PRACTICE PAPER · CLINICAL FRAMEWORK

the skinalchemy method™

A practice-developed framework for assessment, treatment selection, sequencing, reassessment and preservation in medical aesthetics

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The face is architecture. Aging is structural.
Anatomy informs every decision. Art shapes the outcome.

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Abstract

Medical aesthetics has no shortage of treatments. The more difficult problem is deciding which intervention, if any, belongs for the person in front of us.

The skinalchemy Method™ is a practice-developed, structure-first decision framework for moving from a patient's observation to a clinically and aesthetically defensible plan. It begins with broad assessment across four lenses: structure and support, movement, tissue and collagen, and skin. It then asks what is plausibly contributing to the visible concern, whether a proposed intervention actually addresses that contributor, whether the expected improvement is meaningful, whether the timing and sequence are appropriate, and whether the recommendation protects proportion, expression, identity and future options.

At the centre of the framework is the **Treatment Threshold**, a discipline applied to the recommendation rather than to the patient. A treatment should enter the plan only when its role can be defended. Once treatment belongs, it must have a defined job. Sequence must have a reason. Time is treated as clinical information rather than dead space between appointments. Reassessment is part of the plan, not an administrative afterthought. Preservation is treated as an active component of assessment, not merely the absence of treatment.

The Method is not a diagnostic scoring system, a validated clinical instrument, a treatment protocol, a dosing guide, an injection map or a device-setting framework. It does not replace individualized medical assessment, informed consent, professional scope, manufacturer instructions or referral when appropriate. Its purpose is narrower and more practical: to make the reasoning that comes before technique explicit, consistent and accountable across a practice.

The framework was developed under the clinical leadership of Sonia Vilos, NP and is intended to function as a practice standard rather than a founder's personal treatment style. Different practitioners may contribute different expertise while operating within one shared reasoning system.

Keywords: medical aesthetics; facial assessment; treatment planning; multimodal care; facial aging; shared decision-making; treatment sequencing; reassessment; preservation; aesthetic judgment

A note on originality, evidence and scope

The skinalchemy Method™ does not claim ownership of facial anatomy, physiology, established treatment mechanisms, shared decision-making, multimodal care, or other principles that belong to the broader body of medicine and aesthetic practice.

Those foundations come from clinical science, professional education, regulation, manufacturer guidance and the accumulated work of clinicians and researchers across multiple disciplines.

The original contribution of the Method is the way skinalchemy organizes those foundations into a named and explicit decision framework: patient observation, broad assessment through four lenses, contributor reasoning, the Treatment Threshold, defined treatment jobs, deliberate sequencing, preservation and reassessment over time.

Its purpose is not to rebrand established science as proprietary. Its purpose is to make the reasoning that governs treatment recommendations visible, repeatable and accountable across a practice.

> **The originality of the Method is not a claim to have invented the principles of good aesthetic medicine. It is the discipline of making those principles explicit, consistent and accountable across a practice.**

This publication is a practice paper. It is not a peer-reviewed clinical guideline, expert consensus statement, validated clinical decision instrument or evidence of superior outcomes. The scientific literature cited later supports underlying principles in facial anatomy, patient-centred assessment, multimodal planning, treatment sequencing and longitudinal care. It does not independently validate the skinalchemy Method™ as a proprietary clinical model.

That distinction is intentional.

Clinical credibility is strengthened by stating what a framework is, and just as clearly, what it is not.

The Method at a glance

The following are reasoning functions, not a rigid linear protocol. In practice, several may occur together, repeat, or become relevant again after treatment has had time to declare its effect. Preservation is active throughout the framework rather than reserved for the end.

Reasoning function	Core question	What it is designed to prevent
Observation	What has changed for the patient?	Replacing the patient's concern with a treatment menu
Read	What do structure, movement, tissue/collagen and skin show us?	Treating one visible area in isolation
Contributor	What is plausibly driving or amplifying the concern?	Confusing location with mechanism
Treatment Threshold	Has this recommendation earned a place in the plan?	Treating because something is technically possible
Job	What exactly is this intervention being asked to change?	Using a treatment outside the problem its mechanism can address
Sequence	Why this treatment, at this time, in this order?	Treatment stacking and automatic packages
Preserve	What already belongs and should remain untouched?	Turning assessment into defect detection
Reassess	What did the response teach us, and does the next step still belong?	Automatic maintenance and repetition

Figure 1. The skinalchemy Method™ decision architecture

A compressed view of the reasoning architecture. The functions are related, but they are not a rigid linear protocol. Preservation operates across the framework, and reassessment can return the plan to an earlier reasoning function.

PATIENT OBSERVATION	What has changed, what matters, and what should be preserved?
READ	Structure and support · Movement · Tissue and collagen · Skin
PLAUSIBLE CONTRIBUTOR	What is reasonably contributing to the visible concern?
TREATMENT THRESHOLD	Has this recommendation earned a place in the plan?
DEFINED JOB	What exactly is this intervention being asked to change?
SEQUENCE	Why this treatment, at this time, in this order?
TREAT + TIME	Allow the intervention and biological response to declare useful information.
REASSESS	What did the response teach us, and does the next step still belong?

