



October 7, 2011

USA Today
Letters to the Editor
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Dear USA Today:

Jane O'Donnell's recent article which suggests that only board certified plastic surgeons are qualified to carry out cosmetic procedures raises several important questions. First, which cosmetic procedures are we talking about? There are literally hundreds of them emerging every day. Second, what, if any, specialty has the "best" training during their residencies? Third, can the completion of a plastic surgery (or any other residency for that matter) provide adequate training that encompasses rapidly proliferating procedures which evolve outside academia long after residencies are completed? Fourth, what percentage of cosmetic procedures is actually being carried out by boarded plastic surgeons? These are fundamental issues which have never been systematically addressed.

How much training one receives in any residency for specific procedures varies enormously from program to program and is to some degree optional with respect to certain types of cosmetic procedures which fall outside curricular requirements. In point of fact, it is a very rare program that devotes much time to teaching plastic surgery residents how to use fillers, neurotoxins, chemical peels, lasers and dermabrasion. Plastic surgery residencies, which must concentrate on surgical procedures, may have very little time left over or interest in what they regard as non-surgical minor cosmetic procedures. What is agreed upon is that plastic surgery training programs spend a great deal of time teaching their residents required surgical procedures such as face lifts, breast augmentation, blepharoplasty, rhinoplasty and reconstructive procedures.

I'm not sure how much time is spent training plastic surgery residents how to carry out liposuction which brings up an important point, i.e., there's a great deal of variability in the emphasis placed upon training in specific cosmetic procedures. Plastic surgery residencies which concentrate on surgical procedures may have very little time left over or interest in what they regard as nonsurgical minor cosmetic procedures. This fact is reflected in the practices of busy plastic surgeons who often hire nurses or other paramedical personnel to perform these procedures. With respect to liposuction, as you know from the literature received from my colleagues, many skilled dermatologists are successfully performing this procedure on a regular basis using tumescent anesthesia as a substitute for general anesthetic. This innovation, introduced by a dermatologist,

has significantly reduced anesthetic risks. The point really is, you don't have to be a plastic surgeon to be competent to perform certain types of cosmetic procedures, but you do have to show an interest, be willing to take ongoing educational courses, and it is preferable if your training provides a compatible background.

The American Society of Cosmetic Dermatology and Aesthetic Surgery (ASCDAS), founded in 2001, subscribes to two principles: 1) that no residency program can keep up with the rapid changes that are occurring in the availability and types of cosmetic procedures, and 2) interested physicians who have completed residencies in core specialties (dermatology, ophthalmology, otolaryngology, and plastic surgery) are particularly qualified to carry out cosmetic procedures with the caveat that they must receive hands-on post-residency training to keep up.

Founded in 2001 by board certified dermatologists with excellent academic credentials, the ASCDAS estimates to have trained over 10,000 physicians from these specialties in a variety of educational programs which involve large meetings supported by industry, small regional workshops, and in-office training for interested residents. Our goal is to fill the gap between residency programs and what physicians need to know to effectively incorporate new techniques and refinements into their own practice.

No one training program is so superior that it should dominate this highly diverse field. Historically, many of the advances and innovations dealing with cosmetic procedures have originated with experts from a variety of backgrounds. The common thread which underlies competence is physician interest and willingness to undergo long-term training.

It's interesting to note what specialty is responsible for the bulk of in-office cosmetic procedures. In a study published in 2008 (Houseman, Salem, Mir, et al., What Specialties Perform the Most Common Outpatient Cosmetic Procedures in the United States?, *Dermatol Surg* 2008;34:1–8), the authors calculated the percentage of cosmetic procedures performed by various specialties in an outpatient setting. Their finding was that 48% of the procedures were carried out by dermatologists, 38% by plastic surgeons, 4% otolaryngology, 3% ophthalmology. They concluded that dermatology as a specialty performs more office-based cosmetic procedures than any other specialty. They also conclude on a per specialty basis that dermatologists and plastic surgeons have far more experience with cosmetic procedures than any other physicians. A more recent study in *Skin & Allergy News* (Zoler ML, U.S. Dermatology Procedures doubled from 1995 to 2008, *Skin & Allergy News*, Vol. 42, No 9., Sept. 2011) notes that 42% of cosmetic procedures were carried out by dermatologists and only 26% were performed by plastic surgeons. They note that the number of cosmetic procedures roughly doubled during the period studied rising from about 2 million in 1995 to about 4 million in 2008. The most common procedure was injection of botulinum toxin.

Historically, dermatologists have made major contributions and the record speaks for itself. Mohs surgery, pioneered by a dermatologist, deals with extraordinarily complex

reconstructive procedures every bit as difficult and demanding as anything taught in any plastic surgery residency in the United States. The cosmetic application for botulinum toxin was initiated by a married couple; an ophthalmologist and a dermatologist. Dermatologists were responsible for major advances in the treatment of varicose and spider veins using injectables (sclerotherapy), as well as lasers and radiofrequency devices. Dermabrasion, and hair transplant surgery are typically carried out by dermatologists. As new techniques and products emerge, any physician who plans to perform cosmetic procedures can only maintain competence by attending on-going educational programs long after their residencies are completed.

Ms. O'Donnell's simplistic solution which appears to guarantee good results when a boarded plastic surgeon carries out procedures really doesn't hold true in the real world. She has however shed some light on the stunning lack of standardization both in residencies and post-residency training programs for physicians who wish to carry out cosmetic procedures. She may also have performed an important public service. Her interest in determining who is qualified to carry out cosmetic procedures may lead to reforms in training programs and clarification of physician training needs with respect to cosmetic procedures. She hopefully may have initiated a dialogue which can benefit both patients and physicians. What she doesn't mention and has become increasingly important is the number of procedures being carried out without supervision by untrained and incompetent operators in the setting of abysmally unregulated medical spas.

The ASCDAS would be most interested in becoming involved in any process which would clarify the issues surrounding cosmetic procedures in the United States, and we would be most honored if a member of your staff attended our upcoming ASCDAS 2011 Annual Meeting on December 1-4, 2011 in Las Vegas, Nevada.

Sincerely,

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