Has the pandemic changed the way we communicate?

David Westgarth
Editor, *BDJ in Practice*

Introduction

There's a very funny picture doing the rounds on social media that says you can drive for four hours in America and you're on the same road in the same State, but in the same distance in UK the accent and name for a bread roll has changed 18 times. Besides the geographical challenges and differences posed by the countries, it is fascinating how language, accent and dialect change so much. Despite spending precisely zero minutes growing up in the North East, it's still the accent people tell me I have. And yet, after a weekend at home in Cumbria, upon my return to the city my Cumbrian accent is stronger than ever. Few people will forget how hilarious former England football manager Steve McLaren adopted a Dutch accent during his time coaching one of the country's clubs, only for it to disappear on his return to England.

The environment around us has a significant impact on what we say and how we say it. Throughout the pandemic, many of the normal social conventions have been put on hold, altered and changed. Dentistry felt those alterations and changes hard, but just how has communication within the profession been impacted?

Key points

- Has COVID-19 changed the what and the how of communication?
- What are the implications?
- Could the changes be a good thing?

The what and the how

There has been plenty said about the 'how' changes, most notably the increased use of teledentistry for patient-facing processes. Less has been said about the vast quantity of digital learning that has taken place, for dental students and those fully qualified. The disruption, as with most things since March 2020, provided challenges and opportunities. Research has previously highlighted four key areas that have been adversely impacted:[1]

Online communication skills teaching

While not necessarily the optimum way to strengthen communication skills, many teachers are learning and seeking to identify best practices for virtual communication skills teaching during the pandemic.

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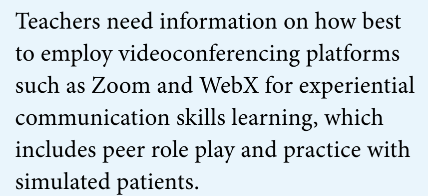

Teachers need information on how best to employ videoconferencing platforms such as Zoom and WebX for experiential communication skills learning, which includes peer role play and practice with simulated patients.

Clinical learners not seeing patients

In many health professional schools around the world, many clinical rotations have been suspended. Sharing resources for continuing case-based and other forms of learning in the absence of direct patient encounters is another pressing need and opportunity.

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Workplace-based learning

Not all learners have been removed from clinical settings during the pandemic and many, such as residents, are experiencing increased clinical obligations. It will be helpful to identify opportunities for continued emphasis on communication skills learning and development in the clinical setting. Innovations that adhere to the need for physical distancing and still emphasise communication content could include virtual rounding, video recording with asynchronous feedback of learner-patient encounters, and communication-focused debriefing of patient/family encounters.

Virtual communication assessments

In addition to in-person teaching, the pandemic has made in- person assessments such as OSCEs untenable. Many schools are developing successful and innovative ways to continue to conduct communication-focused performance-based assessments, including involvement of simulated patients using videoconferencing platforms.

While I found it interesting that the authors highlighted that there are some successes and innovations to aid students, trainers and qualified alike, the impact caused by a lack of face-to-face training was

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not discussed. Dentistry by its very nature is hands-on, so who knows what impact that has had on dental student and course attendees? Only time will tell.

In addition to the setting, the qualifications and the virtual nature of conversations, *what* we say has also changed over the pandemic. Almost every conversation I've had with friends and loved ones has included a discussion on positivity rates, or R value, the vaccine or the desire for things to go back to the way they were. There are few situations where every person on the planet can sympathise and empathise with what you're going through; this is one of those. Pre-pandemic, what did a mask mean? Did it mean ski mask and thoughts of a happier nature? Did it mean a masquerade ball and again, happy, party vibes? In dentistry it was a staple of treating a patient. Its role hasn't changed. The difference was to talk to a patient, you could pop it off as soon as you were done treating them. To this end, it's another example of *how* practitioners talk to patients has changed. Practitioners need to enhance non-verbal communication to compensate for the loss of visible facial expression, as Jane Merivale has previously written:

'Facial expressions signal our thoughts and emotions and most of us become fairly adept at reading the faces of others to understand what they are thinking and feeling. We have evolved 42 muscles of facial expression for this purpose!

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'Being able to observe the mouth can impact on the patient's perception of a dentist's emotional intelligence, and their likeability, which directly affects patient satisfaction, regardless of the actual treatment outcome.'[2]

Masks, necessary as they are, can create problems. Research shows high-frequency sounds are reduced by 3–4 decibels (dB) when wearing a surgical mask, and by 12 dB when wearing an N95 mask.3 A 10-decibel reduction will be twice as quiet as the original decibel reading. As people age, their hearing loss generally affects these higher frequencies, resulting in greater difficulty hearing.[4] Add some background noise (such as air purifiers for the room), and this decrease in decibels is enough of a reduction to affect the quality of speech for people with some level of hearing loss.[3]

Masks also make it impossible to read lips. They muffle sounds, and with more than half of the face covered, it is more difficult to decipher facial expressions. Wearing two masks and a face shield likely affects the quality of speech even more. For patients to be able to make a decision on their treatment based on informed consent and understand all of their treatment options, the ability to hear and understand what we are attempting to communicate is of utmost importance.

