Ep #49: Transforming Your New Patient Process with Dr. Bob Frazer

Full Episode Transcript

With Your Host

Allison Watts, DDS

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Welcome to *Practicing with the Masters* for dentists with your host, Dr. Allison Watts. Allison believes that there are four pillars for a successful, fulfilling dental practice: clear leadership, sound business principles, well-developed communication skills, and clinical excellence. Allison enjoys helping dentists and teams excel in all of these areas. Each episode she brings you an inspiring conversation with another leading expert. If you desire to learn and grow and in the process take your practice to the next level, then this is the show for you. Now, here's your host, Dr. Allison Watts.

Allison: Welcome to *Practicing with the Masters* podcast. I'm your host, Allison Watts, and I'm dedicated to bringing you masters in the field of dentistry, leadership, and practice management to help you have a more fulfilling and successful practice and life.

Hi, everybody. Welcome to *Practicing with the Masters*. Thank you so much for being here to listen to Bob Frazer. I just want to let you know that 22 minutes into the original call the recording stopped.

I talked to Bob and he was kind enough to rerecord it with me. We wanted to make sure that you had all the good juicy information and got the value from this call. So I hope you enjoy it. We'll just start it from the beginning and just know that those of you who were on it, it will be a little different in the second half. Enjoy the call. Take care.

Many of you know Bob very well. We've been friends for a long time and he's a mentor of mine. I'm thrilled to have you on tonight, Bob.

Bob: Thank you so much, Allison. Great to be on with you.

Allison: Absolutely. Bob Frazer is an innovative thought leader in the world of dentistry. He has been a sought-after speaker and consultant for dentists and their organizations for 30 years. He

has presented over 1,000 presentations and workshops across North America and Europe and is a member of the National Speakers Association.

In addition to being a popular presenter, he and his firm offer dentists a range of transformational services including: applied strategic planning, performance coaching, growing emotional intelligence, elevating the new patient experience, hiring high and growing achievers, wilderness leadership adventures, and a national study club which is kind of his version of the "Inner Circle."

He helps dentists realize lives of balance, fulfillment, and significance while he shows them how to make comprehensive and restorative dental practices not only health-centered and highest-quality, truly remarkable, but also profitable. He removes barriers to people's potential providing proven models, principles and processes from which they can design and build a preferred future.

Bob held a successful private group practice for over 30 years and founded his consulting firm R. L. Frazer & Associates in 1991 in response to mounting interest in his coaching and consulting services. He's recognized as a foremost authority in applied strategic planning and strategic management in dentistry today. Also I know you've done some things outside of dentistry.

Bob: We have. We just signed a contract actually to take the Purple Cow transformation stuff to a large food conglomerate we work with and applied strategic planning. So that will be fun. They play at a little more intense level than we do in dentistry so that's kind of fun to do.

Allison: Interesting. Bob is also a masterful storyteller. He shares with humor and poignancy how to harness the powers of vision,

leadership, and emotional intelligence in one's life and practice. He's a fellow of the American College of Dentists and the International College of Dentists and has published over 50 articles in dental journals such as *Dental Economics*.

Bob is also newly elected president elect of the AES, which many of you guys know about that and are members of that. I can see who's on here. That is the American Equilibration Society. And now, is it called something different?

Bob: Yeah, AES, we're going to rebrand it. It's really AES, myofascial pain dysfunction, occlusion, and comprehensive care because it's really what it's about. Our next two programs are going to be very oriented toward comprehensive care with an emphasis on occlusion and myofascial pain. But the whole nine yards of airway and salivary testing and you name it. So I hope everybody on the phone listening will join us. Not the greatest time to come to Chicago, February 21 and 22, but we'd love to have you.

Allison: All right. That's an invite thing…

Bob: That's the invite, yeah. Let me know you're coming and I'll make you a presidential VIP on the 2018 anyway.

Allison: Nice. All right. Bob, again, thank you for being here. If anybody has a question or anything, push *2. I know some of you guys probably read the introduction or the bullet points that I sent out and some of you are doing the Purple Cow, talking about Purple Cow with Bob in his study club. But I want to start by just having you help us understand what you mean by Purple Cow.

Bob: Absolutely. I was privileged when I went into this work. In my previous work, I spent a lot of time with the likes of Pete Dawson and Ralph Youdelis and Frank Spear and John Kois and Gerry Kramer, up at Boston in perio-prosthesis.

When I went into this work, I said, I better get in with some of the best people in coaching/consulting work. So I chose Nido Qubein. Some of you know Nido. He's a speaker hall of famer. He is president of High Point University and has taken that school to an extraordinary level. He's still coaching me and he introduced me to Seth Godin a short while back.

Seth is probably the foremost marketing genius maybe in the world. He's the guy who created *Permission Marketing*. He generated a lot of the concepts that led to blogs and a whole variety of things. In fact, if you go online and you may want to do this, there is a YouTube of Nido Qubein, N-I-D-O Q-U-B-E-I-N, interviewing Seth Godin at High Point University, fascinating interview. It will be well worth you watching.

I have a propriety copy of a talk he gave around the Purple Cow which I used with my national study club and the *Purple Cow* book itself is a very short book. I'm curious, Allison, is there any way to tell how many on the line have actually read *Purple Cow*?

Allison: Sure. If you guys have read *Purple Cow*, press *2 and I'll see your hand go up. One…

Bob: So how many do we have, roughly?

Allison: So far one. I know Ryan has read it.

Bob: Ryan has read it. He's part of the national study club. Well let me talk a little bit about it. In the book, he talks about driving through France. As he's driving through France, he's in a beautiful pastoral area and he sees these cows on this beautiful backdrop of green grass and beautiful trees. His family and him and they were, "Oh, wow. Look at that. Isn't that terrific?"

But they drive for two or three more hours and it's nothing but that. It's just constantly that. They pretty well begin to ignore it. I

will tell you, my belief today, even though dentistry has fractionated into a lot of managed care and those of us that are still in private practice and those of us that are largely, as most of my clients are, non-par in private practice. There's still among the public, there's an awful lot of sameness. In other words, if you go in and think about the average dentist, the kind of examination, I know that nobody on this phone call is an average dentist, you wouldn't be on the call. But it's pretty much the same thing.

It is a transactional experience. One of the things that Nido taught me earlier is that if you provide transactions for people, exams, veneers, crowns, onlays, CAD/CAM, grafts, you name it, and you put that on your website as many dentists do, then you're about a commodity. But if you provide something that is transformational, that is unique in the marketplace, then you have a position in the marketplace which is much less assailable.

So they're driving through the countryside and he said, "Can you imagine if suddenly after seeing all these cows that we'd begin to almost ignore, we saw a purple cow? We'd pull the car over to the side of the road. We'd get out of the car. We'd go over. We'd take pictures. The kids would run up and want to touch it, etc." That's what we have to be in today's world.

