WHILE there are differences between aesthetic and medical patients, the ideal physician-patient relationship in cosmetic medicine should not be much different from that in general medicine. As physicians, the procedures we perform are medical. Whether surgical or non-surgical, invasive or non-invasive, all procedures carry potential medical consequences and require informed consent so that patients understand the risks, benefits, and realistic expectations before paying the bill. The complexity of the therapy determines the level of pre- and post-treatment instructions necessary, but the office must always be available for questions and follow-up. The level of trust between patients and physicians is a critical element to any procedure.

PATIENTS, NOT CLIENTS

The expectations of what makes up the doctor-patient relationship have changed over the last two decades. With the rise of healthcare maintenance organizations came the terms “healthcare providers” and “consumers” in place of “physician” and “patient.” While the terms reflect the economics of the relationship, they leave out its very personal nature whether the person coming to us for treatment has a cancer or wrinkles. I cringe whenever a beauty editor innocently asks me about how I treat my aesthetic “clients” as though they are people coming in for a haircut or waxing. Physicians and our staff are entrusted with every detail of our patients’ lives from medications and past surgeries to marital status. These details inform everything about our ensuing relationship.

Being in a service industry, we cannot select who walks through our doors. Unlike the non-medical community, we also can’t refuse to see the unsatisfied ones without following strict medical ethical and legal guidelines. It isn’t an insignificant issue since so much of aesthetics has to do with realistic expectations. (Has anyone ever given a lecture about a cosmetic procedure without listing “unrealistic expectations” as a contraindication?) The element of relate-ability is probably more influential in the aesthetic physician-patient relationship than for medical doctors. A patient will tell me he or she is happy with the physician who “saved my life”...
and in the next breath say that doctor could use a better bed-side manner. The experiential part of having cosmetic therapies factors in more than those involved with getting to the endpoint of surviving an illness. Dealing with difficult patients is never going to be easy. Having a solid understanding of your responsibilities in that relationship will help you and your staff. First, no one “needs” cosmetic procedures. If a potential patient makes you or your staff nervous, just say no to therapy. Once you start, you have a responsibility to provide follow-up (speak with your medical malpractice carrier for the definition, but it is generally 30 days after the last visit). And of course, you do not want someone in your community telling people that you provided poor care. There is always some polite way to let someone down. I’ve said that I thought a patient would be “better off finding a physician who shares his/her aesthetic vision.” Other colleagues have suggested saying, “I understand your goals, but unfortunately, I don’t think I am the physician best equipped to reach them for you.”

There are always those who will slip through your spidey senses. Only after the procedure do you realize that you cannot satisfy this person: the patient looks at his or her own before-and-after photos and insists there is no improvement, or that the after results look worse. A patient may agree that you achieved a younger or better-looking appearance but complains that the one wrinkle he or she wanted treated was still there. Or he or she may call regularly to complain but refuse to return to the office for a follow-up. It is clearly harder to set expectations with aesthetic than with medical patients: the endpoint is being better-looking, not being cancer-free. Beauty is subjective. We all have patients whom we’ve converted from unhappy consumers to happy patients, but it can be a long road, and the decision to continue care has to be balanced with the risk. Be sure that you and your staff document all contact clearly and objectively.

One example was a significantly volume-depleted woman who presented for fillers. I stressed the critical amount of filling agents that would be needed for her to begin to see results. She said she understood but still wanted to go gradually. Then over the next six months, she complained about her results and the cost at every visit. We reviewed the photos each time and she agreed there was improvement but not enough. At each visit, I suggested either stopping treatment with me or doing more at one time but she insisted on pursuing the slow road despite her unhappiness and impatience. My staff and I still talk about the day she “got it.” She happily told me that I was right that she needed a lot done and she now saw the results. My firm and clear message—which I documented along with the option of discontinuing treatment at every visit—finally made impact and it’s a pleasure to see her when she comes in for treatment.

