Volume 9, Number 1 Winter 2005

Aesthetic Society News

Quarterly Newsletter of The American Society for Aesthetic Plastic Surgery

ASAPS/ASERF Presidents Answer Questions on Advocacy, Education and Support for the Specialty

Aesthetic Society News (ASN) recently convened an informal Presidents' Roundtable with ASAPS President **Peter Fodor, MD**, ASERF President **Jeffrey Lang, MD**, and three invited ASAPS members. Fred Hackney, MD, *ASN* Editor, invited each participating member to address three issues of current importance to the ASAPS membership. Members were chosen whose collective volunteer roles in the Society covered education, administration/finance and communications, and asked to focus their questions on the specific area in which they're personally most involved.

Participants were **Paul Faringer, MD**, Kailua Kona, HI, Vice Chair of the ASAPS Symposia Committee, Co-Chair of the Residents & Fellows Forum Subcommittee, and a member of the Program Committee; **Leo McCafferty, MD**, Vice Chair of the Administrative Commission; and **Michael McGuire, MD**, Vice Chair of the Communications Commission and Chair of the Public Education Committee.

Dr. McCafferty: *The Aesthetic Society has been fortunate to be able to maintain a very strong financial position, relative to its size and scope of activities. What is the significance of ASAPS' success, and what does it suggest about future trends in our specialty?*

Dr. Fodor: When ASAPS was founded in 1967, there was only a relatively small group of surgeons who believed in what it stood for. There was a lot of resistance to the idea of a subspecialty organization devoted to cosmetic surgery. But the times have changed. Today, our specialty is defined by, and really is dependent on, aesthetic surgery more than any other branch of plastic surgery.

"It's the job of ASAPS leadership to balance the needs of ASAPS members with the needs of the specialty, because we have an obligation to serve both."

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The American Society for Aesthetic Plastic Surgery

The Aesthetic Surgery Education and Research Foundation

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Send address changes and membership inquiries to Membership Department, American Society for Aesthetic Plastic Surgery, 11081 Winners Circle, Los Alamitos, CA 90720. Email asaps@surgery.org.

ASAPS Website
www.surgery.org

ASERF Website
www.aserf.org

ASAPS Calendar

ASAPS Meetings & Co-sponsored/ Endorsed Events

The Aesthetic Meeting 2005
April 28 - May 4, 2005
New Orleans Convention Center
New Orleans, LA
Contact ASAPS 800.364.2147
or 562.799.2356
Email: asaps@surgery.org

21st Annual Breast Surgery Symposium
January 20-23, 2005
Grand Hyatt
Buckhead, Atlanta, GA
Endorsed by ASAPS
Contact: Elaine M. McCubbin 703.820.7400

10th Annual New Horizons in Cosmetic Surgery Symposium
January 28-30, 2005
Renaissance Esmeralda
Indian Wells, CA
Co-sponsored by ASAPS/PSEF
Contact: PSEF 800.766.4955

39th Annual Cosmetic Surgery Symposium
February 3-5, 2005
Miami, FL
Endorsed by ASAPS
Contact: Mary Felpeto 305.859.8250

Recent Advances in Cosmetic Surgery &
22nd Annual Dallas Rhinoplasty Symposium
March 3-6, 2005
Dallas, TX
Endorsed by ASAPS
Contact: Jennifer Leedy 214.648.3792

Body Contouring After Massive Weight Loss Symposium
April 1-3, 2005
Dallas, TX
Co-sponsored by ASAPS/PSEF
Contact: PSEF 800.766.4955

SPSSCS 11th Annual Meeting
April 25-28, 2005
New Orleans, LA
Contact: SPSSCS 562-799-0466

President's Report *Mobilizing for Change: The Patient Safety Imperative*


Peter B. Fodor, MD

Recently, in a conversation with several Aesthetic Society members on the East Coast, I was asked why, during the first half of my presidency, I have focused so much effort and attention on the issue of patient safety. "After all," a member said, "it's the other guys -- not our members -- who cause most of the problems, and there's not much we can do about that." I agree wholeheartedly that Aesthetic Society members have been among the leaders in patient safety for nearly four decades. That is exactly why it is so important for us now to continue that leadership in a very proactive way -- for the wellbeing of our patients and for the continued success of our individual practices.

Proactive Versus Reactive: Lessons from the Past

We have learned from the past that being *proactive* is more effective than being *reactive*. That's why I wasted no time last spring in appointing Dr. Felmont Eaves to chair a new Patient Safety Steering Committee, mobilizing the best talent from across the entire committee structure of our organization and engaging them in a cohesive effort to address patient safety on a number of levels. In fact, the motivation for creating this group as a steering committee with representation from our Education, Communications and Administrative Commissions -- rather than a committee within a single commission -- was to better develop and refine a "culture of safety" permeating every facet of our organization.

The landscape of aesthetic surgery practice is changing rapidly, and it is imperative that Society members retain their position of leadership. We have learned important lessons; the challenge is to transform what we have learned into definitive and timely action:

The media often creates a perception that plastic surgery is unsafe and does little to educate the public about the most common factors that can lead to negative outcomes.

Countering the Negative with Positive Change

We have seen what happens when the media gets hold of a negative story about cosmetic surgery. It's their job to create controversy and drama -- that's what drives ratings -- while fairness and balance may sometimes take a back seat. This often creates a perception that plastic surgery is unsafe, and does little to educate the public about the most common factors that can lead to negative outcomes -- such as inadequately trained practitioners, unaccredited surgical facilities or medical risks that are common to all types of surgical procedures.

Our job now is to create, maintain and document a "culture of safety" in our collective practices that can be the source of positive information for the media and the public on cosmetic surgery outcomes and enhanced patient care. We will do this through education, research and outreach.

- **Member education**

First, we have established a new requirement of 20 hours of CME credit in patient safety every three years, consistent with the requirement established by the American Society of Plastic Surgeons (ASPS). The Patient Safety Steering Committee, together with our Members-Only Website Steering Committee chaired by Dr. Charles Hughes, is actively engaged in creating online education activities to help you meet this new requirement. Our Education Commission is also involved in developing new course material for the ASAPS/ASERF Annual Meeting next spring in New Orleans.

- **Data collection**

Second, the Patient Safety Steering Committee is

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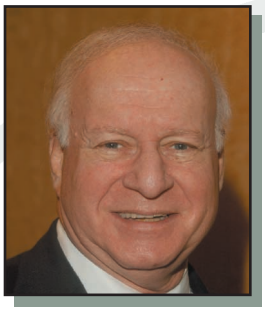
ASAPS/ASERF Presidents Answer Questions
(Continued from page 1)

This will continue in the foreseeable future. Much of the reason why plastic surgery still maintains its leadership in the aesthetic arena is because of the education that ASAPS has provided for nearly 40 years. So it stands to reason that the Aesthetic Society should be, and will remain, in the strong position that it is today. Now it's up to us to use our considerable strength to help make sure that board-certified plastic surgeons continue to be recognized as the leaders in aesthetic surgery.

