Special Article

Captation and patient's loyalty to plastic surgeon

Captação e fidelização do paciente ao cirurgião plástico

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ABSTRACT
This article is about the tender nature of patient-doctor relationship, its limitations, details and particularities. Here, we make some considerations about actual behavior of media and internet, each time more and more demanding and tendentious, as well as how to act in a consultation room. We realized that Ethics and an abroad comprehension of our possibilities and limitations are the key for avoiding juridic problems and to obtain a satisfactory patient-doctor relationship.
Keywords: Physician-Patient Relations. Ethics, Medical. Marketing.

RESUMO
Este artigo versa sobre a delicada natureza da relação médico-paciente, suas limitações, nuances e particularidades. Nele, tecemos considerações sobre o comportamento atual da mídia e internet, cada vez mais exigentes e tendenciosas, bem como o atuar dentro do consultório médico. Observamos que a ética, e um amplo entendimento de nossas possibilidades e limitações são a chave para se obter boa relação médico-paciente evitando demandas judiciais. .
Descritores: Relações Médico-paciente. Ética Médica. Marketing.

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INTRODUCTION

1- MEDICAL PRACTICE AND ETHICS

A very special commitment is assumed between a physician and his or her patient, regardless of whether that physician works independently, on a freelance basis, or as a service provider within a health plan, the insurance industry, a hospital, or a public service. Patients cannot demand the impossible of their doctors, as all that doctors are able to offer is humane treatment and developments in science and medicine, within the limitations imposed by the availability of the resources necessary for diagnosis and treatment. The physician will follow rules dictated by ethics, which, since the beginning of culture and from a philosophical perspective, have been interpreted as the most appropriate way to act and present oneself, thus

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defining right and wrong, fair and unfair, and good and evil.

The principle of autonomy, by which it is understood that the individual is sovereign over the self, the body, and the mind, in the doctor-patient relationship is extremely relevant, in that the physician must bear in mind that he can only manipulate, medicate, prescribe, and lead his patients if they are aware of, and willing to accept, such procedures and attitudes, establishing a respectable and acceptable professional relationship from a social and ethical point of view[1-4].

In his book Epidemics, written ca. 430 BC, Hippocrates proposed that physicians "Practice two things when dealing with disease: help the patient and do no harm." This principle proposes an obligation to avoid causing intentional damage: "*Primum non nocere*." In the doctor's oath, based on Hippocrates' proposal, we introduce the obligations of beneficence and non-maleficence[2,3]. The principle of beneficence, the moral obligation to act for the benefit of others, seeks to maximize benefits and minimize potential damages. The patient, in seeking a health care professional, is looking for a cure for his evil, and the professional will try to make the necessary effort not to worsen the patient's condition but try to cure it[4]. Conversely, the principle of Privacy emphasizes the patient's freedom not to be examined without permission and encompasses anonymity, secrecy, distancing, and solitude. Confidentiality is applicable to all age groups, as every individual has a right to the preservation of his or her personal information. The physician is the worthy trustee of such information, even that of the most intimate nature, which would seldom be revealed, even to a spouse or mother[2-4].

The physician, in dealing with the most precious gift, life, often generates an expectation of infallible outcomes in treatment and cure. However, medical practice, as with any human activity, is subject to errors, obstacles, and difficulties, which are often unpredictable and uncontrollable. Some problems that arise during medical attendance may eventually damage the patient's life or health through action or inaction on the part of the physician[2,4]. Such problems occur under specific circumstances and are characterized by imprudence, negligence, or a lack of skill. In the context of Medicine, imprudence involves the professional acting without necessary caution. Action by omission or with carelessness, such as that involving issuing a prescription incorrectly or rendering inadequate assistance to a patient, is considered to be negligence on the part of the professional. In cases in which a lack of skill is a factor, the physician may act erroneously due to inexperience, incompetence, noncompliance with technical norms, or a lack of knowledge. Such situations, such as those involving adverse outcomes, cannot be confused with procedures running outside of the physician's control, whereby the physician has employed the appropriate resources but obtained unintended results. Adversity arises from an uncontrollable situation and is specific to the progress of the case and the predictive potential of science and medicine.