PRESERVE Active throughout: protect proportion, expression, identity, tissue integrity and future options.

Defined terms and core constructs

The Method uses a small set of defined terms to keep its reasoning consistent across practitioners, treatment categories and documented cases.

Observation. The change identified or experienced by the patient that begins the clinical reasoning process.

Assessment lenses. Structure and support, movement, tissue and collagen, and skin: four perspectives used to interrogate a concern rather than four sequential treatment stages.

Contributor. A structure, movement pattern, tissue characteristic or skin finding that plausibly contributes to the visible concern.

Treatment Threshold. The decision standard applied to a recommendation before an intervention enters the plan.

Treatment job. The specific change an intervention is being asked to produce.

Modality independence. The discipline of allowing the treatment job to determine the tool rather than allowing available inventory to determine the recommendation.

Sequence. The clinically and aesthetically reasoned order in which interventions are considered.

Preservation. The active identification of expression, proportion, characteristics, tissue or future treatment options that should remain unchanged.

Reassessment. The use of treatment response and elapsed time as new information before deciding whether the next intervention still belongs.

Case grammar. READ / TREATED / PRESERVED / REASSESSED: the public structure used to document how the Method is applied in cases.

Method invariants

The skinalchemy Method™ is designed to remain adaptable to the patient and the clinical context. Its application can vary without becoming a rigid protocol. The framework, however, loses its defining logic if the following conditions are removed.

1. Patient observation begins the reasoning but does not select the treatment.
2. Assessment is broad even when treatment is selective.
3. A plausible contributor is considered before a mechanism is chosen.
4. Every recommendation must cross the Treatment Threshold.
5. Every intervention has a defined job and every sequence has a reason.
6. Preservation remains active throughout assessment and treatment planning.
7. Reassessment can confirm, alter, defer or end the original plan.

These invariants describe the logic of the framework. They do not create a treatment protocol, mandatory sequence or substitute for individualized clinical judgment.

1. Why the Method exists

A visible concern is not a treatment plan

Most patients do not arrive at an aesthetic clinic with a diagnosis.

They arrive with an observation.

A hollow that was not there before. A heaviness through the lower face. A line that remains after the expression is gone. Skin that no longer reflects light the same way. A previous treatment that no longer feels right. A change that is difficult to name but easy to recognize in the mirror.

That observation matters. It identifies where the patient is experiencing change and what matters to them.

It is where the clinical conversation begins. It is not where the reasoning ends.

Modern medical aesthetics has created an unusual consumer problem. Treatments are increasingly easy to recognize by name. Patients may arrive asking for filler, Botox, Sculptra, a laser, radiofrequency microneedling, ultrasound-based treatment, resurfacing or a particular branded device before anyone has determined whether the mechanism of that treatment matches the concern.

This is understandable. Treatment names are visible. Decision-making is less visible.

The Method exists to keep that sequence in the correct order.

The patient should not have to diagnose the mechanism of their own concern in order to access good care. They should be able to say what they notice, what they want to preserve, what degree of change feels appropriate, what recovery they can tolerate, and what matters to them.

The practice then has a different responsibility: interpret the observation through anatomy, movement, tissue biology, skin behaviour, medical context, treatment history, risk and aesthetic judgment.

> **You bring the observation. We bring the anatomy. The plan is built where the two meet.**

Clinical assessment does not replace patient preference. It gives patient preference a clinically meaningful set of options.

The patient is not a passive recipient. The treatment menu is not the author of the plan.

The abundance problem

Aesthetic medicine now offers an extraordinary number of useful tools. That breadth can improve care, but only when there is a disciplined way to decide what each tool is for.

Without a decision framework, breadth can become accumulation.

One concern becomes three treatments because three treatments are available. Maintenance becomes automatic repetition because the patient had the treatment before. A new device becomes the answer to several unrelated problems because the clinic recently acquired it. A combination becomes a package rather than a clinically reasoned sequence.

The Method exists to create the opposite pressure.

Before a treatment enters the plan, the practice should be able to identify:

- what the patient notices;
- what appears to be contributing;
- what the proposed intervention can meaningfully change;
- what it cannot change;
- why it belongs now;
- what should happen before or after it;
- what should remain untouched;
- and what information should be reassessed before the next decision is made.

The objective is not to make aesthetic medicine sound more complicated.

It is to do the complexity before making the recommendation simple.

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2. The face is architecture

A worldview, not a claim that every concern is skeletal

“The face is architecture. Aging is structural.” is the worldview behind the skinalchemy Method™.

The phrase does not mean every visible concern originates in bone. It does not imply that skin is secondary, that every patient needs structural treatment, or that every layer should be treated.

It means the face is an interdependent system.