Dr. McCafferty: *ASAPS has recently taken an active role in advocacy efforts regarding state legislation on scope of practice, malpractice tort reform and cosmetic surgery taxation. Is this a new area of activity for ASAPS, which traditionally has been focused almost exclusively on aesthetic surgery education, and how do you see future advocacy efforts impacting the Aesthetic Society's mission and finances?*

Peter Fodor, MD

Dr. Fodor: Advocacy is not a new role for ASAPS, but our commitment to advocacy efforts has increased significantly to meet the current challenges facing plastic surgery on both the national and state level. Without exception, the advocacy issues that we have supported are those having direct impact on aesthetic surgery patient safety and patient care, and so ASAPS *must* be involved. ASAPS' goal is to be a team player. We believe that the coalitions in which we have participated with the American Society of Plastic Surgeons and others are the most effective means to deal with many of these problems. Our recent membership survey showed that the majority of ASAPS members support our current level of financial commitment to advocacy efforts. We believe that our finances can support at least this level of contribution going forward, with no negative impact on our development of quality aesthetic education for board-certified plastic surgeons -- which, of course, remains our core mission.



Jeffrey Lang, MD

Dr. Lang: The commitment that ASERF has made to its members is that 100 percent of member-donated funds go toward aesthetic surgery research. But this doesn't mean that ASERF shouldn't play a role in advocacy. When an additional voice for plastic surgery has been needed to present our positions, ASERF has been a valuable asset, and I foresee us continuing to take part on that basis when asked to do so.

Leo McCafferty, MD

Dr. McCafferty: *Some have suggested that plastic surgery specialty societies should perhaps be "integrated" under one unified umbrella. How does the leadership of ASAPS and ASERF view this concept, and what benefit, if any, would it provide to plastic surgery?*

Dr. Fodor: Frankly, I don't know of anyone involved in plastic surgery who doesn't want to see all the organizations within our specialty truly united in purpose and making the most efficient use of our collective resources. And I believe that a lot of progress has been made and continues to be made. ASAPS has engaged in ongoing dialog with ASPS and others within the plastic surgery community about how we can maximize our effectiveness, jointly and independently. We've initiated a number of significant proposals designed to help achieve these goals. It's the job of ASAPS leadership to balance the needs of ASAPS members with the needs of the specialty, because we have an obligation to serve both. ASAPS members would not be well served by losing control of their

organization -- either philosophically or financially -- but they clearly support our joint efforts with ASPS and others to strengthen the specialty. ASAPS is absolutely committed to this kind of cooperation and support.

Dr. Lang: I would echo what Dr. Fodor has said, but also add that ASERF was created because many of us felt that not enough funding from plastic surgery was being directed toward aesthetic research. ASERF fills a much-needed niche that is even more important today than it was 10 years ago.

Paul Faringer, MD

Dr. Faringer: *The recent ASAPS survey demonstrated that our members overwhelmingly look to ASAPS for their aesthetic education, both in terms of national meetings and regional symposia. How does ASAPS plan to stay ahead of the curve in developing innovative opportunities for aesthetic education, and what role will ASERF play?*

Dr. Lang: Some of ASERF's currently funded research is directed toward enhanced technologies to aid in aesthetic surgery education via the Internet and other electronic learning tools. It's very exciting to me, personally, and I firmly believe these innovations will impact aesthetic education in a major way.

Dr. Fodor: I agree with Dr. Lang that the Internet offers many opportunities for ASAPS members. Even right now, on our ASAPS Members-Only Website, we have a variety of videos of surgical procedures and sessions from our most recent annual meeting that are available to members instantaneously, on demand. This is a tremendous member benefit. At the same time, we haven't lost sight of the importance of the personal contact our members have with one another at our annual meetings and our co-sponsored symposia programs. It goes without saying that the most important aspect of ASAPS education is the outstanding faculty that we provide for all our meetings and co-sponsored events. At the same time, it's vital that all these programs keep pace with the rapid changes in communication technology so that we continue to deliver the most stimulating educational experience possible. Our Education Commission, led by Jim Stuzin, is right on top of this and getting ready for a spectacular educational program in New Orleans.

Dr. Faringer: *Membership in the Aesthetic Society has always been reserved for those plastic surgeons with proven interest and experience in aesthetic surgery. Yet, there is an acknowledged need to incorporate young plastic surgeons into the organization and to give these young surgeons the opportunity for further education and leadership. How does ASAPS plan to do this without compromising its membership standards?*

Dr. Fodor: ASAPS already is doing this very successfully. First, we initiated our candidate program, which currently has more than 700 plastic surgeons. To increase the involvement of candidates and really understand what they are looking for in their future ASAPS membership, we have invited many to serve on ASAPS committees. We have created a young leaders' group, and the members of this group are invited to sit in on some of the high level meetings of the ASAPS Board and Executive Committee. But I think the most important thing ASAPS does to ensure its future high standards of membership is to provide education. Remember, ASAPS has always made its educational programs available to all board-certified plastic surgeons, not just its own members. This opportunity for ASAPS education enables many young surgeons to go out and build a more successful aesthetic practice earlier in their careers. We see an intense interest in ASAPS membership among young plastic surgeons, who rightly view it as a prestigious symbol of their ongoing education and clinical accomplishments in aesthetic surgery.

Dr. Faringer: *Some of ASAPS' recent advocacy efforts have brought the Society into closer contact*

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with other specialists who share certain common interests with ASAPS members, including the desire for aesthetic surgery education. What is the likelihood that the ASAPS/ASERF annual meeting might eventually be opened up to other specialists -- for example, the ENT/facial plastic surgeons?

Dr. Fodor: As you know, we already have been including a number of excellent ENT/facial plastic surgeons as panelists and lecturers at our meetings. I hope that such collaboration among the best of their specialty and the best of ours will continue. But it's understood that our first priority is to serve our members and others within our own specialty. Our meeting surveys and member surveys tell us that those who attend ASAPS meetings don't want them to get too big and don't want them to change their character too much. Part of the incredible dynamics of the ASAPS meeting is a function of its relatively modest size. So, at least for now, we don't see a way to adequately serve our own constituencies and at the same time be more inclusive on a broad scale. I think it's very positive, though, that we are now working on our fourth joint rhinoplasty symposium with the American Academy of Facial Plastic and Reconstructive Surgery, the American Academy of Otolaryngology and ASPS.

Dr. Lang: Speaking for ASERF, we welcome and encourage the support of other specialists in our research mission. Our ultimate goal is to benefit patients, and research is an area in which collaboration among different specialists is often the most successful.

Michael McGuire, MD

Dr. McGuire: *Public education has been a vital part of ASAPS' mission for more than 15 years. Yet some have questioned whether "competition" between ASAPS and ASPS in the area of public education is healthy for the specialty. Would plastic surgery be better served by having ASAPS and ASPS speak with "one voice" to the media?*

"There's no doubt that the Aesthetic Society's prominence in the media has helped to effectively diffuse the argument that board-certified plastic surgeons are 'generalists' rather than the recognized leaders in aesthetic surgery."

Dr. Fodor: There's no doubt that the Aesthetic Society's prominence in the media has helped to effectively diffuse the argument that board-certified plastic surgeons are "generalists" rather than the recognized leaders in aesthetic surgery. This year, serving as ASAPS President, has given me a real insider's view of the public education activities of our Society, as well as a better understanding of how the media get their information. I firmly believe that plastic surgery is stronger by having both ASAPS and ASPS providing unique, yet supportive, information to the press and the public. Reporters always look to more than one source for information. By having two separate and strong voices representing plastic surgery, we are better able to influence media coverage. There are occasions when it's beneficial for us to issue joint statements or opinions, but for the most part it works well for us to contact the media independently. Our key messages work in tandem.

