Ep #54: High Production, Relationship-Centered Dentistry with Dr. Paul Henny

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: Some of you guys may know Paul and if you don't know him personally, you probably have seen him or possibly have seen him on the Bob Barkley Study Club Facebook page. I'm just going to introduce him officially and it will get started. Thanks for being here, Paul.

Paul: It's great to be here.

Allison: Yeah. Dr. Paul Henny was born and raised in Portage, Michigan located in Southwest Michigan where his father Frank was an oral surgeon. Paul's uncle Frederick was also an oral surgeon and he went on to become one of the most well-known oral surgeons of his time in the world as chief of surgery at Ford Hospital in Detroit, president of the Academy of Oral and Maxillofacial Surgeons, and as a member of the Royal Academy of Surgeons in Great Britain. Seated a heavy pedigree in dentistry, Paul always planned on entering the profession with thoughts of specializing in prosthodontics which is how he functionally practices today due to his training at Dawson, Pankey, Spear, and other institutions of advanced dental education. Paul has taught as a faculty member at University of Kentucky college of dentistry, at the Pankey

Institute and at the University of Washington.

He's a 1984 graduate of the University of Michigan School of Dentistry and is the co-founder of the Bob Barkley Study Club which was formed in 1996 with Charlie Varipappa and Dr. Johnson Hagood. He's written and published a series of articles for Dental Economics as well as Dentistry Today and additionally, he speaks and runs workshops on behavioral dentistry, personal branding and the marketing of relationship based health center dentistry. Earlier this year, Paul launched the Bob Barkley Study Club Facebook page and group which have become very popular and are read daily by many of the top leaders in dentistry today. Paul also is the lead author and managing editor of the codiscovery.com website which I know is not active right now but I sure did love that.

Paul: It is now.

Allison: It's back up?

Paul: Yup.

Allison: Great. Cool.

Paul: We're still kind of reworking it but it's up right now.

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Allison: There's a wealth of information on that for sure so you guys probably have that link in your bio, in your email so if you want to go check it out, it's great. We've got a lot of people here and I just want to ... Some of you guys have been here before and some of you haven't. I want to welcome everybody and thank you for your passion for dentistry enough that you want to spend an hour with us tonight talking about how to make your practice better and be better for your patients, and thank you Paul for being here to do this.

Paul: Thanks for having me.

Allison: Yeah. The ones of you who have been here may remember but if you have a question, you can push *2 and we did get your questions via email and so we will try to weave those in as well but if you do want to make sure your questions gets asked, please *2 at any point during the call an as soon as there's a break in the conversation, I'll call on you because I can see your hand raised when you do that, so I think we should jump right in. Is there anything you want to say before we start, Paul?

Paul: Yeah, I want to premise some of the things that I'm going to share tonight. They represent the way I practice every day, the full day to day, and they represent the way a number of my close friends practice who similarly and together developed a practice model which is very relationship driven and patient centered practice model, so the practice model is a small one and so generally one doctor, it doesn't mean that it has to be just one doctor but it's generally the close circle of people that I work with that's generally one doctor, the small staff, usually

just one or two assistants, usually just one administrative person, maybe just one hygienist who works maybe 3 days a week but it's a high production practice model in the sense that these practices tend to produce, these practices tend to gross in the area of 800 to a million dollars a year working probably 145 days a year.

The total number of active patients generally in this practice is relatively small, commonly below 1,000 patients, so a lot of people will look at that and go, "Well that's functionally impossible." I'm here to share with you that's not impossible at all. It's done, has been done a number of times over the years and it's currently being done right now, so a lot of the things that I'm going to talk about tonight are systems and strategies that I use every day in my practice and my friends use as well to produce this very high production per patient business model, and the only way that that can be possible is that you've got to have really effective relationships developed with each patient that comes in, and again, this is a very philosophy driven practice model. Each one is unique in that sense. There isn't a philosophy, there is a philosophy for a practice developed by that doctor and the core team members who share that philosophy.

These practices also have what I would call "Flat managerial model" in that it's not hierarchical and everybody that's on the team is really part of the management team and everybody's kind of treated as co-equals. Obviously, the buck stops with the dentist but the management model is quite flat. Another thing I want to say is that every patient that comes into practice are not treated the same way. I'll probably get into that into little more

detail tonight but there is no one specific path for everybody, and that's really a key thing that makes this effective.

Another thing is that this is a very marketing, very niche marketing oriented business model in that it can only work if the right patients are being attracted towards your practice, so there have to be some fairly sophisticated what I would call "Personal branding initiatives" that are executed via the web and other means that tend to draw people towards you and the way that's done in shorthand is that you learn ways to express who you are in your values through these communications and people who identify with that and who align with that sort of thinking move towards you. I know the things is that this is a insurance free practice model, we do not take assignment and it's really a business model.

It can't work if you take assignment because the fees as a rule are probably twice what an insurance carrier would consider a reasonable in customer and allowable, and that's the only thing that allow you really to afford to do elaborate dentistry, do all the planning required, make fine provisionals, take people to the process, invest a lot of time and energy with them on the front end in planning, so that's another key is there's a specific fee structure that's associated with this model as well. These might be things that are very new to some of you, very foreign, and I would just suggest, they were foreign to me at one time and there was a time when I believe this was impossible but I just want to share with you tonight some insight. This is not to say that everybody needs to practice like I do because I don't believe that.

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This is my personal expression of how I practice dentistry in the most effective way that I know how. It's what brings me joy and satisfaction, so kind of look at everything from that frame. It's also based on some beliefs of mine or some assumptions of mine which are I believe that most patients are capable of making the best decision for them self if we give them the information at the right time in the right way and give them space to make that decision. I say that because I've done it time after time after time. I did it today, closed down a $35,000 case this afternoon using the same method that we'll talk about today.

In the very beginning, it was a leap of faith, in the very beginning, I wasn't sure about, in the very beginning, I stumbled and made mistakes and it didn't work sometimes but fortunately, I had around me a circle of people, my friends and the Bob Barkley Study Club to be exact, who supported me and we shared war stories about what was working and what didn't work and together, we kind of figured out the behavioral piece, and what I mean by that is we don't manipulate people. What I mean by that is we share with others who we are and what we can do and our values, and people who will relate to that respond to that and choose to work with us.

It's becoming effective at those things, what I would call authenticity, getting better and better at that and creating a patient experience that is non-threatening to them that facilitates learning that's really what drives this, so it's a marketing piece, it's a behavioral piece once you get inside of it

but it's all in circle by a philosophy, a way of thinking.

