ORIGINAL STUDY

Communication levels of pulmonologists with geriatric patients during the COVID-19 pandemic

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ABSTRACT

BACKGROUND. Patients were likely hesitant to communicate with physicians during the pandemic, when everyone saw others as potentially infectious. Every other was seen as the most likely to be infected as they were in close contact with infected persons. Likewise, physicians might have been wary of communicating with their patients, who might have been virus carriers. In our study, the communication between physicians (particularly pulmonologists) and geriatric patients was evaluated to develop recommendations for improvement if necessary.

MATERIAL AND METHODS. The study was conducted as an online evaluation questionnaire via e-mail or WhatsApp. The evaluation form, the Social Communication Skills Rating Scale, collected data regarding the respondents' demographic characteristics, whose reliability and validity have been proven in previous studies. The volunteer pulmonologists completed the questionnaire.

RESULTS. The research comprised 200 doctors; 111 (55.5%) were women and 89 (44.5%) were men. Of the doctors who participated in the study, over 40% were in their forties. Pulmonologists' communication skills with their geriatric patients were deemed adequate, and their interactions were evaluated as successful, despite the high risk of infection during the pandemic, the difficulty of examining patients while wearing protective clothing, and the typical communication difficulties of geriatric patients. This has been a crucial advantage for the senior patient group, as, throughout the COVID-19 pandemic, this group has communicated with pulmonologists predominantly owing to medical needs.

CONCLUSION. The pulmonologists' effective communication with their geriatric patients could have made them feel good during the difficult time of the past pandemic period. It could have also been a source of pride for physicians.

KEYWORDS: COVID-19, pulmonologists, communication, geriatrics.

INTRODUCTION

Patient-physician communication has always been an exciting research topic, but physicians' communication with their geriatric patients is even more interesting as it is more complex. In every country, sociocultural relations have changed over the years, and the generation gap has become an essential barrier to communication. As with all forms of interpersonal communication, patient-physician communication is a two-way street, with the patient and the physician communicating with the other. However, the coronavirus disease 2019 (COVID-19) pandemic has made this setup problematic. Everyone was potentially infectious, but physicians were seen as likely to be carriers because they held clinics in the hospital and were exposed to different patients. If physicians were indeed carriers, they were likely to infect their patients if they communicated with them. Conversely, a physician who spoke to an infected patient could also be infected by the latter[1-3].

Communication with geriatric patients carries peculiar problems (e.g., hearing loss, difficulty in movement, mood disorder due to comorbidities, fear of death) at any time, but communication difficulties may have increased during the pandemic both on the part of the

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physicians (e.g., the use of pieces of protective clothing such as surgical masks may affect their communication) and of the geriatric patients (e.g., their fear of getting sick and of dying may have increased, which may affect their communication).

Physicians' communication with their geriatric patients was chosen as the topic of this study because the geriatric group has been declared the riskiest group during the pandemic, and geriatric-patient management should thus be given special attention and care[4,5]. Pulmonologists are especially at risk among all physicians, as they are likely to be the ones in closest contact with COVID-19 patients because those infected with COVID-19 first present respiratory symptoms. Therefore, in this study, we aimed to evaluate pulmonologists' communication process with their geriatric patients, considering the exceptional circumstances of the pandemic, which could help geriatric patients combat COVID-19. The critical issue that needs to be resolved is how long the communication process should take and how it should proceed. We hope our findings will help improve communication between physicians and their geriatric patients.

MATERIAL AND METHODS

The ethics committee approval was obtained from Kırsehir Ahi Evran University's Clinical Research Ethics Committee (Decision No. 2021-02/13). The study and the questionnaire were explained to all the participants before they participated, and the participants read and signed the informed consent form before completing the questionnaire, indicating their willingness to participate.

Study Population

The study was conducted online in February 2021. The online evaluation questionnaire link was shared with the pulmonologist participants via e-mail or WhatsApp (Table 1). Besides the demographic questions, the Social Communication Skills Rating Scale (Adult Form – General Interaction Skills), whose reliability and validity have been confirmed in other studies, was used[6,7].

Volunteer pulmonologists actively working in hospitals' COVID-19 sections were included at the time of the study.

