

The use of communication techniques in the hospital environment : Practical study within the endodontic conservative dentistry department Annaba University Hospital

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Abstract:

The conversation between the doctor and the patient is the foundation of good care. Patients want to be heard when it comes to diagnosing and, where appropriate, addressing their complaints. This observation is certainly not new, but it is still current. In the early 1970s, for the first time, experts analysed interviews between doctors and patients and observed that communication was poor and largely inadequate.

The objective of this study is to discover the current location of communication techniques in health facilities (conservative endodontic dentistry department Clinique Elysa Chu Annaba). It also aims to help doctors analyze and improve interviews with their patients.

Keywords: Medical communication, Communication techniques, public health,

I- Introduction:

Several organizations, associations or institutions criticize the performance of doctors from the point of view of communication and call for the establishment of training programs allowing a real acquisition of the required skills. In addition, research on physician-patient communication has made great strides in recent decades. Thus, the communicative and relational elements necessary for the conduct of an effective medical interview are better known and are a consensus among experts in the field. On the other hand, although some people may have a “natural” ability to communicate, it is now known that the skills required for effective professional communication are not innate and must be learned. However, every day, doctors must communicate with patients and their families as well as with several other stakeholders (colleagues, professionals from different disciplines, managers, etc.). These different facets of communication are often overlooked during medical training. Like many others, we believe that physicians' acquisition of a communication skill is not only a “pleasant enrichment” of their practice but that it is an essential component of overall clinical competence. Finally, it is important not to confuse the teaching of doctor-patient communication with that of medical psychology or psychiatry. The latter are sometimes perceived as indirectly ensuring excellence

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in communication. However, these areas are different and require distinct learning activities and assessment modalities.

The purpose of this study is to diagnose the types of communication techniques that exist in health structures (Conservative Endodontics Department) is to contribute (if necessary) to communication training and medical interviewing that have a real impact on the quality of doctors' communication skills and on the outcome of medical care.

Doctors frequently interrupted patients' stories after less than a minute, sometimes missing important information about their condition. Some patients did not understand the information provided by their doctor and when they left the office, they did not know what their doctor had just explained to them, nor what they had to do.

Conversely, when the doctor and the patient maintain a relationship of trust, a decrease in the number of complications is often observed in the patient. The physician is better able to assess the patient's progress or identify the appropriate time to discontinue drug therapy. This particularly concerns the chronically ill, whose number is constantly increasing. The patient is then more satisfied and remains faithful to his doctor.

Based on the above, we will ask the following question: What are the communication methods used by the OC Endodontics service practitioner in the follow-up of the patient?

This main question is structured in several questions:

- What kind of patients (chronic disease) are treated by the OC Endodontics department?
- Is there a communication protocol used in specific situations during this care?
- Is there a section on physician-patient communication in the medical staff briefing?
- Is there some agreement with communication experts (UBMA Communication Department or others..) to train medical staff?

II- **Objective of the study :**

This study has several objectives :

- Valuing communication as an essential factor for medical practice
- Diagnose the types of communication techniques that exist in health facilities (OC Endodontics Annaba service).
- Promote communication techniques and its place in medical dialogue.

III- **Reasons for choosing the subject :**

Communication is a science that lies at the crossroads of sciences, including medical sciences. In this context, researchers want to prove that communication is appropriate in the doctor-patient relationship. This can contribute to better management of patient care and better explanation of the medical protocol by doctors.

IV- **Data Collection Tools :**

Data collection in the humanities uses qualitative and quantitative methods: interviews (directive/semi-directive), questionnaires, observations (participant/systematic), focus groups, and literature review.

The Main Collection Tools used in this study:

- Literature review: Review of existing documents (archives, reports) at the OC Endodontics department

- Observation : Systematic (coding grid) or participant (immersion), it records behaviors in real context.
- Interviews : Individual or collective (focus groups), they provide in-depth qualitative data (verbatim).

V- **BASIS OF COMMUNICATION**³:

Communication is We constantly communicate with each other and therefore feel that we have sufficient knowledge in this area. Nevertheless, the gap between everyday experience and knowledge is particularly important when it comes to communication. There are three different forms of communication: – Face-to-face communication, verbal or non-verbal, between interlocutors in co-presence: it can be interpreted in different ways and allows immediate responses. – Written communication and communication mediated by computer or telephone without co-presence of the protagonists: it transcends temporal and territorial limits (mail, telephone, emails, facebook, etc.). An answer is possible, but much of the non-verbal information is lost. – Media and public communication (radio, television): in principle, it offers no possibility of response and is addressed to an anonymous public.

