Susan Weinkle, MD, has been involved with cosmetic dermatology for more than 20 years and was one of the first to use collagen and Restylane. She has a busy practice, concentrating on both Mohs and aesthetic dermatology, in Bradenton, Florida.

Job Searching

www

Check out the Academy's online job board for help with job searching: **www.healthecareers.com**

Career Case Study

Career Case Study is a new quarterly feature to help residents with choosing a sub-specialty.

Next issue: Pediatrics

Career case study

The growth of the cosmetic career path

Susan Weinkle, MD, interviewed by *Directions*.

Why did you choose to pursue a cosmetic/aesthetic specialty?

From the very beginning of my career, I was a surgically oriented dermatologist. I have been doing Mohs surgery since 1979 and started injectables very early in my career. As a resident, I did the protocol studies for collagen at Stanford, so I had an early exposure to what was really the birth of aesthetic dermatology. At the time, collagen was new and was the only injectable, and for the most part, it stayed that way for a long time. In 2004, Restylane was approved and hyaluronic acid injections began to come on the market. I found those new advances in aesthetics could be very rewarding and a complement to my practice.

What personality traits are most desirable and helpful in this type of work? Is it more social or solitary? Do you need good people skills?

I have always appreciated art. I think you have to have an aesthetic eye. You have to have an eye for beauty and balance. You have to be able to see and visualize — and then your hands can do the work. You also have to enjoy being with your patients. Particularly in aesthetic dermatology, the expectations from patients are very high. Many patients I encounter have body dysmorphic disorder, so you need to be sensitive to that, as well.

Describe a typical day.

I start each day with two surgery patients on the table ready to go. I see five to six Mohs patients in the morning (along with some patients in between). In the afternoon, it is primarily botulinum toxin injections and fillers. I do administration and paperwork within the day. I have a totally electronic office. The patient's pathology and the picture of the lesion are pulled up for me on my iPad. I do all my own Mohs surgery, including repairs. I also have a scribe who follows me and writes in the charts. The key to my success is that I genuinely care about my patients and I am incredibly efficient. Efficiency is the key to success in this day and age, and that extends to my office staff. Outside the office, I go to a lot of international meetings to teach and expand my knowledge.

What areas of your residency training and education are being put to use the most?

Mohs, in particular. I did so much surgery back when I was a resident, more than 500 Mohs surgeries. A lot of cutting and sewing and refining hand-eye coordination and dexterity. My Mohs experience developed my dexterity, and I found I had good ability with my hands. I used to sew with my grandmother when I was a young girl. Sewing skin is not that much different than being good with needlework! I think that skill set and comfort level with my hands led to an easy transition to doing aesthetics. Because of the growth of cosmetic surgery, there are now cosmetic dermatology fellowships being offered; so there is now opportunity to do an extra year of fellowship strictly in cosmetics after residency. That opportunity was not available when I was a resident.

In terms of need, workforce, and opportunities, how does it compare? Is it more difficult to land a cosmetic subspecialty position than another subspecialty?

Cosmetics has advanced — so there are more opportunities in cosmetic dermatology. Along with that, residents should be aware that the market has become more saturated. Also, the marketplace is changing. Some people are going to spas instead of dermatologists, but it can still be a very good path if you are flexible enough to find the right position in a desirable market. The Academy has some resources that can be very helpful in job searching.

If residents are considering a cosmetics subspecialty, what else should they be considering? Any special training or ways to increase their proficiency beyond their residency?

Many opportunities exist that did not exist 20 years ago. For instance, I have been chairing a resident cosmetic symposium every year in April. I am also involved with a preceptorship program with various volunteer surgeons. I have been directing a course at the AAD meetings every year since 1980 and have spent 12 years doing live patient presentations. I would encourage residents to seek these out and any other educational opportunities that can provide them with first-hand experience. Beyond residency, continue with education and volunteer work. You should never stop learning.

Is there something specific to cosmetic dermatology that is personally rewarding? Why will residents feel satisfied with this choice?

You can really help patients feel better about themselves and it can affect all aspects of their life. I had one patient, a woman, who I treated over a six-month period. She was applying for a position and kept getting rejected. We were able to make her look more attractive, and, equally important, increase her self-confidence. When she got the job, she was incredibly grateful and appreciative. Also, because I have a balance — being able to do both skin cancer surgery and cosmetics — it is very gratifying. And I love what I do. I have been working since I graduated my residency in 1982, and I still love my job. I cannot even imagine retiring! DR