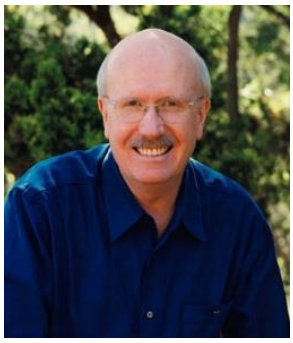
The Right Time to Discuss Fees Part I



The author shares 12 secrets that will allow you to close major cases without quoting fees.

Bob Frazer Jr., DDS

This article appeared in the late 1980's – I added the italicized comments in 2014.

How do you feel about quoting fees? Especially on larger cases or complex treatment? Do you know when to quote a fee? When it is most appropriate in terms of ease of presentation and likelihood of patient acceptance? If you are like I was during my first 10 years of practice, I suspect your honest answer is `No, not really!` or `I never quote fees; I have my staff or financial assistant do it!` *I felt uncertain and awkward, sometimes an awkwardness in my gut in those early years.*

In practical terms, I, too, often delegate quotation of fee, but I must be completely comfortable with the fee and, should the occasion arise, be happy to quote and discuss fees. After 25 years of practice and a lot of time spent with dentists and their teams, I can assure you that you are not alone in your discomfort. *What EI research showed us today is that your patient also feels your emotions and may interpret them as your uncertainty about the treatment. This makes them hesitant to proceed and accept your recommended treatment.*

Most of us really are uncomfortable when it comes to discussing fees or money with patients or, for that matter, staff. I believe the problem with money and fees almost always is that of the dentist first, then the staff and, lastly, the patient. Insurance, managed care-or what is better termed "managed cost"-has overtly and even covertly exploited this for years in both medicine and dentistry.

The 12 secrets described within this two-part article will allow those who read and apply them a way of quoting fees comfortably and timely to a patient who you`ve helped move to a point that he/she already has decided to have you perform the treatment that you have recommended. *Today elevating you and your team's EI would be important.* My focus will be on major treatment, not emergency care.

Although the emergency appointment`s behavioral management embodies eight of the 12 secrets, it truly is another "breed of cat," to be reserved for some other time. (Secrets #2-6 and 10-12 do apply to the emergency visit, plus an entirely different framework of dialogue.)

There are only three reasons why people buy, and the fee is not one of them! Without reading further, can you tell me these three reasons? Take a moment and think about the last major purchase you made. First, why did you buy? And why did you buy from them? I`ll come back to this shortly, but let me illustrate all 12 secrets to closing major cases without quoting a fee with a recent true story of a patient who came to me for a second opinion, through a generic referral from a directory of holistic dentists.

Janet, not her real name, is a physically-healthy woman in her early `60s, with a mouthful of restorative dentistry (including one bridge and several crowns) done episodically as teeth fractured or decayed over the last 45 years. She had good periodontal health, a Class II overclosed bite with severe wear on the upper and lower anterior teeth. Her dento-facial appearance was that of a woman in her late `70s. *She presented both concerned and anxious.*

She had accompanied her husband to an alternative medical clinic in Mexico and, while there was referred for a dental exam. During the exam, she was told that she needed to have all of her amalgams removed, plus several crowns and a bridge replaced. Her husband`s illness had not responded to thousands of dollars in conventional therapy, and multiple medical specialists. In desperation, they had sought alternate therapy, to which he already was responding favorably. He would require several trips back to Mexico and she could accompany him for her dentistry if, as she said, `I can- not get the dental work done here for about the same price as Mexico, plus the cost of airfare.`

This person presented many challenges. Technically, her case would be demanding, requiring probable restoration of her correct vertical dimension through provisional crowns with aesthetic, phon-etic and functional refinement, but the behavioral and communication areas were my immediate concern. First, although I pride myself on a whole-person approach, I do not routinely remove serviceable amalgams without a solid medical reason. She brought no medical referral data or test results with her-not even a letter of physician`s recommendations. Secondly, the patient had that driver-type of personality that already knows what he/she wants and wants it done yesterday. To complicate matters more, they were planning to move to another country in about four months, and both my personal and professional

schedule was quite full for the next two months! And, of course, their finances were tight due to the high medical expenses they had faced over the past year.

