

Went in for Botox and left with a rhinoplasty

The ethics of customer relationship marketing practices for non-surgical cosmetic procedures

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Ethics
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RM practices

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Abstract

Purpose – The purpose of this paper is to investigate how customer relationship marketing (CRM) activities are utilized by plastic surgery providers to encourage the sale of non-surgical cosmetic procedures (such as Botox). These procedures are considered to be an important gateway for future, more invasive (and profitable) services. As a result, the techniques used to build relationships with clients may be unethical, as they prioritize increased financial performance and profitability over customer well-being.

Design/methodology/approach – Conceptual models are presented that compare and contrast the CRM activities, mediators and expected outcomes for plastic surgery providers, motivated primarily by profit, with those primarily motivated by mutual betterment.

Findings – It is suggested that when accompanied by sales promotions, problem augmentation – an approach used by plastic surgeons to broaden the scope of a patient's aesthetic problem to other areas of concern – may generate increased sales in the short term, but reduce the opportunity of positive word-of-mouth to recruit new clients.

Originality/value – This paper applies relationship marketing to a novel context to demonstrate how practices to retain and improve clients may harm their well-being and commoditize the service, unless mutual betterment is a key objective.

Keywords Ethics, Relationship marketing, Word-of-mouth (WOM), Customer relationship marketing (CRM), Ethical marketing, Plastic surgery

Paper type Conceptual paper

Introduction

Non-surgical cosmetic procedures (NSCPs), such as Botox, Restylane dermal filler and laser treatments have been the fastest growing aesthetic and cosmetic services over the past five years (The American Society for Aesthetic Plastic Surgeons (ASAPS), 2015). Offered by plastic surgeons as an add-on service, these procedures are seen as a way of retaining and acquiring new customers – a profitable gateway to more invasive (and costly) procedures (D'Amico *et al.*, 2008). From the perspective of the plastic surgeon, these services provide a natural extension to their business, as they require little more than a treatment room and a nurse injector on site. Plastic surgeons are also able to leverage the credibility of their medical practice when offering these procedures, reducing the perceived risk to their clients, who may have seen these services offered by other, less expert sources, such as medical spas (medispas) or laser clinics (Bajaj, 2012; D'Amico *et al.*, 2008).

Customer relationship marketing (CRM) techniques, such as reminder letters, targeted advertising, cross-selling and price promotions, are means of maintaining an



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active client database in an industry with limited follow on purchase (for a discussion, see American Society of Plastic Surgeons (ASPS), 2015a; Direct Marketing Association (DMA), 2013). Although these CRM practices are adopted by many service-based businesses (i.e. hairdressers, pet-stores and dentists), the services provided by plastic surgeons are unique because they carry the risk of unintended consequences, such as complications arising from treatment, long recovery times or adverse results (Swanson, 2013). Further, the services cannot be easily reversed or refunded, because they result in semi-permanent changes to a patient's aesthetic appearance. When these factors are considered alongside the fact that patients who repeat their use of plastic surgery or NSCPs are likely to be self-conscious of their body image (Swanson, 2013; Atiyeh *et al.*, 2008), they highlight a significant risk within plastic surgery. For instance, body dysmorphic disorder, the "excessive concern with an imagined or minor defect in physical appearance" (Pavan *et al.*, 2008, p. 473), has been found to be more prevalent among individuals who have plastic surgery than among the general population. Therefore, CRM practices geared toward retaining existing clients and increasing the frequency of their treatments are likely to have adverse effects on clients, such as developing patient vulnerability, and in some cases, addiction to cosmetic procedures (Suissa, 2008).

There is an ongoing debate within aesthetic surgery journals as to whether plastic surgery providers should consider themselves businesses or medical services (D'Amico *et al.*, 2008; Atiyeh *et al.*, 2008; Geangu *et al.*, 2013; Swanson, 2013; Wong *et al.*, 2010; Zwier, 2014). The need to be business-oriented and compete for profit, vs the need to be medically oriented and focus on client well-being highlights a real need for ethical considerations of how CRM is utilized by plastic surgeons to acquire, retain and improve clients. This debate has stemmed largely from the narrow scope of the law, which does not adequately protect consumers for non-surgical treatments. For instance, international laws and codes of conduct for plastic surgeons place limits primarily on the solicitation of new clients (such as through coercion or unwarranted promises, see American Society of Plastic Surgeons (ASPS), 2012; Australian Society of Plastic Surgeons (ASPS), 2015b; Royal Australasian College of Surgeons (RACS), 2011), rather than on how existing clients are communicated with, in order to encourage repeat purchases. While countries differ slightly in terms of ethical codes of conduct, NSCPs are considered a low-risk procedure and are either exempted from codes of conduct, as in Australia (ASPS, 2015b), or are adopted in limited form, as in the UK (Royal College of Surgeons of England (RCSENG), 2013). Further, the commoditization of NSCPs (and plastic surgery generally), largely due to the increasing number of providers offering these services (Swanson, 2013), has facilitated an increasing push for a profit-centric model of plastic surgery. The American Society of Plastic Surgeons and other professional plastic surgery organizations offer business seminars and publish articles on how to increase customer lifetime value (CLV) of existing clients, and how to market their medical practices online (ASPS, 2015a; DMA, 2013; Lewis, 2014; Malay, 2010).