Dr. McGuire: *One of the most frequent comments from members is that the public still doesn't understand the difference between "us" -- meaning American Board of Plastic Surgery certified surgeons -- and physicians without this vital credential who promote themselves as cosmetic surgery specialists. How can plastic surgery be more successful in educating the public about why they should choose a board-certified plastic surgeon?*

Dr. Fodor: This is, of course, an immense challenge, but I believe we've made progress. I have seen many more articles and broadcasts that include guidelines on selecting a qualified surgeon, often provided by ASAPS or by ASPS. Our best and most cost effective direct

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Improving Patient Safety By Implementing A Systems-Driven Process

By Mary Lind Jewell, RPT

Issues of safety in aesthetic surgery have always been dynamic in nature, fluctuating from patient to patient and constantly evolving. Now, we also have to deal with a changing patient population. Since aesthetic surgery is elective, plastic surgeons have historically operated on healthy patients. However, the patient profile is expanding, especially for certain procedures, to include people in their 70s who want to recapture a youthful appearance, teenagers with expectations of looking like super models, and other groups who, traditionally, have not been plastic surgery candidates. Patients seeking aesthetic surgery after massive weight loss are a good example of an emerging consumer group.

Reality television has fueled interest in plastic surgery by creating expectations for spectacular outcomes that are challenging for aesthetic plastic surgeons and their staff. Due to the hype created by reality television, patients are beginning to insist on combined procedures that could significantly raise the risk of complications.

Are new rules and standards necessary?

Does this quick fix require a new set of safety rules with risk factors extending beyond those by which aesthetic surgery has traditionally abided? Do we need new standards for improving patient safety for potentially higher risk groups? As health care practitioners concerned with the health and well-being of patients it seems appropriate to ask, "Are we pushing the envelope too far to serve patients, and do new standards need to be set to ensure the safety of those patients with less than perfect health?"

"Primum no nocere"

First, do no harm. Health care today harms too frequently and routinely fails to deliver its potential benefits, according to the Joint Commission on Accreditation of Healthcare Organizations.[1] Patients should be safe from injury caused by the care delivery system. Reducing risk and ensuring safety requires greater attention to systems that help prevent and mitigate errors. Healthcare systems frequently fall short due to the inability to translate knowledge into practice and apply technologies safely and appropriately.

In the past, the envelope was pushed to the limits with regard to lipoplasty. The death rate from lipoplasty increased and patients died from a surgery that is purely cosmetic. With intense educational initiatives on the part of this specialty the death rate from lipoplasty dropped to one in 50,000.[2] Any death caused by medical care is tragic. Education and setting parameters for safety are imperative to ensure that potential risks are kept as low as possible.

Developing a systematic approach to safety

I have found that a practice-wide, systematic approach works extremely well in creating a culture of safety throughout our office. Here are some of the methods we have used successfully to reduce errors and design patient care processes engineered for safety:

(1) Make an unequivocal commitment to patient safety that puts the patient at the center of the entire process.

(2) Make patient safety a leadership and management priority.

(3) Implement recognized safe practices using evidence-based care processes that incorporate human factors and algorithms of care.

(4) Be accountable. Initiate routine audits for patient safety hazards. Focus on high risk areas for quality improvement.

(5) Define specific accountabilities for staff with regard to patient safety. Recognize and deal immediately with professional misconduct or underperformance.

(6) Support efforts to create a non-punitive environment for error reporting.

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Teenagers and Plastic Surgery

By Martha J. Drezin

Those three little words, "Teenage Plastic Surgery" can be incendiary. Now that plastic surgery is served up as mainstream entertainment, the intrigue, curiosity and emotional investment surrounding this field has increased in geometric proportions. In the media plastic surgeons are depicted on a wide spectrum, invested with godlike attributes at one end and mercenary motives at the other.

Media reports of significant increases in teen cosmetic surgery can be misleading. In 1997 there were 43,503 surgical procedures for those 18 and under and in 2003 there were 66,142 surgical procedures for the same population. However, the 18-and-under age group had 3.6 percent of all cosmetic surgical procedures in 2003 contrasted with 4.19 percent of all cosmetic surgical procedures in 1997.[1]

What procedures do our members actually perform in teens? How do we handle the consultation process with this labile group? ASAPS members Laurie Casas, MD, Glenview, IL; Claudio C. de Castro, MD, Rio de Janeiro, Brazil; Alan Gold, MD, Great Neck, NY; Foad Nahai, MD, Atlanta, GA; and Kitaro Ohmori, MD Tokyo, Japan share their experiences and insights.

Age counts

Dr. Gold stresses that age counts. Six years may not seem like a very long time, but in an adolescent there is a tremendous physical and emotional evolution between the ages of 13 and 19. Procedures that may be reasonable in later teen years may be unreasonable in the earlier teen years, depending on physical or emotional development. Appropriate aesthetic procedures for younger teens (even as young as 13) include otoplasty and, less commonly, rhinoplasty and, even less commonly, gynecomastia reduction and chin augmentation. For 14-year-olds, and certainly 15-, 16-, and 17-year-olds rhinoplasty and gynecomastia reduction are more common, and chin augmentation becomes more reasonable as the growth potential of the chin becomes apparent.

Breast surgery in teenage girls is not uncommon, but in the mid-teen group it is usually breast reduction either for bilateral hypertrophy or, occasionally, asymmetry. Sometimes a unilateral breast augmentation may be performed in this age group to correct a true congenital deformity. Eighteen- and 19-year-olds are treated essentially as young adults with adult bodies and, hopefully, young adult emotional stability. Breast augmentation surgery is FDA-restricted to patients 18 years of age or older. According to Gold, "Lipoplasty, except in extraordinary and unusual cases of true lipodystrophy, is not indicated in anyone less than 18 years of age." Dr. Casas is in agreement, but she will perform submental lipoplasty in teens assuming that their body weight is normal and, therefore, not a contributing factor. She will also perform lipoplasty on the outer thigh in emotionally mature 17- and 18-year-olds assuming that the defect is not caused by excessive weight.

Six years may not seem like a very long time, but in an adolescent there is a tremendous physical and emotional evolution between the ages of 13 and 19.

Physical requirements for teenagers vary according to the procedure and deformity. Otoplasty may be performed in children before they become teenagers. In children with emotionally and socially debilitating nasal, chin and breast deformities, surgery may be performed even before growth is complete.

Dr. Nahai has a double standard for the age at which he performs rhinoplasty. For girls, he will perform rhinoplasty at age 14 or 15 assuming the teen has the maturity to understand what is involved. For boys, he usually waits until they are 17 or 18.

In Brazil, Dr. de Castro follows guidelines that are similar to the ones followed by national members. "For teens I usually perform breast augmentation after 18; breast reduction after 16; lipoplasty after 17; gynecomastia, usually after 17; and rhinoplasty, rarely before 16.

