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Communication in Dentistry

The Importance of Communication in Dentistry

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Abstract

Good communication between patient and dentist is associated with increased efficiency and more accurate diagnosis, improved patient outcomes and satisfaction and less likelihood of complaints or litigation. Communication is also a complex (and clinical) skill but, interestingly, its importance is not always accepted or valued either by students or those with more experience.

The aim of this paper is to review the evidence about communication within the context of the dental setting. I consider the need for good communication generally, its role in managing anxious patients and in avoiding misunderstanding and ways in which communication skills can be assessed and updated.

Clinical relevance

Dentists who spend time communicating effectively with their patients and colleagues are likely to have better interpersonal relationships and a more satisfying working life. This in turn is likely to make consultations more efficient and improve patient outcomes.

Objective

To review the psychological and healthcare literature concerned with communication in a dental context.

Background

“The single biggest problem in communication is the illusion that it has taken place” (misattributed to George Bernard Shaw but probably originating from William H Whyte (Quote Investigator) (1)(1)(1))

One comment that I often receive in feedback from dental students is “why do we have to learn about communication – what does it have to do with dentistry?” Attempts to convince students that communication is a clinical skill and one that is well worth developing, can fall on deaf ears; similarly, evidence that a considerable part of dental litigation is concerned with miscommunication and misunderstandings rather than clinical malpractice (2, 3) may be met with scepticism.

In order to answer criticisms such as these, one ought to consider communication theory and the literature on communication in healthcare as well as, perhaps, personal experience. If we stop, for a moment, to think about whether communication events are always successful and whether the intended message is always received or that misunderstandings are “never” events then the need for modification or improvement of communication skills may become apparent.

Why do we have to learn about communication?

With respect to the literature, scholars report that communication within a health care setting is both a clinical and complex skill: (4, 5) that is, one that pertains] to a clinic, direct patient care, or materials used in the direct care of patients” (6) comprising “a set of constituent skills” (7). In dentistry, those constituent skills are likely to include (among other things) the ability to listen carefully, explain clearly using plain, easily understood language (i.e. not jargon or clinical terms), provide reassurance to anxious or upset patients as well as delivering effective persuasive messages to promote positive changes in health behaviour. Without doubt, dental care can take place without these interpersonal skills, but life for both dentist and patient will surely be more satisfactory if they are part of the dentist’s tool kit.

Communication can be verbal (spoken, sung, whispered) and modified by paralanguage (tone and pace of speech; er, um and ah etc), written (letters, social media, advertisements, journal articles, clinical information leaflets, prescriptions) or non-verbal (drawings, models and body language) (see Figure 1).

[Figure 1 about here]

In order to communicate effectively, both a sender and receiver are necessary: someone needs to send a message and, just as importantly (but frequently forgotten), someone else needs to receive the *same* message. Communication comprises more than simply providing information - if a message isn't received as it was intended, then the communication process hasn't been completed (see Figure 2).

[Figure 2 about here]

As shown in Figure 2, the receiver may not decode the sent message in the way it was intended; for that reason, a critical aspect of communication in the healthcare setting is to ensure that the message that has been sent (from patient to dentist or dentist to nurse and any other possible permutation) is the same message that has been received. This can be done by recapping to check that the receiver (patient) has heard correctly or by asking the receiver themselves (the patient) to recap what you (the dentist) have discussed, to ensure that they have understood what has been said. In order to emphasise this point with my students, I often use the following example:

Message 1: "Thelecturersaidthestudentisafool"

Message 2: "The lecturer" said the student "is a fool"

Message 3: The lecturer said "the student is a fool"

In each case, the physical content of the messages is the same – the stimuli are almost identical, give or take some speech marks. However, once punctuation and spaces have been added, each message

means completely different things despite their similarity – no wonder that misunderstandings happen so often!

