

Can we talk?

The small talk you make with patients could affect their impression of you and your practice. Here's how to keep the conversation flowing in the right direction.

It was my first appointment in the practice as a mystery patient. On entering the hygiene room, I quickly ascertained that the hygienist adored her dog. Several photographs were perched on the countertops in easy view of whoever occupied the dental chair. Snapshots were taped to the wall above some patient education pamphlets. One photo was even taped to the bottom edge of the hygienist's framed degree.

As a dog lover myself, I knew immediately that the hygienist and I had something in common. But I wondered if, given the opportunity, "Betsy" would use our brief, valuable time together to regale me with dog tales at the expense of patient education.

"So, you have a sheltie?" I offered, jump-starting the conversation to see how she would steer it.

"Oh, yes. That's MacDuff. He just turned 3 and we had a puppy party for him. Boy, was that a wild time!"

For the remainder of the 45 minutes I heard about the puppy party, how she had found and rescued MacDuff, what sorts of tricks he could do. Although I have always enjoyed having multiple pets, I found a little of this chatter went a long way, especially during a dental appointment. Not once did she attempt to redirect the conversation. I was curious to see how far she would carry it. I was amused when, at the close of the treatment, she handed me a toothbrush and said, "Well, we'll see you next time." It was the only non-doggie comment she made during my appointment.

This was the worst use of patient discussion time I have encountered. Though she might have provided the best cleaning I'd ever received, I wasn't aware of it.

I wondered what other patients might think. Would any of them leave thinking, "Great cleaning, wonderful practice, skilled hygienist"? Doubtful. More likely, they'd think, "She was quite the chatter—a nice person who really loves her dog—but she showed no interest in me."

What you talk about with patients has an impact on their perceptions of the practice as well as on the care provided. It also has a significant impact on a patient's per-

ceptions of value received. Following are some of the most common communication blunders practices make, as well as advice on how to steer conversations back to clinical care, where they belong.

Communication gaffes

You may not realize it, but patients pay close attention to how you communicate with them and other team members in the practice. Here are some of the most common concerns patients have voiced in focus groups:

Personal chatter among the team. For example, during a procedure, the doctor and assistant carry on a conversation that excludes the patient. They could be talking about anything: a date one of the team members had over the weekend, the doctor's sister's job change, an upcoming office renovation. The result: The patient feels invisible, as if he or she is merely a set of teeth in the chair. Focus group members have mentioned this and I've experienced it myself.

Overheard conversations. It is not uncommon to overhear discussions carrying over from the next treatment room. In this day of HIPAA, we are far more aware of privacy issues than we had been previously. But habits are hard to break. It's challenging when physical barriers of treatment areas provide a false sense of security and voices easily drift from room to room and across hallways.

Feuding teams. At times, patients unintentionally may be involved in disputes between staff members. The impact is toxic. This communication can be nonverbal—a doctor who



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glares at the assistant across the patient's supine body—or verbal. On one occasion, while an assistant was guiding me to the treatment room, another team member passed us in the hallway and mumbled a mildly derisive comment that was obviously directed toward the assistant. The assistant rolled her eyes and said, “Hrruumph . . . sorry about that, she’s got a bad attitude.” I hadn’t yet been seated, but already I could tell there were significant problems in this office.

Laughter. It’s nice to have a cheerful office, but be careful. If the patient is alone in the treatment room and hears laughter behind her, she may feel as if it’s at her expense. As ultra-sensitive as that sounds, bear in mind that a patient in a chair is in a vulnerable position. In some cases, it may be helpful to explain the reason for the laughter as you reenter the room.

So, what should you talk about? Maybe the better question is what you shouldn’t talk about. The old saw of avoiding discussions of religion or politics still stands true. But now your patients come to the office carrying baggage that affects us all: war, international-cultural-ethnic issues, terrorism, uneasiness about the economy. These matters are at the top of everyone’s mind, making them easy fodder for conversation.

But, they are emotionally charged topics. You don’t want the patient to become so involved in the conversation that it’s difficult to perform the exam or treatment. Nor do you want to increase the patient’s anxiety level (or your own, for that matter), especially when he may already feel anxious about treatment. And you especially don’t want tension if you and the patient don’t agree.

There are always exceptions, such as when a patient’s family member has just been sent to Iraq. Or perhaps there is late-breaking news of national consequence. Or the practice is situated in a military town. Under these circumstances, the patient may perceive you as unfeeling if you do not acknowledge these situations. But once the issue has been addressed, it is best to transition away. If the patient initiates the discussion, respond empathically. Then transition into a different direction.

Strive for artful segues, which will allow you to move gracefully from one topic to another. An abrupt, unresponsive transition may appear rude or uncaring to a patient. Let’s say a patient enters the office with, “I just heard on the radio about a horribly violent war demonstration in Metropolis, and it’s all so disturbing.” You respond with, “Really! What happened?” You can bet that the conversation is going to move into uncertain waters. For many people, the discussion of political matters is rife with emotion, making it challenging for you

to provide comfortable treatment. However, you also don’t want to respond with, “Oh, I didn’t know that. How’ve you been doing?” Without an appropriate segue, you seem to be discounting the patient’s concerns.

A better way of handling this might be, “No I hadn’t heard that, but I understand how strongly people feel about this issue. It’s a difficult time and stressful for all of us. Let’s hope that our leaders make the wisest decisions for everyone.” With this sort of response, you acknowledge the significance of the issue without getting political. You can pause briefly and offer a caring touch on the arm or shoulder if it seems appropriate. Then say something like, “I am really glad to see you are here safely today.” At this point, you can move slowly into clinical dialogue.

Strike the right balance

You want to connect with the patient, yet you have a limited timeframe. How do you manage the conversation? I recommend the following progression:

1. Begin with an introduction and/or greeting.
2. Make small talk or personal chat.
3. Slowly transition to clinical matters.
4. Move into the clinical discussion with patient education, case presentation and value/benefit of treatment.
5. Transition to close with small talk or personal chat.
6. Offer a warm, sincere closing on departure.

Modify the approach to each patient’s personality and behavioral style. Take note of verbal and nonverbal clues. A patient with a hard-driving style may not want to spend time chatting. Keep the small talk short, to the point and respectful of the patient’s concerns about time. An amiable patient will respond to small talk that addresses relationship issues in a soft-spoken manner.

When you transition to clinical conversation, remember a little goes a long way. Get primary points across without losing the patient in a barrage of clinical data. It is better to get one key point across with clarity than to hit the patient with too much information.

If the patient is part of a referral relationship, reinforce the fact that he is in the care of a total team. Both parties should make supportive statements about one another. Make it clear that these practitioners have communicated with one another about what is best for the patient.

Regardless of style, all patients will respond to sincere compliments about their personal or professional achievements and improvements they have made in their oral health care. □