Ep #52: Facilitating Patient Care with Janis du Pratte

Full Episode Transcript

With Your Host

Allison Watts, DDS

Practicing with the Masters with 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 Watts: 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.

Janis has been in dentistry for over 30 years. If you don't know Janis, you know some of the people that Janis has worked with, I'm sure. She focuses on patient-centered comprehensive care and she is a professional Co-Active Life Coach, she trained extensively with both CTI and The Arbinger Institute.

Janis facilitates Leadership Study Clubs, Team Retreats and Experiential Training Workshops. She also specializes in training advanced level patient facilitation, motivational interviewing, team communication skills, hiring and training for the hi-performance team, and integrating systems that ensure extraordinary service.

Janis is an open-hearted, engaging and powerful coach. She is passionate about empowering teams to achieve their highest potential for success and fulfillment in dentistry. She has a strong track record of helping teams develop healthy self-esteem and confidence, improve

patient and team relationships, and experience a life of purpose and choice.

I love that bio.

Janis du Pratte: There you go.

Allison Watts: And so true so far from what I know of you. Janis, I know we have a little idea of what we want to start with and I would like to open up the call by asking you to tell us—you and I are just going to have a conversation here. For those of you that are coming on, I'm going to ask you to hold your questions until the end.

Janis, I'd love for you to share with us about the expert versus the facilitator model. I don't know if there's any pros of the expert model, the pros and cons of those. I know which way you lean and I know which way I lean. If you'll start with that, we'll flow into the three levels of outcome from there.

Janis du Pratte: I'm taking on a pretty big fish in the sea by debunking the expert model because the expert model is what is currently being taught in dental schools and hygiene schools. It's what we were trained in, it's what we know. It's what we've worked hard to develop. The way I define the expert model is that we are the experts and we teach and tell, we do patient education, and we talk to patients about what we believe they need to do to be healthy.

The problem with the expert model is that it has unintended impact, in a nutshell. The unintended impact is that it creates a barrier for people that don't like to be told what to do. It creates a barrier for people who aren't necessarily dental savvy and the information that you share may be over their head. From a behavioral

perspective, the expert model causes more problems than we like to deal with.

That said, there is a time and place for the expert model. What I'd like to do is talk about the places where the expert model gets in the way of us building really healthy, wholesome, meaningful relationships with patients and helping people get healthier.

Right out of dental school, right out of hygiene school, we're able to do a pretty good exam. We're able to diagnose, we are good at finding problems, and coming up with good solutions. For the most part, that's where we begin with patients. Once the doctor has done his diagnosis and made a treatment recommendation, oftentimes the team then comes in and they talk to patients about benefits and consequences. They may use metaphors and analogies. They may get out the intraoral camera and show pictures.

So there's lots of things that we as dental professionals have learned to do well. My concern about that is really what we're aiming for, is compliance, and not commitment. We're convincing people about the whys of why they should do what we are recommending that they do.

We really aiming at compliance. For people to do things for an outside reason. "My doctor told me I need to do this crown. My hygienist told me I need to floss." Compliance is doing something for an external reason. Really what we want to aim for is commitment. Commitment is when people choose to do something for an internal reason.

I think when we are locked into the expert model of dentistry and that way of communicating with patients, we don't help people get to the internal motivation that is so

important in people moving forward with dentistry, with treatment plans, and ultimately getting healthy.

Then, once we've worked really hard to do an exam and the diagnosis, and the clinical team does so much work in helping people see what you see and understand what the conditions are, you bring patients up to the front. You do a really nice handoff, and you share with them, "Mr. Smith needs a crown on number 14." Ultimately, the facilitation of the decision-making is dropped in the lap of the person at the front desk.

They really are at such a huge disadvantage because they haven't been part of the relationship-building. They don't really know the patient's story. They don't know a lot about the patient. They may not even know what the clinical rationale is for the doctor's recommendation.

The unintended impact of that is that it can appear that the left hand doesn't know what the right hand is doing. It can undermine the patient's decision to move forward with treatment. Oftentimes patients will schedule treatment and I think this is a situation where we experience so much fallout in our schedule, last-minute cancellations and no-shows.

What people go home with is, "The dentist told me I need a crown and now I'm at home and I'm thinking, 'But I don't really want a crown,'" for whatever reason. "I don't enjoy sitting in the dental chair, I'm afraid of it. I'm so busy at work it's hard for me to take time away from work. I don't want to spend the money." That's a lot of money. When you approach a treatment recommendation from the expert perspective, it's really your clinical agenda. It's not theirs. There's a big missing piece.

I think one of the things that happens with dentists that have invested themselves in advanced clinical training, which is most of the clients that I work with. They've gone to Pankey, they've gone to Dawson, they've worked with Frank Spear or Kois, and when they've invested all of those financial resources and time and energy and effort in comprehensive advanced clinical training, they're even more excited about the clinical dentistry. They're even more excited about occlusion.

Patients aren't that excited about occlusion. It's almost like the more we know and the more passionate and excited we are about what's possible in dentistry, the more we can have that unintended impact and overwhelm people and create more of a disconnect than a connection.

A couple of things I see happening: For some practices, there's a big concern about too much, too soon, and not wanting to overwhelm patients. Being afraid if you present a big comprehensive treatment plan that they'll just walk out the door and they won't come back.

When that happens, oftentimes dentists hold back on talking to people about what they see, what their concerns are, and they focus mostly on what the patient is concerned about and what the patient wants help with. Which is fine if that's exactly what the patient is wanting today, right now. However, there's a really important piece missing there, that's left out. That is that the patient may have all kinds of conditions going on in their mouth that they're not aware of, that they don't see, that they don't understand.