Statistical Analysis

IBM SPSS for Windows 21 was used to analyze the data. The Shapiro–Wilk test was used to determine the suitability of the variables for normal distribution. In determining the scale's reliability, Cronbach's alpha was calculated, and Tukey's test for non-additivity was performed to determine if the data obtained from the scale were collectible. In testing the independent samples, if there were two groups, the independent-samples t-test (Student's t-test, independent-samples t-test) was used, and in cases where there were more than two groups, a one-way analysis of variance was used. The Tukey test, one of the post hoc tests, was used to determine the different groups. A chi-square analysis was used to analyze the cross-tables created (Pearson's exact chi-square test). The Spearman correlation coefficient was calculated to determine the relationships between the variables. The mean ± standard deviation (SD), number and percentage were calculated for the descriptive statistics to summarize the data. Statistical significance was set at $p < 0.05$. The Tukey HSD ("honestly significant difference"; post hoc) test was used to determine which group averages were different. The reliability coefficient of the scale was found to be 0.85, and the scale was found to be quite reliable.

RESULTS

A total of 200 physicians were included in the study, 55.5% of whom were female (n=111) and 44.5% male (n=89). Most of the physicians who participated in the study (39.5%) were aged 41–50. They worked in different hospitals, but most of them worked in a state hospital (37%; n=74). Most of them also had 6–10 years of service (24%; n=48). When asked about the average number of patients they examined daily during the pandemic, 27.5% (n=55) of them said it was 55.

With regard to the answers given to the questions in the questionnaire specific to the pandemic period, 71.5% (n=143) affirmatively answered the question, "*Did the clothing, mask, and visor you were wearing during the COVID-19 pandemic negatively affect your communication with your patient?*"; 63% (n=126) affirmatively answered the question "*Did the special pieces of protective clothing you were wearing make you feel underestimated?*"; and 62% (n=124) affirmatively answered, "*Did you consistently wear the special clothing, mask, and visor and observed the necessary precautions to prevent being infected by or infecting your patients?*".

Concerning the answers given by the physicians to the questions in the Social Communication Skills Rating Scale, as shown in Table 2, the percentages of physicians who answered "Always" to these items are as follows: eye contact, 71.5% (n=143); speaking with the appropriate vocal volume, 71.5% (n=143); avoiding using inappropriate voice tones (boasting, whining, bossy, sarcastic), 62% (n=124); refraining from using inappropriate facial expressions (rough, sullen, prone appearance), 62.5% (n=125); using the standing or sitting posture as appropriate for the situation, 79% (n=158); maintaining an appropriate standing or sitting distance from the patient, 90.5% (n=181); using appropriate body language (pertaining to the 1st–7th skills), 81% (n=162); showing appropriate attitudes (saying "please", "thank you", "sorry", etc.), 78.5% (n=157); demonstrating appropriate body language while listening, as if saying "I am listening to you" and "I am thinking about what you are saying," 67% (n=134); sustaining the conversation on the topic or changing the topic smoothly, 24% (n=48); starting one's speech with a greeting, listening while waiting for one's turn to speak,

Table 1. Survey follow-up form.

Patient-physician communication is an interesting subject of research at all times. This communication has two aspects. The first issue is the patient's point of view in the communication of the patients with the physicians; the second is the perspective of the physician who communicates with the patient, who may be an infection carrier. Chest physicians are in close communication with patients during this period. For this reason, we planned to conduct a survey on pulmonologists who played an active role in the fight against Covid 19. Our study has been approved by the Ministry of Health with the number 2020-05-25T22_49_35.
Please kindly answer the attached questions.

Regards.

Assoc. Prof. CC, Asis. Prof. Dr. DZ

Name Surname: Gender: M / F Age:
Health institution:
For how many years Chest Diseases Specialist:
How many patients do you care for a day:

1. **During the Covid 19 outbreak, did the clothing, mask and visor you were wearing affect your communication with the patient negatively?**
   a- I strongly agree b- I agree c- I am undecided d- I do not agree e- I strongly disagree
2. **Do you think that this special outfit you were wearing made patients feel underestimated?**
   a- I strongly agree b- I agree c- I am undecided d- I do not agree e- I strongly disagree
3. **Did the special clothing, mask, and visor you were wearing cause you to stay away from the patient and feel bad by suggesting that the patients were possible carriers of the disease?**
   a- I strongly agree b- I agree c- I am undecided d- I do not agree e- I strongly disagree
4. **Have you been happy with the special clothes, masks, visors you were wearing and the precautions you took to prevent infection from each other and protect the patients?**
   a- I strongly agree b- I agree c- I am undecided d- I do not agree e- I strongly disagree