The aim of the present paper is to demonstrate how the orientation of the plastic surgery provider (profit or medicine) will influence the types of retention strategies employed and their subsequent outcomes. In doing so, we contribute to the relationship marketing (RM) literature by extending the appraisal theory of emotions (Roseman, 1996) to explain why some relationship-building practices such as problem augmentation, can foster negative emotions in clients and may lead to long-term undesirable outcomes for both the service provider and client. Problem augmentation refers to an approach used by plastic surgery providers to broaden the scope of a

patient's problem by pointing out additional areas for concern. Through this, client relationships may be developed by increasing clients' concerns about themselves and motivating them to consider additional treatments, rather than helping them feel good about themselves. Further, this paper contributes to the public policy and ethics debate by advocating for increased regulation of NSCPs use by plastic surgeons, as the ability for motivating clients to upgrade to more invasive procedures is too convenient.

This paper will first review the current research in the field of medical services marketing through the lens of RM, by examining the debate between business and medicine in plastic surgery; the laws surrounding the marketing of plastic surgery; and ethics. Second, two conceptual pathways are presented: one where the primary motivation of the provider is to achieve mutual betterment for both the practitioner and client (medical-oriented strategy), and the other where the primary motivation of the provider is profit maximization while operating within the scope of legal and ethical codes (business-oriented strategy). Finally, drawing from the conceptual models, the authors offer propositions that may guide future research directions and assist practitioners in understanding how RM can be ethically applied to meet the financial objectives of their medical practice.

Conceptual background

RM refers to marketing activities aimed at building mutually satisfying long-term relationships between a business and its customers (Palmatier *et al.*, 2006). Used as a means of retaining customers, rather than merely attaining new ones (Berry, 1995), RM theorizes that firms should build strong, personal relationships with customers, as this leads to reduced price sensitivity (Grönroos, 1994), positive word-of-mouth (WOM), increased financial performance and cooperation between client and seller (Palmatier *et al.*, 2006). The premise of RM is therefore simple: create a positive and personalized experience by building a relationship with the customer and a business can capitalize on increased commitment over time (Verhoef *et al.*, 2002) and CLV (Palmatier *et al.*, 2006). Just as in any relationship, the factors which underpin RM include trust, loyalty and commitment between the service provider and the consumer (Palmatier *et al.*, 2006; Perret and Holmlund, 2013). It may therefore be argued that professional and ethical conduct is the foundation of RM, given that both ethics and RM aim to achieve mutually beneficial and trusting relationships with clients (Laczniak and Murphy, 2006).

RM and plastic surgery

NSCPs assist with drawing in clients, providing a gateway to more profitable procedures (i.e. invasive plastic surgery) (D'Amico *et al.*, 2008). Thus, it is not surprising that medical practitioners would employ RM for NSCPs in order to build, strengthen and maintain relationships with their clients. Although there are laws against personalized services (i.e. developing new procedures without medical clearance, Sterodimas *et al.*, 2011), providers can personalize client services in other ways. For instance, providers may use tailored communications for price promotions or notification of new services the client may be interested in; send reminder notices or pamphlets with tailored promotions; and cross-sell, up-sell or bundle products or treatments, such as Botox and dermal fillers (Chernikoff, 2008; Yelp, 2015). These practices are all within the current scope of the law, which explicitly allows providers to compete on price (ASPS, 2012). They are used to foster an ongoing relationship with

clients with the aim of increasing repeat purchase, and in turn financial performance of the practice and CLV (DMA, 2013; Malay, 2010).