I believe we have an ethical responsibility to help patients understand what their conditions are. We don't have an

ethical responsibility to present a comprehensive treatment plan. For patients to walk out the door and not know what we know about their conditions, I think is a real concern. They're going to go down the street and be told something different. They're going to think that everything's okay, and it may not be. I think it's really short-sighted to withhold that information.

I think there's a way of helping people think about their conditions, doesn't necessarily mean that they're going to do everything right away. But if they know what their conditions are, then they can start thinking about their future and what direction they want to move in. I see that in dental practices and it's a big concern of mine.

The practices that have really well-developed case presentation, I guess I'll call it, do so much to help people understand their conditions. They use digital photography, intraoral cameras, they have panoramic X-rays with magnifying glasses. They do a really good job of helping people see what you see. Sometimes they even have a really nice well-put-together PowerPoint presentation. They may have before-and-after photos, they may even bring up online videos that help illustrate what people's conditions are and what the treatment might look like.

As polished as those consultations can be, and as professional and exquisite as the presentation is, it is still the doctor's agenda. It's the doctor's clinical concerns, the doctor's clinical goals, and the doctor's agenda. The doctor has clinical goals like beautiful aesthetics, a healthy foundation, a balanced, stable occlusion, predictability. We know what our clinical goals are. Our clinical goals are not what's really important to the patient.

We are experts on clinical dentistry, we're not experts on patients. We're experts on clinical dentistry, we're not experts on patients.

In the absence of us investing time in really getting to know them as a human being, and getting to know a little bit about their life and what their awareness is, what their concerns are, then we miss the opportunity to help them make choices that are values-based for them. The way I think of this is that patients don't pay for the dentistry that we offer, that we do. They pay for what the dentistry will do for them. They don't pay for the dentistry; they pay for what the dentistry will do for them. That's what we want to focus on and tap into.

When I think of a doctor's clinical diagnosis and treatment plan, it's a formal itemization with insurance codes and clinical descriptions. That's an internal document for us as a clinical guideline. It's not for the patient. When I think of a patient's outcome, there are no procedure codes. There are no procedure codes for the patient's outcome.

I see three different levels to outcome for patients. The first level of outcome is really listening to what their values are in their story and listening to what their priorities are when they talk about what they don't like. Is their priority appearance? Is it comfort? Is it function? They want to be able to chew a good ribeye steak on Friday night when they take their wife out to dinner?

Is it more of a peace of mind issue? They want to know everything's healthy and stable so they don't have anything to worry about. Is it more of a holistic health issue? Patients have goals that typically fall into those categories. However, that's the tip of the iceberg. That

really doesn't clearly define outcome in a way that patients can really be compelled by it.

The second layer of outcome is looking below the surface and imagining if anything were possible, what would they want for themselves? If anything were possible, what would they want for themselves? Now they begin to think about not just what they don't like, but what they do want. In order to help people think that through, we have to get people way out into the future. People don't imagine what's possible for themselves from the present place.

When they can put themselves out in the future, whether it's six months, or a year, or three years, what is it that they can imagine might be possible for them? What would the meaning of that be for them personally? If they were successful in completing all of this dentistry, and they had a beautiful, stunning smile that is the smile that they have been dreaming of, what will the meaning of that smile be for them personally? What impact will it have for them psychologically, emotionally, socially? How will it impact their quality of life?

That is the below-the-surface place that we want to invite people to think and imagine. When they imagine what it will be like, and of course, we can really help them embellish that image. When they imagine what that will be like, their brain actually doesn't know the difference between them experiencing it right here today or them imagining it out in the future. The brain actually experiences what they're seeing and believing and feeling.

If they can imagine having this beautiful smile and think about how that will have them feel: more confident, more outgoing, ready to smile in pictures, they feel like they will

be more open. When they have that experience, there's an emotion attached to it. That is very powerful for them.

One of the things that we can experience is after patients have completed all of their dentistry and they come back, sometimes we hear stories about, "Oh, I love my new smile." They'll be excited and tell us stories.

What I'm proposing is that before we even get to that, we can help people imagine what might be possible for them and what that would be like for them, psychologically, emotionally, socially, and in terms of their quality of life. What will that feel like? What will that be like? What will that really mean to them personally? When they access that emotion, it actually puts the image of what they're imagining into their long-term memory.

When we experience anything and there's an emotion attached to it, it goes into our long-term memory. Those are the things that we remember years from now. Now they have a vision of what's possible, they've accessed the emotion of it, and the excitement of it, and it's something that they will remember tomorrow and next week and next month.

The third level of outcome, even below that, is how do they imagine having completed all of this dentistry, will impact their life in a bigger picture? How might it impact their family, their friends, their success? It goes beyond what it will mean for them personally and it invites them to look at the impact that this new experience of themselves will have on people that are important to them.

What I find is that when people go to that place, that's where they find a pretty instant and deep emotion. When I'm facilitating a patient, it's oftentimes when we get to that question, "How do you imagine this might impact your

spouse? How do you imagine this might impact your children or your grandchildren, or whoever it is in your life that is important to you?" They get choked up.

When people think about doing something not just for themselves but in service to having a positive impact on someone else, they really get moved by that. I guess is what I would say.

Sometimes we can run into patients maybe not even believing it that they deserve to have the dentistry, they deserve to have the beautiful smile, they deserve to have the peace of mind of knowing everything is healthy and stable. "I don't have anything to worry about. I don't have the stress of all of that anymore." What's that like, to not have the stress of that worry? How does that impact you? How does that impact others? How does it impact your life?

