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BEHIND THE COMPLAINT: WHAT IS REALLY GOING ON WITHIN THE TEAM IN DENTAL PRACTICES

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Abstract
Complaints and professional conflicts within oral healthcare are often viewed as isolated incidents related to clinical treatments or individual disagreements. However, from an evidence-based and practice-based perspective, underlying interpersonal processes, communication patterns, and group dynamics can play a significant role in the emergence and escalation of such situations.
This qualitative, descriptive multiple case reports, partly based on participatory observations and interviews, including retrospective reflections and personal experiences, and investigates how group dynamic processes influence complaints and collaboration challenges within dental practices. Two complementary retrospective cases from the Dutch oral healthcare sector were analyzed. The first case examined organizational and interpersonal changes within a periodontology practice using established theories of group dynamics. The second case used the Situation-Stimulus-Question (SPV) reflection model to analyze a professional conflict that arose following the acquisition of a dental practice. The findings indicate that complaints and conflicts often develop through complex interactions between unclear expectations, changing professional roles, communication barriers, and perceived power differences within teams. Both cases demonstrated that attention to relational and organizational factors may provide a deeper understanding of the mechanisms behind visible complaints.
This study emphasizes the importance of integrating structured reflection and attention to group dynamics into complaint handling processes, as required under the Dutch Healthcare Quality Act (Wkkgz). Although based on Dutch dental practices, the underlying mechanisms regarding communication, teamwork, and conflict management may also be relevant to dental teams worldwide.
Keywords. Complaint and conflict management, communication, oral healthcare, group dynamics, teamwork

Introduction

In the Netherlands, the oral healthcare sector experienced a shortage of qualified practitioners during the late 1980s and 1990s, creating extensive employment opportunities for oral hygienists (Jongbloed et al., 2012). This development raised questions regarding competencies, division of tasks, and collaboration between dentists and oral hygienists. As oral healthcare is increasingly delivered within teams and professional networks, clarity regarding roles and responsibilities has become essential for patient safety and public trust, in particular when dental care is provided by non-dentists (Brands et al. 2015). Although the Healthcare Professionals Act (BIG Act) regulates the division of tasks, uncertainty about its terminology and application remains among oral healthcare professionals (Brands et al. 2015, Brands, van den Heuvel, 2016).

In addition, Dutch healthcare increasingly emphasizes patient-centred care. Under the Quality of Care, Complaints and Disputes Act (Wkkgz), healthcare providers are required to deliver safe, effective, efficient, and client-centred care and to ensure accessible complaint procedures, including independent complaints mediation (Witter et al., 2020; Buunk-Werkhoven, 2022; Sjoerts, n.d.). While the Wkkgz provides a legal framework for safeguarding patient rights and for the handling of complaint, it offers limited guidance regarding the interpersonal and organizational processes that contribute to complaints and conflict escalation (Sjoerts, n.d.).

Previous research has shown that communication problems, unclear role expectations, and hierarchical structures can significantly affect teamwork and conflict development in oral healthcare settings[2] (Buunk-Werkhoven, Kalk, 2026, Salas, 2018, Wei et al. 2020). In oral healthcare, where collaboration between dentists, oral hygienists, and other professionals is essential, such dynamics may directly influence both professional relationships and patient outcomes (Reinders, Blanksma, 2012, Wong et al. 2023). To understand the development of complaints, it is therefore important not only to pay attention to the events themselves, but also to the interpersonal and organizational processes through which interactions develop over time.

Social psychological theories of group dynamics offer a useful framework for analyzing these processes by focusing on factors such as roles, norms, social influence, power relations, and conflict development.

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Examining complaints from this perspective can help explain how collaboration problems arise, escalate, and affect professional practice. Two complementary cases are analyzed: a retrospective qualitative analysis of organizational changes within a periodontal practice and a reflective case study of a conflict following a practice acquisition, analyzed using the SPV model (Situation–Stimulus–Question) [Situatie, Prikkel, Vraag].

The study aims to explore how underlying group dynamic processes contribute to the development and escalation of complaints and professional conflicts within dental practice settings.

Theoretical Framework

The study is based on theories of group dynamics. As Kurt Lewin (1951, p. 169) noted: "There is nothing so practical as a good theory", thereby emphasizing the value of social psychological perspectives for understanding and addressing practical group problems1 (Buunk et al. 2021, den Boer et al. 2021).