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exploring research projects including a "no risk" reporting system to obtain data on safety and complications in plastic surgery. Whether this will be done in conjunction with other organizations or independently by ASAPS/ASERF remains to be determined.

• Media outreach

Third, we have already implemented an expanded outreach to the media highlighting current patient safety information and consumer advisories. You can view some of these materials in the Press Center of the Aesthetic Society website at www.surgery.org/press. This is only the beginning of what will be an ongoing stream of information to the media emphasizing positive aspects of patient safety in plastic surgery.

Taking the Offensive on Advocacy

We have seen what happens when medical professionals, legislators and the public are asleep at the wheel, and dentists use their numbers and influence to expand their scope of practice, potentially putting patient safety in jeopardy. Only our recent actions, along with those of ASPS and others, kept this scenario from repeating itself in California last summer.

• Patient safety and access to care

Our job now is to continue advocacy efforts on behalf of patient safety, both nationally and in specific states that face challenges to safe cosmetic surgery practice. Our focus remains on requiring appropriate certification for physicians performing cosmetic surgery and on mandatory accreditation of surgical facilities. We also will continue to actively oppose measures that threaten to limit patient access to safe cosmetic surgery performed by qualified surgeons -- whether due to the imposition of unwarranted taxation on cosmetic surgery, unreasonable malpractice awards or ill conceived restrictions on accredited office-based surgical facilities with excellent safety records. In our recent ASAPS membership survey, you told us that you support these continued advocacy efforts by the Society, and we believe that ASAPS can make a difference.

Educating Our Patients

We have seen how "reality" TV shows on plastic surgery have trivialized the seriousness of surgery, raised patients' expectations and blurred their judgment when it comes to the amount of surgery that is safe and reasonable for them to request.

We have seen what happens when medical professionals, legislators and the public are asleep at the wheel, and dentists use their numbers and influence to expand their scope of practice.

• Tools for better communication

Our job now, through patient education materials being developed for our members' offices and websites, is to tackle the difficult task of explaining in clear and simple terms why patients must have realistic expectations about their plastic surgery. Most important, patients must understand the safety issues involved in cosmetic surgery and be able to evaluate risk. Finally, we need to do a better job communicating why patients should select an ASAPS member. I believe that patient safety is perhaps the most compelling reason of all.

Cultivating a "Culture of Safety"

The work of the Patient Safety Steering Committee covers a broad range of issues and focuses on the most significant aspects of ASAPS' mission -- education of our members and education of the public. I believe that we have created an organizational structure, through our new steering committees for patient safety and the members-only website, which can effectively address this wide scope of activity -- from education to communication. With your support, we can promote a "culture of safety" in our collective practices that is measurable, verifiable and is an effective tool for enhancing clinical outcomes, advocating for legislative change and educating the public.

Our job now is to continue advocacy efforts on behalf of patient safety, both nationally and in specific states that face challenges to safe cosmetic surgery practice.

The work of the Patient Safety Steering Committee ... focuses on the most significant aspects of ASAPS' mission -- education of our members and education of the public. ■■■

Cosmetic Surgery and the Law

Waking During Surgery: More Sensationalism or a Serious Issue?

"Anesthesia awareness is under-recognized and under-treated in health care organizations." This October 6, 2004 Sentinel Event Alert from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) received immediate nationwide coverage, thereby elevating the issue from a long-standing patient safety concern into a promising source of litigation (National Law Journal 11-15-2004). Although anesthesia awareness is infrequent, surgical patients who are awake and feeling pain but paralyzed tend to create sensational headlines.

Memories are grouped as explicit or implicit; the former involve awareness with recall, while the latter involve emotional responses without the ability to identify the original stimulus. Due to patient credibility, media interest has focused only upon awareness with recall, such as Carol Weihrer, President and Founder of The Anesthesia Awareness Campaign, Inc. (www.anesthesiaawareness.com) who was awake for the removal of a diseased eye, or Jeanette Liska's graphic account of her 1990 abdominal surgery in the book, "Silent Screams", published by the American Association of Nurse Anesthetists (AANA Publishing, Inc.).

The JCAHO Alert identified patient awareness as "under recognized"; anecdotal accounts are less generous, often revealing physician and nurse disbelief until confronted with hard evidence, such as one heart patient recounting conversations and reciting where the different members of the medical team had stood, or Jeannie Smith who recalled, while having her ovaries removed, that the doctor took phone calls from his wife and daughter during the surgery, resulting in a $150,000 jury verdict.

The actual incidence of patient awareness is low, and indications are that it is dropping.

Although anesthesia awareness is infrequent, surgical patients who are awake and feeling pain but paralyzed tend to create sensational headlines.

The actual incidence of patient awareness is low, and indications are that it is dropping. The American Society of Anesthesiologists (ASA) estimates that awareness occurs in only one-fifth of one percent of all surgeries (0.2%); somewhat less compassionately, the ASA Patient Awareness brochure warns against "false memories" and only suggests psychological counseling in cases of "distinct recollections of your surgery." A 1991 study of 1000 patients put the incidence at 0.2%, but a 2000 study reported in Lancet of 11,785 patients placed the incidence at a much lower 0.0015%.

Despite this statistically infrequent incidence, patient awareness nevertheless accounted for 1.9% of American claims against anesthesiologists, and 12.2% of British claims. However, only one such patient claim has been reported at the appellate level: Michael McCulley (McCulley v. Good Samaritan Hospital [1998-Ohio]) who was awake for removal of a throat lesion due to the anesthesia equipment failing to deliver any desflurane. However, following the 2003 FDA approval of the Bispectral Index (BIS) monitor and the recent JCAHO Alert, the media have revealed numerous lawsuits that will invite further legal scrutiny, as well as technological advances to avoid lawsuits.

No existing technologies have yet to provide proof positive against the occurrence of awareness. However, the ASA, FDA and JCAHO Alert acknowledge that the following technologies show promise: electroencephalography (EEG) devices, also called level-of-consciousness, sedation-level and anesthesia-depth monitors, including spectral edge frequen-

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Improving Patient Safety By Implementing a Systems-Driven Process (Continued from page 7)

(7) Increase patients' awareness and accountability for their own safety.

Procedure documentation: simple is better

Systems are engineered or developed from feedback and experience that allows the staff to discern problems and create algorithms of care to facilitate safety mechanisms. Forms are developed by you and your staff to assess medical history, risk profile and suitability for specific procedures. These forms provide for a review of systems and allow you to document such important facts as allergies, medications, herbals and smoking history. System check lists are more likely to uncover a potentially fatal history of cardiac arrhythmias or deep vein thrombosis.

Goals must be realistic and achievable

For your forms to be effective they have to be used by your staff. That's why the best forms are simple, clearly documenting how clinical decisions are made and quality care is delivered. These forms should compliment your normal work routine. Do not raise the bar so high that you cannot achieve your objectives. These patient safety documents need to be readily accessible to each care provider in your office and promote staff understanding of the patient's needs.

Making informed consent a seamless process

Informed consent must be a seamless process in your office, making information available to patients and families that allow them to make informed decisions. You will have better patient compliance if you deliver pertinent information in a form that can be read and understood by all. During the consultation, develop a written plan to which you and the patient agree. A nurse should then give the patient both the consent for surgery and pre- and postoperative instructions with the understanding that the patient is required to read the forms and can ask further questions during the preoperative appointment. After the patient signs the consent forms, the doctor and/or nurse should also sign a form stating that, in their judgment, the patient understands the procedure, alternatives and risks of surgery and that any further questions have been answered satisfactorily.

