UNDER MY SKIN

'You're Doing Great'

Aunt Bessie was beaming. She stopped by my office after her physical with her doctor on the third floor. "I got a good report!" she exclaimed. "Dr. Wax was delighted with my x-ray, and she just couldn't get over how the swelling in my ankles has gone down."

BY ALAN ROCKOFF, M.D.

You would think she was in grade school and had just gotten her report card. In a way, you'd be right.

Many years ago I read a book that attacked chiropractors as shameless, self-promoting hucksters. One piece of evidence the author cited was a pamphlet offering advice for new chiropractic practitioners eager to build up their practices. Sample tip: Develop a repertoire of positive things to say. "You're doing very well, today, Mrs. Jones," "Coming along nicely, Mr. Smith," and so on.

How tacky, I thought. Isn't telling the patient she's getting better just an indirect way of saying how terrific you are? Well, maybe, but not necessarily. And even so, it might be worthwhile doing anyway.

If patients were objective, they would view the course of their disease with clinical detachment. In that case they might assess the ups and downs of their symptoms the way they gauge the state of their neighbor's lawn. Green or weedy, facts are facts.

But patients are not objective. They view the course of their disease the way they look at the state of their lawn. Deterioration means more than distressing or threat; it's a personal shortcoming—an embarrassing failing that reflects badly on them. It means they're coming up short, letting the side down, letting us down. Doing well means the opposite.

Back in school if the teacher said, "Excellent answer, Sidney!" you glowed. If she frowned and shook her head, you felt rotten. You reacted this way even though hearing the teacher's opinion didn't make you one bit smarter or dumber. Patients react the same way even though the way we assess their progress doesn't make them any healthier or sicker. Like the schoolteacher, we're the authority in charge.

Next time it's relevant, go a little overboard and instead of being cool and objective, praise a patient for doing well, as if he'd achieved something special. Instead of giving you a funny look, he's likely to smile. He'll feel he's done a nice job by getting better. If you tell him he's doing poorly, he'll react accordingly.

This does not suggest making things up or not taking the appropriate steps to make patients do better than they have been. Even when things are not going as well as can be expected, there is always something positive to say.

- ▶ Your acne hasn't improved that much overall, but you don't have as many cysts as there were.
- ▶ Your psoriasis has a way to go but the plaques aren't as thick and hyperkeratotic as they used to be.
- ▶ There is another basal cell, but you have fewer actinic keratoses than last time.

And so on. Whether or not this approach helps drum up business, it gives patients a hopeful outlook and makes them more likely to comply with the treatment plan. Beyond that, however, it just makes them feel better about themselves, their illness, and their general condition. And in a basic sense, patients visit us not just to reduce symptom scores but to feel better.

Aunt Bessie's doctor obviously gets this. She sent a copy of Bessie's lab reports a few days later, extensively annotated in red pen to make clear which "abnormal" values (such as the MCHC) were actually fine. In addition, the doctor had written this cheery assessment: "Great labs, Bessie!"

This cheerleading tone may be a bit too bubbly for everyone's taste, but the impulse behind it is sound. Aunt Bessie beamed again.

My own internist clearly thinks the same way. Years ago he sent me my own labs, circled my cholesterol level, and wrote, "A plus!" Nowadays my cholesterol wouldn't get more than a B minus. And that's with 20 mg of a statin. ■

DR. ROCKOFF *practices dermatology in Brookline, Mass. To respond to this column, write Dr. Rockoff at our editorial offices or e-mail him at sknews@elsevier.com.*

GUEST EDITORIAL

Extend Cosmetic Offerings to Medical Patients

We dermatologists, as the experts of the skin, can offer cosmetic procedures as appropriate to individual medical patients. Expansion of dual services to more patients, however, might require adjusting staff training, scheduling, and office layout.

A traditional medical dermatology practice will have many opportunities to use cosmetic techniques. It is a natural extension for some patients—such as those who desire scar revision after skin cancer surgery. We can improve these postsurgical scars with pulsed dye lasers, for example, or blend the scar using ablative or fractional resurfacing. We can also use fillers to restore contour to depressed surgical scars, such as those on the helical rim of the ear.

