Comment: This “Case Study” was presented to a dental tutor as suitable for presentation at examination for a postgraduate dental diploma. No proper examination with appropriate tests was carried out until the third day/visit. There would have been no fee for the time taken doing these tests. By immediately filling the first “hole” that he could see, the dentist ensured that the patient visit generated a fee. (No treatment, no fee.) When the correct diagnosis had been made, it was obvious from the X-ray that this tooth could have been saved by root canal treatment. This was not offered to the patient and the patient was not made aware of the option although they were a regular attender.

When challenged on his approach to diagnosing this problem, the dentist responded “You can’t expect me to do things like that on the health service. There isn’t time.”

Sadly this (quite senior) candidate decided not to change his mode of practice and abandoned his plan to take a higher diploma.

Appendix 1 Scenario II: Advanced Restorative Dentistry Needed.

Referred to Ch .1.1 and 1.2

An affluent woman in her fifties was referred by her (nGDS) dentist to a private practitioner accepting referrals for all aspects of restorative dentistry and with a special interest in managing periodontal disease. The moderately advanced periodontal disease prompting the referral, with a well motivated patient, was very manageable. The lower right quadrant had only two molars distal to the canine, both with large caries free cavities (extensive lost fillings). One was found on X-ray to have a significant apical radiolucency – indicating an infection. This endodontic problem seemed to be very manageable and both teeth would have been very readily restorable eventually with crowns. Since the referral had been for periodontal treatment only, the radiographic information was relayed to the referring practitioner in the expectation that endodontic and restorative treatment options would be given. The patient returned to commence periodontal treatment some weeks later minus both the lower molars (i.e. edentulous behind her lower right canine with an otherwise complete dentition), reporting that she had been told these teeth “needed to come out”.

This scenario illustrates the point that the current system of reward by UDA's is having the effect of disincentivising practitioners from carrying out anything but the most simple treatments. Unfortunately, patients do not know to do anything other than accept advice if told that “these teeth will have to come out”. I have observed that there is a deeply ingrained expectation amongst many patients, even after a lifetime of careful and successful conservative dentistry, that inevitably their teeth will eventually “have to come out”.

Appendix 1. Scenario III. Manageable Periodontal Disease. *Referred to Ch 1*

A longstanding regular patient was “concerned about his gums” and, being keen to keep his teeth, asked his dentist - whom he had known a long time and felt he “got on well with” - if he could “see somebody about it” as he was having increasing symptoms (loose teeth). A referral was made to a periodontist and an appointment made for a Monday. On the Friday before the periodontist visit, the patient returned to his own dentist with increasing pain from his upper right canine – a tooth very visible at the front of the mouth. The dentist said there was nothing he could do but extract that tooth and two others on the other side of his mouth (also near the front of the mouth in the upper arch).

When the patient arrived to see the periodontist for his consultation, therefore, he had three fresh extraction sockets present. The periodontist’s examination showed that there was a moderate to severe level of periodontal disease present. However, this was well within the capacity of the periodontist to stabilise the disease and keep the teeth assuming that the patient was well motivated and compliant (as he certainly seemed to be – having himself requested referral). The critical factor for the periodontist in arriving at a prognosis for the outcome of treatment is the amount of bone remaining around the teeth. The periodontist took X-rays to confirm bone levels and observed that the three fresh sockets which were visible on the X-rays showed that the bone levels there were comparable to the bone levels elsewhere in the mouth. In other words, the three teeth extracted three days earlier, had been perfectly saveable. The symptoms from the upper right canine could have been managed in other ways.

Comment: It is difficult to understand why the upper right canine was removed at all in view of the imminent referral consultation, the patient’s enthusiasm for saving his teeth, and the option of prescribing antibiotics or initiating root canal treatment (according to the diagnosis) to relieve pain. Because he “had faith” in his dentist (and still has – the periodontist had to be careful not to criticise - that would have been “behaviour likely to bring the profession into disrepute” and the cause of very severe censure!) he accepted the advice that two unrelated teeth should come out at the same time! The reason for this advice remains a complete mystery. As well as having periodontal disease, the patient now has a difficult restorative problem as the periodontally compromised teeth were not a good risk for carrying bridge;; a denture would further compromise the periodontal condition; and the patient is a poor risk for implants because of his susceptibility to periodontal disease.

Appendix 1. Scenario IV: NHS Treatment Planning: A Brief Case Study. (Ch 1.2 p.49)

An illustration of the established acceptability of treatment decisions driven by the payment / charging system rather than the best clinical judgement occurred when a candidate for the MGDS examination, being concerned at the rather large treatment plan being drawn up for a patient planned for presentation in an advanced postgraduate diploma examination decided to request a Regional Dental Officer (RDO) examination to validate his judgement (and avoid being accused later of "carrying out unnecessary treatment".

The candidate reported that *"The patient, in his 60s, had been a regular dental attender, well motivated throughout life. He was concerned to keep his natural dentition. Cosmetic issues were secondary to long term prognosis. The whole mouth (basically healthy periodontally with no history of recent caries), well cared-for historically with some aging and deteriorating large or multiple restorations on several teeth and a poorly designed and ill fitting partial acrylic lower denture) was carefully assessed and each tooth considered for possible treatment assessed and evaluated for prognosis for any possible treatment. Some of the crownwork proposed was planned to prepare the mouth for a well designed tooth-borne chrome cobalt lower partial denture. Both upper central incisors needed attention having large composite restorations which were failing at the margins. On the left, a porcelain bonded crown seemed the obvious solution, the tooth was badly discoloured in part, a large part of the coronal tissue had been lost but there was a substantial residue of natural coronal tissue to allow the design of a good preparation with plenty of strength and a good prognosis for the survival of the restored tooth. By contrast, the right central, similarly restored but of better colour and appearance, clearly had less residual natural tooth tissue in the cervical third such that the dentist felt the prognosis was uncertain. If the crown failed it would need elective Root Canal Treatment and a post crown with the more serious and potentially fatal, risks of failure that entailed. The dentist decided that if it were his own tooth he would prefer to have a replacement composite which might survive adequately although not making a "matching pair" with the upper left central. The patient accepted this reasoning and the treatment plan proposed a composite filling for this tooth".*

Before the patient was invited into the surgery, the RDO asked the clinician for his reason for taking this unusual step. The reasons were explained as in the first paragraph above. The RDO seemed a little nervous finding himself dealing with an MGDS candidate who was clearly well equipped to argue his clinical case.

When the patient had been examined and discharged, the RDO advised the candidate that he thought he should provide bonded crowns for both upper centrals. The candidate explained his reason for advising otherwise – as above. The RDO persisted to argue for a crown on the upper right central. The basis of his argument was that the patient was already paying the maximum patient charge so the candidate could do this further crown without the patient having to pay more. The RDO recommended this crown in his report. The candidate explained to the Dental Practice Board his reasons for not following this advice, the patient being fully informed, and the DPB accepted that.

In the event, following the treatment as planned, the patient continued to attend the candidate for a further 11 years before the candidate moved to another practice. During that time UR1 needed no further treatment.

Appendix 1. Scenario V. Person-Centred Dentistry?

A successful young woman: a Medical Practitioner well known as an author of regular columns in medical journals decided that, at the age of 40, she would like to have orthodontic treatment carried out to straighten some mild irregularity of her upper front teeth. This kind of treatment would only be available privately and she arranged to see a specialist in orthodontics in his private practice.

Recounting the experience of her first consultation (amazingly, she did proceed with the treatment) she reported *“He had already got me in the chair lying on my back and looking at the ceiling before he even said “Hello”!* As a prominent and highly articulate member of her profession she said *“I am normally quite assertive and able to make my feelings known, but I felt completely disempowered and unable to express myself. I should have insisted that he sit me up so that I could explain to him why I had come for treatment.”*

Comment: *What can one say? I am concerned at the “management” of the patient. I am concerned that this style of management is so deeply ingrained and accepted in our professional culture that this lady, for all her character, her status and experience as a medical practitioner and undoubted personal skills, felt she had to accept this behaviour even in a private practice.*

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Appendix I. Scenario VI

Referred to in Chap 3.6.,

“A Great New Filling Material”.

