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Reflections on learning and enhancing communication skills through community engagement: a student perspective

Abstract

Students in Peninsula School of Dentistry (PSD), Plymouth, undertake Community Engagement Projects during the first two years of their undergraduate curriculum. These projects involve interaction with a variety of specific community groups and the planning and delivery of an appropriate and meaningful oral health intervention. Many of the project outcomes are based on enhancing communication skills and encouraging students to transfer these into their patient treatment sessions. This report draws on the experience of students who undertook two specific projects to demonstrate how they feel this is achieved.

Introduction

Derived from the Latin "to share", communication can be defined as "the exchanging or imparting of information by speaking, writing or using some other medium". [1] Communication is a vast and complex field, which can be broadly divided into two categories: verbal and non-verbal.[2]

Verbal communication involves the use of language transmitted through both writing and speech. Non-verbal communication refers to wordless communication including tone and pitch of the voice and body language. It is accepted that non-verbal communication plays an important role in communicating emotion and forming relationships.[3]

According to studies by Professor Albert Mehrabian, when expressing emotion or feelings, non-verbal communication accounts for 93% of the total interaction with body language accounting for 55%. This is in stark contrast to the 7% for spoken words. Further studies have indicated the importance of these non-verbal, interpersonal communication skills when related to patient care and health outcomes.[3, 4] In the dental surgery environment where almost half of adult patients claim to suffer from moderate to extreme anxiety, [5] both types of communication are central to the development of rapport and trust between healthcare professionals and their patients. This rapport and trust has been reported to improve clinical outcome and patient experience of each dentist-patient interaction.[2]

Effective communication with patients is considered to be a fundamental skill and basic requirement for a competent dentist.[6] The Association for Dental Education in Europe (ADEE) states:

"On graduation, a dentist must be competent to communicate effectively, interactively and reflectively with patients, their families, relatives and carers and with other health professionals involved in their care, irrespective of age, social and cultural background".[7]

Demonstrating the ability to listen and empathise with patients has been reported to increase compliance and satisfaction with dental treatment;[8] and communication is clearly highlighted in the UK General Dental Council (GDC) Standards for the Dental Team, in which it is identified as one of nine 'core principles'.[9]

According to the GDC, there has been a sharp rise (110%) in the number of complaints against dentists and dental professionals from 2011 to 2014.[10] It has been suggested that many patient complaints are a result of the failure of the dentist to meet the high expectations of the patient. This

can often be due to a breakdown in communication, as explained in professional guidance documents such as the following:

“Clear communication between dental professionals and patients, and between members of the dental team, can often help to avoid complaints or resolve them at an early stage”. [11]

Communication is undoubtedly a skill that is of utmost importance and relevance to dental education. Nonetheless, there are a number of issues that have been raised; it is unclear whether some communication skills can be taught, or whether these are attributes students bring with them into education and there are significant challenges around teaching such a practical subject in the classroom.[12]

