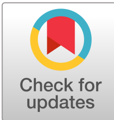

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PERSPECTIVE BRIEF

The value of values: shared decision-making in person-centered, value-based oral health care

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Abstract

In order to provide care that is truly person-centered, dental practitioners must incorporate the informed preferences of our patients into clinical treatment decisions. Shared decision making provides the necessary framework to accomplish this goal, especially in an era of value-based care.

Over the past decade, a conceptual shift has occurred in healthcare, redefining the center of the care experience not as the patient but as the person. This transition is more than mere pedantry; it reorients our clinical lenses to see a person holistically instead of primarily from a biomedical perspective. Although there are many definitions of person-centered care, the American Geriatric Society has elegantly encapsulated this new paradigm, defining person-centered care as "… care in which individuals' values and preferences are elicited and, once expressed, guide all aspects of their health care, supporting their realistic health and life goals. It defines quality and value, not simply through technical measures of care, but through dignity, respect of personal choices, and life outcomes achieved."[1]

Closely coinciding with this shift has been the emergence of value-based healthcare (VBC). While VBC was initially defined in primarily economic terms, it has evolved to address the principal drivers of the triple (or quadruple) aim, including patient experience. For example, personal value – "ensuring each individual patient's values are used as a basis for decision-making in a way that will optimize the benefits for them"[2] – is included as one of the four pillars of VBC in the European Commission's comprehensive "Defining Value in 'Value-Based Healthcare.'"

While it is worthwhile to understand these broad movements within healthcare from a theoretical and historical perspective, it is also important to consider the tangible impact they have on the daily workflow of a dental clinician. Where do person-centered care and value-based care overlap, and how do they impact a face-to-face interaction in a dental setting? The most salient example, and the one that will be discussed in this perspective, is shared decision-making (SDM).

Borne from ethical and philosophical origins, SDM – "an approach where clinicians and patients share the best available evidence when faced with the task of making decisions, and where patients are supported to consider options, to achieve informed preferences"[3] – has been robustly studied and implemented in healthcare settings and systems around the world for nearly four decades, perhaps most notably in the National Health Service (NHS) in the UK.[4] Although SDM shares many characteristics with motivational interviewing (MI),[5] which has risen in recognition, understanding, and implementation within the dental world over the past several decades, SDM in dentistry remains a largely underexplored person-centered style with everyday clinical applications. Table 1 presents common decisions that are made in dental offices where patient preferences and values can and should help guide treatment. While some of the considerations overlap between clinician and patient (or parent), it is an important starting point in SDM to recognize where considerations might differ. How these differences are resolved

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Table 1 Shared Decision-Making Considerations for Common Clinical Decisions

Clinical decision	Common clinician considerations	Common patient/parent values and preferences
In-office or hospital-based pediatric treatment	Patient behavior, impact on future dental experience, provider reimbursement	General anesthesia risk, pain, cost, number of appointments
Silver diamine fluoride use	Success rate, need for additional restorative procedures, need for reapplication, perception of esthetics reflecting on clinical skill	Pain, cost, esthetics, success rate
Remineralization of interproximal caries lesions	Uncertainty of cavitation, activity of lesion (or lack thereof), success of chemotherapeutic agents (e.g., silver diamine fluoride vs. MI paste), fear of undertreatement	Pain, cost, success rate

from philosophical, ethical, and practical perspectives merits more in-depth treatment in the literature as it relates to decisions that affect oral health.