In about 1980 I was persuaded by the dental company representative with whom I usually did business, and in whom I had reasonable confidence – though always aware that his job was to sell – to purchase a relatively new brand of a tooth coloured filling material for front teeth which, unlike the well-established product I was currently using - which had a sandstone-like surface - was *polishable*. This was a significant advantage that won me over. (I had hitherto resisted his persuasions, preferring to use materials I have come to trust for my patients until I am sure that a newer product is really better.)

Three years later, I was having a discussion with the same representative, reporting to him that my nice polishable fillings on my patients' front teeth were already going dark brown. This was clearly not a surprise to him and his response was the question *“Don’t you think it is quite reasonable to have to replace fillings every three years?”* To that I could only retort that *“No I don’t. When I put fillings in my patients’ teeth, neither they nor I expect that I shall have to redo them in three years.”* He was clearly surprised at my concern, appeared not to have met anybody else who shared it, and simply thought it was a splendid opportunity for me to do some more work and earn more fees.

Of course, I could not obtain any recompense either for myself or my patients. *“That is the chance you take when you use the latest materials.”* (A lesson I learnt well.)

Appendix 2: GMC Landmark Judgment 1994

(Referred to in Ch 1.2)

In 1994, shortly before the Bristol problems came to light and approximately 3 years before the Bristol Case hearing by the GMC, another landmark hearing found a Consultant Anaesthetist guilty of Serious Professional Misconduct *“when he failed to act properly after being told by colleagues about the practice of a locum that was giving cause for grave concern.”* In the determination, which was widely publicised, the Conduct Committee said *“Doctors who have reason to believe that a colleague’s conduct or professional performance poses a danger to patients must act to ensure patient safety.....At all times patient safety must take precedence over all other concerns, including understandable reticence to bring a colleague’s career into question”* (Irvine 2003 p125).

Appendix 3: The Bristol Heart Babies Case & Sequelae.

(Referred to in Ch 1.2)

The Bristol Baby Case was a landmark case which, along with a small number of other cases (including the Alder Hey organ retention without consent case; and the Harold Shipman case) had a profound effect on the medical profession and the manner in which they are regulated by the General Medical Council (GMC). The barest facts of a complicated story relate to very high postoperative death rates following cardiac surgery in young children. At a time when concerns were already being raised about high postoperative death rates, a young anaesthetist who had recently moved to Bristol from another unit carrying out similar specialised heart surgery realised that the postoperative death rates at Bristol were very high and reported this (as a whistleblower) to the Chief Executive (CE, A radiologist – i.e himself medically qualified) of the United Bristol Healthcare NHS Trust. Rather than act on the information himself, the CE passed the complaint to the Director of Cardiac Services (DCS) – himself one of the two surgeons carrying out the operations in question. The anaesthetist was rebuked for having written to the CE. The Royal College of Surgeon of England (RCS) reviewed and confirmed the statistics at Bristol upon which both the retiring and the incoming Presidents of the RCS recommended that the DoH de-designate Bristol as a Cardiac surgery centre. This did not happen.

[Comment: The two points relevant to this thesis to draw from this brief account are reflection on the reprimand to the young anaesthetist for reporting the high death rates (blowing the whistle on the consultant surgeons with whom he was working) and the failure of the DoH to act on the advice of professionals - even two Presidents of the Royal College of Surgeons - about de-designating the specialist unit.

The first learning point concerns the whistle-blowing. These events occurred at a time when criticism of a fellow professional was frowned upon – bringing the profession into disrepute - and it was only in 1994, shortly before the Bristol problems came to light and approximately 3 years before the Bristol Case hearing by the GMC, that another landmark hearing found another Consultant Anaesthetist guilty of Serious Professional Misconduct “when he failed to act properly after being told by colleagues about the practice of a locum that was giving cause for grave concern.” In the determination, which was widely publicised, the Conduct Committee said ‘Doctors who have reason to believe that a colleague’s conduct or professional performance poses a danger to patients must act to ensure patient safety.....At all times patient safety must take precedence over all other concerns, including understandable reticence to bring a colleague’s career into question” (Irvine 2003 p125). This ruling clearly articulated the end of the days of the consultant who, by virtue of senior professional status, was beyond criticism and could do no wrong. This legacy from a bygone authoritarian and paternalistic era, whilst now explicitly condemned, will, it is suggested, still take some years to fade as cultural attitudes imbued in early childhood of many practitioners still practising will be displaced by a new generation somewhat more egalitarian in outlook.

The second learning point – the failure of the DoH to listen to professional advice, highlights a problem, it is maintained here, for all professions; namely the propensity for politicians and administrators to abrogate responsibility in matters properly the prerogative of the profession. This tension between the profession and society might well be a tension that will always exist. The professions need to consider (perhaps collectively) how they should assert their authority and find their Voice in these situations. Some reference to such issues in dentistry has already been made in chapter 1.

Appendix 4: Standards for Dental Professionals

(Ref Ch 1.2)

The content of the first page of this document produced by the General Dental Council is reproduced below.

The six principles are supported by explanatory notes for each. The principles are worthy and uncontroversial. They can also be used as fine-sounding slogans that fail to analyse their deeper meaning. The accompanying notes are appropriately worded and, inevitably, fairly general in their brief content. Items 1., 2., and 6. on the list, in particular, call for deep thought and discussion to reach the central issues in day-to-day practice. It is gratifyingly noteworthy that "Trustworthiness" features in the list. Part of the purpose of this thesis is to encourage deeper reflection on the meaning of such terms in the complexities – clinical, technical and, above all, relational – that arise in daily practice.

THE PRINCIPLES OF PRACTICE IN DENTISTRY

Page 1.

There are six principles around which the guidance is built. These should be at the centre of everything you do as a healthcare professional. They are:

7. put patients' interests first and act to protect them,
8. respect patients' dignity and choices,
9. protect the confidentiality of patients' information,
10. co-operate with other members of the dental team and other healthcare colleagues in the interests of patients,
11. maintain your professional knowledge and competence, and
12. be trustworthy.

From: Standards for Dental Professionals
(GDC 2006)

Appendix 5: Transactional Analysis.

(Ref Chapter 2.3)

For the purposes of understanding what is happening in a relational sense beneath the surface of a conversation, the approach of Transactional Analysis proves to be a very useful tool. The approach is based on simple principles:

1. There are two life positions that an individual might occupy
 - i. "I'm OK" and
 - ii. "I'm not OK".

From each of these positions they may adopt two equivalent attitudes towards another

- iii. "You're OK" and
- iv. "You're not OK".

2. Each individual has built up within their memory many recordings from their past life.

Many recordings consist of memories of parental remarks – "Parent"

- i. These may include critical comments or tones conveying the message "I'm OK: "You're not OK". –"Critical parent"
- ii. Or supportive messages - "I'm OK: "You're OK" – "Nurturing Parent".

