COMMENTARY

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Clinical Salesmanship

Brenda's fear that I might turn her into a zombie was understandable, if not strictly rational. She thought it might happen if she took the sertraline I had just offered her for generalized anxiety disorder. This concern is common among patients considering taking their first psychotropic, and has its origins in the days when patients were overmedicated with chlorpromazine or haloperidol; drugs which, in high doses, can indeed make patients stiff, sluggish, and, well, zombie-like.

Although the drug I was proposing was different, it was indeed supposed to alter the way Brenda was feeling. This was all that she—and many other patients—needed to know in order to be wary. Sertraline is a "mind-altering drug," and which receptor it acted on was irrelevant. For treatment-naïve patients, crossing the psychotropic threshold can be fraught with anxiety, and helping them do so may require a particular kind of persuasion.[1]

However, while persuasion is one of our most important tools, the art of it—what might be called clinical salesmanship—receives little if any emphasis in medical training. Obviously the best treatment is worthless if we can't convince patients to accept it. The notion of "selling" a patient on treatment can feel odd or even unethical, but is readily understood and can be taught. I suspect many if not most clinicians come to recognize that their efforts to educate and get compliance from their patients can feel like selling, but are uncomfortable with fully accepting that fact. It is worth examining how clinical salesmanship differs from doing an infomercial.

What did clinical salesmanship look like with Brenda? Because she had led with the zombie problem I addressed it first, and candidly: "You know, Brenda, we actually *do* have medicines that can sometimes make people seem like zombies, but those are old-fashioned medicines and are for schizophrenia, which you certainly don't have." Thus acknowledging the shred of truth in her concern did the trick. Simply telling her that there was no reason to worry would have invalidated her anxiety and left her with the choice of either trusting me or not, rather than making a fully informed decision.

Getting her buy-in for sertraline meant ensuring that she understood other more important things, among them the fact that compliance with my prescription would not threaten her autonomy. Because taking sertraline was not a life-or-death matter I could afford to place special emphasis on this fact. "This is entirely your call, Brenda. I won't be angry or disappointed if you don't try the pill. I think the benefits of taking it outweigh the risks, but I am interested to know more about your worries about it."

Patients thus invited to be vulnerable, complain, or rant can teach the clinician much about barriers to agreement. "I don't want to get addicted," "I don't want a crutch," "I had a friend who went crazy on sertraline," or "you're just a tool of Big Pharma" represent a typical sample of the kinds of impediments to closing the psychopharmacologic deal. Each impediment must be addressed to the patient's satisfaction before both parties can "get to Yes."

For Brenda another concern—quite common in my experience—is that trying a "psych med" feels somehow like signing a mortgage: making a serious commitment from which escape is nearly impossible. Patients sometimes make this concern explicit—"Will I have to take this forever, Doc?"—but it more commonly goes unexpressed. I told Brenda in so many words that although it might feel like she was signing a mortgage, she could give up the experiment at any time, even after taking one pill. In effect I was offering a "free trial." Consciously recognizing the obvious difference between home-buying and medication-taking was actually a relief for her. I try to make these points while conveying my understanding of the momentous quality of their decision.

Clinical salesmanship thus requires acknowledging the patient's emotional position. Barriers to persuasion are typically based on feelings rather than logic, and the clinician must address these feelings in order to return to the chief selling points of treatment. For example, some patients are scared to comply with treatment because they dread suffering the same bad outcome as someone close to them. "They whittled away at my uncle's feet until they took off his legs and he still ended up blind and on dialysis" can be sufficient

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reason to resist proper diabetic treatment through a quasi-magical feeling that "If I resist treatment things will work out better for me than they did for him." Here the barrier to a successful "sale" can often be overcome by diagnosing and discussing the hidden fear: "What happened to your uncle was really awful, but I think if we keep your A1c low you should be able to avoid his fate entirely." Treatment refusal sometimes dissolves when the patent's fears are uncovered and metabolized.

How does a physician "sell" an unappealing "product"? For psychiatrists such as myself this usually means helping a patient consider electroconvulsive therapy (ECT). Since clinical salesmanship is based on empathic understanding, and I know that considering ECT scares the daylights out of most people, I usually lead with that knowledge. "Tom, I'm going to bring up a treatment that I know might scare the daylights out of you but I think is worth considering." When I then bring up ECT, and am met with the usual voluble response of "No way. . ..Cuckoo's Nest. . ..A Beautiful Mind. . .kills brain cells. . ." etc., I can reply by acknowledging that I knew it would be hard to hear but is still worthy of discussion. I don't have to play defense quite so much when the patient knows that I know that what I'm offering seems pretty frightening, even if life-saving. I imagine that such an approach might also work well with, for example, a proposed bone-marrow transplant.

Doctors are not hucksters. Clinical salesmanship is not about profit, advantage, or subtle coercion; it's about helping patients feel more involved in decision-making and having doctors be more aware of barriers to compliance. It is a process that involves understanding, negotiation and persuasion, the sole aim of which is to enhance the success of treatment. The doctor's attitude is not "What will it take to get you into this nice little convertible?" but rather "How can we come to an agreement in which you fully understand my reasoning and I allay your fears?"

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Reference

1. Kahn MW. Does this mean I'm crazy? Hidden fears of treatment-naïve patients. *Harv Rev Psychiatry* 2003;11(1):43–5.