The interview between the doctor and his patient typically involves face-to-face communication, such as daily discussions, practical exchanges of ideas or conflicting exchanges between two people, but also exchanges in the workplace, discussions or disagreements within a group or question-and-answer sequences. Face-to-face communication depends on the following conditions and influencing factors: – personal conditions such as temperament, interest, motivation, competence in communication situations, physical communication skills, fears and attitudes, states of mind, etc.; – the particularities of the situation such as the quality of the relationship, the common basis between the interlocutors, the very purpose of the communication and its purpose, but also the conditions related to the setting and the presence of third parties; – the conditions related to the context such as stimulation or support by the entourage or the values and norms of the society.

1- **Theory and models**:

There are different common theories describing, on the one hand, how communication situations between humans unfold and, on the other hand, how individuals get involved with each other. These theories can be distinguished into two categories: on the one hand, theories that consider communication as a process of exchange between A and B and, on the other hand, those that consider communication as a process that engages the different protagonists in a common movement where individual participation is difficult to identify.

The communication under the first category is comparable to a tennis match: the interaction partners stand like tennis players on either side of the net and exchange balls that consist of verbal expressions and nonverbal messages. The communication in the second category rather refers to the atmosphere surrounding this interaction, without it being able to be attributed to a particular person – it would correspond to what one can feel as a spectator at Wimbledon when one approaches the centre court without knowing exactly who is playing against whom.

Friedemann Schulz von Thun's theory of communication falls into the first category. He is the author of the quote: "We constantly speak four languages and always listen with four ears." Each piece of information thus includes four possible levels of meaning and understanding: self-revelation (what I express about myself), relational level (what I think of you and how we relate to each other), calling (what I expect from you) and content⁴.

³- Learning communication by doctors: conceptual and methodological aspects of a priority academic mission; Bernard M; Marie-Thérèse L; Johanne G; MEDICAL PEDAGOGY - May 2004 - Volume 5 - Number 2; page 110-113.

⁴|||UNTRANSLATED_CONTENT_START||| - Schulz von Thun F.: Miteinander reden 1 – Störungen und Klärungen. |||UNTRANSLATED_CONTENT_END||| (essays) Reinbek bei Hamburg: Rowohlt, 2005.

Typical communication problems arise from the fact that the recipient of the message has the freedom to hear the message in the ear of his choice, without this necessarily corresponding to the intention of the sender of the message. Misunderstandings could be avoided if the content of the message, but also the underlying intent were clear. The Austrian communication specialist, Paul Watzlawick, says that in any form of communication, the material and relational aspects are intertwined. The communication includes not only information, but also an indication of how the sender wishes his message to be understood, on the one hand, and how he perceives his relationship with the recipient, on the other, i.e. the communication includes interpretation. This postulate is one of its five axioms regarding communication⁵:

- We can not communicate
- All communication has two aspects: content and relationship.
- Communication is always both cause and effect.
- Human communication uses two modes of communication: digital and analog.
- Communication is either symmetrical or complementary.

His last axiom is particularly important in health communication, as it highlights that communication is not always symmetrical (as is the case when power relations are balanced), but that it can also be complementary when there are significant differences between participants. Contextual factors determine the roles of the interaction partners; for example, when the patient undergoes a medical examination, his role as a sufferer limits his power and his behavior responds in a complementary way to the needs of the doctor; on the other hand, he can meet the doctor two hours later, in a balanced balance of power as a hospital controller.

Theories that focus not on immediate interaction, but on the climate between partners, are much less known. This "something", difficult to describe, is often defined by the notion of relationship: it is the climate of trust that can be established between individuals. A typical example of such phenomena is the feeling of being sufficiently informed, an impression that usually emerges after a while during an informative interview between the doctor and the patient. What is the basis of this feeling that leads the patient to say, "Thank you, I think I know what this is about now. I agree with the intervention, I trust you." Such statements are not based on any statistical evidence, in the sense that the patient does not know what percentage of the doctor's knowledge is passed on to him; they are based only on the feeling that "it is enough now". There is a similar phenomenon of agreement, without precise justification, at the temporal level: during a visit to a patient or an interview, there comes a time when the feeling emerges that it is time to leave.