Social Communication Skills Scoring Scale

(Adult form - General Interaction Skills)

DIRECTIVE: Please answer the attached questions while examining the patient you encounter in the polyclinic.
1-If he Rarely used the skill
2-If he used the skill SOMETIMES
3-If he has ALWAYS used the skill IMMEDIATELY

	SCORING		
	RARELY	**SOMETIME**	**ALWAYS**
1. EYE CONTACT - Don't look at others while talking and listening.	**1**	**2**	**3**
2. VOLUME – Speaking at the appropriate sound volume for the environment.	**1**	**2**	**3**
3. VOICE TONE - Avoid using inappropriate tones (boastful, grouchy, bossy, sarcastic).	**1**	**2**	**3**
4. FACIAL EXPRESSION - Avoiding inappropriate facial expressions (rude, sullen, snub-nosed appearance)	**1**	**2**	**3**
5. STANCE - Using the appropriate standing and sitting postures	**1**	**2**	**3**
6. PERSONAL DISTANCE - Standing or sitting distance with others are appropriate for the situation.	**1**	**2**	**3**
7. HYGIENE - Keeping your body and clothes in order.	**1**	**2**	**3**
8. BODY LANGUAGE - Using body language appropriate to the situation. (Body language is the combination of skills 1st-7th).	**1**	**2**	**3**
9. ATTITUDES - Using appropriate attitudes (Please, thank you, sorry, and say with your will.	**1**	**2**	**3**
10. LISTENING PRINCIPLES - Body language while listening reflects the notion of "I am listening to you" and "I am thinking about what is being said".	**1**	**2**	**3**
11. STOP ON TOPIC / CHANGING SUBJECT - Continuing conversation on topic in conversations or topic changes are smooth.	**1**	**2**	**3**
12. SPEECHES - she starts her speech with greetings, waits for turn and listens while speaking, and ends with saying goodbye.	**1**	**2**	**3**
13. INTERRUPT-INTERRUPT - Intercepts only when necessary.	**1**	**2**	**3**
14. RIGHT TIME AND PLACE - Thinks if there is a suitable time and place for what she will do and say.	**1**	**2**	**3**
15. OFFICIAL OR NATURAL BEING - Knows why and how to act more formally (befitting and respectful) or more naturally (relaxed and natural).	**1**	**2**	**3**

and ending the conversation by saying goodbye, 66% (n=132). Interrupting the one speaking only when necessary, 49,5% (n=99); thinking about whether what one wants to say is suitable for the time and place, 67% (n=134); and knowing when and how to act more formally (more decently and respectfully) or more naturally (in a relaxed manner), 69% (n=138).

There was no difference (t = 0.121; $p = 0.90$) between the mean or average scores of the male and female physicians' answers to the 15 questions in the Social Communication Skills Rating Scale (Table 3).

The mean score of the male physicians was 2.63 ± 0.33 (n=89), while that of the female physicians was 2.63 ± 0.31 (n=111). As shown in Figure 1, there were also no differences (F = 1.677; $p = 0.17$) in the mean scores of the answers given to the 15 questions by age group.

As shown in Figure 2, however, differences were found (F = 8.51; $p < 0.001$) in the mean scores of the answers given to the 15 questions according to the hospitals where the physicians worked (between public and private hospitals, $p< 0.001$; between state and university hospitals, $p < 0.001$; between private and training/research hospitals, $p<0.01$; and between training/research and university hospitals, $p<0.05$).

By years of service, differences were found in the mean scores of the answers to the 15 questions (F = 3.69; $p< 0.01$), as shown in Figure 3 and Figure 4**.**

In particular, there was a significant difference between the scores of the physicians who worked for 6–10 years and those of the physicians who worked for 21 years or more ($p < 0.05$). By the average number of patients that they have been examining per day during the pandemic, there were no differences in the mean scores of the answers to the 15 questions (F = 1.933; $p > 0.05$).