During our first appointment or Preclinical interview, my health-relationship coordinator, Sandy, learned most of this about Janet. We always begin a comprehensive examination in the comfortable environment of our consultation room, seated at a round table with a cup of juice, water or coffee. Sandy reviews the notes on our telephone card, plus the completed medical and dental preclinical questionnaires which we previously had mailed with a personalized letter of welcome.

This welcoming and listening process between the new patient-or what we consider a guest or visitor to our office (since new patients haven`t yet committed to our care and many simply are checking us out)-and Sandy typically lasts from 20 to 30 minutes before I am asked to join them. In Janet`s case, it lasted nearly an hour.

After my introduction and Sandy`s summary of Janet`s wants, personal circumstances, history and urgent time lines, Sandy left us alone, as is our custom, for us to establish our relationship through a discussion of what I believed our role should be with one another. We began by agreeing to be on a first-name basis (something that I prefer when the patient is comfortable with it-about 95 percent of the time in our practice) and I acknowledged her tight time lines. *Today we would have reflected more of her feelings – anxiousness to get started, budget consciousness, concern about Mexican dentistry and most of all her relief that her husband was being helped .*

We spent much of the 20 minutes together sorting out her experience in Mexico, what she believed was wrong in her mouth and her desired level of dental health. I began to gain an understanding of the terribly stressful, scary previous two years she and her husband, John, had just been through, during which he had nearly died of peritonitis, and his long, slow recovery, which still was ongoing. We concluded this appointment with comprehensive records including: vital signs, a full radiographic series, diagnostic models, a centric-relation bite record and facebow. All she had brought with her from the Mexican office was a set of bitewings and two P.A. radiographs.

Our clinical examination occurred about a week later after diagnostic records had been processed and models had been orthodontically trimmed and, in this complex case, mounted. We began this process with the health-relationship coordinator, Sandy, and Janet, previewing and orienting the

patient to her records. This generally takes 15 minutes or more on a complex case, before I enter the room.

This time, I entered after only five minutes. *(My gut feeling told me to do this.)* After hellos, I reviewed what Janet had told us during her first visit. But, this time, when I came to the part about her husband`s illness and all the stress and responsibility it had thrust upon her (for she had told me that they had a small business for which she became solely responsible, plus taking care of John), I simply acknowledged it must have been one of the most difficult periods of her life. And, I asked how did she get through it so well?

Her eyes filled with tears, although she never really wept as she recounted her story. Janet and John had no family and, I believe, we were truly the first people in whom she had confided. We simply listened in hopes of understanding. *(I listened with something we now teach in our EI training with soft eyes.)* That took at least half an hour, and in the next 45 minutes, we completed our clinical exam, discussing our options, including the very dramatic improvement to her facial aesthetics that would result. Her final question was: "When can we begin and about how much will this cost?"

To which I responded: "We can begin this week with initial cleaning and records for the provisional stage. By the time you do all that we talked about, you will invest every bit as much asyou might in a new car!" "I have a two-year-old Lincoln Town Car," she replied. "Perhaps we could work a swap!"

I told her I wasn`t in the habit of taking cars in trade; plus, unlike fine dentistry, which appreciates with age, cars, even good ones, depreciate rapidly. *She was in fact at least half way "pulling my leg," and we both laughed.* I would write up the formal treatment plan before her next visit and Sandy would review her personal copy with her at that time.

As she left, I heard her tell Sandy that she would like to get John scheduled for this kind of an exam. She later told us that our total fee was over four times what she had been quoted in Mexico. And, although they were ready to dip into already depleted savings, they wouldn`t have to since they were able to sell their house in Austin due to their upcoming move.

Are all my cases this large? And on people who, even with all the medical expenses, are so well off financially? Of course not! But, I do believe that for people in the U.S. today, the great majority will find a way to get anything they truly want and value!

This story perfectly illustrates virtually all of the 12 secrets. When do you believe that this case was closed? When did Janet decide she wanted me to provide her care? I believe it occurred at that second visit, as a result of the trust we had created during the first visit and as a consequence of my listening with compassion for her two-year struggle during John`s illness. Please understand, that is not why I asked. I genuinely felt her struggle and wondered whether she had ever been given the opportunity to really talk about it, so what is Secret No. 1?

There are three reasons why people buy, and fee is not one of them. They are: One, they need it; two, they want it; and last, but by no means least, three, they like the person selling it! Now let's explore the other 11 secrets illustrated by this case and some other cases, where helpful.