Many recordings consist of recalled child memories,

- iii. many carrying "I'm OK" - "You're OK" messages (often happy) - "Playful child"
- iv. and others "I'm not OK" - "You're OK" messages – "Adapted child"

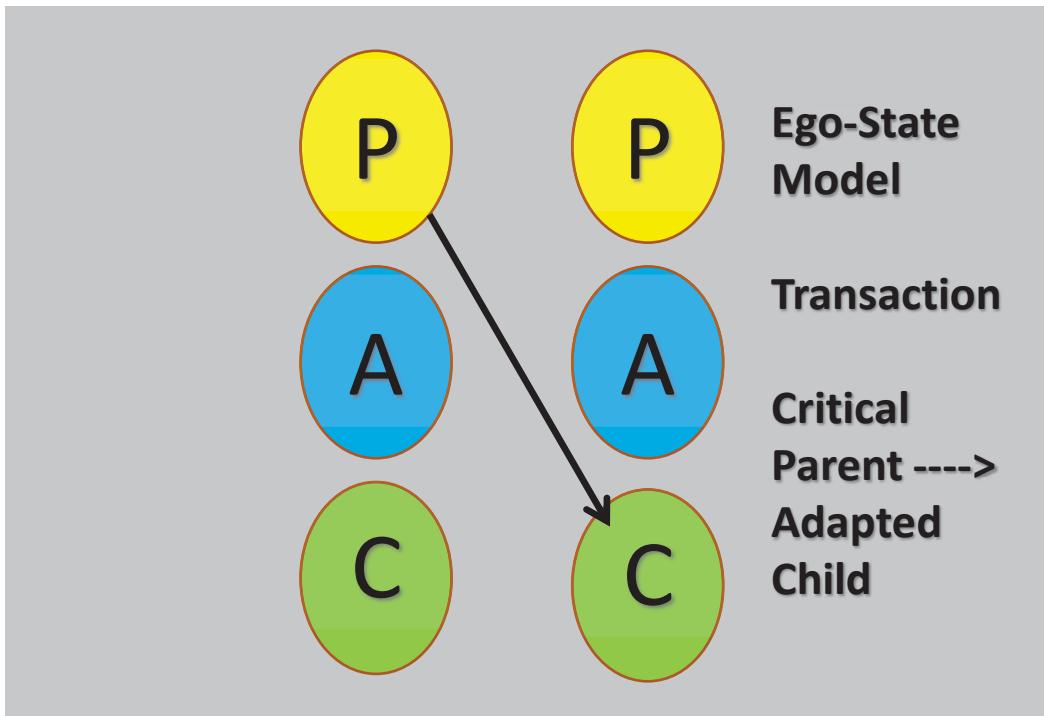
Other recordings consist of adult - OK, not emotionally-laden – memories.

3. **Ego-state Model:** From these basics, a model may be drawn representing the individual person consisting of three circles representing P(arent), A(dult) and C(hild). Arranging these vertically produces the "Ego State Model" (see Fig 1.).
4. **Ego-states:** At any point in time, the individual may be operating psychologically in any of the three modes or ego-states. Clues to this may be found in body language, forms of words used and tone of voice. It is often possible to recognise in which ego-state a person is operating in a given social exchange

Fig 1. Diagram shows 2 persons – Larry and Roger – P-A-C- and the arrow indicates a transactional stimulus – perhaps Larry is a school teacher in critical Parent, saying to Roger (PL-CR) something such as "Stupid Boy: What did you do that for?". An apologetic "adapted child" (CR-PL) response might resolve the situation – such as "I'm sorry: I didn't mean to – my foot slipped." - the return arrow does not cross the first. An alternative argumentative PR-CL

L
arry

R
oger



response, however – such as “It was your fault. You shouldn’t have left that shovel lying there on the floor “ is much more likely to lead to an angry row (and a detention for Roger!) – revealed by the crossing arrows.

5. **Transactions:** When two people are together, sooner or later one of them will speak. This verbal transaction is the “*transactional stimulus*”. When the second person answers, this constitutes the “*transactional response*”. These transactions (represented diagrammatically by arrows from the speaker’s diagram to the recipient’s diagram) may be made from any one of the speaker’s three ego-states (the one they are operating in at this moment – see 4. above) to any one of the addressee’s ego states. As long as the arrows on the diagram do not cross, the transactions are likely to be successful (see Fig. 1.).
6. **Crossed Transactions:** Crossed transactions lead to conflict. On a functional daily basis, good transactions are Adult – Adult. Difficulties often arise when the stimulus is Critical Parent -> Child (often critical / judgemental). A submissive or apologetic Child -> Parent response may work (provided the respondent is happy to take this role in the conversation). A more mature Adult -> Adult response would create “*crossed transactions*” and may become the start of a disagreement or a row.

See Chapter 2.3.p.73 for references.

Appendix 6:

Gardner's Criteria of an Intelligence.

(Ref Chapter 2.3)

Gardner originally accepted 7 intelligences and now has added an 8th to those he considers to meet his criteria. The 8 are:

- Linguistic
- Logical-mathematical
- Musical
- Bodily Kinaesthetic
- Spatial
- Interpersonal
- Intrapersonal
- Naturalist

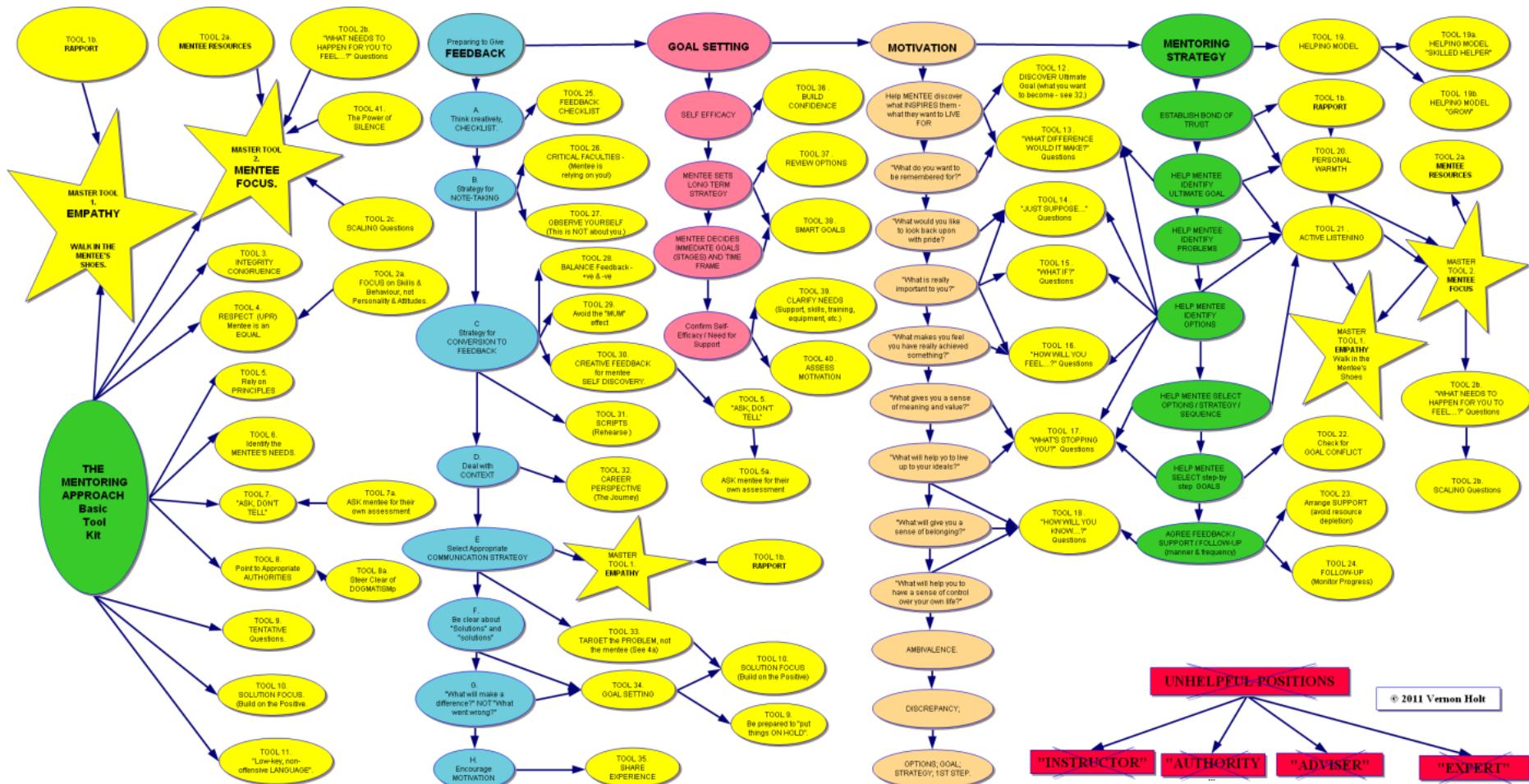
The criteria which the 8 accepted intelligences met are

1. *The potential of isolation by brain damage.*
2. *An evolutionary history and evolutionary plausibility.*
3. *An identifiable core operation or set of operations.*
4. *Susceptibility to coding in a symbol system.*
5. *A distinct developmental history, along with a definable set of expert “end-state” performances.*
6. *The existence of idiot savants, prodigies and other exceptional people.*
7. *Support from experimental psychological tasks.*
8. *Support from psychometric findings. (Gardner 1999 pp 36-40)*

Appendix 7

Some Diagrams and Charts Developed as “*aides memoires*” for participants in the Faculty mentoring course.

