Lost in transition – changes in communication in the leap from dental student to foundation dentist

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IN BRIEF

- Provokes thought into the changes from dental school into practice.
- Analyses the different types of communication commonly used.
- Advises on the requirements of keeping up standards in patient/colleague communication through one's professional career.

OPINION

The art of communication is subtle; it is not as clear cut as other competencies in dentistry may appear but seems to cause more problems than any other. Perhaps this is why so many dental professionals fall foul of patients and colleagues not because they have done anything wrong *per se*, but because they failed to communicate to that party the details and implications of treatments. It is easy to overlook this aspect of clinical practice. Until recently communication was paid no real attention in dental syllabuses and even since more time has been dedicated to it, it is still difficult to teach. Communication is not always face to face. More often than not, when discussing cases with colleagues, medical or dental, the correspondence is written rather than verbal. When I was a student, the only experience I had at writing referrals was the odd case that needed specialist care and one token lecture. This article aims to outline the changes in the way professionals and students communicate with patients and each other. It would seem a common assumption that students are poorer at this competency than graduate dentists, but on the contrary the evidence may suggest the opposite.

As a dental student, explaining conditions and treatments to patients can often be confusing. Not only is the student trying to recall the information themselves, but they have to reformulate the information into phrases that expel any dental jargon. It could be likened to learning a foreign language, only having then to 'un-learn' it to speak to patients. Another dimension on top of this is the assessment by clinical teachers who are often within earshot, adding to already frayed nerves. As a student progresses through the years of dental school, it is presumed that they will become more adept at this, and answering any resulting questions in an appropriate manner. Every dental student knows, from an early stage, the basis of oral hygiene instructions (OHI), but I know from my own experience the lack of care and diligence that disinterested students may sometimes demonstrate when delivering this. As long as the standard, 'Brush twice a day with fluoride toothpaste' is mentioned, and the Prevention Toolkit[1] is reeled off, it is felt that this is sufficient. When I entered my foundation year, the area in which I was placed was one where social deprivation was rife. As a consequence, many of my patients did not have an effective oral hygiene regime.[2] I soon recognised that the lustre with which I delivered my performance on oral hygiene had a direct correlation with the patient's uptake of advice, with no difference in different age groups. Several oral hygiene models ordered later, I am forever re-evaluating the advice I give and tailoring it to different patients. However, in discussion with colleagues I would have to agree with the general consensus that due to time and the way the UDA system reimburses, these preventative measures are hard to fit into a busy treatment plan. A recent study showed that FD1s (first year foundation dentists) believed that OHI was easier to perform as students due to the lack of time constraints.[3] Strictly speaking time constraints should not be an issue for FD1s, but it seems that OHI is perceived to be a low-value time expenditure. Once in practice, this time was no longer available and OHI was given as a reactive measure when patients had active disease, rather than as a generalised preventative measure to every patient. Mentioned in the study is the difficulty FD1s found in expressing the information without feeling as if they were being patronising.

Dental students are taught what to say, not how to say it. For example, I once told an octogenarian how to brush his teeth, an act in my mind which was one of diligence. I was received with the less than flattering review of, 'I think I know how to brush my teeth young man'. I fast realised that it wasn't simply what I said, but the way I said it. Children and younger people seem to respond more favourably to the 'teacher' role taken on during OHI, whereas my opening line with patients who are older has to be more carefully phrased: 'I can see you brush your teeth well, but a few areas you could re-visit might be...' Such advice is a lot less patronising and frustrating to patients. This is supported by Yamalik[4] who discusses the need for dental professionals to avoid technical language and patronising behaviour. I wouldn't speak to anyone in a patronising way in normal conversation, but when one dons the clinical tunic, it is much easier to fall into the stereotypical role that can come across that way. The information that we transmit to patients is not always received

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in the way we intend and the message can often be misconstrued. A dated, yet in my view relevant study conducted in 1969 in a children's hospital in Los Angeles[5] stated that it is the perceived importance of the information being expressed, combined with the warmth and empathy of the patient-clinician relationship and the clarity of the clinician explanation of the diagnosis, that governs the likelihood of patient compliance. Although this study relates to paediatric medicine, the principles as they relate to our practice as dental professions are still pertinent.