The second secret was found in Janet`s story during that first appointment. It is Seek first to understand then to be understood. *(Today we know that it is not through a recitation of every technical detail your patient relates, rather it is by reflecting how what they have been through has made them feel – their emotions. That is when people feel truly understood.)* This kind of listening has been popularized in a best-selling book titled, "The Seven Habits of Highly Effective People," by Stephen Covey. Covey lists this as the fifth habit of highly-effective people, and he goes on to say that they listen with the intent to understand, not to reply!

Perhaps none of the secrets to interpersonal effectiveness is more difficult for the highly-trained, busy professional to practice. We were taught, as doctors, to be experts and, indeed, we are, but most of us spend our early years with large inferiority complexes, for which we overcompensate trying to impress patients with our brilliance. Sir William Osler, the father of surgery, said it well years ago: "If you will but listen intensely to what the patient tells you, he will tell you exactly what`s wrong with him." …a*nd, how he or she feels about it.*

Too often, in my own past, I would rush in to meet a new patient, listen all too briefly, while thinking of my response before he/she or my assistant was through talking. I never really let him/her know I heard what he/she was saying *and feeling* before I jumped in with my advice or recommendation. If you are thinking of a response before another is through speaking you are by definition not listening!

How does one adopt this new habit? Simply begin by attempting to paraphrase to the speaker what you heard him/her say. If there is some emotion in what he/she said, acknowledge it. It often helps to add, "Is that what you meant?" If it is a feeling, such as "I hate dentists," then it can be effective to simply respond that "it must have taken some courage for you to even come in today, given your past experiences." Remember, such comments as “I hate dentists “say more about them than about you!

My friend and mentor, psychologist Ken Olson, said it well in one of his books: "The more I listen, the better they hear me." I believe that Janet cared far more that she was understood… than that she understood my diagnosis and treatment recommendations! *This is one of the areas where all our new technology – although helpful to us in diagnosis and treatment planning - has too often gotten in the way of our humanity. As my teacher Rachel Naomi Remen, MD said – “The Medical technician celebrates the CAT Scan, while the patient celebrates the outstretched hand!”*

Curiously, we have yet to add the wonderful technology of the intraoral video camera to our patient-education tools, not because it isn`t very useful and motivating, but because we simply haven`t needed one. I continue to believe that people care more that they are understood than that they understand! *We did add this but it plays a smaller part in patient acceptance than those who sell the technology would have you believe. It enhances your credibility and trust when employed correctly.*

The third secret has never been more important than in today`s world of increasing depersonalization of health care, with the increasing intrusion of third parties. That secret is we must have relationship, not merely rapport, with our patients as early as possible! Most practitioners and their staffs are good at establishing rapport, which simply means interpersonal warmth. This usually will get you to first base, but not much further when your advice goes up against spouses or employer insurance with whom they have relationship.

Relationship is defined as mutually shared and agreed upon concrete expectations of one another. During our first visit, preclinical, I take the time to initiate a dialogue with the patient as to what I believe my role should be and what role he/she might take in our work together. As with Janet, once Sandy had completed her summary, we were left alone to begin that process. I told Janet that I would like to share a bit of the philosophy of what I believe I should do for people and see if it fit for her.

I begin by clearing the name basis of our relationship. Whenever possible, I prefer to be on a first-name basis. I find people usually smile when I say I like to be called Bob, rather than Dr. Frazer. Why do they smile? I`m not totally sure, but I believe it elevates their self- esteem, making them feel more equal as a person when on a first-name basis with their doctor. The use of my first name by a patient after this initial meeting also signals a higher level of comfort and trust. How many people sue a doctor they call by his or her first name? Few, if any!

I let them know that I believe my primary responsibility is to help them become as healthy as they want to be and to keep their teeth for a lifetime, if that is their desire, with as little additional dentistry after what we do here as is possible. I then ask them to rate their current level of dental health on a 1-10 or excellent, good, fair, poor scale and briefly to summarize why they chose that level. I`m involving their judgment and understanding. But, more importantly, they are expressing their dental self- image. Another person`s self- image is critical to his/her sense of identity. To communicate effectively, I must know and respect it.