Another key point is that I don't believe that I can give health to anyone. I believe that I can cure somebody, I can intervene, I can repair things, but I can't bequeath to you, Allison for example, health. Health is something that you have to pursue yourself. Health is something that I can facilitate your pursuit of but it's not something I can give you, and so that puts me in a little different role than maybe the traditional dentist tends to think about dentistry, and this mindset really is rooted in the work of Bob Barkle, hence the study club and so forth.

I approach dentistry with that frame of mind, that my job is to facilitate health in my patients, not to try to give it to them because anybody that's been around dentistry, any period of time knows that a lot of the things that we do even when we do them on a very, very high level as best as we know how and technically as good as we can at that moment, some of it just doesn't work out. Sometimes it doesn't work out for reasons we can't figure out, so there's a certain shared responsibility in this practice model.

Most people also, and this is kind of a clear assumption that I have when new patients come into my practice is that most people don't know where they are what they want, and particularly in cases where their situation is very complicated, it's going to take some time for them to learn where they are and how things are trending and it's going to take them a while to sort of process that in addition to deciding whether or not they trust you to help them, so it's very important to come in to

every relationship understanding that the patient probably isn't where you think they are. We tend to project on patients all the knowledge that we have and we assume that they know a lot more than we know, they know as much as we know or they value things in a similar way that we value them when in fact that's really not true, and then we also have biases that we bring into it as well.

You need to enter every relationship with kind of an openness and non-judgmental, just listen. Our role tends to be one facilitating learning. We don't believe it's appropriate, I personally don't believe it's appropriate in the absence of pain and swelling and infection or neoplasm to impose our values and priorities on other people, and a lot of people will look at that and say, "Well, isn't that incredibly inefficient to have to run a practice or a business that way when you're not trying to organize everybody, get them in straight rows and move them on through an X amount of time and so forth," and I will say, "Yes, it's very unproductive on the front end because I have to get to know people on that level, but the payback is on the backend, when they say yes to big treatment plans routinely and then you don't have to have a lot of people in that sort of business model.

Again, I don't want to imply that this is the way, everybody has to run their practice or they even have interest in it. I just want to share with you some of the internal workings of how this business model functions, and the other thing is just sort of ownership. It's a very collaborative kind of process where the patient's responsible for certain things. Showing up, paying the bill, taking ownership of their own oral health. Our responsibility

is to be there when we've made a commitment. Our responsibility is to do work at the finest level that we know how our responsibility is to back up every decision that we've made. Our responsibility is to be non-judgmental and listen, and to try to figure out how to help this person the best way we know how.

Having said all that, it's not our responsibility to try to treat everybody, and there are certain people that basically are incompatible with our mission, and those would tend to be people who don't show up, don't pay their bills, are disrespectful or continually make choices that undermine our purpose, which is to advance health.

That was kind of a long monologue. I'll let you say something now, Allison, but I thought I'd better frame that first before we got in too deep into this.

Allison: I think that was great. It's for people to know where you're coming from. I think everybody in this call could get great value and maybe like you said, they hadn't even thought about that this is a possible way to practice, and it is. It's different but it is doable so maybe it's even, to give somebody a picture of what could be possible.

Paul: Right.

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Allison: We actually already have a hand raised so I do have a question for you that I wanted to start the call with but I'm going to let, it says Leona Bush and I've opened up your line, Leona.

Leona: Hi. Can you hear me?

Allison: Yes.

Leona: Okay, great. I wasn't sure if there was supposed to be a PowerPoint or a video or anything going along with this. Is this just ...

Allison: It is just a call, just an audio.

Leona: Okay. That's all. I just wanted to know. Sorry to interrupt the call. I just wanted to know if I was logged in properly.

Allison: No problem. Are you hearing everything okay?

Leona: I am.

Allison: Great. Okay, well thanks for the question. I'm going to un-raise your hand and if you have another one, you can just push *2 again. All right, Paul, so what I wanted to start off with was we talked the other day and I don't know if most dentists realize

this and we may want to talk about how it's measured also because I do think that's important. You said that the case acceptance rate for I guess the average case acceptance rate for dentists is about 50% and-

Paul: That's what's on the data is that I have seen, yeah.

Allison: Yeah, and I think that's pretty interesting and I think it's probably true. I think most dentists are out there looking for more new patients and looking for things to fill our schedule because people are coming in and then they're not doing the treatment that we're recommending, so I think that's probably a pretty accurate number. My question really is like why do you think it's that way and how do we change that?

Paul: I would answer that by saying that my case acceptance rate is consistently above 90%, and you should immediately be cynical and skeptical of that, but let me tell you how you do that. You only present treatment plans to people that you know are going to say yes, and if that is the frame then it really should be about as close to 100% as you can get, and so if we unwind that and think about it, the reason most people say no to treatment plans is that they don't value it yet or they maybe never will, and I would say that's probably, there's a fairly decent chance it's a symptom that whoever presented that treatment plan doesn't know the patient very well, and sometimes treatment plans are absolutely right on, spot on as far as diagnosis and plan but the timing of the presentation is wrong or the timing of the presentation isn't sensitive to their circumstance.

For instance, today, I had a big treatment plan that was accepted today. This turns out to be a patient that I originally examined right before the economy crashed in 2008 and she worked at a company nearby that sells light fixtures, elaborate light fixtures for new homes and businesses and prior to 2008, they were making money hand over fist, the economy collapsed and she disappeared. 2 weeks ago, she showed back up, she said, "I'm ready," and today we put the finishing touches on redeveloping the treatment plan because some things have changed since 2008 and she said yes, so again, a lot of case acceptance is very situational and a lot of times when the answer is no or they don't follow through, they're really signaling "I don't value it yet" or "I can't yet," and you should know why somebody can't say yes. It shouldn't be a surprise.

A lot of times, problem also has roots in patient's too strong affiliation to their insurance carrier. In fact, it's stronger than their affiliation to you, and that's a problem because every treatment plan will be driven by what the coverage is and not instead of what they really need to be doing now, so they're not really interested in participating in the discussion about what's appropriate for them or even any long range planning whatsoever, the conversation ends up always getting turned back into "Does my insurance plan cover that?" Which is another way of saying, "I don't value it yet." Am I answering your question all right here, Allison?

Allison: Yeah. I love what you're saying, "I don't value it yet" and I'm super curious about you said that you only present cases to people who are going to say yes. How do you know they're

going to say yes and now you're talking about the situational and that we should know why a patient's saying no, so are you talking about you're just point blank asking them? I don't have a problem doing that but some people might, but just kind of curious what the process is that you ... I mean that's totally a different paradigm for you to say like "I get 90% success and it's because I'm only presenting cases to patients who are going to say yes" I think.

Paul: Basically, I only present cases to patients who ask me "How much is this going to be?" That's after we've gone through a process of planning and discussion and what their priorities are and even what some of their budget limitations are. The last conversation we have is cost, not the first. Your relationships with your patients need to be built in a way that that's the order of events, and if the patient is from the very beginning wanting to talk about cost, then you're hitting a dead end really soon, and that's probably an indication of patients you probably shouldn't be doing a big elaborate exam on or presenting a big elaborate treatment plan on.

