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Better by Design: Guide to Micro-Interventions for Optimizing the Dermatology Appointment

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The corporate world has long recognized the impact of interpersonal dynamics, communication, and behavioural economics on business outcomes. Countless books are written on leveraging behavioural science and psychology to optimize negotiations, build alliances, and improve customer experiences. Publications such as the *Harvard Business Review* exist to translate evidence and ideas in leadership, management, and psychology into practical insights that help business professionals lead and communicate effectively.

Yet, this wealth of evidence and insight remains largely untapped by the Dermatology world. At the crux of it, the dermatology appointment is a powerful and complex encounter. Dermatologists must establish trust and rapport almost immediately, creating an environment that supports open communication and safety. Only then can they effectively provide patient education, and the intricate negotiation and shared decision-making required for patient centred care.

Dermatologists spend years mastering what to say to patients, yet receive far less training on how to deliver the information. As a result, dermatologists rely on intuition and role models during training to shape the way we interact with patients, and once in practice we rarely have the opportunity to see how our practice differs from our peers. Yet, small physician behaviours, often lasting only seconds, shape first impressions, trust, satisfaction, and our patient's willingness to follow our recommendations.

First impressions play a critical role in shaping a patient's trust, comfort level, and perceptions of physician competence. While a number of factors contribute to these judgements, evidence suggests that **what a physician wears has a significant impact**.

Evidence from two North American image-based studies has shown that the colour of a physician's scrubs matters. In an online photographic survey with 562 responses, evaluating male and female plastic surgeons,

navy and blue scrubs were associated with higher ratings than black scrubs across several domains. For female surgeons, navy and blue scored significantly better than black for skill, representativeness, trustworthiness and compassion. For male surgeons, navy and blue scored better than black for knowledge, skill, representativeness, trustworthiness and compassion.[1] Similar findings were reported in another study, showing that **physicians in blue were perceived as the most caring**, whereas those in black were most frequently rated as the least knowledgeable, skilled, trustworthy, and caring for both men and women.[2] Scrub colour aside, patients also seemed to have opinions on scrub style, with fitted scrubs being preferred over the traditional loose hospital style scrubs.[1]

A 2025 *BMJ* systematic review relayed fascinating insights regarding physician attire. "Gender-specific findings indicated that male physicians were perceived as more professional when wearing formal attire with white coats, while **female physicians in similar attire were often misidentified as nurses or assistants**."[3]

When dermatology-specific publications are examined, the findings suggest that patients prefer white coats.

In one study, 54% of patients preferred their dermatologist to wear a white coat, with female patients placing greater importance on the appearance of the physician than male patients.[4] Similarly, a 2019 survey of 834 patients, including 140 dermatology patients, has shown that the combination of white scrubs with a white coat received the highest composite rating for knowledge, trust, caring, approachability, and comfort. Dermatology and neurology patients were also more likely than infectious-disease patients to report that physician attire mattered (41% vs 32%; p=0.038).[5]

Once a clinician enters the room in their blue scrubs, the next step is to sit down. In a randomized controlled trial, patients perceived physicians who sat at the bedside as having spent more time with them versus those who stood, despite no difference in the actual duration of the encounter. **When a physician sits, patients report a more positive interaction, a better understanding of their condition, and improved compliance to treatment recommendations**.[6]

When taking a seat, consider adjusting the height of your chair to the patient's eye level. This non-verbal cue conveys attentiveness and availability. One trial has shown that **patients were significantly more likely to report that physicians seated at eye level "always" carefully listened to them** and explained things in an easy-to-understand manner, and almost all patients stated the time the physician spent with them was "just right".[7]

Introducing yourself clearly is a simple act that is highly impactful. In a survey of 353 hospital patients, 89.7% reported that a physician introducing themselves positively influenced their healthcare encounter. **Addressing patients by name early in the encounter signals recognition and personalization**. In a prospective inpatient study, use of the patient's name was significantly associated with higher Hospital Consumer Assessment of Healthcare Providers and Systems scores, with most preferring to be addressed by their first name.[8]

Having introduced yourself, resist the temptation to look at the computer. Make eye contact with the patient first. Video analysis of 100 primary-care encounters found that physicians with a technology-centred communication style spent significantly less time making mutual eye contact with the patient. When physicians looked at the computer, patients were more likely to look away, potentially disengaging.[9]

A strong start to the appointment matters because patient satisfaction depends largely on whether their doctor understands and responds to what the patient had hoped to accomplish during the visit.

Begin the appointment by asking about the patient's goals and expectations. Understanding what they hope to learn, improve, or achieve helps to make sure that both physician and patient develop a mutually agreed-upon agenda for the visit, and provides an opportunity to manage patient expectations.