He defines Purple Cow as something that describes something that is phenomenal, counterintuitive, and exciting, and flat-out unbelievable. It's not a marketing function, this is really key, that you slap onto your product or your service. Purple Cow is inherent. It's built in and if it's not there, it's not there. Period. The essence of Purple Cow is that it must be remarkable. What he means by remarkable is something that people talk about. It's worth talking about. It's worth noticing. It's exceptional. It's new and it's interesting.

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One of the things, Allison, that you know because you were in coaching for a while, one of the things we do as you adopt this three-phase examination process which I learned from the great Bob Barkley. I don't know how many of you had the opportunity to delve in. I know Mike Lewis has and maybe many of you, the rest of you on the phone conference will. If you haven't already, go to Lynn Carlisle's wonderful website inthespiritofcaring.com because he's got a wealth of Barkley information on there that you can look at and you can read about.

Barkley was talking about things in 1976 in the area of health-centered and relationship-based dentistry that are as pertinent today as they were in 1976. When you look at what Seth Godin is talking about, there's a connection because Barkley was talking about creating a patient experience. Not simply an exam, but an experience for that patient that was transformational, that was indeed a Purple Cow.

As I said earlier, when we were working with Allison, what we expected to see after she mastered this three-phase exam and I know that you're still doing that, Allison, and I know you're doing it, Ryan. That one third of the new patients at their first visit would go to the desk and ask to appoint somebody else at the end of that appointment for the same kind of examination, whether that be their husband or their friend or neighbor or whatever or they would refer somebody. That's pretty remarkable to get people going out and talking about that experience in such an enthusiastic way that they're already referring people to you.

We expect that. That's one of the cardinal markers we use with our coaching clients to monitor how quickly do people refer after their first visit with you. Godin went on a little bit further. Let me give you a couple more quotes to kind of roll around as I

talk about what we pioneered over that 30-year period. I think, Mike, I think you use this process very similar to what Barkley taught.

Godin goes on to say, “A new product or a service offering is nothing more than an idea.” That ideas that are spread are more likely to succeed than those that don’t. So how do you create an idea that spreads? You don’t try to make a product for everybody. That’s the first thing. Because when you make a product or a service for everybody, it’s really for nobody.

He talks about the bell curve. He says where you want to be in today’s world, if you look at dentistry, the great mass of dentists fall on the bell curve. I don’t care whether they're managed care or they're in private practice, you want to be at the perimeter of the bell curve because that’s where people will see you and see you as being unique and different. You have to begin that with that first phone call, your website, everything has to speak to that difference that you are.

He says, “When everybody’s products and services, when they're all taken, and in fact the everybody products and services are all taken.” What you want to develop in your practice are “sneezers.” Sneezers of your idea virus. I’m going to talk about a number of ideas tonight in the context of that new patient experience. What I’m really going to try to do is to share with you what I've labeled some secrets to how you can have this emotional intelligence, relationship-based, health-centered, values-interpreting practice and have an indeed Purple Cow experience in multiple places.

In fact, when we brought the national study club together back in October and they had read this book, we asked everybody to bring at least one Purple Cow from their practice and present it to the group. It was pretty extraordinary. But you’ve got to have,

in my opinion, again, these are my truths, everybody knows about truth.

There was a true story back in 1938, a bull elephant escaped from a zoo in St. Louis. Now that wasn't the real story. The story was that after 24 hours looking for this bull elephant, they couldn't find him. St. Louis was a pretty big city in 1938. A call comes into the police station the next morning, a little old lady saying, "Officer, officer, there's a huge animal in my garden." To which the policeman said, "Okay, fellas, relax. We've found the elephant." He said, "Ma'am, what's the elephant doing?" She says, "Well, he's pulling up all my vegetables with his tail."

The policeman then says, "Well, ma'am, what's he doing with them after he pulls them up?" She says, "You wouldn't believe it if I told you." So she is seeing what she thinks is the tail of the elephant is the trunk of the elephant. When I talk to you tonight, I'm very passionate about my truths. But realize that my truths may not be yours and that's okay. And sometimes the opportunity of truth is truth. So take what I'm saying with an appropriate grain of salt.

Lastly, two more quotes from Godin and then I'll move into what we've done and how we've pioneered this. I'm going to ask the group a question or two. He says that, "It seems that we face two choices" and I think this is true in dentistry. "We can be invisible, anonymous, un-criticized, and safe, or we can take a chance on greatness, uniqueness, and the cow. Because in today's world, being safe is really risky."

Lastly, he says that what you want in these people who are the sneezers, these people that are your target market—by the way, another excellent book if you haven't read it is a book that was written by the Drucker Foundation called *The Five Most*

Important Questions You Will Ever Ask of Your Organization. Excellent book. Sharp book. But who is your target market?

Well in this, he's talking about the target market for those people who created Purple Cow. He talks about something called otaku which is a Japanese word which translates into something that's more than a hobby but less than an obsession. He says what you want is consumers with otaku who will seek you out and then sneeze on their friends the idea virus that comes out of a well-designed new patient experience.

Then he asks, "Are you obsessed or are you just making a living?" He notes that everybody who works at Patagonia is an outdoor nut. I can tell you that in our practice, we had chosen our team members very carefully and they were very passionate and enthusiastic about what we did.

Lastly, he says, "Remember that your practice can't be vanilla." Because in every market, that niche, the vanilla niche, is a boring slot and it's filled. So I want you to imagine if you're on this call that I want you to think about the results you want from your new patient experience. I'm going to ask you to tell me what results would you like to get from your new patient experience?

As we think about that, I mean, after they've experienced whatever it is you're doing now, what are the results you're hoping to have happen for this new patient? Let me take a response or two from the group, or three.

Allison: Bob would like to know what are the results you're looking for from your new patient experience? Oh, there's a hand. Dr. Susan Maples. I just unmuted you.

Susan: Hi, Allison. Hi, Bob.

Bob: Hey.

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Allison: Hi.

Bob: Susan could be teaching this.

Susan: Oh, yeah right. I want trust. I want kind of an authentic collaboration where I get the patient's needs really right on my own. I can see what they want. I want a mutual agreement and I want a financial closure and I want booking. Is that too much to ask?

Bob: Not at all. Trust, collaboration, mutual agreement, did you say?

Susan: Yeah, I want to know that I got it right too. I want a sense that I really kind of hit a home base with the patient.

Bob: Then you want them to choose your best advised dentistry. Terrific.

Susan: Financial closure is a big one.

Bob: Financial closure, yeah. Who else has something that they want that hasn't been mentioned by Susan?

