Practice and Educational Gaps in Cosmetic Dermatologic Surgery

Abigail Waldman, MD[a], Joseph F. Sobanko, MD[b], Murad Alam, MD, MSCI, MBA[a,c,d,*]

KEYWORDS

• Practice gaps • Educational gaps • Cosmetic dermatologic surgery • Best practice

KEY POINTS

- This article identifies the current gaps in the practice of cosmetic dermatology, cosmetics education, and how to best overcome these limitations.
- First, there is a rapid development of new devices and procedures, with limited data, patient-reported outcomes, and comparative effectiveness research from which to develop best cosmetic practice.
- Unfortunately, there is limited funding available to ascertain such data.
- We suggest that there is a need for increased research and funding dedicated to these goals, improved and convenient training for staff looking to adopt new devices/procedures, and continuous evolution of databases to pool outcome data and develop outcome sets.
- Additionally, resident education can be improved by dedicated resident cosmetic clinics, didactic teaching from visiting professors, attendance of cosmetic dermatology courses and meetings, and encouraging postresidency training.

Cosmetic dermatologic surgery has been an integral part of dermatology practice for more than half a century. Procedures that have been developed by dermatologists include hair transplants, tumescent liposuction, botulinum toxin for facial rhytids, many cutaneous laser and light devices, and soft tissue augmentation injectables. In recent decades, cosmetic dermatologic surgery has evolved from a few related procedures to a major subfield of dermatology, an expansive and coherent body of knowledge that is increasingly viewed by others as part of the special expertise of dermatologists. Residency training in such procedures is increasing, and a growing fraction of the typical dermatologists' practice is devoted to cosmetic procedures. Fellowship training in cosmetic dermatologic surgery has been accredited by the American Society for Dermatologic Surgery (ASDS) since 2013. Recent research has confirmed that primary care physicians view dermatologists as the preeminent specialists for many cosmetic procedures, including neurotoxins, fillers, and lasers.[1]

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[a] Department of Dermatology, Feinberg School of Medicine, Northwestern University, 676 North St. Clair Street, Suite 1600, Chicago, IL 60611, USA; [b] Department of Dermatology, University of Pennsylvania, 3400 Civic Center Boulevard, Philadelphia, PA 19104, USA; [c] Department of Otolaryngology, Feinberg School of Medicine, Northwestern University, 676 N. St. Clair, Suite 1600, Chicago, IL 60611, USA; [d] Department of Surgery, Feinberg School of Medicine, Northwestern University, 676 N. St. Clair, Suite 1600, Chicago, IL 60611, USA
* Corresponding author. Department of Dermatology, 676 North St. Clair Street, Suite 1600, Chicago, IL 60611.
E-mail address: m-alam@northwestern.edu

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PRACTICE GAPS IN CLINICAL DERMATOLOGY PRACTICE

Best Practices

Best practices for cosmetic dermatologic surgery pertain to various elements of patient care: patient selection, the cosmetic consultation, development of a treatment plan, selection of procedures, performance of procedures, management of adverse events, and follow-up (**Box 1**). Cosmetic dermatologic surgery is a broad area, and individual variation is the norm. General best practices are described in this article. Practices specific to laser and light treatments, whether cosmetic or medically necessary, are reviewed elsewhere in this issue (See Murad Alam, Abigail Waldman, Keyvan Nouri, et al: Practice and Educational Gaps in Light, Laser, and Energy Treatments, in this issue).

Regarding patient selection, best practice includes avoiding procedures on patients with body dysmorphic disorder or unrealistic expectations. Psychological concerns are often integral motivators for patients seeking cosmetic procedures, so a necessary next step is a cosmetic consultation where the patient and dermatologist get to know one another; the dermatologist understands the patient's concerns, preferences, and risk threshold; and the patient comes to understand what is possible, and how much it may cost in terms of time, money, risk, and downtime. At the culmination of the cosmetic consultation, a treatment plan is developed that entails one or more procedures delivered over a defined time window to achieve specific objectives.

Cosmetic dermatologic procedures are safe outpatient procedures usually performed under local anesthesia. Best practice includes using Food and Drug Administration–approved drugs and devices, or other appropriate mechanisms, in a manner that poses minimal risk to the patient

Box 1
Cosmetic dermatologic surgery: practice gaps

Best Practice

- Personnel delivering procedures be well-trained in that procedure, and if not a dermatologist themselves, be supervised by a qualified dermatologist.
- Cosmetic consultation with appropriate patient selection and close follow-up.
- Trained use of Food and Drug Administration–approved drugs and devices, or other appropriate mechanisms, in a manner that poses minimal risk to the patient and is associated with a reasonable likelihood of success.
- Reference of available guidelines for care and consensus statements when available.

How Current Practices Differ from Best Practice

- Rapid rate of change within field with newer materials and advanced techniques not adopted by all practitioners.
- Cosmetic procedures may often be delegated to ancillary staff.
- Dearth of high-quality posttreatment patient-reported outcome data with few reliable standardized measurement tools to assess clinical outcomes after cosmetic procedures, limiting patient and practitioner clinical decision-making.

Barriers to Best Practice Implementation

- Need for improved, increased, and more accessible training for clinicians.
- Limited research funding, work force focused on clinical outcomes, and multicenter pooled data.

Strategies to Overcome Barriers

- Availability of convenient, practical, and concise on-line education in addition to improved in-office training of dermatologists by clinical staff employed by the manufacturer.
- Increase in research funding and fellow research commitments to improve pool of future investigators.
- Creation of on-line databases to pool data across centers (eg, Dermbase), development of core outcome sets (eg, those developed by IMPROVED group) should be continued and expanded. Once core outcome sets are implemented, patients and physicians will be better able to select procedures and products that are most suited to a particular patient's circumstances.