How do you cultivate a population of patients with whom you’ll be able to develop a long fulfilling doctor-patient relationship? Think about your favorite patients, the ones who make you feel good about yourself and your skills. These aren’t always the people who spend the most in your office, but they are usually the ones who don’t continuously ask for discounts or complain about costs (which doesn’t necessarily correlate with socioeconomic level). These are people who appreciate what you do for them and generally radiate a positive energy whether they are in your waiting room or exam room. For example, I see many of my contemporaries. They appreciate that I understand their medical, financial, social, and family issues and constraints. I talk about the procedures I’ve had as I’ve aged, which gives a real sense of my aesthetic and whether it matches theirs. And we joke that I will keep us growing older but looking younger together. That doesn’t mean I don’t like to see other patient groups—but this core recommends their friends, husbands, siblings, children, and parents. As in any aspect of life, having something or someone in common can speed the development of a good relationship.

When turning down patients, be as polite as possible. For example, consider telling a patient that she or he might be “better off finding a physician who shares his/her aesthetic vision.”

As patients age, they may tend to look at themselves through magnifying glasses and mirrors, altering their perspective.
For a patient on the fence about getting a procedure, recommend something that gives results independent of a future surgery like laser resurfacing: the skin quality will be improved and do better for any future procedure.

AESTHETICALLY SPEAKING

A patient on the fence about laser resurfacing of the skin could be motivated to seek treatment by the physician’s recommendation of a procedure that offers benefits independent of future surgery. The doctor might recommend non-invasive treatments such as laser resurfacing, which can improve skin quality without the need for subsequent surgery.

My number one rule in speaking with patients is honesty. That isn’t always the best short-term business decision. People don’t want to hear that they are responsible for their condition, be it wrinkles from tanning and cigarette smoking or scars from excoriating acne lesions. A certain percentage will be insulted. However, in my experience, more people appreciate your candor; rather than fighting you, they become your partner in moving forward with their care. And part of why I went into medicine was the cooperative nature; we work with our patients to achieve their goals.

Another short-term money sink that pays off in the development of solid long-term relationships is telling a motivated “buyer” that he or she doesn’t need the procedure he or she is requesting. Just recently I saw a 28-year-old woman with clear, bright, uniform, smooth skin who asked if I would give her Botox (onabotulinumtoxinA, Allergan) for her glabella and Fraxel (Solta Medical) laser resurfacing on her full face. She said another physician recommended that she have both “preventively,” but she wanted to ask me while she was in the office for something else. I explained that I saw nothing to treat and that without an endpoint I would have difficulty knowing if I’d helped her. I promised I would let her know when the time came to start procedures and suggested the first would likely be fillers since she was so slim, but it would be unlikely for several years. Afterward, the dermatology resident shadowing me commented that the appointment had been longer than most appointments she’d seen when people signed up for procedures. She noted that despite the time spent, all I could charge was a visit fee. It was true, but my honesty helped achieve the deeper level of trust with the patient conducive to patient retention and referrals (plus I can look myself in the mirror ethically).

What about the patient whose condition is really beyond the scope of the non-invasive therapies being sought? When seeing that type of patient for the first time, I ask if she or he is considering surgery. If the answer is yes, then it is important to point out that the combination of non-surgical therapies I would have to recommend could be more expensive and less effective than a surgical blepharoplasty or rhytidectomy. I may suggest a surgical consult before embarking on my therapeutic plan. For a patient who is on the fence, I’ll often recommend something that gives results independent of a future surgery, such as laser resurfacing: the skin quality will be improved and do better for any future procedure, invasive or non-invasive.

One of the benefits of the Internet age is that the majority of patients who come into your office for consultation have done some homework about the procedures you perform. Putting the patient at ease is a matter of education. Start by asking them questions, such as:

• What procedures have you had done?
• What did you like or not like about the results?
• What bothers you most now?
• Are you trying to look better generally or for a specific event?

Ideally, my staff has started the process in a pre-consultation before I enter the room. Even if they can’t get all the information, at least the patient has started thinking about the issues and more data usually comes to light when I repeat the questions. Then with the patient looking in a mirror, I discuss what I see, if I think the patient’s goals are realistic, and the approach I recommend. That is also the time I will point out if I think there is some other issue that, if improved, would have an even more impressive outcome, for example, filling the tear troughs and defining the jawline instead of simply filling the nasolabial folds. The process takes more time than just listing procedures, but I find a more educated patient tends to become a more satisfied patient.