This is particularly important in dermatology, where patients often arrive with numerous concerns and expectations about diagnostic certainty, treatment speed, skin clearance, and

long-term disease control. A simple invitation at the start of the visit, such as, "What would you like to make sure we address today?"—can significantly reduce unaddressed concerns. Importantly, **appropriately phrased agenda-setting has been shown to reduce unmet concerns by 78%, counterintuitively without significantly increasing the visit duration**.[10]

Explicitly asking for a patient's expectations has been shown to more than double the likelihood that patients felt their clinician understood what they hoped to achieve.[11] In my clinic I often ask, "what are you hoping for today".

Importantly, patient-centred care does not require fulfilling every request. Studies have shown that **patients generally tolerate an expectation not being fulfilled as long as it is acknowledged, discussed, and replaced with a credible alternative plan**.[12]

Dissatisfaction arising from a mismatch between patient expectations and what can realistically be provided can be reduced by identifying the patient's underlying goals, setting clear expectations, and offering an appropriate alternative when the requested investigation or treatment is not indicated. Early discussion about goals and expectations creates an opportunity to prioritize concerns, define realistic outcomes, and develop a shared plan.

As the appointment moves beyond the first few minutes, effective communication is paramount. Yet, physicians are rarely given practical guidance on what empathy, validating concerns, and engaging in shared decision-making should sound like in everyday practice. Although these skills are vital, translating them into language that feels comfortable, efficient, and normal-sounding during a busy dermatology visit can be challenging.

Drawing on evidence from communication, business, psychology, and medical literature, we can use and adapt the following evidence-informed "micro-scripts" to optimize both communication and efficiency in the clinic.

Improving patient satisfaction is not the only goal of optimizing communication. There is much power in the therapeutic relationship itself, with evidence showing doctor-patient relationships can have a therapeutic effect, regardless of prescribed drugs or treatments. In a randomized trial involving 719 patients with the common cold, **encounters rated as highly empathic were associated with lower symptom severity and shorter illness duration**.[13] "Physicians who adopt a warm, friendly, and reassuring manner are more effective than those who keep consultations formal and do not offer reassurance."[14]

Practically, phrases such as "That must be exhausting," and "it sounds like you've been through a lot" can show empathy, along with techniques such as emotion labelling, for example: "That sounds incredibly frustrating." Mirroring, or repeating the patient's last few words or key phrases is also strongly supported in the psychology and communication research, and helps to convey understanding. Showing empathy strengthens the therapeutic relationship and has the potential to improve a patient's health beyond the effects of any treatment we prescribe.

In dermatology, where most conditions are chronic, setting expectations around outcomes is key. Unclear expectations can lead to a disappointed patient and follow-up appointments become much more challenging. Without a clear timeline, patients may interpret the lack of immediate improvement in their skin as treatment failure.

Specifically, **patients should be told when they can expect to see improvement, and when peak improvement will occur**. For example, when treating acne, I tell my patients "I expect that in 3 months your acne should be about 20–25% better, and it will get even better after a year". Explaining to patients that little visible change is expected after a week of topical steroid use helps them understand that meaningful improvement requires time, compliance with medication use, and persistence.

For more challenging chronic conditions such as lichen planopilaris, it is important to define success in realistic terms by saying "our goal is control, not perfection." Patients can also be reassured by knowing there is a backup plan by briefly describing next steps if the current treatment fails. Setting realistic positive expectations can improve both patient-reported and physical outcomes.[15]

Finally, the last 60 seconds of the appointment provide an ideal opportunity to implement several evidence-supported micro-interventions that can optimize both the patient experience and clinical outcomes. A 2025 study of 718 dermatology patients reported that adherence was significantly lower for topical therapies compared with systemic treatments, with complex topical regimens and insufficient physician instructions among the factors associated with lower adherence.[16] Instructions should be concise and clear. Dermatologists should eliminate ambiguity by explaining what medication goes where, how often it should be used, and for how long.

One of the most strongly recommended communication strategies is the use of teach-back techniques to confirm understanding. Using phrases such as "Just so I know I explained it clearly; can you tell me how you're going to

