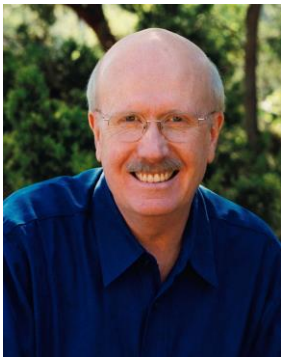
The Right Time to Discuss Fees-Part II



This month, the author introduces you to the learning ladder and his definition of a fair fee.

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

Last month, I shared the story of a patient alias, Janet, and how she came to our office seeking a second opinion regarding a major amount of dentistry she`d had recommended in Mexico. She wanted the work done, but was hopeful I could do it for the same fee, plus the cost of airfare, if she were to fly back to have it done there. During our preclinical interview, we had discovered that she had just experienced a terribly stressful two years with the near death of her husband, John, and his lengthy recovery.

Her diagnosis and treatment plan in Mexico were severely lacking. At the beginning of our second appointment, the clinical exam, during a recap of what she had told us at the first visit, I acknowledged the extremely difficult two years she had been through. She spent the next half hour pouring her heart out, while we simply listened with compassion, *reflecting the feelings of anxiety, hopelessness, frustration and more recently relief and hope .*

In Part I of this article, I discussed the first five secrets to closing major cases. By way of recap, those first five secrets are:

#1: There are only three reasons why people buy and fee is not one of them! The three reasons are...One, they need it. Two, they want it. And three, they like the person selling it.

#2: Author Stephen Covey`s fifth habit of highly effective people...Seek first to understand, then to be understood. *That true understanding comes from your reflection of the feeling behind what the patient expresses in telling their story.*

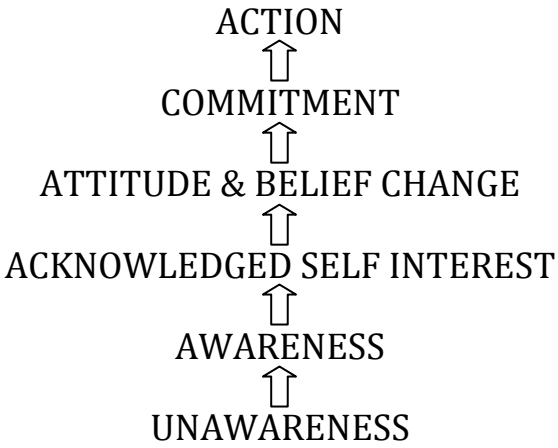
#3: Establish relationships, not merely rapport. *This portion involves you revealing some of your humanness, being appropriately transparent when you have feelings. Most of us need Emotional Intelligence training to do this spontaneously and well. Too often we advance our technical and diagnostic skills without advancing our communication skill set. That's a recipe for rejection and frustration.*

#4: Identify and serve wants and values, not needs! Part of serving values is the necessity that we interpret value in terms of what we do. *The provider of a service always sets the fee; however, it is the buyer who determines the value. Patients are unable to interpret the value – especially of fine dentistry – before it's rendered. You and your team must learn how to do that or your best most complete care will too often be rejected...and you will grow discouraged and frustrated.*

#5: Address the appropriate level of "need" from Maslow`s Hierarchy of Human Needs. Some of what he calls needs, we would today call values.

Let`s pick up now with the sixth secret: Learning progresses logically via the learning ladder. The literal definition of the term doctor is teacher. I believe this is our most important role in diagnosis and treatment-planning. To be effective, we must understand how people learn. I define learning as behavioral change; otherwise, it is simply the imparting of information. How often have you or your hygienist taught a patient how to floss? Yet, how often has that very same patient returned not having flossed for more than a week or so after his/her last visit? I submit that he/she didn`t learn because he/she did not follow the learning ladder. People usually begin at the lowest rung of the ladder and progress upward to genuine learning.

THE LEARNING LADDER



For all of us learning begins first in a state of unawareness: We move to a state of Awareness; then we must Acknowledge Self interest; then there is often an Attitude and Belief Change; then we move to Commitment and only then to effective Action. Without a behavioral change, there has been no *true learning and* acceptance.

If we return to the example of Janet, we can see this progression perfectly illustrated. She presented with one set of concerns, namely amalgams and a leaking bridge. She was, indeed, unaware of the larger issues of bite collapse and secondary occlusal trauma. We helped her discover this during the clinical examination and showed her how it had affected her dento-facial appearance. She very quickly acknowledged a self interest to change to a more youthful or age-appropriate look. *More importantly it gave her a sense of excitement about what was possible .*

Her previous unspoken belief was that she really couldn`t do much about it – *a feeling of hopelessness and resignation.* At least, that was her response during the preclinical interview when I asked her how she felt about the appearance of her teeth and smile. At the end of that same first visit, I also asked: "If I could magically change your teeth or mouth, what would you do?" She quickly said, "I`d have a beautiful smile again!" And, although the commitment to my providing her care had occurred before we even examined her, she had not committed to complete rehabilitation until the clinical exam.