There is considerable evidence illustrating the importance of good communication skills in dentistry (8-11). Once a person has decided to seek health care, good and effective communication is associated with patient-centred care (12): patients are more likely to comply with treatment plans, their health outcomes will be better and they are more likely to report higher levels of satisfaction with the care that they receive (13-15); similarly, dentists with effective communication skills are likely to be more accurate in their diagnosis and their practice will be more efficient (16). When treating children, an understanding of the benefits of supportive communication can facilitate effective behaviour management - one study has shown that a letter to a child reminding them of how “good” their last dental visit was (i.e. a photo of them smiling after treatment) and a comment to the parents about how good the child has been, can have a positive impact on the subsequent dental visit: blind assessment by others show that the child’s behaviour improves and self-reports from the children themselves indicate that the amount of perceived fear is reduced (17).

Many patients will have an extensive “knowledge” of dentists even if they have never stepped over the threshold of a dental surgery: dentists are represented in fictitious media such as “Marathon Man” (18)(18)(18) and the TV programme “My Family” (19)(19)(19) and they are sometimes represented with more or less accuracy in the national print or television media. Children receive communication about dentists and dental experiences from their parents, siblings and friends and adults communicate both positive and negative messages about their “dental careers” to anyone who listens. All of these messages may contain perceived information about the dentists themselves or about dental procedures and they are subject to interpretation by others e.g. are dentists kind and understanding? Do they take the time to put their patients at ease? (20) Are they professional? Are specific procedures painful, lengthy or expensive? Through communications such as these,

dental patients will have sent and received messages about dentists long before they sit in a dental chair and will have their own perception about what dentists “are like”.

Am I allowed to ask about that – won't it make things worse?

Patient-dentist communication often takes place around sensitive issues: it may be that an individual seeking dental care is anxious, fearful or even phobic or that they have a chronic condition that they are concerned about disclosing (21). They may be embarrassed or ashamed e.g by the state of their teeth / because they haven't attended for a long time / because they are anxious and scared and worried about being perceived as troublesome – such perceptions can perpetuate an avoidance of dentists and treatment (22, 23) (see Figure 3):

[Figure 3 about here]

The shame and guilt felt by a patient may promote anxiety about going to the dentist which, in turn means that the individual is less likely to attend; consequently their dental health is likely to deteriorate causing their shame and embarrassment increase, taking them back to the beginning of the cycle (22, 24) . Anxious patients may perceive that dentists are efficient and in a hurry or that s/he won't listen to them or take them seriously (25); around 47% of patients also feel that they have no control over what happens to them once they are in the dental chair (26): these feelings are also likely increase the individual's anxiety of dental situations and, as in Figure 3, result in dental avoidance.

Increasingly, there is evidence that patients *want to be* asked how they feel about being at the dentist: they want their dentist to know that they are anxious and worried (27). This can be done with simple and straight-forward questions asking the patient whether s/he attends frequently and how s/he feels about coming to the dentist. If the patient admits to being anxious then care should be taken to find out why: is the anxiety due to hearsay, a difficult experience or shame or embarrassment?

Sensitive questions about tobacco, alcohol and recreational drug use, pregnancy and sexually transmitted infection are likely to be asked at some point during a dental consultation, risks of treatment options may need to be communicated or bad news may need to be broken. In each of these specific contexts, different types of communication skills will be required: e.g. explanation, reiteration and recapping to check understanding; permission seeking to either ask sensitive questions during a social or medical history or to give details of bad news or planned treatments; reassurance that enables patients to ask questions and feel involved in decision making about their treatment; negotiation about behaviour change and treatment options (28), and so on. While good communication in such sensitive situations is a priority for dental patients it can also benefit the dentist too: patients with HIV or diabetes have reported that they are more likely to disclose important details from their medical histories if they are comfortable with and trust their dentist (21), a relationship status that is achieved with good communication and the development of rapport. Such rapport relies on the dentist believing that s/he is justified in asking questions about sensitive topics and having the confidence to broach them: this means that s/he needs a clear understanding of why this sensitive information is relevant to patient centred dental care in order to provide a clear explanation for the patient.

Surely they know what I mean.....

