10 Non-Financial Reasons Patients Don't Schedule

Karen Zupko

There is a common perception among aesthetic surgeons that the primary reason a patient doesn't schedule surgery is because of the fee. You aren't "cheap" enough. You won't discount or haggle. Someone across town charges less so they probably scheduled with him/her.

It's simpler to assume that it's all about the money than it is to face the reality that many factors contribute to a patient's decision to say "no." Some of them are under your control, some of them are not. But the answer is rarely as cut and dried as the fee. In fact, a vast number of reasons have nothing to do with money at all.

For more than a dozen years, I've asked attendees of The Aesthetic Meeting workshop I conduct for advanced patient care coordinators: *What are the non-financial reasons that patients don't schedule?*" Hundreds of patient care coordinators from practices all across the U.S., Europe, and Australia have participated in this exercise. Attendees are broken into discussion groups that work together to develop a list of reasons and report them to the entire room.

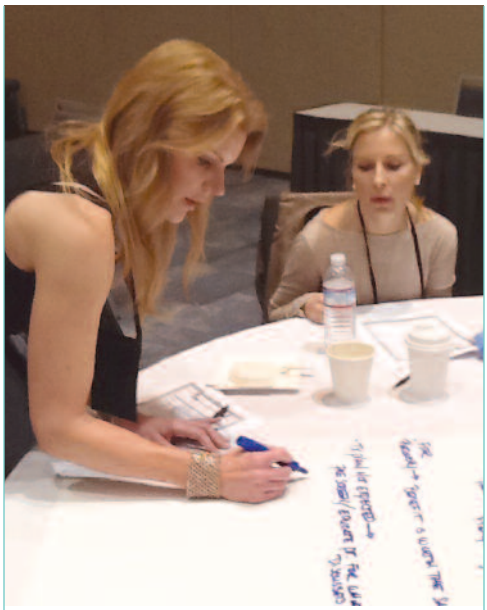
Interestingly, the reasons they list are strikingly similar and consistent, regardless of region, practice type, or size. I believe that this is because these non-financial reasons are human reactions. Many are real fears and concerns that cause a potential patient to pause. It's up to the surgeon and staff to understand how to address them.

Here are ten of these reasons, synthesized from the workshops, and with some suggested solutions.

1. Lack of connection with the surgeon.

This happens when the surgeon rushes through the consult, gives too many options by "thinking out loud," doesn't listen, uses too many technical terms, or doesn't demonstrate an understanding of the patient's needs. You may very well have the best hands in town, but the patient can't assess that. What he or she really wants is to feel connected and understood.

Here are a few things that can improve this. First, your body language. Sit side-by-side or lower than the patient and offer an appropriately reassuring touch on the arm or shoulder. Both go a long way toward making



the surgeon seem "human." Second, build rapport by asking a few personal questions about the patient. The patient care coordinator can provide clues from her conversations with the patient. Or you can take a look at the "Occupation" line on the registration form—or "Interests" if you ask about those. This is a strategy called FORD (because you ask about Family, Occupation, Recreation, and Dreams), and it's a terrific communication builder. The Fall 2014 issue of *Aesthetic Society News* covers it in detail. Third, *listening more and talking less* is an ideal way to convey empathy and make the patient feel understood.

2. Didn't connect with the patient care coordinator.

A common mistake many patient care coordinators make is to lead with the fee quote, firing prices and a dizzying number of policies at the patient before he or she has a chance to ask an opening question. Another is making the quote conversation a "tell" by doing all the talking and concluding the pitch with, "do you have any questions?" When patient care coordinators "process" patients like this, they fail to engage them.

Rapport building is an essential part of the patient care coordinator's job. Her role is to become the patient's "BFF," the non-clinical confidant to whom she can ask questions that might be too embarrassing to ask the surgeon. An effective patient care coordinator becomes a bridge between the surgeon and the patient's support team. She can be the one who will listen when a patient says she has no encouragement from her adult children or spouse. She helps patients find solutions to childcare during early post-op.

To successfully achieve this, the patient care coordinator must be able to facilitate conversation. Train her to ask open-ended rather than closed questions. Open-ended questions invite conversation, and begin with words such as how, what, and tell me about. "Do you have any questions?" can be answered yes or no, thus ending the dialogue. But questions such as "tell me what you enjoyed about your conversation with Dr. Kind," or "how do you feel after hearing what Dr. Kind recommended for you?" will both get the patient talking and in doing so, elicit all kinds of feedback, fears, and objections. Once on the table, the patient care coordinator has something to connect with. And once a rapport is established, it's much easier for the patient care coordinator to schedule a follow up call with patients who aren't ready to schedule.