Two instruments are fundamental to ensuring a sound relationship between physician and patient: the medical record and the free and informed consent form, which was developed in the 1960s and 70s through studies in the sociology of health that dealt with the doctor-patient relationship and intentional consent—currently known as informed consent[3,5,6]. This consent is already part of current medical practice and is seen as a patient's right and a physician's obligation. The purpose of this form is to formalize or document the treatment, its consequences, and the risks that arise from the medical act or proposed treatment. Consent may be provided verbally, although the present tendency is for transcription and inclusion in the medical record as a document. The form cannot be imposed, does not exclude responsibility on the part of the physician, and is not valid for the avoidance of a possible claim for damages in future; that is, it does not constitute permission for the physician to waive responsibility or an incentive for the patient to obtain some sort of future indemnity, but it legitimizes the physician's goodwill in clarifying and following previously stated ethical principles.

The patients' psychological condition is extremely important and referral to psychotherapy should be considered whenever necessary. A patient's mood during consultation is an indicator of the possible course of the postoperative period and the level of expectation regarding treatment[5,6]. Choleric patients are determined, dominant, and impulsive and tend to dominate the situation. If the physician's instructions contradict their own expectations, they will counter-argue or will not accept the instructions. Phlegmatic patients are calm, observant, passive, and deductive and usually accept the physician's instructions, but they think methodically and carefully, seek new information that will allow them to better assess the situation, and may also need more time to comprehend all that they have heard. Regarding melancholic patients, who are sensitive, emotional, and intuitive and normally only develop a few deep relationships, care should be taken regarding how to

provide them with information, particularly when the information could generate some fear or anxiety, as they tend to become depressed. Sanguine patients are unstable, seductive, and attractive and have numerous easy relationships that tend to be superficial; they will probably accept the physician's arguments and instructions easily, which does not mean that they are entirely convinced of everything the physician has told them. They will probably not follow the physician's instructions correctly, claiming that they have forgotten them, have no time, or have too many tasks to complete, among several other possible excuses. It is obviously unlikely that patients will manifest only one of the four personalities described; however, one of them is always predominant, and knowing how to deal with these personalities increases the chance of success significantly[5].

2- THE DOCTOR-PATIENT RELATIONSHIP

Medical practice training and method both tend to be more technical in nature, but the human body should not be seen as a machine, and any evident deformities should not be interpreted as a disorder of function requiring simple and linear correction.

There are changes in anatomy, physiology, biochemistry, or genetics and acquired changes, which can be treated but should not be analyzed solely from a physical perspective. Mental dimensions are often important in triggering a complaint.

Deformities are interpreted as deviations from the norm on the part of biological variables. This model, grounded in a mechanistic view, considers complex phenomena as being comprised of simple principles (i.e., cause and effect, a Cartesian distinction between body and mind, or analysis of the body as a machine) that minimize the social, psychological, and behavioral dimensions. The physician is not encouraged to think of the patient as a psychosocial being or understand what it means for the patient to become ill or carry a disease or deformity. Illnesses and deformities have an educational role: to show that something is not as we would like it to be and enable a change, often on an interdisciplinary level, using resources that the physician must know how to indicate and coordinate. The psychological assessment of patients should be a frequent part of preoperative assessment in order to know the surgical candidate better. A process of the humanization of Medicine is in order, although this does not mean that physicians are required to turn into psychologists or psychoanalysts, but that beyond the technical-diagnostic support, they require the sensitivity necessary to understand the patient's reality, listen to his or her complaints and find, together with the patient, strategies that facilitate his or her adaptation to a lifestyle influenced by disease or deformity.

There is a scientific rationalization of modern medicine, which is based on objective and quantitative measurement and a dual mind-body view. This model underestimates the psychological, social, and cultural dimensions of the health-disease relationship and everything that the disease may mean for the patient and his or her relatives. Physicians and patients, even if they belong to the same culture, interpret the health-disease relationship differently as they do not position themselves on the same plane. This is an asymmetrical relationship, in which the physician holds a body of knowledge from which the patient is usually excluded[7,8].

The prerequisite for a soundly grounded doctor-patient relationship is based on the transmission of friendliness, welcome, trust, security, and support. A patient who is approached with these qualities will certainly be more willing to welcome whatever he or she is informed of and required to do. In order for this to take place, it is important that the physician's attention is turned entirely towards the patient, understanding him or her emotionally, walking "in his shoes" figuratively speaking, being attentive to his or her time and in tune with his or her rhythm (which means not to "run him or her over"), and seeking affective tuning, so that the patient sees the physician as someone who knows how he or she feels and, in particular, is able to help him or her[5].

