

# Health Behavior Change in the Dental Practice

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## CHAPTER 1

# **INTRODUCTION TO HEALTH BEHAVIOR CHANGE FOR THE DENTAL PRACTICE**

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## HEALTH CARE IN THE TWENTY-FIRST CENTURY

Health professionals working in this century are presented with a unique combination of patient care scenarios. The unprecedented advances in the development of scientific knowledge, means of knowledge dissemination, clinical skills application, public health initiatives, and workforce diversity are well recognized in today's health care environment. However, many additional factors influence the opportunity for patients and clinicians alike to achieve the goal of attaining health and continued wellness. Some of these may be derived from catastrophic events associated with the conflicts of war, natural disasters, and critical socio-economic factors. Others are more reflective of circumstances for individuals and the lifestyle choices they make throughout their lifetime. In many situations, health status is not a result of the influence of a single element working in isolation. It is more likely that we see a number of components present in the overall environment in which the patient chooses to exist. The acknowledgement of the potential impact of a variety of influences on health status allows the health professional to work with the patient to understand the individual approach for optimal wellness. As oral health professionals, this recognition is integral to the future development of patient care plans that are not limited to treating the signs and symptoms of common dental diseases.

There is increasing evidence suggesting oral health status can affect general health and quality of life in people of all ages. Most oral diseases are common chronic diseases and are momentous public health issues with a high prevalence across all populations worldwide. Some of the etiologies of oral diseases are well known. They include (1) the causal factors induced by oral biofilms, and (2) the lifestyle risk factors common to a number of chronic diseases: insufficient oral hygiene, tobacco use, diet, behaviors causing injuries, and stress. All of these elements are modifiable and associated with the influence of health behaviors as determinants of disease prevalence.

As we are living in a century of heightened awareness of chronic diseases, health care challenges are becoming more diverse, with an increasing percentage of the population in the developed world being diagnosed with health decline associated with "lifestyle" behaviors. Therefore, the health professional is continuously presented with a dual focus—control of current disease while facilitating the understanding of continuous self-management as part of an effective and equitable long-term solution. Oral health professionals are not exempt from this approach to patient care as we continue our efforts to manage common oral diseases as a chronic condition rather than simply

treating the sequelae of acute episodes. This introductory chapter sets the stage for this book through a discussion of past, current, and future understanding of the dental clinician as a health professional supporting the promotion of total health rather than a provider of operative dentistry alone.

There is substantial evidence that oral health can be maintained by adequate behaviors such as regular oral hygiene, avoidance of tobacco, and consumption of a healthy diet. Future public health policies should be reoriented to incorporate oral health practices recommending behavioral support and the common risk factor approach for health promotion. Oral health care professionals should gain an understanding of the health effects of inappropriate behaviors in order to successfully target prevention and disease control. As a consequence, services for primary and secondary prevention on an individual level oriented toward the change of inappropriate behavior will become a professional responsibility for all oral health care providers.

From a practical point of view, it may be preferable to apply methods for health behavior change counselling in oral care that are shown to be effective in both primary and secondary prevention of oral diseases. These methods should be

- based on the best available evidence,
- applicable to oral hygiene behavior, tobacco use prevention and cessation, and dietary counselling, and
- suitable for implementation by the dental practice team in a cost-effective way.

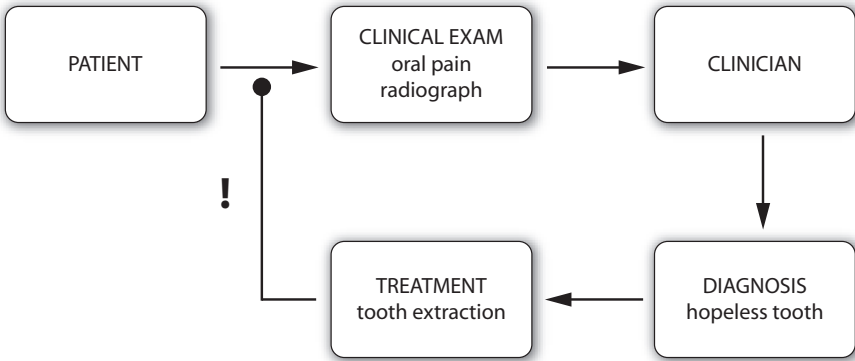
## THE OPPORTUNITY IN THE DENTAL SETTING

The dental setting provides a unique environment for the provision of care for a range of health issues. For some time, in many developed nations, people have tended to visit the dental practice more frequently than they visit the medical practitioner. They have been more likely to seek medical advice when they are experiencing discomfort or have recognized symptoms that require assistance. The concept of the regular, 6-month “dental check-up” has enjoyed strong recognition and relevance with many members of the public. In more recent times, health practitioners and public health care initiatives have embraced the concept of regular visits as part of a monitoring/preventive

