I enjoy seeing the articles in cosmetic dentistry in which clinicians recount their creation of art through digital restorative dentistry. In most of the case studies I am aware the patient fees reach well over US$15,000 or more.

Let me ask you this: What percentage of your patients whose fee is US$15,000 or more are ready to start care immediately after you present their treatment plan? I have directed this question to thousands of my dentist auditors members over the last decade and the overwhelming response is “fewer than 5 percent.” Why is it that patients do not understand dentists’ treatment recommendations? How do they fit into their budgets? Chances are that both these apply.

As dentists we are pretty good at helping patients understand our treatment recommendations. What we are not good at is understanding our patients and the manner in which our treatment recommendations fit into their lives. If you have heard it once, you have heard it a thousand times and the key to case acceptance is patient education. Go to dental seminars, read journals, listen to consultants; most of it sounds the same—educate, educate, educate. Now let me ask you this: Is it true? Is patient education the solution to case acceptance?

If it is, then why do many new patients who have been thoroughly examined, educated and offered comprehensive treatment plans leave your practice and never return for care? Is it that you did not educate them sufficiently? Or is it that the challenge in case acceptance, patient education is not the only answer?

Let’s consider the new patient process and case presentation and learn when patient education works for us and when it chases patients out the door.

Inside-out versus outside-in

How do we get patient education to make the distinction between an inside-out versus outside-in approach? A traditional new patient process is inside-out. It begins by studying the inside of the patient’s mouth—the examination, diagnosis and treatment plan. It is after this inside look that we educate the patient with regard to all the care we plan to do for them. After we’ve shown them how she/he got them and what we can do about them, for example case presentation—our quote our fees and discuss financial arrangements. It is only once we have gone through our inside process that we discover what is happening outside the patient’s mouth—his/her budget, work schedule, time and significant life issues. The flow of conversation starts with inside-the-mouth conditions and ends with outside-the-mouth issues. I label this traditional way of managing the new patient the inside-out process (Fig. 1).

For patients with uncomplicated dental needs—fees of US$5,500 or less—the inside-out approach with appropriate patient education works well. Here’s why:

First, patients with minimal clinical needs are often un-aware of their conditions since periodontal disease, asymptomatic peri-apical abscesses, and incipient carious lesions must be made aware of them and educated about their consequences. Patient education is the driver of case acceptance when patients are unaware of their conditions.

Next, the inside-out process works well for patients with fees of US$3,500 or less because the outside-the-mouth issues—fees, time in treatment and life issues—are such that most patients can proceed with your treatment without undue hardships or inconveniences. Dental insurance reimbursements, patient payment plans such as CareCredit and credit cards usually soak the stings of fees for US$5,500 or less. Fees at this level are not insurmountable and usually do not anger or embarrass patients out of your office. But what if you present complex dentistry for more than US$5,500?

The flow of conversation starts with outside-the-mouth issues and ends with inside-the-mouth treatment recommendations. I label this an outside-in process (Fig. 2). An excellent example of an outside-in process is the purchase of a home. Imagine you and your spouse decide to buy a new house. You go to a real estate agent and, just a few minutes into the conversation, you talk about price range, neighbourhood, schools, proximity to work, financing and down payment. These are all big picture, outside-the-home issues. Once you settled on the broad outside-the-home issues then, and only then, does it make sense to begin discussing the detailed inside-the-home issues, such as room size, carpet and tile selection, lighting, etc. Good estate agents discover what the suitability factors of home buying are (price, down payment, monthly payments, location, etc.) before they get into the inside details. In other words, the flow of conversation is outside-in.

Now imagine you and your spouse go to the estate agent, but this time she is a former dentist and uses the traditional inside-out process she used as a dentist. As soon as you sit down she begins educating you on the inside-the-home issues—and where you want to live. What would you think? You would think about finding another estate agent, wouldn’t you?

How many of your complex-care patients, after experiencing your inside-out process, find another dentist for the most likely reason that you spent a bunch of time teaching them on inside-the-mouth details before you had any idea what was suitable for them? You educated them right out your door.

An outside-in process works best for complex-care patients. Here patient education is not the driver of case acceptance. This is why: first, patients with complex needs often come into your office with a specific complaint—embarrassment about their appearance, aggravation by their dentures or fear of losing their teeth. They do not need to be educated about their chief complaint. They may not be aware of all their conditions, but it is most likely that they have lived with the complaint that brought them into your office for a long time.