That's somebody that you need to either make a decision on whether or not they sit with your practice or not, and if the answer is yes, and certainly there are other examples of that. I have patients in this practice that are originally from the practice that I bought and they're now in they're now in their 80's and they haven't had a full mouth reconstruction and everything perfect in their mouth. They've got amalgams and they're probably 60 years old. Most of them are still serviceable, they're not great but they show up on time, they're pleasant, we love to have them here, they're respectful of us, they pay their bills,

and that works for us, but there are other people we don't feel like that. They don't show up for their appointments, so forth, and some of the people just need to be either moved out or discouraged from continuing.

The short answer is that you shouldn't present elaborate treatment plans to people that you don't know or going to say yes, you need to present a phase one plan to those people, and then they should say yes to that. If they don't say yes to that, then what are you doing? What's the purpose of the relationship? Is your job just to be there in a crisis? Then you need to ask yourself, is that a role that I'm interested in being in for this person? Sometimes the answer to that might be yes, but that's how you get there.

Allison: Yeah. I just want to remind everybody, if you have a question, push *2. I've had a couple of more people come on. Can you walk through, I think this would be helpful anyway, so you have a patient and I know what your process is and maybe this would be helpful to share. If you're using Bob Barkley's model then you've got the first visit is like a pre-clinical. Do you take records on the first visit?

Paul: Yeah. Let me take everybody through this.

Allison: Okay, and I'm thinking that, yes, you can walk us through what's happening with the patient that you're getting feedback that you know like, "Okay, I'm not going to present them a full

treatment plan."

Paul: Let me dial this back a little bit so everybody's got perspective on it. In my practice, we basically have four different kinds of exams. An emergency exam, we call that a "Type 1 exam." We have an exam that we call a "Type 2 exam" which is something that has very simple to limited needs and my initial impression is that an initial contact with them through my hygiene department or with my hygienist is an acceptable way to begin the relationship, with the caveat that however you begin a relationship, it's very difficult to change it once it's gotten down that track.

In other words if you allow somebody with complicated needs into your practice through hygiene, it's much more difficult to change the inertia back to getting them to look at big picture stuff, because what you just did was set them in the same track that they've been used to for years and years and years, and when you try to disrupt that, after you've begun, they become very suspicious, so we have a type 2 exam. Let's say the prototypical 18 year old that's never had a filling, something like that. We have what we call a "Type 3 exam" which is a comprehensive examination and now it includes study models, occlusal records, mounting the case on articulator, digital photography, internal camera photography, and a rough approximation of the Barkley three stage presentation.

Then I also have TMJ treatment. TMD treatment is a significant practice as well and some people come to me just for that and they maintain a relationship with their generalist so we have a

separate track exam for that, and then there, you can add another one if you're doing sleep apnea that maybe some people are going to be part of your practice or part of your practice only for that thing, so with that mindset, let's now just sort of look at the type 3 exam, the comprehensive exam because I think everybody else is somewhat familiar with how the other ones would go, and that's probably what you're here for is to hear that part. Am I correct, Allison?

Allison: I think so. Yeah, because what you're doing in the comprehensive example is you're going all the things that you said in the beginning. You're building trust, educating them about your philosophy even if it's indirectly in your values and you're doing all the things that are going to lead to them saying yes to bigger treatment or whatever level of treatment they're ready for.

Paul: Right. We're trying to make a rough approximation on the front end, an exam that's appropriate for their need level and I know that can't be 100% accurate but we try to make an approximation of that on the front end, and let me get into how we do because I think that's key. When patients call my office through targeted marketing initiatives, my staff, my administrative leader is tasked, we're trying to get them to come in for what we call a pre-treatment conference, and that's just an opportunity for them to come in and sit down with me for maybe 15 minutes and share with me what their situation is. These tend to be people who know they have an issue and they're searching out answers.

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They may not be at a place where they think I'm the one they're going to choose, we want to create an opportunity where these people come into our environment, experience it, have an opportunity to meet me, listen to me, and not necessarily directly hear me tell them my philosophy but to just experience it, and my primary goal of that appointment is to just listen to them, and a lot of cases, these are people that have never been listened to thoroughly by a dentist ever. They've had problem after problem after problem and they've been unsuccessfully resolved, they're skeptical, they're afraid, they're cynical, their head is full of a bunch of dental myth that aren't even accurate in a lot of cases, and they're just searching for somebody to listen to them.

A lot of these people, if you just simply do that, if you don't judge them or even try to correct them, just listen to them and essentially offer them a helping hand via a proper exam, so I just shared with you the one and only thing in my practice that I sell and that is complete exams, and I sell a complete exam by trying to support the value of it to a person who knows they have a problem and they know that the way it's been addressed in the past has been unsuccessful and I try to tell them why. It's never been looked at thoroughly, it's never been analyzed, they've never been part of the discussion about what their goals were or what the limitations were and that they need to approach their dentist in the same way that perhaps they were going to build a new house.

They wouldn't just jump in, grab a carpenter down the street, start driving nails. That would never happen. They would get an architect, they would a surveyor, they would make a plan.

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Before any board was ever cut, any nail was ever driven, there would be a discussion about sizes of rooms and how people are going to live in those spaces and how it's going to heated and cooled, so why isn't dentistry done more like that? I will have a, depending on the person of course, and if the person leans towards me in the trade or something then I'll lean more of a conversation in that direction, but it'd be some kind of analogy like that that the key and sort of the end of that storyline, the key to success in dentistry is to have a good plan and execute the plan and make sure the plan is what you want.

I will often say to people, at the end of the day, how this all works out 10 years from now isn't going to affect me at all, but it's going to affect you tremendously, so I try to frame it in some kind of way that they would understand it. If the person's a mechanic, and I had one of those coming last week, kind of a master mechanic that owned his own shop, and I said, "If you're going to build a custom car," I've used that sort of analogy, "You would map it out. You carefully select your parts and you would put it together very carefully," and I said, "Your issue is that nobody has ever worked with you in dentistry in that sort of way, in that context," and they'll just nod their head and they'll go, "You're right. Everything has just been crisis driven and it's just been one quickly imposed solution following another but there's never been a map, there's never been any kind of broader goal or anything," so yeah, I'll use that.

Allison: I had a question for you. You may want to walk more through the exam part but you talked to me quite a bit when we were getting ready for this call about, and I know this is probably more when you're talking about, well actually it's probably

through the whole process is keeping the patient the right side, like on the right side of their brain.

Paul: Yes.