Anatomical literature describes facial aging as a multilayered process involving the facial skeleton, retaining structures, fat compartments, muscle, connective tissue and skin, with the pattern and rate of change varying between individuals.[1-4]

Bone remodels. Ligament and support relationships change. Facial fat can change in volume and position. Repeated muscle recruitment alters the way expression is read and the way the surface folds. Collagen and connective tissue change over time. Pigment, vascularity, barrier function and texture change. Previous treatment can alter the anatomy and tissue environment presented at the next assessment.

Medical history, weight change, hormonal change, medications, healing capacity and broader health context can change the picture again.

A structure-first practice therefore does not treat the face as a collection of isolated booking areas.

It asks what relationships are producing the visible concern before deciding whether any one of those relationships deserves intervention.

That can lead to treatment in the exact area the patient noticed.

It can also lead somewhere else.

It can lead to skin rather than volume. Movement rather than filler. Tissue remodeling rather than immediate contour. Correction of previous treatment before anything new. Another practitioner. Another specialty. Time. Or no intervention at all.

What architecture changes operationally

A structure-first worldview changes several assumptions:

- A line is not automatically a neuromodulator indication.
- A hollow is not automatically an invitation to add volume.
- A lower-face concern is not automatically a lower-face treatment problem.
- The strongest device in the clinic is not automatically the correct device for the patient.
- A treatment that worked previously is not automatically the correct treatment now.
- A global assessment does not require global intervention.
- A visible feature is not automatically a defect.

The practical rule is simple:

> **Whole-face assessment does not mean whole-face treatment.**

The assessment can be broad while the intervention remains highly local and selective.

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3. The patient's observation is part of the clinical reasoning

The patient's observation is not an inconvenience to be corrected by clinical language.

It is a form of data.

A patient knows when their face no longer feels like the face they recognize. They know which change draws their attention. They know which characteristics feel important to preserve. They know what level of intervention, recovery or maintenance is realistic in their life.

The clinician or practitioner contributes another form of information: anatomy, tissue behaviour, movement, skin biology, treatment mechanisms, limitations, risk and scope.

Good aesthetic planning occurs where those two forms of information meet.

This is consistent with patient-centred literature emphasizing goals, treatment history, preferences, counselling and shared decision-making as important parts of aesthetic care.[5-7]

The Method therefore does not ask only, "What can be done?"

It also asks:

- What is the patient actually trying to change?
- What do they want to preserve?
- How much change would feel meaningful rather than excessive?
- What recovery is realistic?

- How do previous experiences shape their current priorities?
- Is the desired outcome something this treatment can reasonably influence?

Clinical intelligence should define the meaningful options.

The patient's priorities help determine which meaningful option is worth pursuing.

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4. Read broadly: the four assessment lenses

For communication, the skinalchemy Method™ organizes the clinical read into four lenses:

1. Structure and support
2. Movement
3. Tissue and collagen
4. Skin

These are not four diagnoses. They are not four mandatory treatment categories. They are not four steps that every patient must move through in order.

They are four ways of interrogating the same visible concern before a treatment is chosen.

4.1 Structure and support

This lens considers skeletal support, ligament relationships, facial fat, volume distribution, contour, transitions and proportion.

It asks:

- What support has changed?
- Is the visible concern being influenced by a relationship elsewhere?
- Is there true loss of support or volume, or would adding volume simply add weight?
- Has previous filler altered the current relationship?
- Which structural characteristics already serve the face well?

This lens is not an argument for filler.

Its purpose is to understand structure well enough to know whether filler has a job at all.

A structurally informed assessment may support filler. It may support a different injectable strategy. It may make a collagen-focused or energy-based treatment more relevant. It may reveal that local volume is not the meaningful problem.

4.2 Movement

This lens considers muscle recruitment, resting tone, expression, dynamic pull and compensatory patterns.

It asks:

- What changes between rest and expression?
- Which movement contributes to the concern?

- Which movement is part of the patient's identity?
- Is the visible line primarily dynamic, static, or mixed?
- Would reducing selected muscular pull improve the concern without flattening expression?

Movement is not noise to be eliminated.

Expression gives a face recognizability, warmth and character. The objective is not an absence of movement. The objective is to understand which movement is creating unwanted pull and which movement should remain.

4.3 Tissue and collagen

This lens considers tissue thickness, firmness, connective matrix, collagen decline, healing capacity, laxity and the quality of support within the soft tissue.

It asks:

- Is immediate shape actually the job, or is the deeper need tissue remodeling over time?
- Does tissue quality limit how much refinement another treatment can create?
- Is collagen decline contributing to the visible change?
- Would a regenerative or energy-based approach be more coherent than adding volume?
- Does the patient's healing capacity or medical context alter what is appropriate?

This lens is especially important because many treatments in aesthetic medicine operate on different biological timelines. A treatment can be clinically appropriate and still require patience before its effect can be meaningfully judged.

4.4 Skin

This lens considers barrier integrity, pigment, vascularity, inflammation, sensitivity, texture, photodamage and surface behaviour.

Skin is not the decorative finish on facial architecture.

It is the surface through which the architecture is seen.

It also determines what can be safely and meaningfully tolerated.

