DERMATOLOGY’S CHANGING FACE ... AND BODY
Practices adapt to new demographic and racial shifts
By Rahul Shukla, MD

Given shifting demographics occurring within the North American population, not only is it important for the dermatologist to become skilled in diagnosing and managing disease in skin of color, it is important for the dermatologist to understand cultural practices performed by different ethnicities and their potential for dermatologic sequelae.

Cupping
Cupping is a form of traditional Chinese medicine used to treat a variety of ailments whereby a localized vacuum is created against the skin breaks the superficial blood vessels in the papillary dermis creating distinctive, circular, cutaneous lesions. A number of theories have been proposed to the benefits of the intervention, including improved circulation leading to the elimination of toxins as well as placebo effect. In order to perform cupping, an alcohol-soaked cotton ball is ignited and placed into a cup where it is inverted and placed onto the skin. When the flame extingishes, a vacuum is created causing the involved skin to be pulled into the jar. Modern techniques employ the use of a hand help pump to manually create suction. In addition to circular, eechymotic, or purpuric macules, cupping has resulted in bullae and skin burns.

Some traditional dress causes lesions
Cultural practices of South Asians may also lead to dermatologic manifestations. Traditional clothing such as the sari and salwaar kameez are garments worn by South Asian women that have the potential for inducing or precipitating cutaneous lesions. The sari and its accompanying petticoat are tied around the waist of women by a drawstring with overlapping layers of the sari resting between the skin and petticoat. The salwaar kameez elicit similar cutaneous effects. Frictional forces exerted on the waist by both garments can lead to hyperpigmentation.

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ETHICAL CONSIDERATIONS:
TRUTH TELLING AND THE DOCTOR-PATIENT RELATIONSHIP

What’s a physician’s obligation to absolute honesty?
By Karen Scully, MD, MA, Ethics

As physicians, are we obligated to be truthful to patients? The answer to this question is not as straightforward as it seems. In this column, I will discuss our obligation of honesty to patients and the subtleties involved in telling the truth.

Honesty in the informed consent process has replaced a paternalistic approach in which physicians of the past told patients little or nothing about their diagnosis, particularly if it was cancer or a terminal illness. Physicians made decisions for patients, and they decided on treatment without patient involvement. The physician was not questioned. Frank dishonesty on the part of the physician was not unusual.

Today, informed consent involves patients in their health care process. Autonomy is now one of the four important principles involved in ethical medical care.

There are three arguments which justify the ethical obligation of honesty to patients. First of all, honesty is based on respect for others. Secondly, honesty has a close connection to fidelity and promise keeping. When we enter into a relationship with a patient, we implicitly promise not to deceive them. Lastly, doctor-patient relationships depend on trust, and being truthful is essential to trust.

Karen Scully, MD, is a board-certified dermatologist in Canada and the United States, and has an MA in ethics from UNC, Charlotte.

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a hyperkeratotic groove of skin as well as koebnerization of vitiligo and lichen planus’. Rarely, “sari cancer,” a form of squamous cell carcinoma presumably induced by friction of the sari and petticoat has been reported to occur[7]. Wearing of a sari or salwaar kameez, especially by obese women with diabetes, can also promote superficial cutaneous infections by contributing to an occlusive and humid environment at the waistline and by providing a potential source of entry for organisms via the trauma induced by constant pressure[8].

Tattoos and body art

Henna tattoo is a form of body art enjoyed by many South Asians with potential dermatologic repercussion as well. Henna is derived from the shrub Lawsonia inermis with its active ingredient being lawson. Women of South Asian descent frequently apply henna or “mehndi” during cultural events. Henna use appears to have increased popularity in the Western world as it is of increasing importance. Young physicians, therefore, should be encouraged to become more aware of conditions that are prevalent in cosmopolitan cities, locales that focus on skin of color, and obtain more international experience. These skills will be needed as the face of North America continues to evolve.

References

Dr. Shukla is an associate dermatologist at Dermatology Centre in Hamilton, Ontario, Canada; Bertucci MedSpa in Woodbridge, Ontario, Canada; and AvantDerm, Toronto, Ontario, Canada.
SEVEN RETIREMENT PLANNING STRATEGIES FOR DERMATOLOGISTS

By James M. Dahle, MD & Lawrence B. Keller, CLU, ChFC, CFP®

Retirement planning focuses on saving money today in order to provide a lifestyle for you and your family in the future, when you decide to slow down or stop practicing dermatology altogether. If you want to retire comfortably, you need to live below your means in order to invest, reduce your debts, and increase your net worth. This article will provide you with seven strategies to help you achieve that goal.