Once we have helped a patient think and imagine and actually shape a vision for themselves, now we can help create relevancy between what we're offering them in the way of a treatment plan, and what they want for themselves. If we can't connect the dots between what they have identified as important to them and what we have diagnosed and treatment planned and recommended—if we can't connect those dots, the patients will not see the treatment plan as personally relevant to them. It will be, "The doctor told me that this is what they recommend." It will continue to be the doctor's clinical perspective, the doctor's clinical goals, the doctor's agenda.

I would say if I could emphasize one word in all of this, it would be relevance. Our job is to help patients see the relevance between what we're offering and what they're

imagining for themselves. When we're successful in doing that, now we've got something to work with. Now we can move forward.

Whether we do it all right now, or we phase it over time, that's up to you to collaborate with the patient on. But once they've envisioned that possibility for themselves and they've accessed the emotion and really the personal impact of it, then they won't forget that. It will be compelling to them next month and next year. It will keep them moving forward, it will keep them on track.

It's really important I think for people to be given the invitation to go out into the future and use their imagination to really see what's possible out there. It can't be our answer. It really can't be our answer. The questions that we pose are for them to answer. Then it's theirs, it's genuine and authentic to them.

Rather than us talking about the benefits of a beautiful smile, and we know there are benefits, we're excited about it, we love doing beautiful dentistry. We've worked with enough people that we see the results. We have a lot of confidence in what the impact will be. We know what it will be. But for us to try and convey that to the patient really is us convincing them. Trying to convince them to do something, so we're back in the game of compliance.

If they come up with their own answers, then they will choose to do the dentistry for internal reasons. Now we have commitment. That's what we're after.

Allison Watts: Beautiful. All of those things that you were just talking about, when you started talking about the outcomes, I have a couple of things to ask. When you started talking about the patient's outcomes, that's your facilitative model.

Janis du Pratte: Yes.

Allison Watts: Okay. Do you work through that, is that a process of asking questions? Is it like an outline, where you start with a level one question? To me, it kind of seems like those questions are more heady, in their head a little bit. Then you go to the deeper questions, which sounds like to me, I'm just going to say it, I got this visual of like you're taking your patient from their head to their heart.

Janis du Pratte: Yeah.

Allison Watts: When you start asking those deeper questions. Does it have to be linear like that?

Janis du Pratte: Well, I think that we begin to learn about people from the first moment we have contact. The person that answers the phone and talks to a new patient, if they do a good job of facilitating that conversation, they begin hearing the patient's story. Hearing what they're concerned about, or what they are thinking they want help with. Even some sort of aspect to their personal life, we want to be listening for their values, listening for the underlying meaning for them. I think it starts there and it builds throughout the whole process.

I'm glad you asked that because I really have a strong bias for developing a facilitative team. In many practices they have a treatment coordinator, or a new patient facilitator, who does the lion's share of the facilitation. I believe that when you have everyone on the team trained as facilitators, that it is such a cohesive process and it so smoothly flows from one person to the next, to the next.

It allows you to do really a different level of handoff from one person to the other. It allows you to hold the story and build on it. I think when everyone's trained as a

facilitator, everyone understands that when you create this level of intimacy with a patient, it really is a special moment. I think of it as a sacred experience. That's the way I hold it, as really a sacred moment.

People are going into a place where they have vulnerability, where maybe they have fears, insecurities, they're not sure they deserve it, they're dreaming, they're imagining. It's an incredible experience to share with a patient, to be in the presence of. The more people on the team that understand that, the more congruent in the patient moving through the whole process.

I don't know if that completely answered your question. I think it's something that builds. Allison, what I would say is, I know where I'm aiming with patients. I know what's possible and I know where I'm heading. I know that I want to explore a potential dream with this person. I want to look at their future, I want to get into a place of imagination. I want to access all three levels of outcomes.

I know that I'm going to ask questions that will take us there. Sometimes it is linear. Sometimes it's very structured. It's one, two, three. Other times it just emerges through the conversation, throughout the whole process. I'm always listening for values. I'm always listening for underlying meaning.

I'm doing reflective listening, which is very different than active listening. When I hear someone talk about something, I reflect it back with a hypothesis or a meaning attached to it, always in the form of a question so that I'm interpreting and I'm clarifying. Oftentimes people don't have the words but when you do a good job of reflective listening, they'll say, "Yes, that's exactly it." It helps them

shape not only what they don't want, but what they do want. It helps them shape it.

I guess I would add one more important thing here: Facilitating outcomes is not asking the question and getting an answer. I don't think that patients walk in your front door able to articulate their goals and outcomes about their dental health. Most people haven't thought about it, most dental practices aren't investing the time and energy and effort to sit with people long enough to explore long-term health goals.

If we were to just ask the question and look for the answer, that's data gathering. That's not what we're talking about here. Facilitating outcome is we're going on a journey with them and helping them imagine and shape a vision for themselves for the future.

Allison Watts: Thank you for saying that. I do think that it's really easy to just put a bunch of questions on a form and think that you're going to ask about their family, and you're going to ask about their goals, and you're going to ask about whatever. You can design this form and it's not the same thing that you're talking about.

Janis du Pratte: No, what I'm talking about is pretty organic. I have pages and pages and hundreds of questions. People often ask me, "Do you have these questions written down?" Yes, I have lots of questions. I think it's a good place to start to have a handful of questions to begin with. But ultimately, it's an organic process and you want to find questions that are authentic and genuine to you.