Balint8, in his book "O médico, o paciente e a doença" (The physician, the patient and the disease), points out at the beginning that the most frequently used drug in general practice is the physician him or herself and, more importantly, that the medicine bottle is the way the physician offers it to the patient; that is, the atmosphere in which the substance is administered and received. In the process proposed by Balint, the first phase consists of demonstrating the importance of "listening" as a way to collect information for the anamnesis, followed by phases involving "understanding" and the "use of understanding so that it has a therapeutic effect." The physician, in discussing his or her attitudes, enables the development of an understanding of him or herself as an object in the relationship; that is, he or she begins to understand the nuances of his influence on the therapeutic relationship[9-11]. The ability to listen varies with each physician, who interprets the complaint brought by the patient and experiences a knowledge-sharing exercise. The introduction of

"medical humanities" in university training and continuing education implies the incorporation of elements of the human sciences (philosophy, psychology, anthropology, and literature) in the training and practice of health care professionals[12] as a means of rethinking medical practice and acting on the quality of assistance, involving personalization of the relationship, humanization of medical practices, and appreciation of the patient's right to information. Most complaints from patients refer to communication problems with the physician rather than his or her clinical competence, and such complaints occur as a result of bad relationships.

Four doctor-patient relationship models have been proposed[3,7]. The priest model is the most traditional, as it is based on the Hippocratic tradition. In this model, the physician assumes a paternalistic attitude toward the patient, and the decision made by the physician does not take the wishes, beliefs or opinions of the patient into account; the physician exercises not only his authority but also his power. The engineer model, unlike the priest model, places all decision-making responsibility on the patient. The physician assumes the role of an information relay and executor of the actions proposed by the patient. The patient is regarded as a client who demands the provision of medical services and the physician executes low-involvement decision making, characterized more by the physician's attitude of accommodation than the patient's domination or imposition. The professorial model does not differentiate the roles of physician and patient in the context of their relationship. The decision-making process implies high involvement, and the physician's authority is not characterized as professional. The power is shared equally, with any resulting loss perceived in the context of the doctor-patient relationship. The contractual model, on the other hand, holds that the physician preserves its authority as the holder of knowledge, technical qualities, and specific skills, assuming responsibility for making technical decisions. The patient is also an active participant in the decision-making process, exerting his or her power according to his or her lifestyle and moral and personal values. There is an effective information exchange, and the decision making may imply medium or high involvement based on the compromise agreed by the two parties. This seems to be the ideal model for the doctor-patient relationship as it preserves the authority of the physician but limits the exercise of such authority to an intimate relationship of trust between patient and physician and a reciprocal information exchange, which is necessary for establishing a true relationship of affection, credibility, and trust between the parties[3,7].

A team is a group of people who have their own goals but work together, even if each one strives to reach the common goals in his or her own way. It is akin to conducting a well-tuned harmonic orchestra, in which each instrument has its own importance and a turn to enter the scene. The medical team can generally rely on teams of nurses, physical therapists, nutritionists, psychologists, and attendants. All of the team members try, and should try, to interpret, understand, and welcome the helplessness felt by the patient as a result of the brisk rupture to daily life, whether through surgery, fear of death or other complications, the unknown caused by a new situation, or physical and psychological pain. All of the members should be sensible and understand that the patient's frailty weakens his family and may even make it sick, and welcoming the family also implies a necessary additional effort[5,6].

In the name of efficiency, physicians occasionally place themselves at an ineffective distance and show difficulty in conducting treatment wholeheartedly. In general, they have excellent ability to perform technical procedures but do not always have humanized professional attitudes, protecting themselves in an aseptic cloak that generates insecurity in the patient and anger in the family, as if the attendance of the team should not include tenderness or welcome the feelings that arise when experiencing the shock caused by surgery. There is a longing for the birth of a new professional image, responsible for the effective promotion of health, which considers the patient's physical, psychological, and social integrity, rather than taking a purely biological point of view[3,4,6,9-12].

By accepting a patient, a marriage is established, mostly without the right to divorce, in which physicians are more limited, as patients may choose to disengage, but the physician generally cannot take that position. We therefore observe that when events occur that are harmful to a good relationship or full professional performance, the physician has the right to deny treatment, as long as he or she provides the patient or his or her legal guardian with prior notice, ensuring continuity of care and providing all of the necessary information to the succeeding physician[4]. Often, the hardest part is denying treatment, particularly when there is a visible physical alteration. The lack of a surgical option will take place because, clinically, the risk is high, there is excessive expectation or a psychological imbalance on the patient's part, or there is technically no way of performing the treatment the patient requests. Denying a patient surgery requires courage and firmness rather than coldness; one

has to be very emphatic about the reasons leading to such decision. However, the frustration this may cause should be borne in mind, in addition to the possibility that feelings of anger and revolt may occur because of this denial.