Plastic surgery practices are able to capitalize on these techniques because of the high information asymmetry between health-practitioners and their clients (Babakus *et al.*, 1991; Sterodimas *et al.*, 2011). Babakus *et al.* (1991) argue that physician services have attributes that the average client may only be able to evaluate subjectively, through bedside manner or subjective evaluations of aesthetic outcomes. However, it has also been noted that, unlike RM used within traditional services that actively encourage customer participation (Doorn *et al.*, 2010), in medical services the risks of treatment and the importance of the aesthetic outcome for the client are likely to inhibit participation (Hibbard, 2009). Here, the client is more likely to look to the healthcare practitioner to make suggestions or offer advice, which may lead to increased compliance with the physician's recommendations (Hibbard, 2009; Sterodimas *et al.*, 2011), rather than active participation with the provider (i.e. expressing goals or voicing concerns, Sterodimas *et al.*, 2011). In this sense, rather than a positive and mutually participatory relationship, the relationship is hinged on power asymmetry (Babakus *et al.*, 1991) and the potential to create dissatisfaction with a client's current appearance, providing opportunities for the provider to suggest additional treatments or surgeries, which are likely to be seriously considered by the client (Swanson, 2013; Atiyeh *et al.*, 2008).

Some clients recognize this manipulation, as suggested by reported experiences of pushy medical practitioners who have pointed out "everything wrong" with their appearance (Yelp, 2015). Some clients also realize they are being up-sold, namely, encouraged to purchase more treatments targeting areas they had not previously expressed concern about (Browne, 2014). This approach to client consultation also appears to be built into the core business of the practice. For example, UK nurses have reported being asked during job interviews if they were prepared to "sell Botox" in order to gain employment within plastic surgery practices (All Nurses, 2011).

The importance of building relationships with clients has been emphasized in both practitioner and academic papers, from both a financial (DMA, 2013) and medical standpoint (Hausman, 2004; White, 2008). For instance, building relationships with clients in a medical setting can help to foster positive client behaviors, such as increased disclosure and trust in the practitioner (White, 2008; Sterodimas *et al.*, 2011). Developing relationships with clients can also foster positive WOM (Palmatier *et al.*, 2006), assisting the provider to acquire new clients through referral and advocacy. Prospective clients are more likely to consider WOM from other clients than doctor referrals (Dobele and Lindgreen, 2011).

Given the nature of plastic surgery services, and medical services generally, an increasing emphasis is placed on encouraging and receiving referrals via positive WOM, due to legal limitations surrounding the solicitation of new or prospective clients (ASPS, 2012, 2015b; RCSENG, 2013). This has resulted in many practitioner websites discussing strategies to acquire new clients, within the scope of the law (e.g. ASPS, 2015; Lewis, 2014). We therefore argue that the two most important outcomes of RM for plastic surgery providers are increasing financial performance and positive WOM.

Ethics in RM

"Ethical marketing puts people first" (Laczniak and Murphy, 2006, p. 157). This customer-orientation to marketing is also the same approach taken within RM (see Grönroos, 1994; Berry, 1995). It is for this reason that RM may be considered to be

the ethical alternative to a more transactional marketing practice (see Murphy *et al.*, 2007). However, in a recent paper on ethics in marketing, Hill and Martin (2014) discuss that within RM there is an internal conflict between meeting the best interests of the firm and simultaneously serving the needs of clients, leading to a dichotomy of RM within businesses. On the one hand, there are egotistic firms that use RM to maximize self-gain and whose only barrier is the fear of being caught and punished by consumers; on the other hand, there are moral firms that use RM to nurture relationships with consumers and are sensitive to the ethical issues that surround the exchange.

In the context of plastic surgery, there are opportunities for both approaches to RM outlined by Hill and Martin (2014), as the client has limited knowledge of medical practices and is increasingly dependent on the expertise of the service provider (Bush *et al.*, 1997). Plastic surgery providers can choose to capitalize on the asymmetrical power relationships with their clients and engage in financially motivated selling tactics; or they may choose to foster mutually beneficial, trusting relationships which may encourage advocacy behaviors and positive WOM by clients.

This tension exists, in part, because the scope of the law for plastic surgeons is narrower than the scope of ethical behavior (Geangu *et al.*, 2013), and the opportunity for ethical violation is high. For instance, at present there are very few codes of conduct for NSCPs that dictate how existing patients should be consulted or how the relationships can (or should) be managed. Rather, the focus remains on reducing consumer risk by limiting the way new clients may be acquired and how plastic surgery services may be advertised (ASPS, 2012, 2015b; RCSENG, 2013). Therefore, the onus is on the practitioner to subjectively and independently manage client relationships by ascertaining the tolerance of the client for additional services and, from this, the amount of value that may be appropriated from the client over the duration of the relationship (DMA, 2013).

