

# The New Patient Exam: Sequencing the Problem-Solution correctly



By Dr Michael Sernik

**DENTIST:** Your teeth are very heavily filled and cracked. I think you need crowns.

**PATIENT:** How much will that cost?  
Why is it so expensive?  
My other dentist didn't say that.  
Can't it wait? Do I really need this?  
But it doesn't hurt!

The above scenario is quite familiar to most dentists and when faced with these objections, we usually want to know the best way to *handle* these objections. As communicators it makes the most sense to use techniques that *prevent* these objections rather than be doomed to create them and then struggle to deal with them. So if the dentist has created a communications problem, what exactly could he/she do to prevent this from recurring?

The new patient exam is a psychological minefield...with many mines...and this article will only deal with one of them...In traditional sales, the mantra is to find out what the client wants and give it to them. This is not the case for many dental patients. The average patient is not enthusiastically looking to have a lot of expensive treatment. The typical patient is emotionally resistant to even being there. From the patient's point of view this is a New *Dentist* Exam and they are assessing whether they can trust this new dentist.

If someone wants to buy a car, they go to a car dealer in order to make a purchase and they know how much they are prepared to spend. The buyer is *initiating* a purchase. But many dental patients come with a built-in reluctance for treatment. It is the dentist who has to *inspire* the patient to want treatment. Many patients are there for a 'check-up' or for minor treatment. The common default position is that they do not want to spend money and they want only the minimum treatment.

On the other side of the equation is the dentist's position. The dentist perceives chronic disease that the patient is unaware of. Most cracked teeth, worn teeth, rotated teeth and periodontal disease do not cause any discomfort. The patient may have orofacial pain and is convinced the correct treatment is pain killers, whereas it might be caused by a dysfunctional bite and require complex treatment.

So the dentists are often faced with the challenge of having to convince the new patient that their *asymptomatic condition requires treatment*. More often than not, the best treatment will also be much more expensive than the patient thought which further compounds the communications challenge.

Every consumer's purchase can be viewed as a solution to a problem. As a provider of dental services this means that the cost of the solution needs to match the scale of the problem in the patient's mind. Clearly, if a patient is considering a \$10,000 solution (treatment) they will be more likely to spend the money if they perceive a \$10,000 problem. While many patients may not be experiencing significant current discomfort--- they may be on a path that will *lead to an unpleasant outcome* in the

future such as the loss of teeth or the degeneration of their bite or their appearance. It's as if the dentist can see into the future and sees an unpleasant outcome, but the patient wants to believe that everything will stay the way it is. If the patient has no concern regarding the ramifications of their current condition, they are unlikely to do much about it.

This concept leads us to a new definition of motivation and it relates to concern. It is the *dentist's role to have the patient appropriately concerned* about the deleterious ramifications of their current condition. How much is appropriate concern? It is the *same* degree of concern that the dentist would have, were he/she to have the patient's condition. No more; no less.

Very often, the dentist will suggest treatment (a solution) and then spend a lot of time on dental education trying to explain the problem (diagnosis). Then the dentist then tries to justify the solution with more details of the problem. This is a case of sequencing 'Solution-Problem' instead of 'Problem-Solution'.

Talking to a patient about a solution (treatment) before the patient has a strongly *perceived* problem is at best useless and at worst counter-productive. Sometimes, the more the dentist tries to educate the patient, the more the patient feels the dentist is trying to justify a 'sale'.

Dentists will be more successful if they refrain from talking about the treatment until the patient has a clear intellectual and more importantly, emotional appreciation (concern) of the deleterious ramifications of their current condition.

Understandably, you might be wondering *how to effectively create appropriate concern*.

The first step in problem-solving is to *recognise and define the problem*. Let's be clear about something. Whenever the dentist calls out the charting and says to the DA, that a tooth needs say, a crown, (a solution) it is common for the patient to ask the price. This will lead to a discussion about the details of the treatment..which is an example of 'Solution-Problem'. If on the other hand, the *problem is described* during the charting process and the *solution is withheld*, we will create in the patient's mind, a *need* for a solution.

Our communications with patients should take the form of conversations rather than lectures. Lectures can be scripted and rehearsed. Conversations cannot be scripted. Conversation training cannot be linear- it will be organic and cannot be mastered with a series of learned scripts. I hope this article has shined a light on this complex issue and can inspire dentists to be more conscious that:-

1. The dentist is *responsible* for their patient's objections and
2. The *scale* of the patient's problem should have a relation to the scale of the treatment (a \$10,000 solution needs a \$10,000 problem)
3. The *sequence* of Problem-Solution is an important sequence and is commonly and unwittingly reversed.

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