What are you willing to change to promote your patients' oral health?

Full Version of the ms Submitted to

The Journal of the Ontario Dental Association (J Ontario Dent Assoc)

By

Clive S. Friedman, DDS, Cert Ped Dent

Don Morrow*, PhD

&

Jennifer D. Irwin, PhD

*Dr Morrow is the Corresponding Author (donmor@uwo.ca)

We work *with* our patients; therefore, communicating effectively is of central importance to our daily professional lives. Currently, the *Ontario Dental Association* website has a whole section on "Patient Communications;" it features self-assessment mechanisms for initial patient contact, the dental exam, discussing dental treatment options, discussing costs and insurance, and concluding the visit. We commend the *ODA* initiative and respectfully suggest that there are ways to make patient communications far more effective for both patients and dental staff. From our experience, a day in the life of a dentist might include at least one time where at least one dental team member asks a patient to change his or her oral health behaviour. Our colleagues share the frustration of spending seemingly endless hours trying to convince our patients about the need to improve their oral health, their sanative procedures, and yet we often end up repeating this every time they come to us for care appointments. What if the issue is more about how we communicate with our patients than it is about our patients not heeding our expert advice? What are we willing to change about our communicative methods in service of our patients?

Motivational Interviewing (MI) is one powerful behaviour change process that allows the communication and information aspect of what we do to be relatively stress-free. Further, our research shows that MI empowers patients to make the decisions needed for what they want to achieve with respect to their health behaviour changes in general.[1] This article will provide an introduction to MI; render illustrative examples and discuss cases regarding why MI works; and offer an applied introduction to the use of MI specifically within professional health practices such as dentistry. Our overall intention is to raise the awareness among dental professionals of the potential utility to short- and long-term oral health care in integrating readily-learned MI methods within clinical practices.

Definitions of MI vary and might be encapsulated in this one: a client-centered, yet goal-directed counselling method for helping people to resolve ambivalence about health behaviour change *by building intrinsic motivation and strengthening commitment*.[2] The architects of MI, psychologists William R. Miller and Stephen Rollnick[3] were heavily involved in finding an adjunct method for working with people suffering from addictive behaviours, primarily those who were alcohol dependent. While the word 'counselling' in the foregoing definition might, at face value, suggest that MI is only for professional counselors, it most definitely is not a technique or method confined to that professional category. Instead, the fundamentals of MI can be learned and utilized by any health professional who seeks to have a more mutually satisfying, working relationship with his or her patients/clients. MI is a communication style, a way to be *with* patients in service of health behaviour changes that work and persist for the patient and for dental staff members.

What does success look like for a dentist in the 21st century?

What does success feel like for a dental patient in the 21st century?

In parallel fashion to the salient part of the MI definition, the latter part of the ODA mission statement merits highlighting: "*The ODA…is dedicated to the provision of exemplary oral health care and promotes the attainment of optimal health for the people of Ontario.*" Clearly, the mouth is the primary gateway to anyone's health. If we subscribe the ODA's mission, then 'exemplary' oral health care means much more than merely treating the teeth and gums of our patients. Similarly, the 'attainment of optimal health' signifies much more than dental treatment techniques. That said, how many dentists and dental staff members would give emphatic yes-answers to these questions:

- Who among us are frustrated that the (oral) health instructions given at every check-up never seem to get anywhere - you feel like you repeat yourself at every visit?
- Who among us feel that you work harder at achieving good oral health for your patient than the patient does?
- Who among us feel that when you speak to some patients or patient care-givers, it seems as if they just shut down or look at you as if you are from another planet?

We have a wealth of health information and dental expertise but it seems that patients are reluctant to take our advice, don't perceive its relevance, and/or don't heed that advice – there is some disconnect happening. What can you do to close that gap or make the connection happen? What if, instead of feeling like you are wrestling with your patients, you could move toward a sense of being in partnership with your patients? We suggest that a way to do this is to learn and adopt some basic MI methods and ways of being in connection and communication with your patients.

