A COMPANION CLINICAL GUIDE

The Modern Consultation Framework

A three-phase approach for understanding the patient's existing model, calibrating expectations against clinical reality, and planning treatment around the individual.

01	02	03
ASSESSMENT	**CALIBRATION**	**PLANNING**
Understand the model the patient has already built.	Bring that model into line with clinical reality.	Translate shared understanding into individualised care.

Designed for

- Aesthetic surgeons
- Injectable practitioners
- Doctors
- Registrars
- Clinical teams working in high-expectation consultations.

GOVERNING PRINCIPLE

Begin with the patient's reasoning before you begin with the procedure.

The facts may be correct while the certainty attached to them exceeds what the evidence or the patient's biology can support.

The clinical sequence

Patients no longer arrive as blank slates waiting to be informed.

They arrive with a working model of their condition, the procedure they believe they need, the outcome they expect, and how recovery should unfold. The framework gives the consultation a deliberate sequence without adding a separate process around it.

"The first and often most important task is no longer to educate but to assess the reasoning process that brought the patient to this point."

HOW TO USE THIS GUIDE

Use the three phases in sequence.

The questions are prompts, not a script.

Listen for how the patient reached the conclusion, how firmly the conclusion is held, and what evidence or experience carries the greatest emotional weight.

Treat interpretations as areas for further exploration, not as diagnoses or proof of unsuitability.

01 PHASE ONE

Assessment

OBJECTIVE

Understand the model the patient has already built before offering correction.

Begin by mapping the patient's existing knowledge model.

Spend the first part of the consultation understanding how they arrived at their current beliefs. Useful opening questions include:

- What have you seen or read that feels most relevant to your situation?
- Which stories or images have stayed with you?
- What outcome or timeline are you expecting and why?

Listen for the sources (specific influencers, online threads, AI visuals) and for the emotional weight attached to certain ideas. In practice this phase often takes only a few minutes but reveals whether the patient's model is built mainly on exceptional cases or on a balanced view. If a patient says, "I saw someone heal in two weeks and look perfect," you now know exactly which belief needs calibration later.

What to notice

- Whether one dramatic case has become the patient's reference point.
- Whether the patient can distinguish another person's experience from a probable outcome for themselves.

- Whether the sources are varied or repeatedly reinforce the same conclusion.
- Whether the patient remembers evidence, or primarily remembers images, stories, and exceptional outcomes.
- Whether the patient's language leaves room for uncertainty or presents the conclusion as already settled.
- Which belief the patient returns to, defends quickly, or appears most invested in preserving.
- Whether the requested procedure is being used as shorthand for a broader outcome the patient has not yet articulated.

What the response may indicate

What the patient says	What it may indicate	What to clarify
"Everyone I have seen looked normal after two weeks."	The patient may be generalising from selected or highly visible cases.	Ask who "everyone" refers to, what stage of recovery was shown, and whether complications or slower recoveries were included.
"I know my body. I always heal quickly."	Previous healing experience may have become a guarantee within the patient's model.	Separate prior experience from the anatomy, tissue demands, and recovery variables of this procedure.
"I just want to look like myself again."	The desired outcome sounds clear but may still be undefined.	Ask what specifically feels changed and what "myself" means in visible, practical terms.
"I do not expect perfection."	The statement alone does not establish realistic expectations.	Ask what result would feel disappointing, unacceptable, or like a failure.
"I have researched this for months."	The volume of information may be functioning as evidence of certainty.	Ask what information changed the patient's mind, what sources disagreed, and what uncertainty remains.
"I know exactly which procedure I need."	The patient may have reached a procedural conclusion before individual assessment.	Ask what problem they believe the procedure will solve and what alternatives they considered.

Points of clinical caution

- Moving to procedure recommendations before the patient's existing model is understood.
- Asking where information came from without asking what conclusion the patient drew from it.
- Treating all online research as misinformation rather than assessing its quality and the certainty attached to it.
- Correcting the first inaccurate statement before the patient has revealed the larger model.
- Mistaking confident language for informed understanding.
- Focusing on what the patient wants without establishing why they believe that outcome is achievable.