Muffled sound through 15 months (and counting) of masked communication may also impact on how we pronounce our words. At Michigan State University Sociolinguistics Lab, a team of researchers have been collecting recorded speech from Michigan residents since the beginning of April 2020 to track changes to language during the pandemic. According to them, the most recent time a major event had such an impact on language was the Second World War, because it brought people together who ordinarily wouldn't have had contact with one another. They would have had to speak louder and clearer during bombing campaigns, for example.

With the pandemic, it's just the opposite. We've been pried apart, and 'you're on mute', 'you broke up a bit there' and 'I can't quite hear you' have become norms for meetings. Research isn't available to date, but anecdotally I would think I've probably changed how I speak – I'm louder, slower and clearer, for masks and for virtual discussions. For someone softly and quietly spoken, they would perhaps have had to adapt more than a public speaker, for example. And yet, as one of the points in Box 1 shows, it can be difficult to speak louder for clarity and retain patient confidentiality. This may well have been improved upon since the beginning of the

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pandemic, but as restrictions persist and foundation dentists take up posts from next month, it is something many will be encountering for the first time.

The implications

In the last ten years, the biggest change we have seen to communication is that it has become a lot more immediate. Instead of sending emails back and forth from the computer, and waiting for the recipient to be at their desk before they can send a reply, most people now have got access to instant messaging software, which is now becoming integrated into working offices too. When the very first iPhone came out back in 2007, no-one could foresee how smartphones would come to dominate our lives. Our phones are an essential lifeline – they're on the same checklist as keys, wallet and masks when you leave the house. Chances are you're probably reading this on your phone, too, as the number of mobile web users has now outstripped their desktop counterparts. Email does still have its place, but instant messaging apps will soon make them obsolete and a thing of the past at current rates of progress.

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This immediacy means patients have come to expect it too, which is why you wonder if – for a large segment of patients – it should stay. It's one less barrier to getting patients into the practice. Toothbrushes use smart technology to send data back to a patient's dentist. It would perhaps be more cost-effective and enable dental practitioners with targets to achieve them easier. Would it even be a cost-effective bridge for patients to access private dentistry more often and take the pressure off the health service, clearly under pressure? These parameters would apply to a small section of the population, but the implications for a return to 'how things used to be' simply places pressure on a system still essentially operating with peak-pandemic restrictions; it shouldn't happen.

This has also led to another change in precisely how we communicate, namely the length of how we communicate. It wasn't all that long ago that you could expect lengthy emails about even the simplest of topics, Now, though, there's no need to do that when you're communicating with someone in 'real-time'. Conciseness is the order of the day, particularly because that ease of communication means that we often have a lot to keep on top of at once.

And that rings true of most scenarios, except for consent.

Conciseness is not the order of the day. As with consent, and the changes adopted

Box 1 Tips for masked communication

Dr Jane Merivale, senior dento-legal advisor for BDA Indemnity, has previously suggested the following for communicating wearing a mask[2]

- The environment – Minimise the noise and distractions in the surgery; patients need to understand what is being said and if not hearing fully, especially in the absence of lip-reading cues, they will 'make a guess' at what's been said, particularly patients with a cognitive or hearing impediment
- Make eye contact – This conveys 'I see you' activating empathy and connection. Too much and the patient feels uncomfortable, but enough strengthens the greeting and promotes trust
- Introductions are key – Wear a name badge so everyone knows 'who's who' and their job title
- Explain why you are wearing a mask – This can enhance trust in the dental setting signalling adherence to cross infection control measures given dentistry is carried out at such close quarters
- Listen well – Let patients tell their story, uninterrupted
- Give reassurance that the patient is safe and acknowledge the extra difficulties imposed by wearing a mask
- Check your tone of voice – The tone conveys over 38% of the non-verbal emotional content of what we say. The pace, rhythm and pitch of spoken language is called prosody. Prosody infuses a layer of emotion that goes above and beyond the singular meaning of each word and we are all highly sensitive to variations in tone of voice. In a famous study by Nalini Ambady, audiotapes of surgeons talking with patients were filtered so only the volume, pace and rhythm of their communications were audible. When the tapes were played to a group of volunteers, listeners could determine the surgeons who had a history of complaints and claims
- Name your emotion – If the PPE makes it difficult to express it: for example, 'You make me smile' or 'I empathise with you'
- Convey openness, warmth and respect with body language – Sit down with patients, turn towards them, and sit at eye level whilst maintaining social distance.
- Encourage questions to gauge understanding – In the face of any lack of comprehension that is critical to obtaining valid consent. Information gathered by the dentist may otherwise be incomplete leading to clinical and consent inaccuracies.
- Use gestures – Thumbs up or down to clarify what has or hasn't been understood
- Give more supplementary written information than usual
- Safeguard confidentiality – It can be difficult to speak louder for clarity. You may have to move somewhere more confidential if the situation demands it
- Use technology creatively to supplement information given - some dentists are experimenting with live transcript applications compatible with mobile phone technology as a means of communication solving, so the patient can listen again when they've left the surgery.