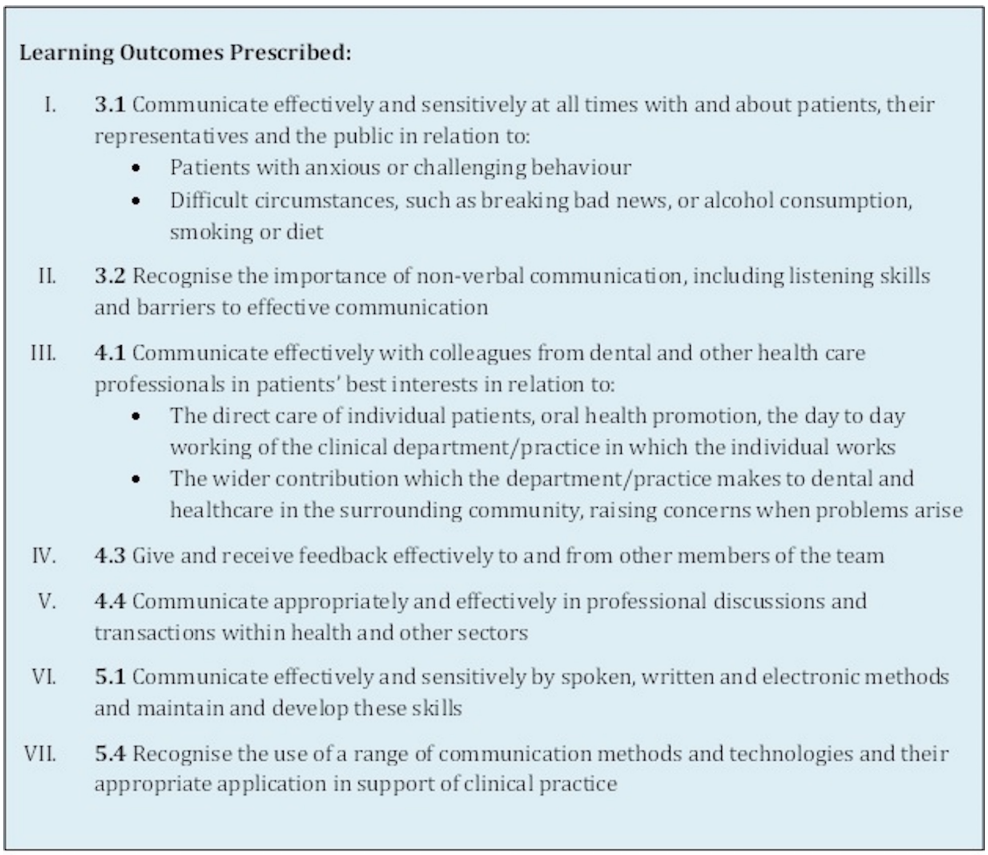
The Challenge of Communication from a Student Perspective

In the early years of undergraduate dental education, students may face challenges with communication due to a lack of confidence and previous life experience. This can be evident as the first patient is nervously collected from the waiting room, when many students have never before been expected to speak to another person in such a professional manner.

Communicating with individuals from a diverse range of cultural and socioeconomic backgrounds presents a further barrier to those who are less experienced. Student ‘friends’ who socialise together in the evenings and weekends become professional colleagues within the clinical environment: a difficult transition for many. In an attempt to support these challenges, the GDC published new outcomes for dental education in its “Preparing for Practice: dental team learning outcomes for registration 2012 (2015 revised edition)”. To be deemed suitable for registration and worthy of gaining their BDS, all UK dental graduates must have been assessed as successful against each of these outcomes, many of which relate to communication.[13]

The main outcomes relevant in this report specifically related to communication are outlined in figure 1**.**

In dental schools, communication skills have not always been explicitly ‘taught’ and where they have been addressed it has been via the use of lectures, workshops, case studies and seminars.[6] During the last decade, there has been a departure from these traditional teaching methods to a more adult learning-based approach that includes work-based, experiential learning opportunities and outreach clinics where students work within unfamiliar community populations and learn from reflecting on these experiences.[14] Outreach training is becoming an integral part of both UK and US dental school curricula. Community-based attachments allow students to increase their awareness and understanding of oral health promotion and social care for priority groups in the wider community, in addition to enhancing communication and interpersonal skills.[15]



Learning Outcomes Prescribed:

I. **3.1** Communicate effectively and sensitively at all times with and about patients, their representatives and the public in relation to:
- Patients with anxious or challenging behaviour
- Difficult circumstances, such as breaking bad news, or alcohol consumption, smoking or diet

II. **3.2** Recognise the importance of non-verbal communication, including listening skills and barriers to effective communication

III. **4.1** Communicate effectively with colleagues from dental and other health care professionals in patients' best interests in relation to:
- The direct care of individual patients, oral health promotion, the day to day working of the clinical department/practice in which the individual works
- The wider contribution which the department/practice makes to dental and healthcare in the surrounding community, raising concerns when problems arise

IV. **4.3** Give and receive feedback effectively to and from other members of the team

V. **4.4** Communicate appropriately and effectively in professional discussions and transactions within health and other sectors

VI. **5.1** Communicate effectively and sensitively by spoken, written and electronic methods and maintain and develop these skills

VII. **5.4** Recognise the use of a range of communication methods and technologies and their appropriate application in support of clinical practice