Allison: Dennis, your hand is up also. Hello?

Dennis: Hey, how are you? Dennis Abbott. Susan Maples, hello. One of the things that we do is we have that kind of Purple Cow I guess that you were talking about in that we really try to service mainly oncology patients. So one of the things that is important for us is for the patient to really understand the journey that they're about to undergo because usually we're going to see these patients right after diagnosis and before they get into treatment.

So a lot of times I'm able to answer questions that they may have left the oncologist still having and especially as it relates to what's going to be going on in the mouth, especially in our head and neck patients. The one thing that's important for us is

for the patient to feel like that experience has been phenomenal enough to go back and report back to their oncologist and say, “Thank you very much for sending me over there” because that’s how we market is marketing to physicians. It’s the financial closure for us because we’re pretty much getting that in that they have to get certain things done in order to get clearance, in order to move forward in their treatment. Yet, that kind of continues to grow our practice and then it makes us feel like they're welcomed and they're a part of it.

The other thing that we really try to do is really make sure that the patient understands that we’re there for more than just the dentistry because we’re also kind of an oral medicine practice. Want to make sure that they know and really feel that we’re sincere whenever we say, “We want you to call us as you're going through things if you have any problems at all that come up in your mouth.” So having them take that ownership and that stock in “I’ve got somebody on my team now that can really handle these kinds of situations.”

Bob: Beautiful. Beautiful. That’s beautifully said, Dennis. Who else has something that they might add that hasn’t yet been said? An awful lot has been said.

Allison: I’ve got Juliana Rowland.

Bob: Juliana, okay.

Juliana: Hi, Bob.

Bob: Hi.

Juliana: I remember you from the Middle Fork a few years ago.

Bob: Okay, yeah.

Juliana: Yeah, how are you?

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Bob: What a wonderful—yeah, I'm getting ready to do it again. I've got the Truth North study club is having me come talk to them. That will be fun. I'm doing good. How about you?

Juliana: Wonderful.

Bob: What did you think of that we haven't said yet?

Juliana: I agree with what's been said and I also would add I want that patient to go, "Wow. I've never been so listened to. I've never had this experience of really sitting and talking and understanding." I guess that's what would make your sneezer.

Bob: It would. That's beautiful, Juliana, thank you. Let me tell you what ours are. They really will echo some of yours. We want them to feel uniquely welcomed and safe. We want them to be oriented and we want to give the patient as much control as we possibly can. We want them to understand and we want to reflect and use empathic listening to listen to both their needs, their wants, and especially the emotions behind those.

One of the things I've gotten extremely excited over the last ten years is emotional intelligence because I think people really feel understood. Not when you necessarily repeat the details of what's going on in their mouth and you've heard it really well but when you reflect to them the emotions behind the details of what they've told you. I'll give you an example of that in a little bit.

We also want to begin a collaborative relationship. We want a client to assess their self-image dentally and medically. I'll show you how we do that. In other words, we don't start in the treatment room. We start in the consult room in what we call a pre-clinical three-phase exam which we were taught by Barkley. We even do something even weirder and we think it's very

Purple Cow-ish. We do not exam people on the first appointment unless they have an emergency.

We get to know them. We find out who they are. We get our full records and then we exam on the second visit which is generally within seven days, sometimes as many as ten days. We have all of our records in front of us between the models, the photographs, the digital radiographs, etc. If we were using CT scans, we'd have those too. We want to explore both their probable and preferred future because we know if we don't understand what they perceive as their probable future, they are educably handicapped.

Barkley taught me this way back. He said, "If you go to the slums and you study slum children. The ones who excel in school are not the masses of the slum children. The mass of slum children don't excel in school because they're told that their future is probably pretty bleak. "You'll always be working for somebody else. We've always been garbage collectors in our family, you probably will be too."

Patients come to us with a probable future dentally. We need to understand what is that. What do they expect to happen over the next five or ten years. I'll tell you how Barkley got at that and we're still using his magical questions around that to get at that. But we want them to also express what they would prefer as to their dental future.

The other thing we do, it's been interesting when I do my coaching even among well-trained people maybe like might be on this teleconference tonight, they take a short-term perspective with their new client. Meaning they look at what's wrong now and what might be wrong in the next year or two. We literally tell people that not only are we looking at what's wrong now and what they want us to do for them and what

might be developing, we want to help them develop a plan for the rest of their life. To look down the road the next 10, 15, 20, 25, 30 years. The nice thing about dentistry, it's highly predictable and we can generally do that.

Lastly, we want to make quality our constant and let time be the variable. Again, Bob said too often what we do is, "Well, Ms. Smith, here's your three choices: good, better, and best. We must do it now, which will it be?" Well most people have coupons they're redeeming for their college education of their son or perhaps other coupons for a new home or a remodel or perhaps a special vacation or a trip and they come to us with those already due and payable.

Suddenly we're telling them all this dentistry that needs to be done. Most of us on the call I think know that with probably six or seven procedures we can take almost anything that is acute and turn it chronic and buy people time so that they're able to do it in the very best way possible.

The other piece of that though that's very important is that we have an outstanding pending treatment system. That's a discussion for a whole other time or it's on some of the audios that we have available if you're interested in that.

Again, now that we've talked about the results we want, what is the behavior we have to have in order to get those results? Allison, we're the only two on the call right now because of our technical glitch earlier. What kind of behaviors are we going to need? Give me a couple that you think are necessary in this new patient experience for us to manifest, what kind of behaviors to get the results we want?

Allison: I would say listening.

Bob: Outstanding, Allison.

Allison: Yeah, outstanding. I was going to say profound listening.

Bob: That's good. What do we have to listen for?

Allison: Listen for, I think what they want.

Bob: Yes.

Allison: Their fears. Their concerns. Listen for, I do like how you talk about in emotional intelligence, listen for the emotions underneath what they're saying.

Bob: Absolutely. If the patient tells you that they're still not happy with their smile and they've had orthodontics three or four times, let's say three times, and you get all the details of how they had them when they were early in their teens and then maybe in college and then as a young adult they had another round of treatment, you figure out that they had Crozat earlier and then they had Edgewise, etc. You get all that down on paper, you know, that maybe useful to us technically but it doesn't really tell the patient they were heard.

What tells the patient they were heard is, "Oh my gosh, you've had orthodontic treatment for, sounds like over seven or eight years and it hasn't corrected the problem that you wanted to have corrected. That must have been very frustrating. That must be feeling a certain sense of hopelessness that it could ever be corrected." That's when the patient knows that they're understood. Not when you let them know that you knew they had removable ones and etcetera etcetera etcetera.

One of the most challenging things we have with our docs as I'm doing coaching with them is to listen tight for those emotions so they can respond to the emotions. That makes sense?