Allison: I thought that would be a really interesting conversation and I don't know where that fits in but I just thought I would bring that up.

Paul: No, I think it's perfectly timely now. Let's say a patient has come in, either by a phone call and they've agreed to do a comprehensive exam or my preference really is to not schedule for that until I've met with them face to face and I've really had a chance to share the value of that decision with them, and so let's say they've decided to proceed in that regard. The examination process needs to be structured in a way that the patient can engage it without being threatened or overwhelmed with information they don't understand, or in an environment that's foreign to them and it makes them feel at ease. In other words, you want to engage them as if they were coming over to your house and you want to get to know them as a friend.

You want to listen to them. You want to hear what their fears are. You even want to hear what the myths are in their head, because that's where you have to begin. You don't begin by imposing your philosophy on them, you begin by trying to listen to them and their frame of mind and their beliefs, and then you work from there, and this is what Bob Barkley was brilliant at. He figured out a way to do this through working with … that was

very right brain oriented all the way through until the very end, and so the way Bob did it and the way I do it is that the initial examination or the initial appointment is mostly is a kind of a get to know them appointment to listen to them, and I don't even do an exam on my first appointment. I just do records so it's much more analogous to an orthodontist appointment for the first time. I take photographs. Basically, my main focus is to get to know them and my staff as well.

Allison: Now you're talking about not the 15 minute part but the first-

Paul: I'm talking about my first appointment.

Allison: Okay. Got you, yeah.

Paul: My goal for that appointment is to get to know them, get them through that appointment in a way that they don't feel threatened, they're optimistic, they see the value in what we're doing, and I get an excellent set of radiographs, I get excellent digital photographs, I get excellent models and bite records. I consider that a victory, and they leave happy and optimistic. We've had no discussion about insurance because we haven't talked about treatment. They haven't been hurt because I haven't been probing on them or do anything like that.

The second appointment, we'll have them scheduled and we'll have all that organized and ready in my conference room and the first thing I'll do is I'll just sit down with them and say, "I just

want to share with you what we know at this point on a preliminary level. Let me kind of take you through it. Here's your X-rays, here's your photographs," and we'll kind of go through and I'll explain this and that regarding what we see on the images. We'll look at the amount of study models, I'll let them touch them, similar to the way Bob Barkley did, and I'll just kind of get them more familiar with their mouth because they've never seen anything like that before.

They've never had that perspective of them self before and you just need to go slow and let that sip in, and then once they're kind of familiar with what things look like and what's some of the broader, more obvious issues are, maybe localized bone loss that I explain in a very generalized way or a broken tooth or a missing tooth or a fragment of a root, these are things that they can understand, and once we've done that, then I do my exam with them, so when I do the Co-Discovery exam, they're already familiar with what their mouth looks like and when I'm calling off certain things to my assistant, they're generally familiar with what we're talking about. They're already aware that let's say they have bone loss around number three.

I'll say to them, "When we go back here in a minute, I'm going to check this very, very carefully and see if there's active infection there," and so I do the exam and I'll say, like I did today actually, there's an infection there that their gums are totally healthy. That bone loss is historical, it's stabilized, we're not going to have to worry about that, but we'll make a note of it. They get to see things and experience things in a couple of different levels in ways that mean something to them, so we do it that way, and once we finish the exam, when we go back in

the conference and then I start saying, "What are you thinking at this point?" I'll just shut up and I'll say, "Well, that's really a problem. I really like to do something about this or that." Also, I get them engaged already. I'm trying to engage their right brain in creative problem solving, and you'd be amazed at what patients come up with.

I've had patients treatment plan, very elaborate things with me, just right there by my side. We grossly underestimate what people are able to do, so the long and the short of it is let's say, like the case today and the one I had yesterday, let's say the case is too complicated to really plan everything out right there, you need to do a wax up or maybe you need a consult for implants or something, then you just plan to meet again and you continue ... I just say, "Let's continue this conversation. We need to gather a little more information," and then we do that. I'll present the wax up at that point in time and it's really not until they go, "Oh yeah, that's what I want. That's beautiful. That's exactly what I'm thinking." That's when the case fee is presented, when they ask for it.

Can you see how that they have been involved in designing the treatment plan, they've given the green lights all the way down the street, and at the very last one, I present the case and they almost always say yes. Can you see how that going to happen?

Allison: I can.

Paul: That might be outside a lot of people's paradigm but I'm telling you, when you get good at this, it happens every day, but you got to be sensitive to the patients, and let's flip this over. Let's say the patient agrees to do a type 3 exam but then in the middle of it, they're kind of backing off and they don't want to participate all of a sudden. Then I would not foresee what fully came to plan in that case. I would pull back and I would say, "I'm sensing that you're really not ready to plan this all the way out and that's fine. Why don't we just setup what I would call phase 1 plan, stabilize everything, and that will give you more time to think about it. How do you feel about that?" They'll say yes. That's another yes. That's another yes, I count that as a yes. We continue the relationship and we continue to build value and we look for opportunities to go deeper with that person when they're ready.

It may be a financial thing. It may be a personal crisis thing. It may be they're not ready to trust yet. That's all fine. That's how we do that.

Allison: Well I'm going to ask you a question that we got emailed today because I think it feels like it's a good place to ask it and that is, and I'll see if I can pull in as many as possible, this is an overly broad statement. He said, "When patients say yes, what are they saying yes to? Is it yes to what the dentist is recommending? Is it yes to agreeing with the dentist's goals and objectives for the patients by true agreement or is it by acquiescent?" He said, "My reaction is that something has to interpret this query to mean that the patients that accept the level of technical competency of the dentist, whatever that maybe, and is the patient even able to do that and on what they

assisted they make that judgement? Does the patient know if it is a cooperative effort of a dedicated and competent staff and the can the patient elect to defer extensive and expensive treatment?" There's a lot in there.

Paul: Yeah, that was Bill.

Allison: Yeah, that was Bill.

Paul: I thought it was great.

Allison: Yeah.

Paul: I would answer that by it depends on the nature of the relationship that you have with the patient. If the way that you structure your relationships with your patients is to intentionally create collaborative coequal relationships, then what they're going to say yes to is collaboration, something that they have agreed on. If you intentionally or not create relationships that are co-dependencies, in other words the person is dependent on you to make all the decisions and you own all the problems if everything goes wrong, then that's really a decisions that's made because you're in a position of power and authority and they're surrendering to it, which is fine. It makes things go faster on the front end but you own everything going forward.

Allison: Right.

Paul: If you play this game long enough, you don't want to do that on big expensive cases, because every case has odd twists and turns in it and you got to have them kind of working with you same way that you're building a house, the carpenter or the plumber or somebody always comes up to you and goes, "Oh by the way, we didn't think about this. It's going to be X more" or "How do you want to do this because that's not going to work. The architect drew it up wrong," and dentistry is like that too. There's just a lot of stuff that we can't know in the front end and so we deconstruct teeth and see what's inside, where the cracks are or whether or not it's something savable or whether an implant's going to work, there's stuff we just can't know all.