Summary Diagram of Mentoring Tools:



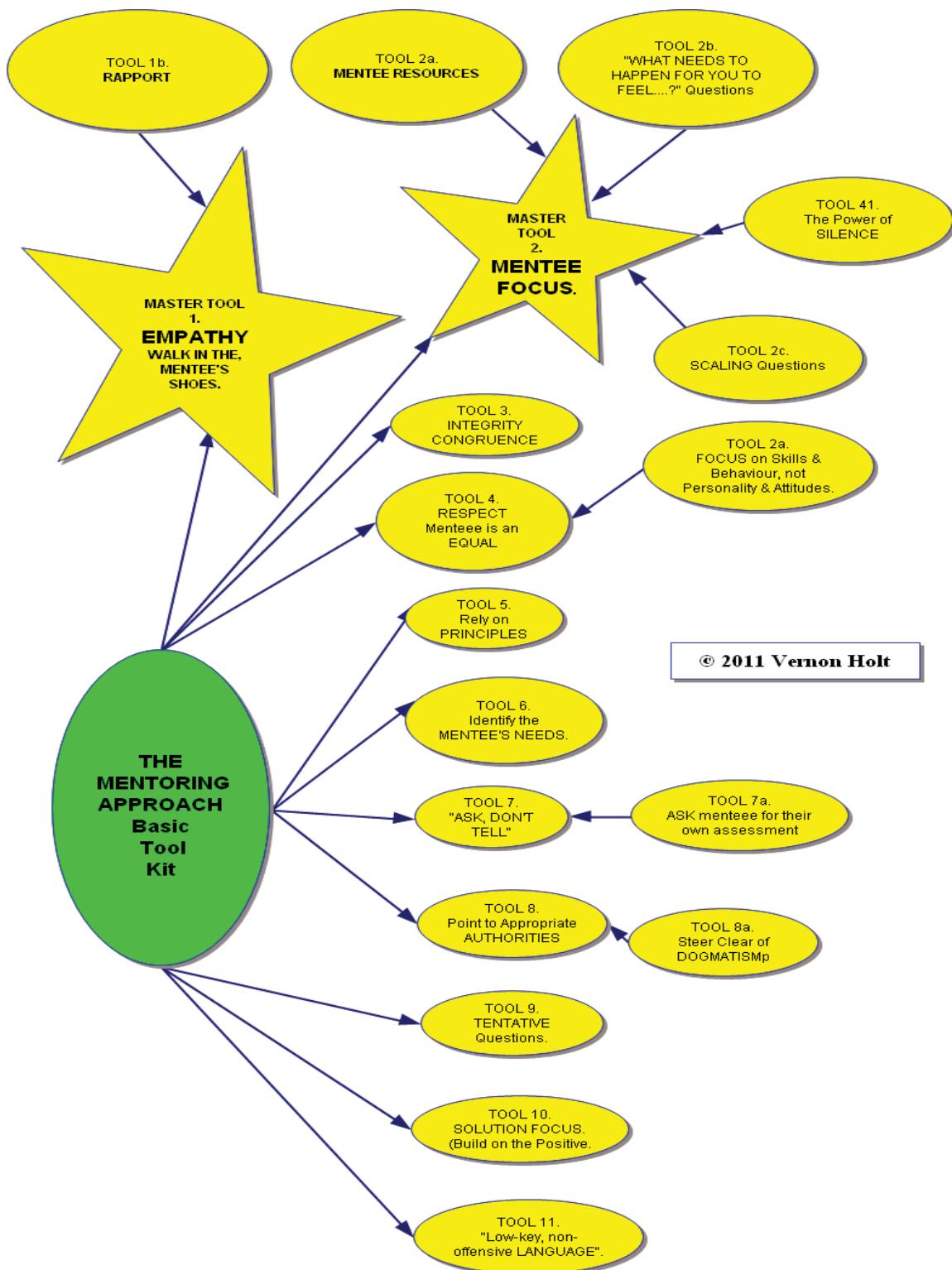


Fig 6.8 Diagram of Mentoring Approach

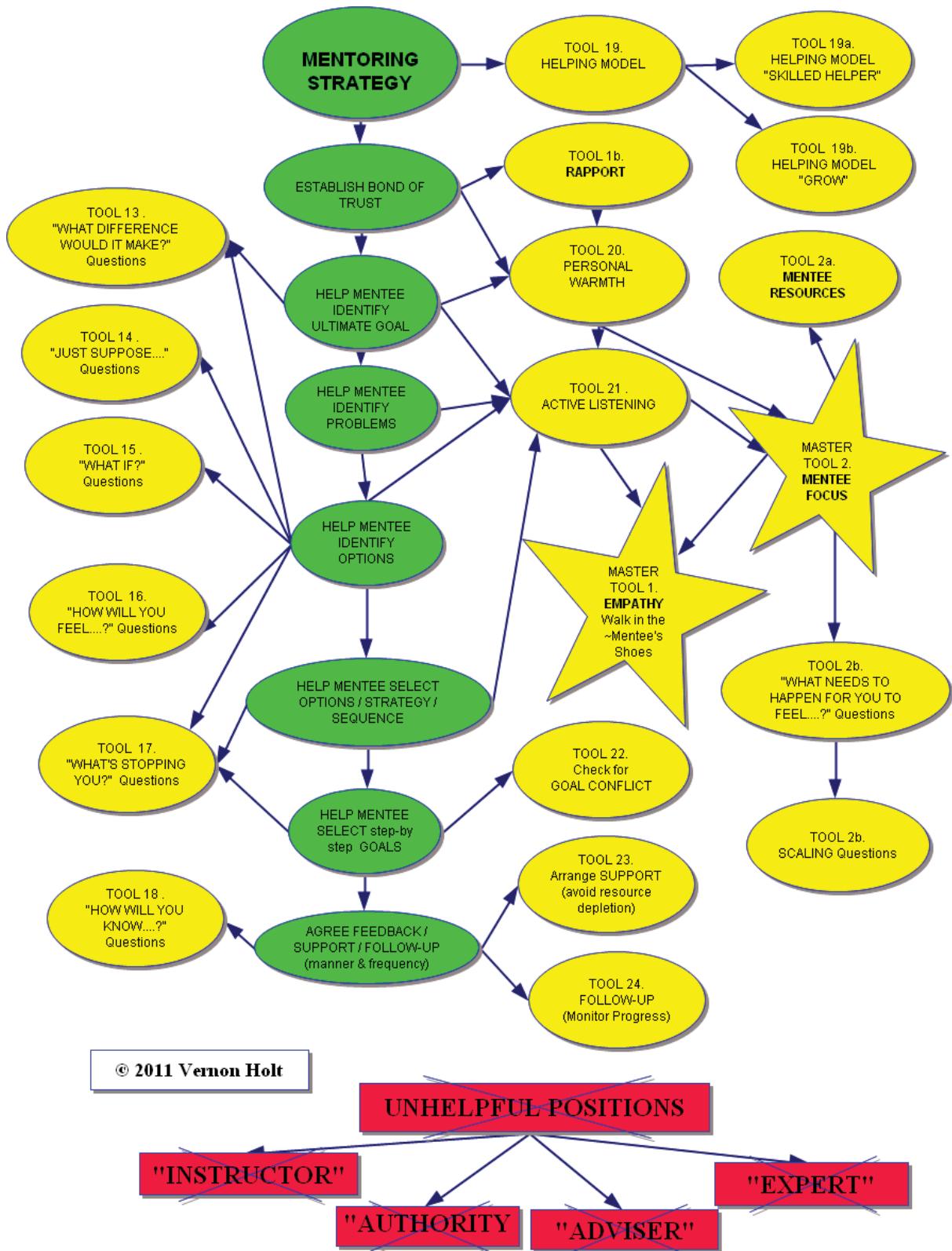


Diagram of Mentoring Strategy.