Knowledge management

It is the responsibility of the entire staff to promote patient safety by collaborating and communicating to ensure an excellent exchange of information and coordination of care. Ask your staff if they know your position on the issue of "how much surgery is too much." Can your staff articulate what procedures you will not undertake if the potential patient smokes? If your office received a call from a patient who was one week postoperative from an abdominoplasty and was experiencing shortness of breath or lower extremity discomfort, would your receptionist know how you would like her to handle the call? If the person being seen in consultation is taking three anti-depressants and one is an MAO inhibitor, does your nurse know how you would treat this patient? If a member of your staff suspects the patient will not have adequate postoperative care, is there an established protocol to proactively deal with the problem?

Empower your staff to troubleshoot patient safety issues. For example, if you tell your nurses about drugs that cross-react with sulfa allergies such as Celebrex and Bextra, then your staff will be more vigilant for the possibility of life threatening reactions.

Audits and surveys

Audits and surveys are essential assessment tools that should be developed with the goal of minimizing your mistakes. From these tools, you can learn important lessons from the mistakes that are made. We regularly perform audits to document the quality of our medical care. Here is an example of four issues that are audited from our OR records:

- Informed consent given.
- Prophylactic antibiotics administered 45 minutes prior to surgery.
- DVT prophylaxis used.
- Postoperative education of the patient's caregiver is provided.

The accountability of the staff is measured best with audits. Q&A that is done routinely prevents staff from overlooking important details and obviates the need for "archeological digs" to discover missing records when it is done only at the time of purging records.

Encourage patients to be part of the process

As healthcare practitioners, we should encourage shared decision making with staff, patients and caregivers. Patients should be given information and the opportunity to exercise a degree of control over healthcare decisions. They also must participate in and be accountable for their own safety. It is important to document the extent to which patients participate in their rehabilitation process postoperatively. Surveys allow patients an opportunity to provide feedback to the healthcare system, and they help practitioners provide continuous quality improvement. Surveys work to improve the quality of care, especially if you treat patients who probe and ask questions as valuable consultants.

Safety as a continuous improvement strategy

Develop a system of reliable checks to promote patient safety. Promote team work and shared collaboration among staff with responsibility for patient advocacy and reducing errors. Evidence-based decision making should be well documented in each patient's chart and easily accessible on a few important forms. Patients should receive care based on the best available scientific knowledge and should be provided with whatever is necessary to ensure that they can make informed decisions. Increase consumer confidence and ensure better compliance by getting patient agreement on safety issues. Establish criteria for patient safety and audit the chart to ensure it is working. Regularly survey your patients about issues of their safety and be open-minded about changing policies and procedures to facilitate continuous quality improvement. ■■■

Reference

[1]Weaving the Fabric: Strategies for improving our nations health care. Available at www.jcaho.org.

[2]Hughes CE. Reduction of lipoplasty risks and mortality: An ASAPS survey. *Aesthetic Surgery Journal* 2001; 21:120-127.

Mary Lind Jewell, RPT has managed the practice of Mark Jewell, MD for the last 25 years. She has taught multiple courses on practice management, finance, personnel, and service delivery at ASAPS Annual Meetings and at the ASAPS Resident and Fellows Forum.

Teenagers and Plastic Surgery (Continued from page 9)

Teenagers, with their unflagging faith in their own immortality, may need to hear about possible complications a second or third time since they have difficulty accepting that such complications can actually happen to them.

You can't measure emotional maturity wth a caliper

All of the ASAPS members interviewed stress the necessity of emotional maturity in their teen patients. Without it a teenager may have very unrealistic expectations regarding plastic surgery.

Dr. Casas has a sure-fire way to test the maturity of a teen who desires a breast reduction. She asks the teen if they would prefer to weigh 20 pounds less. If the answer is "yes," Dr. Casas responds that it makes no sense to do the surgery before the weight loss. She explains that if she reduces the breasts now the patient will most likely have breast ptosis after the weight loss leading to a secondary procedure. If the patient replies, "Thank you, I did not know that; I'll go home and lose the weight first," Dr. Casas considers her mature. If, however, the patient is unwilling to go this route, Dr. Casas will not undertake the surgery.

Dr. Gold says that emotional stability is crucial in any patient, regardless of age. He contends that there are teenagers who are more emotionally mature than some adults. He does not use an objective screening procedure or standardized psychological test to evaluate patients, but depends on his judgment. "I also do not hesitate to defer surgery to a later date or reject outright patients who I feel are inappropriate candidates for surgery……at any age." Contrary to opinions that teenagers, with their so-called evolving body image, have greater difficulty adapting to a new or altered feature, Gold has found that, if he carefully screens them, teenagers often adapt more quickly to the frequently dramatic appearance changes after rhinoplasty and chin augmentation than adults who have the same procedures.

Listen carefully

Considering teenage emotional lability, hormonal surges, and peer pressure as well as preoccupation with headphones, cellphones and blackberries, ASAPS members were asked, "How do you get teenagers to listen adequately to get a realistic notion of the surgical procedure, postoperative experience, and results?" Interestingly, what our members stress is the importance of listening to these young patients.

Dr. Ohmori listens vigilantly to ferret out those teens with unrealistic expectations. "Such expectations may stem from psychiatric, personal, or developmental problems." For these patients, he uses a psychiatric consult.

He frequently deals with teenagers seeking the "double-eyelid" operation. Both single and double upper eyelids are considered normal, but double-eyelids are recognized as more attractive in recent years. Most teenagers are quite pleased with the results of the double-eyelid operation. The problems arise with teenagers who want to look like Western film stars. "In patients who desire a total westernization of the face, we really question their motives. They may have highly unrealistic expectations of the results of such surgery. It is forbidden to perform such operations based on my ethical code."

Dr. Gold explains "I speak *with* and not just *to* the patient, and try to really listen to what they say and evaluate how they express their concerns and desires. I listen to find out if the perceived defect is real or imagined, is an appropriate focus for the patient, and if the magnitude of the concern is proportionate to the reality of the deformity or problem. Then I explain to the teen, in great detail and with comprehensible language: (1) what is involved in the surgery and postoperative period; (2) what the risks and benefits are; (3) what the patient may realistically expect; and (4) the need for patience until activity restrictions are lifted, bruising and swelling subside, and the final result is seen. Teenagers, with their unflagging faith in their own immortality, may need to hear about possible complications a second or third time since they have difficulty accepting that such complications can actually happen to them."

