Hearts and Habits: Making Prevention Stick



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Preventive dentistry does not fail because patients disagree with it. It fails because agreement is not behaviour. Every day, clinicians provide evidence-based recommendations that patients genuinely intend to follow – only to see those intentions disappear in the reality of busy lives. Closing this gap requires more than better communication or stronger motivation. It requires understanding how habits are formed, sustained, and supported over time.



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"Prevention is better than cure" is rarely disputed. Most patients already believe it. The real clinical challenge is something else: can they turn that belief into repeatable behaviour, day after day, amid fatigue, distraction, and a missed routine? Disease rarely comes back because patients lack information. It returns because sustainable behaviour takes more than knowledge; it takes design, and designing for behaviour is something most clinical training never teaches.

This matters enormously for oral health. Long-term outcomes depend on clinical skill, yes, but they depend just as much on whether the patient can maintain a stable oral ecosystem at home: effective biofilm control, structured interdental cleaning, and regular professional care. Most dental treatments don't fail on the day of surgery. They fail later, at home, in the evening, when the patient is tired, and motivation has thinned. The behavioural side of oral health isn't a nice extra: it's one of the main factors determining whether treatment lasts.

The gap between knowing and doing

So why does this keep being underestimated? Start with a pattern every clinician recognises. Patients understand that bleeding gums signal inflammation, yet they still normalise it. Calling this non-compliance misdiagnoses the problem and backfires clinically. Patients aren't passive; they actively protect existing habits that feel familiar, coherent, and theirs. Change disrupts that, creating real psychological discomfort, especially when they notice the gap between what they value and what they do. In the dental chair, that discomfort turns into excuses: "my gums have always bled," "it's genetic," "I don't have time." These aren't signs of laziness but a form of self-protection that needs a clinical response tailored to it, not a louder version of the same advice.

Here's the uncomfortable part, and it applies well beyond the dental chair. Declarations, symposia, magazines and journals: all of them can fall into the same trap as the patient who nods along and changes nothing. Agreement is not behaviour. A movement built only on shared conviction risks producing beautiful statements and very little else. Prevention doesn't fail because people lack belief. It fails because nobody designed for what happens after belief. That's what the rest of this piece is actually about.

Where behaviour breaks down

Start the design with one question: when a behaviour doesn't happen, where exactly did it break down? A patient who has never been shown how to use an interdental brush has a different problem from one who intends to clean every evening but has no cue to remind them. The first is missing a skill. The second is missing an anchor. Three things can make a behaviour possible: the ability to do it, the chance to do it, and the drive to do it. Remove any one of them and the behaviour doesn't happen (Michie et al., 2011). Naming the missing piece tells the clinician what to do next. Naming "non-compliance" tells them nothing.

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There's a second, equally common breakdown: after a patient decides to change, the intention quietly dissolves within days, not because it was weak, but because deciding to change and sustaining it draw on different mental resources (Schwarzer, 2008). One bridge works remarkably well: instead of "I'll floss more," the plan gets specific: "I'll use the interdental brush after toothbrushing, before bed." That level of detail, specifying when, where, and right after what, has a strong track record across health behaviours (Gollwitzer & Sheeran, 2006).

From telling to collaborating

None of this works if the conversation feels like pressure: clinical communication has to move from telling to building together. The clinician's job is to help the patient find their own reasons to change, working with their ambivalence instead of arguing against it. That's the core of motivational interviewing (Rollnick et al., 2008). Motivation imposed from outside behaves nothing like motivation built on meaning the patient finds for themselves (Deci & Ryan, 2008); the first predicts relapse the moment pressure lifts, the second predicts that the behaviour sticks. This is also why the relationship itself isn't a mere detail: shared goals and a bond built on trust determine whether the patient returns, remains engaged, and keeps going (Bordin, 1979).

Even the words matter: "hygiene" sounds clinical and neutral, but it often comes across as judgemental, and judgement makes people defensive (Brehm & Brehm, 2013). Framing a recommendation as the ideal can lead the patient who can't meet it to drop the whole routine rather than keep a smaller version. A better question isn't "what does perfect look like?" It's "what's the smallest version of this that the patient can actually start, stick with, and build from?" This works because believing you can do something in a specific moment is one of the strongest predictors of whether you start and keep going (Bandura, 1997). That belief grows through small wins, not by repeatedly falling short of a high bar.

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The appointment is only the beginning

Something more fundamental lies underneath: a recommendation with no emotional weight is filed as information and rarely turns into action; emotion and decision-making run together, not in separate systems (Adolphs & Anderson, 2018). Connect a recommendation to what the patient actually cares about, such as confidence or ease in social situations, and it sticks in a way pure facts never will. A behaviour becomes durable not when the patient understands it, but when it no longer requires a decision (Wood & Neal, 2007). That shift, from "I'm trying to remember to do this" to "I just do this," is where most maintenance plans fall apart, and where the clinician usually disappears.

Maintenance needs its own place in the treatment plan, not as an afterthought tacked onto the real work. Motivation isn't fixed; it rises and falls with pain, with visible results and with time. Once the original complaint is gone, the motivation that drove the first round of change often goes with it. Structured maintenance and regular follow-up aren't a courtesy for anxious patients: they're cost-effective in protecting outcomes over time (Gaunt et al., 2008). And relapse, when it happens, isn't failure. It's information. It points straight to which part of the routine wasn't yet realistic, didn't yet mean enough, or hadn't become automatic enough to survive a bad week (Marlatt & Gordon, 1985; Taleb, 2007).

This changes what the clinician's job actually is. The clinician still diagnoses and treats, but also designs the conditions for behaviour change and stays involved in maintaining it. The real question isn't only "what did we treat?" It's what the appointment leaves behind: one small, practised, specific action the patient genuinely believes they'll repeat tomorrow. That work doesn't stop when treatment ends; it runs before, during, and after, so health has something solid to stand on, not just the belief that it should.

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