This lens asks:

- Is the barrier ready for the proposed treatment?
- Is pigment or vascularity contributing more to the concern than shape?
- Is inflammation present?
- Is the patient's skin likely to tolerate the proposed energy or resurfacing load?
- Would preparation improve the safety, recovery or usefulness of a later treatment?
- Is a device being selected because of the target, or because it happens to be available?

A technically powerful device can still be the wrong treatment on the wrong day.

Systemic context surrounds the four lenses

The face exists inside a body.

Medical history, hormonal change, weight change, medication use, nutrition, healing, inflammatory conditions and broader health factors can affect what is seen and what is safe or useful to treat.

Systemic context therefore surrounds the four lenses rather than becoming a fifth cosmetic treatment category.

It changes the read when it is clinically relevant.

> **We assess broadly so we can treat selectively.**

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5. Understand the contributor before treating what is visible

The place where a change is visible is not always where the decision begins.

This is the key intellectual move in the Method.

A visible concern is an observation. The next question is what is plausibly contributing to that observation.

An under-eye shadow, for example, may be influenced by pigment, vascular show, skin thickness, adjacent support, true hollowing, fat-pad prominence or fluid tendency. A lower-face fold may reflect local tissue, movement, or changes in support elsewhere. A line may be predominantly muscular, predominantly dermal, or a mixture of both.

The same visible concern can therefore lead to different treatment decisions in different people.

The Method does not claim certainty about every biological cause from an aesthetic examination.

That would overstate what aesthetic assessment can establish.

Instead, it asks the practice to identify **plausible contributors** and then determine whether the mechanism of the proposed treatment matches the part of the concern the treatment is being asked to change.

That wording matters.

The objective is not to invent a causal story for every visible feature. It is to avoid selecting treatment from appearance alone when the clinical and anatomical context suggests more than one plausible explanation.

Earn simplicity through assessment

A patient should not leave a consultation carrying a more complicated version of their face than the one they arrived with.

The complexity belongs to the assessment.

The recommendation should become simpler because the assessment was thorough.

Ideally, the patient should understand:

- what they noticed;
- what appears to be contributing;
- what the proposed treatment can change;
- what it cannot change;
- why that treatment belongs;
- why another treatment may not belong;
- what should happen first;
- and what should remain untouched.

> **Anatomy is the evidence. Decision-making is the method.**

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6. The Treatment Threshold

Inside the skinalchemy Method™ is a discipline called the **Treatment Threshold**.

It is the defining decision standard inside the framework.

The Treatment Threshold is not a score. It is not a branded patient eligibility test. It is not a beauty scale. It is not something a patient passes or fails.

It is the standard the practice applies to its own recommendation before an intervention enters the plan.

A recommendation should cross the Treatment Threshold only when the practice can defend why this intervention belongs for this patient, at this time, for this reason.

The six questions inside the Treatment Threshold

6.1 Do we understand the concern well enough to act?

The first requirement is legibility.

Treatment should not be selected from guesswork, from the name of the appointment booked, or from the assumption that the visible location is the entire problem.

The practice should understand the patient's concern, treatment history, relevant anatomy or skin findings, and the limits of what can be inferred before deciding that intervention is appropriate.

Uncertainty does not automatically prohibit treatment. But uncertainty should be recognized rather than disguised by a confident treatment recommendation.

6.2 Is there a plausible contributor?

The practice should be able to identify the structure, movement, tissue or skin finding that plausibly explains why this treatment is being considered.

The contributor does not need to be the only contributor.

Many aesthetic concerns are mixed.

The purpose is to ensure that there is a clinically coherent reason for choosing the mechanism, rather than treating the visible location because it is available to treat.

6.3 Does the proposed treatment actually address that contributor?

This question separates recognition from mechanism.

A practitioner may correctly identify that something has changed and still choose the wrong tool to address it.

Mechanism and problem must match.

Neuromodulators alter selected muscle activity. Fillers alter volume and support. Biostimulatory and regenerative approaches act through different tissue processes. Light, laser, radiofrequency and ultrasound-based technologies have different targets, depths and biological effects.

No treatment should be asked to perform a job its mechanism cannot reasonably perform.

6.4 Is the expected improvement meaningful enough to justify intervention?

Technical possibility is not the same as clinical or aesthetic usefulness.

A feature can be treatable without the treatment meaningfully improving the face.

The expected change must be large enough, relevant enough or valuable enough to justify the treatment burden, including risk, cost, recovery, maintenance and the possibility of changing something the patient already likes.

This is one of the points where clinical reasoning and aesthetic judgment meet.

6.5 Is the timing and sequence right?

A correct treatment can be mistimed.

Previous treatment may still be evolving. Swelling may obscure the read. Skin may need preparation. Recovery from one modality may change when another should be introduced. Medical history or medications may alter readiness. The practice may still need information that can only be obtained by waiting for the first treatment to settle.

Timing is therefore part of the treatment decision, not merely an administrative detail.