Next, many complex-care patients have heard the patient education lecture about plaque, pockets and sugar many times before. It’s old news and thus not a subject that distinguishes you. For many patients, patient education efforts bounce off like BB’s fired at icebergs. Expecting to influence them into a US$10,000 treatment plan that does not fit into their budget by showing them how to floss well is naive.

Let me be clear at this point: We are going to spend some time on the patient education process with complex-care patients, it is just not one of the conversations we will have. The first conversations we will have with complex-care patients are about discovering ways to make the patient feel more comfortable about the likeability conversa-

The earlier influencers in my dental career emphasised that a significant part of being a good dentist is to get patients to change. Change the way they clean their teeth, change what they eat and teach the priori-

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Let’s suppose your fee is US$10,000 and it involves multiple, long appointments and your patient would lose time from work. Do outside-the-mouth issues get in the way of case acceptance? Yes, they do. Does patient education make the unaffordable affordable? No, it does not. How do you know? Have you proven it, have you not?

It is with the patient whose fee is greater than US$5,500 that recommending an outside-in approach. Employing an outside-in approach involves initiating your new patient procedures with conversations—telephone, new patient interview—that focus on understanding what is happening outside the patient’s mouth, such as significant life issues, budget and work obligations. Later in this article, I’ll show you how.

After we have an understanding of outside-the-mouth issues, we do our examination. Then, during the post-examination conversation and case presentation, we link our treat-

“Patients with minimal clinical needs are often unaware of them.”

There are two issues in which your treatment plan might fit: first, you present dis-

Fit versus change

The earlier influencers in my dental career emphasised that a significant part of being a good dentist is to get patients to change. Change the way they clean their teeth, change what they eat and teach the priorities in their life and put dental health at the top. It took me ten years and thousands of patients to realise that patients change when they are ready, not when I tell them to.

I learned to replace the concept of change with the concept of fit. Instead of telling patients they need to change to accommodate my treatment plan, I accommodated to my treatment plan to fit their life situation. Patients, especially the older ones, and my complex-care patients, have complex fit issues. These include finances, family hassles, work schedules, special current events, travel, stressors, health factors, significant emotional issues; in short, any issues dominating the patient’s energy and attention. When you present complex-care dentistry, it has to fit into the patient’s life.

Think about it. If you offer most patients a US$10,000 treatment plan, something in their life has to happen. People need to wait to receive their tax refund, wait for a child to graduate from college, become...
For the third year in a row, the DTSC hosts its annual CE Symposia at the GNYDM, offering four days of focused lectures in various areas of dentistry. Find us on the Exhibition Floor in Aisle 6000, Room #3.

Each day will feature a variety of presentations on topics, which will be led by experts in that field. Participants will earn ADA CERP CE credits for each lecture they attend. DTSC is the official online education partner of GNYDM.

PLEASE SEE PROGRAM DETAILS UNDER WWW.DTSTUDYCLUB.COM/GNYDM

SUNDAY, NOVEMBER 28
10:00 - 11:00 Howard Glazer, DDS, FAGD
BEAUTIFUL, GO WITH THE FLOW - COURSE: 3020
11:20 - 12:00 John Ricks, DDS
LIGHT CURED ADHESIVE DENTISTRY - SCIENCE AND SUBSTANCE - COURSE: 3030
1:20 - 2:20 Martin Goldstein, DMD
A SIMPLIFIED APPROACH TO MULTI-LAYER DIRECT COMPOSITE BONDING - COURSE: 3040
2:40 - 3:40 Jay Remnick, DMD, MD
3D IMAGING AND CT-GUIDED DENTAL IMPLANT SURGERY - 3050
4:00 - 5:00 Louis Malamuch, DDS, MAGO
TOTAL FACIAL ESTHETICS FOR EVERY DENTAL PRACTICE - COURSE: 3060

MONDAY, NOVEMBER 29
10:00 - 11:00 Mr. Neil Kandula, BSc
ECO-FRIENDLY INFECTION CONTROL UNDERSTANDING THE BALANCE - COURSE: 4120
11:20 - 12:20 Gregor Kurtzman, DDS
INTEGRATING NEW ADVANCES IN DENTAL MATERIALS AND TECHNIQUES INTO YOUR RESTORATIVE PRACTICE - COURSE: 4130
1:20 - 2:20 Damien Mcllroy, DDS
OPTIMIZING YOUR PRACTICE WITH 3D BEAM TECHNOLOGY - COURSE: 4140
2:40 - 3:40 Edward Kab, DDS
IMPROVING PATIENT CARE WITH 3D CORE BEAM COMPUTERIZED TOMOGRAPHY - COURSE: 4150
4:00 - 5:00 George Friedman, Fay Goldstein and Edward Lynch
SOFT TISSUE LASERS AND CARIES DIAGNOSIS - COURSE: 4160