I will say that when I'm working with beginning facilitators and I offered them a question about the second or third layer of outcome. "If you can see yourself a year from now, we've completed all of your dentistry…" I'm

recapping everything that they have described that were goals for them. “What will that mean for you personally?”

Most beginning facilitators think that’s a very awkward question. It’s not a question they’ve ever asked. Sometimes team members have an issue of privacy or not wanting to go to a place of vulnerability. So we have different boundaries and what I encourage them to do is swing out there and give it a go.

As odd as the questions may seem, I can tell you 100% of the time, people have answers. People will answer that question. They may not go where you think they might go. As a matter of fact, that’s one of the most exciting and fun parts of facilitating is, you never know where it’s going to go. You never know what people are going to come up with.

Allison Watts: Don’t you think that’s one of the things about it that makes it scary for the new facilitator?

Janis du Pratte: Yes.

Allison Watts: Like, “Oh my gosh, what if I can’t handle what happens?” I’ve had people ask me that question before. “I don’t want to go there because it’s too deep too fast. It’s kind of scary for me. I don’t know how to handle it.” Sorry for interrupting you.

Janis du Pratte: No, that’s okay. We are building a relationship and we are creating an environment of safety and trust. We want to build trust and confidence with people. We want to create an environment of safety and nonjudgment. It is something that is established during the course of our conversations. I don’t think that we ask that question right out of the chute. It comes later down the road. Where we really have a connection and we are so connected to this

person that we genuinely are fascinated to know what their answer will be.

That is a common mindset for me, when I'm facilitating, I'm fascinated to know what they'll say. Even the question, when people say they want to keep their teeth. When I ask them what's most important to you about keeping your teeth. It's fascinating to me, the stories that come out of that. I've heard hundreds of different stories come out of that single question.

It's a place to help people explore and ask themselves questions that they've never thought of. They've never thought to ask themselves. It's really a vibrant process. There's lots of engagement and ultimately the patient is doing most of the talking.

Allison Watts: Janis, is one of the objections that you might get from dental teams, "Doesn't this take a ton of time?"

Janis du Pratte: It takes time.

Allison Watts: I know when you have these open-ended conversations, a lot of people are concerned about managing time and not, "What if I don't get all the data? I need to fill out this form," or, "I need to know this data." What we've done is if the preclinical part of the exam runs over, we just don't do some of the clinical part. We finish it next time.

Janis du Pratte: That certainly is a strategy. I guess what I would say is, typically our dentist-clients are not the facilitators. Because we want you dentists making tooth dust.

Allison Watts: Right.

[Laughter]

Some of us like doing the facilitation part.

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Janis du Pratte: We have some dentists who just won't give it up. Then they have the bigger dilemma, because how do they meet payroll and pay the bills at the end of the month? They're having so much fun talking to people.

We recommend that you build a facilitative team. They have more flexibility as long as you have the room and the space for it. There is a time management issue. There's no question about it. You really don't know where it's going to go.

I have a confession. I don't confess this often. I haven't done a new patient facilitation in less than an hour in 15 years.

Allison Watts: Wow.

Janis du Pratte: I know, it's bad. When I go into a practice and we do a new patient experience training and I facilitate patients for a couple of days, I build it into the schedule. Everybody works around it and I allow myself an hour for an intake interview. I know that there's lots of places to go and it's easy for me to fill it.

Most practices want to get that intake interview done in 15 minutes. Fifteen minutes is a good place to start. I think once you start exploring those deeper places and really getting into a different level of the patient's story, it just takes time. It takes time and I'm so committed to creating safety and honoring the intimacy of what occurs for people. I'm very successful at helping people feel safe with me and so they open up. When people open up and access that vulnerability, you don't shut it down because it's time to take records.

But there is definitely a time management issue. Especially for hygienist facilitators, they've got more of a

schedule to work with than someone that is just doing facilitation.

Allison Watts: I don't want to take us off-track. If you want to answer this question now, it's perfectly great. If not, we can talk about it later. I'm curious how that intimacy gets transferred to the doctor then, if the doctor is not actually… Obviously, the doctor can have a limited facilitative conversation but I'm curious if this is the time for this? If not, we can do it at the end.

Janis du Pratte: No, I'm happy—there is one more point I want to make but let me answer this. When you have an intimate conversation with someone, they'll reveal things that are private between the two of you. It's important as a facilitator to know where you must honor confidentiality. Everything that you learn doesn't get shared in the handoff.

You may share with the doctor, "Mrs. Smith has some financial concerns right now, so we'll want to consider that as we move forward." I've heard the whole story about her husband lost his job, and bankruptcy, and they're foreclosing on their house, and what's going on with the kids, and her, so I've heard all the details of the whole story. All those details don't get shared in the handoff.

Allison Watts: Okay.

Janis du Pratte: But when you create that level of intimacy, you get the whole story. One of the skills of a facilitator is to know how to reel people back in, because people will go off on tangents. It's an important skill to know how to reel people back in and hold the focus and how to move things along. To know when to go deeper and when enough is enough. There are lots of skills in the doing of facilitation, which we're not really talking about today.

The one final point that I want to make about the expert model is there absolutely is a time and a place for us to be the experts. People come to us because we are clinical experts. People are counting on us to be clinical experts. There is a time and a place for us to influence patients, to inspire patients maybe to strive for a different level of health than they've ever considered for themselves. There definitely is a place for that. I see that as the end of the process.