For instance, in the USA, plastic surgery providers are not prohibited from engaging in price-competition or advertising their medical practices, but are limited to how clients may be solicited – there are restrictions on direct marketing activities, such as telecommunications or mail-outs to clients not already within their system of clients (ASPS, 2012). In Australia, a comprehensive outline exists for ethical conduct within the field of plastic surgery, including laws that place limitations on encouraging patients to have unnecessary amounts of plastic surgery through CRM tactics such as bundling, bonuses or bulk-discounts (ASPS, 2015b). However, these guidelines explicitly exclude cosmetic injections from their definition of what constitutes a procedure (ASPS, 2015b). In the UK, which boasts the most complete code of conduct across the countries sampled in this paper, regulations for plastic surgeons are classed by the invasiveness of the procedures. As in Australia, the most stringent regulations are reserved for more invasive (i.e. surgical) procedures (RCSENG, 2013). Here, psychological assessments of patients (i.e. for low-self-esteem or body dysmorphic disorder) during consultation and offering cooling-off periods are mandatory for invasive procedures (i.e. surgery), but are encouraged as optional for NSCPs (RCSENG, 2013). Taken together, two implicit assumptions underlying these codes may be offered; first, the law assumes that the client is the only actor asking for the procedures being performed; second, the regulations do not appear to consider the potential for NSCPs to be used as a sales tool for invasive surgery.

It may, therefore, be argued that there is a significant gap between laws related to plastic surgery and the way NSCPs are used to maintain and improve a consumer base.

While it has already been noted that the scope of the law is very narrow (Geangu *et al.*, 2013), the scope for NSCPs may be even narrower, with few mechanisms in place to protect the potential exploitation of consumers. While consumers may pay a premium to have NSCPs performed by a trained medical professional, they are perhaps no more protected from unethical selling and retention strategies than they would be if they had opted to see a registered nurse or beautician at a medspa. Indeed, the potential for exploitation is higher due to the broader scope of services (both non-invasive and invasive) on offer. For example, even though cost competitiveness is within the scope of the law (i.e. providers are not limited from competing with others on costs, ASPS, 2012), there are opportunities for ethical violations, in that consumers may be enticed to make spontaneous and irrational decisions, based on a special offer (for a discussion see O'Malley, 2014).

Finally, one of the interesting ethical considerations within plastic surgery is the firm-focussed view of ethical conduct (see ASPS, 2012). This firm-focussed view also draws similarities among the ways that ethical RM approaches are discussed. For instance, Murphy *et al.* (2007) found that the majority of papers discussing ethical RM discuss ethical practices as typically done to consumers rather than with them. It is only recent papers that have suggested that ethics should become embedded within the relationship through a co-created process of dialogue, collaboration and partnership with consumers (see Abela and Murphy, 2008; Murphy *et al.*, 2007).

While this offers a sound solution in theory, ethical RM within plastic surgery must factor in the asymmetry of power (Babakus *et al.*, 1991; Sterodimas *et al.*, 2011), the uncertainty of the outcome (see Sterodimas *et al.*, 2011; Zwier, 2014) and the potential for irrational purchase decisions by consumers (see O'Malley, 2014). For example, it may not simply be plastic surgery providers who attempt to up- or cross-sell treatments to clients. Instead, the client may approach the provider for additional treatments that would be inappropriate, or ask for an outcome that is unachievable. In this sense, plastic surgery providers are faced with a moral dilemma regarding whether to focus on increasing profits, or focus on what is ethically best for the client, even if it means declining their requests. This decision will, in turn, influence the way that RM is employed by the plastic surgery provider, and ultimately will affect the way consumers respond to the CRM approaches used. Importantly, the decision to do either may reside in the plastic surgery provider's own business model.

First and foremost, are we a business or a medical service?

The CRM strategies employed by a plastic surgery provider may be influenced by whether the provider sees its core activity as being a medical service or a business (Swanson, 2013; Miller *et al.*, 2000). For example, by striving primarily for improved financial performance, providers may focus on exploiting the information asymmetry by persuading clients to purchase more services. Contrastingly, providers who focus primarily on providing a medical service and enhancing patients' well-being may focus on providing the best possible outcome for patients without augmenting other aesthetic concerns a patient may present with, but has not discussed (for a discussion, see Sterodimas *et al.*, 2011).

The debate of whether plastic surgery providers, particularly those that offer NSCPs (such as injectable or laser treatments), should be considered a business or a medical practice has been prominent in aesthetic surgery journals with arguments for a more profit-oriented model of plastic surgery (for a discussion, see D'Amico *et al.*, 2008; Atiyeh *et al.*, 2008; Zwier, 2014). In contrast, others have argued that the higher degree

of care owed to consumers within the medical profession reinforces the argument that medical procedures (and even Botox) should not be considered as business (see Swanson, 2013). Practitioners have argued that because physical, social and psychological concerns bring consumers into plastic surgeons offices (Swanson, 2013; Atiyeh *et al.*, 2008; Bismark *et al.*, 2012), providers should not allow entrepreneurialism to “supplant good medicine” (Atiyeh *et al.*, 2008, p. 832), or “professional integrity” (Miller *et al.*, 2000, p. 355). As Swanson (2013) points out, patient vulnerability is the basis for holding medical care to a higher standard of ethical behavior than most businesses, and should therefore be considered when managing the relationship between patient and health-practitioner.