Figure 1: communication outcomes related to CEPs

Student feedback from these projects has suggested that communication skills with patients from less familiar communities improves, [16] and that they adopt a more holistic approach in providing dental care for all their patients.[17]

Peninsula School of Dentistry (PSD) was one of the first schools in the UK to teach and implement clinical care in a primary care setting, [18] so overcoming the need for clinical outreach placements.[19] Patients are not initially seen in secondary care by a consultant via a referral system, but instead the student provides the overall holistic care for the patient from first examination to completion of treatment, incorporating all specialities.[20] Students have the opportunity of communicating chairside with patients from multiple and diverse community groups (as in day-to-day practice) supporting them to benefit from the 'situated learning' experience and modelled by their clinical supervisors. [20]

Embedded into the curriculum at PSD are Community Engagement Projects (CEPs) which encompass a unique community-based model of teaching and learning that maps many of the Preparing for Practice learning outcomes.[21]

CEPs allow students to move beyond the walls of the dental school into an external group of individuals belonging to one of an assorted variety of populations in the local community. Developing communication skills is one of the primary learning outcomes of the CEP. This is thought to be achieved in a variety of ways including increasing the cultural and social awareness of the students through interpretation of the oral health needs of those specific local populations; developing a broader understanding of 'health'; reflecting on the actual experience of developing and delivering their oral health intervention.[16]

Aim

The aims of this article are:

1. To reflect from a student's perspective on the relevance of the Community Engagement Projects (CEPs) as an effective learning tool for enhancing communication.
2. To demonstrate how the use of CEPs relate to the assigned GDC learning outcomes in relation to communication.

The Projects in Action

As part of the spiralling curriculum, [22] the CEPs develop from year one to year two. In their first year, students visit a local community organisation to develop an insight into the health and wellbeing of their group through interviewing and interacting with members. In the second year, they work in conjunction with a specific population to investigate, define and respond to their particular needs. Population groups include adults with learning disabilities, sufferers of Sjögren's syndrome, the elderly, the homeless, oral cancer sufferers, refugees and patients with heart disease, among others. Working collaboratively in small groups of 8 or 9 with a designated tutor as mentor and guide, students design, develop and deliver targeted evidenced based oral health support strategies following the principles described in figure 2. The populations that the authors of this report were allocated could not have been more diverse; a support group for people who suffer with Sjögren's syndrome and a group of adults with a range of learning difficulties. The principles of developing the project remain the same.