6.6 Does the decision protect proportion, expression, identity and future options?

The Method does not ask only what can improve.

It asks what could be lost.

A short-term correction should not create a larger structural, expressive or aesthetic problem. A treatment should not flatten expression that belongs. It should not create weight where support is already adequate. It should not erase a characteristic simply because it is technically alterable. It should not make future correction unnecessarily difficult when a more measured option exists.

Possible outputs of the Treatment Threshold

The threshold can reasonably produce several different decisions:

- Treat now

- Stage treatment
- Treat another layer first
- Correct previous treatment first
- Wait
- Preserve
- Refer
- Reassess
- Recommend no treatment at this time

The Treatment Threshold is not designed to make plans smaller.

It is designed to make every part of the plan more defensible.

> **Some of the most important work here is the treatment that does not happen.**

Restraint as stewardship

Restraint is often mistaken for minimalism.

They are not the same.

A small plan can be poorly reasoned. A comprehensive plan can be highly selective.

Restraint can mean waiting. It can mean treating another layer first. It can mean reducing what was originally expected. It can mean staging care, correcting previous treatment, referring elsewhere or leaving a feature alone.

It can also mean recommending a substantial multimodality plan when several contributors genuinely matter and each treatment has a defined role.

The discipline is not “do less.”

The discipline is:

> **Do only what has earned a role.**

And the threshold belongs to the recommendation, not the patient.

The patient is not being judged.

Our recommendation is.

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7. Every treatment needs a job

Once an intervention crosses the Treatment Threshold, it needs a defined job.

A treatment is not justified by availability, popularity, novelty, price, a promotional calendar, or because another treatment is already being performed.

The question is not “What else can we add?”

It is:

> **What is this treatment being asked to change?**

The current public treatment architecture at skinalchemy is organized into four routes because the mechanisms answer different kinds of problems.

7.1 Facial Architecture

Facial Architecture includes injectable treatment when movement, support, contour or proportion has a defined role in the concern.

Neuromodulators and dermal fillers are obvious examples of why treatment names cannot substitute for treatment jobs.

Neuromodulators alter selected muscle activity.

Fillers alter volume and support.

Neither substitutes for the other.

Biostimulatory injectables introduce another type of job, one that may involve tissue quality or structural support over time rather than immediate volume alone.

The category is therefore not “injectables because injectables are available.”

It is the use of injectable tools when the anatomy, movement or support problem is one those tools can meaningfully address.

7.2 Collagen + Regenerative

Collagen-focused and regenerative treatments may belong when connective tissue quality, collagen support, repair or tissue remodeling has a defined role.

Published literature increasingly examines multimodal use of biostimulatory approaches while also noting variation in protocols and the need for stronger standardized evidence.[9]

The Method does not turn that evolving evidence into a universal promise.

It asks a narrower question: is tissue quality actually part of this patient’s concern, and is this mechanism an appropriate way to address it?

7.3 Laser Medicine

Pigment, vascular change, texture, resurfacing and collagen remodeling are different jobs.

They may require different technologies.

The device should not organize the plan.

The target, skin biology, readiness, tolerance, recovery and sequence should organize the choice of technology.

This matters in a practice with access to multiple devices because technology breadth can create a subtle bias of its own: the assumption that owning more technology proves better care.

It does not.

Technology breadth becomes clinically useful only when it creates freedom **not** to force every concern into one platform.

A practice with several mechanisms still needs judgment. The advantage exists only if the assessment determines the job and the job determines the technology.

> **Technology breadth is not the Method. It is useful only when it keeps the Method honest.**

7.4 Skin Therapy

Barrier integrity, inflammation, sensitivity, pigment behaviour, texture and recovery influence what the skin can tolerate and benefit from.

Skin Therapy may function as treatment in its own right, preparation for a larger plan, support during recovery, or long-term maintenance of skin integrity.

Skin is not a finishing touch to the architecture.

It is the surface through which the architecture is seen.

Home care

Home care supports defined skin needs and the long-term plan.

Products are tools, not the plan.

The same rule applies at home as it does in the clinic: every recommendation should have a reason.

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8. Breadth should increase freedom, not pressure to treat

A practice with a narrow set of tools can still make excellent decisions.

A practice with a broad set of tools can still make poor ones.

The presence of more treatments does not by itself create clinical depth.

What breadth can create is **modality independence**: the ability to recognize that one concern belongs to a different mechanism than the patient expected, or that no device in a particular category should be used at all.

That freedom matters because treatment inventory can quietly shape treatment recommendations.

If one platform is expected to address pigment, texture, vascularity and collagen simply because it is the platform a clinic owns, the equipment has begun organizing the plan.

The Method requires the opposite sequence.

1. Read the concern.
2. Identify the plausible contributor.
3. Define the treatment job.
4. Choose the tool whose mechanism fits that job.

This is why a broad practice should still be able to say:

- this is not a filler problem;
- this is not primarily a laser problem;
- this skin is not ready for energy-based treatment;
- this previous filler should be understood before anything new is added;
- this concern belongs to another practitioner or another specialty;
- or this does not need treatment yet.