Allison: Totally.

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Bob: What other behaviors will we need? Let me just give you ours. Number one, we want to be warm and welcoming as a guest. When somebody comes to your office and you call them a new patient, they're really not a new patient. You haven't done any treatment, they haven't committed to any treatment yet. So treat them as a friend or a guest.

We want to give them a tour of the office, our health relationship coordinator does that. We know at the morning huddle who is coming in. If they were referred by Allison Watts or Ryan Coulon or Mike Lewis, we're going to acknowledge that and everybody on the team will know that because in the morning huddle we made sure everybody did. We always give a tour of our office and we take them through the make-ready.

We always says, "Now we're going to take you through the sterilization make-ready area. We'll move through there rather quickly because it's like a busy kitchen." But we want them to know what we're doing. We show them that. We show them the turtle pond. We show them private areas of the office they can have if they need to get alone with their telephone or whatever and people greet them as they come through. We want them to be a very special guest to the office. Where did we get that?

I was fortunate to have as a very long-term patient Ann Richards, governor of Texas. While she was governor, she'd come in with a Texas Ranger and we'd often say, "Boy, don't we roll out the red carpet for Ann. Why don't we do that for everybody who comes through this practice? Let's treat them like they're the governor of Texas." So I hope everybody is doing that with their patients.

We need to be fully present. What does that mean? We need to be there mentally, emotionally, physically, and spiritually. That's not easy in the middle of a very busy day, maybe you're

preparing another case. Maybe that margin you're chasing on the distolingual of tooth number 18 is giving you a fit. But now you've got to go meet somebody and you need to center yourself. My team is really good at helping me center myself before I go in there.

They'll tell me, "Bob, would you take a big, deep breath?" This is usually in the reception—not the reception—but in the make-ready area as we're walking back to the consultation room. The other thing, patients want your undivided attention. So when you go in to meet that new patient, it's really important that they're the only thing that matters right now. Put everything else and know that you've got a competent team taking care of other things. You want to be uninterrupted in that new patient experience. Another reason why we do it in our consultation room.

That's what we call the pre-clinical which is Barkley's three-phase examination. Again, Barkley's three phases, preclinical, the intake interview. We move from that to the codiagnosis where we're co-discovering with the patient, a collaborative way talking about choices and which choices they have, including the choice to do nothing. We certainly recognize that that's a choice and let them know that early during preclinical. As long as it's an informed choice, they're aware of the consequence of that choice, we can accept that choice.

You have to take the time to listen with respect, understanding, acceptance, and gratitude. That gratitude one may be the most powerful of all. I mean, all of us should be very grateful that in today's world with the aggressive advertising that's going on out there, the patient actually comes to see us out of all the dentists they could have seen.

I was fortunate that—and many on this phone call are probably the same way—I had people that would fly across the country to see me. Or they would come from Houston which is three and a half, four hours away, or San Antonio, or Dallas. A lot of good dentists in Houston. A lot of good dentists in Dallas. So I think we need to be grateful that they're there.

Be genuinely caring. You see caring all the time in advertisements but you're genuinely caring because deep in your belief system, you really do care. Interpret value in the context of their wants. You know, the provider of a service always sets the fee but it's the consumer, the patient, who actually determines the value. But for the kind of dentistry represented by the people on this telephone call, they don't realize the quality efforts that you go to.

They don't realize that you look at your dyes under magnification until you mark your margins. That you work with only the best lab. That you're using probably noble metals if you're going to use metal. That you go through a series of steps to make sure that it's as enduring as it can possibly be. But they don't know that. So we have to be interpreters of value. Everything we do from the very first phone call through the welcome, through the actual preclinical dialog, through the codiagnosis, and then in the consultation when we help them understand exactly what the treatment plan looks like.

Finally, as we deliver our treatment, we need to continue to show people what we've done, that extra mile, that Purple Cow, if you will, that's unique. That they won't have seen before. Hopefully when that crown goes in and you barely have to touch it, even if touch it at all, because it's in good occlusion because you took the time to take an accurate bite record, etc.

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Be real transparent attentive and helpful in what we do with people. That's another behavior. Truly educate. Helping people clarify their choices. Educate in the sense of Gibran. Which is a book that I love, *The Prophet*, it's on my bibliography and third-most widely read book in the world. He talks about the master going down to the sea. As he does, he's asking all these questions. One of those is about being a teacher. You know the literal definition of the word doctor is teacher.

Well in Gibran, he says that the teacher who is indeed wise does not bid you to enter the house of his wisdom. Rather they lead you to the threshold of your own mind. The teacher who walks in the shadow of the temple among his followers gives first of his lovingness and then of his wisdom. I try to make that my creed and it seems to be very, very helpful. It's what Carl Rogers said years ago about helping people is unconditional positive regard for a person. Does that make sense, Allison?

Allison: Mm-hmm.

Bob: I know you have that in your being. So if all that's true, and what we did when we were recording everybody is I said the first question about what are my results I want for my new patient are fairly easy to answer. The second question, what behaviors do I need, a little tougher to answer. The most difficult question to ask is "What are the beliefs I have to have and my team has to hold in order to sustain the behavior?"

You know, oftentimes consultants will come in, they'll diagnose you. They'll prescribe a certain behavior to maybe your front office people or your clinical team or even you as the doctor. You do it for awhile. Then after six, eight weeks, six months at most, you stop doing it. Why'd you stop doing it? You stopped doing it because they never got to your belief system. Your

beliefs drive your behavior. Covey talked about this beautifully in his *Seven Habits of Highly Effective People*.

So what are the beliefs we hold? Interesting enough, the first list of results, they're eight on that list. The second list of behaviors, there's seven behaviors. On this list of belief, we have 15 beliefs that we hold.

Number one, people have an innate drive toward health. People absolutely, everybody we meet, unless they're psychologically ill, they want to be healthier. People want our best and most complete care. They just don't have the same timelines to receive that care. Some people are going to take maybe years to get it done where others may do it in weeks or months.

Both health and illness can be a growth process. Health and illness occur within a larger context, meaning our lives. I think I mentioned to you last night and I'll mention it again here, that we had a patient once who was named Harvey. Harvey was in middle management at IBM. Frankly, his mouth was kind of like the bottom of a bird cage most of the time you saw him. You wondered whether he actually used the toothbrush or he used the right end of the toothbrush.

Well, Lorraina, my hygienist worked with him and got him cleaning his mouth a little bit better but he never would floss. He would come in and he came in one time, he'd been with us about nine months at the time, and we were seeing him about every three months. By the way, he had a number of areas of carries that I placed IRM in because he wasn't ready for definitive dentistry. Don't put definitive dentistry in people's mouths who aren't ready to take care of it because it's going to fail and you've hurt them and hurt yourself.