Appendix 9 Mentoring Questions.

(Ref Chapter 2.4)

A SELECTION OF MENTORING QUESTIONS

AND

QUESTION TYPES

Mentoring Question Types and Examples

Three Basic Types of Question.

Closed Questions call for a single word answer which can effectively end the conversation (“Yes” or “No”) or at least require the questioner to think of another question.

e.g. *“Did it go well?”*

Focused Questions (which some authors describe as another form of “closed” question) ask for specific information or detail. This can also effectively end the conversation (as would happen with the question below if the respondent said *“Ten.”*) or at least require the questioner to think of another question.

e.g. *“How many turned up?”*

Open Questions (which some authors call “Open-ended” questions) open up the possibilities for the respondent to describe, discuss, explore whatever aspects of the subject seem important to them.

e.g. *“How was the meeting?”*

If you are not already familiar with these “types” of questions, you could have some fun thinking about closed/focused/open questions about any subject you like whilst you are standing in a queue, waiting for a train, sitting in a traffic jam. It’s all good CPD!

Mentoring Questions:

In mentoring and coaching in general we shall be using open questions for we want to help the mentee to open up their thinking and explore their ideas and inner resources.

If we start asking focused or closed questions too soon we are, in effect, directing them our own route by narrowing the conversation down. If you are using good open questions you will not need to ask many because you will generally set your mentee off on an exploratory journey. If you are having to keep asking more questions, then check to see whether you are really using “open” questions or whether your questions are too focused.

Follow-up Questions are often also open questions to encourage further exploration. To take the open question example above –

“How was the meeting?”

This might be followed up (for example) with open questions such as

“What else was said?”.....“Anything else?”....“What did it feel like having to deal with that?”

There is a section later on **“The Closed Question Trap”**. (p34)

The next section looks at the use of questions in mentoring.

Mentoring Question Types and Examples

General Principles:

- Open questions are used – to help to draw out the mentee's thoughts and ideas.
- The session is about helping the mentee explore their inner workings – hence the use of questions because only the mentee can have this insight (they are the expert).
- Questions need to be placed to draw out thinking helpful in the mentoring process at this time. However, strings of questions without a real focus are NOT appropriate.
- It is helpful to supplement questions with prompts and probes, echoing, reflecting back, paraphrasing and giving occasional summaries (or asking them to summarise).
- Open questions usually begin with “Who, What, Why, Where, When or How” of which you will probably find “What” and “How” are the most versatile.
- Be careful with “Why” as it can often imply criticism – e.g. “Why did you do that?” even when you are careful with your vocal inflections! Even “What” can be a problem – e.g. “What did you do that for?” For these situations questions such as “What were your reasons for choosing that.....etc.?” or “How did you arrive at that particular.....etc.?” are safer. Think up your own versions NOW so that they are ready in your mental library!
- As implied above, it is helpful to think about the way you phrase questions in general so that, in the heat of the moment you can draw down on them and you have already “made them your own”.
- That is not to say that you will not have to “invent” a question “on the hoof” very often. Of course you will. That brings us to the next bullet....
- Sometimes a “question” is not a question but a statement with a vocal inflection – e.g. “You think that will take too long?” or even a couple of words echoing the mentee and seeking confirmation, e.g. “Too long”. It is OK to hesitate to find the right turn of phrase. Do not feel you must drive a mentoring session forward at high speed. Quick glib responses and thoughtless, pointless, questions are not required. Both you and your mentee need time to reflect and express yourselves clearly. Your mentee will appreciate that you are taking care to say, or ask, exactly what you mean for their benefit.

The following pages illustrate some examples of questions or question-types. Notes on their particular uses in mentoring generally and the Skilled Helper Model in particular are in italics.

Some references will be given at the end. These are sources that have contributed to the list below and you are encouraged to explore the thinking of these authors to augment your own experience and ideas with theirs.

Some Questions and Question-Types.

SEE LIST OF PRINCIPLE SOURCES AT THE END OF THIS SECTION.

GETTING STARTED: At or near the beginning of a session (usually):

*Questions such as these, following greetings and pleasantries, convey the unspoken message:
"Now we're starting work."*

*These questions also carry the implication to the mentee
"This is your agenda. You are in control."*

Nearly all these questions are open questions. Those that are not are really "open requests" for more information.

1. What would you like us to talk about (discuss) today (in this session)?
2. What is the issue that prompted you to arrange this meeting?
3. What needs to happen in this session for you to feel that your needs at this moment are being / have been met?
4. What issues..... have you got in your mind / seem to be most important to you..... at the moment?
5. How would you like us to use the time in this session today?
6. I'm curious to know what you would like to get out of this session.
7. How have things been going for you since our last meeting (session)?
8. What has changed since our last session?
9. What have you achieved/managed to achieve since our last meeting?
10. How would it be/work/feel for you if we spent (start by spending) a few minutes reviewing what we have covered/done/achieved so far?

EXPLORING THE MENTEE'S THINKING ABOUT THEIR SITUATION

11. What's the Issue?
12. What is going on?
13. What else is going on in the background?
14. What other underlying issues are we dealing with here?
15. I'm wondering if there is more going on here than meets the eye. (?)
16. How do you think (someone you know well - relative, partner, colleague) would describe this situation/ behaviour/ etc.?
17. If they were here talking to me, how would they describe *YOUR behaviour/ reaction/ input / handling of the situation /etc. (this is a gentle challenge to the mentee to examine their own part in this.)*
18. What is REALLY going on?
19. What might we (you) be overlooking here?
20. Is there anything that you might have missed?
21. How long has this been going on?
22. What makes it important now?
23. What is really concerning in (all) this?
24. Would you like to give me an example (some examples) of that?
25. You talked about,,, (*an experience, viewpoint, thoughts, intentions etc.*) could you give me a bit more detail or perhaps an example.....? I think it's important I understand / get a clear picture of....this.
26. So how does this affect.....(you/the way you work/ etc.)?

27. What impact does this have on..... (you/the way you work/ etc.)?
28. How does that affect the way you feel about.....?
29. I'm wondering if anything else is going on (in your life / here, in this environment...) that is having an impact on the situation / problem/process.....?
30. I'm wondering if there is something here that could be turned into an opportunity.....?
31. I have been wondering how you might begin to see a way forward with this.
32. I wonder if you could give me a bit more background to this. It seems to be important to you....
33. That's seems very interesting / relevant / important/ etc. I wonder if you could expand on that a bit.
34. We've covered a lot of ground there. Could you just go back a bit and allow me to clarify a few things to make sure I have got the story correctly? First, if I understand you correctly you think..... etc.
35. What do you think / feel would be the consequences if you didn't do anything about this / take this opportunity / respond to this challenge / etc.?
36. What have you done about this so far?
37. How have you dealt with this kind of situation in the past?
38. What's stopping you (from...)?
39. Out of all this which part is causing you the greatest trouble/concern/irritation / worry /frustration etc.?
40. What seems the most important?
41. Out of all this, what element do you think would make the biggest difference for you if it were addressed/dealt with/tackled?
42. Which part of the problem is the most manageable for you at this time?

EXPLORING THE MENTEE'S THINKING: POSSIBILITIES FOR THE FUTURE

43. What would this (problem) situation look like if you were managing it better?
44. What changes in your present lifestyle would make sense?
45. What could YOU do that would influence things / change / help the situation?
46. Given this leverage point, what possible Goals have occurred to you so far?
47. What do you really *WANT*?
48. If the situation was just as you wish, what would it look like?
49. What would you be doing differently with the people in your life?
50. What behaviours would your colleagues/friends/family notice in you that they do not see at present?
51. What achievements would you have accomplished that you have not so far?
52. Whom do you know (of) whose lifestyle / behaviour exemplifies your ideal?
53. What are all the possibilities in your ideal scenario?
54. What other ideas can you think of?

BRAINSTORM “WHAT”?

- a. What else?
- b. Can you think of anything else?
- c. One last thing?