Breadth is valuable when it protects the decision from the limits of the inventory.

It is not a claim of superiority.

It is an operating condition that makes selective planning possible.

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9. Combination care is not treatment stacking

Multiple modalities can belong in one plan.

That does not mean more modalities automatically produce a better plan.

Contemporary aesthetic literature describes individualized multimodal planning and combination approaches while also recognizing the importance of patient selection, sequencing and treatment burden.[6,8,9]

The Method uses those principles without treating “multimodal” as a synonym for “more.”

A combined plan is coherent only when each modality has a distinct role.

Examples might include:

- structural support and pigment treatment addressing different contributors;
- movement treatment and skin resurfacing performing separate jobs;
- collagen-focused treatment preceding refinement because tissue quality is the foundation;
- skin preparation before energy-based treatment because readiness changes risk and recovery;
- or staged care because one treatment needs to settle before the next decision can be made responsibly.

A combined appointment should make sense biologically as well as logistically.

The cumulative recovery burden matters. The patient’s tolerance matters. The interaction between treatments matters. The ability to distinguish what produced the result matters.

> **Combination care is not treatment stacking.**

If the reason for combining treatments is simply that both are available, the Method has not been applied.

10. Sequence is part of the treatment

The order of aesthetic care can materially change the logic of the plan.

Different treatments act on different structures and declare their effects over different timelines.

Swelling resolves. Neuromodulation develops. Hyaluronic acid integrates. Collagen remodeling evolves. Pigment clears. Barrier function recovers. Tissue response becomes more legible with time.

A treatment can therefore be appropriate in principle and still be wrong in sequence.

Structural support may deserve attention before refinement.

Skin may need preparation before energy.

Tissue quality may need to improve before a contour decision becomes clear.

Movement may be disproportionately important and change how much of a static concern remains after it is treated.

Previous filler may need to be assessed or corrected before new product belongs.

The patient's timing, recovery capacity and priorities can alter the order again.

The sequence should be an output of assessment, not a predetermined package.

> **Every treatment needs a job. Every sequence needs a reason.**

11. Time is clinical information

A staged plan is not an unfinished plan.

It can be a deliberate information-generating strategy.

This is one of the most important distinctions in the Method.

When treatment has had time to settle, the face provides new information.

The patient experiences the result outside the treatment room. Tissue swelling resolves. Movement is seen in ordinary expression. Collagen changes over time. Pigment response becomes clear. Skin tolerance becomes easier to judge. The patient may discover that the original concern feels less important, more localized, or different from what they expected.

That response can change the next decision.

What remains may be:

- smaller than expected;
- different from expected;

- more clearly attributable to another layer;
- appropriate for a second stage;
- or no longer worth treating.

Time is therefore not merely the interval between appointments.

It is part of the clinical read.

> **We do not rush the second decision before the first one has taught us anything.**

This principle also protects against the pressure to complete a conceptual plan simply because it was discussed at consultation.

A plan is allowed to change when the information changes.

That is not indecision.

It is longitudinal care.

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12. Reassessment: no autopilot

Aesthetic care happens over time.

The face changes. Skin changes. Health context changes. Previous treatments continue to evolve. The patient's priorities can change. A treatment that made sense six months ago may still make sense, but it should not be assumed to.

Reassessment is therefore part of the Method, not an administrative follow-up after the "real" work is finished.

Reassessment asks:

- What changed?
- What resolved?
- What still matters to the patient?
- What should now be protected?
- Did the first intervention change the need for the next?
- Does the original next step still cross the Treatment Threshold?
- Has medical history, skin condition, previous treatment or patient preference changed the plan?

Expected duration can inform when review is useful.

It cannot replace review.

> **Maintenance should preserve the thinking, not merely repeat the treatment.**

Maintenance is not the accumulation of everything a patient has ever done on a fixed calendar.

Sometimes the correct decision is repetition.

Sometimes it is a different dose, different area, different modality, different timing, or no treatment yet.

Sometimes the first intervention reveals that a second one is more useful than expected.

Sometimes it reveals that the second one is unnecessary.

The longitudinal pattern is intentionally cyclical:

> **Assess. Decide. Treat. Observe. Reassess.**

A good plan can become smaller, larger, different, paused or complete as new information appears.

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13. Preservation is an active clinical and aesthetic decision

Assessment is not a search for more defects.

The Method requires the practice to identify what already belongs and what should remain untouched.

Some movement belongs.

Some asymmetry belongs.

Some facial characteristics are not evidence of treatment failure or aging that needs correction. They are part of the person's recognizability.

This matters because the technical ability to change a feature can create a subtle pressure to treat it.

The Method creates an explicit counterweight.

The assessment should ask not only:

What could improve?

It should also ask:

What is already working?

What would be lost if this were changed?

What should remain unmistakably the patient's own?

Artistry begins after anatomy narrows the options.

It is the judgment of proportion, transition, expression, light, negative space and identity. It determines not just where to intervene, but how far refinement should go and when the face is better served by stopping.