[CONTINUED ON PAGE 16]

Introducing an ASAPS Members-Only Exclusive:

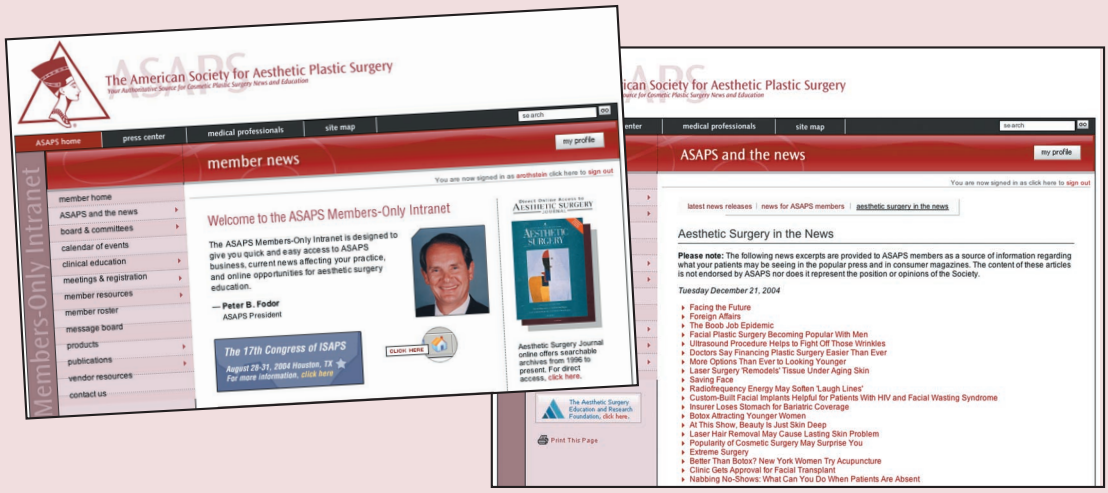
Aesthetic Surgery in the News

The newest feature on the Aesthetic Society's Members-Only Website is **"Aesthetic Surgery In the News."** This timely service provides you with succinct summaries of the most prominent plastic surgery-related articles presented in the national and international media. These are the same articles your patients read in popular consumer publications and then ask you about.

This exclusive service accesses more than 7,000 news sources, from consumer magazines to scientific journals to government publications; summarizes the most relevant stories, and delivers them directly to your ASAPS Members-Only Website every month.

In order to find and read all of these articles on your own, you would need to subscribe to hundreds, perhaps thousands, of publications and then sift through each one to find those articles pertinent to your practice. The Aesthetic Society is providing you with this valuable service **to save you the time and money it would take to find and read these articles.**

Each month, you'll receive an e-mail notice containing abstracts from stories and a link to the page on your Intranet with other abstracts of recent news articles. You'll also find an archive of past articles listed by surgical procedure.



Recent Abstract Titles from *Aesthetic Surgery In the News* include the following:

The Boob Job Epidemic, *Cosmopolitan* (2004-12-01)
Ultrasound Procedure Helps to Fight Off Those Wrinkles, *Herald-Dispatch* (2004-11-22)
Insurer Loses Stomach for Bariatric Coverage, *Crain's New York Business* (2004-11-15)
Better Than Botox? New York Women Try Acupuncture, *Reuters* (2004-11-04)

To read the latest abstracts, go to www.surgery.org/members, scroll down to *ASAPS and the News* and click on *Aesthetic Surgery In the News.*

If it pertains to the practice of aesthetic plastic surgery, you'll find it on our website, devoted *exclusively* to the unique needs of your aesthetic plastic surgery practice.

In a teen not all procedures are created equal

The most common procedures performed in teens, 18 and under, are rhinoplasty, breast reduction, correction of breast asymmetry, treatment of gynecomastia, chin augmentation, and lipoplasty.[1] However, according to Dr. Casas, some procedures are emotionally loaded.

The procedure that is least fraught with adolescent Sturm und Drang is rhinoplasty, especially the way Dr. Casas engineers her preoperative consultation. Teens are always accompanied by a parent, but mostly for legal reasons. In consultation, Casas addresses her remarks to the adolescent. She holds a mirror in front of the adolescent and then discusses with the patient each part that she can fix such as the dorsum, tip, projection, nasolabial angle, and size of their nostrils looking straight on. Her rule is simple: If the patient is not mature enough to specifically verbalize what he or she does not like about the appearance of their nose than that adolescent is not mature enough to have surgery.

However, with breast reduction procedures, which Dr. Casas does not offer to patients younger than 17, there is a heavy emotional overlay. Hormones affect breast size and so does body weight – loaded issues for any woman, but especially for teens. There are three significant questions Dr. Casas asks that frequently provoke emotional outbursts:

1. **Do you use birth control?** Dr. Casas does not offer breast reduction without first asking the teen if she uses, or is planning to use, birth control pills. Since birth control pills may increase breast size, Casas prefers that adolescents use it before breast reduction. Dr. Casas has had two patients who had to undergo secondary procedures because birth control pills were initiated after the breast reduction.

2. **Are you happy with your body weight?** The issue of body weight is very relevant to breast size, and many young girls are overweight as a way of hiding their large breasts. If the adolescent weighs 160 pounds, but during the consultation states that she will lose weight after the reduction when she can exercise more easily, Dr. Casas cautions the teenager about the downside of this approach. "Breasts tend to develop ptosis after weight loss of more than 10 pounds. Therefore, weight loss should be attempted before breast reduction surgery." The immature teen will interpret this to mean that breast reduction surgery is not an option without weight loss. Weight issues are typically a very emotional topic. Therefore this line of questioning can illicit emotional outbursts that reveal the emotional maturity of the teenager.

3. **You will need your mother's help in changing your dressings. Will you be comfortable with this?** At a time when most teenagers are individuating or psychologically separating from mothers, breast reduction surgery, of necessity, draws the teen closer to mom. Dressings need to be frequently changed and mom is the logical "nurse." Frequently, Casas can read from body language that the teen is very hostile to her mother, making this reinstatement of dependence very uncomfortable.

With breast asymmetry there is an intense psychological overlay. For starters, the teen most likely feels like a freak and is extremely embarrassed about this deformity. The easiest scenario is when one breast is fine and the other needs to be reduced. But when an implant is needed, Casas informs the adolescent of some unpleasant realities: (1) the implant will not last forever, (2) breast size fluctuates with weight and hormone levels of pregnancy and lactation, and, finally, the breast will be a work in progress, needing lifetime maintenance.

Dr. Nahai has very firm rules about breast implants and teenagers. He uses implants in teens only for patients with congenital deformity, such as Poland's syndrome; acquired deformity; or lack of development due to previous surgery. For example, a patient may undergo open heart surgery as an infant and the incision may pierce the breast bud, resulting in a breast that did not develop. "Teens lack the maturity to realize that breast augmentation is not maintenance-free and requires a lifetime of followup and a definite implant exchange." He believes that breast reduction may be appropriate provided that breast growth has arrested. However, the drawback is that in some teens breast enlargement can occur later. He would also consider surgery to correct breast asymmetry.

Parental involvement

In Dr. Gold's practice the role of the parent is clearly defined. Since consent for surgery for patients under 18 must be given by a parent or guardian, he requires that parents go through the full consultation and informed consent process with the teenage patient.

"It is always important for the patient to have an emotional support system throughout the surgical process. If a parent is not in favor of the surgery or at least supportive, it is extremely unusual to be able to proceed. The desire and decision for the surgery, however, should come from the patient. Teenagers should be doing the surgery for themselves, and not to please anyone else……exactly as I would require for an adult to be considered a good surgical candidate."