I have some information about treatment _____. Would you like me to share it with you?

Consider the question in the box above. As dental professionals, we have expert knowledge and advice and the tendency or habit might be to dispense that advice as though it were prescriptive and highly desired by our patients. We are trained to *fix* teeth, gums, the mouth etc., in short, to right what's wrong. However, in the area of human behaviour change and in the words of MI practitioners, it is important to 'resist the righting reflex,' the tendency to give prescriptive, unsolicited behaviour change information or advice. Instead, what if you asked each patient for permission to share that information? This might, at first glance, seem counterintuitive – of course they want my advice, that's why they are here. However, unless you have asked and/or

established this pattern of seeking permission to give your expert information, how do you know your patients want it? Just as we dispense verbal advice, we often assume that giving patients pamphlets of dental health information is effective communication. Is it? And how do you know? Knowledge or information is not power, only potentially so; getting permission to impart knowledge is power-ful. Obtaining permission is like bringing the right substrate in contact with the correct enzyme – the biological comparison is apt and the behavour change platform is established for real, two-way communication to happen. People are more motivated to make change when the change is based on their own decision – in this case, their 'yes' – than when an authority figure tries to impose change[4]. We cannot make patients follow our advice, but we can communicate with them far more successfully if we know what they need and what they are willing to hear and/or do about their oral health care in partnership with our dental staff.

Health promotion is the process of enabling people to increase control over and improve their health (World Health Organization)

This brings us to a key feature of *optimal* (from the ODA mission statement) oral health care and it is this. Oral health care is as much about aural care as it is oral care. We cannot expect to work in concert with our clients unless we actually listen to them *and* show them we are listening. Listening, truly listening is a huge and integral component of enabling patients to increase control over and improve their health. People need to be *seen* for who they are and what they are experiencing and for the most part, seeing someone means using your ears before your mouth reacts. Consider a couple of examples concerning the impact of not listening versus listening. A parent comes with her child and says to a dental team member, "we're really scared

about being hurt; I told my son you wouldn't hurt him with a big needle." One common, very reactive, non-listening response by a dental team member might be, "that won't happen here, we're very careful" (a prime example of the 'righting reflex'). While the intent might be to reassure, the impact is that the patient/parent is not seen, certainly not heard. A more reflective, 'seeing' response might be, "I see that you're scared. What's that like for you?" and then waiting for a response, followed by, "What would help you?" The latter response acknowledges the patient's fear, asks what it's like to be him-in-fear (and listens to the patient's response) and then asks what might be done to help. The effect on the patient is profoundly different. Instead of feeling dismissed or kind of stepped-over in the reactive response, the more reflective, truly *aural* response engages the patient and dental team member as a partnership – substrate to enzyme – and, very likely, goes a long way toward establishing a bond of trust. We suspect this is a very different way for dental team members to speak with your patients; our encouragement is to ask you to try it.

What's important to you about your oral health care?

What if oral health care is about much more than oral health care? Consider a second, real clinical example of listening attentively to a patient. We offer this abbreviated case as an illustration of the power of effective communication even with what might seem like an extreme case, one unlikely to be seen by a general practitioner. A 37-year-old man with moderate hemophilia came to dental university hospital clinic in another country. He was married, had a tremendous anxiety disorder centered on hospitals, and was perceived to be argumentative, generally difficult in demeanor, and 'smelly' by clinical staff members. A severe hemorrhaging

