

An Interview With...

Joel Cohen, MD is a third generation dermatologist, following in the foot steps of his father and grandfather. As a Mohs College surgeon, his practice focuses on skin cancer, but he also spends about a third of his time performing cosmetic procedures and conducting a variety of clinical trials. Dr. Cohen is a member of the ASDS Patient Education Work Group, which is developing patient education materials for the members' practices and this year won the prestigious ASDS Public Service Award for his involvement as Co-Chair of the Summer Solstice: Miles to Fight Melanoma Run in Denver. He enjoys medical writing, editing, clinical trials and lecturing and keeps busy with his 18-month old daughter, Tillie.



Joel Cohen, MD

What made you decide to become a dermatologic surgeon?

During my residency I had the privilege of working with Drs. Ed Krull and George Mikhail. Observing these two pioneers of dermatologic surgery made me realize early on that this was the career path I definitely wanted to take. In my fellowship, I was fortunate to also study with Alastair Carruthers, MD, and saw firsthand how one couple's observations and work can impact the future of our specialty. Along the way, collaborating with major leaders in our society such as Drs. Rhoda Narins, Leonard Goldberg, Sue Ellen Cox and Gary Monheit has shown me that it is possible to balance a busy practice with personal career desires of being a prolific author and tireless leader with an insatiable intellectual curiosity.

Who has been the most important influence on your career?

My father has been a very important role model for me. I am a third-generation dermatologist, so it has been in the family for many years. I was really headed toward doing something different and going into urology. My father encouraged me to at least take a serious look at dermatology. I spent some time with him in his office and saw the diversity of dermatologic diseases and the wonderful rapport he had with his patients. Over the years, I had seen him receive many touching and emotional thank you notes from patients who appreciated his listening ear and dedication to them. Even after retiring several years ago, he is still approached at all kinds of community outings by very appreciative patients.

After contemplating other fields of medicine to perhaps do something different, my father, as an individual and through the caring and compassionate career he led, made me realize I wanted to continue this family tradition into its third generation.

Importantly, my mother has exemplified her "stick-to-it-iveness" and dedication in the face of complicated and challenging situations. Her perseverance and wisdom have been the grounding and guiding forces in my decision-making processes and everyday coping with challenges.

What is the focus of your practice?

As a Mohs College surgeon, my practice focuses on skin cancer for the majority of my time. I also spend about 35% of my time doing cosmetics and various clinical trials. Being involved in trials has been a very rewarding experience. It is nice to be a part of scientific investigation, and it has given me a deep appreciation of

just how rigorous it is to have new drugs or devices get FDA approval.

What's been the most important innovation in dermatologic surgery?

I think Mohs surgery has been the single most important advance in dermatologic surgery, as a procedure that has dramatically reduced recurrence rates and improved accuracy in the removal of cutaneous tumors. I see this as a unique area where we can work together with our colleagues in plastic surgery fields and share patients, as some cases certainly necessitate the skills of both disciplines. Building bridges in the community in this fashion helps them realize the tissue-sparing nature and precision of Mohs surgery. It is a chance to educate them on the Mohs literature, such as the *Dermatologic Surgery* article by Ross Campbell, MD in June of this year, demonstrating not only co-participation with plastic surgery, but also documentation of an extremely high cure rate when permanent sections were done by a plastic surgeon after Mohs surgery ("Post-Mohs Micrographic Surgical Margin Tissue Evaluation with Permanent Histopathologic Sections").

While I close the vast majority of my defects referred to me by dermatologists, I always send patients back to their referring plastic surgeons. In addition, I look for opportunities to work together with facial and oculoplastic surgeons in terms of an occasional very large facial or eyelid defect. I did a general surgery internship and have OR privileges, so it is nice to be able to follow a patient to the operating room with them in some of these cases as well.

What was the best item you purchased for your practice? Why?

Two identical Leica 1510S cryostats — this allows for two histotechs to be cutting for maximal efficiency, plus there is no bias between new and old machines or one type of machine versus another. They are both the same and my techs truly appreciate having some of the best equipment available.

In addition, the morale of a Mohs tech is so important that I actually built the Mohs lab in my new office to have an outside wall lined with windows. Too often I see these labs in a dark and dumpy area of an office and these techs often simply have a bad back and no concept of time in the office. I think it is important that we realize that these people are sitting at these machines most of the day and their comfort in well-padded and positioned lab stools and access to window light is essential.

Tell us about your most memorable patient.