Clinical purpose	Evidence-supported phrasing	Compared with	What the evidence specifically shows	Dermatology example
Make a collaborative treatment proposal	**"How about we…?"**	"I'll start you on …?."	"How about we…" invites collaboration and gives the patient more agency.	"How about we start with phototherapy?"
Offer control	**"Would you like me to prescribe ___?"**	"I'm going to prescribe ___."	"Would you like me to…" gives the patient greater decisional authority and options.	"Would you like me to prescribe something for the itch while we wait for the biopsy results?"
Give a clear professional recommendation	**"I recommend ___ because ___."**	Listing options without stating a recommendation.	"I recommend…" clearly communicates clinical judgement while allowing for discussion.	"Given the severity of your eczema, I recommend starting a biologic therapy because topical treatments alone are unlikely to provide adequate control."
Personalize a recommendation	**Use the patient's own words: "Because you told me the itching is keeping you awake…"**	A generic description of the clinical problem.	Using the patient's own words in the recommendation has been associated with greater treatment acceptance and reinforces that the plan reflects their priorities.	"Because you said you'd like your acne clear for your wedding, the best next step is…"
Recommend against an unnecessary treatment	**First state what you recommend: "For the symptoms, I recommend ___. Antibiotics will not help because this is viral."**	Leading with "You don't need antibiotics."	Patients are more likely to accept a non-antibiotic plan when an alternative is offered first, followed by an explanation of why antibiotics are unnecessary.	"For this tinea infection, I recommend an anti-fungal treatment. Antibiotics are not likely to help since it's caused by a fungus."

Table 1. Evidence supported phrases for clinical encounters; *courtesy of Irina Oroz, MD, FRCPC, DABD*

use these creams?" avoids testing the patient. This approach allows physicians to assess understanding and improve patient education. Teach-back is supported in both the general medical literature and dermatology-specific research.[17]

5 S's of the final 60 seconds

1. **Signpost**
   "Before we wrap up, is there anything important we haven't covered?"
2. **Summarize**
   "You have eczema, and our goal is to get the inflammation under control with cream."
3. **Simplify**
   "Use this cream once daily on red, rough areas for two weeks, and moisturize twice daily."
4. **Show understanding**
   "Just so I know I explained it clearly, tell me how you're going to use the two creams."
5. **Specify next steps**
   "If it isn't better in four weeks, contact us; otherwise, I'll see you in three months."

For complex treatment plans, give the patient a written action plan. This evidence-based intervention counterintuitively improves efficiency by reducing time spent counselling and repetition, while making patients feel more comfortable. An effective action plan should include what treatments to use, where and how often to apply them, how long to continue treatment, what to do if symptoms improve or worsen, and when follow-up is recommended. In a randomized trial evaluating a pre-printed eczema action plan, parents receiving the plan had significantly greater understanding of atopic dermatitis treatment.[18] While written action plans may not be necessary or relevant for all dermatology patients, the concept can be applied to complex treatment plans, elderly patients with memory challenges, and parents managing chronic skin condition in young children. For dermatologists already using artificial intelligence-assisted documentation tools, creating a patient treatment summary can be a practical way to implement this approach.

Clear, understandable instructions from the dermatologist are the most important factors for treatment adherence. Conversely, inadequate instructions are associated with poorer medication adherence.[19]

The **5 S technique** creates an intentional closing sequence that uses the final 60 seconds of the visit to make sure that the patient leaves feeling heard, understands the treatment plan, knows how to carry it out, and is clear about the next steps. A recent paper on optimizing the conclusion of clinical encounters highlights the concept of "Signposting:" explicitly telling your patient that the visit is drawing to a close before you begin the closing sequence.[20] The key point is that you avoid the abrupt transition from discussion to departing. This is particularly relevant in dermatology, where last minute "doorknob" concerns frequently emerge, which can derail the flow of an appointment.

When considering strategies to optimize the patient experience, it is important to recognize the limitations of the available evidence. The patient experience is difficult to study, and many available investigations measure outcomes such as trust, satisfaction, perceived empathy, or understanding rather than objective measures such as medication adherence or clinical outcomes. In addition, the evidence is distributed across multiple specialties and disciplines, with relatively few studies specific to dermatology. While many of the strategies discussed here are supported by randomized or interventional studies, others are based on observational data or principles extrapolated and interpreted from communication science, psychology, and other fields.

Not all patients value the same communication approaches. Preferences vary with age, culture, specialty, clinical setting, and the individual. These recommendations are not meant to be used as a script or a checklist for every appointment, but rather as a collection of practical evidence-informed tools that can be adapted to the patient sitting across from us. Further dermatology-specific research is needed to determine which of these small interventions translate into meaningful improvements in patient experience, adherence, and clinical outcomes.

As dermatologists, we rely on evidence to guide our investigations, treatment decisions, and our approach to disease management. We have the same opportunity to apply an evidence-

based mindset to how we deliver care. The patient experience is not simply about making patients happy; it can influence trust, understanding, engagement, adherence, and ultimately outcomes and the quality of care we provide. Many of the behaviours that contribute to a positive patient experience are also specific, teachable, and remarkably simple. No single phrase, clothing choice, or communication technique will completely transform a patient encounter. Rather, it is the combination of small, intentional choices throughout the visit that matters. Improving the patient experience does not require more time with patients, but greater intentionality in how we use the time we already have.

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