No relationship was shown between the gender and age variables (chi square = 3.56; $p = 0.31$). Correlations were found, however, among gender, nature of the hospital where the physicians were working, years of service, and average number of patients examined per day during the pandemic (chi square = 20.38; $p = 0.001$; chi square = 16.46; $p = 0.002$; and chi-square = 26.143; $p < 0.001$, respectively), as shown in Table 4.

There was a relationship between the ages of the physicians and the hospitals where they were working, their years of service, and the average number of patients they were examining per day during the pandemic (chi-square = 57.48; $p < 0.001$; chi-square = 297.90; $p < 0.001$; and chi-square = 74.74; $p < 0.001$, respectively), as shown in Table 4.

Relationships were also found among the nature of the hospital where the physicians were working, years of service, and the average number of patients examined per day during the pandemic (chi-square = 74.00; $p < 0.001$; chi-square = 55.80; $p < 0.001$; and chi-square = 93.028; $p < 0.001$, respectively), as shown in Table 4.

Significant negative correlations were found among the mean ± SD values, the average scores for the first four questions, and the average scores for the last 15 ques-

Table 2. Physicians' responses and rates to the questions of the "Social Communication Skills Scoring Scale".

	Rarely (N (%))	Sometimes (N (%))	Always (N (%))	Total (N=200)
Question 1	13 (6.5%)	44 (22%)	143 (71.5%)	
Question 2	13 (6.5%)	44 (22%)	143 (71.5%)	
Question 3	36 (18%)	38 (19%)	126 (63%)	
Question 4	27 (13.5%)	49 (24.5%)	124 (62%)	
Question 5	6 (3%)	69 (34.5%)	125 (62.5%)	
Question 6	10 (5%)	32 (16%)	158 (79%)	
Question 7	-	19 (9.5%)	181 (90.5%)	
Question 8	2 (1%)	36 (18%)	162 (81%)	
Question 9	8 (4%)	35 (17.5%)	157 (78.5%)	
Question 10	6 (3%)	60 (30%)	134 (67%)	
Question 11	14 (7%)	96 (48%)	90 (45%)	
Question 12	7 (3.5%)	61 (30.5%)	132 (66%)	
Question 13	7 (3.5%)	94 (47%)	99 (49.5%)	
Question 14	5 (2.5%)	61 (30.5%)	134 (67%)	
Question 15	2 (1%)	60 (30%)	138 (69%)	**200**

Table 3. Relationship between gender and institution, duty year, rates to the questions of "Social Communication Skills Scoring Scale".

		Gender		Total
		Male	Female	
Institution	State Hospital	27 (30.3%)	47 (42.3%)	74 (37.0%)
	Private Hospital	20 (22.5%)	4 (3.6%)	24 (12.0%)
	Education and Research Hospital	16 (18.0%)	34 (30.6%)	50 (25.0%)
	University Hospital	26 (29.2%)	26 (23.4%)	52 (26.0%)
Duty year	0-5	13 (14.6%)	27 (24.3%)	40 (20.0%)
	6-10	22 (24.7%)	26 (23.4%)	48 (24.0%)
	11-15	14 (15.7%)	30 (27.0%)	44 (22.0%)
	16-20	20 (22.5%)	6 (5.4%)	26 (13.0%)
	21 and over	20 (22.5%)	22 (19.8%)	42 (21.0%)
During the epidemic, do you think the clothing, mask and visor you were wearing affected your communication with the patient negatively?	I strongly disagree	2 (2.2%)	2 (1.8%)	4 (2.0%)
	I do not agree	20 (22.5%)	10 (9.0%)	30 (15.0%)
	I am indecisive	7 (7.9%)	16 (14.4%)	23 (11.5%)
Do you think these special clothes and masks you were wearing made patients feel underestimated?	I strongly disagree	20 (22.5%)	5 (4.5%)	25 (12.5%)
	I do not agree	44 (49.4%)	43 (38.7%)	87 (43.5%)
	I am indecisive	12 (13.5%)	25 (22.5%)	37 (18.5%)
Did the special clothing, mask and visor you were wearing cause you to stay away from the patient and feel bad by suggesting that the patients were possible carriers of the disease?	I strongly disagree	14 (15.7%)	11 (9.9%)	25 (12.5%)
	I do not agree	37 (41.6%)	23 (20.7%)	60 (30.0%)
	I am indecisive	6 (6.7%)	7 (6.3%)	13 (6.5%)
Did the measures make you feel safe?	I strongly disagree	25 (28.1%)	16 (14.4%)	41 (20.5%)
	I do agree	43 (48.3%)	63 (56.8%)	106 (53.0%)
	I am indecisive	4 (4.5%)	14 (12.6%)	18 (9.0%)
	I do not agree	9 (10.1%)	16 (14.4%)	25 (12.5%)