Further, the ongoing commoditization of NSCPs (Bajaj, 2012) has been of particular importance to this debate. Plastic surgery providers are held to higher levels of accountability for the promotion of these services to clients, while other providers of these services, such as medical spas (medispas) or laser clinics fall outside the boundaries of legal plastic surgery constraint (Atiyeh *et al.*, 2008). Plastic surgeons therefore argue that, due to the lack of distinction between medicine and beauty, there is significant motivation for reputable plastic surgery providers to compete for business through cost-leadership or promotion (Atiyeh *et al.*, 2008) or, contrastingly, to make use of external cues, such as board certification, to increase their perceived competence and prestige by consumers (Babakus *et al.*, 1991). These latter strategies may be used to appeal to risk-averse consumers who would typically prefer the expert status of a plastic surgeon to perform NSCPs over a less credible or competent source (i.e. laser clinics or medispas, American Board of Cosmetic Surgeons (ABCS), 2015; D’Amico *et al.*, 2008).

Conceptual model development

As RM has been conceptualized extensively in previous papers (for an overview, see Palmatier *et al.*, 2006), this paper seeks to understand how RM may be employed to achieve the desired outcomes for a plastic surgery practice (i.e. WOM, repeat purchase, relationship commitment and financial performance). RM is usually discussed as a means to build trusting and committed relationships with clients. However, we argue that in industries with high information asymmetry, uncertainty (risk) and client vulnerability, relationships may be built with clients in less positive ways. The aims of the conceptual models are to present a number of propositions related to the means and consequences arising from the two relationship pathways. These pathways reflect the CRM strategies that may be used when the primary motivation of the medical practice is to increase profitability, vs when the primary motivation is to encourage mutual betterment (i.e. upholding ethical medical practices).

The relationship pathways presented are examined for two reasons. First, any ethical considerations regarding how relationships should be managed are currently outside the scope of law or ethical codes (ASPS, 2012, 2015b; RCSENG, 2013), and therefore the way that RM is employed by plastic surgery providers may be considered more an ethical dilemma than a legal one. Second, although there is a debate surrounding whether plastic surgery can be considered a business or medical practice, there has not been any discussion surrounding why a provider may choose one approach over the other, what types of CRM activities would be employed, and what kind of outcomes may be expected. This is because the majority of viewpoints mirror the statutes within legal and ethical codes of conduct in plastic surgery, which focus on advertising and soliciting new clients, rather than on what plastic surgeons do with

their existing clients (see Zwier, 2014; Wong *et al.*, 2010). It appears there is an acceptance that because plastic surgery is elective (Sterodimas *et al.*, 2011), the client has come to the provider of their own free will and any CRM activities employed by the provider that result in additional treatments are also of the client's free will. As will be shown, this argument is too simplistic to encapsulate the already observed behaviors that occur in plastic surgery practices (i.e. pushy behaviors and problem augmentation, see Browne, 2014; Yelp, 2015) and, therefore, warrants further exploration.

Pathway 1. Providers motivated by profit (plastic surgery as business)

As previously discussed, the CRM activities plastic surgery providers may adopt in order to maintain their relationships with clients may not result in positive, long term, and mutually beneficial relationships with clients. For instance, reminder letters, pamphlets or newsletters, tailored communications, and price promotions may be used to retain relationships with clients over time, and encourage them to return for additional treatments. Additionally, selling techniques, such as the problem augmentation of a client's appearance, up- or cross-selling, or bundling may be used during consultation by the plastic surgery provider to encourage additional or spontaneous treatment purchases. These two approaches may also occur simultaneously – for instance, during consultation, a provider may point out an additional area of concern to the client or describe a new procedure, and then follow-up with tailored communications regarding this procedure in order to encourage the client to consider and purchase it. Figure 1 depicts an overview of CRM activities and outcomes when the plastic surgery provider is motivated primarily by profit.

In this scenario, the plastic surgery provider is motivated primarily by its business objectives (i.e. increasing profitability and CLV), while operating within the scope of the law. These providers may be more willing to use CRM activities that generate dissatisfaction with a client's appearance, building a relationship based on negative affect to which the cosmetic procedure offers a temporary solution. Appraisal theory suggests that negative emotions are elicited after assessing an event according to the likely impact on an individual's well-being and agency (who the negative event is attributed to) (Bagozzi *et al.*, 1999; Roseman, 1996). We suggest that as clients who seek the services of a plastic surgeon generally have low-self-esteem (Pavan *et al.*, 2008), they are likely to blame themselves for the issues pointed out with their appearance (e.g. their aging skin being a result of not wearing sunscreen, or wrinkles as a result of smoking). Thus the client's appraisal of the problem augmentation event results in self-directed negative emotions, such as guilt or shame (Bagozzi *et al.*, 1999; Roseman, 1996). This negative affect may make clients more willing to accept the solution offered by the provider, as