A search of the literature suggests that misunderstandings in communication can and do occur. A sizeable proportion of complaints and litigation occur not because there has been a technical or clinical error but because patients did not understand, were not listened to or were not treated with respect (2, 3). These aspects of communication skill are often rated as “least good” in surveys about patient satisfaction (29, 30). The communication of risk is one area where there is room for improvement. The risks of treatment not going as expected at best, or going wrong at worst are a sensitive topic. People undergoing dental treatment want their treatment to go well but, in order to provide informed consent, they need to understand both benefits and risks as well as alternatives. The importance of communication of this type is considered in detail in a synthesis of the literature

by Asimakopoulou and colleagues (31) who conclude that the communication of risk may be undermined because dentists may not communicate risk information clearly and consequently that patients may not, therefore, understand the risks they may be exposed to. Similarly, there can be misunderstandings in the professional communication between dentists and dental and health care professionals (DCPs, HCPs): e.g. within referral letters and prescriptions that convey messages between general and specialty dental practitioners and between dentists and technicians (32, 33). Such miscommunication can result in unsatisfactory outcomes, not only for patients, but also for dentists and DCPs (34, 35). Misunderstandings are not the only adverse outcome as far as written communication is concerned: a poorly written letter may prompt misunderstanding of the written content and, subsequently, inappropriate follow-up and investigations at worst or time-consuming re-investigation at best. Patients expect to be sent a copy of any letters concerning them and so letters ought to be understandable to people with no dental knowledge. In the unfortunate event that something goes wrong or a complaint is made, lawyers and insurance companies may also ask for evidence of communication between dentist and patient or DCPs and HCPs. For this reason, communication and documentation (referral letters and clinical documentation) should be comprehensive, thorough and unambiguous (36).

Gender also has an impact on communication. Women and men communicate differently (37): women express more non-verbal warmth and emotions with higher levels of self-disclosure whereas men are more direct (38). Differences in dentists' communication and interaction style as a function of their gender (39)(39)(38) may impact on the working relationship between dentist and nurse: in the findings from several studies dental nurses report that male dentists are more likely to have a business-like and gender-influenced communication style whereas female dentists are more likely to practice a personal attention and friendly-relation communication style (40). Such differences can impact on job satisfaction and staff turnover as well as levels of stress within the working environment and so time spent on checking that everybody is receiving the same "messages" is likely to be time well spent. Similarly, there are also reported interactions between the gender of the

clinician and that of the patient: in one study of medics, female patient satisfaction was highest when female clinicians were rated as caring rather than non-caring whereas male clinicians were rated more highly if they displayed moderate rather than lots of patient-centred communication. Ratings of satisfaction by male patients do not seem to be a function of communication style by either male or female clinicians (41).

How can I improve?

So far, this paper has comprised a summary of the communication literature in dentistry. Given the considerable evidence that there are issues with the effective and appropriate transfer of information from one person to another in a variety of dental contexts, what steps can be taken to refresh or improve one's communication skills?

The Calgary-Cambridge communication guide (4) provides a structure for effective and appropriate communication with patients and family members. It breaks the consultation process into a series of stages - initiating the consultation, gathering information, understanding the patient perspective, providing structure to the consultation, building the relationship and closing the consultation - with well-defined actions at each stage, many of which are generalizable to a variety of situations e.g. posture, eye contact, expressions of sympathy / empathy / emotions, listening and negotiation skills.

Motivational interviewing (42) is a method often practiced by healthcare practitioners in different disciplines. It guides individuals in motivating themselves to change their behaviours and / or to better adhere to treatment plans. People exposed to motivational interviewing are more likely to begin, remain within and to complete treatment plans e.g. flossing, changing diet, cutting down or stopping smoking and drinking alcohol.

Other tools relevant to more specific communication contexts include the SPIKES protocol (designed to help clinicians break bad news clearly, honestly and sensitively) (43) and an academic discussion about the different ways in which risk can be communicated (e.g. is one's risk of caries possible or probable) (44). Twelve tips for good written communication are provided by Keely, 2002 and

Davenport, 2000 considers the importance of good communication between dentist and technician (34, 36).