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as a result of the Montgomery case, records and consent need to be tailored to the individual patient and therefore being concise will never work in your favour. There is no substitute for good communication, and it is important that what is written in the records actually took place; the patient may argue that there was no such dialogue and no such agreement to proceed on those terms. BDA Indemnity has previously reaffirmed:

'In order to be valid, the consent process needs to be tailored to each patient and their particular circumstances, taking into account what matters most to them. Essentially, this summarises the legal precedent created by the Montgomery case in 2015. Hence your records are the only sure method of demonstrating the consent process which will inevitably evolve over the period you are treating the patient; remembering also that the patient can withdraw their consent at any point.'[5]

When providing dental treatment, it is important that every patient fully understands any dental treatment that is proposed in order to make an informed decision about how they would like to proceed. Fully and concise in this scenario do not mix, and it is important to consider the implications of discussing treatment plans with a patient via traditional means and the problems associated with masks, and digital means, particularly if the patient seems like they'd rather be elsewhere.

Conversely, some of the problems that may arise from muffled communication – those with hearing difficulties, those who do not have English as their first language, those living with a disability or other impairment – may reverse the 'instant' nature of communication. Could practitioners be extra cautious about giving patients too much information if there are concerns about misinterpretations or misunderstandings? It's not beyond the realms of possibility, and yet there is still a balance to ensure the patient gets information they can understand and will digest.

True progress, or progress for the sake of it

Sometimes it can feel like technology is being used for the sake of it, and as a result there's no communication, other than with a responsive piece of software. Dentistry must not find itself implementing changes purely for the sake of it – any of the pandemic learnings integrated into everyday practising should be done so for the benefit of the patient and practitioner.

Take receptionists, for example. An integral part of the dental team, yet for some there will be a temptation to make the check-in process digital through touchpads and/or voice-activated programs. Their numbers could potentially dwindle. Besides the fact they're one skillset most at risk from COVID-19 given how many different people they see in a static environment, they're an invaluable asset in any practice. Could a touchpad resolve a query? Yes, most likely. Could a receptionist be able to iron out the beginnings of a complaint? Yes, absolutely. It's those intangible aspects that savings – which many practice owners will naturally seek to find post-pandemic – cannot replace.

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For dental students, would a hybrid model of learning be something they wish to incorporate? Do they need to be present in lectures as well as clinics? There's an argument for one, but a weaker one for the other.

Do practice meetings need to be in-person when everyone has adopted and integrated technology replacements so ably?

It's easy to say technology – in these scenarios – replaces the need for in-person communication. Truth is they do. The question is *should* they replace them, to which the answer is anything but straight forward. The 'soft skill' is something many are concerned is lacking in many students and young dentists, given their focus on clinical skills. Researchers have previously concluded that: '*An increase in service industry and competitive private practices emphasises the need for soft skills. Soft skills are used in personal and professional life.*

'*These soft skills help to organise, plan and manage, and track changes during the course of the growing dental practices. However, understanding of the soft skills in practice management, its simplicity and complex contexts of practice is essential. It is really helpful to all practitioners to grow their practices using soft skills.*'[6]

Given the shift to instant communication, and in a post-pandemic world where we're actively discouraged from being face-to-face with someone, being able to read the conversation, the flow and the body language, it will be fascinating to see the long-term impact this has on the profession – and wider society – moving forward.

COVID-19 has changed clinical communication practices, of that there is no doubt. The transition from and the balance of face-to-face communication with remote encounters has shifted, even for a profession as reliant upon in-person as dentistry. Which of those changes becomes the norm will only be seen once COVID-19 is in the rear view mirror – for how much longer will masks be mandatory for the entirety of the appointment? For how much longer will practitioners have to speak above air filtration units on top of that? How will this affect those of partial hearing too? How those changes affect the way we communicate will take even longer to gestate – will we all end up speaking slowly and loudly, like Brits abroad do when they want to order something off the menu from behind the counter but have no idea of how to do so in the local language? ◆

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