

Do American sales techniques work well for Australian dentists?

By Dr Michael Sernik



I do a lot of work in the US. I used to live there and my wife is from there...so I have a reasonable understanding of that culture and I am generally an Americophile. But I am allergic to one area of US culture...the sales techniques that I come across. When I speak to our American clients and describe some of the sales techniques they use as being 'American', they usually cringe. The truth is that most Americans hate anything that feels pushy just as much as we hate it. Many dentists in the US have attended sales courses promoting the Influencing Cycle, and Benefit Selling sales methods, and find them as distasteful and unprofessional as do Australian dentists.

Dentists always say that they never pressure their patients. However to some patients, any recommendation for comprehensive treatment can equate to sales pressure. When dentists give a case presentation and at the end the patient says "I'll think about it" the dentist has just been rejected. Chances are the patient felt that the dentist was selling them something.

The patient often has a chronic condition that they are largely unaware of. There is usually a discrepancy between the patient's needs and their wants. They might need it but they don't want it.

So what should we do? Should we just do whatever the patient wants. That would be easy. No pressure, no rejection. But this would place us in the depressing world of symptomatic 'patch and fill' dentistry. An ethical dentist should have an agenda to deliver the highest quality dental care.

It is our job to get them to want it....and we will be far more effective without sales pressure.

Reactive vs preventive communications training.

The first sign that many doctors have that there is a problem with case acceptance, may be when the patient phones and asks that their records be transferred to another doctor. The doctor's solution to this situation might be to want to train the appointment coordinator in handling this type of call. This would be an example of seeking a *reactive* solution to a problem.

A moment's reflection could lead the doctor to wonder whether the problem could have been traced back to something in the doctor-patient communication.

We can put our energy into *reactive* solutions or *preventive* solutions. *Most communications training is focused on reactive responses* - what to say when the patient says "Why is it necessary?", "Why is it so expensive?", "Can't it wait?", "But it doesn't hurt!", "My other doctor said it was fine!" etc. The consequence of never finding a preventive solution to these objections is that it condemns doctors and their teams to a career with a *continuous loop of reacting* to the same types of problems.

We create our patient's objections

Hypothetically, if the same patient were to see 100 doctors, we would see a wide range of treatments. Some doctors routinely do elaborate comprehensive treatment, whereas some cannot seem to find any patients who want this type of work. The variable is the doctor's communication skills.

An epiphany for many doctors is to realise that they themselves *create all their patient's objections*. If we can believe we created the objections, it empowers us to realise that we can *prevent* the objections.

Here are 2 examples of how we create objections.

Example 1.

The doctor sees a cracked tooth. What's the intuitive question to ask? "Does this tooth hurt when you bite on it?"

If the answer is 'no', what does the patient infer? (*Since it doesn't hurt, it can't be much of a problem.*)

Doctor "well there is a crack there".

Patient "but it doesn't hurt"

Now we are forced to try and convince the patient that it actually *is* a problem.

Example 2.

Doctor to patient: "Are you aware that there is food caught between these teeth?"

Patient: "No. It's just that I didn't brush before I came here"

Doctor: "Well actually, the food looks like it's been there for a long time. You are not cleaning in there"

Patient: "I don't feel anything. I clean my teeth. It's just that I didn't have a chance to clean because I was at work"

So now the doctor and the patient are in subtle disagreement. Most doctors want to know how to convince the patient that they need treatment. The better approach is to understand how *we created the conflict* and then learn *how we can prevent these conflicts*.

How a negative proposal is always a win-win (without sales pressure)

Back to the cracked tooth example.

First imagine that you are both looking at a digital photo of the cracked tooth.

Doctor: "I imagine this cracked tooth *never hurts* even when you bite very hard"

If the patient says "no it doesn't" we can agree with them and say:

"I didn't think so. Teeth with cracks almost never hurt, ... until it's too late".

Let's assume the doctor and patient are both looking at a digital image of the area with food impaction.

Doctor: "I imagine *you are never aware* of food being forced deep between these teeth"

Patient: "No I'm not." We can agree with them and say:

Dentist: "That's not unusual. Science tells us that bacteria will breed painlessly in any food stuck under the gum. It rarely causes discomfort until more of the jaw bone has been eaten away by the colony of bacteria that breeds in these areas."



In this example when the patient *agreed* with the doctor's negative proposal; there was no conflict and furthermore the doctor was able to slip in some information designed to give the patient some knowledge of the disease process and deepen some concerns.

In both cases we have not disagreed with the patient because we **began with a negative proposal which is always a win-win**. Of course if the patient disagreed with us and said that the tooth *did* hurt or the food impaction *was* a problem, then we are moving in the right direction because **a concerned patient is a motivated patient**. That is our agenda. Preventive communications is much more complex than reactive communications.

We spend years on clinical training, only to find our patients do not always view their chronic dental conditions with appropriate concern. Without advanced communications skills, dentists can find themselves frustrated by having clinical skills that cannot be used to help their patients.

Communications training bridges the gap between having clinical skills and *using* them.

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