The patient facilitation of their outcome comes before the doctor steps in as the clinical expert. The doctor has an opportunity to express their concerns that may not be the patient's concerns, and to influence and inspire. There is a time and place for that. My motto is seek first to understand and then be understood.

Allison Watts: I love that. That makes total sense. A doctor's expertise comes in more at the case presentation or when treatment is being discussed. I feel like I do a pretty good job of facilitative model and blend it at the end with—is that what you're saying, at the end of the, like case presentation? When you're actually talking about treatment?

Janis du Pratte: Once we are clear about what is important to the patient. What the patient's outcome is, what the patient's priorities are. Once we've had that conversation, we're clear, they're clear, now we get to come in with our expertise.

For example, a patient may have come in aware that their gums were bleeding, but, "That's just normal for me." Not a concern. As we do the exam, we discover they've got pretty significant periodontal disease. We move through the whole process where they're now back for a consultation and we're talking about what their priorities

are, what they've been thinking about, what's rising to the top for them, where would they like to begin? And we start mapping out a plan.

Oftentimes patients won't put periodontal therapy at the very top of their list. What we know as clinicians is that it's important to have a healthy, stable foundation to build on. Then we come in with our bias about treating the periodontal disease. There is a time and place for it. It is important. I don't mean to debunk it.

What I see so much of is people that are so proud of their patient education skills and it's a one-way conversation. I'm always looking for more engagement. Creating an opportunity for people to find their own path.

Allison Watts: Well, like you said, if we can't make what we're talking about relevant to what they're wanting and their outcomes, then they're not really interested in doing the treatment for us. Or if they do, they're going to have buyer's remorse or not show up for their appointment or whatever.

Janis du Pratte: Yeah.

Allison Watts: That's the key. Relevance, and having them actually want to do dentistry instead of just need it.

Janis du Pratte: Yes. Allison, in some of our conversations we spoke about wants-based versus needs-based dentistry. That's been around for, gosh, over 40 years, Avrom King. We've talked about that a lot in dentistry, wants-based dentistry versus needs-based dentistry. As much as that talk has been around, I don't see it happening in most practices. I really don't. I see the expert model.

Allison Watts: Yeah. I can see how that's true.

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Janis du Pratte: Even the use of the word need: “You need a crown.” When you tell a patient they need a crown, and they go home and change their mind and don’t do it. Then they come back six months or a year later and they’ve never done the crown and they’re still living and breathing and not experiencing any pain. There’s no trouble with that tooth, and “You told me I needed it.” Right? “So now can I trust anything you say, or are you just after my money?”

Language is very powerful. Questions are really powerful. There’s lots of skill that go into all of this. From a philosophical perspective, to really go after the patient’s outcome first. Then talk about our clinical goals. Then put it all together with patients very clear about the relevance between what we are recommending or offering and what they want for themselves.

Allison Watts: Beautiful. And don’t you find that when this process is done correctly that patients usually end up doing more dentistry? Or, they self-select out and that’s a great thing because they didn’t need to be doing it anyway. But most of the time they’re talking about things that you never—if you just would have walked in and told them what they need, or if the facilitator doesn’t ask these questions, there’s a whole lot of things that the patient wants to hear about or wants to talk about or would like to address. If we just went in there on a needs-based thing, we would miss.

Janis du Pratte: Yes.

Allison Watts: Cool. And then the patient’s happy when we talk to them about the comprehensive care because it’s what they asked for.

Janis du Pratte: Yes. There’s an excitement and an enthusiasm and commitment.

Allison Watts: Yeah. Awesome.

Janis du Pratte: Commitment versus compliance. We especially see this in hygiene, don't we? Poor hygienists. I see hygienists come out of hygiene school and they're floss-bosses and doing the oral hygiene instruction. They're really good at patient education and I won't say for the most part, but it often goes in one ear, out the other. Or they might floss their teeth for a week or two or two months but it's compliance versus commitment.

It's frustrating. I think it's what burns hygienists out. It's very frustrating to work so hard and to care so much about people's health. When we care more about their health than they do, that is not a healthy relationship.

Allison Watts: Gosh, we could probably do a whole series of calls for the hygienists. That seems like a real dance to be able to do that.

Janis du Pratte: Yeah. I love working with hygienists because it's so easy for them to become complacent or apathetic about their career because they see people come back and they have to start all over again. It's painful to watch that. I think there is a very different way of doing hygiene. It's behavior first and clinical second. Start with the facilitation and then move to the clinical skills. So, that's another day.

Allison Watts: Yeah. At least a day. Do you want to—I'm thinking there might be some people that need to get off. Do you have any place they can go if they have questions, or anything if they need more information from you, contact information or something?

Janis du Pratte: Yes. My phone is always available. I might not answer or get back to you right away, but certainly within a day or two. Everyone is welcome to have my phone number:

916-276-5686. I just would like to say that Terry Goss is my business partner, so when I talk about the "We believe," it's Terry and I. Terry is just as much a part of all of this as I am. She can be reached also at 307-690-1902.

My email address is my name janisdupratte@hotmail.com. I'm happy to receive emails and respond. Anyone that would like to set up a telephone appointment, I would be happy to do a one-hour telephone appointment at no fee. That's something that we could arrange. I'm happy to offer that.

I love my work and I'm passionate about dentistry. I think dentistry is such an exciting profession. It's so innovative. What we can offer people is so incredible and it creates such an amazing opportunity for women to experience fulfillment in their work. There are so many different roles, so many different avenues to grow yourself professionally and personally. I would love to make myself available to anyone that might be interested.

