

OPINION ARTICLE

Needs and Demands in Cosmetic Dermatology

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Changes currently taking place in Spain in regard to developing—against a background of adaptation to the European Higher Education Area—new curricula for medical and other university faculties and schools offer a historic opportunity to overhaul both medical degrees¹ and dermatology teaching content. Analyzing dermatology in terms of concept and teaching content also begs reflection on current needs and demands in relation to cosmetic dermatology.

Cosmetic dermatology is the component of dermatology that refers mainly to treatments for healthy skin, and cosmetology is the science and art of caring for and enhancing the esthetic features of a healthy skin. The conceptual definition of dermatology currently valid in Spain was adopted unanimously at the 7th Hispanic-Portuguese Medical-Surgical Dermatology Conference held in Granada, Spain, in 1969. Reflecting the philosophy of the dermatology school headed by Dulanto, dermatology was defined as the comprehensive medical and surgical organ-based specialty that comprises the skin, skin appendages, mucous membranes, and associated external structures.

This is the selfsame concept of dermatology that we have been trained in, that we defend, and that we will continue to teach. The above definition, moreover, covers all aspects of skin care—including the prevention and treatment of aging and the correction of skin imperfections. In other words, the definition of dermatology includes cosmetic dermatology, and, since this definition is still considered to hold true for our times, we need to ask ourselves: what are the cosmetic dermatology needs and demands of today?

The demand for cosmetic dermatology services have grown in line with the development of the welfare society and the aging of the population, as made manifestly clear by both epidemiologic and marketing studies. A study by Torras and López² in regard to cosmetic dermatology developments between 1973 and 2003 revealed that the sale of cosmeceutical products grew nearly fivefold in this period—from 22 million units to 105 million units. Furthermore, the profile of the most popular cosmetic dermatology products changed in the same period—from soaps to face creams and shampoos. According to a study

on the market potential for cosmetic dermatology products and dermatology services, conducted in 2002 by La Roche-Posay pharmaceutical laboratory, the most frequent conditions for which patients consulted were acne, atopic dermatitis, seborrheic dermatitis, and alopecia, for which 99% of the dermatologists included in the study prescribed cosmetic dermatology products. In terms of prescription frequency for the most common conditions, 75% of patients were prescribed a cosmetic dermatology treatment for acne, seborrheic dermatitis, and alopecia, and 80% of patients were prescribed a cosmetic dermatology treatment for xerosis, photoprotection, sensitive skin, oily skin, hyperpigmentation, rosacea, and photoaging. Nowadays, dermatologists typically deal with 2 types of consultations, firstly, by patients with classic dermatologic disorders; and secondly, by patients requiring cosmetic dermatology advice and treatment. The latter patients are motivated by any or all of the following: a desire to remain eternally young, the importance attached to physical appearance in our society, and a broader concept of health that refers not just to the absence of disorders and diseases, but also to full physical, mental, and emotional well-being.

Given this enhanced demand for cosmetic dermatology, what needs have to be met? From a health care planning perspective, a need can be defined as the gap existing between a desired state and a real state that pinpoints a health care problem.³ In other words, a need is an expression of how an identified health care problem may be addressed. Below I identify current needs in cosmetic dermatology.

Which professionals are responsible for cosmetic dermatology? The current situation is such that specialists working in esthetic centers, capillary treatment centers, and beauty parlors, and also cosmetic surgeons without accredited training, are responsible for this area of dermatology. However, dermatologists should be considered responsible for cosmetic dermatology, as this area is embraced by their specialty. This gap between reality and what is desirable identifies a first need.

Where do cosmetic dermatology services belong? The reality is that a large proportion of the population does not consider cosmetic dermatology procedures as part of the dermatology discipline. What is desirable is that the population becomes aware that the concept of dermatology includes care for healthy skin. A second need is thus evident in this difference between public perceptions and how things should be.

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What is lacking? At present there is no legislative provision for specific training in cosmetic dermatology, whether at the undergraduate or postgraduate level, or by means of specialist courses of study. The fact that training in cosmetic dermatology should, but does not, form part of dermatology course programs, doctoral programs, and specialist programs is an evident third need.

As with demands, therefore, needs in terms of cosmetic dermatology are many. Need, even though it is a relative concept, should be taken into account in health care planning. Some health care needs—neither exclusive nor exhaustive—include expressed needs, felt needs, and the need for standards.

Expressed needs are synonymous with demands—as expressed by the population in its demand for particular services. Market studies have highlighted the expressed cosmetic dermatology needs of the population, manifest in greater numbers of consultations and increased sales of cosmetic products. Felt needs, which have always existed, are needs perceived by the population, whereas expressed needs are a consequence of developments that have led to the unfolding of a new reality. Formerly, going bald, having acne, or developing wrinkles were all accepted as associated with age, and aging was accepted as a natural process; nowadays, however, people seek treatments and solutions. Nonetheless, we should not overlook the fact that it is not always possible to offer solutions, as patients sometimes express needs that cannot be met, particularly in cosmetic dermatology where ethical concerns may arise. Mascaró⁴ referred to “esthetic ethics” and the fact that the basic rules governing the cosmetic dermatologist should be the same as those governing all medical decisions: only cosmetic dermatology treatments that imply a clear benefit for an individual should be prescribed, used, and promoted.

There is a problem in the fact that the population feels and expresses cosmetic dermatology needs but does not consider that the dermatologist should be responsible for meeting those needs. Note also that felt and expressed needs arise in the population, and dermatologists need to respond to these needs through the third need described above, namely, a framework that is recognized by experts and health care analysts. This would cover teaching curricula and legislation specifying who should provide dermatology services.

Legislation should also redefine infrastructure and staffing needs with a view to achieving predetermined objectives. In the case of cosmetic dermatology, this means providing appropriate and reasonable means for ensuring healthy skin. New legislation is essential to enable agreements to be entered into between universities and health care authorities that would ensure continuity between basic and specialty training. Since medical and dermatology training by necessity has to adapt to both scientific advances and social change, it is important to ensure sufficiently flexible curricular structures that enable adaptation to changing circumstances.

Despite the legislative shortcomings, some Spanish universities enable dermatology electives to be chosen from among optional course subjects or any of the subjects taught by the university. The dermatological therapy and cosmetics division of the Spanish Academy of Dermatology and Venereology (AEDV) offers a 2-day training course to third-year resident physicians and organizes an annual meeting of dermatologists.⁵ These initiatives responding to societal demand for cosmetic dermatology services, however, do not count towards core subject credits nor are they recognized by official dermatology programs. Training in cosmetic dermatology needs to be included in medical curricula and appropriate equipment needs to be made available in teaching centers and hospitals.

There are few scientifically rigorous studies providing high-level evidence that convincingly demonstrates the beneficial effects of many cosmetic treatments. Studies of this nature would not only discourage cosmetic dermatologists from flippantly referring to “miracle” solutions in a way that would not be possible in other areas of medicine; they would also endow cosmetic dermatology with the scientific and medical rigor it deserves.

In conclusion, faced with many demands and felt and expressed needs, there is an evident need for minimum standards and legislation. It is ultimately desirable for all felt and expressed needs to converge so as to ensure a response to the cosmetic dermatology demands of contemporary society.

The demands and needs of society today embody the challenge facing cosmetic dermatology, the commitment required of dermatologists, and the responsibilities to be assumed by medical academics. As dermatologists, we need to support legislative developments in all areas of professional activity, whether as public or private physicians, as academics or researchers, or as legislators.

Conflicts of Interest

The author declares no conflicts of interest.

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