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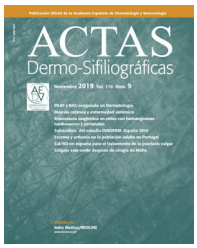

OPINION ARTICLE

''Aesthetic'' Dermatology?☆

Dermatología ''¿estética''?

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The dictionary of the Royal Spanish Academy defines the word *oxymoron* (*oxímoron*) as a combination of 2 words of opposite meanings grouped in a single syntactic structure to create a phrase with a new sense.[1] The term is also used colloquially to refer to any combination of 2 apparently contradictory words. In our opinion the phrase *aesthetic dermatology* is an oxymoron, at least in part.

The World Health Organization defines health as ''a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.''[2] Medicine is defined as the discipline that applies a set of knowledge, skills, and practices for the maintenance of health as well as for the prevention, diagnosis, improvement or treatment of physical and mental illness.[3]

Dermatology is a medical specialty that studies the health of the skin, subcutaneous tissue, skin adnexa, and mucosal tissues within view. Beyond the treatment of disease, this specialty also prevents possible diseases by promoting the health of the organ; in summary, the aim is the care and maintenance of healthy skin. We might add that dermatology is indirectly involved with the emotional health of individuals through all aspects involving the skin. The curriculum for training new dermatologists puts it very well: the first foundation of our practice is our knowledge of general medicine itself, given that no area of medicine can lie outside the specialty's interest.[4]

''Aesthetic'' dermatology normally refers to a subspecialist area whose aims are to improve the appearance of the skin of individuals with no skin disease by attempting to correct or delay skin aging, attenuate physical defects, or simply improve the person's appearance. Certain tools, techniques or procedures are usually assumed to play a part in achieving these goals. Given these common assumptions, it would seem logical for the subspecialty to have a theoretical foundation that links therapeutic aspirations and outcomes that focus only on the improvement of appearance (aesthetics), without there necessarily being a direct con-

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◊ Appendix A lists all members of the Comprehensive Skin Health Group.

nection to improving or encouraging the health of the organ or an actual person (as in medicine). We postulate, however, that this picture is largely misleading given that most of the procedures said to lie in the sphere of ''aesthetics'' actually manage to improve the skin's appearance or a person's well-being precisely by either 1) directly improving skin health or 2) indirectly improving emotional aspects related to the skin.

We also argue that most of the interventions usually associated with ''aesthetic'' dermatology are in reality medical acts with a direct impact on skin health. Article 7.1 of the code of ethics of the Organization of Medical Colleges of Spain defines a medical act as any lawful action undertaken by a licensed physician — whether caring for a patient, teaching, researching, or sharing expertise, etc. — with the intention of curing a disease, alleviating suffering, or promoting overall health. The code adds that the mission of any professional in the health sciences — including a dermatologist — is to promote health, which is to say, help individuals increase their control over their own health and improve it.[5]

Therefore, the association of the term *aesthetic* with the term *medicine* is problematic, unless aesthetic improvement is a direct consequence of the betterment of an individual's health. In fact, if we compare the 2 terms we might say that *health* refers to an objective, universal concept, namely a commitment to improvement by scientific means, whereas *aesthetics* pertains to a subjective notion that is highly influenced by culture and evolves outside the constraints of the scientific method. It is dynamic and changes periodically. The person represented by Michelangelo's *David* might be as healthy as the persons depicted in the paintings of Rubens, but the aesthetic aspirations of these works of art differ greatly.

Medicine — and therefore dermatology — and aesthetics are independent concepts. They are even opposites, at least vocationally so, even though they may occasionally aspire to the same goals. It is possible for there to be a dermatology that seeks to approximate aesthetic canons through the process of promoting health. It is even possible for there to be a dermatology that aims to achieve a specific aesthetic without directly seeking to improve health. The only point on which such a dermatology would completely abandon the realm of medicine would be by failing to comply with the principle of doing no harm to an individual's health. But in our opinion, the proper way to refer to this subspecialty would be ''satisfactive,'' not aesthetic, dermatology.

Satisfactive dermatology would involve scenarios in which care is only sought voluntarily, which is to say, the interested patients would approach the physician not to alleviate or cure a disease but rather to improve their physical appearance.[6] Paradoxically, the procedures that might be included in this type of practice would be few in comparison with the bulk of procedures traditionally considered ''aesthetic'' and which normally attempt to offer solutions for disease processes that arise from a chain of causes and effects that must be treated in order to restore health. When we intervene directly to treat a specific organ (in our case, the skin) on the basis of a diagnosis reached using medical expertise and then propose a therapy, we are practicing traditional,[7] not satisfactive, medicine. Dermatologists are all familiar with the improvement of functional reserve — and therefore of the skin's appearance — when we treat signs of photoaging, for example. Many of the topical applications and other procedures we use for certain conditions not only improve health but also prevent disease. Field cancerization is an example. Curiously, this type of argument can also apply in situations that are supposed, a priori, to be less favorable to health and traditionally associated merely with the improvement of appearance.