OR IDEAL SCENARIO

55. Imagine this issue is resolved and you are in your ideal situation 5 years down the line (etc.)

- a. Where are you now?
- b. What has changed?
- c. Describe it.
 - i. What does it look like?
 - ii. What is happening?
 - iii. What are you doing?
 - iv. *Ask for sights, sounds, smells, feelings*
 - v. Who else is there?
 - vi. What else?
 - vii. Can you think of anything else?
 - viii. One last thing?
 - ix. And how do you feel?

56. Out of all these possibilities which is the one that you feel is right for you to go for now?

57. How would that influence the situation?

58. What will have the biggest impact for you?

59. Which goals might give the best yield for the cost/effort involved?

60. What would your life /job / etc look like in a year's time?

61. What are the main challenges or problems with pursuing that line?

- a. And what are the greatest benefits?

62. How do you balance that against the advantages of (other options)....?

63. So if you go for that option, what do you see as the biggest gain or reward?

64. So if you go for that option, what do you see as the biggest challenge or obstacle?

65. What has stopped you from doing this in the past?

66. What is going to be different this time?

67. Who else might be affected by this?

68. How do they need to be involved or advised?

69. So how do we turn this into a SMART goal?

70. So, all things considered, do you regard this as a REALISTIC goal for you at this time?

71. How important is this to you now?

SCALING QUESTION.

72. So will you now state this goal using the formula

By.....I will have.....and I will feel.....

EXPLORING THE MENTEE'S THINKING ABOUT THE WAY FORWARD

73. What experience have you had dealing with an issue / challenge / opportunity like this before?

- a. How did you approach it?
- b. What did you learn from doing it that way / taking that approach?

74. What possible OPTIONS, solutions / ideas / ways forward have occurred to you so far? What other ideas can you think of?

BRAINSTORM “HOW”?

- a. What else?
- b. Can you think of anything else?
- c. One last thing?

75. From this list of OPTIONS which one(s) do you feel will suit you, your style and values best?

76. Which strategies might give the best yield for the cost/effort involved?

77. Which strategies best fit your values?

78. What conflicts might ensue with others as a result of the proposed change(s)?

79. Who is there who might support you in taking this forward?

80. What other pressures on you / your time might put this project in conflict with them? (?FORCE FIELD ANALYSIS)

81. How are you going to reduce this goal conflict?

82. How confident are you (Scale of 1-10) that you will accomplish this goal>

83. What can you do to raise this level of confidence even further?

84. How badly do you want what you say you want?

85. What plans do you have for dealing with contingencies?

86. What incentives do you have / can you give yourself?

87. What will the rewards be?

88. What support are you arranging?

89. What resources do you need?

90. How will you arrange to have those resources?

91. What skills or knowledge will you need?

- a. How will you acquire them?

92. What can you do to maintain your level of enthusiasm for this?

93. How will you plan the execution of this strategy?

94. What is your planned sequence of operations?

95. How might a timeline help, for example?

96. So how are you going to translate this all into action?

97. What evidence will you see that the strategy is working?

98. How will you assess progress?

99. What will your next step be?

100. When will you do it?

101. What arrangements have you made for feedback on your progress?

SOME QUESTIONS TO HELP WITH GOAL SETTING

102. What would really INSPIRE you?

103. We often say *“I would DIE for that!”* What would really like to LIVE for?

104. What you would like to be remembered for?

105. What is really important to you?

106. What makes you feel you have really achieved something?

107. What is it about a “good day” that makes you feel so good?

108. What gives you a sense of real achievement?

- 109. What gives you a sense of meaning and purpose?
- 110. What do you REALLY value.....?
- 111. What will help you to live up to your ideals?
- 112. What will help you to feel you have control over your own life?
- 113. What will give you a sense of belonging?
- 114. When you are in your nineties, what would you like to be able to look back upon in your life and say “Yes, I achieved THAT!”?
- 115. What could YOU do that would change things / make a difference?
- 116. What would make a reasonable short term goal as a first step?
- 117. How will you frame a strategy over the years to attain that end GOAL?

SOME QUESTIONS TO HELP WITH MOTIVATION

- 118. What difference would it make if.....? questions.
- 119. Just suppose....., what would it feel like? / look like? ... questions.
- 120. What if.....? questions.
- 121. How will you feel.....when / if / ? questions.
- 122. What's stopping you?
- 123. Scaling questions – “How important....” Etc.

TENTATIVE QUESTIONS.

The strategy of using “tentative questions” is designed to make a question feel less challenging to the mentee or sometimes to air a possibility that the mentee might not have thought of for themselves. Such a question might be introduced by a phrase such as

“I don’t know how you feel about this but I wonder.....what difference / how you would feel.../ ...how it would work if..... whether you think.....etc.?”

“I haven’t thought of it this way before and it might not be your style but how would it work for you / strike you / appeal to you / ..help you....affect the situation.....if you..?”

The Closed Question Trap.

In a problem-focused culture typical of the modern world and of which dental professionals are an extreme example we tend to focus down immediately onto a “problem” to make a “diagnosis” and discover a “solution” or (in dentistry) create a “treatment plan”. This means we instinctively lapse into asking focused and closed questions very early on.

You will find yourself doing this in the mentoring situation! We need to keep an eagle eye on ourselves; listen to what we are saying and reflect back on our conversations in order to recognise our standard mode of working.

We try to catch ourselves asking a “closed” question. STOP! And we rephrase it as an “open” question. Examples of open and closed questions were given at the beginning of this section of the workbook. Here are a few more.

You will find lots of examples in your own life to work on. Generally, try to start the open question with “How” or “What (difference, etc.)”. You can even try it out on patients. Instead of asking “*Has it been comfortable?*” Ask “*How has it been....?*” Or “*What difference did the (treatment) make?*”

Have fun! You may find your patients giving you more (valuable) information!

Closed / Focused

Have things been going well?

Has that helped?

Do you think it would be a good idea to....?

Does that sound good to you?

Would you like to try....?

Did that work?

Open

How have things been going for you since we last met?

How has that changed the situation? Or
What difference did that make?

How would you react to the idea that.....? Or
How do you feel about the idea that....?

How does that sound to you?

How do you think it would work if.....? or
What difference would it make / What effect would it have....if.....?

How effective/helpful did you find that? Or:
What was the effect/impact of that?

Appendix 10: Illustrative List of Values

(Ref Chapter 3.8)

In this Appendix, the ways different values are manifest in behaviour are briefly outlined. The values shown below are of particular relevance to our present discussion and, indeed, fundamental to any manifestation of human being.

Whilst – as indicated – all values may be conceived of as having an opposite antonym, antithesis or “anti-value”, so that, e.g. the value of “Care” is deemed to have a polar opposite “Indifference” (not caring). These dialectically polar opposites represent extremes of value held.

Each **value** is indicated in bold text (often with near-similes or descriptors), and commentary made in normal text.

The antivalue (often several near-similes used) is given in bold text with commentary in normal text, with the antivalue commentary distinguished in italics and shifted to the right on the page as is this paragraph.

Note: This short list is illustrative only of the dialectical treatment I give. There is an enormous range of possible values and “Care” (augmented as “Care for Other”) and the “Person” are both discussed in Chapter 3.8 and only discussed here briefly. They are assumed, however, as the *Primary Values*. Below there are only a few relating to community and planetary values.

Values Expressed Particularly in Relationship.

Value: Care (in Vocation)

Attention to needs of the “other” to standard sought “as if” it were “my daughter” or “My mother”. A foundational professional value reiterated here.

The antivalue is unprofessional (non-altruistic) and exploits the client/patient instrumentally as a means of generating income.

Antivalue: Indifference.

Value: I-Thou, Relational Depth .

Buber’s speaking of the “primary word” of relationship, “I-Thou”, conveys the recognition of the “Thou” (for Thou’s sake) as of value and worthy of caring and within the field of responsibility of the “I”. This is

person (*qua person*) to person (because the *Thou* is “person”), shown unconditional positive regard by a congruent “I”, communicating empathically.