3. No family support.

Patients need a support team. Not only to help them post-op, but to make them feel comfortable about their decision to have surgery. When there is not family support—and when there is familial negativity—it can be a real challenge for them to make a decision.

This one requires a delicate and nuanced conversation by the patient care coordinator, not the surgeon. If the patient has thrown out some verbal clues that her husband is not totally on board, questions such as *Who can you count on to help you make important decisions? I'm curious about who will help you after surgery?* are important to understanding whether or not the patient has an alternative circle capable of support. In the end, this one may be a difficult objection to overcome—no matter how well your team has built the relationship with the patient.

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4. Fear of scars.

This one consistently ranks as number four, based on input from workshop participants. It's a big concern for patients and is often dismissed by physicians who believe that explaining where they'll hide the incision line should be enough to calm the patient. We think this one is a particularly stealthy objection that many surgeons don't realize is impacting their patient acceptance rate. Maybe the patient has seen a bad scar on the Internet. Or perhaps on a friend. These images stick with them. If you gloss over their fear about scars, it makes patients feel you don't care about them.

After interviewing a number of surgeons and staff for a recent white paper on this topic, here are a few things we know work. Most important is that you take patient fears and concerns about scars seriously. Don't be dismissive even if the concern seems melodramatic. A little empathy and education will go a long way toward strengthening patient confidence.

Show patients photos of the healing process, setting the expectation that yes, the incision will look rough the first few days after surgery, but here's how much better it will look only one month later. Assure patients that it can take up to a year to fully heal. Most lay people don't know that. And use the term incision line instead of scar. The perception being that incision lines can be cared for and heal. Scars are the result of something bad.

5. Your plan didn't align with patient expectations.

After finishing a client mystery-shopping project, one of our firm's consultants said this about a surgeon who was visited: "I was only interested in a rhinoplasty. When he told me I needed a chin implant, I thought to myself—*there's nothing wrong with my chin!*"

When you recommend different (or additional) procedures than what the patient came in for, it can be quite a shock. She came for a breast augmentation, and you said she needs a lift or an augmentation and a lift. Your advice was right, but you have to be tactful in the way you propose it so that the prospective patient believes it.

A post-visit summary from the surgeon can be persuasive, to continue educating the patient about what you've recommended. A personal follow up call or email from the patient care coordinator can help too. And, offer a complimentary second consultation with the doctor for the patients who "need to think about it" to allow for additional questions and relationship building with the surgeon and staff.

6. Fear of anesthesia.

The so-called Joan Rivers Effect has made this one even more important lately. Patients who fear anesthesia are those who fear being out of control and require reassurance that they will be safe. This isn't a reason that can be resolved by citing statistics about the low complication rate of anesthesia.

Get the patient to put their concern in context. Did she personally have a bad experience with previous anesthesia? Did a family member? Aging parents may have had issues that a 50-something won't experience. Or maybe it was a television or movie star case.

Having or offering a conversation with the anesthesiologist well before surgery can put people's minds at east. And if you work with the same anesthesiologist for all cases, that's a plus that patients should know about as well.

7. Worried about the result.

What if I don't like it? What if I look too different? What happens if they turn out too big—or too small? Then what? These are just a few of the questions going through head of a patient who is worried about whether the result will be to their liking.

These people need *reassurance* that they are making the right choice for achieving their desired results. This reassurance can come from the personal stories of patients who had the same procedure, and by explaining the options available if the patient is not fully satisfied. Encourage the unsure to speak with previous patients or staff who have had the same procedure. Develop and maintain a list of patients who agree to speak with people considering the same surgeries they had. And make sure these patients understand their options if the outcome isn't what they'd hoped, being clear about what is appropriately a "revision" and what is not.

8. Afraid of being judged.

Female patients who have spent most of their adult lives caring for others and raising children may feel self-conscious spending money on themselves. I remember the woman who said, "I could spend this money to remodel my bathroom." The patient care

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coordinator immediately said, "I am pretty sure you'll be happier if you invest in yourself. You live with that result 24/7." Smart response.

The patient care coordinator can point out that being 50 or 60 today is *not* what it was for our mothers. And for patients who've spent their lives "doing" for others, an effective approach can be, "now it's your turn." Assure patients they'll have a natural result and look "well rested" not "over done." Especially when the procedure is combined with a new hairstyle, and a loss of a few pounds.