CHECK BEFORE MOVING FORWARD

Can you summarise the patient's working model in your own words?

Do you know which belief carries the greatest certainty or emotional weight?

Have you identified the expectation most likely to shape the patient's judgement of the outcome?

Calibration

OBJECTIVE

Bring the patient's model into line with clinical reality without dismissing what they already understand.

Once the assessment is clear, move to calibration. Here the practitioner aligns the patient's model with clinical reality.

1. Reinforce what is sound.
2. Fill in what is incomplete.
3. Carefully adjust areas of overconfidence.

For example, when a patient overestimates how quickly swelling will resolve, you might say:

"You are right that many people see major improvement by six weeks. What I see in practice is that the final contour can continue to refine for several months, and a small percentage need a minor revision. Let me show you some examples from my own patients at different stages."

The key is to acknowledge the correct part of the belief first, then gently expand the picture with your own data or photographs. This reduces defensiveness and makes the conversation feel collaborative rather than corrective.

What to notice

- Whether the patient can hold both the likely outcome and the remaining uncertainty at the same time.
- Whether agreement is accompanied by a genuine change in understanding or only polite compliance.
- Whether the patient continues to return to the original timeline, image, or promised result after it has been discussed.
- Whether the patient interprets ranges and probabilities as guarantees.
- Whether photographs are being understood as examples of variation rather than promises of equivalence.
- Whether the patient's concern is a lack of information or the personal meaning attached to the outcome.

What the response may indicate

What the patient says	What it may indicate	What to clarify
"Yes, I understand," followed by the same original expectation.	The patient may have heard the information without integrating it into the existing model.	Ask the patient to describe the expected recovery or outcome in their own words.
"But that would not happen to me."	General risk information may be understood but not applied personally.	Explore what makes the patient believe their individual probability is different.
"I am fine with a small chance of revision."	The words may conceal a different emotional threshold for accepting revision.	Ask how the patient would feel and what they would expect if revision became necessary.

What the patient says	What it may indicate	What to clarify
“Those photos look much worse than what I have seen online.”	The patient’s visual reference range may be narrow or selectively positive.	Explain what the photographs show, when they were taken, and why variation matters.
“I only need to be ready for one event.”	The event date may be functioning as a fixed deadline rather than a preference.	Clarify what “ready” means and distinguish social visibility from complete recovery.
“I know there are risks, but I am healthy.”	General health may be operating as reassurance against procedure-specific uncertainty.	Explain which variables remain relevant despite good general health.

Points of clinical caution

- Correcting without first identifying what the patient has understood accurately.
- Providing generic risk information that does not address the patient’s actual belief.
- Replacing the patient’s certainty with equally absolute clinical language where uncertainty remains.
- Using exceptional positive outcomes to counter exceptional negative stories.
- Assuming the patient has revised an expectation because they agreed verbally.
- Giving more information when the actual issue is the meaning attached to the information.
- Using photographs without clarifying timing, variation, and the limits of comparison.

CHECK BEFORE MOVING FORWARD

How is the patient now describing the likely outcome and recovery?

What feels different from what they expected before the consultation?

What uncertainty do they now recognise?

Can they explain the limits of comparison with another patient’s result?

Planning

OBJECTIVE

Translate the calibrated understanding into a treatment plan grounded in the individual patient.

Only after assessment and calibration does the conversation turn fully to procedure options, risks, timelines, and decisions. At this stage the patient and practitioner are working from a more shared foundation. The planning phase becomes more efficient and the consent process more meaningful because it addresses the actual beliefs the patient brought into the room rather than generic concerns.

You can now tailor the discussion:

"Given what you mentioned about your timeline expectations, here is how we can stage things to give you the best chance of the result you want."

Plan where expectations meet clinical reality

- Individual biology and anatomy.
- Tissue quality and healing capacity.
- General health and relevant metabolic factors.
- Patient goals, concerns, and expected timeline.
- Clinical judgement, sequencing, and consent.
- The degree of uncertainty the patient is able and willing to accept.