The seventh, eighth, ninth and tenth secrets are closely related, and I will weave them all into a review of the first two appointments of

our comprehensive-examination experience. By way of review, our comprehensive exam is divided into three visits. The first, or preclinical, is a unique, low-stress, very positive experience, wherein we get to know one another, carefully listen to the patient`s perceived needs, begin to clarify his/her concepts and values relative to health, and especially dental health; share a philosophy of care and expand his/her concept of what is possible with today`s dentistry. *The feelings engendered are trust, that this is a safeplace, genuine caring, hopefulness and curiosity among others.*

We also take a medical and dental history, vital signs plus comprehensive radiographs, diagnostic models with a centric-relation bite record and, on occasion, intraoral photos. The dialogue *and openness to feelings* part of this appointment is the foundation for everything that follows and it occurs at a roundtable in a comfortably-appointed consultation room that reflects us personally and professionally, while it speaks of excellence.

The first visit begins with a brief welcoming tour of the office, including an invitation to view our make-ready/sterilization area, with the understanding that we are at work today and, therefore, it may look a bit like a busy kitchen. Sandy or Jean, our health-relationship coordinators, begins all of this, plus conducts the initial interview, which takes anywhere from 15 minutes to, in some major cases like Janet`s, an hour. An hour is blocked on the book for the consult room, plus about a half hour of chair time. I`ll be involved for about 20 minutes. During this nonclinical visit (there is chair time for the records or to take a quick look at something the patient may feel could be an emergency), we address the next four secrets.

Perhaps you`re thinking, this sure seems to take a lot of time. Why don`t they do the exam now, after talking? ….As far as the patient is concerned, we simply need time to process the records and we would like the records before us at the time of the actual exam. Our prime reason for breaking the comprehensive exam into two visits is to allow our patients to comfortably absorb what we would like them to understand and leave with very positive feelings after the first visit. At the second appointment, when we are no longer total strangers, they have a thorough exam, during which we will find some things wrong of which they were unaware. If we compressed all of that into one visit,

they would leave a bit negative and often overwhelmed. That would begin our relationship on a negative note.

I believe our mindset that we must do it all in one visit, coupled with the uncomfortableness and likely rejection we`d experience, subconsciously keeps most dentists from even offering a comprehensive exam. A pioneer in this values-driven, person-centered approach, Dr. Bob Barkley, again said it well, "Only dentists would diagnose and treatment-plan relative strangers and then wonder why their recommendations were rejected!"

During the preclinical interview, we address the next four secrets to closing. Number seven, we "access the patient`s probable vs. preferred future," as we did with Janet, when Sandy asked about her parent`s dental history and whether she was more like Mom or Dad. In the book "Learning for Tomorrow," Benjamin Singer brilliantly shows how an individual`s image of his/her future becomes a self-fulfilling prophesy.

Recent educational research, as presented in the classic Teaching As A Subversive Activity, by Postman and Wiengartner, demonstrates that people are educably handicapped until their perceived, probable future is acknowledged and, even more importantly, until they express a preferred future. *The feelings around both may be even more important.*

We all are powerfully pulled toward our greatest hopes or fears. As health professionals, we have the opportunity to help people express their greatest hopes! When I asked Janet the level of dental health to which she aspired, and she responded, "excellent," she expressed her preferred health future. This guided me to focus on excellent treatment options.

During these early discussions, we manifest secret number eight, when we act as "collaborative problem-solver servants," not in servitude, but in a spirit of service. During my first few minutes alone with the patient, after having been briefed by Sandy or Jean, while I`m sharing what I believe I`m supposed to do for people, I state something like this: "I believe I should be your servant to help you achieve the level of dental health personally appropriate for you."

It also is at this time that I address secret number nine: "I`m here, Janet, to provide choices and to help you understand those choices, including the choice to do nothing (for now). *It is important that this is said with complete willingness to accept doing nothing as a choice. It is both your countenance and voice which conveys this the loudest.* "I will help you understand the consequences of each valid choice, including what will happen if you do nothing; as well as the time lines, urgencies, sequencing or priorities. I will help you select the best solution for you in respect to your preferred level of dental health. We will discuss what I would do for myself, my wife or sister, if we had that same problem, but will respect your right to choose something different than I might choose."

