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Probing *Status Quo Bias* in Dentistry

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ABSTRACT

The status quo bias in dentistry refers to a practitioner's preference for certain treatment modalities and resistance to contemplating the need for a change. Lack of updating skills and amending their work routine accordingly can result in them providing treatment that is dated or even totally obsolete. It could even be detrimental to their patient's oral health and open them up to the risk of litigation. The concept of Continuing Professional Development (CPD) was introduced to try enforce clinicians to improve their knowledge and skills, and keep abreast of current best practice recommendations. However, it should not be seen as a mere points collecting exercise that has little effect on bringing about changes in their work. Dentists need to continually review their work, and make adjustments when necessary in order to do better and be better. Only then can they claim to be acting in their patients' best interest and fulfilling their duty of beneficence.

INTRODUCTION

The status quo bias relates to a person's "preference for the current state of affairs, resulting in their resistance to change."[1] It can occur in any situation where people have become accustomed to and content with "the norm." Making a change would require a conscious decision, followed by a definitive action, which requires both mental and physical effort. Unless the individual starts to suffer under their present situation, they may find it far easier to leave things the way they are than to try make a change. It may be argued that for many trivial issues, staying in a functioning and comfortable situation "frees up mental resources for other more important tasks."[1] However, it also leads to the risk of "missing out on new opportunities that could be more beneficial."1 In dentistry, a greater risk is that a lack of effortful planning could lead to decisions and actions that are not always based on "sound and considered reasoning." This, in turn, could result in clinicians providing treatment that is not in the best interest of their patients.

Status quo bias in dentistry

The status quo can be likened to the "default position" or the "habitual" practice in dentistry. It serves as the baseline for treatment planning and often results in clinicians treating patients in a routine manner, based on their training, experience, and at times, personal preferences. Their preference for the default is an easier option than spending time and effort on clinical debate and reasoning before commencing with each new case. However, it is not always an indication of laziness. Sometimes, it is chosen because the norm is "familiar and comfortable," and clinicians know what outcomes to expect. It thus acts as a shield to protect them from potential risks associated with trying out new methods. This stance can be seen as a form of "loss aversion or regret avoidance," where practitioners place greater weight on the potential losses they may face than the gains that could be achieved if they attempted something new.[1] They will rather avoid choices and decisions that may result in them having to face feelings of regret later on. They tend to be blind to the possible advantages of purposeful deviation and don't even contemplate the potential gains that could be achieved by choosing alternatives.[2]

At the same time, access to social media has allowed patients to become far more aware of and knowledgeable about different treatment options available. This has led them to place increasingly high and, at times, unrealistic and/or unachievable demands on the clinicians. Furthermore, there has been an explosion in new dental materials, techniques, and treatment modalities becoming available. It is no wonder that modern dentists often feel overwhelmed with all the options and resort to the status quo because it is "safe." Research into status quo bias substantiates this notion. Nebel (2015) showed that its influence is "positively correlated with the number of options available".[3] Others suggest that this "choice overload" may lead to people making worse decisions.[4] It is then easy to see why busy practitioners routinely resort to their usual and preferred treatment modalities. This may be useful for minor and mundane decisions where it may save time and "free up mental resources for the more important decisions".[5] However, dentists who charge consultation fees are ethically and legally obliged to justify these by thoroughly assessing each patient, weighing up all the options, and formulating a definitive treatment plan tailored to their needs.

This reliance on the status quo can have negative consequences. If it is always the preferred position, it never allows practitioners to progress or improve their skills and services. Patients, too, will suffer by being treated with methods and materials that may be dated and not in accordance with current evidence-based best practices. Imagine if dentists still did cavity preparations according to the GV Black design principles or believed in "extension for prevention" when removing caries. These concepts may seem ludicrous to clinicians in 2022, yet they were taught to dental students who studied in the eighties and nineties. Some practitioners continue to "prophylactically" remove wisdom teeth or do full mouth clearances on patients scheduled for radiation therapy to the head and neck regions despite there being no conclusive literature to support the former and abundant papers negating the need

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for the latter. The above examples illustrate how those who cling to the status quo may be doing a disservice to their patients, and this could even be accused of malpractice.

Attempts to overcome the challenges of *status quo* bias

Having a qualification is no guarantee that clinicians will maintain their proficiency, keep abreast of current philosophies and treatment modalities, or maintain lifelong competence.[6] Yet, patients have a right to therapy that is provided by practitioners who are skilled, up to date, and competent.[7] As long ago as 1972, Dubin first spoke of the "half-life" concept in medicine, wherein he estimated that knowledge becomes outdated in as short a time as five years after graduation.[8] Several years later, the professional medical and dental bodies worldwide took cognisance of this tendency for established clinicians to fall into the status quo bias trap and the associated risks this posed for their patients. To try and mitigate these, they introduced the requirement for all practitioners to undergo compulsory life-long academic training in the form of Continuing Professional Development (CPD) activities. Compliance is monitored by the relevant governing bodies in each country

The Health Professions Council of South Africa (HPCSA) introduced mandatory CPD point acquisition in 2007. Those who failed to comply would have their names erased from the register and effectively be unable to continue practicing. The reasoning behind CPD was that it would allow professionals to constantly update their knowledge and, by implication, their skills as technology advances.[9] The problem with CPD is that there is a lack of evidence that it results in concrete changes, such as clinicians changing their routine habits or updating their practices to embrace the latest modalities.[10] Dentistry, in particular, has and continues to, undergo rapid advancement in terms of materials, equipment and techniques. This makes it easy for stagnant practitioners to become dated in the services they offer and provide to their patients. CPD points can be gained through journal clubs, online courses, research projects, supervision of students, and professionals meetings such as congresses/conferences. Journal clubs are popular as they can be arranged at convenient times and locations. In addition, they encourage the participants to analyse and review research papers and discuss them critically.[11] Most other CPD activities are also preferred over formal testing, but very few are structured to test and ensure clinical competency. In addition, mere attendance and point compliance are of little use if the information and skills gained are not implemented on a practical level. It is thus the responsibility of the practitioner to ensure that they do this in order to provide treatment that is in keeping with current, evidence-based best practice. To this end, the profession and service providers should focus less on using CPD as a money-making venture and more on promoting activities such as journal clubs, discussion circles, and skills transfer courses. These will allow dentists to engage in critical thinking and robust debates with colleagues, gain convincing knowledge and improve their practical skills. Clinicians themselves need to view CPD courses as constructive means of self-improvement and not punitive regulated obligations.

CONCLUSION

Clinicians need to be aware of the status quo bias to recognize when they may be resorting to this mode out of ignorance, laziness, fear of the unknown, or feeling overwhelmed. Breaking out of this habit requires a conscious effort. It also necessitates spending time and mental energy weighing up all the options and making the best decision for each patient based on sound reasoning and knowledge of the current best-practice recommendations. Only then can dentists genuinely claim to be acting in their patients' best interest and fulfilling their duty to beneficence.

Perhaps clinicians should conduct regular introspective status quo bias reviews. When necessary, they may need to make mindset edits and delete phrases such as "This is what I've always done, so why change what works ?" and replace them with more proactive affirmations like "This is what I've always done, but how can I do better?"

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