What Are You Willing to Change to Promote Your Patients' Oral Health?

Find out how motivational interviewing can help you help your patients

Communicating effectively is of central importance to dental professionals. The ODA understands this and its website has an entire section on Patient Communications (please visit www.oda.ca) that 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 would like to offer additional techniques to make communications more effective for both patients and dental staff.

Frequently Asked Questions

A day in the life of a dentist might include at least one occasion where we ask a patient to change his or her oral health behaviour. Our colleagues have shared with us the frustration of spending hours trying to convince certain patients to improve their oral health behaviours, only to repeat this every time these patients return for care appointments. What if the issue is more about how we communicate with our patients than it is about patients not heeding our expert advice? If so, are we willing — and able — to change our communication methods?

Motivational Interviewing (MI) is a behaviour change process that can help dental professionals communicate more effectively. Our research shows that MI can help patients make the decisions they need to make to achieve health behaviour changes in general.[1] This article will provide an introduction to MI and include examples of cases that used MI specifically within dentistry.

Definitions of MI vary but might be encapsulated in this one: MI is a patient-centred, goal-directed counselling method that helps people resolve their ambivalence about health behaviour change by increasing their motivation and commitment.[2] The architects of MI, psychologists William R. Miller and Stephen Rollnick,[3] were involved in finding an adjunct method for working with people suffering from addictive behaviours. The word "counselling" might suggest that MI is only for professional counsellors, but it is not a method confined to that professional category. Any health professional who would like to have a more mutually satisfying relationship with his or her patients can learn and use the fundamentals of MI. MI is a communication style, a way to *be* with patients in service of health behaviour changes that work for the patient and for dental staff.

Do your patients really hear you?

Akin 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." The mouth is the primary gateway to one's health. If we subscribe to the ODA's mission, then "exemplary" oral health care means much more than merely treating patients' teeth and gums. Similarly, the "attainment of optimal health" signifies much more than dental procedures. That said, how many dentists and dental staff members would give emphatic "yes" answers to these questions:

- Are you frustrated that the (oral) health instructions given at dental exams rarely seem to result in positive change?
- Do you feel you work harder at achieving good oral health for some of your patients than the patient does?

By adopting some MI methods, instead of feeling as if you are wrestling with your patients, you could move toward a more effective partnership with them.

Learn to *share* advice, instead of *dispensing* it

As dentists, we have a wealth of information and expertise. It's possible that, given our knowledge, we have a tendency to dispense advice as though it were prescriptive and wanted by patients. We are, after all, trained to fix teeth, gums, and the mouth — in short, to right what's wrong.


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However, it is important to resist the "righting reflex" (the tendency to give prescriptive, unsolicited 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've sought permission to give your expert information, how do you know your patients want it?

Obtaining permission is like bringing the right substrate in contact with the correct enzyme. In general, people are less defensive and more motivated to make a change when the decision to do so is their own rather than when an authority figure tries to impose change.[4] We cannot make patients follow 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.

MI has an acronym for its core strategies to move a person from status talk to change talk, **OARS**:
Open-ended, probing questions
Affirming or acknowledging responses
Reflective listening
Summarizing[5]
By following these strategies, you can establish real two-way communication and a firm footing toward positive behaviour change.

Listen well (the Reflective component)

Oral health care is as much about *aural* care as it is oral care. We can't expect to work in concert with patients unless we actually listen and show them we are listening; this means using your ears before your mouth reacts. Consider a couple of examples concerning the effect of not listening versus listening. A parent comes with her child and says to a dental team member, "Jessie's really scared about being hurt; I told him you wouldn't hurt him." One common — and reactive and non-listening — response by a dental team member might be, "That won't happen here, we're very careful." It's a prime example of the righting reflex, or reassurance and, though it's well-meaning, it's not effective. A more reflective, "seeing" response might be, "I see that you're scared, Jessie. Can you tell us more about how you feel?" Then, after the answer, ask, "What would help you?" This type of response acknowledges the patient's fear, shows empathy by asking what it's like to be him-in-fear (and by listening to his answer), and then asks what might be done to help. Instead of feeling dismissed, as in the reactive response, the patient might feel respected. The reflective, truly aural, or seeing, response engages the patient and dental team member as partners and, likely, will go a long way toward establishing a bond of trust.

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What if oral health care is about much *more* than oral health care? Consider this second clinical example of the power of effective communication. A 37-year-old married man with moderate hemophilia came to a dental clinic. He had an anxiety disorder centred on hospitals, and was perceived by clinical staff as argumentative, generally difficult in demeanor, and exhibiting an unpleasant body odour. The cause? A severe hemorrhaging issue that followed an appendectomy in his teens, coupled with substantial bleeding after the removal of his wisdom teeth when he was 20, meant he had not been to a dentist in 17 years. His wife had persuaded him to come to the clinic, but he would not allow anyone to look in his mouth and was visibly distressed. When he spoke he covered his mouth with his hand, and the dental team noticed severe halitosis. His wife would no longer kiss him. He had become scared to use a toothbrush because he was afraid of bleeding.