2- Communications objectives

In the 1990s, scientists Bird and Cohen-Cole proposed a model to describe the goals of physician-patient communication. The model has three objectives:

1. Gather information.
2. to inform the patient.
3. Considering feelings.

Other models prefer to focus on higher levels. Their objectives are adapted accordingly (e.g. the model of Lazarus, Putnam, & Lipkin, 1995):

- Develop, nurture and enter into a relationship;
- Identify the nature of the problem and monitor its evolution;

⁵- Watzlawick P., Beavin J., Jackson D.: Menschliche Kommunikation. Formen, Störungen, Paradoxien. Huber-Verlag, Bern 2000.

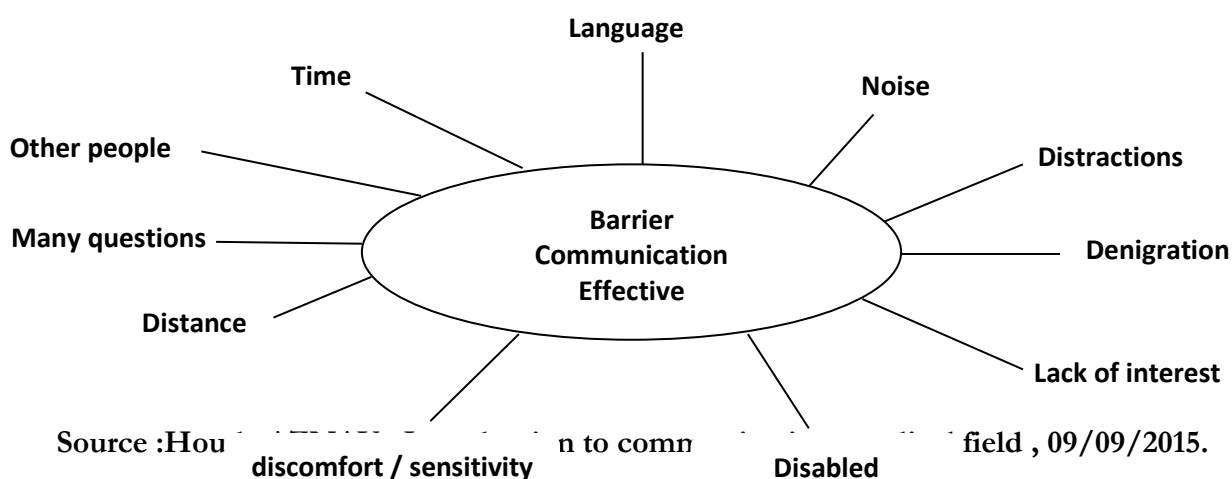
- Communicate information to the patient and establish a treatment plan⁶.

Comparing these two models shows that the objectives are set at quite different levels. The first objective, "gathering information", can be verified by observing the behavior of the doctor, who is able to perform a more or less complete anamnesis. The third objective of the Bird and Cohen-Cole model can also be verified by observing the physician's behavior, provided that the patient expresses his or her feelings directly or indirectly. In the model of Lazarus et al. the meaning of the relationship between the doctor and the patient is highlighted. This relationship could theoretically be described based on the perspective of both partners in the interaction; this model does not define criteria to be met for an interview between the doctor and his patient to be considered successful⁷.

However, looking more closely, objectives that, at first glance, seem simple – such as the transmission of information – turn out to be complex tasks: when information is transmitted in order to inform the patient, the loop must be closed at the end of the interview: the doctor checks what the patient has understood. The same principle is applicable to the information transmission phase: the transmission of information is successful when it is understood as a recursive process (transmission, waiting for the reaction, transmission, waiting for the reaction). This brief discussion shows how difficult it is to define general objectives for physician-patient communication, because – after a detailed analysis – these often turn out to be complex tasks that are far from suitable for all consultations.

3- Communication obstacle :

Barrier to effective communication



4- Mainten

3-1- Definition of the time frame and themes:

It is important to define the time frame at the beginning of the consultation, especially when patients are not yet familiar with the functioning of a doctor's office or an outpatient care service. If the doctor has a fixed schedule, he should let the patient know at the beginning of the consultation and clarify with him the issues to be discussed during the consultation. A consultation that starts this way offers the possibility of joint decision making⁸.

Throughout the discussion, the interview is centred successively on the patient and the doctor, which ideally leads to specifying the medical hypotheses: when the patient-centred discussion phase has

⁶- de Haes H., Bensing J.: Endpoints in medical communication research, proposing a framework of functions and outcomes. Patient Educ Couns. 2009; 74: 287–94.