A final thought shared during this visit is secret number 10. As might have been said with Janet, had her time lines been less urgent or as I did say to Debra, who wanted to know her entire plan, but clearly could not afford to proceed immediately: "Debra, with every plan, there are two major aspects. The first of those is time-when do we do it? If there is an urgent problem, I`ll tell you that upfront and I`ll tell you how long I`d guess you have-a few days, weeks or a month or more. You understand, at best, these are only educated guesses. Baring emergencies, there is really only one person who knows what time lines are right for you. Do you know who that is? "

Over 95 percent of my patients answer as Debra did." "I suppose that`s me!" Then I respond, "That`s correct-time will be the variable and you`re in charge there. You will let us know how far you wish to go in your plan over what period of time. There are, of course, some things which are best done together, and we`ll group those on your treatment plan."

The second piece of this 10th secret relates to the quality of what we`ll do. I share it this way: Debra, the second aspect to every plan is quality. You have said that you aspire to excellent; but even there, there may be some choices-gold vs. ceramic, etc. Once you make your choice, who do you suppose controls the quality of your treatment? Again, nearly everyone says-"Well, you, the dentist, do." I acknowledge that and then add that I will do it in such a way that I would be willing to sign it and have someone I respect greatly in technical dentistry look at it and know that it is my work. In other words, we will make quality our

constant and time the variable-secret number 10. This is the Achilles` Heel of many a dentist and also one reason insurance has become so pervasive. Too many dentists feel we must do it now; therefore, they ask, "Will it be good, better or best?" Given that urgent choice, it is no wonder everyone wants to know: "What will my insurance pay for? Or, at best, they choose better, but not best!"

In the story of Janet shared in last month`s issue, I believed that she decided that I was the one to provide her considerable treatment, even before her clinical exam. Felt she made that decision during the preliminary discussions at the beginning of our second visit wherein I reflected her emotions. After her opportunity to truly share the struggle of her last two years, that`s really when closure occurred. So when does case closure usually occur?

It usually occurs during our first or second appointment and rarely at the actual consultation appointment. That is our third appointment, which we generally combine with a first small step in treatment. This third appointment does allow us an additional opportunity to raise the patient`s perceived value for what we will be doing. I am almost never involved in the consultation unless a complex question arises.

The health-relationship coordinator, in addition to providing a color-coded, patient-friendly set of our records, generally illustrates a case we have treated similar to the patient`s via slides or before-and-after photos. I urge any of you who don`t already have a good 35 mm clinical camera to get one and start taking before-and-after photos. This will not only raise the patient`s perceived value for your work, but it will raise the quality of your work. For those patients with a bit of an engineering bent, we will show a few of the laboratory/behind-the-scenes steps. This all occurs before we get to the total fee and rarely takes over 7 to 10 minutes.

This brings us to the 11th secret, "When value is perceived, cost is not an issue!" and its corollary, "When value is not perceived, cost is always an issue!" This leads us squarely to the subject of what is a fair fee? A fair fee can be defined by this equation:

$$\text{Fair Fee} = \frac{\text{perceived value in mind of patient}}{\text{Cost/your fee}} > 1$$

What this really says is never quote a fee until you are certain that the patient`s perceived value has been raised to an appropriate level. Do this and you will meet with outstanding case acceptance! We also prefer to quote total fees, not piecework; although, we will arrange procedures by ideal appointment-grouping with total fee.

For major treatment, we begin the discussion of fee by gaining a commitment to the time they will need to invest to accomplish the treatment-for example, six visits over as few as two or as many as six months. Once they commit to the time, we use a comparison to quote the fee as I did with Janet-such as what you might invest in a car, in her case; but often something smaller, a room of furniture, a new couch or, perhaps, a custom set of golf clubs, etc. And, we do not refer to it as a fee, but rather as, "Your investment in this will be $xx."

The 12th and final secret is the most important of all. For without it, all the rest are but ways of manipulating others and, in the end, will hurt you more than help you! The final secret is that you must "Walk the walk, not just talk the talk." The Good Book promises we will reap what we sow. Over 150 years ago, Emerson said, "What you do thunders and I can not hear what you say!" Integrity trumps everything.

You must strive to deliver what you promise and to raise your own standards of excellence. It is indeed an unending journey, but one that can be filled with joy and abundance . . . one that can neutralize every threat, including that of managed cost, when you decide you will only do work you would be willing to sign!

The author practiced in Austin, TX until 2013, and is a former Dental Economics Editorial Board member, an internationally-known speaker on values-based, fee-for-service dentistry, emotional intelligence and applied strategic-planning. He now Coaches a few dentists to the Top 2% in terms of financial/material success within a joyful, balanced life of significance.