1) Set a goal

The first step is to determine your goal — the more specific the better. How much money do you want to have each year in retirement and when do you want to retire? We all know this answer is likely to change throughout your career, but seeing the end from the beginning goes a long way toward achieving your goals.

A typical physician can retire quite comfortably on 30 to 60 percent of his or her pre-retirement income. You’ll pay less in taxes, have no need for retirement savings, be free of your mortgage, and have the kids out of the house and, hopefully, out of college or graduate school. Visit http://whitecoatinvestor.com/percentage-of-current-income-needed-in-retirement/ for thoughts related to the percentage of current income needed in retirement for physicians.

2) Start early

Let’s look at a dermatologist who wants to be able to spend $100,000 per year in retirement (and expects $25,000 from Social Security). He will need a portfolio of $1,875,000 (based on a 4 percent withdrawal rate) in today’s dollars, and he achieves an average return of 5 percent per year (after expenses, taxes, and inflation), he would need to save approximately $27,000 per year (increased each year at the rate of inflation). However, if he waited until age 50 to start, he would have to save approximately $83,000 per year to ensure the same income in retirement.

3) Apply a reasonable rate of return

Many physicians mistakenly assume their investments will grow at a rate of 10 percent or more per year. The truth is that after investment expenses, taxes, and inflation, a typical portfolio is likely to grow at only 4 to 5 percent per year. That means you have to start earlier and save more money than most physicians believe.

4) Minimize your expenses

The less you pay in advisory fees, commissions, and management fees, the more money you keep. Many physicians find that having most or all of their retirement funds invested in a few diversified, low-cost index funds helps them minimize their investment expenses and portfolio complexity, while still capturing market returns.

5) Minimize your taxes

Your most significant investment expense is likely to remain your tax bill. Maximizing your use of 401(k) plans, 403(b) plans, 457 plans, profit sharing plans, and defined benefit plans will not only reduce your taxes initially but will allow your money to grow on a tax-deferred basis.

We also recommend that dermatologists take advantage of Roth IRAs. Although you might think your income is too high to allow you to contribute, you can take advantage of a loophole that allows anyone to convert a non-deductible traditional IRA to a Roth IRA regardless of their income. You can learn more at http://whitecoatinvestor.com/retirement-accounts/backdoor-roth-ira/.

Although Roth IRAs don’t save you anything on your current tax bill, they do provide tax-free growth and tax-free withdrawals in retirement, providing valuable tax diversification.

6) Saving 10 percent for retirement isn’t enough

Dermatologists should also save 20 percent of their income towards retirement — starting the day they graduate from residency. While it’s true that if you start early, you can save less, saving 20 percent provides flexibility for years where you might not be able to save as much, to allow for poor investment returns, or for a personal or financial catastrophe such as divorce or disability. If all goes well and none of these scenarios materialize, then you will be left with a wonderful choice: retire earlier or retire wealthier.

7) 4 percent withdrawal rate

A rule of thumb often used by financial advisors is to withdraw 4 percent of your portfolio each year in retirement. This will allow you to withdraw 4 percent of your portfolio each year in retirement. Providing valuable tax diversification.

See Retirement Planning on page 7
Should male skin be treated in a different way than female skin? Earlier this year, at the AAD’s 70th Annual Meeting in San Diego, Davi de Lacerda, a dermatologist in private practice in San Paolo, Brazil, posed this question as part of a Cosmetics Symposium on March 18. While a majority of the session attendees agreed with the statement that both “male skin biology and behavior have specificities that can be exploited to improve male skin care,” Dr. de Lacerda explained that most products for men are simply women’s products packaged with the words “for men” on the label; they don’t offer different formulations for male skin.

Currently, there is a focus on evidence-based differences in male versus female skin; however, “the evidence is limited. We have very few studies done on the topic,” Dr. de Lacerda said.

**Biological distinctions between male and female skin**

Dr. de Lacerda has identified several aspects of skin health care where male and female differences may suggest using specific cosmeceuticals and treatments.

In his discussion of hair, Dr. de Lacerda focuses first on androgenetic alopecia. He states his belief that topical minoxidil can be considered a “male” cosmeceutical because it improves skin appearance for men with this condition. Studies have shown that the inhibition of 5α-reductase helps manage androgenetic alopecia. Many botanicals have the potential for 5α-reductase inhibition, such as green tea extract, Serenoa repens, Artocorpus incises, isoflavonoids and lignans, among others. “They need to be in high concentration, but we don’t know yet how to deliver them to the hair,” he said.