By way of example, consider applications of botulinum toxin (BT), which is an injectable neuromodulator derived from toxins released by *Clostridium botulinum*, the bacterium responsible for botulism. BT is a metalloproteinase able to inhibit neurotransmission between peripheral nerves and muscles, blocking the release of acetylcholine. These attributes make BT an effective treatment for problems that stem from forceful or frequent muscle contractions.[8]

One of the most common uses of BT is for the treatment of wrinkles caused by facial expressions in the upper third of the face. With this approach, it seems logical to consider BT injection to fall under satisfactive dermatology for aesthetic purposes. However, we believe there are reasons to argue that the aesthetic goal is merely a consequence of a much more fundamental indication for treatment, one that affects not only the health of the skin but also the well-being of the individual, by way of emotions.

First, wrinkles related to facial expressions are consequences of a stress mechanism acting directly on the skin: a hypertonic, and often hyperkinetic, contraction is maintained, causing the damaged skin to modify both function and properties in order to adapt. Moreover, holding a muscle contraction, especially between the eyebrows, generates secondary problems such as tension, discomfort, and headache — effects that are far from the healthy intention of expressing a particular emotion or reaction. All such considerations intrinsically pertain to the sphere of health, understood as functionality, and therefore lie outside the sphere of aesthetics.

Second, appropriate communication requires the expression of feelings by means of gestures, which in turn influence our mood and that of others around us.[9] Studies have shown that adopting a facial expression enhances the degree to which an emotion is felt; consequently, reducing the ability to express an emotion might also reduce the ability to feel it.[10] It has been shown that patients who have been treated with BT in the region of the glabella and who cannot furrow the brow are less susceptible to depression and anxiety than those who receive other types of aesthetic intervention, through a phenomenon known as facial feedback.[11] Overall, these observations fit with the approach to health laid out here, given that treatment leads to improvements in mental or emotional health as well as physical well-being. We might say, therefore, that BT is also a modulator of emotions.

Within this framework, we can define BT therapy as a medical act specifically intended to help the organ recover health and function and maintain the ability to express emotions independently of an exaggerated, conditioned movement. The improved appearance, according to current canons of beauty, is a secondary outcome that is not a medical concern and might change in the future — if great attractiveness and intellectual weight were ever to become associated a furrowed brow. Should that come to pass, we could even then ask ourselves if so-called ''aesthetic'' dermatology could conceivably concern itself with artificially

creating a furrowed brow, even to the detriment of skin health.

The phrase *aesthetic dermatology* not only fails to contribute to our understanding of many such questions but also detracts from the image this branch of our specialty has of itself, the message we transmit to our peers in training, and, above all, the impressions of a large group of patients who reject or even blame this subspecialty for carrying out certain procedures considered unnecessary, superficial, or frivolous.

We therefore believe it is necessary for dermatologists to reflect sincerely on questions that to date have fallen under this heading so that we can define the issues, procedures, and techniques that actually pertain to dermatology proper, to the degree that they are tied to skin health. We must distinguish them from issues, procedures, and techniques that pertain to satisfactive dermatology, which attends to the specific aims of particular patients. Also needed is the creation of a new theoretical foundation for this subspecialty, expressed in new language that might further our understanding and favor communication. Building such a foundation would confer value on our subspecialty's treatments, both in our own eyes and, above all, in our patients'.

We sincerely call on our peers to put behind us the concept of ''science in the morning and theatricals in the afternoon'' and claim a place for our subspecialty's defense and promotion of healthy skin and skin adnexa. We know this challenge is great and probably runs counter to many traditional points of view. The challenge may even generate controversy and meet with disapproval. Nonetheless, this proposal reflects our profound interest in promoting collaboration. We believe it is time to reform this aspect of our practice and bring it closer to the dermatology's core approach as well as to meet the requirements and new challenges of the 21st century. We call for a dermatology that takes the lead on matters of skin health, its function, and its role in expressing emotions, a specialty that speaks out vigorously. Dermatology — with no need for qualifiers.

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Conflicts of interest

The authors declare that they have no conflicts of interest.

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