tions ($r = -0.23$; $p < 0.01$). Considering the relationships among the scores for the four questions specific to the pandemic in Table 5, significant results were obtained for the variables of gender, age, nature of hospital where the physicians were working, years of service, and average number of patients examined by the physicians per day during the pandemic.

DISCUSSIONS AND CONCLUSIONS

During the COVID-19 pandemic, the geriatric patient population was particularly vulnerable owing to their comorbidities, complications, immunocompromised conditions, and high transmission risks. In terms of communication, they had difficulties due to their poor hearing, among others[4,5].

Pulmonologists, on the other hand, were the physicians with the highest risk of transmission during the pandemic. They were expected to have communication problems as they had a high probability of being infected and a heavy workload, which may have weakened their immune system.

In our study, despite their high risk of infection during the pandemic and difficulty in examining their patients while wearing protective clothing like face masks, aside from their usual communication difficulties with geriatric patients, pulmonologists were evaluated as having sufficient communication skills and being successful in their communication with their geriatric patients. In the resource, it is stated that a large percentage of the patient profile in this area are geriatric patients. Most of these patients have chronic diseases such as hypertension, diabetes, and coronary artery disease[8]. For this reason, it has been stated that the hospital and emergency room admissions of geriatric patients at present are frequent. These patients may also have communication problems as

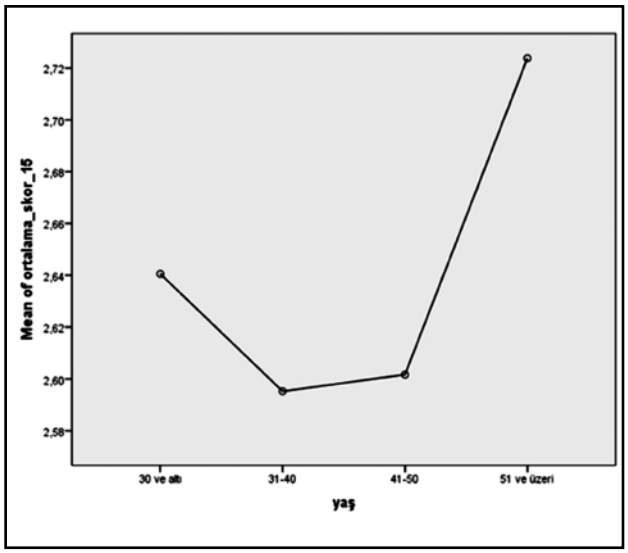

Figure 1. Average score according to age groups (graphic: mean plot).

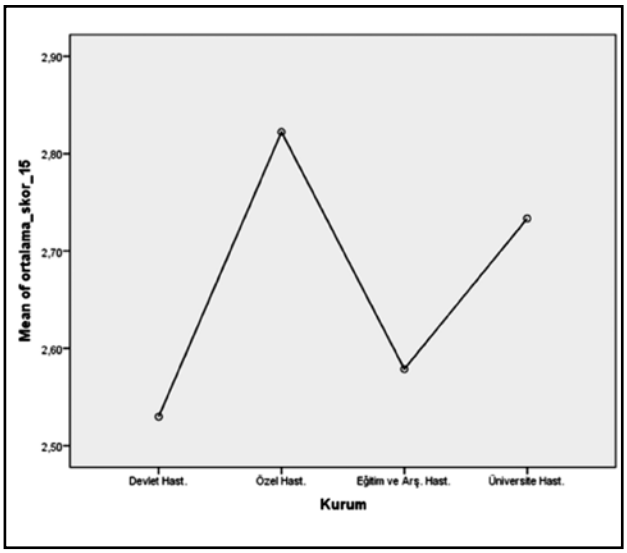

Figure 2. Average score according to the hospitals where the physicians worked (graphic: mean plot).