Men with facial hair can suffer from skin conditions like pseudofolliculitis barbae or seborrheic dermatitis, and there exist many cosmeceuticals that can be used to treat and improve both conditions. Available treatments for folliculitis include exfoliating with retinoids, α-hydroxyacids, and scrubs; using anti-inflammatories like aloe vera or poly-hydroxyacids; or using antibacterial/anti-inflammatory combinations like benzoyl peroxide. Zinc and other probiotics may provide relief to men with seborrheic dermatitis.

Sweat and body odor is another aspect of skin health that differs between men and women. “Men sweat 40 percent more than women,” Dr. de Lacerda said. Sweat rate, sebum production, pH, and biofilm influence typical male odor. One simple solution is to use magnesium hydroxide, which reduces odor by interfering with sebum-degrading microflora enzymes without adding fragrance, he said.

Excessive oiliness is a common cosmetic complaint for men. Unlike women’s skin, oiliness in male skin does not decrease significantly with age. This is because men have larger pores and greater sebum production, approximately three times the amount of women. “When addressing cosmeceuticals for men, it is important to deal with oiliness,” Dr. de Lacerda said. Retinoids — like tretinoin — sebum-absorbing beads, and light primers, which help reflect light differently, are all ways of addressing this issue when developing products for male skin.

In the first decades of life, dermal thickness decays at roughly the same rate for males and females. While androgens increase dermal thickness, the male dermis starts decaying earlier. Male skin thickness may affect the amount of UV penetration and absorption of applied products. Also, more and more men use hormonal replacements after forty-five or fifty years of age. Dr. de Lacerda questions the effects of using hormones, like Dihydroepiandrosterone (DHEA), on skin thickness, broadly considering the possibility of whether a DHEA supplement could be safely used to delay dermal decay in male skin. “This is something that is still open,” he said.

Dr. de Lacerda’s discussion of skin thickness leads to questions of whether epidermal thickness can interfere...
with the incidence of skin cancer. Developing cosmeceuticals for sun protection may be even more important for men since more men are diagnosed with melanoma than women, Dr. de Lacerda said. “Maybe if we increase the epidermis in men with the use of retinoids and alpha-hydroxyacids, we could reduce UV damage,” he said. He also raises the question of whether cosmeceuticals could increase anti-cancer immune response. “Cosmeceutical antioxidants may lower UV-associated DNA damage,” Dr. de Lacerda said.

**Male behavior and marketing strategies**

When developing cosmeceuticals for men, it’s important to take advantage of male behavior patterns and psychology. Products adapted to male behavior increase adherence, Dr. de Lacerda noted. For example, shaving offers ways to educate males about skin care health and deliver cosmeceuticals that will benefit their skin. Depending on skin type, there are products that work best for sensitive, aging, or acne-prone skin. Shaving can involve a number of products, from face wash and the shaving vehicle (foam, cream, gel) to aftershave or other moisturizers. Each of these products can be formulated to accomplish specific male skin care needs.

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**Cosmeceutical approach for men adapted to shaving habits**

Men prefer products to be pragmatic; they should be simple to use, quick-acting, and efficient, Dr. de Lacerda said. A product with multi-functional properties is preferred, and fragrance should be discreet and not change body odor. All of these factors further support the need to differentiate male and female products to drive male consumption.

In this example, beneficence would indicate that telling the whole truth is not always in the patient’s best interests. This has been referred to as “benevolent deception.” The obligation to tell the truth may be outweighed by other moral considerations, such as the obligation to do no harm. There are, however, arguments against this line of reasoning. Shielding a patient from bad news to prevent anxiety, for example, may be inadvisable; not telling the patient the whole truth may result in causing more anxiety. Furthermore, it may threaten the doctor-patient relationship by causing the patient to mistrust the doctor. As opposed to the practice of benevolent deception, it may be inferred from this latter argument that being completely honest and disclosing all findings with all patients may be the best action in our care of patients.