Gaining the confidence of the aesthetic patient is also aided by having a clear aesthetic yourself. What look does the physician project? You reflect your aesthetic. For procedures you can’t do for yourself, be picky about who you let treat you. If there is something you don’t like (your lips are temporarily too big or your brow accidentally dropped), point that out during the consult and make it a teaching point. Remember patients also respond to the appearance of your staff and the general environment of your practice. Women will never go to a make-up counter and purchase from someone whose make-up they don’t like. In my practice, the natural appearance of my front staff and nurses and an attractive but clearly medical environment appeal to my patient population. In another city or for another specialty, staff who appear more “done” or glamorous and a slicker
Once you’ve gained a better sense of what a patient wants and how they see themselves, you can focus on identifying where they should spend their money. People appreciate your respect for their costs. For the elderly woman with one lentigo she finds difficult to cover with her daily foundation, a simple one time Q-switched Nd:YAG spot treatment makes more sense than a series of Fractionated laser resurfacing. Clear it and she will be eternally happy because that’s all she and her older friends see. I had an elderly woman on oxygen that removed her nasal prongs for me to inject collagen into the lines around her lips. Did it make her look younger? No. But it made her happy to keep her lipstick running and based on her age, health, and economics, I thought it was a reasonable result. On the other hand, the 50-year-old woman with hollow tear troughs who says she looks tired because of the line in her chin is better served with a discussion of filling versus shaping, volume loss, and recommendations that may be more expensive but would have a greater impact on her appearance.

These examples bring up another point: Everyone has a relationship with his or her face that begins in infancy. As we age and start to require magnification for more daily activities, the details and “defects” we saw then seem gigantic now. It’s our job to understand that psychology but also to put things in perspective. I guide my patients to look at their faces from the distance normal for an acquaintance for a “macro” view in place of the “micro” view seen in the magnifying mirror. For example, what is the overall face shape? Is the viewer’s eye drawn upward to the eyes or downward to a frown and jowl? It may be time-consuming to determine the answers to these questions, but it is worthwhile to get patients on plan. Similarly, everyone walks in the door with a particular belief system. It may be a shape? Is the viewer’s eye drawn upward to the eyes or downward to a frown and jowl? It may be time-consuming to determine the answers to these questions, but it is worthwhile to get patients on plan. Similarly, everyone walks in the door with a particular belief system. It may be a fear of botulinum toxins or of looking unnatural with fillers. You and your staff need to feel out who will be amenable to education and with whom it is better to back off quickly.

Also factor in the lifestyle. Be realistic about what is within the patient’s capacity and discuss what they are willing to do at home. For example, a multi-step topical cosmeceutical regimen doesn’t work for a busy car-pooling mother of four. Just the same, the unrepentant tanner shouldn’t be peeled in July, and the person unwilling to do his or her homework on massaging the face isn’t an ideal candidate for Sculptra (Valeant Aesthetics). Also be realistic about downtime. If a patient is attending a wedding in two days, she should know that while using a cannula to inject a hyaluronic acid gel may reduce the risk of bruising, it’s not a guarantee. In other words, aesthetic procedures and results don’t sit in a vacuum. Part of the physician-patient relationship is an implicit agreement that the physician will be clear about what’s needed for maximal results and the patients about what they are willing to do.

Ultimately we go about interacting with patients in our own unique way, but one thing we should continually remind ourselves is that procedures are collaborative. Whether you’re discussing the logistics of treatment plan or cost plans, it’s important for the patient to understand that aesthetic procedures are never a “one and done” situation, but rather tend to involve a long process of treatment. Setting those expectations at the start while also trying to listen and understand the patient’s desires are paramount to achieving the best outcomes. And whether we’re at the first consultation or treating a patient for 20 years, we must never forget that our relationship with patients remains the foundation of sound aesthetic procedures.

FULFILLING OUR ROLE

Part of our job is to see the patient— their face, body, health, psychology, and lifestyle—as a whole. Patients may come to us with specific complaints, but we are charged with understanding how the procedures and products at our disposal can increase the overall beauty of the patient. Part and parcel to this task is interacting with patients in a way that allows them to trust you and makes them part of the process. We should never lose sight of the fact that while aesthetic procedures can make up a strong business, they also represent a medical endeavor for the betterment of our patients’ health. That’s part of evaluating their needs and expectations. The best way of developing long-term relationships on a foundation of trust is by honoring our role as physicians to care for and take care of our patients.

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