Allison Watts: Thank you for that. That's wonderful. Do you want to open it up for questions?

Janis du Pratte: Sure.

Allison Watts: You guys that have been waiting, if any of you have questions, now is the time. Lisa's already got her hand raised. Okay, Lisa. If anybody else has a question, you can push *2 and I will see your hand go up. You'll be in line. All right, Lisa, you're unmuted.

Lisa: Thank you. Fantastic. I am just soaking up all of this information. I have a couple questions. One, I heard you mention a couple of times the three levels of outcome, and I think I missed what those were, if you could say

those again. The other is, do you have any tips to help keep from getting sucked in to answering a question when the patient asks us questions, especially in the intake. From just answering their question and losing the goal of having them be the one giving information.

Janis du Pratte: Okay, let me do the three levels of outcome first. The first level of outcome is what is their number one priority with respect to their health? Is it appearance? So they want to feel more confident about their appearance? They want cosmetic dentistry? Is it comfort? People that have had lots of breakdown and pain, one bad experience after another, they want to have their mouth be completely comfortable so that they can enjoy hot foods, cold foods, and not have to worry about pain.

Function, the way things are working for them, what they're able to eat and chew and enjoy. How their joints feel and all of that. Peace of mind. I hear so many people say, "It seems like every time I go to the dentist, there's one more thing wrong. I just want to have the peace of mind of knowing that everything is taken care of. I have nothing to worry about." That's a peace of mind value.

The last category is health. People that have concerns about the relationship between periodontal disease and heart health or diabetes, those kinds of things. More whole-body health. Lots of people are learning more and more about those things. What is the priority for people with respect to their dental health? Sometimes it's two or three, but you want to get a sense of the order of priority.

The second level is, if anything were possible, what do they want to be different and how will that impact them personally, psychologically, emotionally, socially? And how will it impact their personal quality of life? That's level

two. Level two is about what will it mean for them personally.

Level three is about impact in their life outside of themselves. A bigger spectrum. If they're successful in completing this dentistry, and they've imagined everything that could be possible for them, what impact do they imagine it might have on others in their life? Their personal life, their work life, their level of success, that sort of thing. It's more out-focused. Impact on others.

When patients ask questions—can you give me an example of a question that throws you or that you want help with?

Lisa: I can imagine being in an intake and starting with the intention of asking the patient questions and getting information and having them share and being curious. Then what I've noticed for me is sometimes they'll ask me a question, like what do I think. Or, "What do you think about this?" or, "What should I do?" or "What do you all do?" Any questions like that and I will fall into this trap of answering them. Then we go on, get more into details or clinical instead of staying with just the personal.

Janis du Pratte: I think I have a sense of that. Of course, if someone asks me, "What do you think," I don't think I would hesitate if to say, "If this were my mouth, for me, what's important to me is this. This is what I would choose for myself. Let's talk about what's important to you. How might this be important to you?" I would answer that question and then give it back to them, kind of like hitting the tennis ball back in their court.

Lisa: I love the analogy of seeing it like a tennis ball. It just pushes it back to them. As opposed to a football where I just take it and run.

Janis du Pratte: Don't take the football and run with it, don't do it.

Lisa: Thank you, that was very helpful.

Janis du Pratte: One of the things about, I think it's really good to train your ear for is who is doing most of the talking. We're really wanting the patients to be engaged in this process. We want to ask powerful questions and be really good listeners. Way over there, laser focused on that person. What are they saying? What does that mean? What's the underlying meaning? Listen, listen, listen.

If we hear that we're talking more than the patient, stop the train. Stop talking. Stop talking and ask a question. Lots of questions. Work, one question that is a super easy go-to is, "Mrs. Smith, what do you think so far?" If you find yourself doing more of the talking than listening, it's like hitting the tennis ball back over there. Ask a question, and get that engagement. Does that help?

Lisa: Very much, thank you so much.

Janis du Pratte: Sure.

Allison Watts: Lisa, are you complete for now?

Lisa: I am, thank you.

Allison Watts: Okay, I'm going to mute you again. We have a question from Jill. Jill, you are unmuted.

Jill: Thank you. Hi, Janis. Awesome.

Janis du Pratte: Hi, Jill.

Jill: I enjoyed every minute of it.

Janis du Pratte: Thank you.

Jill: How do you feel about—obviously, legally, you have to do a full treatment plan. What you see, enter everything in

the computer: decay, crowns, whatever they need. How do you feel about when you present a treatment plan, saying, “First things first. We have to tell you what we see. Legally. We can start out with the thing that is going to be of concern first.” Obviously you’re going to find out what their main concern is, if they have a toothache or they haven’t been in for a while, or we find something that they came from another state, or whatever.

You tell them, “Okay, first things first. We have to tell you everything that we see, that we find. Legally. So you can understand, you don’t have to do it all at one time, we’ll utilize your insurance to its utmost ability,” because a lot of people have questions about that, the whole money situation thing. Then go from there and present it that way.

Janis du Pratte: Well, do you really want my “capital-T” truth response to that?

Jill: Yeah. I do, actually.

Janis du Pratte: The way I do it is pretty radical for what it’s worth. I’m going out on a limb here. There’s a process that I call co-discovery and co-diagnosis. During the course of the exam, I invite lots of engagement with the patient. They’re learning while we’re learning what’s going on in their mouth. Sometimes we put intraoral camera photos up there.

Jill: Yeah, we do that at our office, yeah.

Janis du Pratte: At the end of the exam, to sit the patient up and say, “Okay, so what are you thinking about what you just learned?” I like to get them talking about what they heard, what they think, what they remember. Then I like to send

a letter to patients after the exam summarizing three things.