We can't know everything on the front end. Elaborate restorative dentistry is they process and it requires trust on the part of both of us, and I think you're crazy personally to do elaborate dentistry on people that you don't have a trusting collaborative relationship. They're just full of land mines, okay?

Allison: Every step along the way, you're like feeling them out to see if they're with you and I'm like air quoting that. Are they with you? If they're not with you then just a continual process and you don't do anything unless they're with you basically.

Paul: Absolutely, and everybody that's sitting in on this call has the capacity to sense when something is going well with a person and when it's not. It doesn't even have to be verbal. You can

just feel it. What I would say to you is get more sensitive to that and trust your intuition and slow down when something isn't feeling right, and don't get judgmental and hoppy and "You're wasting my time" or whatever. Just be patient with people and respectful. They'll move towards you when they're ready, and that may not be on your time table and you guys got to get okay with that.

Allison: We actually have another question that's kind of similar. The question is about engagement. "Some patients are so easily engaged, some are a mile away, I get that some will, some won't, so what's next? It is challenging when the patient is in a situation where they could lose their teeth and they simply don't care or that's the attitude that they bring. What are some questions that would aid in breaking down those walls to help them get engaged?"

Paul: How about the most obvious one? How important is it to you for you to keep your teeth for the rest of your life, and to be able to say that in a way that's not judgmental, because in my point of view, unless they get a mouthful of infection, and teeth is a lifestyle choice, they can live without teeth. We see it all the time. They can live with bad occlusions, they can live with poor aesthetics, it's up to them. We're so quick to want to do what the best of dentistry could do for them but you know what? We shouldn't do that. We should just listen to them, and then we need to decide is what they want to do in line with my purpose? Yes or no? If it's no right now, is it somebody that's trending towards maybe changing that point of view or not? It's all about reading them and responding to them. Is that helpful?

Allison: Yes, I think so. I'm reading the questions that we got on, I think that's basically, if they're not engaged, ask a question where you can find out where they really are and at some point, they may not be a good fit for your practice. Obviously, to me it's obvious but if the dentist is philosophically a tooth keeper and the patient doesn't care and they really don't care and you finally figured that out at some point, maybe it's better for the dentist to not keep trying to keep somebody's teeth when the patient really doesn't ... It's just take a step with them until you can't take a step with them anymore and ask them to step-

Paul: We've all been in a situation where one more of that happen and all of a sudden, your paradigm shifted. They finally hear you, and so my point I guess is if your relationship generally is good with this person, they show up, they're pleasant, they bring you cookies for Thanksgiving, you like to have them around. Be patient with them. Just love them. Listen to them. A moment might arise where it will be more relevant. Get okay with that.

Allison: Cool. There's a question here too and I think I can guess what you might say and I can't pull up the question because for whatever reason, my computer's freezing, but the question is basically how important is it to have the significant other there? I think that varies depending on the patient but what would you say to that? How important is it to have them there?

Paul: It completely depends on the nature of their relationship is the answer to that, and I think in a more conventional traditional

relationship, one spouse may look to the other because they're the financial keeper of household and they always make decisions together in that realm, but I mean they usually will indicate that to you. Today, I had it happen. I had a patient that we did a TMD exam on and she was an appropriate individual for orthotic split therapy and we went all the way through the exam and she was green light, green light, green light. Everything is good and when we had presented the fee and then when we got to that point, she said, "I'm going to have to talk to my husband about this because this isn't covered by my insurance and it's going to have to come out of our checking account and I need to discuss that with him first," and we just say fine. That's appropriate.

He didn't have to be invited in for that but I have another patient that I'm working with where the husband always comes in. It's the wife that we're working on. She had gone to one of these clear choice clinics and then quoted a fee for extracting all of her mandibular teeth, 7 of which were completely savable, and they were coming to me for a second opinion because it didn't make sense to them, and so they're skeptical and he's there. He wants to see the whole process. He wants to participate in it and I'm like, "Great. Glad to have you." They're going to move forward on a very big treatment plan that will involve implants and restorative dentistry, and it never would've happened if he wasn't there, so it depends on the nature of the relationship is the answer to that.

Allison: I think the personality of the patient.

Paul: Yes.

Allison: Some of the patients are not decision makers, so I'm going to ask another question that we got in email about, and I know this lady is on the phone. It's the same person so she wants to know what kind of supporting documents would you recommend giving the patient either when they leave that day or as a follow up in regard to treatment summaries, timelines, et cetera.

Paul: I'm assuming that we're talking about the treatment plan's been presented and accepted.

Allison: I would assume that too and I know Roxanne, you're on the phone so if you want to raise your hand, you can push *2 if you want to say anything specifically, but I'm thinking that ... There she goes. Okay, let me open it up. Okay, Roxanne, you're unmuted. Roxanne, if you're talking, I think your phone might be muted on your end because you're unmuted over here and we can't here you.

Roxanne: That was the trick. Thank you.

Allison: We got you.

Roxanne: I have a good double mute security so I don't bother anyone if something comes up at my house in the evening, so thank you

both and yes, you had it exactly, like if you know you're at the point where it's a $35,000 case and they've said yes but it just seems in a complex situation, clarity for them or give them detail that make it straightforward.

Paul: Absolutely.

Roxanne: How do you do that?

Paul: I think that probably the most damaging thing you can do at that moment is to give them a printout, the standard printout that Dentrics provides or SoftDent or whatever, and all this is a bunch of-

Roxanne: Right, with the itemized treatment fee. That's bad.

Paul: Yes, dental jargon with some code they don't understand and don't value and a number associated with it that's big, and all the time you spent building value and all this solutions, you just jolted them into their left brain and they're just looking at money, so the answer to that is a written treatment plan that has minimal dental jargon in it that's written in paragraph form, "Phase 1 ... We're starting the upper arch and we're going to do this and that, we're going to remove all," and say it in very simple terms. "We're going to remove all the old dentistry and clean everything up and make sure that all the decay is removed and seal everything up, and then we're going to move then to provisional restorations that simulate our end goal," and

that sort of language, "And you're going to start to develop some of our concepts of how it's going to look and feel and function, and the fee for that is X."

No codes. No ability for them to take that to the place down the road and say, "Can you do this cheaper?"

Roxanne: I hadn't thought of it that way. That's excellent. Is that something you're somehow able to have prepared when they leave or get mailed? How do you handle that part?

Paul: It depends on how complicated it is. We've got some of that's boiler plated but some that's real elaborate, just got to be done custom and it would have to be sent to them later.