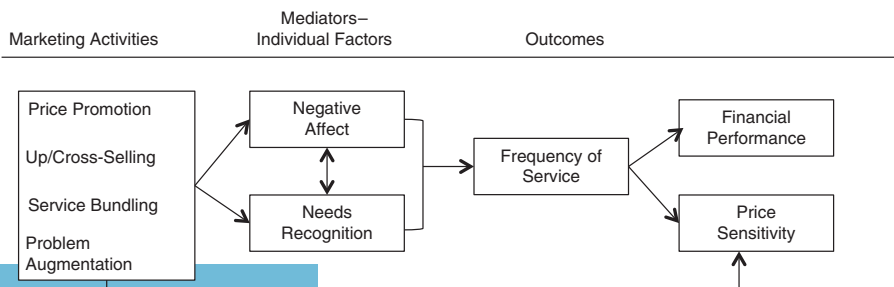


Figure 1. Marketing activities, mediators and outcomes for providers motivated by profit

consumers have previously been shown to try new things in order to elevate their mood (Maxwell and Kover, 2003). In this sense, the relationship between client and provider develops via repeated service encounters that involve problem augmentation and promotional strategies to entice the client to try more or new procedures.

Additionally, it is argued that the relational benefits that accumulate over these repeated service encounters, such as increased confidence, social and special treatment (Gwinner *et al.*, 1998), may not only mitigate the impact of negative encounters (Priluck, 2003), but are likely to act as buffers to clients' questioning the need for ongoing treatment or suggestions for more costly, invasive treatments. For instance, clients may consider ongoing problem augmentation to be based on social factors in the exchange, whereby the client perceives that the provider is pointing out additional concerns for the client's own good, rather than for the provider's own financial gain. One potential fall-out to this approach, however, is that the negative self-directed emotions of shame or guilt are unlikely to elicit positive WOM or referral behavior by the client (White, 2010), representing a missed opportunity for the plastic surgery provider.

Highlighting how financial gain is clearly placed ahead of client well-being, Figure 2 illustrates the use of problem augmentation and needs recognition by plastic surgery providers in the form of text messages to a past client. A problem is created (i.e. not feeling ready or fresh) and a solution (i.e. Botox and fillers) is offered as a way to correct this problem. The combination of problem augmentation and needs recognition is also accompanied with a price promotion to entice the recipient to accept the offer within a limited time frame. In addition to encouraging the increased use of NSCPs, providers may also attempt to persuade existing clients to engage in more invasive procedures (i.e. plastic surgery). This is highlighted by a shadow shopping exercise, in which a consumer asked for Botox and was told that surgery would be a better corrective technique (Browne, 2014).

One unintended outcome of the frequent use of targeted price promotions as part of a provider's CRM strategy is the increased commoditization of the treatment. The risk of plastic surgery (Swanson, 2013) has been one of the key leverage points for plastic surgery providers to exert their expertise or knowledge on clients and therefore charge a premium for it (see D'Amico *et al.*, 2008). Instead, by enticing consumers with promotions and price bundling, alongside the augmentation of problems with a client's appearance, the client may be more likely to engage in spontaneous treatments, become cost-sensitive to the price of treatment or may even consider having the treatments performed elsewhere, should they receive a better offer. In this sense, the interaction becomes less about building a positive relationship with the patient, and more outcome-focussed or transactional, whereby the provider wants to maximize the number of procedures and resulting value that may be obtained from one client. Furthermore, the client may be more willing to shop around

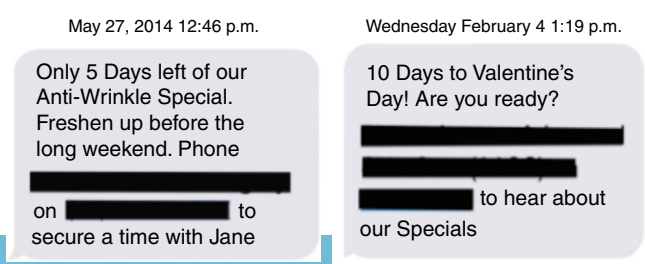


Figure 2.
Examples of problem
augmentation used
by an Australian
plastic surgery
provider

or see the service provider as interchangeable, given the likelihood that the service rendered is uniform across a number of providers with the same credentials (i.e. plastic surgeons) (Dobele and Lindgreen, 2011). In this scenario, providers may ultimately resort to price promotions to stave off competition, which may diminish the profitability these providers sought to capitalize on.