Now we've got better materials today than IRM but that's what we did. Lo and behold, after a few appointments, he came to me and said, "Bob, if I hear one more time I've got to floss, I'm not going to floss. I'll come in as often as you want to see me." So we had him on a monthly recare because he had some early periodontal disease. He came in for about two years that way. Then suddenly one day he comes in and Raina came to me and she said, "You won't believe Harvey's mouth. It's clean as a pin and he's flossing." I said, "Are you kidding?" She said, "No."

I went to him and I met with him and I said, "Harvey, what happened?" He said, "I've been promoted. I used to manage two people, now I'm managing 25 people. I need to get my mouth cleaned up. I want to get it restored. I want it to look good. I'm going to take care of it." You understand that our dentistry is to enhance the quality of people's lives. We have to work with them to figure out where are they in their life and what is it they need to achieve their own life goals? People care more that they're understood than that they understand is another of our beliefs.

Our most valuable service is diagnosis. Another belief we have is that authenticity, realness if you will, and congruence are fundamental. Interestingly enough when you study loyalty of any customer to a brand, you will find that the number one determiner of brand loyalty, and that would be true of dentist-patient loyalty is authenticity. Is what they say they are, are they actually that?

In other words, are they genuine and authentic? How do you become authentic? Well, you know this very well, Allison. You've got to do some inner work yourself. I know you've done it. I've been with Bill Woodburn who teaches EI with

me. I've had counseling there. I've done Bradshaw's healing the inner child because I needed some work around that.

Only way I can be authentic is to know myself. L.D. said that beautifully, "Know thyself." That's how you become authentic. Health is a journey. It's a process, not a steady state. A team committed to core values is essential. Our practice is founded on values-based decisions by all concerned. If we have a major decision that's going to affect the lives of our team, we're going to make it in a joint discussion. I'm not going to make it unilaterally.

We cannot consistently treat our patients better than we can treat each other, especially the doctor and the team. The health of the relationship is another belief. Health of the relationship is more important than the health of the patient.

Then more time in the beginning because we start slow means less time when we go into treatment and into the future, relative to dental care. We had a logo that was a turtle with a delta around it. Every now and then people—we also had turtle pond, people looked out on it. They would ask about the turtles. I'd say, "You know, we're a little like these turtles. You remember the story growing up with the turtle and the hare?"

"Oh, yeah."

"Well you remember the turtle started pretty slow didn't they?"

"Yeah."

"But who won the race? We intend to do the same thing."

Lastly, be willing to sign our work. Be competent. I used to tell a patient in preclinical that when I place something in their mouth that I wanted to be willing to sign it and have somebody like David Hildebrand in Dallas, bless his heart, I know he's had

health problems, or Fred Simmons in Houston, two really fine dentists, they would see it and they'd know it was my work.

Lastly, that people gladly pay for what they value and want but reluctantly pay for what they feel they need but don't want. So again, as we look at those beliefs, remember that beliefs drive behavior. Same way with our patients. So if and when you encounter the patient who wants certain results and they're not getting them, you have to not only try to modify their behaviors but try to understand their beliefs.

There's two kinds of doctors. This I learned from Rachel Naomi Remen and many of you know her, she's a pediatric oncologist that's written a book called *The Human Patient*. She's also written *Grandfather Taught Me How*. There is the active caring doctor who treats the patient's disease. If you come in with moderate periodontitis or mild periodontitis or occlusal disharmony, you're treated pretty much the same way. They focus on the disease and the patient is very passive.

There's also the receptive, caring doctor who focuses on the patient's experience with their disease. That's what Barkley taught me, that we had to understand what was going on for them emotionally, physically as well, and mentally around whatever it was that was going on in their life dentally and in terms of their oral health.

So in this process we want to focus on wants, not needs. Wants, they equate with words. Needs equate with costs. We rarely use the word need in our practice. There's only three reasons why people buy and it's one of the secrets when I teach. I don't know if everybody knows what they are. They are, number one, they need it. Number two, they want it. Number three, they like the person selling it or the persons selling it.

So it is important, you don't like people you don't know. It's important I think in your office to have pictures of you and your team and perhaps their families. In a relationship-based practice, you're drawing relationship-motivated people and they love to see relationships in your life. I often noticed more patients standing around looking at some of our pictures of our team and their children and their dogs and my kids and some of my adventures than they were looking at my wonderful plaques and diplomas of this perio-prosthesis course that I took or that one or etc.

As we're looking at this, I'm reminded of the story of a woman by the name of Loretta. Loretta came to me and we have five levels of entry. Let me talk about that for a moment. The five levels of entry in our practice begin with the same one that I know everybody's got this one, it's urgent. It's an emergency. If they call with an emergency, we ask them how soon can you get here. It may be 10:00 in the morning and they say, "Oh, I can't get there until 3:00 in the afternoon." They just told it wasn't as much of an emergency as you might have thought.

But we will tell them that Dr. Frazer or Dr. Bush will get you out of pain. "They do have regularly scheduled patients so there may be a slight delay when you get here but we don't want you to be suffering." Discussion of emergencies are a discussion for a whole other day because whatever you do in emergency care, get the patient out of pain, get in surgically and get out and for heaven's sakes, don't try to educate them. They're not at a point to be educated.

The second level of entry in our practice—by the way, when someone calls, we don't tell them we have five levels. We listen to them and then we triage them to the level that we think would be most comfortable and feel safest to them. Level two is what is called cursory care. What does that mean? It's you come in

through hygiene, it's kind of the old standard hygiene appointment with some vertical bite wings, maybe a PA here or there. In the vernacular of John Kois or Frank Spear, it's a biological exam. We don't do much else.

We'll look a little bit at biomechanical or structural integrity but we don't evaluate esthetics and we don't evaluate dental facial if you will. And we don't evaluate very much beyond that in terms of function. That's in the comprehensive exam. So they come in through hygiene. Now only about eight or nine percent of our patients enter through hygiene.

Some will enter through hygiene because they were referred by really outstanding dentists like Allison Watts or Ryan Coulon or Mike Lewis or Gary Arnold and they've been well taken care of. So they come in and they're in great shape and we don't have to do much with them. They come in that way and we've gotten a good transfer of records.

But most people who come in at level two generally are extremely cautious and they just are wanting to put their foot in the shallow end of the pool. They come in through hygiene and it's a typical kind of dental exam if you will with the encouragement to move to level three.

What's level three? Level three we call self-care. That's a patient who calls, they want their teeth a lifetime. They acknowledge that in their intake interview on the telephone but they have their foot on the brake. There's something going on. Maybe they're new to Austin. Maybe they're a single parent. Maybe their husband is between jobs. We've heard that on the phone and it's wonderful for me to know that this patient comes in with a yellow light, I need to go slow. I need to phase their treatment, etc.