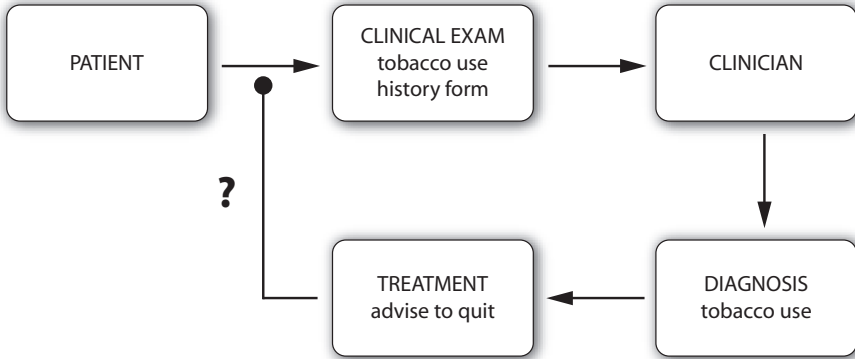
approach rather than a response to an acute episode. This frequency of visitation has allowed collaborative patient care plans to develop with interprofessional exchange. For example, many optometrists regularly screen for signs of diabetic retinopathy as a possible indicator of undiagnosed diabetes or as a consequence of managed diabetes. Within the context of the dental setting, a patient may be a part of the practice for many years and, in some cases, a lifetime. Additionally, the practice may also provide care for the patient's family members and their friends, who all form part of the individual's environment and lifestyle. This unique situation allows the oral health professional to acknowledge and gain a broad understanding of the myriad of influential health care factors associated with patient care. The dental setting, therefore, provides a privileged situation in which the dental professional can realize the opportunity to form a long-standing and supportive relationship in health care management with his or her patient. However, this opportunity is often underutilized or ignored completely when the clinician assumes a more conventional role.

Historically, dental clinicians have been characterized as “active,” “powerful,” and “expert,” while patients have been described as “passive” and “cooperative.” The dental treatment room itself, where the patients are in a submissive position and the clinicians are in a controlling position, supports these traditional roles. With a focus on technical expertise, dental clinicians may believe that their communications with patients will be based on common sense or are secondary to the provision of successful treatment. As shown in Figure 1.1, this traditional view of dental care is generally understood as operative oral medicine, or even dental surgery alone. Even though a patient suffering from oral pain will be correctly diagnosed with a hopeless tooth by the clinician, and subsequently treated with a tooth extraction, the patient may not be approached any further with the measures necessary for the prevention of further tooth loss.

Even if the need for preventive measures is recognized, some dental clinicians struggle with interviewing skills, may miscalculate how much (and how) information should be shared, have difficulty detecting and resolving issues with patient cooperation, or have varying levels of skill in interpreting non-verbal behaviors. Quite possibly due to a familiarity with diagnosing a problem, followed by providing a solution, preventive approaches are delivered in a prescriptive format. This may result in a situation that is illustrated in Figure 1.2: tobacco use is identified in the health history form of a patient who will be approached with the advice to quit. However, since there are no further measures taken, doubt remains whether beneficial health behavior change, such as smoking cessation, will occur.



**Figure 1.1.** Operative oral medicine.



**Figure 1.2.** Preventive oral medicine.

Consequently, current advice-giving or health education approaches appear to be unpredictable in accomplishing long-term change, potentially leading to frustration of both the patient and the clinician. Yet, the patient may be blamed for poor compliance and further oral health education may be judged as pointless.

## Adoption and integration of health behavior change

History has demonstrated that the past efforts of health professionals to promote changes in behavior that support positive health outcomes have



potential for improvement. Compliance with medical recommendations is generally poor across all chronic disease regimens, which increases health care expenditures and prevents patients from achieving the full benefit of health behavior interventions. A number of studies have been conducted investigating ways to improve compliance, but research results have not shown to affect significant changes in compliance behavior (Berg et al. 2006).

This dilemma of patient and clinician agreement regarding long-term changes in health behavior has been systematically examined for over 50 years. In 2001, the World Health Organization (WHO) convened a conference to focus on the issues associated with outcomes commonly termed as treatment adherence and compliance. Poor adherence to treatment of chronic diseases was reported at a rate of 50% in developed countries with even lower rates of adherence in developing countries (WHO 2003). This review not only demonstrates the challenges associated with health behavior change but also provides a catalyst for health practitioners to review their role as a significant factor in the success of compliance strategies.