issue following an appendectomy in his late teens coupled with massive bleeding after wisdom teeth -removal at 20 years of age, meant that he had not been back to a dentist in 17 years. His wife persuaded him to come to the clinic and he was in abject terror, could not allow anyone to look in his mouth, and was visibly shaking and distressed. When he spoke, he covered his mouth with his hand and the dental team said they could smell his halitosis two meters away; his wife reported she could not bear to kiss him. He said he had become scared to put a toothbrush in his mouth in case he broke anything and because he was afraid of bleeding. When they finally were able to talk with him, the dental staff asked him some standard dental-clinic entry information inquiries and one very powerful question, "*what's important to you about your oral health?*" Two of the staff members had undergone some basic MI-training and were trying out their newly-acquired interviewing skills. The patient perked up immediately at the question, stated that he had never been asked that before, and he said he had 3 priorities: to get rid of his halitosis; to have his decayed teeth removed; but most importantly, above all else, to have better relations with his wife. It turned out that he and his wife had not been intimate for more than a year. He deeply loved her and his entire motivation in even coming to the clinic was tied to his feelings for her. There was a long process of getting him into surgery and lots and lots of reflective listening and encouragement , all related to his primary motivation, followed with complete technical success in treating his oral health issues (inclusive of smoking cessation later in the process) and he now receives regular dental care. The turning point was this fundamental, *what's-important-to-you* question together with really listening to and respecting his response. If we can find out *what is important about* each patient's oral health care, by using similar questions as the one above and by listening to the responses (that is, using MI methods),

practicing dentistry might be more fulfilling and patient adherence and satisfaction might be increased concomitantly.

What are your goals for your oral health care?

Listening implies something has been elicited in conversation. MI is predicated on the use of open-ended, probing questions. We suggest that effective, guiding communication – an MI conversation – is an implied nuance of oral health care, in this case, a dental staff member communicating orally. The intent of MI questions is not to interrogate the patient but rather to guide them toward the oral health care changes they want to make when they are ready to make them. Ideally, we want to move them from *status talk* to *change talk*, that is, from using the language of old habits, the way it has always been, to the language of possibility, from 'I can't' or 'it doesn't work' to 'I want to' or 'I really need to' or 'I can.' For the most part, probing, open-ended questions pry the lid off of resistance to change and most often those questions start with 'what' not 'why.' Notice the boxed question above; it invites a patient to reflect on his or her goals, perhaps resulting in a list of those objectives, as in the patient with hemophilia example provided earlier. If we ask the question, 'why do you think oral health care is important?' or 'why aren't you able to take better care of your oral health?', we will get either a list of what patients think we want to hear, the "right" answer, and/or we will get justifications, from a place of defensiveness, for their behaviour. What-style of questions invite; why-style of questions tend to build barriers, put up defenses even though they might be well-intentioned. In addition, what-style questions demonstrate that we are interested in our patients' perspective (goals, in this case) and they give us information, answers about oral health care from which we

can build treatment plans and understand our patients' needs and desires. Listening to the answers to open-ended questions means reflecting back or mirroring the answers your patients give, perhaps charting those answers. If we asked,

What are the important components of your oral health?

and the response was something like: feeling good about me, avoiding cavities, and my smile, then we might say something like, "So, if I'm hearing you correctly, it sounds like you want to feel good about yourself, have a nice smile, and prevent cavities as much as possible, is that accurate?' By reflecting back, using the words used by your patient, you show you have heard them and that you are affirming or acknowledging them in your response. MI has a good acronym for its core strategies to move a person from status talk to change talk, **OARS**:

- **O**pen-ended, probing questions
- **A**ffirming or Acknowledging responses
- **R**eflective Listening
- **S**ummarizing[5]

Summarizing, for example, involves confirming what the patient says is her first step in meeting or achieving one of her stated goals for her oral health care. Asking the patient to summarize what you have discussed can often cement the patient's movement toward his or her proposed oral health care change/s.

What would a revised, MI-based intake and exit set of questions look like?

One place to start the process of shifting to the use of MI within a clinical practice is in shifting the way we ask patients' appointment and/or extended care intake and exit questions. For example, instead of asking, 'Why did you attend your dental appointment today?, consider the impact-potential of these intake questions:

- **What** is important to you about attending your dental appointment today?
- **What** are your goals or priorities for your teeth and gums or your oral health care?