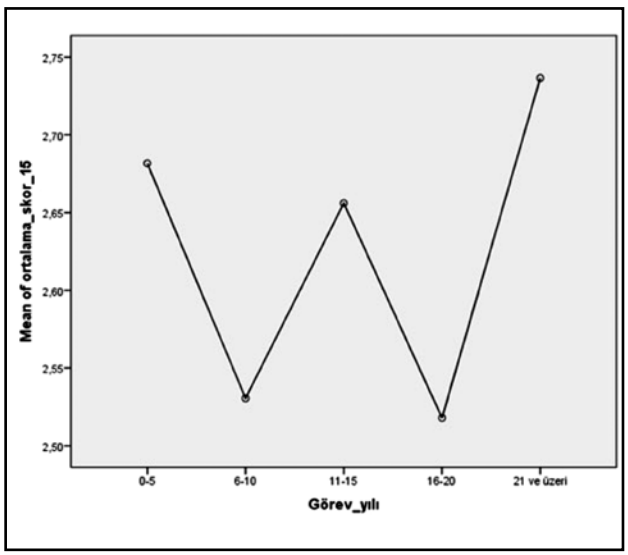

Figure 3. The score averages of physicians according to their years of duty (graphic: mean plot).

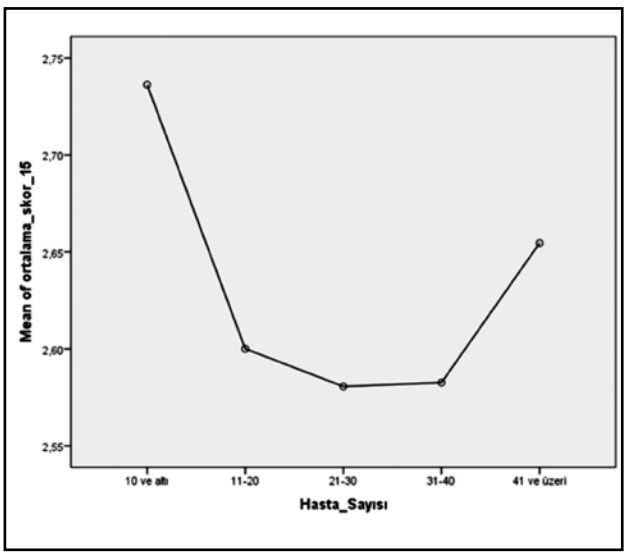

Figure 4. Physicians' mean scores according to the number of patients examined daily during the pandemic period (graphic: mean plot).

many have hearing loss and difficulty expressing their complaints clearly. It has also been reported that this patient group's ability to use inhaled drugs is low. Therefore, not being able to benefit from treatment, they may be compelled to have frequent doctor visits, which may cause anxiety in them. Especially these days, many geriatric patients usually live alone, with limited family support. Therefore, the fear of death is common among them and can lead to physical or medical complaints or unhappiness and despair. As pulmonologists have been in close contact with the geriatric patient population even before the pandemic, they are well aware of what their geriatric patients are going through. This may thus explain why their communication with their geriatric patients was not impaired even during the pandemic.

The pulmonologist participants in this study stated that during the pandemic, they had to communicate with their patients and examine them with their face masks on. They also had to keep their distance from their patients to prevent contamination. While these practices gave them confidence that they would not contract the virus, they also think that these practices offended their patients.

As mentioned earlier, more than half of the physicians who participated in this study answered "Always" when they were asked how often they practiced the following communication skills: establishing eye contact with the one you are speaking with; speaking with the appropriate vocal volume;

Table 4. Relationship between physician age and institution, duty year, rates to the questions of "Social Communication Skills Scoring Scale".