Number one, what's our understanding about their outcome? Number two, what are the things that they were aware of before we even did the exam? Then number three, what are the things that we discovered during the exam? And I have just categories, simple categories: teeth, gums, bite. Maybe if there's a cosmetic concern I will say appearance. It's a brief summary of exam findings, conditions. Nothing about treatment plan.

At the end of each paragraph, I put a statement of hope. We may have found decay in five teeth, we may have found two teeth that have cracks, whatever the summary is. Then I might say something about, "We have wonderful materials with today's modern dentistry. We have materials that will allow us to restore these teeth to health and stability." I put some sentence in that is encouraging or gives them hope.

When they come back for the consult, typically they have their letter in their hand. I think people have a hard time tracking and once they walk out the door they have a hard time remembering. They walk in the door with their letter and I sit down and say, "So, what have you been thinking about since we were together?" They pull out their letter and they've got notes and circles and they want to go over things. I actually put paper and pen in front of them and let them write up their own treatment plan.

Jill: That's nice.

Janis du Pratte: I say, "Where would you like to begin? Here's paper for you to jot down any notes or anything that's important for you. Where would you like to begin?" I let them lead the way. I keep them in the driver's seat. They might talk

about, “Well, after the exam, I really am concerned about my gums bleeding.” “Okay, great, let’s talk about that.” Then we talk about what our recommendation is to help them get their gums healthy.

I ask them, would they like to know about the fees for the services as we go, or wait until the end. I give them the choice and then, “Where would you like to go next? What’s next on your priority list?” I let them build and write the treatment plan in their own priority. They write it in their language, they put number one, number two, number three. They put notes about money.

Jill: So that gives them ownership to it, for their priorities. They take ownership to it and they will proceed, hopefully, with the rest of their treatment plan. That keeps them happy.

Janis du Pratte: Yeah. Now here is where the expert model now comes in. After they’ve identified everything that they’re concerned about and that they would like help with, if they’ve left anything out, now it’s our job to say, “So you do have…”

Jill: “Tooth number three needs a root canal and no you don’t need whitening.” I get that a lot too. “My number one concern is whitening.” It’s like, “Well, you have decay and you need a root canal on number three.” How do you—whitening should be the last thing in the whole realm of things. It should be the last thing you’re thinking about.

Janis du Pratte: I want to caution you about using the word “should” because patients don’t know what we know, right?

Jill: No, they don’t.

Janis du Pratte: If someone comes in and they are excited about getting a white smile, then we want to honor and respect that. They don’t know what we know. Once they’ve put down

everything that they want, and maybe they put whitening or new veneers right at the top of the list, and they have periodontal disease.

Once they finished with their part, if they've left anything out, I address it. Then I start talking about priorities from a clinical perspective. "We're so excited to help you with all of this. Let me help you understand why it's important to do this before this."

Jill: Okay.

Janis du Pratte: It's not taking away anything, it's rearranging things in a way that is honoring and respectful. This is where we get to be clinical experts and explain to them the whys.

Jill: Okay. I really have to say that I do like your wording on imagine and value and impact. "What can you imagine of your outcome? What will it mean to you?" Impact. I really like that wording. I'm going to incorporate that.

Janis du Pratte: Good.

Jill: Very good. I really enjoyed this phone call. Thank you.

Janis du Pratte: Thank you.

Jill: Someone have my office manager listen to it on Friday. Allison, will this be available on Friday?

Allison Watts: Yeah. It should come out tomorrow.

Jill: Because I'm going to stay after work on Friday. We work until noon and I want my office manager to listen to this.

Janis du Pratte: I just have to ask, have any of you seen the funny video about the patient? It's a cartoon about the patient that comes in and wants whitening? The dentist tells them that, "You have periodontal disease."

"But I want whitening."

"Your breath is putrid."

"But I want whitening."

Have you seen that? It's hilarious. I will get a link to that to you, Allison.

Jill: Allison's page.

Janis du Pratte: And you can share it. It's so hilarious. We played it in big retreats, and conferences, and with small teams. I do have to have, there's one caveat. The F-bomb gets dropped. But it's hilarious and I think it will give you a little bit of sense of humor about what you're addressing right here.

Jill: Okay.

Allison Watts: Thank you.

Jill: Thank you.

Allison Watts: Yeah, thanks, Jill. I'm going to mute you, okay? Are you complete for now?

Jill: Yep.

Allison Watts: Okay. Janis, I'm just going to point out something that I love what you did. I don't know if everybody noticed this, or everybody may have totally noticed it, but you also separated out diagnosis, conditions, from treatment plan.

Even when I heard Jill ask the question, she said something about "we legally" have to give them a treatment plan. I thought that was really interesting. I'm not even sure if that's true. Is that true? Are we legally, do we have to give them a treatment plan? Or do we just legally have to tell them the conditions?

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Janis du Pratte: I don't believe it's legally true but I could be wrong about this, Jill. Maybe want to do some research. When I talk about talking to them about their conditions, the way I phrase that is, "I believe we have an ethical responsibility." To be integrity and to be really ethical, I believe we have a responsibility to help people understand what their conditions are. I don't believe that we're required to give them a treatment plan. I could be wrong but I hope I'm not wrong.

Allison Watts: Okay. That wasn't really my point. My point was that I loved how you separated out, it's separated by appointments, but you also separated out at that co-diagnosis. All you're really talking about is findings and conditions. Then the treatment planning and the treatment recommendations come after. Jill, I'm going to unmute you. Sorry. Okay, I may have started a controversy here.