For those who would like to assess their own personal skills, a variety of measures exist (the Communication Assessment Tool (CAT) to acquire feedback from patients (45), the Communication and Working Styles Questionnaire (CWSQ) for feedback from dental nurses (40))

Conclusion

Soft skills, including communication skills, are important in dental practice as they reflect dental care professionals' personal values and interpersonal skills and they also contribute to the successful provision of health care (46). For this reason it is important that dentists and other dental care professionals consider the way in which they communicate with others – patients and colleagues - either wittingly or unwittingly, in spoken or written form. Communication is a clinical skill that needs to be learnt well, practised, reflected upon and updated on a regular basis if miscommunication and misinterpretation are to be avoided. This will entail taking the time to think about and improve one's communication skills: focussing on patients (and colleagues) as individuals, listening to them as they give their perspective of their teeth and their oral health (or professional issues and concerns), providing opportunities to ask and answer questions as they arise and, ultimately, making sure that any communication that takes place is "real" and complete (9). Concerns that good or patient-centred communication takes time are unfounded: research suggests that the time taken for a patient-centred consultation is, at worst, the same as for a biomedical (disease focussed) consultation and at best, is reduced because the main point of the consultation is accessed more quickly (47).

Figure 1: The relative importance of different communication modalities

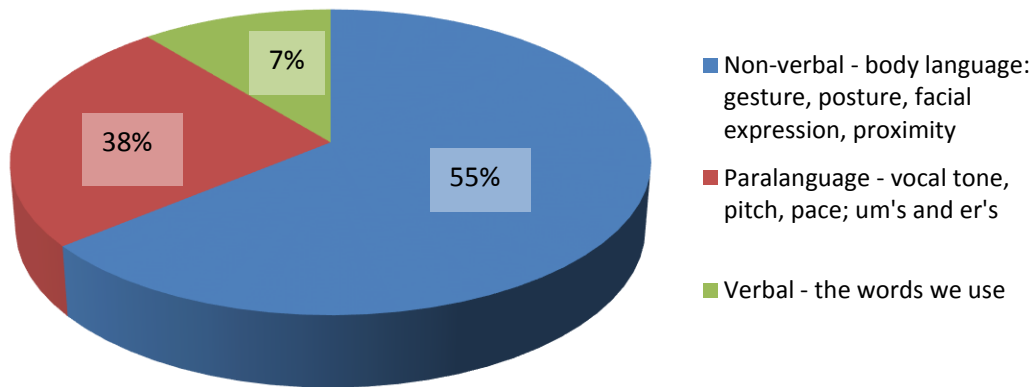


Figure 2: The roles of sender and receiver in the communication process

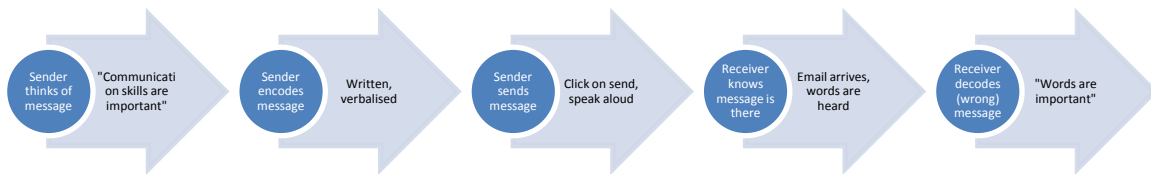
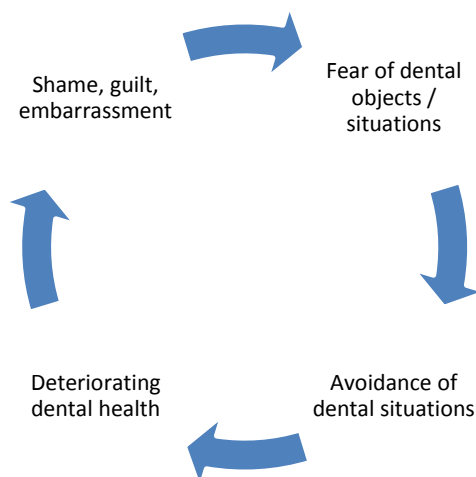


Figure 3: Berggren's model of dental anxiety (22)



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