Pathway 2. Providers motivated by mutual betterment (plastic surgery as medicine)

In this scenario, the plastic surgery provider is motivated, first and foremost, by practicing good medicine. This does not indicate that the provider does not try to be cost-effective (Rohrich, 2001), but that the practice does not exclusively consider clients as a mechanism for driving profitability. Figure 3 depicts an overview of CRM activities and outcomes when the plastic surgery provider is motivated by mutual benefit.

In this scenario, the provider concentrates on developing positive relationships with clients by building the reputation of their brand and reducing perceptions of risk. Clients are not persuaded to buy more than they had intended or, more importantly, to buy more than they need. Instead, the focus is on performing services that will address the concerns the client expresses. The building of a trusting and committed relationship has been shown to lower a client's perceived risk of having these services performed (Stanaland *et al.*, 2011), as well as reducing cognitive dissonance following treatment (Sharifi and Esfidani, 2014).

Trust and commitment are considered two important outcomes of relationship investment (Morgan and Hunt, 1994) and firm reputation, which can, in turn, influence positive WOM and loyalty to the service provider (Walsh *et al.*, 2009). Building trusting and committed client relationships also encourages greater participation within the service experience (Doorn *et al.*, 2010). Importantly, increased participation in the service experience can, in turn, increase firm competitiveness, as well as function as a cyclical driver of firm reputation over time (Doorn *et al.*, 2010). Taken together, these findings highlight the importance of relationship investment with existing clients, as well as managing the reputation of the plastic surgery practice. By encouraging customer participation (rather than inhibiting it, Hibbard, 2009), these activities are likely to foster an ongoing cycle of increased trust, positive WOM and loyalty

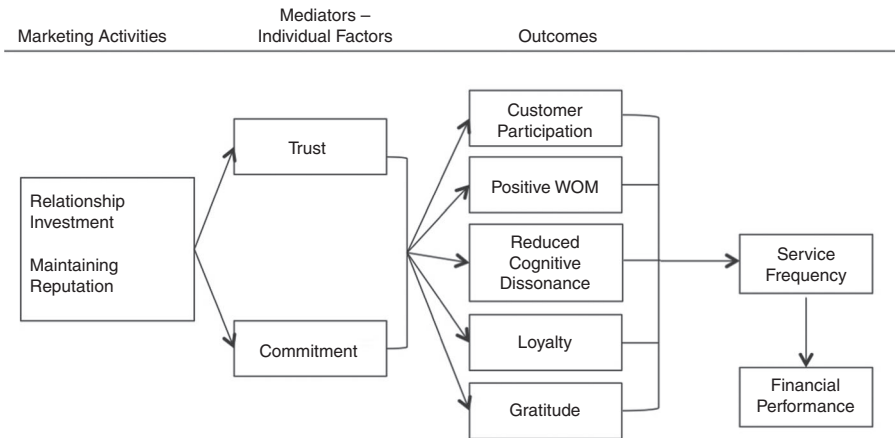


Figure 3. Marketing activities, mediators and outcomes for providers motivated by mutual betterment

(Walsh *et al.*, 2009). This is particularly meaningful in the context of healthcare, as client participation is associated with increased satisfaction and service (Gallan *et al.*, 2013). Customer participation in healthcare can involve expressing goals, stating preferences or exploring treatment options (Sterodimas *et al.*, 2011). This approach may also uncover concerns that the client may have, which may lead to an organic increase in the number of treatments sought by the client.

Although when compared to pathway 1 this approach may appear to compromise financial performance in the short term, consistent with the findings of Palmatier *et al.* (2006), relationship quality is the strongest predictor of financial performance, as clients become less sensitive to competitive or promotional offerings. Developing trusting relationships with clients may assist in encouraging financial performance, by empowering clients to consider or ask about additional treatments, vs being encouraged to have them. Importantly, building positive relationships is likely to also generate gratitude-based reciprocal behaviors from clients, which can assist in facilitating ongoing, mutually beneficial relationships and drive business performance (Palmatier *et al.*, 2009). This suggests that relationship investment is a critical component of financial performance and co-participation in the service experience. Additionally, by focussing on making clients feel good about themselves and improving their well-being, providers are also able to capitalize on the positive WOM they are likely to receive from clients (White, 2010). Importantly, WOM is critical for new client recruitment in plastic surgery, given the legal limitations surrounding new client solicitation (ASPS, 2012, 2015b; RCSIENG, 2013). Research has also found that new clients recruited by referrals are more likely to be retained, and contribute higher margins, than those recruited by sales promotions (Schmitt *et al.*, 2011).