Apply what you learned at the start

- Speak directly to the expectations and concerns the patient shared.
- Structure the approach around the timeline they expected, including where that timeline cannot be guaranteed.
- Explain how the sequence of care supports the most appropriate outcome for their body.
- Link risks and limitations to the beliefs the patient really holds, rather than relying only on generic disclosure.
- Confirm that the patient's decision reflects the calibrated model, not the original untested assumption.

What to notice

- Whether the patient is choosing between realistic options or still pursuing the original fixed outcome.
- Whether the patient understands why a different procedure, sequence, or timeline is being recommended.
- Whether the patient's words and practical plans are consistent with the recovery discussed.
- Whether consent reflects shared understanding or merely completion of the information process.
- Whether the same words, natural, subtle, ready, healed, normal, carry the same meaning for both practitioner and patient.
- Whether the patient can tolerate the remaining uncertainty without converting it back into a guarantee.

What the response may indicate

What the patient says	What it may indicate	What to clarify
"I understand, but I still want the original procedure."	The preference may remain unchanged even though the reasoning behind it has changed, or it may not have changed at all.	Ask the patient to explain why the option still fits after the calibration discussion.
"I will make the timing work."	Practical constraints may be minimised to preserve the preferred plan.	Review work, travel, caregiving, events, and support requirements in concrete terms.
"I trust you; just do what you think is best."	Trust is present, but the patient may not yet be participating meaningfully in the decision.	Confirm goals, acceptable trade-offs, and the patient's own understanding of the plan.
"As long as it looks natural."	The desired result remains open to different interpretations.	Ask what "natural" means and use examples to establish shared visual language.
"I am happy to sign whatever is needed."	Readiness to proceed does not by itself establish informed understanding.	Return to the individual risks, alternatives, limitations, and expected course.
"I can handle anything."	The patient may be expressing confidence rather than a considered response to specific possibilities.	Discuss concrete recovery demands and possible deviations from the expected course.

Points of clinical caution

- Returning to a standard explanation after gathering highly individual information.
- Discussing the recommended procedure without explicitly linking it back to the patient's expectations.
- Leaving timeline assumptions unaddressed.
- Treating consent as information delivery rather than confirmation of shared understanding.
- Proceeding while the practitioner and patient are using the same words to mean different things.
- Planning around the requested procedure instead of the patient's anatomy, biology, and actual objective.
- Assuming trust in the practitioner removes the need for the patient to understand and participate in the decision.

CHECK BEFORE PROCEEDING

Does the patient understand why this plan is being recommended for them?

Can the patient describe the likely course, material limitations, and remaining uncertainty?

Have the patient's practical timeline and support requirements been reconciled with the plan?

Are the practitioner and patient using the same language to describe the intended result?

Interpretive safeguards

The framework is designed to improve understanding, not to convert ordinary consultation responses into psychological conclusions. A response may identify an area that requires clarification, it does not, on its own, establish diagnosis, deception, poor suitability, or impaired consent.

Do not assume

- Extensive research automatically means unrealistic expectations.
- Social media use automatically means poor judgement.
- Agreement necessarily means understanding.
- Correct factual knowledge establishes well calibrated certainty.
- A patient's chosen procedure reveals the outcome they truly want.
- Calm presentation establishes that the patient has considered uncertainty.
- Emotional investment by itself means the patient is unsuitable.
- Confidence about recovery reflects an informed appraisal of the specific procedure.
- A signed consent form resolves a mismatch in the underlying model.

CLINICAL BOUNDARY

Where a response raises a concern that falls outside the consultation's ordinary scope, use the practitioner's established assessment, consent, referral, and safeguarding processes. The framework supports those processes, it does not replace them.

A consultation that follows the reasoning

Assessment opens the model.

Calibration tests its certainty.

Planning brings it into the realities of the individual patient.

"The most important question in a modern consultation may no longer be what procedure this patient wants, but what pathway of information led them there."