This is critical before I begin a comprehensive clinical exam, during which I am likely to discover problems they didn`t know about. If someone sees himself/herself as excellent and I discover he/she is fair at best, I must walk softly in the co-discovery process. When he/she is on the same page with me, as was Janet, who saw her dental health as poor then the process is much easier.

Before closing this discussion, I also ask them what level of health they wish to achieve. My job is to discuss treatment choices during diagnosis and it is extremely useful for me to know the level of health to which they aspire. It also can prove helpful later if the subject of insurance arises. Most insurance is designed to do the very minimum or essentially get someone between fair and good, but not excellent. All of this establishes our relationship.

The late Dr. Bob Barkley said it well: "The health of the relationship is always more important than the health of the patient." Why? Because if the relationship is not good, the patient will not let you help him/her!

This entire first visit leads us to the fourth secret, Identify and serve wants, not needs! Dr. Chuck Sorensen described a need as a feeling that I have that I want to be rid of and do not want again. If you have ever been in pain or truly hungry, once that need is satisfied, you never want it again. I believe the

vast majority of dental practices are needs-driven. Once a need is satisfied, it no longer has a motivating effect. The patient will go away until he/she has another need. This puts these practices at risk and demands a very high volume of new patients to stay profitable.

A values-driven, *relationship based* practice contrasts sharply through its focus on clarifying, *interpreting* and serving people`s values. Sorensen defines a value as a feeling you have that when you have it, you want more of it. We have all treated the patient on whom we replaced an ugly anterior restoration. Suddenly, he/she decides that several other restorations that had been acceptable are no longer acceptable. Values-based dentistry is highly discretionary. In the values-driven practice, the vast majority of your treatment is discretionary or elective, such as a bonded veneer on an unsightly tooth or an inlay or onlay in lieu of a large amalgam, etc.

The fifth secret is closely related to the fourth, but with a focus on the whole person and his/her current state in life. It is: Address the appropriate level of need on Maslow`s Hierachy of Human Needs. Most of us have heard the name Abraham Maslow, who was the first psychologist to study healthy, instead of sick people.

He believed that if we knew the behavior of well, fully-functioning people, we could help ill people learn new healthy behaviors. This concept has revolutionized much of counseling psychology. The old system simply categorized people, as in you are an acute paranoid schizophrenic. I think I spoke to a conference of those not long ago; every other chair was empty! But, seriously, what Maslow really did in his study of self-actualized individuals was to label five levels on which we all function, based on our response to the events in our lives at any given moment-The Hierarchy of Needs. But, here is the point most of us missed. Maslow said, do not address a higher level of need until the lower-level need is essentially satisfied!

A few years ago, a young woman in her last two years of graduate school, we`ll call her Debra, came to me for a comprehensive exam. She had avoided going to the dentist for some five years, although she had been a regular patient for all the years before. During our pre-clinical appointment, we learned that about five years earlier, she had a root canal on a lower molar, after which she was admonished to have a crown placed on the tooth as quickly as possible. Both she and her husband were in graduate school and could barely afford the root canal, so rather than return to the dentist only to be "yelled at for not having the crown" (her words), she simply stayed away

and felt guilty *and anxious*. Where is a crown or, for that matter, any fine discretionary dentistry on Maslow's Hierarchy? The self-esteem level? Where was Debra? The security level, of course, and if at all possible, I should not push for the crown at this time.

It has been most helpful for me and my team to keep Maslow`s Hierarchy in mind as we help people choose our best and finest care. We do this by being sensitive to where they are on this progression before making major recommendations. In a small sense, every new patient/guest who enters our office probably progresses through the top four levels just becoming comfortable with us. But, that is not what I`m referring to; I`m referring to the patient`s life at the time of his/her comprehensive exam.

Next month, I`ll take you into the final seven secrets of closing major cases without quoting fees. I`ll also include the definition of a fair fee. See you then!

The author practices in Austin, TX at the time of this article through 2012 , and is a former Dental Economics Editorial Board member, a member of The Select Blue Ribbon Advisory Panel to The Council on Dental Practice of the ADA, an internationally-known speaker on values-based, fee-for-service dentistry and applied strategic planning for dentists and their organizations.

Today, Dr. Bob Frazer is one of the foremost Performance Coaches for dentists wishing to have both a balanced, joyful life and practice and achieve and maintain Top 2% status in terms of financial and material success, while being significant in the lives of those they serve.