Propositions and implications for practice

Over the course of this paper, we have argued that there is a dual-pathway approach to CRM activities in the plastic surgery industry because there are few regulations in place regarding how NSCPs can and should be administered to clients. We propose four main contributions to the practice of RM within plastic surgery.

By demonstrating how plastic surgeons primarily motivated by profit may be likely to engage in unethical CRM activities, in order to maximize CLV, we argue for further regulations on the administration and promotion of NSCPs. The need for increased regulation is made more apparent by the asymmetry of power and knowledge between plastic surgery providers and their clients (Sterodimas *et al.*, 2011). Despite regulations that typically prevent a surgeon from not exploiting the relationship (ASPS, 2012, 2015b; RCSIENG, 2013), we have shown that the way NSCPs are consumed by clients, and promoted by professionals leaves scope for opportunistic behaviors from both the client (who may ask for too much) and the medical professional (who may offer more than is deemed necessary). Namely, because NSCPs may be used as a gateway for more expensive or invasive procedures (D'Amico *et al.*, 2008), regulations should stipulate that plastic surgeons conduct compulsory psychological assessment of all clients – not just those seeking invasive surgery (as in the UK, RCSIENG, 2013) – and a thorough consultation regarding the client's past surgery and desired outcomes:

- P1.* There is an increased need for regulation of NSCPs within plastic surgery practices as, unlike alternative service providers, there is the opportunity to upgrade to more invasive services.

As previously discussed, by engaging in CRM activities that encourage maximizing financial performance rather than client well-being, the relationship between health practitioner and client is likely to become increasingly transactional. The use of directed sales promotions to existing clients leads to the increased commodification of NSCPs. As such, client cost-sensitivity is increased. Therefore, providers will need to decide whether they want to compete directly with other providers on price or differentiate by engaging in relationship-building activities that focus on creating trust and commitment. Future research should focus on how to best implement ethical marketing activities that can simultaneously maximize both business objectives and the relational quality between health professionals and their clients:

P2. CRM activities, such as tailored sales promotions and product bundling to existing clients, contribute to the commoditization of NSCPs.

A plastic surgery provider's decision to emphasize a business-first model of operation, vs a medical service may be moderated by the level of competitive intensity, which is considered a substantive moderator of financial performance (Kirca *et al.*, 2005). In this sense, increased competition in an industry can lead to an over-emphasis on financial performance, rather than firm reputation. We argue that, while it may be important to be market-oriented and to understand what other providers of NSCPs are doing, there must also be an acknowledgment that clients select plastic surgeons for treatment based on the prestige and expertise of the practice, which they hope will offer them a better service experience and reduced risk of a negative or unanticipated outcome (ABCS, 2015):

P3. The decision to emphasize financial performance relative to mutual betterment is moderated by the degree of competitive intensity.

Last, eliciting negative affect in the form of guilt or shame may be considered a relationship-building tool. Needs are evoked when there is a discrepancy between actual and desired states. In the context of plastic surgery, appearing younger or fresher (desired state) is a commonly used narrative by plastic surgery providers who may highlight "everything wrong" (Yelp, 2015) with a client's appearance in order to create dissatisfaction (negative affect) with their current appearance. In this sense, the relationship with the plastic surgery provider continues due to an ongoing need to feel better about one's self by reaching a desired state which continues to be pushed further away. We argue that plastic surgery providers who facilitate this ongoing cycle of negative affect and offering NSCP treatments or plastic surgery as a solution, may encourage negative client outcomes, such as overuse of procedures, psychological harm, and in extreme cases, addiction to plastic surgery (Suissa, 2008). We show that, not only are these outcomes detrimental to the health and well-being of clients, but it is also unlikely that they will yield any positive outcomes for the provider, such as positive WOM:

P4. A relationship based on the continued use of problem augmentation will reduce the propensity of positive WOM by the client.

Directions for future research

We suggest that future research be aimed at understanding how negative emotions are elicited via sales approaches, such as problem augmentation, and how these may be better managed within the provider-client interaction. Understanding whether the negative emotions cultivated are purely self-directed (i.e. the client feeling negative

about oneself) or bi-directional (emotions attributed to either the self or to the provider) can assist providers in better managing client relationships, and encouraging the attainment of positive outcomes for the plastic surgery practice and its clients.

Conclusion

This paper has aimed to understand how plastic surgery providers utilize CRM activities in order to encourage the sale of NSCPs (such as Botox). Because these procedures are considered to be important gateways for more invasive (and profitable) services (D'Amico *et al.*, 2008), this paper has argued that the techniques used to build a relationship with clients for these services may be unethical. Further, building a relationship underpinned by negative effect through the practice of problem augmentation may encourage clients to engage in more frequent or expensive services. However, these clients are unlikely to generate positive WOM, which foregoes the opportunity to gain a rich source of new clients.

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