		Age				
		≤30	31-40	41-50	≥51	Total
Institution	State Hospital	0 (0.0%)	0 (0.0%)	6 (26.1%)	17 (73.9%)	74 (37.0%)
	Private Hospital	24 (42.9%)	10 (17.9%)	18 (32.1%)	4 (7.1%)	24 (12.0%)
	Education and Research Hospital	37 (46.8%)	4 (5.1%)	21 (26.6%)	17 (21.5%)	50 (25.0%)
	University Hospital	13 (31.0%)	10 (23.8%)	5 (11.9%)	14 (33.3%)	52 (26.0%)
Duty year	0-5	23 (100.0%)	17 (30.4%)	0 (0.0%)	0 (0.0%)	40 (20.0%)
	6-10	0 (0.0%)	33 (58.9%)	15 (19.0%)	0 (0.0%)	48 (24.0%)
	11-15	0 (0.0%)	0 (0.0%)	38 (48.1%)	0 (0.0%)	44 (22.0%)
	16-20	0 (0.0%)	33 (58.9%)	18 (22.8%)	8 (19.0%)	26 (13.0%)
	≥21	0 (0.0%)	0 (0.0%)	8 (10.1%)	34 (81.0%)	42 (21.0%)
During the epidemic, do you think the clothing, mask and visor you were wearing affected your communication with the patient negatively?	I strongly disagree	0 (0.0%)	2 (3.6%)	0 (0.0%)	2 (4.8%)	4 (2.0%)
	I do not agree	4 (17.4%)	2 (3.6%)	10 (12.7%)	14 (33.3%)	30 (15.0%)
	I am indecisive	3 (13.0%)	4 (7.1%)	9 (11.4%)	7 (16.7%)	23 (11.5%)
	I do agree	6 (26.1%)	41 (73.2%)	33 (41.8%)	15 (35.7%)	95 (47.5%)
Do you think those special clothes and masks you were wearing made patients feel underestimated?	I strongly disagree	1 (4.3%)	4 (7.1%)	12 (15.2%)	8 (19.0%)	25 (12.5%)
	I do not agree	4 (17.4%)	24 (42.9%)	31 (39.2%)	28 (66.7%)	87 (43.5%)
	I am indecisive	0 (0.0%)	14 (25.0%)	21 (26.6%)	2 (4.8%)	37 (18.5%)
	I do agree	15 (65.2%)	11 (19.6%)	13 (16.5%)	4 (9.5%)	43 (21.5%)
Did the special clothing, mask and visor you were wearing cause you to stay away from the patient and feel bad by suggesting that the patients were possible carriers of the disease?	I strongly disagree	0 (0.0%)	3 (5.4%)	14 (17.7%)	8 (19.0%)	25 (12.5%)
	I do not agree	7 (30.4%)	22 (39.3%)	16 (20.3%)	15 (35.7%)	60 (30.0%)
	I am indecisive	0 (0.0%)	0 (0.0%)	11 (13.9%)	2 (4.8%)	13 (6.5%)
	I do agree	9 (39.1%)	25 (44.6%)	28 (35.4%)	16 (38.1%)	78 (39.0%)
Did the measures make you happy?	I strongly disagree	3 (13.0%)	14 (25.0%)	14 (17.7%)	10 (23.8%)	41 (20.5%)
	I do not agree	18 (78.3%)	28 (50.0%)	41 (51.9%)	19 (45.2%)	106 (53.0%)
	I am indecisive	2 (8.7%)	4 (7.1%)	10 (12.7%)	2 (4.8%)	18 (9.0%)
	I do agree	0 (0.0%)	8 (14.3%)	12 (15.2%)	5 (11.9%)	25 (12.5%)

avoiding using inappropriate voice tones (boasting, grouchy, patronizing, sarcastic); avoiding using inappropriate facial expressions (rude, sullen, snobbish appearance); using standing and sitting postures appropriate to the situation; standing or sitting at an appropriate distance from the one you are speaking with depending on the situation; using body language appropriate to the situation (combination of the 1st-7th skills); showing appropriate attitudes (saying "please", "thank you", "sorry", etc.); demonstrating appropriate body language while listening, as if saying "I am listening to you" or "I am thinking about what you are saying"; sustaining the conversation on the topic or changing the topic smoothly; starting one's speech with a greeting; listening while waiting for one's turn to speak, ending the conversation by saying goodbye, thinking about whether what one is about to say is suitable for the time and place, interrupting the one speaking only when necessary, and knowing when and how to act more formally (in a befitting way and respectfully) or more naturally (in a relaxed manner). In another study[8], in which physicians' social communication skills were evaluated, the physicians aged 35-44 got the highest score on the communication skills scale. As our study population was predominantly

Table 5. Correlations: There is an inverse relationship between the average scores from the first 4 questions and the scores from the last 15 questions.