The antivalue is Buber’s second primary word, “I-it”, is the instrumental relationship. Here the Thou is now addressed as the “It” – the object of the transitive verb - arranged, organised, manipulated, advised, told, instructed, ordered, persuaded, bought, taught, “won over”, hoodwinked, cheated, treated, operated-upon, “handled”, “passed”, failed”, “referred”, (BUBER)

Antivalue: Instrumental, Use, Manipulate, Exploit, (I – it)

Value: Other, Thou:

Valuing the other and their needs and interests. Addressing their “*Thou*” with my “*I*”. This underlies “Respect” (below) and is the root of altruism,

The antivalue places me and my perceived self-interest above others. Seeking to promote my own self-interest at every opportunity regardless of other’s claims or needs.

Antivalue: Self; Me; (Note: “Me”, NOT the relational “I”)

Value: The Person (The Whole Living Person) *Homo sapiens*:

Valuing the person of the “other” as the source of caring, of nurturing, and of love that sustains us: *gratitude and indebtedness*:

Valuing the individuality of the “other” (Levinas BBBB; Harré MMM) – the “cared-for” (Noddings 1986 pMMM) - as another-who-is-as-myself, who, as one-like-myself, has needs to which I feel an imperative to respond (“*responsibility*”), sharing with them the caring relationship - “*I - Thou*” (Buber 1937/000) - that nurtured us and brought us to where we are; a *sense of responsibility, obligation and commitment. Unconditional Positive Regard*.

Valuing the other person who, as a fundamentally relational being (Buber, Taylor, Harre, Goleman ROGERS etc), invites us to become complete in relation; enables us, in serving them, to become fully ourselves and address their “*Thou*” through our “*I*”.

This value, taken alongside the value “community” is fundamental to conduct in human society.

The antivalue does not value the person for their self but for what they can do, to what use they can be put, directed, controlled, manipulated, managed, exploited (customer, patient), colloquially “treated as a thing”. Their value is instrumental not personal. As the object of “I-it”, they are subordinate in value to “I”.

Antivalue: Denial/disregard of Person and life; Conformity: not individuality.

Value: Congruence, genuineness:

Valuing myself as a whole being (*Unconditional Positive Self-regard*). Listening to the different “voices” within – body, mind, heart and spirit – seeking to resolve discord between those voices, resolving the tensions and inner conflicts and inconsistencies until I feel that my whole being is

“speaking with one voice”, each voice in harmony – congruent – with the others; a deep “*felt sense*” (Gendlin 1978/2003 p 32) of freedom from inner conflict.

The antivalue may be too pre-occupied on the surface to take time to listen and feel the deeper things going on inside. There may be “conditions of worth” (Ref Rogers, Cooper or Merry?) taken on board – “introduced” - from significant others in earlier life that are the source of pain and conflict (which the superficial “busyness” may mask) and need attention and resolution. In some cases these “conditions of worth” present a serious problem resulting in substantial psychological distress needing professional support.

Antivalue: Incongruence, Disharmony, Divergence, Discrepancy.

Value: Respect (Unconditional Positive Regard):

Non-judgemental (unconditional), acceptant, prizing of the other as a person of worth, resourceful, with their own tendency towards actualisation of their full potential. When applied to the self, this is Unconditional Positive Self-regard. (Relates to valuing of “Person”: here valuing “Respect” as a social attitude.)

The antivalue withholds positive regard, is judgemental, imposes “conditions of worth” and trusts neither the person’s resources nor their inherent tendency, given suitable facilitative conditions, to move toward a more fully actualised condition.

Antivalue: Ignore, judgmental, disregard, disrespect; “conditions of worth”.

Value: Openness and Transparency

Based on *congruence*, there is nothing to hide. With the *congruent* person “*what you see is what you get*”. There is no need for pretence, posturing, disguise, deceit, manipulation, half-truth, dishonesty. The fully congruent person can afford to be open and transparent, offering their self, unadulterated, undisguised, in relationship with the “other”. Free to enjoy “*who I am*” without adornment or elaboration there is a freedom “*To BE*”, to be “*fully present*” (REFNatiello) in the relationship (with the patient or client in the case of a professional).

The antivalue speaks of hidden (ulterior) motive. There is “another agenda” implying manipulation, exploitation, and even potential oppression. (Glossary)

Antivalue: Deception, secrecy, closed.

Values Expressed Particularly in Exercising Responsibility.

Value: Community; Collective, Society, Common Good:

Valuing the community (family /profession / village / nation / world community etc.) and my place in it as a member of a social group. Playing my part and respecting and supporting others.

The antivalue seeks my interests. Meism, “every man for himself”, demanding my rights!

Antivalue: Individual; Self Interest.

Value: The World, The Planet, Stewardship, Conservation, Perspective, Balance, Wisdom, Harmony (with nature):

Consciousness of being a small, dependent – and vulnerable - part of our small and fragile planetary system, capable of using our intelligence to create conditions favourable to the survival of the planet; responsibility for our planet and for future generations of our children.

The antivalue is happy to live for today; to let somebody else find the solution - “It’s not my problem” - leave the problems for the next generation; “make hay while the sun shines”; “I’ve got my life to lead”; “I need these things. It’s looking tatty – throw it away and get a new one.” It’s easier to use disposable products.

Antivalue: Me, self, profligacy, consumerism, acquisitiveness, possession, greed, ill-advised, short-sighted, disproportionate.

Value: Authority,

Using knowledge and skills as servant leader and guide; service, support, pastor.

The antivalue (1) might choose to abrogate authority, “I don’t want the responsibility”; “let somebody else do it”; or (2) might choose to exploit the position of authority and take advantage – seek domination, enslavement, oppression.

Antivalue: Abrogation, domination, enslavement, oppression

Value: Influence,

Using power, energy, intellect, to promote fairness and justice for all.

The antivalue seeks to keep a low profile, not take risks, “Don’t put your head above the parapet”; “Play safe”; “Someone else will do it”; “Don’t make yourself a target”.

Antivalue: Anonymity

Value: Responsibility with power, wisdom, judgement, balance, justice, egalitarianism

Use of power to facilitate social relations, support all citizens, promote co-operation, mutual respect and caring.

The antivalue may be (1) abrogation of responsibility, - “leave it to somebody else”; It’s the system there’s nothing I can do about it”. I’ve got to make a living – earn some UDA’s.” (2) The use of power to gain advantage and control (“Power-over”); (3) in a society not dedicated to the egalitarianism then there is powerlessness, victimisation and oppression.

Antivalue: Power-over, control, arrogance, domination, opportunism, exploitation; vulnerability, victim, oppression, powerlessness.

Value: Leadership, vision, inspiration, purpose,

Larger vision, perspective, political awareness, socially responsible.

The antivalue is submissiveness, the follower leaves it to somebody else “I haven’t got time”; the shirker, cowardice.

Antivalue: Submissiveness, follower, shirker,

Values Expressed Particularly in Calling/Vocation

Health

A fundamental value for a health professional; health, it is suggested, needs to be viewed by dentists both holistically and with an eye to the long term outcomes or consequences, (See below)

The antivalue loses sight of the orientation to health and focuses on “doing treatment”; instability and repeated intervention as cycle of “failure and repair” revolves; progressive loss of natural tissue (caries or periodontal). A scenario of progressive deterioration.

Antivalue: Distress, dysfunction, disease,

Lifetime Perspective

This value requires consideration of the long term consequences of treatment choices, quality choices and, in the case of dentistry where active disease may remain unmanaged, the prioritisation of appropriate management strategies and interventions. This value may conflict with demands arising from a dissatisfaction with appearance and may conflict with the dentist’s own valuing of treatment which provides a high return on time invested.

The antivalue goes for the quick fix, earn a fee, the cosmetic makeover is more lucrative; the long term consequences remain largely undisclosed; “teeth for life” are under threat.

Antivalue: Short-term, myopic, quick fix,

Collegiality

The collegial relationship is fundamental to the concept of professionalism (REFFreidson) and implies support both through education and through personal presence, maybe in mentoring. Thus support extends to the commitment to provide tactful negative feedback to a colleague who is “underperforming”, and failing to act on discovering such a pattern, far from representing collegiality, takes the professional into connivance and protectionism.