In a field that has been long dominated by women’s products, attention is finally being given to the fact that men, too, have biosocial specificities in which differentiated products may be more effective. Dr. de Lacerda

**Ethics**

Although deception in medicine is wrong, the obligation of complete honesty to patients is not absolute. An example of not telling the whole truth is treating a very sick patient who asks his/her physician not to reveal to him/her the diagnosis. The physician should respect this patient’s autonomy. As physician/ethicist Edmund Pellegrino states, “To thrust the truth … on a patient who expects to be buffered against news of impending death is a gratuitous and harmful misinterpretation of the moral foundations for respect for autonomy.”

In the case of the patient with a terminal illness, by respecting the patient’s autonomy, the physician would not immediately disclose the patient’s fatal illness as soon as it was diagnosed. Since the patient asked the physician not to disclose the diagnosis, he/she presumably would not be ready for the cold, hard facts. The physician would help the patient to come to terms with the reality of his/her impending death over time. This process attempts to achieve truthfulness gradually, respecting the principles of beneficence and non-maleficence within the time constraints of the patient’s terminal illness.

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Generally in North America, there is direct, frank honesty in sharing information with patients about diagnosis and treatment options, but a less direct approach in sharing prognosis. Most physicians agree that compassion and sensitivity for patients would lead to disclosure of a poor prognosis over time. In this way the physician attempts to let the patient know that his/her prognosis may be guarded but at the same time optimistic, and appeal, for example, to statistics of patients with the same disease. The process of sharing bad news with the patient depends on the individual doctor-patient relationship, the patients’ understanding of his/her medical problem, and all the particular nuances of that patient’s medical problem.

As physicians we are ethically obligated to be honest with our patients. Some of us may decide to be “benevolently deceptive” in our compassion for certain patients at certain times. Others will decide to be strictly honest with all patients at all times. It is up to each of us to determine how to fulfill this ethical obligation.

**References**

planners is that you can safely withdraw about 4 percent of your nest egg each year of retirement. This rule says, in essence, that you must save about 25 times your annual expenses, or that you can withdraw about 4 percent of your portfolio in the first year of retirement and then adjust that amount for inflation each year, with little chance of running out over a 30-year retirement.

Summary
Saving for retirement isn’t as hard as you might think. Begin educating yourself now, set your goals, save early and often, minimize your investment expenses and taxes, and most

Articles in Young Physician Focus represent the perspective of the individuals author(s) and should not necessarily be construed as advice from the American Academy of Dermatology or the Young Physician Committee.

RECOGNIZE SOMEONE?

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The AAD Volunteer Recognition program was designed to encourage volunteerism and recognize those who make the commitment to give back to the field of dermatology. Find out more at www.aad.org/VolunteerRecognitionProgram.

The Members Making a Difference award is the highest honor that a volunteer can receive in the Academy’s Volunteer Recognition program. One award is given each month and the winner is profiled in Dermatology World. Learn more at: www.aad.org/MembersMakingADifference.

The American Academy of Dermatology has the distinguished honor of being selected as one of only five medical societies that were considered to administer the Arnold P. Gold Foundation Humanism in Medicine Award. The esteemed award is given to a practicing dermatologist who exemplifies compassionate, patient-centered care. Read more about the award here: www.aad.org/humanisminmedicine.

The Academy also confers a Master Dermatologist Award, recognizing an Academy member who, throughout the span of his or her career, has made significant contributions to the specialty of dermatology, as well as to the leadership and/or educational programs of the American Academy of Dermatology. More information can be found at www.aad.org/MasterDermatologist.

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As young physicians active in patient care, volunteerism, advocacy, teaching, and research, we are presented with a multitude of leadership opportunities in the community and in academia. Recognizing these occasions and maximizing the impact of our contributions necessitates leadership skills. I suppose there exist among us “born leaders”; however, for most of us, developing the ability to lead effectively requires focus, practice, and persistence. The success of an individual in achieving skill in leadership is also linked to the quality and nature of the leadership development program, among other factors.

As dermatologists, we are fortunate to have the support of the American Academy of Dermatology, whose key priorities include developing leadership capabilities across the specialty. Having been a mentee and now continuing on the leadership learning curve as a mentor, I have come to fully appreciate the skill involved in operational (task-oriented) and organizational (people-oriented) leadership. Participating in leadership training has been one of my most gratifying experiences with the Academy, and one that has allowed me to become more effective in my day-to-day activities.

The 2013 Annual Meeting program will include several courses on leadership development addressing topics like communication, change management, and understanding group dynamics. These courses are identified by the icon in the program book. I encourage you to add these courses to your Annual Meeting schedule.

For more information on leadership development programs, please visit the Academy’s Leadership Institute Web page at www.aad.org/leadership.

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