

“What Matters to You?”: Shared Decision Making in the Post-Paternalistic Era of Oral Health

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We live in an individualistic age. People can follow who they like on social media, read news that aligns with their preconceived notions of right and wrong, and generally avoid critical engagement with ideas they disagree with or situations that make them uncomfortable. This modern phenomenon has led to quick judgement and rapid recoil when others share ideas or information that challenges the inertia of their beliefs and choices. In a post-expertise culture [1], people simply don't want to be told what to do. This is a problem for the profession of dentistry, where the prevailing paternalistic norms for the better part of the past 150 years have focused on the dentist as the unilateral authority, with the primary responsibility of promoting oral health through “education” or “counseling” – polite euphemisms for telling people what to do. Despite our growing body of scientific evidence showing we can keep people and their teeth healthy, we have become collectively exasperated that this evidence-based information isn't enough to change the behaviors necessary to prevent disease. As healthcare providers, we wonder why people have stopped listening (if they ever really did). But stepping back, we only need to think for a minute about our current cultural milieu, where the curation of consensus leaves us unfollowed, and worse, blocked.

The concept of shared decision making has been developed and explored by our medical colleagues for the past 30 years [2], but there is a dearth of understanding and application in the dental profession. If we truly want to help people become healthier, we have to find places to stack hands with them instead of pointing a finger at them. We have to respect our patients' autonomy, create partnerships, and collaboratively share information. Our success or failure in the new era of healthcare will be defined by our ability to move beyond our paternalistic roots, voluntarily laying down the habit of dispensing technical expertise as universal axiom, while simultaneously embracing our role as co-creators, working alongside our patients to achieve optimal oral health.

A friend, who happens to be a dentist, is a high-level executive for a local federally qualified health center. She is a visionary, developing and implementing systemic solutions that will shape the future of oral health. She is also compassionate and personable, maintaining her time in clinic with her patients so as to never forget the real reason she works so hard. Her son, who was recently adopted from China, was at high risk for dental caries, having sipped on honey water and deprived of fluoride for the first years of his life. This all changed when she and her husband brought their son home. His oral care is now immaculate, and protective factors far outweigh his risk factors for dental caries. However, she recently took him to a pediatric dentist, where she explained her desires for following the most up-to-date principles of cariology, and her hope to stay a supportive mom instead of a consulting dentist for any possible treatment. She was disappointed and dismayed when presented with a \$1500 plan that included the possibility of treatment under general anesthesia (for an additional \$2500), all aimed at treating interproximal caries lesions that were limited to the enamel. At no point was she given other treatment options, and nobody initiated a meaningful discussion of the risks and benefits of the treatment plan. She left feeling frustrated and not only misunderstood, but with the sense that nobody tried to understand her values and preferences. She is currently looking for another pediatric dentist [3].

Another friend is low caries risk, with no history of periodontal disease, and happy with the way his teeth look. He refers to his 6 month recare visits as his “semi-annual scolding.” If he, with teeth and gums healthy by any objective standard or outcome measure, views a visit to the dental office as a misbehaving child views a sullen trod to a disappointed parent, then it seems we still have some way to go before our profession shakes its old paternalistic habits. Unsurprisingly, the habits for which he is “scolded” remain largely unchanged year after year.

So how can our profession move forward based on this deeply rooted paternalistic history? We think the practice of shared decision making would be a good place to start, and three core principles can help us make a positive change.

First, we need to fundamentally respect, honor, and support our patients' autonomy. For too long we have viewed our role in dental diagnosis and treatment as a license to act authoritatively, with the implicit belief that we know best. We may think we are simply

offering a patient treatment options, like implants or partial dentures, but for most patients, making a choice, especially while face-to-face with the dental “expert,” can be muddled with the pressure of salesmanship and coercion. The patient justifiably senses what we as dentists feel—the range of emotions from disappointment to disrespect to disgust if the patient does not choose what we think is best. However, entire counseling styles and theories of behavior change are built on the prominence and communication of patient autonomy, helping to reduce defensiveness and making change more likely [4,5]. We can’t make our patients start brushing their teeth, choose a treatment that we might want, or come back as often as we might think they should. However, paradoxically, when we accept this fact, our patients often behave in the ways we might have thought best to begin with.

Second, we should seek engagement with our patients as partners in their oral health care. A growing body of evidence suggests that patients (and families) who are engaged as partners in their care improve the quality of health outcomes, while simultaneously making the care safer and less expensive [4]. It is important to recognize we can theoretically view patients as equals, and simultaneously maintain a unidirectional flow of information from provider to patient. Partnership is the practical work of equality. Working *with* our patients, instead of working *on* them, must become a priority. When we collaborate with our patients, we move from *consultation*, where a patient receives information about a diagnosis or treatment, to *partnership and shared leadership*, where treatment decisions are made based on patients’ preferences, the best evidence, and sound clinical judgement [6].

Finally, we must learn to share information with patients in a way that honors the above two commitments. This is not easy, and many parts of our job will look and feel different, from value-based conversations about overall goals for oral health to engaged conversations around informed consent to the use of evidence-based tools like patient decision aids (PDAs) that support patient knowledge and understanding before preventive or surgical interventions are chosen. The little evidence that does exist with regard to shared decision making and dentistry is centered on PDAs. True shared decision making is more than ensuring patients have the information and understanding they need to make an informed decision, but it certainly cannot be less than this. Taking the extensive resources from the medical field as an example, we can and should, as a profession, use our technical and diagnostic proficiency to create PDAs specific to dentistry, knowing that both patients and professionals will benefit from their use.

In his recent guest editorial in the Journal of The American Dental Association, Marko Vujicic argues that the dental care system is stuck, and offers four ways in which he believes we can begin to gain traction as we strive for forward movement [7]. His insightful solutions are important system reforms that will help change the profession from the top down. Shared decision making has the potential to compliment these proposed changes from the ground up. The postures of autonomy support, engaged partnership, and collaborative information sharing can reshape everyday clinical encounters, and serve as the foundation for the grassroots change that accompanies any worthy revolution. Change is indeed upon us, and if we can embrace these ideals, shifting our primary question from “What is the matter with you?” to “What matters to you?” [8], the post-paternalistic era of dentistry will likely evolve to a time of true oral *health*.

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