			Average score 4	Average score 15
Spearman's rho	Average score 4	Correlation Coefficient	1.000	-.226**
		Sig. (2-tailed)	.	.001
		N	200	200
	Average score 15	Correlation Coefficient	-.226**	1.000
		Sig. (2-tailed)	.001	.
		N	200	200

**Correlation is significant at the 0.01 level (2-tailed).

composed of physicians in this age group, it may be said that the adequacy of pulmonologists' social communication skills during the pandemic depended on their age. However, the results of our study show that the physicians in our study adequately communicated with their geriatric patients during the pandemic despite the challenges involved in such circumstances because they are conscious of the sacredness of their profession regardless of the prevailing conditions, how they feel about their profession, and whether they are surgeons or internists[8]. Thus, the social communication skills of pulmonologists were not adversely affected despite the fact that their work was life threatening as they were in touch with and treated active COVID-19 cases and despite their heavy workloads, which may have weakened their immune system. Our study differs from the previous one because while in the latter, no difference was found between the male and female physicians' social communication skills, in our study, the male physicians' social communication skills were found to be better than the female physicians', as shown by the female physicians' lower scores in communication skills. This may be because during the early part of the pandemic, schools were closed and "doctor mothers" found themselves in a challenging situation as they had higher chances of contaminating their children while working. Despite these difficult conditions, the female physicians' social communication scores with the at-risk geriatric patient population were considerably high albeit lower than the male physicians. This can be explained by female physicians' very high sense of duty and responsibility. A limitation of the study, though, was that the percentage of "doctor mothers" was not determined.

In our study, no difference was found in the pulmonologists' social communication scores with their geriatric patients by age and by the number of patients they were examining per day during the pandemic. Differences ($p < 0.05$) were found, however, according to the nature of the hospital where they were working and their years of service. There were statistically significant differences between the scores of the following physicians: those who were working in state hospitals and those who were working in private hospitals ($p < 0.001$), those who were working in state hospitals and those who were working in university hospitals ($p < 0.001$), those who were working in private hospitals and those who were working in training/research hospitals ($p < 0.01$), and those who were working in training/research hospitals and those who were working in university hospitals.

When the relationships between the physicians' communication skills with their geriatric patients during the pandemic and their gender, age, years of service, average number of patients examined per day during the pandemic, and nature of the hospital where they were working were investigated, significant results were obtained for each variable and parameter.

Although many studies on the geriatric population have been conducted, age-based discrimination continues, and this population's social problems persist. Our study showed no discrimination, however, in the health sector, the most critical sector during the COVID-19 pandemic. The approach to this group in this sector was at the required level. Social restrictions were stringent in this group, but because social support could not be provided, the geriatric group has had difficulty meeting their essential needs during the COVID-19 pandemic period. Efforts were made to meet the young population's needs (children, grandchildren), but the rate of infection in the geriatric population increased[7]. The disease's course has also been more severe in the said group; there have been prolonged hospitalizations even in the intensive care units. Geriatric patients also experienced more severe and prolonged post-COVID-19 symptoms[8-14]. Thus, those who had acquired COVID-19 had to maintain their device dependence (e.g., oxygen concentrator and/or non-invasive mechanical ventilator) due to lung damage sequelae.

While protecting the elderly from the pandemic's adverse effects, respecting and supporting them in that extraordinary situation was necessary. When the pandemic put high pressure on the healthcare system and the available resources were not enough to cope with everyone's needs, we had to bear in mind that age could be a negative factor, and we had

to advocate treating all older people with respect during those times.

This article discusses the risks of the elderly, who were among the vulnerable and disadvantaged groups in society during the COVID-19 pandemic, the age factor in the pandemic triage, and the areas of intervention. Marginalizing, discriminatory attitudes, and behaviours toward social groups, especially the elderly, should thus have been prevented. Those who did not show sensitivity to them in public health should not have been left unpunished[9-14].

It was found in this study that even in the difficult times of the COVID-19 pandemic, pulmonologists' communication with their geriatric patients was maintained at a sufficient level. This has been a significant advantage for the geriatric patient group. They communicated with pulmonologists mainly due to medical necessity. The physicians' effective communication with them could have made them feel good during such a difficult time. It could have also been a source of pride for such physicians.

If we do not want to have unhappy older people and if we want to show our respect to them, we should provide them with social support, especially during the pandemic periods, if possible, even with regular psychological support. For this purpose, social responsibility projects can be planned, and volunteers can obtain support.

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