The other is complete dentistry, the person who has their foot on the accelerator. They want to move forward and have the care done as quickly as possible. Lastly is something called Wellness Resource, which by the way, we were doing this back in the late 1970s and the early 1980s. It was a network of other healthcare providers in the area of stress, nutrition, weight loss, stress management, although we had our own biofeedback therapist on staff. We also did some nutritional analysis in house. Admitted, much of that was referred out.

So if you'd come into Wellness Resource, we were going to help you elevate your entire health. As we're listening to the intake and somebody is telling us they had natural childbirth or that they're a vegan, etc. She might say, "We think you might enjoy entering our practice on level five which is called Wellness Resource."

"Gosh, what's that?" Then they explain it.

The other thing that's important is when you're doing an intake interview on the telephone, make sure that the person taking that call is uninterrupted. She's not trying to check somebody out. So we always slightly overstaffed our front desk or many times they were handed off to the health relationship coordinator, that's the person in our practice who was the case worker for all new patients. That was her entire job for the most part.

She welcomed them. She read their online surveys that they had completed ahead of time. She highlighted them. She then showed them the tour of the office. Sat down in that preclinical appointment which was about an hour and spent the first 20 minutes with them just getting to know them. Then I would come in and I would be introduced.

Ep #49: Transforming Your New Patient Process with Dr. Bob Frazer

Well a woman by the name of Loretta came to our practice and about maybe 45 minutes after she came in and I'm ready to go in, Sandy still hasn't called me in. So I decided I would knock on the door. I did enter the room. And Sandy said, "Oh, Dr. Frazer, we've been having an extensive discussion. This is Loretta." Loretta stood up; not all woman do that. She reached out, grabbed my head rather strongly if you will, strong grip. Looked me right in the eye and said she was glad to see me. Then she sat down.

Sandy proceeded to tell me how she had been referred by a clinic in Tijuana, Mexico and referred because she had eight amalgams that were poisoning her system. Well I didn't get many patients from Tijuana, Mexico. We were listed in a directory of people, this is in about 1983, 1984 that didn't use amalgam. It was a little more challenging back then than it is now. But in any case, we didn't take out serviceable amalgams. We just didn't use it. We thought there was enough question marks around it and we didn't also like the thermal expansion of amalgam after people got older and teeth got more brittle and fractures occurred. So we weren't like giving up a whole lot when we gave up amalgam.

The point I want to make is Loretta found us in a rather strange way. Then I listened to her story and Sandy told me how they ended up in Tijuana because her husband, Loretta's husband, had had a serious medical problem that was basically GI oriented but it never got better, never got better and they saw something like 24 different physicians in three different states, were not getting any help with it. Finally she heard about this center in Tijuana that did holistic treatment and use chelation therapy. They went down there and lo and behold he got well.

While she was there, they did an exam and they also did not like heavy metals. So they told her she needed to get these

replaced and they gave her my name because I was in a directory for people who didn't use amalgam. I didn't even put myself there. Don't know how I got there but I was in that directory.

She also had told Sandy how they almost lost their business during that period of time and that they went through a very, very difficult period. They had little or no family to support them. When I walked in the room and I first met her and she smiled, I noticed her incisors were probably about 5mm long. You know on the telephone that they should be at least 10mm long.

As we sat down and we visited and we talked about a variety of things and got clear on what I thought I was supposed to do as her dentist and what I was going to ask her to do as my patient, that's what's called relationship by the way. We don't have time on this call to go into it in great detail but Barkley always said that we were good at establishing rapport, interpersonal warmth. But not so hot at establishing relationship which meant what are the expectations of me as your dentist getting clear on those? And what are the expectations of you as my patient?

Well we went on and we got the records. This time I took a facebow. Didn't always do that routinely but with a case like her, I would do it in phase one on every patient but not always at the first visit. We would always take a centric relation bite record and we would trim those in an orthodontic way. That's something for another talk as well so that we could look at CR but without the articulator. But we took a facebow and we did a number of other things.

She came back for codiagnosis about a week later and the first thing that happens there is she sits down with the HRC and they review the records. They review the photographs. They review the radiographs. She's just orienting her to the mouth,

looking at the models as well. Pointing out areas that look suspicious. You know, our value is determined by the size of the problem we solve.

Think about your best team member. Your best team member is really good at solving problems. That's why she is your best team member. The same thing applies to a dentist. If a dentist solves only small problems, they're not worth much. But if they solve large problems, they're worth a lot more.

By this approach, by going into that codiagnosis, by them looking at their records before you even look at their records, they are beginning to grow the size of the problem in their own mind or the number of problems that they've got. So by the time you get there, they're ready to talk about these things. So we came in and I came into her preclinical a little earlier than normal actually. Sandy had not done as much orientation as she normally would do because I just had the sense that this driver personality wanted to see me.

Came in, Loretta was glad to see me. Sat down. Reviewed what she told me on her preclinical questionnaire. When I came to the part about them almost losing their business and almost losing her husband and going through these 24 physicians, I said, "You know, that must have been one of the most difficult, challenging and just heart rendering experiences of your life."

Then this very tough lady spent the next 20 minutes telling me pretty much chapter and verse of everything that happened. I listened. I reflected the feelings, the emotions of fear. The emotions of feeling confused, feeling lost, not knowing where to go. I just listened to her.

Now our exam on a person like that is about an hour and a half. So now Sandy has taken about 10 minutes, I've taken 20 minutes, we're 30 minutes into a very complex exam and we

haven't even looked at anything dental. We looked a little bit at the records. We talked about a few things that we wanted to make sure we looked at. We talked about the wear on the teeth. Then we decided to move out of that consult room back to the chair.

When we go back, we use Frank Spear's approach of using a dental facial evaluation. We like the patient to be standing up for that. We give them a mirror. As I look at her, I had her smile. I began to talk about Earl Pound and how he studied 200 of the most beautiful smiles in the world and how as I looked at hers, I couldn't hardly see her teeth. If anything, they were reversed. The curvature did not follow the contour of the lower lip and that if she'd like we could help her smile be more age appropriate or more youthful in appearance.

She said, "Gosh, you could do that?" I said, "Yes, we could." We went through the phonetic evaluation noticing that again she was short on her F sound, her S sounds and etc. I began to talk to her about as we were now sitting in the chair talking to her about we would have to go through a period of transitionalization. Oh, I forgot to tell you that during preclinical she said she'd only be here for another month and she wanted to get these amalgams taken care of before they moved out of the country.