The antivalue does not wish to get involved, may see others as competition, follows their own path, may be “difficult to get on with” and not relate well to patients, unreceptive of help as well as reluctant, or unable to share support with others.

Antivalue: Maverick, rebel, freewheeler, loner, competition, protectionism

Learning, Growth, Personal & Professional Development

Lifelong learning is an inevitable requirement in an age where knowledge is expanding at an exponential rate. It becomes all the more pressing for the healthcare professional where the well-being of other persons in the role of patient is involved.

In an era of required CPD and imminent revalidation, the antithesis of this value is probably untenable. The charmer may be able to keep patients happy but revalidation will force some limited development. It remains to be seen whether this will be enough for those who really do not want to learn but only go through the motions.

Antivalue: Complacent, unmotivated, disincentive, unprofessional

Appendix 10

(Ref chapter 3.7)

Wilkinson's Findings. (Wilkinson et al 2009)

Themes and Subthemes for Assessment from Wilkinson's study

Adherence to ethical practice principles, including but not restricted to:

Honesty/integrity, Confidentiality, Moral reasoning, Respect privileges and codes of conduct.

Effective interactions with patients and with people who are important to those patients, including but not restricted to:

Respect for diversity/uniqueness, Politeness/courtesy/patience, Empathy/caring/compassion/rapport, Manner /demeanour, include patients in decision-making,

Maintain professional boundaries, Balance availability to others with care for oneself.

Effective interactions with other people working within the healthcare system, including but not restricted to:

As for "interactions with patients" above plus *Teamwork*,

Reliability, including but not restricted to:

Accountability/complete tasks, Punctuality, Take responsibility, Organized.

Commitment to autonomous maintenance and continuous improvement of competence in:

Self, including but not restricted to:

Reflectiveness, personal awareness, and self-assessment, Seek and respond to feedback. Respond to error. Recognise limits. Lifelong learning. Deal with uncertainty.

Others, including but not restricted to:

Provide feedback/teaching. People management. Leadership.

Systems, including but not restricted to:

Advocacy. Seek and respond to results of an audit. Advance knowledge.

Appendix 11

(Ref Chapter 3.7 p. 170)

Summaries of Values, principles etc from various professional bodies.

Nursing Profession: “Defining Characteristics”

The Royal College of Nursing (RCN) produces a list of six “Defining Characteristics”, extracts which are summarised below. To ensure that the statement reflects the views of British **nurses**, and in particular RCN members, a. Values Clarification Exercise was undertaken before its preparation..

1. Purpose: to promote health, healing, growth and development and to prevent disease, illness, injury and disability...to minimise distress and suffering and to enable people to understand and cope with their disease or disability, its treatment and its consequences...[and]... to maintain the best quality of life until its end.
2. Mode of intervention: ...empowering people and helping them achieve, maintain or recover independence... includes the identification of nursing needs; therapeutic interventions and personal care; information, education, advice and advocacy; and physical, emotional and spiritual support.
3. A particular domain: supporting peoples' unique responses to, and experience of health, illness, frailty, disability and health-related life events.
4. Focus: the whole person and the human response rather than a particular aspect of the person...
5. A particular value-base: ...ethical values which respect the dignity, autonomy and uniqueness of human beings, the privileged nurse-patient relationship, and the acceptance of personal accountability for decisions and actions.
6. A commitment to partnership: nurses work in partnership with patients, their relatives and other carers, and in collaboration with...a multidisciplinary team.

Defining Characteristics of Nursing.

Source: Leaflet “Defining Nursing” (RCN 2012).

**The core values for nursing practice at LHSC,
London, Ontario, Canada. Source: London Health Sciences Centre (2012)**

These core values are integral to the practice of nursing at LHSC and underpin work on the Nursing Professional Practice Model.

Patient/family-centred care:

- patients and families are the focus
- patients are seen as partners and are actively involved in care
- nursing has a key role in coaching and empowering patients/families
- patients have the right to decide/be informed
- we provide holistic care and pay attention to the uniqueness of individuals

Interdisciplinary collaboration:

- interdisciplinary team approach to patient/family care
- involves mutual respect and co-operation

Caring relationships:

- honesty, integrity, flexibility
- importance of two-way communication in all relationships
- feeling safe in risk-taking is critical
- the value of the professional conscience for patient care
- respect, tolerance, acceptance and dignity for patients and colleagues

Accountability:

- personal and professional accountability
- commitment to lifelong learning
- research-based nursing practice
- competency-based practice
- shared decision-making in practice
- conscientious application of critical thinking and clinical judgement

Nursing: “*Essential Values and Skills*”

The Naugatuk Valley Community College, USA. identify six core nursing values:

- Critical Thinking
- Safe and Competent Practice
- Caring
- Professionalism
- Communication

- Holistic Care

(NVC 2012)

Physiotherapy

The Chartered Society of Physiotherapy publishes a *Code of Members' Professional Values and Behaviour*, in which "Four Principles of the Code" are listed with illuminating *supplementary statements* expanding on the principles.

The Four Principles of the Code

1. *CSP members take responsibility for their actions. Members*
 - Demonstrate appropriate professional autonomy and accountability;
 - Act within their individual scope of practice
 - Make informed decisions
2. *CSP members behave ethically. Members*
 - *Adhere to legal, regulatory and ethical requirements;*
 - *Act with integrity, honesty and openness;*
 - *Engage with relevant professional and social contexts.*
3. *CSP members deliver an effective service. Members*
 - *Put the needs of service users at the centre of their decision-making;*
 - *Respect and support individuals' autonomy;*
 - *Communicate effectively;*
 - *Work effectively with others.*
4. *CSP members strive to achieve excellence. Members*
 - *Seek to continuously improve;*
 - *Demonstrate innovation and leadership;*
 - *Support others' learning and development;*
 - *Support the development of physiotherapy.*

(CSP 2011)

Occupational Therapy

The current UK definition of Occupational Therapy (is succinct and mentions three values.

"Occupational therapy enables people to achieve

- health,
- well-being and
- life satisfaction

through participation in occupation.

in COT 2010)

A View of Professionalism from Education

The Institute for Learning professes a strong values base under five headings:

- Professionalism
- Development and Innovation
- Autonomy
- Integrity
- Equality

IFL (2008).

The British Association of Social Workers “Code of Ethics for Social Work”

This very comprehensive and well thought-out document demonstrates very well the move towards a more person-centred approach in recent decades.

It lists **Ethical Principles** under four headings, giving values for each heading and enumerating “*practice principles that indicate how the ethical principles should be applied in practice..*

Human Rights

Value: Respect for the inherent worth and dignity of all people

1. Upholding and promoting human dignity and well-being;
2. Respecting the right to self-determination;
3. Promoting the right to participation;
4. Treating each person as a whole;
5. Identifying and developing strengths;

Social Justice

Value: Social Justice

1. Challenging discrimination;
2. Recognising diversity;
3. Distributing resources;
4. Challenging unjust policies and practices;
5. Working in solidarity;

Professional Integrity

Value: Uphold values and principles of the profession; reliable, honest and trustworthy.

1. Upholding the values and reputation of the profession;
2. Being trustworthy;
3. Maintaining professional boundaries;
4. Making considered professional judgements;
5. Being professionally accountable;

Ethical Practice

Value: Acting with integrity and treating all people with compassion, empathy and care.

1. *Developing professional relationships;*
2. *Assessing and managing risk;*
3. *Acting with the informed consent of service users.....;*
4. *Providing information;*
5. *Sharing information appropriately;*
6. *Using authority in accordance with human rights principles;*
7. *Empowering people;*
8. *Challenging the abuse of human rights;*
9. *Being prepared to whistleblow;*
10. *Maintaining confidentiality;*
11. *Maintaining clear and accurate records;*
12. *Striving for objectivity and self-awareness in professional practice;*
13. *Using professional supervision and peer support to reflect and improve practice;*
14. *Taking responsibility for their own practice and continuing professional development;*
15. *Contributing to the continuous improvement of professional practice;*
16. *Taking responsibility for the professional development of others;*
17. *Facilitating and contributing to evaluation and research.*

(BASW 2012.)

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