The dental staff asked him some standard entry-information questions — as well as another question, "What's important to you about your oral health?" Two staff members had undergone basic MI training and were trying out their newly acquired interviewing skills. The patient perked up immediately at the question and said he had three priorities: to eliminate his halitosis, to have his decayed teeth removed and to have better relations with his wife (this last one was his primary motive).

The surgical treatment was completed under diazepam sedation; five teeth were extracted together with deep periodontal treatment that included root debridement. This process resulted in complete success in treating the patient's oral health issues (including eventual smoking cessation). He now receives regular dental care in the form of

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three individual visits for scaling, polishing and oral health instruction. Twelve months post-surgery the patient has no new disease and although he still has extreme phobia for any medical/dental treatment, he is absolutely motivated and committed to attend oral health-care sessions to ensure his mouth stays healthy. The turning point was the fundamental, what's-important-to-you question, together with really listening to and respecting his response.

If we can find out what each patient values about his or her oral health care — by using questions similar to the one above and by listening to the responses (that is, using MI methods) — practising dentistry might be more fulfilling, and patient adherence and satisfaction might be increased concomitantly.

Ask open-ended questions (the Probing component)

The intent of MI questions is not to interrogate but rather to guide patients toward the oral health-care changes they want to make, when they are ready to make them. Ideally, we want to move patients from status talk to change talk or 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. " Open-ended questions can lead to that change, and most often those questions start with "what," not "why."

What are your goals for your oral health care? This question invites a patient to reflect on his or her goals, perhaps resulting in a list of objectives, as it did for the patient with hemophilia. If, however, we ask a "why" question such as, "Why is your oral health care important? " or "Why don't you floss?" we will get either a list of what patients think we want to hear (that is, the "right" answer), or justifications (from a place of defensiveness) for their behaviour.

"What" questions demonstrate that we are interested in our patient's perspective (goals, in this case) and give us information from which we can build treatment plans and understand our patients' needs and desires.

Show you understand each patient (the Affirming component)

The best way to show you've really listened to the answers to open-ended questions is to reflect back the answers your patients give, and perhaps chart those answers. If we asked, "What's important for you about your oral health?" and the response was, "My smile and avoiding cavities," then a reflective response might be something like, "So, if I'm hearing you correctly, it sounds like you want to have a nice smile and prevent teeth problems as much as possible, is that accurate? " By reflecting back, using the words used by your patient, you show you have heard the patient and that you are affirming or acknowledging him or her in your response. Affirming your patient means you are "seeing" that patient in his or her uniqueness as a *person with specific oral health concerns*, rather than merely fixing the dental issue at a particular visit.

Confirm (the Summarizing component)

Summarizing involves confirming what the patient says he or she will do toward making a behaviour change (for example, ask her to repeat her first step toward achieving one of her stated oral health goals). Although dental staff can summarize for a patient, asking the patient to summarize your discussion can be more effective in cementing his or her stated oral health-care changes.

Samples of MI-based intake and exit questions

One place to start the process of using MI within a clinical practice is to shift the way you ask intake and exit questions. Formulate the questions so they are open-ended and individually patient-centered.

For example, during an *intake* visit, instead of asking, "Why did you attend your dental appointment today?" consider the impact-potential of these question:

- **What** are your goals or priorities for your teeth and gums or your oral health care? (As well, ask the patient to itemize these goals: one, two, three etc..)
- **What** can we do to help you achieve these goals?

Consider charting patients' responses to these questions and use that information on an ongoing basis to monitor oral health-care goals and achievements.

The same holds true for such dental-visit exit questions. Ask:

- **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 collaborative approach, and summarize patient intent, satisfaction, intended behaviour change and goal-oriented actions. Note that intended behaviour changes are just that, intention or direction; goal-oriented actions are the committed, stated actions to put the intention into effect.

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

Dentists and dental team professionals are in a unique position to play a leading, collaborative role in the oral/systemic health care of patients. Learning to use more effective communication skills via MI does not mean dental staff must become experts in nutrition, physical activity, weight management, diabetes, smoking cessation or any other health care issue. Rather, the use of MI involves motivating patients to change, collaborating with patients, and facilitating the change.

The intent of this article is to offer an introduction to MI and its potential for improving the overall process of oral health care for patients and dental staff. Like any new skill, MI takes learning and practise. With training, you can take

MI (an evidence-based,[6] patient-centred communication method) and include it in the repertoire of your dental practices and skills so you can more effectively meet your patients' oral health needs.

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References

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.
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