In medicine, the Internet has gained importance at a slower pace relative to more traditional business sectors, and the existence of a large number of medical portals housing huge amounts of information has generated confusion to the lay person. This fact may be explained by the ethical and legal questions involved, which are stricter than those in other areas. This new means of communication will certainly be one of the main promoters of correspondence between physicians and their patients in this era of instant communication, and it is influencing the standard and quality of medical assistance as well as the nature of the doctor-patient relationship. The Internet does not have one single owner, and its real power lies in the people and information that are connected by this international computer network. Having a presence in the Internet's virtual world has become common, and an absence from this forum would be considered a remarkable omission.

A professional website is a necessary component of modern medical practice, and online marketing is a new tool. An important objection regarding Internet-based professional marketing is that of excessive commercialism. The stigma of publicity in medical practice has been widely discussed during the past two decades, although the ethical standards are stricter than those applied to general business. Providing quality medical information, educating users regarding the differences between information sources available on the Internet, and communicating with patients via email are important and differentiating services provided by physicians. Such services are evidence that there is a dedicated professional decision to promote the doctor-patient relationship using a more current form of communication. However, physicians providing personal advice or medical care online should respect fundamental ethical medical conduct besides informing and educating their patients on the limitations of healthcare offered via the Internet.

3- PATIENT ATTRACTION AND LOYALTY

Throughout the entire diagnostic and therapeutic process, familiarity, trust, and cooperation are closely linked to outcomes in medical art. The better the doctor-patient relationship established by a professional, the better his or her ability to attract and retain patients. The key to this secret is found inside each one of us. We stress the importance of the plastic surgeon's training here, in addition to his or her affiliation with the Brazilian Society of Plastic Surgery, as presenting the appropriate credentials and knowledge are essential to both attracting patients[6] and practicing the specialty appropriately.

Client seduction must occur at first contact as countless colleagues of excellent quality and training and with differentiated prices for their procedures fight for a piece of an increasingly competitive and restricted market. The wide range of possibilities available for treatment for aging and changes in body contour has resulted in surgical treatment being postponed as much as possible. Plastic Surgery aims to create its own space in fields that are repeatedly fused with other specialties and so called aesthetic medicine, in which training is questionable but promises of results are extremely convincing, making it an unfair competitor.

In this small universe that is the human being, individuality may be the attribute that most attracts the attention of both healthcare professionals and those interested in marketing. Therefore, medical attention and marketing projects are ultimately directed at the client, with the goal of building mutually satisfactory, lasting relationships. The key to achieving these goals in this new century is to precisely determine the desires and needs of the individuals comprising the target markets. Understanding these desires is the starting point for the activities of marketing specialists and healthcare professionals. Therefore, provision of medical services will be successful if it delivers the intended value to the patient.

In marketing, client loyalty means client retention, preventing them from migrating to competitors and increasing the business value they provide. The competitive advantage a company has lies in knowledge about its clients. Everything else may be offered by the competition at any moment[13]. Companies require loyal clients to obtain financial gain. In contrast, in personal relationships, such as those between doctors and patients, loyalty is directly linked to emotional advantage. As in personal relationships, loyalty cannot be bought; it is conquered over the long term with attitudes conveying trust, respect, care, attention, and kindness toward another person. Retention is a continuous process of conquering loyalty, as no patient is loyal every now and then—or forever. Loyal patients are much more likely to return to the doctor's office and tend to consume more, even if they do so through outpatient procedures. As patients' expectations increase over time, they tend to become dissatisfied if the physician cannot keep up with their changing needs and desires; this requires time,

investment, and renewal of knowledge on the part of the physician.

The more loyal his or her patients, the greater the financial value associated with the physician's "brand."[13] The effort put into patient retention is an investment that will guarantee more appointments and lower spending. A dissatisfied client usually contaminates 13 other clients, whereas a satisfied client only influences 5. It is only through a relationship based on trust between the patient and the doctor that barriers against the activities of competitors can be raised. People trust those who respect, listen to, and surprise them, and they are loyal when and while they trust; moreover, there are no guarantees that a satisfied client will turn down the competition's offers.

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