Roxanne: Okay.

Paul: Obviously, as soon as you can, or even have them come back to review it if you want. More time face time is always better when it's a big case. When they don't feel like you're running the clock on them, you're just developing a trusting friendship with them so why not?

Roxanne: Right. That's a great way to look at it. Okay, that was really helpful. Thank you. You could say more.

Paul: Yeah. I mean this is bigger case dentistry, it's completely different mindset and functionality than working off insurance plans, because the fees aren't associated. The fees represent all that other work, the provisionals and the planning and the wax up and all that stuff. You can charge insurance fees and do that and make any money. You can do it as a hobby but you can't be profitable at it.

Roxanne: Do you tell them if they have insurance that you'll maximize their benefits and not all-

Paul: Yeah. We'll complete the forms for them. We'll even submit them in their behalf but we're going to direct them to send all payment to them and that the communications are always between us and the patient directly because that's where it matters.

Roxanne: Great. Thank you, Paul.

Paul: Sure.

Allison: Thanks Roxanne. I'm going to mute you and un-raise your hand, okay?

Roxanne: Okay.

Allison: Thanks. Paul, I'm just going to say out loud that we're past time and I usually, I want to honor everybody's time and we usually go an hour but Paul said he was willing to stay on. Are you still good with answering a few more questions?

Paul: Yeah, I can keep going. Sure.

Allison: Okay, cool. Appreciate that. I know Matt Fineberg is on here. Matt, do you want to ask your question or do you want me to do it for you? If you want to ask it, you can *2 yourself. You know Matt, right Paul?

Paul: We met, yes.

Allison: Okay.

Paul: A long time ago.

Allison: Matt's being quiet. That's not like him. There he goes. Hi. I was going to say, "What the heck?"

Matt: Where is he, huh?

Allison: Where is he? He's got himself mute or he can't hear me or

something.

Matt: My question, I can't even remember exactly the question I asked but we all have relationship based practice, we're very ... I've taught Panky and what are some things that we may be missing, and I've been listening to you now so what are things that we may be missing in talking to this patient and getting to know the patient, what is the key thing that you're picking up now that maybe you didn't know 10 years ago that you feel is so critical now especially now in this world where we have, the internet I mean, it's a different world now when talking to patients. It's totally different from where it was 10 or 15 years ago, and trust of course is the key, but people will leave in a heartbeat now. The receptionist says something to them and they're gone.

A practice like yours, I have patients that have been with me for 34 years, but what is one key thing, if you could pick one key thing over the last 10 or 15 years that you think matters most that you see then is not doing consistently, what would you say it would be in getting the patient to say yes?

Paul: I would say a couple of things really, Matt. It took me a long time. I worked with a guy Stan [inaudible] who helps me a lot with a lot of my marketing work and we've known each other for like 20 years, and when I first met him, he said, "You know, you really need to meet with your clients before you ever do your exams and just get to know them. That's the way I run my agency and it works great," and it took me like 6 years to finally do it and as soon as I made that decision to try to funnel

everybody into a pre-treatment conference, not a pre-clinical exam but a pre-treatment conference.

Matt: Right.

Paul: I'm really honing things down already. I'm weeding out patients who are unlikely to want to engage, and so I think the most successful things that I have done is that I have really tried to match what we do with what people want and try to figure that piece out as early in the relationship as I can, and if you do that then everything else kind of flows much easier, so I would say that's a key thing.

Matt: I love that. I call all new patients. When a patient calls, I talk to them first, but I love the idea-

Paul: Yeah, I think that's great. The other thing that we're experimenting around right now that's turning out to be very successful is that we have actually recorded about five or so different videos. Britney who's my administrative leader, so whenever patients sets up an appointment, it might be for that pre-treatment conference or it might be for the next appointment, for the initial exam process, she'll send in a text or an email and say, "Is it great to talk to you today? Here's a little video about what to expect at your next visit," and it's actually a video segment of her saying, "Welcome to our practice. This is what we're going to do. Dr. Henny is going to take a look at this and this" and build value in the next step and give them a reason again to keep that appointment and to frame what to

expect.

Research says that people only retain about 20% of what we say to them, so think about that. You talk to them on the phone, they got like 20% of what you tried to tell them on the phone about the exam and why it's a great thing and the sun always rises and sets on Dr. Fineberg, but they don't hear her in any of it, but then you send them a video that basically repeats that in different words and then they finally get more of it, and you just build it and build it and build it, and everything is congruent, every message is relationship centered message and it's turning out to be very effective, and the other piece is to design your website to always to speak to those same things.

When they go to your website, what they should be experiencing is who you are philosophically, how is it going to feel when they come to see you, what to expect, why it's different, why it's valuable. Not that you do crowns or you do sleep or whatever. Everybody does that. Why are you different? These are tools that can really set you apart now and everybody needs to understand how to use them effectively. It's a great time to be a dentist because we have these amazing video tools now, so those are kind of some key things.

Matt: All right, well thank you so much. Thanks, Paul.

Paul: Sure.

Allison: Cool. Thanks Matt for the question.

Matt: You're welcome.

Allison: Good to talk to you. I'm muting you and putting your hand down. We had another similar question Mike Crate asked and I don't know if he's on here but he can raise his hand, maybe so because there's a Michigan number on here, but anyway, Mike asked what are the most effective presentation techniques for impacting high case acceptance?

Paul: I went through that and I think the most powerful thing that you can do is to preheat all the big issues before you do the exam, and that's where I would say Panky's got it wrong and Spears got it wrong, at least from my point of view is that we're trying to get too much done with a patient and I absolutely understand that there are some people that are extremely masterful of CoDiscovery and that can do that, but the average dentist isn't that great of a communicator and it's putting too much pressure on them and it's just too high of a bar, and it's much easier to kind of do a preliminary review of findings and then do the exam because when you get the probing, that six and bleeding, it means something to them. "Oh, that one spot in the upper right that you mentioned, yup, it's bleeding. I think it's infected," and the light goes on in their head.

Some of these concepts are just too hard, we got to get out of our mindset that they understand things on a level that we do. They do not. They're like a 3 year old in terms of their

understanding of our language, and so you really need to go out of your way to make it easy for them and comfortable for them to understand what's going on and why it's important, and so that to me is really helpful, and I know some people will look at that and go, "God, it's crazy. You're going back and forth and look at all the time it takes." Look at the treatment plans they're saying yes to. How can you say that's not worth the time?

Allison: You're helping people that if you don't take the time to walk them, go back and kind of hold their hand and really walk them through it, they would maybe never say yes and never get the treatment they needed, they probably would never say yes to anybody, and so because it takes that time and helping them understand for them to get to the point where they get it.