Well at that point I told her, "You know, Loretta, this is going to take more than a month. It may take six to nine months." You have to go in and do the clinical exam. I'm looking at really good records. I'm dialoging with her. Then she said, "So you're going to do one set of crowns and then you're going to replace them?" I said, "Yes, we're going to make some provisionals that will be our guide to our permanent ones."

To which she said, “Gosh, that’s going to cost more than my automobile.” I said, “Well, what automobile do you have?” She said, “I have a Lincoln Mark IV, a new one,” which was a little surprising to me given that she told me about her economic situation but nonetheless I said, “Gosh, well, you know…” Again, this was a few years ago, “You're in the ballpark there.” She said, “You mean $28,000?” I said, “Well, probably close to, in that vicinity. I won't know until I’ve worked out your complete treatment plan.”

“Oh my gosh,” she said. “Well will you take my car in trade?” I said, “You know, Loretta, I'd love to take it in trade but unfortunately as you know cars depreciate when you drive them off the parking lot. Fine dentistry is like fine jewelry, it does the opposite, it appreciates in value over time.”

“Oh, so you won’t take it in a trade?”

“No, I won't take it in trade, I’m sorry.”

“I didn’t think you would.”

She leaned back, finished the clinical examination and sat her up. Said, “Let’s get you started with our hygienist next time. At that same appointment, we will have a consultation.” It’s the way we did it. We always decided on the first step in treatment, usually sometimes it was a diagnostic mounting, sometimes it was a hygiene visit. Oftentimes a hygiene visit because we didn’t usually clean their teeth before we examined them. At the same appointment we would do the consultation. She said she was ready to do that then and I would write that up between now and the next time.

As she’s walking out, she tells Sandy, my HRC, “I want to get Joe in here as soon as possible to have this same kind of examination.” I think I said early in our discussion that we would

look for at least one third of your patients in that first or second visit that they came in making an appointment for someone else or getting a card to make sure they recommended you to someone else. That would be a cardinal sign that your new patient experience is indeed a Purple Cow. So let me ask you. Allison, you kind of know the answer to this, when did Loretta decide I was going to be her dentist?

Allison: Yeah, I think it was definitely when you were listening to her at the preclinical and specifically when you understood the emotions behind her experience with her husband and the health problems and all that she was feeling at that time.

Bob: Exactly. Would it surprise you that in most audiences where I tell that story and I ask them where did she decide to be my dentist that the majority of dentists will say, “When you did her dental facial and told her that she could have a youthful smile.”

Allison: Yeah.

Bob: Yeah, that’s not where she decided. That was icing on the cake. She decided that I could trust this guy. He really understands who I am, what I’ve been through, and boy, that’s wonderful. That’s a joyful way to practice. I know that you know that. I’m preaching to the choir.

So let’s bring this all together and bring it to closure because I know we’re running out of time. When you work with patients, you have to be there fully present. You have to listen with your whole self. You have to listen with your head as well as your heart. It’s the heart part that will speak to them the most powerfully. Remember too that patients in order to truly learn meaning that they're going to manifest new behavior because of what happened with you in that practice, you're going to climb something that Bob Barkley called the learning ladder.

The learning ladder said we begin at a state of unawareness and we move to a state of awareness. “I didn’t know that if my gums bled when I brushed that meant there was something wrong.” Unfortunately, that’s not enough. The next rung of the ladder, rung three, is they have acknowledged self-interest. Is that important to you? Would you like to correct that? Don’t assume that they would. Find out if they would.

I remember one time asking a young woman who had some pretty moderate periodontal disease if this is something she’d like us to address and she sighed deeply and said, “You do whatever you need to do. I can't do anymore.” Which I later learned she had just been filed on for divorce. She had two children. We don’t know what’s going on in people’s lives and sometimes we need to be sensitive to that. So she couldn’t acknowledge self-interest yet. So we need to hold her until she can.

Then there’s an attitude and belief change because some people believe that if you brush your teeth hard enough, they're going to bleed. I’m using just one simple example. Or that maybe you're going to lose your teeth anyway. Then there needs to be a commitment by the person that they want to do something. And finally, action. So those are the six rungs of the ladder.

What we mostly do is we go from unawareness to awareness and we go right to commitment and action. Then we create post-purchase dissonance, that patient who says to you, “Hey, which chair did I buy anyway?”

Allison: Yeah.

Bob: That’s the patient who’s having some sense of post-purchase dissonance if you will. So as I bring this to closure, let me just

touch on a couple of really important points in that preclinical which for me is the most powerful of all the appointments.

Make sure you assess their self-image. What's their probable future? What do they believe is going to happen to them? The easiest way to do that? Ask about mom and dad's dental health. When they tell you then simply ask, which are you more like? Then if they say they're like mom who had terrible dental health and lost all her teeth at age 62 as Loretta told me, and Loretta is 58.

"Are you like your mom?"

"I am."

"Well what would be your rathers?" Find out what their preferred future is.

Then also assess their self-image because if I don't know what their dental self-image is before I go sticking my hands in their mouth, then I am at great risk. What I mean by that is I simply take a piece of paper, draw a line on it. At one end of the piece of paper, I put a little hash mark and I say, "This would be the most excellent. I'm going to ask you to rate your dental health. This is not scientific."

We have this on videotape because we filmed our new patient experience as a training module. It's available online if you're interested in it. We had Cliff Katz, a PhD, DDS, psychologist interview the patient after each step of our treatment. Our first preclinical and then codiagnosis and then talk about what was being felt, thought about, but not said. We integrated the two together. Very, very powerful videotape.

During this piece when I asked her, she said to Cliff later, "I thought I was back in grade school and I was giving myself a grade until he told me, 'Oh, don't worry, this is not scientific I

just want to know what your opinion is.'" I say there's a range of excellent. There's a range of good and draw a hash mark on that line. There's a range of fair and a range of poor. Then I ask them where are you today in your total dental health?

Why is that so important? That's so important because if I go into their mouth and they told me they're good to excellent and I see that they're fair to poor, I've got a very different communication challenge, don't I? Now the other piece of this that's terrific is I want them to summarize, I know they've told me a lot, this is toward the end of the preclinical dialog and I'm asking this question.

I am going to ask them, "Tell me in thumbnail fashion what's pulling you down. Is there anything you haven't mentioned that's pulling you down?" Then I ask them the $64,000 question, "When we're all done, wherever that is, where do you want to be on this scale?"

If somebody tells me I want to be good to excellent or I want to be excellent, maybe I could never be at the top, and I'm going to talk about replacement of a missing tooth, I'm not going to talk about a bridge. I'm going to talk about an implant. That's the most excellent way to replace that. We might touch on a bridge as a secondary choice but does that make sense, Allison? That we're trying to figure out where they want to go? Begin with the end in mind?

Allison: Yes. Absolutely.