⁷- Bird J., Cohen-Cole S.A.: The three-function model of the medical interview. An educational device. Adv Psychosom Med. 1990; 20: 65–88.

⁸- Armstrong K. et al.: Using survival curve comparisons to inform patient decision making can a practice exercise improve understanding? J Gen Intern Med. 2001; 16: 482–5.

made it possible to collect enough information to be able to formulate hypotheses, these are verified in a doctor-centred phase, which potentially leads to the formulation of other hypotheses which are then taken up by the patient in a patient-centred, but more targeted, discussion phase. During this exchange, the patient moves from one style of speech to another, from a free narrative style to a brief and concise report ("factual" style). These episodes should be communicated to the patient through changes in themes and styles so that they are able to adapt their communication behavior⁹.

3-2- **ARRR communication techniques**

The acronym ARRR (Wait (Attendre) – Repeat – Reformulate – Summarize(Résumer)) designates four typical techniques of patient-centered communication; the first three techniques – Wait, Repeat and Reformulate – open the discussion or keep it open. The Summary serves as quality control, on the one hand, and helps to structure the conduct of the interview, on the other hand. The main difficulty related to the waiting phase is to assess how long a break can last without the silence becoming burdensome. As a rule, breaks that last up to three seconds are not felt to be disturbing. For the pause or wait to be interpreted as an invitation, the doctor's attention must be directed to the patient; this attention is mainly manifested by eye contact¹⁰.

But the pause fulfills still other rhetorical functions that also have their importance in the communication between the doctor and the patient. The first function of waiting is the invitation: it offers the patient the opportunity to take the time to think about what he wants to add or how he could express his concerns. This function also applies to the doctor when he pauses after the patient has made unexpected or particularly striking remarks and he must assimilate what he has heard. If the doctor shares his impressions, he should be careful not to give too much space to his own consternation so that the patient can continue his story. The following two functions are taken from the rhetorical toolbox: pauses make it possible to underline certain words, by highlighting words expressed previously or later. The absence of such pauses is particularly striking when the doctor wants to show empathy with a sentence like, "I can easily understand how much it disturbs you." When after such a remark, the following theme is addressed without pause ("I would still like to know how you support the new pills"), its empathetic scope is reduced.

In the repetition phase, the words expressed by the patient are simply repeated; this phase only occurs when the flow of words is hesitant and must be restarted:

Patient: "Well, then my husband thought I might ask you if it could come from the heart."

The patient: she looks at the doctor and is silent. [Obviously, she's waiting for the doctor to react]

The doctor: "From the heart?"

Patient: "Yes, his heart problems started in a very similar way.

He too still had that cold feeling in his lower jaw and pressure in his chest and then he had a heart attack."

In the reformulation phase, the doctor repeats what he has heard or understood from the patient. This concretely implies that the doctor only reformulates the content of the patient's speech.

Doctor: "And now you're worried that this could be something serious...?" [Reflect emotion; name emotion]

Patient: "Yes, and moreover, when my mother was about my age, in her mid-fifties, she suffered a sudden and unexpected heart attack during her holidays in Mallorca; they then returned very quickly and the doctors told her that she had been very lucky."

⁹- Doak C.C., Doak L.G., Friedell G.H., Meade C.D.: Improving Comprehension for Cancer Patients with Low Literacy Skills: Strategies for Clinicians. CA Cancer J Clin. 1998; 48: 151-62.

¹⁰- Cohn E., Larson E.: Improving participant understanding in the informed consent process. J Nurs Scholarsh. 2007; 39: 273-80.

The doctor: "Now I can understand your concern." [Show that the emotional dimension is understood].

This is one of the techniques to "open the space", as it is used to allow the patient to express herself more easily. It is not a final evaluation. However, this difference is not always easily identifiable in the transcription of interviews. It results above all from the modulation of the voice: the intonation descends at the end of a declarative sentence and tends to rise (interrogative tone) during a reformulation in lieu of an invitation.

The function of the summary is not to open the space for dialogue, but to allow the doctor to check whether he has understood the patient's words correctly. The summary consists of "closing the loop", but in the opposite direction: the patient provides information and the doctor "closes the loop" by communicating on his own initiative to the patient what he has retained. In addition, the summary offers the physician the opportunity to decide which aspects he wishes to report in detail or in summary form. For example, the doctor might want to summarize at a high level of abstraction the difficult professional situation described in detail by his patient as follows: "... and obviously, you are currently under extreme pressure in your profession..."¹¹.