Paul: Yeah. You got to go at their case, not yours, and that we get ... As dentists, we're all very left brain inclined and we want everything to be like conveyor belt and predictable and boxed up and labeled exactly and stacked right, perfectly color coordinated, that's the way we like our world as dentists, but people don't come to us that way. People come to us in all sizes and shapes and different paradigms and myths in their head and different beliefs and all kinds of stuff and that's where you got to begin whether you like it or not. There's no way to run a practice without people, none that I've found anyways. Granted, there are some people that you can't work with but that's okay. The key is to figure that out early. Everybody else in the business world does that.

The problem is that everybody gets all wrapped up in these

bizarre relationships with insurance companies and they can't say no to anybody, and that's the root of a lot of conflict. They're in codependency relationships with patients that they don't like and the patients don't like them either, but they're bounded into this contract with an insurance company and it's just tearing them up.

Allison: Yup, it's true. I have a couple of questions. We have the question at the beginning of the call about insurance and I know there's a couple of other people who are asking what should case acceptance metrics be and how do you measure it and does the doctor present all cases and then I have another one that said the same thing, who presents the treatment?

Paul: I can only, in my practice model, and I want to restate this, in my practice model, I present the treatment plan. I don't necessarily present the fee, the total fee, but I take them up right to that point and there may even be some preliminary conversations about the general cause of this because a lot of people, when you kind of get towards the final yes, they're giving you signals, they're giving "Buying signals" basically. They're going, "Well, how much does it cost? How much does something like cost?" I'll give them a rough idea. I'll say something like, "Well, roughly speaking you probably figure on maybe $1500 which is probably a good idea for the ones that not talking about implants," and they'll do the quick math in their head. "Oh geez, we're probably upwards $30,000 on this." They're either flinching on that or they're just going, "Oh geez, … to make that work."

Then I'll just say, "Do you want me to have Britney come in and get you the final fee on this?" I ask permission and they say, "Yeah, have her come in." I say, "I just want you to know that you're in the driver's seat on this, we can pay just any way you want, you're the one that's in ... It's your schedule and your time and your financial commitment and we're here to just try to be flexible enough that you can get this done. At the end of the day, we want it to work for you so any other questions, I can answer for you," and I'll just exit the room at that point. That's how I do it.

Now that's not to say that you can't have a really well trained patient care coordinator do that. Obviously, there are many that do that, but that takes a special person that's very well trained and very intuitive and has exceptional interpersonal skills, but it's not the way I do it. That doesn't mean it's right or wrong, I just do it the way I do it.

Allison: Yeah. That's the way I prefer it as well. I think Leona's on here so Leona, these are your questions, and Kimberly too about the doctor. You guys had a more specific question about that and then Leona also asked what should case acceptance be? I think she's just asking like what ... She said what should case acceptance metric be an how do you measure case acceptance?

Paul: Again, it depends on what your paradigm is. In my world, it should be 100%.

Allison: That's what I thought you were going to say.

Paul: If it's not 100%, I missed something, or something came out of the blue. Everything was go, go, go and their mother died, or everything was go, go, go and they got diagnosed with breast cancer and everything is back burner, but it's not really a no.

Allison: I was going to say if anybody missed at the beginning of the call, Paul said he only presents treatment to patients who are ready basically, so that's why he said it should be 100%. Anyway, keep going, Paul. I just wanted to throw that out there.

Paul: Right. The other thing is probably some of you who are listening to this call are thinking, "Oh my god, how do you do that when you got 60 new patients a month?" I don't have 60 new patients a month. I have like 12 to 15, so in my work month or week, I have time set aside to invest in developing people. That's what I'm doing is developing people. I'm allowing them time to explore and understand where they are and allowing them the opportunity to kind of clarify their values and what's important to them, what their priorities are. I'm giving them space to make decisions, giving them enough information that they can make good choices, and like I said, it's based on a philosophy that I have that most people will do that well if I gave them a chance. You don't need 60 patients a month when you're working with people on that level.

Allison: Leona raised her hand so let me see. Did you have something

you wanted to add, Leona, or ask?

Leona: Yeah. First of all, can you hear me?

Allison: Yes.

Leona: Okay. Thank you, Dr. Henny. You did answer the question that I was asking about in the beginning of the call. Two questions on that. If somebody who you were not going to do that full exam that you were going to just do, they were not ready for that, and so you would just make the decision to present maybe just the first phase to stabilize them out. Did I understand that ...

Paul: Yeah. Assuming that we kind of proceeded towards doing what we call a type 3 exam, a full comprehensive exam and maybe somewhere along the way, I'm just not feeling it, and mainly what I mean by that, I'm not feeling like they really want to participate in the planning for their own health, then I will say there's some broader issues here but let's just start with focusing on your immediate needs. Let's get things stabilized sort of like you going to the ER and getting all your vitals stabilized. Let's go there, let's get all the disease stopped and stabilized, and then let's start a plan maybe a few months from now, we can sit back down and just kind of continue the conversation about where we want to go long term and nobody will say no to that, and so that's what I'll do. I won't put pressure on them to make any commitments they're not ready to make. That's what I do.

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Leona: Thank you. That clarified that, Dr. Watts. The other question is if you have people that are coming from miles away, they're coming from out of state, how do you condense it? Do you do some by the phone?

Paul: Yes.

Leona: How do you move them in that process when they don't live there locally?

Paul: Well we have to handle all the time. I have patients probably come in probably from 100 mile radius to my practice, and so like I have people that drive up from North Carolina, we're in Virginia, Southwest Virginia, I have people come up from North Carolina, people that come over from West Virginia up from Northern Virginia, all over the place, and so in a situation where there's significant amount of travel involved, what we'll do is the first part, the records gathering part, we'll do it in the morning, allow my staff enough time to mount the case and have all the radiographs ready to be viewed, and then we'll see them later in the afternoon and we'll continue with the exam at that point in time, so yeah, we will do that. Obviously, that takes a-

Leona: Do you have a pre-treatment conference on the phone? Do you do the pre-treatment ...

Paul: Usually in those cases, they are really singling me out. It's not a random call by any means that they've called our office if they live 100 miles away, and they usually been researching me on the internet or they've talked to somebody or something, so they're already kind of pre-qualified and that person will just skip that pre-conference and we'll move right in to the first part of the exam. Does that make sense?

Leona: That makes sense. Yes, it does, thank you.

Paul: That puts more the burden on Britney, my administrative leader, but she's good at that and I'm sure she'll offer them a pre-conference if they're uncertain, but a lot of times they'll go, "We're driving from 100 miles away. What can we get done?" We'll just go ahead and set the whole thing up to happen in one day, all right?

Allison: I think she-

Leona: Thanks.

Allison: There you are, okay. Did that answer your question, Leona?

Leona: Yes.