> **We do not change faces. We restore structure.**

Results without announcement

The desired result is not invisibility of change.

It is invisibility of the procedure as the dominant thing another person notices.

A patient can look more rested, supported, balanced or coherent without looking as though the treatment itself has become a new facial feature.

The purpose is not to make change imperceptible to the patient.

It is to keep the person more visually important than the procedure.

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14. One Method across the practice

The skinalchemy Method™ was developed under the clinical leadership of Sonia Vilos, NP, but it is intended to function as a practice standard rather than a founder's personal treatment style.

That distinction matters.

A practice cannot credibly claim a shared Method if the framework disappears when the patient moves from one room to another.

Different practitioners bring different histories, scopes and areas of depth.

Those differences should not be flattened.

Sonia Vilos, NP leads the assessment philosophy, medical governance, prescribing and clinical standards within her scope.

Tina Nguyen, RRT brings respiratory-therapy and high-acuity clinical formation alongside aesthetic practice within the authorizing structure required for her role.

Alexandra Kingston brings more than two decades of skin and aesthetics education and practice, with depth in skin, laser, light and energy-based treatment.

Their credentials are not interchangeable.

Their capabilities overlap in some areas and remain distinct in others.

Shared patients are a normal part of the practice. One practitioner may lead one layer of care while another manages a different layer because the treatment job belongs to different expertise.

The plan can move between practitioners without becoming separate plans.

This does not mean every patient is jointly treated by all members of the team or that every case requires a formal case conference.

It means the clinical system is designed so that another perspective can be brought in when it improves the decision.

> **Different hands. One standard of reasoning.**

The Method should therefore be visible not only in language, but in behaviour:

- shared assessment concepts;
- clear professional scope;
- provider matching based on the job in the plan;
- documentation that records the reasoning;

- cross-consultation when another perspective belongs;
- treatment-specific boundaries;
- reassessment;
- and case evidence over time.

If the Method exists only in writing, it is branding.

If it changes how recommendations are made, documented and revisited, it becomes a practice standard.

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15. Clinical accountability without publishing the internal playbook

A public clinical framework should make the philosophy visible without disclosing the operational details that properly belong inside the practice.

The skinalchemy Method™ therefore names the reasoning standards that patients and other professionals should be able to understand, but it does not publish internal protocols, dosing decisions, treatment parameters, emergency procedures, device settings, competency documentation, delegated-act processes, detailed decision trees or staff training materials.

Those remain governed by professional scope, regulation, manufacturer instructions, clinical standards and internal practice procedures.

This boundary matters for two reasons.

First, a public philosophy should not be mistaken for a substitute for clinical training.

Second, rigor is not demonstrated by publishing operational detail simply to make a brand appear more medical.

The Method describes **how the practice thinks about whether treatment belongs**.

It does not teach another practitioner how to perform that treatment.

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16. The Method in documented cases

A clinical framework becomes more credible when its reasoning can be seen in actual care.

For that reason, case evidence will form an important companion body of work to this publication.

Version 1.0 intentionally establishes the framework before building the case archive around it.

Future editions may incorporate selected cases, and companion publications may be issued as **The skinalchemy Method™: Case Notes**.

Cases should be real, documented and published only with appropriate consent and privacy safeguards.

No fictional or composite patient should be presented as clinical proof.

The case grammar

The public case structure is:

> **READ / TREATED / PRESERVED / REASSESSED**

READ

What did the patient notice? What did assessment identify or rule out? Which contributor appeared most relevant to the concern?

TREATED

Which intervention earned a defined job, and what was it being asked to change?

PRESERVED

What was deliberately left alone? What expression, proportion, characteristic, tissue or treatment option was protected?

REASSESSED

What changed after the result settled? Did the original next step remain appropriate? Did the plan become smaller, larger, different or unnecessary?

A strong case should also be able to explain:

- what was intentionally deferred, declined, corrected or referred;
- why the sequence was chosen;
- whether another clinician became involved and why;
- what limitations remained;
- and what cannot be inferred from the result.

Before-and-after photography is evidence of change in one patient.

It is not evidence that the same result will occur in another patient, and it is not independent validation of the Method itself.

The purpose of the case series is more specific:

> **The photographs show what changed. The reasoning shows why the result matters.**

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17. The public compression

The full Method is deliberately detailed.

Patients do not need to memorize it.

The framework can be compressed without losing its meaning.

READ

Read what changed and what is contributing.

TREAT

Treat only what has a defined job.

PRESERVE

Preserve the expression, proportion and characteristics that already belong.

Then reassess what remains.

This compression is not a replacement for the full Method.

It is a patient-facing way to recognize the logic underneath it.