According to Forsyth's (2014) framework, group dynamics can be understood from various complementary perspectives, including motivational, behavioral, cognitive, systems, and evolutionary perspectives (Buunk et al., 2021). Four dimensions are particularly relevant for this case. First, group structure refers to roles, status, attraction, and norms that shape behavior and expectations within teams. Second, mechanisms of conformity and social influence explain how individuals adapt their attitudes and behavior to group norms. Third, power relations concern the ability of individuals to influence others through informational, legitimate, reward, coercive, referent, or expertise power. Finally, conflict development and management addresses how conflicting interests, competition, communication issues, and power imbalances can contribute to the escalation or resolution of conflicts.

Together, these concepts provide a framework for analyzing how organizational changes, professional relationships, and team processes influence collaboration and complaint handling within oral healthcare.

Methods

This qualitative descriptive multiple-case study used reflective practice to examine how organizational changes, professional relationships, and team processes influence collaboration and complaint handling in Dutch oral healthcare. Two retrospective cases were selected because underlying interpersonal, communicative, and organizational dynamics appeared central to the conflicts. Case I analysed organizational changes within a periodontal practice, while Case II examined a professional conflict following a practice acquisition using the SPV model.

Both cases were analyzed and interpreted using social psychological concepts of group dynamics. Particular attention was paid to group structure, social influence, power relations, and conflict development. The aim of the analysis was to identify and understand mechanisms that may contribute to the emergence and escalation of complaints and professional conflicts within oral care teams, rather than to establish causal relationships or determine prevalence.

Results

Table 1 shows the analyzed and interpreted findings, focusing on three phases: joining the group, active collaboration, and the period preceding a member's departure of Case I ‘Retrospective qualitive analysis of group dynamics within a Dutch practice dedicated to periodontology’.

Table 1. Main findings of Case I analysed through group dynamics concepts

Dimension	Key observations	Interpretation
Group structure	The team consisted of dentists, oral hygienists, assistants, and secretaries in a hierarchical structure based on expertise and autonomy. A prevention assistant temporarily received additional clinical responsibilities, altering the existing hierarchy.	Role changes created role ambiguity, status tensions, and reduced cohesion. The assistant experienced increased expectations without sufficient support, resulting in stress and eventual departure.
Conformity and social influence	New members generally adapted to existing norms and routines. Resistance emerged when professional roles changed.	Group acceptance depended on conformity to established norms. Support or opposition from colleagues influenced adjustment and retention.
Power relations	Dentists occupied positions of legitimate, expert, and reward power. Informal influence also emerged through personality and social relationships.	Power differences shaped decision-making and responses to organizational change. Shifts in status generated competition and subgroup tensions

Dimension	Key observations	Interpretation
Conflict development	Conflicts emerged primarily during organizational changes involving roles, responsibilities, or relationships. Two examples involved the prevention assistant's new role and an oral hygienist reducing her involvement in the practice.	Uncertainty, conflicting interests, communication breakdowns, and perceived threats to status escalated tensions. Attempts to restore stability often involved reverting to previous structures.
Outcomes	Several members ultimately left the practice. Organizational changes affected collaboration, morale, and group stability.	Structural, interpersonal, and psychological processes interacted to influence team functioning and professional relationships.

Group structure. Initially, the team (group) consisted of dentists, oral hygienists, dental assistants, and secretaries, organized in a hierarchical structure largely determined by professional expertise and independence. Dentists held the highest position due to both their authority and their knowledge and expertise, followed by oral hygienists, while assistants and secretaries ranked lower in the hierarchy. *Communication patterns* reflected this structure: formal, task-oriented communication, particularly regarding patient care, was centralized around the dentists, while informal interactions were more decentralized. As Dutch periodontology practices grew, their structure also changed. *Roles* became more clearly defined, and norms shifted from individual to collective, embedded within the team. A key example of structural change involved a dental assistant who was temporarily assigned additional clinical responsibilities. This new role altered the existing hierarchy and positioned the assistant between the oral hygienists and other assistants. The change led to a role conflict, as the assistant faced higher expectations without sufficient support. The oral hygienists viewed the change as a threat to their professional position, while other assistants responded with rivalry and resentment. The assistant herself experienced stress and eventually returned to her original role before leaving the group entirely. The roles within the team were shaped by both individual motivation and the degree to which team members were interdependent. Differences in status reflected expectancy theories, whereby team members considered more competent had more influence and received more opportunities. The tension that arose when the assistant assumed a new role resembled a type of hierarchy, with members of higher status resisting what they perceived as a threat to their position. Social exchange processes also played an important role, as team members evaluated their interactions in terms of costs and benefits. The prevention assistant's decision to leave can be explained by an imbalance between the effort she exerted and the reward she received, coupled with a lack of social support. The attraction and cohesion within the team were influenced by similarities and a shared professional identity. Relationships within the various roles or occupational groups, such as those between secretaries or oral hygienists, remained stable over time. People tend to feel connected to others who share similar attitudes and use comparisons with colleagues to guide their behavior. The unique role of the prevention assistant, on the other hand, meant that she had no direct colleagues, making it more difficult for her to determine how to behave and contributing to her discomfort.

