



Making Standard of Caring Part of the Standard of Care

CLYDE SCHULTZ, DDS

ABSTRACT Effective risk management focuses on consistent patient communication to inform patients of the benefits of dental health and the breadth of alternative treatments. When education is effective, it helps patients develop new understandings of health and disease. New understandings make appropriate treatment choices possible, and those choices reduce the chances of legal action and contribute to the health of the patient as well as the health of the practice.

AUTHOR

Clyde Schultz, DDS, has taught year-long postgraduate study groups on advanced occlusal techniques for full-mouth reconstruction as well as courses on communication at universities and dental associations throughout the United States and Canada. He has a restorative and preventive practice in Petaluma, Calif.

Dentists must employ effective risk management. Protecting ourselves from lawsuits brought by unhappy patients is an important management responsibility. However, few of us view our risk management protocol as a pathway to a more productive practice, it's more of a nuisance we accept as part of doing business. Even so, I can tell you from experience that the communication strategies that are advocated as part of a careful risk management program can profoundly impact practice profitability.

The Standard of Caring Promotes Success

For most of my 33 years in dentistry, I practiced in San Francisco. During that time, I purchased eight dental practices and incorporated each one into

my one downtown location. Eventually, I sold that practice and moved to Sonoma County where I purchased my ninth dental practice. I had never been a resident in Sonoma County prior to purchasing the practice. My wife and I did not know anyone in our small town of Petaluma. However, in just over two years, production increased by more than 200 percent over the previous dentist's levels and is still growing.

The increase in practice production is the product of consistent communication. Quality communication focuses on the same primary objective as that of good risk management: it is a consistent and caring message. Demonstrating caring values to patients recruits their trust, and trust is fundamental to effective communication.

Effective communication, in turn, is crucial to the success of patient education, which impacts the treatment choices patients make. However, I feel completely secure that most of my colleagues have a shared frustration with patient education, which more than occasionally does not result in better treatment decisions from patients.

The “why” of ineffective patient education is complex but part of the explanation is that learning does not take place unless patients are willing to listen. It is natural for us to take it for granted that our message is clearly heard by our patients because it seems so clear to us when we speak. But fearful or suspicious patients have an incentive not to hear what we tell them. Before we can reach those patients, it is necessary to facilitate their willingness to listen by establishing trust.

For the dentist who is committed to a more profitable practice, successful patient education is a requirement, and that puts us in the business of trust. It is crucial for us to understand how patients assign trust, why they choose not to, and what to do about it.

I believe that our (my team and me) success at establishing trust with patients is confirmed by the fact that we have retained more than 95 percent of the original patients in the practice. In addition, our referrals from friends and patients have more than tripled since January 2007, even though Sonoma County is one of the hardest hit in the San Francisco North Bay by both falling home prices and unemployment.

The need to establish trust with patients is a problem that faces all practitioners, but the transition of a practice that results from a change of owners amplifies the urgency of the problem. During a practice purchase transition

there is one chance to recruit the trust of each patient to remain in the practice. Without realizing it, the patient will impose the “10-second test,” the amount of time it takes them to form an opinion of the dentist and decide whether they are staying or moving on.

If it’s difficult for you to believe that a consistent message can alter the outcome of such a brief and intense encounter, you’re right, it can’t. But the dentist’s message is heard by the new staff again and again. If that message is clear and

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consistent, and if it seems to be motivated by genuine caring, it will win the staff over and, together, the dentist and staff become one team, and that’s what wins the patient over. Patients are very perceptive when it comes to judging the team’s feeling about the dentist.

I recently met a patient of record who had not been in for more than two years. When I asked her why she had finally decided to come meet me, she told me that she “kept hearing a rumor that (I) was a pretty good guy.” It’s difficult to know exactly where reputations originate, but it’s a safe bet that if my Petaluma-born and raised team hadn’t been in agreement, the rumor would not have survived.

I regularly attend risk management lectures as I’m sure you do. When the

speaker tells us what we should say before a situation arises, it’s part of sound risk management. But we dentists already understand the importance of informing patients in advance. Warning a patient in advance about possible postoperative discomfort resulting from a procedure is an explanation but telling them after they experience pain that it “sometimes happens” is often perceived as an excuse.

In any case, I don’t want to sound like an attorney when I speak to my patients. Risk management teaches us what we need to say, but we aren’t obligated to say it the way an attorney does. We should take what we need from their playbook and express it in our own words. One of the most valuable plays in that book is consistent communication.

