I enjoy seeing the articles in Case acceptance in complex-care dentistry. In most of the case studies that I've read, 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 your treatment plan? I have directed this question to thousands of my dental and medical colleagues over the last decade and the overwhelming response is “fewer than 5 percent”. Clinicians recount their clinical success and patient presentation and learn when patient acceptance, patient education, and informed consent are necessary. Does it 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: 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?

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 in the challenge of 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 process? The traditional new patient process is inside-out. It begins by studying the life and the case of the patient—the mouth—the examination, diagnosis and treatment plan. It is after this inside look that we educate the patient with regard to all that we plan on doing. The outside-in process is the reverse. Let’s compare how she/he/she/they got them and what we can do about them, for example case study. After our office presentation, we 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 stressors. 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 unprepared. They have conditions such as periodontal disease, asymptomatic periapical abscesses and incipient carious lesions must be made aware of them and educated as to their health ramifications. Patient education is the driver of case acceptance when patients are unprepared of their conditions.

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

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 I know? You have proven it, have you not?

It is with the patient whose fee is greater than US$10,500 that recommending an outside-in approach. Employing an outside-in approach involves initiating your new patient procedures with conversations—telephone or office new patient interview—that focus on understanding what is happening outside the patient’s mouth, such as significant life circumstances and where you want to live. What would you think? You would want to find another dentist, would you not?

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, neighborhood, 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 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 dental 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—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 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.

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

MONDAY, NOVEMBER 29
10:00 - 11:30 Mr. Noel Redmond, Esq.
ECO-FRIENDLY INFECTION CONTROL: UNDERSTANDING THE BALANCE - COURSE: 4130
11:30 - 12:30 Gregory Kozman, DDS
INTEGRATING NEW ADVANCES IN DENTAL MATERIALS AND TECHNIQUES INTO YOUR RESTORATIVE PRACTICE - COURSE: 4130
12:30 - 2:30 Damien Molyb羰, DDS
OPTIMIZING YOUR PRACTICE WITH 3D CONE BEAM TECHNOLOGY - COURSE: 4140
2:40 - 3:40 Edward Kan, DDS
IMPROVING PATIENT CARE WITH 3D CONE BEAM COMPUTERIZED TOMOGRAPHY - COURSE: 4150
4:00 - 5:00 George Friedman, Fay Goldstein and Edward Lynch
SOFT TISSUE LASERS AND CAVITIES DIAGNOSIS - COURSE: 4160

TUESDAY, NOVEMBER 30
10:00 - 11:00 George Friedman, Fay Goldstein and Edward Lynch
SOFT TISSUE LASERS AND CARIES DIAGNOSIS - COURSE: 4110
11:20 - 12:30 Greg Diamond, DDS
LASERS IN PERIODONTAL THERAPY - COURSE: 5120
12:30 - 2:30 Dov Almog, DMD
INTRODUCTION TO CONE BEAM CT (CBCT), ESPECIALLY AS IT PERTAINS TO PREVENTION OF FAILURES IN ORAL IMPLANTOLOGY - COURSE: 5130
2:30 - 3:30 Maria Ryan, DDS, PhD
DETECTING CORONARY HEART THROUGH PERIODONTITIS AND PERI-IMPLANTITIS - COURSE: 5140
4:00 - 5:00 Dwayne Karleskind, DDS
CONTEMPORARY CONCEPTS IN TOOTH REPLACEMENT: PARADIGM SHIFT - COURSE: 5150

WEDNESDAY, DECEMBER 1
12:00 - 11:30 Mr. Al Duke
BEST MANAGEMENT PRACTICE, WASTE MANAGEMENT FOR THE DENTAL OFFICE, AND OSHA COMPLIANCE - COURSE: 4060
11:00 - 12:00 Glenn van As, DDS
HARD AND SOFT TISSUE LASERS - COURSE: 6070
12:45 - 2:45 Dr. Bernard Balthazar, Dr. David Heister, Dr. Jeffrey Huns, Dr. Dwayne Karleskind, Dr. Elaine Metho, Jr., Dr. Ethan Randow
THE FIRST ANNUAL COLLEGE UNIVERSITY SUMMIT: IMPLANT DRIVEN DENTISTRY - COURSE: 6040

THIS PROGRAM IS SUBJECT TO CHANGE.
more settled in their new job, or take a much-needed vacation. Knowing the manner in which your patient’s treatment plans fit into the current or foreseeable circumstances of your patient’s life 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—which we call “chit-chat.” Another purpose of chit-chat is to learn about those fit issues in your patient’s life impacting their treatment decision. When chit-chat is intentional, I call it fit-chat—an indirect way of discovering patient fit issues.

When you fit-chat, be curious and listen more than you talk. Listen to the manner in which patients spend their time and what this tells you about 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.

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.

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

“...advice on case acceptance is highest when the complexity of the care (and its associated fee) is minimal.”

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- **Bancohn Dental Personality** Prof Nasser Baghi, Dental Institute, University of Texas, San Antonio, USA

- **Dental Education Award Winner: Excellence in Personality** Prof JuanYepes, University of Kentucky, USA

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