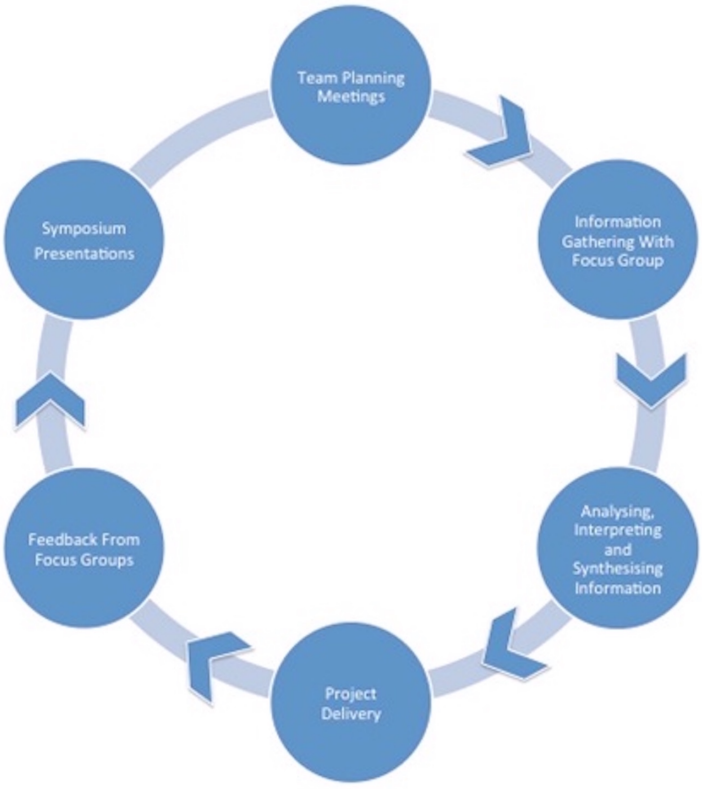


Figure 2: the process followed for all CEPs

Students are expected to prepare and conduct a background scoping review of the literature relating to the challenges faced by their groups before meeting them, and relate this information to the personal experiences of their group members. This in itself can be very challenging for the students as they discover that real life does not always neatly fit with the textbooks. Students may find for the first time that many people have a negative opinion of healthcare and 'evidence', in particular dentistry, for any number of personal reasons applicable to their individual circumstances. For example, every individual in the Sjögren's support group had faced challenges in finding support to understand and manage their condition. None had been given any advice from a dentist, and all felt they had been unwell for a minimum of 8 months before eventually receiving a diagnosis from their GP. Overcoming such negative and, on occasion hostile, feelings can be very uncomfortable for students and reflection on how to deal with this provides an excellent learning opportunity as described later in this report.

Due to the targeted nature of the projects, the oral health interventions vary greatly. Having initially established the needs of the population and synthesised that information to design and deliver relevant oral health advice in an appropriate format, patient outcomes and benefits are also highly specific. Consequently, the adults with learning disabilities had acclimatisation visits to the school's Dental Education Facility to help tackle reported anxiety associated with going to the dentist. The group suffering with Sjögren's syndrome received a wallet-sized concertina 'Top Tips' card containing easy-access advice on managing specific aspects of having a dry mouth (figure 3). As patient outcomes are specific to each project, students collect feedback from their community group after completion of the project both immediately and at a later date. Member feedback relates to satisfaction with the process and on whether the expected outcomes had been achieved. This feedback forms the basis of the project's success from the patients' perspective.

Figure 3: Top Tips card for sufferer's of Sjogren's Syndrome

Students are encouraged to reflect on their experiences of all aspects of the CEP using a familiar tool (e.g. Gibb's reflective cycle) [23] individually and as a group. This process is guided and supported by the clinical tutor, and is conducted prior to the assessments.

The assessment consists of each student group jointly presenting a description and results of their projects, as well as reflections on their experience, at a symposium. A group academic poster is displayed and a short verbal presentation delivered to peers and a panel of official assessors.

Students are formatively assessed on their communication and presentation skills, alongside team working and leadership skills, professionalism, ethical understanding and inclusivity, self-reflection and evaluation.

Further summative assessment requires students to submit an individual 1,500-word report detailing the project from a more personal perspective.

In addition to enhancing communication skills, this unique teaching method provides students with an important insight into the oral health challenges faced by many communities that is difficult to authentically teach in the classroom. This enables them to further appreciate the wider responsibilities of being a 21st century dental professional.

Student reflection

Each stage of the overall project, from team meetings to project delivery and presentation, provides a multitude of opportunities to address one or more of the assigned learning outcomes detailed earlier in figure 1 (I – VII). These are depicted in figure 4.

Figure 4: barriers and enablers to communication encountered within different stages of the projects

There are also numerous barriers to communication evident throughout the process, both within the student teams and between students and the members of the community groups.

These include:

- Lack of skills and experience
- Prejudice and ignorance
- Lack of interest and motivation
- Time and resources
- Differing and often opposing agendas
- Decision making where multiple viewpoints are apparent
- Unrealistic expectations

Many of the adults with learning disabilities reported that they were very anxious at the prospect of visiting the dentist. Students reflected that through taking the time to use active listening techniques and targeted questions, they were able to learn which aspects particularly worried and concerned the members (figure 1: I, II).

After trust had been established, ideas were jointly brainstormed with group members and carers about how to manage some of this anxiety, and it was agreed that an acclimatisation visit to the Dental Education Facility was a positive starting point (figure 1: I, II, III, V, VI). This visit incorporated a step-by-step introduction to a dental surgery and included all members of the dental team. It was delivered in a friendly manner, combining positive body language and reassuring tone of voice to allow the clients to feel more at ease in the dental setting (figure 1: I-VII). Feedback confirmed that the majority of clients felt more comfortable in the dental environment after this, and subsequently signed up to the dental school patient waiting list where they are now regularly seen for their ongoing dental care (figure 1: IV).