3-3- **Technical SAED (Situation, antécédents, évaluation, demande):**

Situation, background, assessment, application: A tool to facilitate communication between healthcare professionals.

Communication breakdowns are one of the main root causes of adverse events in healthcare settings¹².

3-3-1- **Communication difficulties :**

- **Professionals**
 - Interindividual variations: human factors, Interprofessional; interspecialty; entry-level to senior
- What are the impacts?
 - Impaired transmission of essential information : Quality and safety of care
 - Misunderstanding or dissatisfaction .Professionals: quality of work life

3-3-2- **The "Saed" tool¹³ :**

- Origin : Used in healthcare since 2002
- Recommended by : WHO, JCAHO, IHI, NHS, Ministry of Health (PNSP, HAS guide)
- A standard of care : United States, Canada, United Kingdom, Australia, etc.
- Deployed in various specialties : Obstetrics, cardiology, perinatology, emergency medicine, intensive care, outpatient care, rehabilitation, home hospitalization, general practice, etc.

3-3-3- **SAED What is it?**

A mnemonic tool for structuring/standardizing communication with another professional.

For use in private practice or healthcare facilities.

What is its main objective?

¹¹- Edwards A.G. et al: Personalized risk communication for informed decision making about taking screening tests. Cochrane library 2008.

¹² - Joint Commission. Sentinel Event Data Root Causes by Event Type. 2004-2012.

¹³ - <https://www.has-sante.fr> accessed on 25-02-2026 at 20:22 PM

To prevent adverse events that can result from misunderstandings during communication between professionals. To overcome obstacles to implementing clear and concise documented communication.

3-3-4- **When to use the Saed tool¹⁴?**

- Verbal requests for advice (by phone or otherwise)
- Urgent communications
- Patient transfer
- Multidisciplinary or interprofessional staff
- Morbidity and mortality reviews (MMRs)
- At all stages of the patient's care pathway
- Communication between nurses and physicians, physicians and physicians, midwives and gynecologists, physiotherapists and nurses, pharmacists and physicians, etc.
- Written exchanges.

3-3-5- **Saed: How effective is it?**

- Improvement
 - Quality of communication between professionals
 - Content and clarity of information provided
 - Analysis of information received
 - Professional satisfaction
 - Communication of new professionals
 - Occurrence of adverse events
- Documented progress
 - When the Saed tool is used in conjunction with a multifaceted teamwork model (safety culture, communication).



I am describing the patient's current situation:

I am: first name, last name, position, department/unit

I am calling about: Mr./Ms., patient's first name, last name, age/date of birth, department/unit

Because he/she is currently presenting with: reason for the call

His/her vital signs/clinical signs are: heart rate, respiratory rate, blood pressure, temperature, pain assessment (VAS), etc.



I am providing relevant background information related to the current situation:

The patient was admitted: date and reason for admission

Their medical history includes: ... Their allergies include: ...

During their stay, they underwent: surgeries, investigations, etc.

Current treatments include: ... Their test results include: lab results, X-rays, etc.

The patient's usual condition is: confused, in pain, etc.

The current condition has changed in the last: minutes, hours, days

¹⁴ - <https://www.has-sante.fr> accessed on 10-03-2026 at 09 :15 AM

E

**I am giving my assessment of the patient's current condition:
I think the problem is: ...
I have: administered oxygen, started an IV, etc.
I am not sure what is causing this problem, but the patient's condition is worsening.
I don't know what is happening, but I am genuinely worried.**

D

**I formulate my request (for advice, a decision, etc.):
I would like you to: ...
for example:
I would like you to come and see the patient: when?
AND
Can you tell me what I need to do: what and when?**

Source : <https://www.has-sante.fr>

3-4- Emotion management – the NURSE model¹⁵:

This acronym conceals five techniques that can be useful to manage a patient's emotions:

Naming: naming emotions

U nanding: whenever possible, express understanding for these emotions

Respecting: expressing respect or recognition for the patient

Supporting: providing support to the patient.

Exploring: investigating other aspects specific to emotions.

Putting a name on the emotion (Naming) consists of reformulating: the feeling experienced by the patient is named as it is perceived. This step is only relevant when the patient has not already expressed their feelings themselves. For example, if the patient says, “I am terribly afraid of having something serious,” it seems unnecessary for the doctor to repeat his words.