TUESDAY, NOVEMBER 30
10:00 - 11:00 George Friedman, Fay Goldstein and Edward Lynch
SOFT TISSUE LASERS AND CARIES DIAGNOSIS - COURSE: 3110
11:20 - 12:20 Greg Diamond, DDS
LASERS IN PERIODONTAL THERAPY - COURSE: 3120
1:20 - 2:20 Dov Almog, DMD
INTRODUCTION TO Cone Beam CT (CBCT), ESPECIALLY AS IT PERTAINS TO PREVENTION OF FAILURES IN ORAL IMPLANTOLOGY - COURSE: 3130
2:30 - 3:30 Maria Ryan, DDS, PhD
DETECTING CORONARY HEART THROUGH PERIODONTITIS AND PERIIMPLANTITIS - COURSE: 3140
4:00 - 5:00 Dwayne Karlslund, DDS
CONTEMPORARY CONCEPTS IN TOOTH REPLACEMENT: PARADIGM SHIFT - COURSE: 3150

WEDNESDAY, DECEMBER 1
12:00 - 1:00 Mr. JL Dale
BEST MANAGEMENT PRACTICE, WASTE MANAGEMENT FOR THE DENTAL OFFICE, AND ORAL COMPLIANCE - COURSE: 4060
1:20 - 2:20 Glenn van As, MDMS
HANDS AND SOFT TISSUE LASERS - COURSE: 4070
12:45 - 1:15 Dr. Emily Spalvent, Dr. David Hester, Dr. Jeffrey Hoo, Dr. Dwayne Karlslund, Dr. Eric Mann, Dr. Ethan Feldman
THE FIRST ANNUAL GSEB UNIVERSITY SUMMIT: IMPLANT DRIVEN DENTISTRY - COURSE: 4080

THIS PROGRAM IS SUBJECT TO CHANGE.
I know I can help. What I do not know is whether this is the right time for you. You mentioned you travel a lot and your company is in the middle of a big re-organisation. Do you go ahead with your treatment now? Do we wait until later? Or do we do it over time? Help me understand how I can best fit your treatment into everything that is going on in your life."

This advocacy statement leads to a conversation about the patient’s fit issues. This conversation reveals what treatment fits and what does not. You will find that this approach results in many complex-care patients doing their treatment over time, allowing them to stay within the limitations of their fit issues. This is a good thing. I would rather treat two patients for US$5,000 each than no patients for US$10,000. It also yields lifetime patients for you. Patients will exhibit fierce loyalty to you when they experience advocacy.

The decision to educate

The decision when to educate and when to advocate is situational. Figure 5 demonstrates that the impact of patient education on case acceptance is highest when the complexity of the care (and its associated fee) is minimal. Patient education is the driver of case acceptance when a patient’s conditions and fees are minimal. However, when the complexity of care increases, the role of advocacy takes over. Advocacy is the driver of case acceptance when the patient’s conditions are complex and fees are high. Copy Figure 5 and keep it in area where you will see if often. Then, right before you go into case presentation, look at it and ask yourself: does this patient need education or advocacy? Let the situation guide you. When you do, you will discover how to keep from educating your patients out the door.

I am very good at helping patients fit their dentistry into what is going on in their life."

Whether you are using an indirect fit-chat or a direct approach to discovering fit issues, you need to take the fit issues into account. It is a mandatory skill for practising complex-care dentistry. Without fit, there is no case acceptance, regardless of the level of dental IQ or your zeal for patient education.

Discovering fit issues

Your team often knows what is going on in the patient’s life. How do they know? They talk—they chat—with the patients and they make friends. Another purpose of chat-chat is to learn about those fit issues in your patient’s life impacting their treatment decision. When chat-chat is intentional, I call it fit-chat—an indirect way of discovering patient fit issues.

Some patients do not fit-chat well. They are simply not talkers. I am that way. When I get my hair cut, the last thing I want is a chatty experience. When you have a complex-care patient who will not fit-chat, you can try a more direct approach to discovering fit issues.

An absolute prerequisite to a comfortable conversation is for you to have a connected communication style. This means you hold good eye contact, listen carefully and patiently; you maintain a conversational tone of voice and in their life—health, money and/or family issues. If they mention something you believe may influence a treatment decision, be curious, listen attentively and encourage them to talk more about it. Through indirect fit-chat, you’re going to discover what’s going on in patients’ lives.

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