We miss a fertile opportunity to build relationships with patients if we look at the protocols for informed consent and careful recordkeeping as a chore. Those guidelines for consistency provide a framework to structure a consistent message and they teach us to define in advance what needs to be said. Adopting that communication strategy reminds me to plan my message in advance to present what patients need to hear rather than what I want to say.

Developing a consistent message that can be used repeatedly is different than scripting. Scripting defines what we want to say, but the message is usually intended to overcome objections by justifying what we wish to defend. Often, this tactic utilizes words like “feel, felt, found.” If I were to use this approach to pass the 10-second test, it might sound something like this: “I can hear how you feel about changing dentists, Mrs. Smith. It is difficult to lose the dentist you have known for almost 30 years. Many patients once felt as you do. However, they have

found that in the end, there is a benefit from diagnosis by a fresh pair of eyes.” It is an effective way to dismiss concerns rather than demonstrating that we share them, and patients often recognize it. To them, it is obvious that the dentist or team member, who holds the power in the conversation, has shifted the agenda from addressing the concern to “winning” what has now become a debate.

Compare that language with the message I used when I first met an older patient in the practice not too long ago. She was already seated in the dental chair when I walked into the room. She had been with the previous dentist for more than 30 years and I could see from her body language that she was apprehensive about meeting me.

I shook her hand and sat down next to her. Seconds ticked. Then I spoke.

“I know it’s hard to change dentists, especially after so many years. But I have the same two responsibilities to you that Dr. Smith (different name) did. The first is to warn you about problems as soon as possible, so we can address them before they get out of hand.”

She wrinkled up her face into a skeptical frown. “And the other responsibility?” she asked.

“To make sure I never recommend something that wasn’t necessary,” I replied.

She looked at me for a moment, and then blurted out “Oh my God! You’re nice too!”

I rely on this message when a new or transitioning patient seems reluctant to communicate with me. This consistent message achieves two objectives when meeting transitioning patients: First, it demonstrates caring values which confirm I am trustworthy. Second, it establishes affiliation between my patient and me by demonstrating to them that

we share common ground since we both agree about what is in their best interest. Demonstrating affiliation is an important step in the process of establishing trust.

Developing a consistent message is not intended to be a tactic for manipulating patients or a strategy for saying what I believe they might want to hear. It tells patients that I am not conflicted by any agenda other than what is in their best interest. I have not changed this message for 20 years, and I have met few patients who doubt that I mean it.

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What risk management underscores is the necessity of a protocol, a set of guidelines for communicating a consistent message in critical situations. Whether we are talking about the information we share with patients, or how we record that information in their chart, we need to see our communication as one of the critical systems in our office.

A consistent message is as powerful in dentistry as compounding interest is in banking. It doesn’t always seem like much until we look at what it adds up to over time. I will fast-forward the careers of two practicing dentists to illustrate that point.

In the 1970s, I bought my first two San Francisco practices within two years of each other. The first practice I purchased was what we used to refer

to as a “crown and bridge” practice. The dentist who built that practice restored almost every patient using gold inlays, gold or porcelain to gold crowns and fixed bridgework. Partial dentures often had precision attachments. I was convinced that the success of that practice could largely be attributed to patients who were of above average affluence.

The patients in the other practice were almost entirely restored with silver amalgams and standard partial dentures or stayplates. I was equally confident that money was a greater obstacle to premium dentistry for these patients than it had been in the previous practice.

The patients in each practice loved their dentist, and trusted him implicitly. That trust meant that when the dentist explained treatment to the patient they listened. However, I assumed the patients in these two practices must be very different from each other. After all, the patients in the first practice paid, on average, more than twice what the other patients paid for their dentistry.

But from the moment patients from one practice met the patients from the second practice in my reception room, it was obvious that they knew each other. They lived in the same neighborhoods, attended the same churches and synagogues, and sent their children to the same schools. Many even worked for the same large corporations. The only difference between the two groups of patients was their choice of dentists.

The difference between the two practices had nothing to do with demographics or the cost of dentistry. What made the practices different was that each dentist had a consistent message that facilitated effective patient education. As patients learned what the dentist wanted them to understand, they came to believe what the dentist believed. It

was the consistent communication from each of the previous dentists that had forged the character of each practice.

One believed in using gold to restore teeth. As a result, their patients shared that belief. The other dentist preferred silver amalgam, which was a common choice at that time and their patients preferred silver amalgam as well, even though they could have easily afforded the dentistry their neighbors received. These two practices taught me a powerful lesson about how a consistent message can impact the character and profitability of a dental practice.

Of course, it was a different world in the 1970s. Dentists weren't as aware of risk management issues as they are now; they focused on their message to educate patients to adopt their beliefs about dental treatment. Now, it is necessary to present every treatment option to patients, not just the one we prefer.