Once the emotion has been expressed, it is up to the doctor to assess whether he has understood it correctly. If this is the case, Understanding is a very beneficial intervention where the doctor prototypically shows all his esteem for the patient and his experience¹⁶.

¹⁵. Communication in everyday medicine; A practical guide; Grempfer AG, Basel; 2022 Swiss Academy of Medical Sciences; page:22-28.

¹⁶. Schillinger D. et al.: Closing the Loop – Physician Communication With Diabetic Patients Who Have Low Health Literacy. Arch Intern Med. 2003; 163: 83–90.

Especially in cases where patients report difficult life situations, it is always possible to value the efforts they make to get out of it. The following typical interaction shows how the physician demonstrates respect for the patient (Respecting):

The patient lost her husband six months ago, she is sad and cries when she mentions this loss. She then says that she started a language course at the popular university, because she plans to stay in Andalusia with her friend in a few months. She concludes with the following remark: The patient: “We will see if I can use the knowledge of Spanish acquired in this course.” The doctor: “This period is certainly very difficult for you. [Express emotion]. But I think it's great that you took the initiative to learn a new language.”

Supporting is not, strictly speaking, a communication technique, but refers to the natural disposition to help a person in distress and this support offer takes on a professional character when it is mentioned without being directly implemented.

The last technique is the investigation of feelings: Exploring. This investigation is particularly advisable when the doctor does not know the emotional state of his patient. He perceives that there is something, but does not have enough information or does not perceive his emotional state precisely enough to name the emotions of it (Naming: reformulation).

VI- Data sheet on the Department of Dentistry Conservator Clinical Endodontics Elysa Chu Annaba:

The Department of Conservative Odontology (OC) and Endodontics in Annaba is mainly attached to the Annaba University Hospital and the Faculty of Medicine (Department of Dental Surgery in Zaafrania). He specializes in conservative care, including caries treatment, fillings and pulp care, with practitioners like Prof. Mentouri Assia who is also the head of this department.

The Department of Conservative Dentistry and Endodontics of the Elysa Clinic is a reference structure in Annaba, often associated with the research work of the Annaba Faculty of Medicine. He is dedicated to preserving natural teeth through advanced restoration techniques.

– Medical Acts & Treated Pathologies:

- **Conservative Dentistry:** Treatment of dental caries (restorative dentistry), care of pathologies of the hard tissues of the tooth and dental alignment.
- **Endodontics: Root** treatment, devitalization, management of periapical infections and dental pulp diseases.
- **Dental Imaging:** The department has means of diagnosis by radiology for endodontic assessments

VII- Study Result :

- The OCE service takes care of patients who are not homogeneous by age, gender or overall state of health (chronic and/or serious diseases) or even social situation. In addition, there are public organizations that deal with this service as a prison in the wilaya of Annaba.
- The OCE service faces daily conflicts regarding the number of people who require immediate care from practitioners within the service.
- During treatment or restoration, medical staff have difficulty communicating with patients to maintain oral hygiene.
- Weekly medical staff briefings do not even provide the necessary foundation for effective physician-patient communication.

- No medical communication module is included in the training curriculum within the Department of Dental Surgery during the six years of training, especially in post-graduation all specialties.
- Optimising the doctor-patient relationship by learning communication techniques is a priority for OCE staff.
- The OCE department relies on the Department of Dental Surgery for the teaching materials and resources necessary for training. On the other hand, there is no arrangement to use communication trainers (in the years 2010-2011-2012, a medical communication module was provided by the Department of Communication, Faculty of Humanities and Social Sciences, Badji Mokhtar Annaba University).

VIII- **Conclusion:**

The company is calling for doctors who are more human and communicate better with patients. Experienced clinicians and researchers in the fields of medical education and communication emphasize the central role of physician-patient communication in the clinical approach for the success of diagnostic and treatment strategies. Accreditation bodies in several countries require a major improvement in physicians' communication skills. The work of recent decades has made it possible to identify the key factors of effective communication and the elements promoting the learning of the required skills. The choice of learning means must take into account the outcome of educational research on effective strategies (solid repository, demonstration, practice and immediate feedback, specific assessment, self-knowledge activities, presence of role models, longitudinal curriculum). The medical school must take into account that the integration of communication as a complementary element is crucial for the education of future health professionals, in order to ensure optimal patient care and high-quality training.

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