Jill: I'm not trying to ruffle anybody's feathers; I was just always told that you have to inform the patient of the conditions that you find. Say, and we all know this happens, they go to another office and, "That doctor didn't tell me that I had decay on tooth number three." Just as a legal thing. It's either whether they weren't informed or it wasn't charted in the computer. Something of that nature.

I haven't really ever seen it happen in the 28 years I've been in dentistry, where somebody's actually went to the Board or peer review or whatever. I thought it was always, you're supposed to tell the patient and they know this is what we have found. If they do go to another office and "My last doctor didn't tell me I needed a root canal" or whatever.

Janis du Pratte: I agree with you completely, and what you're talking about is condition. We are responsible to tell them they have

periodontal disease. I don't believe we have a legal obligation to give them a treatment plan. When you ask, has it ever gone to court or Board or peer review? Absolutely, absolutely. The primary focus has been periodontal disease.

There was a time, and you've been in dentistry long enough to probably remember this. There was this time when there were lots of practices that weren't up to speed on diagnosing periodontal disease. Lots of lawsuits, lots of money paid out.

Jill: I haven't seen it lately.

Janis du Pratte: No, I agree. We've gotten smarter in dentistry.

Jill: Okay, I wasn't trying to ruffle anybody's feathers, sorry.

Allison Watts: No, no, I didn't think you did.

Jill: I was just throwing it out there.

Allison Watts: Yeah, it was perfect. It was a great question and I just wanted to say, that I noticed Janis separated diagnosis and condition from the treatment plan.

Jill: Oh, yeah.

Allison Watts: It's so easy to walk in there and look at a tooth and say, "This needs a crown." Without actually going through an actual diagnosis. Or what the actual problems are that cause it to need a crown. For yourself.

Janis du Pratte: When you do that, what happens is the patient gets it in your treatment plan. It gets really messy. Because then they start saying, "Well, do you have to do a crown? Can't you do this, can't you do that?" And they start wanting to be the clinical expert and they're not.

Allison Watts: Interesting.

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Jill: Janis, you can out to Arizona.

Janis du Pratte: Yes.

Allison Watts: She would love to.

Janis du Pratte: Yeah, I would love it.

Allison Watts: She's not that far from you, did you hear me say she's in California?

Jill: Oh, yeah, that's right. That's cool.

Allison Watts: She lives in California. Yeah.

Janis du Pratte: If you would like to contact me and talk about that, I would love it. It's be fun.

Jill: That's awesome. I don't want to take up any more of anybody's time.

Allison Watts: It's fine, I just wanted to make sure nobody else had a question. Thank you so much, Jill.

Janis du Pratte: Thanks, Jill. Anybody else?

Allison Watts: We don't have any hands raised right now. If you want to ask a question, speak now or forever hold your peace. Actually, don't speak, push *2. Actually, you don't have to forever hold your peace. We do have another question. Gary, I have unmuted your mic, Gary. Hi.

Gary: Hello, Janis.

Janis du Pratte: Hello.

Gary: This is Gary and I'll see you in two weeks.

Janis du Pratte: Oh my gosh, my Gary.

Gary: I'm trying to learn this all over again. I'd loved it, thank you. I just wanted to say, in response to the last question,

what do we have to at the first appointment? We have this paradigm that we have to do everything in one appointment. The diagnosis, the treatment plan, everything. I think we have to get out of that idea, to get into a second or third appointment, if that's necessary. That was my idea or my comment on that.

The other thing is, this is really a change in the paradigms for treating new patients for many, many people, because it's not taught very often. It's really hard for people that haven't done this to start off. How do we do it in baby steps? What do we do first?

My suggestion, and I want to know what you have to say, is we've done a lot of stuff in roleplaying with our teams. It's really easy for me to ask that first question. It gets a little harder for me to ask the second question. It gets really hard for me to ask the third question without having to give answers all the time.

I found doing things in roleplaying with the staff, then that gets us a little bit more comfortable, because this isn't comfortable for everybody. I just wanted hear what you had to say about how we take baby steps to start to integrate this into the practice, which is the important thing. Besides, the most obvious thing is having you and Terry out to your office.

Janis du Pratte: Thank you so much for addressing the fact that this is a paradigm shift. I believe that it's a 180-degree paradigm shift. It's not just implementing a couple of new questions. It really, from a philosophical perspective, it's a different purpose, it's a different intention and a total different way of being.

To make a paradigm shift is not easy. That's why I chose to start talking about this from a philosophical perspective

instead of a how-to. I think people really must hear that it's a shift from doing the teaching and the telling, the informing, to asking powerful questions, being good listeners, and being a guide. It's a very different role. Thank you for bringing that up. It is a paradigm shift and it is not an easy change to make.

I love the idea of roleplaying. I know that you have been so successful in building a team of facilitators and helping them grow themselves. And, yes, that roleplaying is very powerful. Allison mentioned early on that we do experiential training workshops. Every year we do facilitation training workshops. It's three days, on the beach, in a big house with a bunch of women that are crazy about dentistry and everything is experiential. We teach a concept, we send people off in pairs or groups, and they practice on each other for three days. That is the best way to—

Allison Watts: Hello, everybody, thanks so much for joining us tonight. Unfortunately, our recording time ran out while Janis was fielding this last question. Actually, I think we had a couple questions after that. We did stay on kind of late tonight. I hope you all enjoyed it. Thank you so much for joining us, and I look forward to seeing you next time on *Practicing with the Masters*.

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