If the goal of the practice model is to present patients with all of their treatment options, then the practice must focus on education in order to help patients develop the understandings that are necessary to make appropriate choices. Effective education is an essential step in providing dentistry that meets the standard of care. Simply put:

- success comes from patients' acceptance of standard of care treatment;
- to make appropriate treatment choices possible, education is necessary; and
- trust facilitates effective education.

Trust is Necessary to Facilitate Effective Education

Effective patient education is not easy or simple. To understand why patient education is so difficult to achieve, it's necessary to recognize that old beliefs patients bring with them act as barriers to listen-

ing. These preconceived notions act as obstacles to learning, obstacles we must overcome in order to help patients choose treatment that best serves their needs.

Patients rarely, if ever, suffer from a lack of information about dental health and disease. Instead, they suffer from misinformation, which contributes to confusion about the health and disease in their mouth. One such belief is that the absence of pain equals an absence of problems. In other words, "if it doesn't hurt, it ain't broke." Many

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patients take that belief one step further and argue, "And if it ain't broke, don't fix it." Using that logic, we only "fix" the teeth that hurt. Sound familiar?

The challenge of patient education then, is to overcome the long-held beliefs that confuse our patients before we attempt to present new information that will only be rejected by the patient's need to defend what they already believe.

The obstacle to the patient's attention and curiosity is the fear and suspicion that many patients bring with them to the dental office. Generally, people who feel fearful or suspicious are not very good listeners. Until fear and suspicion are resolved, patients aren't going to hear very much of what we say, no matter how clearly we say it, so it is pointless to attempt sharing

new information with them. This includes technical information that we typically regard as "patient education." I have never experienced a significant success rate from patient education until fear, suspicion, and existing beliefs have been resolved.

Surprisingly, if we borrow the communication strategies advocated for sound risk management, we find the answer to the patient education dilemma. Nine practice transitions have taught me there is an order to things and it usually works best to address "first things first." Communication is best begun by recognizing that people will only listen to a message when it comes from a trusted source.

I spent the better part of an hour explaining periodontal disease to a woman who runs a big ranch just outside of town. When I finished, I knew I was no closer to building her concern for something that "doesn't hurt" than I was when I started. I encouraged her to think about what I had said and then accompanied her to the front desk where she ran into her neighbor from the next ranch over.

The two talked for a minute and then the other woman turned to leave, but first turned back to say "He's a good guy; did a root canal for me and never did hurt me once."

After the door closed, I said "Bye Carol. See you next time." Before I could turn she interrupted by saying "Oh no you don't. We haven't finished talking yet. What were you saying about my gums?"

I had become a "trusted source" and my message was now being allowed through the filter the patient used to screen out unwanted messages.

Establish Trust

For dentists, the Catch-22 is what to say to establish trust when patients don't trust what we say. Patients who hear our caring words will not listen to

them until they are sure those words are genuine and are not intended to manipulate. The answer is: when you can't tell people you are a caring person, show them you are a caring person. The goal of convincing patients of the authenticity of our caring values begins to gather momentum as others become willing to confirm that the dentist is a "good guy" (or "person," if you prefer) as the patient did in the encounter I described.

However, even after a third party has expressed their trust, patients who are unsure if it is safe to trust what they hear will watch to determine if they trust what they see. When team members demonstrate cooperative and caring behavior, especially toward one another, their behavior is congruent with the caring words the patient hears. It is congruent behavior throughout the office that confirms the authenticity of the team. Seeing that the people in the office "walk their talk" makes it easier to believe they are genuine and to trust them as people. When patients trust us as people, they transfer that trust to us as professionals.

A Standard of Caring

When the behavior of the team establishes a "standard of caring," they are ready to send a unified message that lays the groundwork for the practice to define its standard of care. Meeting the standard of care does not occur by chance. It is the result of defining that standard and then adhering to it.

But how does the team know what the standard of care really is, and how does the practice implement one common message that reassures and educates patients? Caring is a choice, it cannot be taught by someone else at a weekend course or implemented by setting down a protocol at a staff meeting. If the office is to have a unified code of behavior and a shared

value system, it must be brought to them by a dentist who leads by example.

When I took over the reins of my current practice more than two years ago, there was no such code of behavior or shared understanding even though the individual staff members were caring people. It was my example that rallied the team behind me. Just as the staff must become a team in order to win over the trust of patients, it is the role of the dentist to win over the staff and make them a team by demonstrating what caring and integrity looks like.