Dr. de Castro has a surefooted approach to the teens in his practice. "I require total parental involvement. I require total agreement with the procedure that will be performed. I explain to parents and to the teen every step of the surgical procedure. I discuss all the complications that may occur, the limitations of the surgery, and I emphasize that the patient must follow all of the postoperative recommendations." ■■■

Reference

[1]The American Society for Aesthetic Plastic Surgery. Cosmetic Surgery National Data Bank, 1997 Statistics, 2003 Statistics.

Cosmetic Surgery and the Law (Continued from page 11)

cy (SEF), median frequency (MF) and the 2003 FDA approved Bispectral Index (BIS) monitor, which converts brain wave activity into a sedation index. A BIS value of 100 is fully awake; less than 65 signifies a less than 5% probability of return of consciousness within 50 seconds; and 0 indicates no brain activity.

Practitioners do not yet agree upon the value of BIS monitors. Some report shortened recovery time, fewer incidents of patient awareness, and cost savings from using less anesthetic. Detractors claim that the BIS is one more piece of information to monitor; inexperienced anesthesiologists may fixate on the BIS reading and sacrifice their own clinical experience and accept the results of the BIS monitors instead. Moreover, patient awareness is so uncommon that routine use of the $6,000 BIS monitors (www.aspectmedical.com) is not cost effective.

Cost effectiveness will probably not sway a jury. The consequences of patient awareness can include anxiety, such as the patient who feared her cancer would return when she overheard her doctor saying he "couldn't get all the black out," when in fact he was talking during surgery about retiling his bathroom. It can also be severe, such as post traumatic stress disorder, with a low startle response, uncontrolled crying and a fear of doctors, hospitals and going to sleep.

JCAHO's Alert contains several recommendations that seem non-intuitive in a litigation climate, until one recalls that malpractice litigation claims correlate with lack of physician compassion, not with outcomes.

For patients who report awareness after surgery, JCAHO recommends:

- Interviewing the patient
- Noting everything in the chart
- Apologizing
- Assuring the patient of the credibility of their account
- Sympathizing with the patient's suffering
- Explaining what happened and why, especially if it was necessary for the patient's physical health
- Offering psychological or psychiatric support
- Notifying the patient's surgeon and other key personnel

As for patient compassion during surgery, since hearing is the most difficult sense to suppress, one North Carolina anesthesiologist took matters into his own hands and had signs posted in all his operating rooms which read, "The patient is listening". Whether we like it or not, so are their lawyers. ■■■

Media Notes & Quotes

A sampling of current media coverage on cosmetic surgery

A trial is underway in Los Angeles Superior Court. It pits Irena Medavoy, 45, wife of veteran film producer Mike Medavoy, against Botox and the doctor who administered it to the one time swimsuit model and Dallas actress. In a nation where Botox has become the top cosmetic procedure, a Medavoy win could throw up a roadblock for this runaway success. Its purveyors are resolute. "Botox appears to work incredibly well for most patients in most situations," says Mark Jewell, president-elect of the American Society for Aesthetic Plastic Surgery.
-USA Today
October 6, 2004

Holidays have long been occasion for giving loved ones image-improving presents, such as expensive ties or diamond earrings. This season, a few adventurous gift-givers are addressing the issue more directly – by wrapping up certificates for Botox injections, liposuction, even breast implants… The gift of lift is just the latest frontier for the plastic surgery business, which increased 22% last year from 2002, to $9.4 billion, according to the American Society for Aesthetic Plastic Surgery (ASAPS).
-Wall St. Journal
December 3, 2004

"Many patients walk into my office and say, the only thing I'm afraid of is the anesthesia," says Dr. Peter B. Fodor, the president of the American Society for Aesthetic Plastic Surgery (ASAPS)… Anesthesia-related mortalities run 1 in 250,000, compared with 1 in 5,000 twenty years ago…Even nongeneral anesthesias have their risks. "In very large doses, lidocaine can act in the same manner as a general anesthetic, but its effects are uncontrollable because a breathing tube isn't used. Doses above the recommended limit can trigger seizures, apnea and cardiac arrest," Fodor warns, underscoring the importance of having doctors with up-to-date training and state-of-the-art equipment to monitor your progress and cope with any emergencies that occur. "Whether you have your procedure done in a hospital, an outpatient surgical center or a doctor's office, the key is to make sure the facility is properly accredited," says Fodor.
-Town & Country
November 2004

Dermatologists and cosmetic surgeons say it's difficult to tell whether the TV spotlight has helped business; the number of cosmetic procedures in the United States has quadrupled in the past seven years anyway. But they do say women are asking fewer questions, demanding more procedures and increasingly viewing surgery as a quick fix for all their problems. "I'm starting to see patients whose attitude toward a complicated procedure is very light," says Peter B. Fodor, MD, a plastic surgeon in Los Angeles and president of the American Society for Aesthetic Plastic Surgery (ASAPS). "They'll say, 'While you're doing my eyelids, throw in a tummy tuck.' They don't even have the patience to listen to what it takes to do it safely. They just want the same miraculous transformation they saw on television." Maybe we need a little reality check when it comes to reality TV…reality is the inverse of reality TV: the less extreme the makeover, the better. "Plastic surgery is not intended to change your entire life," says Robert Bernard, MD, of White Plains, New York, immediate past president of ASAPS. "If you think surgery can do that, you're going to end up disillusioned."
-Self
November 2004

The numbers tell the story. According to the American Society for Aesthetic Plastic Surgery (ASAPS), men had nearly 1.1 million cosmetic procedures last year, an increase of 31% from 2002. To Dr. Mark Jewell, A Eugene, Oregon based plastic surgeon and president-elect of ASAPS, it's nothing to be surprised about: "Men have bought into the benefits of cosmetic procedures because it makes them look and feel good."
-Fortune
November 1, 2004

communication with the public is our ASAPS website, and we have an immense amount of consumer information on plastic surgery credentials and patient safety available there. Of course, we necessarily rely on the media to disseminate a great deal of our news and information, so it's imperative that we focus adequate resources on educating this important group. Again, this is where having two strong voices delivering plastic surgery's message of training and credentials is so valuable. Reporters are more likely to be convinced of facts that they hear from more than one credible source.

Dr. McGuire: *ASAPS has remained a "membership driven" organization, partly because of its smaller size but also because of the philosophy of its leadership and the very active participation of its members at all levels of the organization. Realistically, with plastic surgery practice becoming more and more complicated and demanding, can ASAPS hope to maintain this high level of member involvement in the future?*

Dr. Fodor: Absolutely. It's member involvement and member control that make ASAPS work so well. One of the ways we can maintain this is by simply continuing to ask our members what they want us to do for them. There are going to be more "mini surveys," focus groups and other communications from ASAPS aimed at soliciting feedback. As long as the members keep responding in record numbers, as they have done, then we'll be able to make decisions that are based on what our members truly want.

Dr. Lang: ASERF is committed to the same membership-driven model that has helped make ASAPS successful. In our case, this involves identifying the research issues that currently are most important to our members' practices and then acting on this information in a speedy and scientifically sound way. One of my goals in 2005 is to keep the members informed of ASERF research initiatives, so that they understand the significance of the work we're doing. We also want to encourage more members to suggest topics for directed research.