In the Sjögren's support group, students perceived members to initially be hostile towards them as previously described and therefore reticent in providing information. Facing this hostility, learning how to manage the situation by listening without judgement and without becoming defensive was one of the biggest learning curves noted in this particular group (figure 1: I, II, V, VI). The students achieved this successfully and at the end of the first meeting one participant wrote: *"This is so encouraging to know that young dentists are being made aware of Sjögren's and its consequences. Anything that can help other people to not have to go through what I have had to."*

At a later meeting it became apparent through non-verbal cues such as deep sighing and changes in eye contact; eye rolling when a student spoke; and some derisive snorting, that the expectations of one member of the group were still not being met. While feeling uncomfortable and challenged, students realised that it was important that they were aware of their responding body language and tone of voice to again ensure that frustration or distress were not displayed. This enabled expectations to be discussed and personal agendas identified without confrontation. Through negotiation and a clear explanation of the limitations of the scope and outcomes of the project, the issues were overcome. Later reflection demonstrated that valuable lessons had been learned regarding awareness of our (often unconscious) body language in response to perceived attack, along with negotiation skills to enable clear expectations to be set. Once consciously realised, these essential skills can be taken into students' future work (figure 1: II, IV, VI, VII).

Overall, participants felt they had been listened to and one specifically noted that the meeting was *"very welcoming and positive in every way, and receptive to all our comments"*.

Negotiation skills also became essential within the student groups, as all the different opinions and ideas from the student peers are shaped and moulded into a short information gathering exercise, then defined and developed into a meaningful project. Students often find this one of the biggest challenges as they develop skills to sell their ideas, explain and justify their thoughts, listen and analyse others' arguments and often accept compromise on final outcomes in the group and project's best interests. Where conflict becomes apparent, the tutor can intervene and support the resolution, and students reflect that conflict resolution skills are vital to take forward into their effective communication with colleagues as well as patients in future. (figure 1: II, III, IV, V, VI, VI).

Students acknowledge that they learn from one another, understand how to use each person for their particular skill, and appreciate varying approaches. Examples of successful behaviours can be modelled in numerous and various ways (interpersonal skills, literature reviewing, creating presentations, negotiating, presenting etc). Community participants often comment on the positive impact of these successful team dynamics on the final project delivery (figure 1: V, VI, VII).

"I thought it was very well organised. A great deal of thought had been given to the questions."

"The final product was just brilliant … I have used it with my whole family … It would be great if all Sjögren's sufferers could be given one as soon as they are diagnosed."

Students determined that the communication skills acquired throughout the CEP process equip them to break through real, and assumed, barriers with patients in order to adopt a more holistic approach when caring for individuals in a rapidly evolving health environment. They have also linked this learning explicitly to the GDC learning outcomes described.

Feedback from the community group members reported that they enjoy the experience of the CEP, and that the projects inspire confidence and build self-esteem in the participants along with achieving the specified oral health outcomes.

Conclusion

The aims of this article were to reflect on the relevance of the CEPs to improving communication skills, and how the experience of the CEP relates to the identified learning outcomes. Through highlighting different aspects of the projects, it has been demonstrated how these relate to the learning outcomes on a practical level, and given specific examples. Students feel that their communication improved through enhanced listening skills, giving and receiving feedback and an explicit awareness of non-verbal communication; especially an appreciation of the value of picking up on body language cues in order to gain rapport and trust with patients. These are fundamental skills that will no doubt benefit them in their future careers.

The challenges students initially faced in terms of lack of confidence and experience were overcome in part by involvement in the CEPs. In particular, the exposure to a range of individuals in society from a diverse range of groups with differing cultural and socioeconomic backgrounds is a key factor that helped improve those communication skills. As the challenges of teaching communication skills in the classroom have been identified, the CEPs have provided an amplified understanding of communication outside the comfort zone of dental school and into the community.

CEPs demonstrate a positive impact in responding to local needs, providing a long lasting benefit for improving oral health in the Plymouth community, as well as enhancing the communication skills of the students.

During the live experience of conducting the CEPs, students may not appreciate how much their communication skills were being developed at the time of the projects. The relevance in developing communication and interpersonal skills is, however, clearly identified through the reflection, presentation and discussion of the experience.

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