Conformity and social influence were present, but mostly implicit. New members tended to adapt to existing norms, especially when they perceived benefits in doing so. Familiarity with the group, attraction to the group, and dependence on others increased the likelihood of conformity. However, not all members adapted equally well. People with lower self-confidence or limited adaptability struggled to integrate and sometimes left the team prematurely. Social influence became more apparent during periods of change, such as role redistribution, where support or resistance from others significantly influenced outcomes.

Power relations were closely linked to hierarchy and expertise. Dentists possessed various forms of power, including influence based on expertise, legitimate power, and influence based on rewards, which affected group decisions and individual behavior. These power structures influenced an oral hygienist's decision to join the group and their subsequent behavior. Informal power also existed, whereby certain individuals exerted influence through personality, communication style, or social relationships. Dynamics within subgroups sometimes led to power imbalances and tensions, particularly when roles shifted or when members competed for status.

Conflict is a normal part of working in a team, also in this Dutch practice dedicated to periodontology. Minor disagreements occurred regularly during team meetings, but these were usually resolved through open discussion. Larger conflicts typically arose when something changed within the team, such as roles or relationships, and team members felt insecure or threatened. The situation with the prevention assistant is a clear example: it involved a conflict at both a personal and a group level, caused by conflicting interests, uncertainty, and unclear rules. At such times, collaboration often turned into competition, and members used various strategies to deal with it, such as applying pressure or avoiding the problem. Ultimately, stability was often restored by returning to the old way of working. A more personal conflict arose when the oral hygienist

decided to spend less time with the team to focus on other activities, but the dentists alias team leaders viewed this as a loss. This led to tension, as both parties pursued different goals. Communication broke down, and the leaders attempted to pressure her to remain more involved. Emotions ran high, making it more difficult to understand each other. Although attempts were made to improve the situation, the oral hygienist ultimately chose to leave, hoping to find better opportunities elsewhere. Her departure not only affected her personally but also caused greater instability within the group and led to others leaving as well.

Table 2 shows the analyzed and interpreted findings of Case II: Reflective case analysis of a professional conflict following practice acquisition.

Situation. An oral hygienist had been working in a general dental practice for approximately three years, in addition to managing her own independent clinic. During an informal interaction, the practice owner announced the sale of the practice to a corporate chain. This announcement came as a surprise to the entire team. Prior to this, the oral hygienist had explicitly indicated that she did not wish to work within a corporate structure, citing professional autonomy and work culture as key values.

Stimulus. The lack of prior communication and involvement in the transition process contributed to uncertainty and tension. A formal meeting between the oral hygienist, the dentist, and representatives of the acquiring organization was delayed for several weeks and was experienced as unproductive. Subsequently, the oral hygienist decided to terminate the collaboration after a short transition period. The situation escalated when communication regarding her departure took place via informal channels, including requests concerning patient communication and the abrupt termination of her access to the practice.

Question. From a reflective perspective, several questions arise regarding communication practices, professional responsibility, and ethical conduct. To what extent did the absence of transparent communication contribute to the escalation of the conflict? How did differences in expectations and professional values influence the interaction between the parties? And what role did informal communication channels play in shaping perceptions of professionalism and respect?