9. Fear of making a decision.

Patients with this fear can become overwhelmed and decision-paralyzed. "There are so many options," they think to themselves. "What if I choose the wrong one?" Or perhaps they fear missing their usual, manic exercise routine. Or some party or event or a work function that's scheduled during recovery.

The surgeon can be the first line of defense on this one by refraining from presenting too many options. Again from our mystery shopping experience, we have been in consultations where surgeons seem almost wishy-washy when it comes to being decisive about what is in the patient's best interest. So, corralling the options into several instead of many is the first step. The patient care coordinator can then take the reigns with questions such as *Which of the surgeries you talked with Dr. Kind about appeal to you most?* and if the patient is considering multiple areas can reassure with statement such as, *You know, we can also discuss staging all of these so all your needs are met over time, which is often easier on the budget.*

10. A myriad of scheduling issues.

An overbooked appointment schedule is a problem. It makes patients mad. Some even leave without being seen. And when you can't find a surgery date that accommodates a patient's schedule or important event, it's frustrating to the patient, who may decided not to schedule at all. There is no one, easy answer to schedule issues. But there are a few things we know work.

Before the consultation is booked, the patient should *always* be asked if they have a special event or date in mind for surgery. Why frustrate yourself or the patient? If their expectations are unrealistic, the patient should be called before they ever darken the doorway. A good patient coordinator will look at this information prior to the patient's appointment and already be thinking about scheduling options.

Absolutely make sure staff update patients in the reception area when the schedule is running behind. There is no excuse for not doing this, and it's a way to prospectively diffuse anger. Equip staff with a few points to use about why the surgeon is "worth waiting for."

Complimentary consults with a non-MD provider can easy the schedule crunch and get people on the schedule within 1–2 weeks. And group consultations for breast augmentations are a good idea, if they are thoughtfully implemented.

I hope you will use this list to foster meaningful discussion with staff. Make this a topic of discussion in meetings. We'd love to hear how you and your staff address these. Pick up the phone or send us an email. You'll find all of our contact channels at karenzupko.com.

Karen Zupko, President of Karen Zupko & Associates, Inc., is an internationally sought-after speaker, author, and practice management consultant. For more than 30 years, she has been advising and educating plastic surgeons on management and marketing issues, including personnel, billing, technology, coding, and practice expansion.

Ms. Zupko will teach a two-hour, advanced version of Overcoming Scheduling Objections at 9AM on April 5 at the 2016 Aesthetic Meeting. The highly interactive program focuses on identifying and addressing the non-financial reasons patients don't schedule surgery. Alums of KZA and ASAPS Patient Coordinator workshops—and anyone looking to learn concepts beyond the basics—are encouraged to attend.

Ms. Zupko and her team are featured regularly at workshops and events held by the American Society of Aesthetic Plastic Surgeons and the Plastic Surgery Administrators Association.

See Karen Zupko in Person at The Aesthetic Meeting 2016*

Sunday, April 3, 2016

2:00pm – 4:00pm

111 Relationship Marketing: What It Means and How to Put It in Action

Monday, April 4, 2016

9:00am – 4:30pm

S12 Skills for Successful Patient Coordinators

Tuesday, April 5, 2016

9:00am – 11:00am

S14 Patient Coordinator Alums: Overcoming Scheduling Objections

12:00pm – 1:00pm

S15 Financial Management for Spouses and Managers

1:30pm – 4:30pm

403/503 Managing the #1 Headache of Practice—Staffing Issues

Wednesday, April 6, 2016

THE BUSINESS SIDE

10:15am – 11:15am

Panel: Motivating and Compensating Staff
Moderator: Robert Singer, MD
Panelists: Mary Lind Jewell, Marie Olesen, Karen Zupko

2:00pm – 4:00pm

616 Reading Prospective Patients More Effectively and Improving Scheduling Results

Thursday, April 7, 2016

THE BUSINESS SIDE

8:45am – 9:45am

Panel: Developing a Marketing Plan
Moderator: Mark Mofid, MD
Panelists: Dana Fox, Catherine Maley, Karen Zupko

10:15am – 11:15am

Panel: Mystery Shopper
Moderator: Mark Mofid, MD
Panelists: Catherine Maley, Karen Zupko

**Additional Fees May Apply • Program Subject to Change*