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Establishing a new "standard of caring" begins with each chairside interaction with a patient. It should not be motivated solely by the communication guidelines that Art Curley and other risk management attorneys advocate, but it nonetheless adheres to those guidelines closely. The first step in establishing a standard of care for patients is to define the standard of understanding we want them to achieve before asking them to make choices about treatment.

A Standard of Understanding

If our objective is to achieve sound risk management, one part of that goal is to develop a communication protocol that satisfies our patients' right to know about all of their treatment options.

The process of sharing the breadth of the available treatment options not only demonstrates to patients we respect their ability to choose, but also that we are committed to helping them make choices that are in their best interest.

Full disclosure of treatment options may sound like it can only benefit an attorney, but it demonstrates respect and concern. That behavior helps to overcome the greatest single threat to patient trust, which is the perception we are attempting to manipulate them. Early in my career, I found myself the victim of that unfortunate perception more than once and it was almost always because I attempted to guess what the patient wanted to hear or what they would accept as treatment. Eventually, I devised an experiment to help me discover why patients made the choices they did.

In an effort to understand why some patients accepted treatment and others rejected it, I focused on standardizing my communication to help patients develop similar levels of understanding. My thinking was that if I could eliminate a lack of understanding as a cause of treatment rejection, I could then focus on other factors that influenced the choices patients made.

As it turned out, the "experiment" was short-lived, because almost all of the patients started saying "yes" to treatment. By helping them to understand the problem first, I had provided them with the understanding they needed to recognize optimum treatment choices.

Insurance and the ability to afford dental care made little difference in the treatment patients desired. Of course, those things did impact what they could afford, and so many of them had to compromise treatment from the optimum solution to another choice that was still within standard of care.

That's when the treatment plan should be compromised, after the patient has developed a standard of understanding. Of course, patients sometimes need to compromise treatment because of cost or insurance coverage, others have medical conditions that limit the stress they can experience. It is acceptable to compromise treatment within the standard of care when necessary, but it is not acceptable or necessary to compromise patients' understanding of the problem. Still, the process of helping patients to develop new understandings can be challenging. I am still puzzled sometimes at the way in which patients reach those understandings.

Not too long ago, I saw a patient who had fractured the buccal cusp from his upper first bicuspid, leaving a large MOD amalgam showing. I explained why teeth fracture, showed him the X-ray on the flat-screen and took a close-up image of the tooth using the intraoral camera. I was sure the close-up of the blackened amalgam would help him to recognize the importance of restoring the problem quickly.

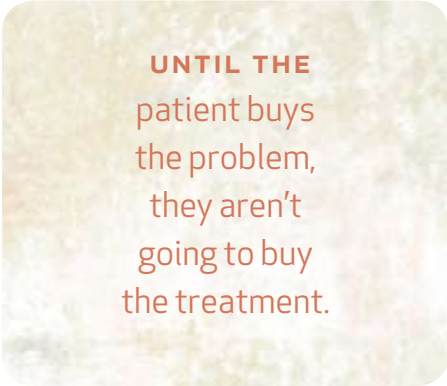
He looked at the images and then he said, "Doesn't hurt." After a bit more discussion about treatment, he left the office promising to "think about it." About two weeks later, he called the office to schedule an "urgent" appointment to restore the tooth. When I saw him for treatment, I asked if he was experiencing pain. No, he wasn't.

He had been photographed at a wedding in his tuxedo, flashing a big smile. The dark amalgam made it appear as though there was a huge hole in his smile. I had already shown him a digital image of how the tooth looked, but as Joe put it, "Yeah, but I didn't know it would look that bad in a tux."

Joe had already been given the information he needed to understand

the problem, but information alone was not enough. To recognize the benefit of treatment, he needed to accept personal ownership of the problem. Until the patient buys the problem, they aren't going to buy the treatment.

In the dental office, all of us lead lives in 10-minute time segments. We all feel the pressure to finish a task and move on to the next. Patients do not develop ownership of their disease with the same tempo. As long as we recognize that patients need to own the prob-



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lem before they can resolve the cost/benefit question, we will know when the process of education is complete.

A standard of understanding contributes to informed consent, as well as to the trust of your team members who eventually emulate the dentist's caring and empathy for the patient. It also allows us the confidence that we have helped the patient to develop the understandings necessary to make informed choices. As a result, it is possible to pick up the patient's chart, record the conversation, and capsule the presentation of treatment choices as risk managers have taught me: "Presented and explained all R, B, and As (risks, benefits, and alternatives) for replacing a missing tooth." It is acceptable to have the patient sign and date that entry.