  1, 2, 3 – have them itemize goals/priorities
- **By when** would you like to achieve each of these goals?
- **What** do you need to say 'yes' to in order to achieve these goals?
- **What** do you need to say 'no' to in order to achieve these goals? [these 'say yes/no to' questions might have more resonance for some than the what-changes version]
- **What** can we do to partner with you to help you achieve these goals?
- If our staff members have information/suggestions for your oral health care, would you like us to share that information with you?

Notice that these questions are open-ended and individually patient-centered rather than more standard yes/no type of intake questions. **What if** you charted patient responses to these questions and used that information on an ongoing basis to monitor oral health care goals, goal-seeking, and achievements? The same holds true for such dental visit exit questions as:

- **What** was the best thing about your dental appointment today?
- **What** would have made today's appointment better for you?

These exit questions provide staff with important feedback, reinforce the team or collaborative approach to ongoing health care, and they summarize patient intent, satisfaction with, and intended behaviour change, goal-oriented actions. Perhaps these, and other intake and exit questions could be added to the Patient Communications' section of the ODA website to encourage greater attention to patient motivation via more potent two-way communication.

What is the future of patient-centered oral health care?

Dentists and dental team professionals are in a unique and important position to play a leading, collaborative role in the oral/systemic health care of their patients. Dental staff personnel are stewards of the gateway to oral and aural health care. Learning to use more effective communication skills via MI does not mean dental staff must become experts in the areas of information dispensing about nutrition, physical activity, obesity, overweightness, diabetes, smoking cessation or any other health care issue, in fact, just the opposite. The use of MI involves igniting patient motivation to change, collaborating and facilitating that change, if asked, and perhaps pointing to patient-identified and needed resources or support in achieving their oral health (and by implication, systemic) care. Our intent in this article was to offer an applied introduction to MI and its infinite potential for improving the overall process of oral health care. We would recommend MI training for all dental staff members in any clinical setting; like any new skill MI takes learning and practice. Clearly, MI is an evidence-based,[6] patient-centered communication method that can, with training, be readily inserted into the repertoire of dental practices and skills, fully in service of *promoting the attainment of optional health for the people of Ontario*.

What are you willing to change to promote more effectively your patients' oral health?

[1] See, for example, Newnham-Kanas, C., Irwin J.D., & Morrow, D. (2011). The utility of motivational interviewing using co-active life coaching skills on adults struggling with obesity. *Coaching: An International Journal of Theory, Research & Practice*, 4(2), 104-122. In addition, see a list of health-related MI-intervention research at http://www.monarchsystem.com/?page_id=54

[2] Miller, William R. and Rollnick, S. 2002. *Motivational Interviewing: Preparing People for Change*, 2nd edition. The Guilford Press, pp. 24-26.

[3] See the more applied text, Miller, William R. and Rollnick, S. 2008. *Motivational Interviewing in Health Care: Helping Patients Change Behavior*. The Guilford Press. For a more focused and detailed discussion of the spirit of MI in dental practice, see Ramseier, Christopher and Suvan, Jean E. 2010. *Health Behavior Change in the Dental Practice*. John Wiley & Sons.

[4] This is a point echoed throughout the research by Edward L. Deci, Edward L. 1980, in, *The Psychology of Self Determination*. D.C. Heath. Self-Determination Theory (SDT) is a theory of motivation that is very well researched, supported, and practiced worldwide. It is concerned with supporting the natural or intrinsic tendencies to behave in effective and healthy ways. For a specific application of SDT to coaching/MI, see Pearson, Erin S. 2011. The 'how-to' of health behaviour change brought to life: a theoretical analysis of the Co-Active coaching model and its underpinnings in self-determination theory. *Coaching: An International Journal of Theory, Research and Practice*. Vol. 4, Issue 2, 89-103.

[5] Rosengren, David B. 2009. *Building Motivational Interviewing Skills*. New York: The Guilford Press, 30-31.

[6] For a set of research articles pertaining to the use of MI in dentistry, see the following resource list: http://www.specialtybehavioralhealth.com/wp-content/MI-Dentistry-References.pdf