A unique feature of our medical practices, compared with a medical spa, is the steady flow of patients through our offices. For example, we can treat someone with psoriasis who may have questions about Botox. Or we might treat a patient with significant acne along with prominent postinflammatory erythema who can be treated with photodynamic therapy activated by a pulsed dye laser or a pulsed light device.

Dermatology is really under siege from clinicians who say that they specialize in cosmetic dermatology when in fact they come from other areas of medicine. This is frightening indeed.

I have seen patients firsthand who have had a complication—or even a missed skin cancer—caused by one of these physicians. The patients specifically told me they had trusted the medical spa physicians as skin experts because the advertisements and logos used the word dermatology.

This type of misleading advertising has led me to write letters to the state medical society expressing concern over misleading our public, but the letters have been returned indicating no violation had taken place. If these impostors want to use the word dermatology to describe their practices, they should pursue a dermatology residency program, too. We need to continue to press this issue with our state societies and the media. We need to rein things in and realize that our medical dermatology patients are a wonderful resource for educating others about the cosmetic procedures that dermatologists provide and, in many cases, pioneered.

BY JOEL L. COHEN, M.D.

My practice comprises about 40% Mohs surgery. In the rest of my time, I see a mix of cosmetic and medical dermatology patients. To bring aesthetics into your practice, you do not need to market such services aggressively—there are subtle ways to determine which medical patients might be interested. In some cases, however, discussing cosmetic services with certain patients is inappropriate. For instance, the majority of my Mohs surgery patients are referred from other dermatologists. My staff knows not to discuss cosmetic services or even have brochures around another dermatologist's patients.

Often you can sense when medical patients are interested in having a cosmetic procedure. They might ask you about a cream they bought at the store or a product a friend is using.

That is an opportunity to educate them not only about sunscreens and skin cancer, but also about photoaging and the benefits of some topical therapies, such as retinoids. That conversation can be extended to discuss chemical peels and laser procedures for lines, wrinkles, and lentigines.

Training your staff to be fluent in both medical and aesthetic services is very important. This approach not only avoids the need to hire additional people, but allows well-versed staff to answer questions medical patients have about cosmetic offerings. Most of my staff have assisted on these aesthetic techniques or undergone some of the procedures themselves.

Thoroughly training staff to use new devices and equipment is also very important. For example, I use a lot of lasers in my office. When we integrate a new laser in our practice, we typically delay scheduling our general patient population for about 6 weeks and start treating staff members, then family members, and then patients who we know very well. We offer treatments to these initial patients at a significantly reduced cost as a way of thanking them for their dedication.

Optimal scheduling of patients is procedure specific. For example, I schedule patients for erbium laser resurfacing at the end of the day, usually on a Thursday or Friday, so that the treatment interferes less with their work. In contrast, you can offer botulinum toxin at any time. I explain very carefully to patients that procedures using fillers such as Restylane or Juvéderm should not be scheduled before any major social event. Patients do not want to risk bruising or swelling before a wedding, for example.

Consider as well the physical layout of your office and where patients will wait before medical or aesthetic services. We have a general waiting room for medical patients. The cosmetic patients usually go to a separate smaller waiting room where they may have topical anesthesia on their face for fillers or are incubating with Levulan prior to photodynamic therapy

Putting patients in separate rooms makes sense for a lot of reasons. For instance, if a surgery patient is in the waiting room coming in for suture removal after a huge flap on their cheek, a cosmetic patient in the next chair might think, "Wow, what is going to happen to me here?"

In short, integrating aesthetics into a successful medical dermatology practice is a logical step in this era of a booming beauty industry. ■

DR. COHEN *is director of AboutSkin Dermatology and DermSurgery in Englewood, Colo.; chair of the American Society for Dermatologic Surgery Patient Education Committee; and assistant clinical professor of dermatology at the University of Colorado in Denver.*