I know from talking to my grandparents that some people of an older generation are prone to taking the advice of medical and dental professionals as gospel. There is a lack of questioning, even when there are questions to be asked. This misplaced respect for perceived authority is potentially unhelpful as it may prevent the full participation of patients in their treatment. Patients' desire for information and clarification is not always demonstrated in their actions and desire to participate in discussion.[6] As a student, one avoids the patients' perceptions of authority as you are advertised openly as being in training. This is demonstrated only too well when suddenly at dinner parties apparently sociable and friendly new acquaintances will cover their mouths and become shy upon learning that you are a dental professional, or perhaps it's just me! To this end, it is important as professionals not to make the choice for the patient as to what information to give, but to always give in a way as to allow an informed decision from a patient about their treatment to be made.

This idea can be extended generally into all aspects of dental care. One of the main reasons dentists are sued is because a patient wants answers.[7] The old stereotype of the stuffy inapproachable medical or dental professional whose advice is to be obeyed without question is now deemed unacceptable by society and the profession.

As a student, it is sometimes difficult to remember to give all the information that is relevant and necessary (sometimes quite the opposite can be true: students give too much). This is why keeping good records is so important. By writing down what has been said, as it is said, you have a checklist already there. Another area of communication in dentistry is clinical record keeping. Qualified dentists in practice have been shown to be notoriously bad at keeping good records.[8] Dental students show the same fault before continued teaching in what constitutes good notes.[9] Upon leaving dental school, when the eagle eyed tutors are removed, FDs must keep good records to avoid issues that they had some degree of protection against at university. The General Dental Council (GDC) writes the following with regards to patient communication:[10]

'Listen to patients and give them the information they need, in a way they can use, so that they can make decisions. This will include:

- Communicating effectively with patients;
- Explaining options (including risks and benefits); and
- Giving full information on proposed treatment and possible costs.'

Giving patients information in a way they can use it is essential to avoid confusion. The simplest way of doing this is by the removal of technical terms from one's vocabulary when explaining situations and issues to patients. Lipp *et al.*[11] showed that in three groups of patients about to undergo dental local anaesthesia, it was those given 'basic' information rather than 'minimal' or 'extended' information that felt the largest decrease in anxiety before and after treatment.

Students invariably talk to one another; they discuss patients and ask each other for advice. This is carried on upon graduation, but on the whole if not face to face, is done via formal referral letter. I once received a message via a social networking website from a fellow student containing patient details and asking me to see them. Most hospital and community dentists will confirm that they receive poor referral letters approximately 20% of the time.[12] This lack of clear communication is unacceptable; the GDC states [dental professionals should] 'Communicate effectively and share your knowledge and skills with other team members and colleagues as necessary in the interests if patients. In all dealings with other team members and colleagues, make the interests of patients your first priority.'[10] It is difficult to see how a poor referral letter is in the patient's best interests. When a referral letter is written as a student, it is usually double and triple checked for accuracy and inclusion of information. Many general dental practitioners (GDPs) and FDs write referrals as proformas, which has been shown to increase the quality of referral correspondence.[13] However, when these are completed poorly, they may lead to the clinician accepting the referral having little or no information at all.

In conclusion, the gap between foundation dentist and dental student is large, but with regards to the need for communication, there is little difference. Dental students are sheltered from litigation issues and have the benefit of a more experienced clinician supervising them. While FDs have the support from their trainer, they are very rarely there to observe the entirety of an appointment, to view the level and quality of communication that is being carried out. To this end, FDs have to be vigilant in their practice and the way that they interact with patients, for they are vulnerable to miscommunication and omissions of important information that keep both the patient and clinician happy and safe. We see that dental students are often superior to their graduate FD colleagues in their abilities to communicate successfully and appropriately with patients and other professionals. As students we are taught strict standards that are regulated by staff and clinical tutors. When students graduate, many of these restrictions are lifted and self-regulation is applied (for example, standards of record keeping). Even more so now, with the abolition of Dental Reference Officers (DROs) the onus is on the graduate to be strict with oneself and keep standards of communication with patients and colleagues as high, if not higher, as when we were students.

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