Bob: Beautiful. So then during our codiagnosis we use John Kois' and Frank Spear's four food groups. We do a dental facial functional evaluation, structural integrity, etc. By the way, we always have them do the same thing for their overall general health, the same scale. What's interesting, more times than not,

they see their overall health better than their dental health with many of our patients.

The other thing, while we're doing our examination, we will prioritize. That means on a non-full reconstruction case we're going to let them know that if we find something we're going to tell them whether it's a 1 priority, something that should be treated within the next year, maybe even a 1A, within the next six or eight weeks. Or a 2 priority, that could really wait until the second year to be treated. Or it could be a 3 priority, it could wait a little longer if it needed to be.

Obviously if a 1 and a 2 are together or opposing each other, best done together, both from a cost standpoint and a final result standpoint. That really helps patients because then when we finish the codiagnosis, we can let them know since they're almost always a little overwhelmed by a comprehensive exam, we can let them know how many 1s they had that they need to deal with immediately and maybe how many 2s. Then we'll write that up between now and their next visit.

As I bring this to closure and there's so much more to say, it's really important that we never quote fee unless value is perceived. Now you know with Loretta, she'd already perceived value. She quoted the fee to me by using a comparison. So I was okay giving her a ballpark. I think it ended up being a little bit more than her car. But the point being that normally that doesn't occur until we come to consultation.

Our consultation is our third visit. It's associated with our actual first round of treatment which is usually something in hygiene. Could be a splint record, something like that, which we did quote at codiagnosis what the investment would be for that particular piece. By the way, when we quote our fee, we never do it until we know value is perceived. How do you know value

is perceived? At that consultation. We ask the patient, “Can you tell us again what Dr. Frazer and you talked about you’d like to have done for yourself?” Yes, we’ve written it all up.

I don’t believe in case presentation unless it’s a case of fine Scotch whisky. Don’t try to sell things to people. Collaboratively develop a treatment plan and let them choose your best and finest care. So never quote fee until value is perceived. We would generally kind of summarize what they told us about, they want to get the bite corrected. They want to get their teeth whiter. They want to get that gum problem corrected. Well here’s our write up.

By the way, it’s never itemized. It’s always by total phase or a total appointment if we have to go down that far. We will itemize for insurance purposes which by the way we don’t call dental insurance “insurance.” We call it a dental benefit. We say that about five times, the patient will generally ask us, “Why don’t you call this insurance?” We don’t call it insurance because it’s really not insurance.

So I think I've pretty well covered the waterfront, Allison. This may have gone slightly longer than that last one because I added a of couple things I didn’t last night.

Allison: I think it was perfect. I just want you to talk a little bit, I know you mentioned that you have some tapes. I have those and they're fantastic. So I know you have support materials but I also want you to mention that I know you have a New Patient Experience that I’ve been to multiple times. It’s fantastic and it’s coming up in September.

Bob: It is. While we’re on the subject, the New Patient Experience in September is September 22 and 24 in Austin. I teach that with one of my finest clients, Dr. Don Taylor. Don is doing multiple of these a week. I’m not doing them anymore. So I teach the

foundational material but you get to see Don actually do this with a real live patient. Then you're also given a patient and you're asked to do this under our coaching. It's limited to not more than seven doctors and right now we have three offices signed up. So there are four places left open. Again, that's September 22 through 24 here in Austin.

Who do you bring? You bring the doctor, your key front office telephone person because your telephone triage is huge. Angela Ward on my team, by the way, if you haven't called and talked to Angela, please do so. She's one of the finest people on the telephone you've ever met.

Part of the session we're in separate groups and Angela is working with your front relative to telephone triage and interprets value from the very first phone call. You'll actually see us do preclinical codiagnosis and consultation, including quoting fee, dealing with insurance and all those things. You'll be asked to do the same thing with our coaching.

The second course we give that we truly love to give, it's probably the most fun course we offer is November 10 through 12, it's the applied emotional intelligence course. It is actually titled Inspiration, Empowerment, Wisdom, and Community: Applied Emotional Intelligence. I teach that with Bill Woodburn who is a gifted counselor who before he was a counselor was an actor and it's a lot of fun. You've been to that, right, Allison?

Allison: Oh, yeah, many times also. I'm a remedial student.

Bob: Yeah, what we expect to happen out of the attendance at the New Patient Experience we would expect your case size to grow by between 50 and 100 percent, either the treatment you're going to be recommending to people and people will accept.

Then we would expect in the EI course for your leadership ability among your team and your patients and the team members to your patients to grow as well as customer service by at least 75 to 100 percent. I don't know if you would agree with that, but when you start learning about emotional intelligence, you become very powerful.

Allison: Yeah. It's affected my whole life in a positive way.

Bob: Thank you so much. The other thing I have is I have an audio series that I'm very proud of. We have the DVD series of the New Patient Experience and any of your listeners who left us know that they are the—what do you call your series again? It's the *Practicing with the Masters*?

Allison: *Practicing with the Masters*.

Bob: Yeah, if they let us know that they're with Allison Watts or *Practicing with the Masters*, we will extend to them a 20 percent discount on any of these things that they might like to purchase. The Proven Strategies, they come bimonthly or you can buy them as a set. There are six chapters. The fourth chapter is the one that is all about complete care.

If you register for our New Patient before July 1, then you will receive the two-hour audio "Choosing Your Most Comprehensive Care Routine." That's part of that Proven Strategies series. If you buy it, we'll credit that to you. That's $187 value by itself.

If you sign up for the EI by September 1, then you'll receive a copy of "The Dentist on the Couch" which is my interview of Bill Woodburn when he was telling me about those dentists that we've worked with that seem to always be stumping their toe and never quite getting over the hump, both in their leadership of their team and with their patients, as well as those that seem

to excel. It's a fascinating discussion. Several of our clients said they listened to that one 3 to 5 times.

So we'd love to have any of your members seek us out. You can look at our website at www.frazeronline.com that's F-R-A-Z-E-R, Z like zebra. Frazeronline, one word. Or send me an email at Bob@frazeronline.com. If you send me an email, I'll be glad to send you two things I think you'll enjoy. One is an article that summarizes everything I talked about that was published a few years ago called "The Right Time to Quote Fees." I'll also send you a beautiful essay called "The Portrait of a Helper." So I guess I'm done, for the second time.

Allison: Yeah, thank you so much, Bob. I really, really appreciate it. I appreciated it last night and I appreciate it even more today. I'm amazed and impressed and appreciative.

Bob: You're welcome.

Thanks for listening to *Practicing with the Masters* for dentists, with your host, Dr. Allison Watts. For more about how Allison Watts and Transformational Practices can help you create a successful and fulfilling practice and life, visit transformationalpractices.com.