Allison: Awesome. Thanks for the question. I think we only have one question left other than the question, I don't know if you even want to feel the question about the financing. Mike, and I don't know Mike's last name, but his most difficult patients are the seniors that are 70 to 80 years old. They're reasonably healthy but have structurally compromised teeth, like large amalgams and deposits that survived many years and been patched and are giving the patient no problems. For the moment, they're fine but they're at a risk for problems down the road when the patient maybe less healthy or able to do dentistry either for a health concern or financial, so even with the relationship with the patient, it often seems weird discussing a solution to a problem they don't have.

Paul: I know, yeah, sometimes those are difficult situations, there's no doubt about it, but honestly, sometimes those big amalgams are more serviceable than a full coverage restoration when their mouth goes dry and they get recurring decay under all the restorations, and that's only a conclusion that I can make after playing this game for over 30 years, because I mean there were certainly times when I thought every big amalgam had to be ripped out of there and restored beautifully and everything, and now I don't think so much that way. It's very situational. That doesn't mean that you don't have a conversation with that patient about the risks of certain situations. "Okay, so this tooth really looks fragile to me, it might make sense for us to do something before it breaks," but at the end of the day, its' their decision. I don't believe it's your responsibility to impose your standards here on them.

Allison: Right. I don't know what kind of practice Mike has but I do want

to say that to me, any patient who it feels like we're presenting a solution to a problem they don't have, something that really helps if you're not already doing it is photography. I don't know if Mike is practicing with photography and he may be and I know that that's not always the solution but it does help a lot to have patients-

Paul: Yeah, and it's difficult. It kind of goes back to my earlier comment. It's difficult to change the nature of a relationship after it's already been established, so if the patient is very habituated into the routine of recall and she likes Suzy the hygienist and everything just sort of flows there, where else can you go? We need to stop because we got all this problems, we need to take photographs, peek at models, the red flags go up particularly in a generation that grew up approximate to the Depression and all this stuff, so those, got to be careful there.

Allison: Yup. Cool.

Paul: The danger is you can take ownership of the problem away from the patient if you're really god at selling, but if anything goes wrong, you own it.

Allison: True.

Paul: That your best intention was to restore this very fragile tooth and you do it and then like a year later and he's endo and they're mad because you got to cut through it and it's another

1200 bucks or whatever.

Allison: Right, and you made him do it. You didn't need them.

Paul: Right.

Allison: Cool. The last question was just about financing. I don't know how much you want to get into that but he just ... Carry sweets. "If you have various financing options available, IE CareCredit, Wells Fargo, and if there are any tier 2 lenders should a patient not be qualified? I don't know what that means for tier 1 prime lender. Also, should a handshake agreement be made in the office? What is the recommended interest rate for a payment plan? Also, should we charge interest in that? That was the question. I don't know.

Paul: I know that one's kind of too far into the admin side of things but like I said, I am very, very biased against talking about money until the very end. You want to keep them in a right brain, creative, problem solving mode to the point to where they are clear about what they want and decide on what they think they want to do and then talk to them about how they can afford to do it. Help them work through that and that's where CareCredit and these other things come into the picture, but if you're talking about that on the front and you are automatically talking about the limitations of this or that and the interest of this or that and the caring charges of this and that, and all of them is just a left brain conversation. All the right brain thinking is just shut

down, it's over.

Allison: Cool. When you say right brain, you're wanting to keep them in the conversation about possibilities and what they're wanting, and what else does that look like? What is that? What is happening in the right brain conversation?

Paul: Barkley used to say that, Barkley wasn't perfect at this all along. In the beginning, he used to try to teach oral hygiene instruction to everybody and then he realized after doing that a whole bunch and seeing a whole bunch of other dentists fail at doing it, that that was a bad idea, and then he came around and said, "I am going to stop trying to impose my philosophy on other people. What I'm going to try to do is figure out what their philosophy is and help them discover it, and this philosophy basically is their belief system about dentistry and how that fits into the bigger picture, and everybody comes into a relationship with us and in a different way in that regard.

Allison: Cool. That's actually really cool, I've never heard that. In some way, shape or form, I guess yeah, I guess I've done that sometimes but I wasn't intentionally trying to figure out what their philosophy is. That's cool.

Paul: We were all in it, within it, overly talked to this way but we all were led to believe that okay, we're going to go to this big elaborate process and we're going to create our belief, identify our values and put all that together with the team and then we're going to make a purpose statement and a vision

statement and we're going to put it on the wall and then we're going to salute it every day, and we're so proud of it, we're going to take every patient in a closed room and we're going to read it through them like The Gettysburg Address, and there is rollback in their heads and they go, "What the hell does that have to do with me?

Allison: Right.

Paul: I've got this upper right tooth, it's been bothering me for 3 freaking weeks and you're telling me this? They just send me at least shut down, they don't feel heard, so that's what Bob was saying is that you need to listen to them and figure out what's their philosophy? How did dentistry fit into their life? Where is that? Is that something that can be developed to a higher level of understanding or is pretty rigid, and if it's pretty rigid, you want to deal with it, so it's a Steven Covey thing, "Stick first to understand, and that's what Barkley was saying.

Allison: Yeah. I think that's probably a great way to end this conversation. We don't have any hands raised but I think that's probably the key to all of this because you as the doctr and the team wanting to understand the patient the more we do that. The more they feel heard, the more they feel listened to and understood and that our treatment is actually related so what they're asking for in one thing, the more trust and the more likely they are to accelerate treatment that fits with that.

Paul: Think about it this way. This is the story about it this way. There's this startup good and exotic. What are the chances of the patients say no to a treatment plan that they helped create?

Allison: Right.

Paul: It should be zero. 0% chance are going to decline that. The times where it's messing up, it was either you didn't do your job and hear them well or something else happened in their life that just kind of put the breaks on it suddenly, and that happens. When patients say no, I think as dentists, we try to blame shift it on to the patient. When a lot of times it's us, we just didn't handle it that well. The timing might have been, our intentions might have been perfect or diagnoses may have been spot on, our wax up could have been impeccable, but maybe the timing was wrong, and it all matters.

Allison: Cool. I think that's a great place to end. That makes total sense to me. Why would a patient say no to something that they helped create? Yeah. All right, well if nobody else has any questions, if you do, press *2, if you do not, raise your hands what I'm going to do is I'm going to open up the lines, I'm going to stop the recording and we can say good night and thank you to Paul.

Well thank you guys for being on and Paul, thank you so much. It was really, really nice to have you on and thanks for staying late to get all the questions answered.

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Paul: Thanks for having me.

Allison: Absolutely. We'll be talking some time soon.

Paul: All right, see you.

Allison: All right. Have a great night, everybody. Bye.

Paul: Thanks, guys.

Allison: Thanks.

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.