The emphasis on personal values and preferences in SDM aligns well with the emphasis on the patient perspective in patient-reported outcome measures (PROMs) and patient-reported experience measures (PREMs). PROMs and PREMs are likely to have an important role in the measurement of value in a value-based care environment.[6] One might even go so far to say that SDM stands at the clinical confluence of person-centered care and value-based care and is therefore uniquely positioned to help capture and interpret both PROMs and PREMs. This is in large part due to the centrality of honoring patient voice within the SDM framework, style, and skills. As Editor-in-Chief of the Journal of the American Dental Association, Michael Glick recently noted in an editorial, "…the success documented in the use of PROMs in medicine have all been contingent on how effectively the health care professional responded to patients' voices. An iterative dialogue with patients about their values, preferences, and expectations must be integrated in everyday dental practice."[7]

My personal experience with SDM, both in my practice and in training other practitioners, has had a profound impact on my understanding of the role I play in clinical decision-making. Previously, many treatment decisions were one-sided, relying exclusively on my clinical expertise and treatment philosophy to create a plan for the patient. I worked hard to do what I thought was best for each patient, feeling justified in this stance given my commitment to a prevention-first, minimally invasive treatment approach, whether using silver diamine fluoride or silver modified atraumatic restorative technique fillings, attempting to arrest and remineralize caries whenever possible, or placing sealants for both children and adults to protect at-risk pits and fissures. I gave evidence-based advice and tried to help patients see a recommended treatment through my clinical lenses. Although my paradigm had shifted from "drill and fill" to something much less invasive, it was still mainly *dentist-driven*. Applying the style and skills of SDM has allowed me to attempt to understand their values and preferences from a phenomenological perspective to narrow treatment possibilities. Once we have arrived at that point together, I can offer the best available evidence and information instead of giving advice, guiding the patient to a treatment decision that has involved each of our perspectives, and was ultimately driven by what matters most to them.

Training other practitioners to practice SDM has helped me identify several common barriers to its implementation and one foundational tool to help begin to overcome these barriers. First, many well-intentioned dentists continue to practice as they learned during their initial training, and evidence-based effective communication styles and strategies, including MI and SDM, have not commonly been taught in dental schools to levels of proficiency. Second, as is commonly seen with other healthcare professionals,[8] dental practitioners mistakenly believe they are already practicing skills like SDM when in fact they are not. Finally, dentists are hesitant to employ the approach for fear it will take an inordinate amount of time. In my experience, the use of a patient decision aid (PDA) is the most universal solution to all of these barriers. PDAs seem to help practitioners feel more comfortable in taking the first step with a new skill; they act as a conversation guide and support. While many decision aids exist for a wide range of medical decisions, PDAs focused on dental decisions are few and far between. It is imperative that dentistry helps design, test, and implement PDAs to guide the decision-making process. Clinicians must start to use these tools in dental school, with continued education, training, and practice thereafter. From a patient perspective, the importance of PDAs is well known (at least regarding medical decision-making). "Compared to usual care across a wide variety of decision contexts, people exposed to decision aids feel more knowledgeable, better informed, and clearer about their values, and they probably have a more active role in decision making and more accurate risk perceptions. There is growing evidence that decision aids may improve values-congruent choices. There are no adverse effects on health outcomes or satisfaction."[9] Decision aids generally seem to help patients choose less-invasive (and

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less expensive) treatment options and, on average, do not add considerable length to a consultation.[10] Similar research regarding the use of PDAs for making dental decisions would be of great benefit to patients and practitioners alike.

In a world upended by COVID-19 and reshaped by protests for racial equality, dentistry finds itself in a "kairos" moment, with the opportunity to ensure a more just dental care system. It is also the opportune time to ensure that the paternalistic history that has influenced the patient experience of dental care is re-envisioned with principles of relational egalitarianism and respect for patient autonomy. The future of person-centered, value-based care in dentistry sees shared decision-making ready to play a pivotal role. Practitioners must learn to partner with patients to make clinical decisions based on elicited values and preferences, or care will not be person-centered. Similarly, practitioners must learn to respond to what patients value, measured via PROMs and PREMs, or care will not be value(s)-based. As a profession, we can stop making decisions *for* patients. Instead, we can start sharing decision-making responsibility *with* patients, creating partnership, satisfaction, and value for stakeholders across the spectrum of a reimagined dental care system.

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