Health care providers may harbor an unwarranted sense of their own importance in inspiring behavior change, ignoring other variables that impact a patient's behavior. This may serve to diminish the patients' key role rather than empowering the patients themselves. Although health care professionals typically believe that they are providing quality care, it is generally from their own perspective that they are defining quality (Larsen et al. 2006). The patient perspective of quality could be very different, as there may be a fundamental disagreement of needs and expectations in the clinician-patient relationship. Even if there is agreement, the acceptance of care or behavior change (adoption) and the practical application (integration) of care or behavior change often requires further exploration to ensure ongoing success.

Many oral health professionals underestimate the importance of communication as compared to technical skill. This tends to foster a focus on compliance rather than collaboration. Additionally, the framework of dental care delivery reinforces a traditional model of clinician-patient roles that diminishes the value of the communication necessary for successful partnership (Gochman 1997). Despite the possible negativity associated with past approaches, oral health professionals should be encouraged, knowing they operate in an environment that is extremely conducive to success. The nature, frequency, and longevity of clinician-patient interaction within the dental setting are unlike any other health care environment. Therefore, the opportunity to work with patients toward the adoption and integration of positive health behaviors into their current lifestyle is limitless. As oral health

professionals choose to take advantage of this privileged situation, they will find themselves valuable providers of integral support across the complete spectrum of health care.

## **The role and responsibility of the dental professional**

### **Ethical**

The ethical basis of interactions with patients to guide behavioral change still needs to be defined. Health care delivery requires competent clinical practice by professionals and avoidance of negative responses by patients that such interventions may induce (such as confusion or loss of self-confidence).

Health behavior change interventions must be devoid of gender, ethnic, cultural, and age bias and designed to be effective for persons of widely varied levels of formal education (Redman 2007). The patient must be an active participant and must willingly engage in the change process. Health care professionals who impose their own values and beliefs on the patient limit the patient's possibilities and create situations of domination and dependence. Ultimately the patient has the ethical right to choose whether or not to change, to choose when to change, and to determine what form any change will take (Chin 2006).

### **Legal**

The legal basis of all interactions with patients directed at guiding behavioral change has been established through case law, regulations governing professional practice, and prescribed requirements for health care institutions. It is particularly guided by the doctrine of informed decision making and consent (Redman 2007).

In the United States, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) and the Centers for Medicare & Medicaid Services (CMS) mandate both patient and family education for hospitals and long-term care facilities that are participating in CMS programs. These mandates include the need for documentation of patient education during hospitalization. The organizational structure of such hospitals provides an infrastructure by which coordination, counselling, and documentation may occur for the institution to meet the JCAHO standards

(Rankin et al. 2005). In order for smaller health care organizations (including dental clinics) to meet these goals, the leadership must demonstrate its need. To date, in the United States, no policies or educational guidelines exist for dental care provided outside of hospital settings. Changes in dental professionals' behavior, in education or practice, typically have been slow unless they are regulated or have a potential impact on livelihood (Gift and White 1997).

## **Collaborative care toward whole health**

Historically, the dental profession has suffered as a result of its isolation from others working in health-related fields (Brown 1994). This isolation may have, in turn, allowed preventable patient suffering caused by a fragmented view of the patient's health care network. However, for the future, integration with other health professions is seen as mandatory in order to successfully address the education and practical implementation of health behavior change in the dental practice.

This realization has been the stimulus for the collaborative efforts initiated to write this book. Each of the co-authors has integrated the health behavior change principles in his or her clinical research agenda, patient care plans, or dental and dental hygiene curricula. The six subsequent chapters are uniquely aligned as a course to inspire and facilitate integration of health behavior change counselling in the dental practice.

Following this introduction, chapter 2 reveals "The Challenge of Behavior Change" and highlights the complexity of behavior change counselling in a clinical setting. Within chapter 3, "Communication and Health Behavior Change Counselling," the importance of establishing a good rapport is introduced together with the styles and key skills for effective communication. Subsequently, chapter 4 focuses on "Motivational Interviewing (MI) and Its Basic Tools" for use to engage the patient in discussion about behavior change. In chapter 5, "Brief Interventions in Promoting Health Behavior Change," several approaches on how to engage the patient in a short amount of time are introduced. In order to demonstrate the "Implementation of Health Behavior Change Principles in Dental Practice," chapter 6 presents the translation of the theory into practice. It presents a case scenario adapted for the dental practice. Chapter 7, "Health Behavior Change Education," discusses the implementation of health behavior change counselling into the dental and dental hygiene curriculum.

The theoretical content presented in this book provides more than sufficient background for the implementation of health behavior change counselling into practice. The reader may prefer to follow each chapter in sequence or utilize the key points provided at the beginning of each chapter to locate specific information.

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