Table 2. Case II: Conflict analysis using the SPV model

Component	Key content	Interpretation
Situation	Oral hygienist worked in a general practice while running an independent clinic. Practice was unexpectedly sold to a corporate chain without prior consultation.	Sudden organizational change created immediate misalignment with the hygienist's values of autonomy and professional independence.
Stimulus	Lack of transparent communication; delayed and unproductive formal meeting; informal communication (i.e., WhatsApp) about departure and patient handling; abrupt access termination.	Communication gaps and procedural ambiguity intensified uncertainty and perceived disrespect, accelerating conflict escalation.
Question	How did communication absence, value differences, and informal channels influence escalation and perceptions of professionalism?	Reflection focuses on ethical and relational dimensions of professional communication and decision-making.
Overall interpretation	Conflict emerged from accumulated tensions rather than a single incident.	Escalation resulted from interactional processes, miscommunication, and misaligned expectations.

Discussion

This descriptive study examined complaints and collaboration issues in oral healthcare through group dynamics and reflection. Combining a retrospective team analysis (Case I) with a reflective conflict case (Case II), it shows complaints are rarely isolated but stem from ongoing miscommunication, unclear expectations, and shifting power relations. In both cases, limited transparency and poor alignment increased tensions. These findings support existing research showing that communication breakdowns and hierarchical structures are major drivers of conflict in healthcare teams, highlighting the need for better communication, clearer roles, and more reflective practices to prevent escalation and improve collaboration.

In Case I, multiple change processes occurred simultaneously, affecting group structure, conformity mechanisms, and power relations. These interacting factors influenced both individual behavior and collective functioning, demonstrating that team dynamics are inherently complex and cannot be explained by a single theoretical framework. An integrative approach, combining perspectives from systems theory, motivational theory, and social psychology, proved more effective in capturing this complexity.

Case II further illustrated how conflicts may develop through interactional processes over time, rather than resulting from a single triggering event. The application of the SPV model enabled a structured reflection on the situation, highlighting how the absence of timely and transparent communication contributed to misunderstanding and escalation. The use of informal communication channels in a professional context appeared to reinforce perceptions of disrespect and lack of professionalism, thereby intensifying the conflict.

Within the framework of the Wet kwaliteit, klachten en geschillen zorg (Wkkgz), complaint handling is primarily organized around procedural requirements, such as accessibility, independence, and timeliness (Witter et al. 2020). However, the present findings suggest that such procedural approaches may be insufficient to address the underlying relational and communicative dimensions of complaints. This indicates a potential gap between formal complaint structures and the practical realities of conflict development in healthcare settings (Leonard et al. 2004, McGuier et al. 2024, Salas et al. 2018). However, a structured and reflective approach, such as the SPV model, may support complaints officers and healthcare professionals in identifying underlying mechanisms and facilitating more constructive dialogue (Buunk et al. 2021, den Boer et al. 2021, Kersbergen et al. 2023, Mathieu, et al. 2000, Sjoerts, n.d, Turcotte et al. 2023). By focusing not only on the content of complaints but also on the interactional processes that give rise to them, it may be possible to prevent escalation and contribute to more sustainable professional relationships (Buunk-Werkhoven, Kalk, 2026, Wong et al. 2023). This descriptive study is based on a limited number of cases and includes retrospective and reflective elements, which may introduce bias. Both authors are Dutch oral hygienists (Jongbloed et al., 2012), and the role of oral hygienists within oral healthcare varies by European country. There is not only great variation in their education, but also in their workplace, as well as in their annual salary and requirements for further training (Rederiene et al. 2024). Additionally, the findings are context-specific (within the Dutch oral healthcare setting/system) and may not be directly generalizable to all healthcare settings. However, the underlying mechanisms of group dynamics, e.g., role ambiguity, power relations, social influence, and conflict development, are relevant to dental teams in various care contexts and countries. The presented frameworks and reflection models can help dental professionals, managers, and complaints officers worldwide understand how organizational changes, professional collaboration, and communication processes can contribute to workplace conflicts and complaints, regardless of national regulations. Future case reports could further examine the role of structured reflection models in complaint handling and explore their applicability across different organizational contexts. Overall, this study emphasizes the importance of integrating relational, communicative, and structural perspectives into the analysis of complaints within oral healthcare.

Conclusions and practical implications

This study shows that complaints and collaboration problems in oral healthcare are shaped by group dynamics like communication, power, and roles. Complaints are not isolated but arise from ongoing interactions. Adding reflective methods to formal procedures, such as the Wkkgz, could help. The SPV model proved useful, and increasing team awareness may improve collaboration, complaint handling, and prevent conflict escalation.

Disclosure Statement

The authors report there are no competing interests to declare.

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