A Consistent Message

If it is your goal to increase the production of your practice, have you considered that presenting treatment options too early in the process of educating patients may be having the opposite effect? If so, the problem may be that you are attempting to secure treatment acceptance without the benefit of a standard of understanding to prepare the patient to choose treatment with confidence.

Defining our consistent message to each patient helps to maintain the standard of care in the practice. Defining a standard of understanding allows us to know when it is appropriate to redirect our attention from explaining the problem to explaining the treatment. It means that patients are not asked to choose treatment until they understand the problem.

Acknowledging the need for patients to understand the problem before choosing a solution means that we explain the same problem to different patients using the same words. In this way, the team hears a consistent message, and everyone receives the same level of understanding before deciding what to do.

If it is not possible to define a consistent message by whom the patient is, then it is necessary to define the message by focusing on who we are. Doing that runs counter to our instinct, it seems much more logical to attempt to win the patient over. But patients are so unpredictable that customizing a different message for each one is unworkable. To demonstrate the values we want people to trust, we need to express them with a consistent message about who we are.

When I practiced in San Francisco, I once walked into the room where a new patient was seated. She was a very elegantly dressed woman with expensive

but understated jewelry, designer clothes and perfectly coiffed hair, and she was reading *Forbes* magazine. I extended my hand and introduced myself.

She did not return my gesture. Instead, she slid the readers down her nose so she could look over the top of them, and said, "I hear you're one of the most expensive dentists in town."

I paused for a moment and then smiled. "And here you are," I replied, "which tells me that you are more concerned about personal service and thoughtful care than you are about cost." She smiled faintly. I had just passed the 10-second test.

It was a sort of a trap that patients like to set for us sometimes, just to see who we are and how we react. There was no answer to her accusation that would pass the test, it would have been pointless to rationalize or attempt to defend myself. Instead, I told her who I was, which was what she was really trying to find out in the first place. Eventually, she shook my hand, and we had a long and successful doctor-patient relationship.

While it may seem like a brilliant (or lucky) spontaneous answer, it was simply part of a philosophy that utilizes consistent communication. That philosophy accepts the importance of my role as an educator because I chose to be a dentist, and most patients need to be educated how to make appropriate treatment decisions.

I can't be effective in that role unless I have the trust of my patients, because they won't listen to me until we have established a relationship where we both feel safe. To that end, the most important goal I can initially achieve is to make sure they aren't confused about who I am or that I am committed to their best interest.

Many of us in dentistry are skeptical about the impact that communication can have on the success of our practices. We are trained perfectionists. (Some of us

are recovering perfectionists.) Nonetheless, we are doers, not talkers. We believe that if our practice is falling short, the answer lies in more perfect margins and better execution of our smile plans.

Clinical excellence is of paramount importance in dentistry. Without excellence, we are not providing the care our patients deserve. There is a point, however, when taking something we already do very well and doing it better does not address the real problem of how our practice is perceived by our patients.

THE MOST IMPORTANT goal I can initially achieve is to make sure they aren't confused about who I am or that I am committed to their best interest.

There is a story about a teamster who took his wagon to the village blacksmith for advice. He explained that he kept replacing horses that became exhausted struggling to pull it. He reviewed everything about the wagon with the blacksmith, looking for a reason his horses found pulling it so difficult. Finally, he got to the wheels. He pointed out that the wheels were certified by the manufacturer to be of perfect size, weight, and conformity to reduce resistance to rolling. They had been lubricated with the specified grease for reduced friction. The teamster had even checked their alignment to be sure they ran true. Finally he asked the blacksmith: "Do you feel the wheels could be better?" The blacksmith thought for a moment and then answered, "Nope. A fourth one would help though."

For many of us, communication is the fourth wheel in the practice. We weren't trained in communication. We don't know how to listen to the communication in our office and diagnose the problem the way we can find decay sneaking under a crown in a digital X-ray. So we focus on what we know and hope we can drag the practice along by maintaining our focus on clinical excellence.

Conclusion

What the risk managers have been trying to tell us is that patients rarely judge us by our margins or the strength of our bonded surfaces. They judge us by what they can hear and see, and by how it feels to be in our offices. Often, their decision whether to go forward with a lawsuit has more to do with the way they perceive they were treated by the team than it has to do with the treatment itself.

Communication is an essential element in an effective risk management protocol for a reason: It is the linchpin for how we are perceived. Good risk management requires clear and consistent team communication to clear the bar.

Look beyond that and you will find effective team communication to be a rich resource for generating new growth and satisfaction in the practice. Good communication generates trust, which leads to effective education and an increased openness to accepting the standard of care in treatment. Our clinical success depends on meeting the standard of care, but our relationships with patients depend on our ability to communicate a standard of caring. ■■■■

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