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18. What the skinalchemy Method™ is not

The Method is not:

- a proprietary medical diagnosis system;
- a validated scoring instrument;
- an algorithm that tells a patient what treatment they need online;
- a beauty score or eligibility test;
- a fixed step-by-step process every appointment must visibly follow;
- a dosing guide;
- an injection map;
- a device-setting protocol;
- a substitute for manufacturer instructions;
- a substitute for individualized medical assessment or informed consent;
- a claim that all facial aging is caused by skeletal change;
- an instruction to perform fewer treatments at all costs;
- an argument that surgery, dermatology or another specialty is inferior;
- permission to blur professional scope or credentials;
- a claim that access to more devices automatically means better care;
- or evidence that the framework itself has been externally validated as a clinical outcome model.

Interaction, technology and branding should not convert the Method into pseudo-diagnosis.

A patient should not be able to click through an online face map and be told which treatment they need.

A public framework can teach why one concern may have several contributors. It should not pretend to resolve clinical suitability without assessment.

The purpose of the Method is to make judgment explicit, not to make judgment look algorithmic.

19. A closing principle

The skinalchemy Method™ does not exist to make aesthetic medicine sound more complicated.

It exists to do the complexity before making the recommendation simple.

A visible concern deserves to be understood before it is assigned a treatment.

A recommendation should earn its place before it enters the plan.

A treatment should have a defined job.

A sequence should have a reason.

Time should be allowed to produce information.

Maintenance should begin with reassessment rather than repetition.

And every assessment should ask not only what could change, but what should remain unmistakably the patient's own.

> **Anatomy informs every decision. Art shapes the outcome.**

> **Structure first. Refinement always.**

> **We do not change faces. We restore structure.**

Framework provenance

The skinalchemy Method™ was developed from practice-based assessment and treatment-planning principles under the clinical leadership of Sonia Vilos, NP, and formalized into the named framework described in this publication in 2026. Public Version 1.0 constitutes the first public edition of the complete framework.

The publication record is intentionally versioned. Future revisions should identify material changes rather than silently replacing the framework first published in Version 1.0.

About the clinical framework lead

Sonia Vilos, BSc (Hons), BScN, MScN-NP, NP is an Ontario Nurse Practitioner, founder and Medical Director of skinalchemy in London, Ontario.

Her aesthetic practice is centred on full-face assessment, injectable medicine, biostimulation and regenerative medicine, correction and dissolution, facial ultrasound where clinically appropriate, and longitudinal treatment planning. Her advanced education has included facial and vascular anatomy, repeated cadaver study and ongoing professional education in aesthetic medicine.

The skinalchemy Method™ formalizes the decision principles developed under her clinical leadership and is intended to function as a practice standard rather than a personal treatment style.

This publication does not imply that Sonia personally performs every treatment available within skinalchemy. Different practitioners contribute different expertise within their respective roles, scopes and authorizing structures.

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Regulatory context

The Method operates within, and does not replace, the professional and regulatory requirements applicable to the people providing care.

Relevant public regulatory sources at the time of Version 1.0 include:

- College of Nurses of Ontario. *Aesthetic Services Practice Guideline.* 2026.
- College of Nurses of Ontario. Patient guidance on receiving aesthetic services from a nurse.
- College of Respiratory Therapists of Ontario. *Respiratory Therapists Working in Medical Spas.* Effective March 1, 2026.
- College of Respiratory Therapists of Ontario delegation resources.

Current legislation, regulator guidance, professional scope, manufacturer instructions and patient-specific clinical judgment supersede any general description in this publication.

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Clinical framework lead and author: Sonia Vilos, BSc (Hons), BScN, MScN-NP, NP
Role: Founder & Medical Director, skinalchemy
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1.0	August 2026	First public edition. Establishes the architecture worldview, patient observation, four assessment lenses, contributor logic, Treatment Threshold, defined treatment jobs, modality independence, sequencing, time as clinical information, preservation, reassessment, practice-wide standard and case-proof grammar.

This publication is intended to remain versioned rather than silently rewritten.

Material changes to the framework should be issued as a new version with a dated revision note. Minor typographic or formatting corrections that do not change meaning may be corrected without changing the version number.

Future documented cases may be published separately as **The skinalchemy Method™: Case Notes** and may later be incorporated into a revised edition with a clear version history.

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The public disclosure of this framework does not disclose skinalchemy's internal clinical protocols, treatment parameters, device settings, training materials, competency records, detailed decision trees, documentation standards or operational procedures. Those remain separate internal practice standards.

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The skinalchemy Method™ is a practice-developed clinical philosophy and decision framework.

It is not a validated diagnostic instrument, clinical practice guideline, treatment protocol, dosing guide, injection map or device-setting protocol.

It does not replace individualized assessment, informed consent, professional scope, manufacturer instructions, regulatory requirements, referral when appropriate or independent clinical judgment.

Treatment suitability, sequencing, risks, alternatives, recovery and expected outcomes vary by patient and must be determined through appropriate assessment.

No outcome is guaranteed.

The scientific references in this publication support underlying anatomical, assessment, multimodal-care and longitudinal-care principles. They should not be interpreted as independent validation of the skinalchemy Method™ itself.

The face is architecture. Aging is structural.
Anatomy informs every decision. Art shapes the outcome.
Structure first. Refinement always.