A few years ago, a patient requested I take over her care. She was in her early 80's, and had had four surgeries for a multiply recurrent SCC on her lower lip. She now had regional metastasis and paralysis of the left side of her face. Unfortunately, she had not received radiation or even an evaluation by a head and neck surgical oncologist until the time of her presentation with regional disease.

Despite radiation and chemotherapy, her disease became more advanced and within a few months she had a feeding tube. I became very close with her and her husband during these long months of watching her decline. Three months later she passed away. The funeral was out of town, but my wife and I did spend time with her husband upon his return. Watching his pain, I could not help but think if things could have been different...if only the radiation was begun sooner for a recurrent SCC on a very high risk site...if only she had been referred to an oncologist sooner for input on treatment.

Although I joined in her care very late, after she already had advanced disease, she is still the person I think of on all of my difficult Mohs days. Even if our days get busy, long or difficult, we need to really think of all the options and advise our patients of their options, so that we won't look back with the benefit of hindsight wishing things were done differently. In addition, staying current is vital to our commitment to our patients and new diagnostic tools such as sentinel lymph node biopsy may prove helpful and appropriate for some higher risk tumors.

Complete the sentence, "I can't live without my..."

...compression stockings and my wife's lunches. For several years, I dictated at the end of the day with my legs high-up on cushions stacked on my desk. A few years ago, after years of recommending compression hose to my patients with varicosities, I tried them myself. Not only do I now dictate in much more comfortable positions, but I can also go home and go for a run or walk without painful swelling or fatigue in my legs. I now wear light weight 15-20 mm hg compression stockings every day, and replace them about every 4-6 months. This has also allowed me to be a happier and more active father and husband after long days on my feet at work.

As for my wife's lunches, nothing beats them, and I am grateful to her for taking the time to take care of me.

What are your interests outside of dermatologic surgery?

Outside of dermatologic surgery at the office, I enjoy medical writing, editing, clinical trials and lecturing. But my family time is becoming more and more precious. My wife Goldie (a pediatrician) and I had a baby girl about 1½ years ago. Baby Tillie (named after my grandmother) was born with esophageal atresia and a tracheo-esophageal fistula. After nine weeks in the ICU, four surgeries, oxygen at home for ten months and a feeding tube for almost a year, fortunately Tillie is doing great.

We are very thankful to the doctors, nurses and staff and Denver Children's Hospital. It has certainly been a rough road, and I don't want to miss out on time with her or giving my wife a hand. She is really the strength within me and truly my best friend. She has pretty much single-handedly turned my daughter around medically through everyday physical therapy and at the same time helped me with various important office or scientific projects. I now bring plenty of paperwork home from the office for the late-night or the hours well-before sunrise, so I can spend quality time with them in the evenings.

Where do you see yourself in five years, both as a dermatologic surgeon and personally?

In five years, I hope to be an active Board member for the ASDS. I enjoy being involved with many of our societies and helping put things together. Currently, I am Vice President of the Colorado Dermatologic Society and a Board member of the American Society of Cosmetic Dermatology and Aesthetic Surgery. I am also a member of the AAD Membership Committee, the ASDS Patient Education Work Group as well as the ACMMSCO Public Affairs Committee. I think we as dermatologic surgeons have some complicated issues ahead of us in terms of dermatology "wanabees" (to borrow a phrase from Gary Monheit, MD), non-physician practice within our field, defining the parameters of "supervision" of mid-level practitioners, as well as scope of practice and office credentialing. And I want to make sure my voice is heard.

What would you have done differently in your practice knowing what you know today?

I would have started my own practice right after finishing my fellowship. It is really not that much work and it has actually been quite fun designing a practice, building out a space and adding an associate. If someone is not inclined to do that, or simply wants to work part-time, I would advise them to speak to many docs in the community about the various practices they are interested in. Drug reps are also a valuable source of information. And for sure, I recommend speaking in great detail to any docs who left a practice that they might be interested in.

Do you have a favorite quote, saying or words-to-live-by?

The founding Dean of Mount Sinai School of Medicine, Dr. Thomas Chalmers, had a quote that has been passed on for many years, "data is not the plural of anecdote." In this age when novel therapies seem to be springing up every day and many "early adapters" are, in my opinion, too early. I think it is important to live by the principles of science. We have to be guided by science and science has to be guided by data. We have this obligation to our patients and to our specialty. Unfortunately, picking up the newspaper we see misleading advertising to the public every day about various unsubstantiated therapies—take mesotherapy, for example.