Dr. Fodor: Two-way communication is the key to a lot of what we've been discussing. Whether it's within our own Society or within plastic surgery, or in our education of the media and the public, we need to do more than just talk -- we need to listen. That's what effective leadership really is about. ■■■

ASAPS Names New Director of Marketing and Public Education

John O'Leary has been appointed Director of Marketing and Public Education for the American Society for Aesthetic Plastic Surgery (ASAPS), the nation's leading organization of board-certified plastic surgeons specializing in cosmetic plastic surgery. He will be located in ASAPS' Los Alamitos, California office while supervising ASAPS' media relations staff, which remains in the organization's New York City office.

Mr. O'Leary has more than 20 years of experience in marketing, communications and education. He has held senior marketing and communications positions with *The New England Journal of Medicine*, Chartwell Home Therapies, and Brigham and Women's Hospital. A graduate of Boston University's School of Public Communications, John has been an advisor to the home infusion industry during the Dingle Commission hearings, has been recognized by the Oley Foundation for excellence in patient education, and served as adjunct professor of marketing at Massachusetts College of Pharmacy and Allied Health Sciences.

"John brings a track record of success as a marketing and education professional to ASAPS," said Peter B. Fodor, MD, ASAPS President. "With his knowledge and experience, I have every confidence John will greatly assist our efforts to communicate with ASAPS members and the public-at-large."

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- Develop a global understanding of approaches in cosmetic surgery
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To view the complete registration brochure online, please log on to www.sugery.org/meeting 2005

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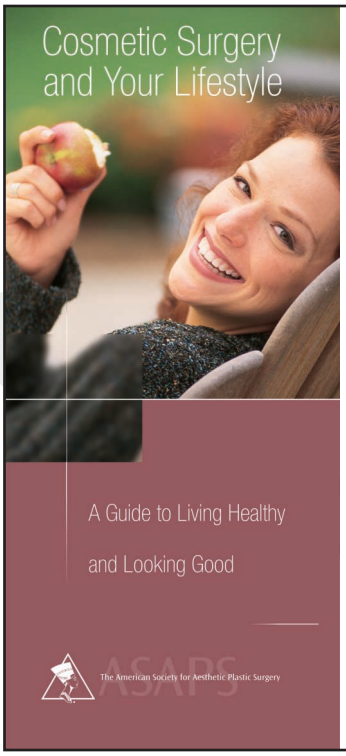
ASAPS Announces New Patient Safety CME Requirement

Beginning in 2005, the Aesthetic Society will require all Active Members to earn a minimum of 20 CME hours in patient safety related topics over a three year period. By attending the entire Scientific Session at the 2005 meeting in New Orleans, attendees will earn three patient safety CME hours. Additional hours can be earned by attending selected optional courses, up to a maximum of 13 hours. The courses are identified throughout the Annual Meeting brochure by a symbol that contains the number of hours within the presentation that are applicable toward patient safety CME. The Central Office will automatically submit attendees' CME credits and attendance record for the combined Physicians Recognition Award report maintained by ASPS.

An invitation to all new members: Join us on May 2 in New Orleans

Congratulations on becoming a member of the Aesthetic Society. As you are well aware, this is no small feat. You are now part of a select group of aesthetic plastic surgeons who insist on the very best for your patients. As the Chairman of the New Member Committee, I want to welcome you to the Society and help you take advantage of the many benefits of membership in ASAPS. To help you get started, the Committee is organizing the New Member Open Forum. It is being held on Monday, May 2, at the upcoming ASAPS meeting in New Orleans. You will meet other new members and the leadership of ASAPS. Common issues will be discussed in an informal open microphone setting. You are also invited to attend a special VIP Reception which precedes the Presidential Dinner Dance on Monday evening. Tables will be reserved at the dinner dance for new members and members of our Committee. Once again, welcome and we hope to see you in New Orleans.

— Clyde Ishii



New patient education from ASAPS

Cosmetic Surgery and Your Lifestyle
A Guide to Living Healthy and Looking Good

Helps you become your patients' most trusted "age management" resource.

Cosmetic Surgery and Your Lifestyle, a new patient-education brochure developed by ASAPS exclusively for ASAPS-member practices, suggests a variety of simple and time-tested ways to promote health, boost energy and maintain appearance. While providing well-established guidelines for healthier living, it also discusses how lifestyle factors can impact patients' choices for cosmetic surgery.

Cosmetic Surgery and Your Lifestyle

- Offers common sense advice to help your patients look and feel better
- Covers basics of nutrition, exercise, sun protection, smoking, sleep and more
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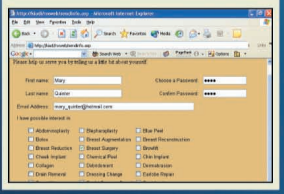

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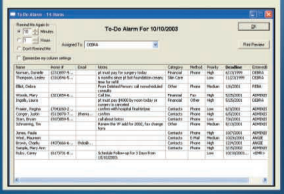

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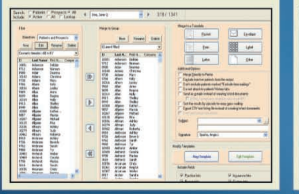

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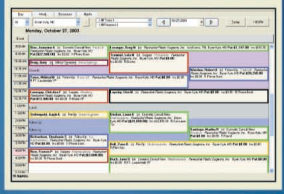

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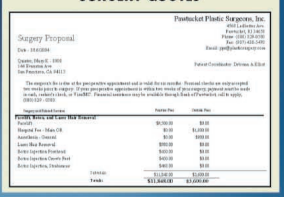

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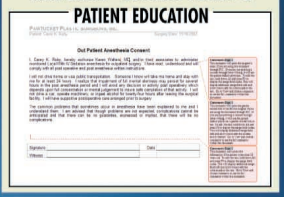
NEXFORMS - CONSENT FORMS & PATIENT EDUCATION



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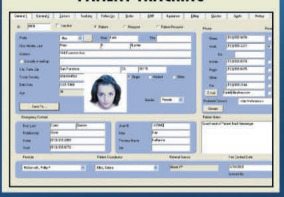

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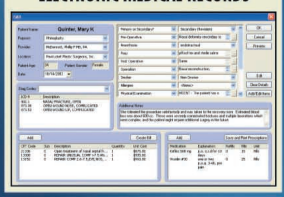

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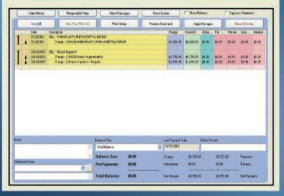

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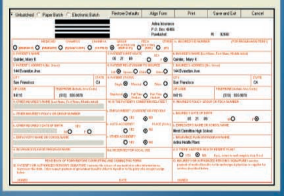

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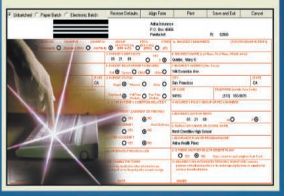
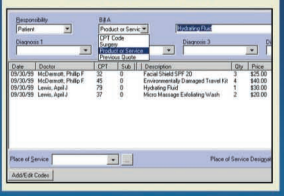
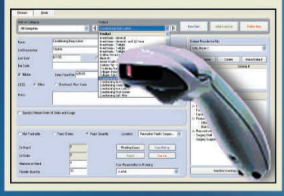


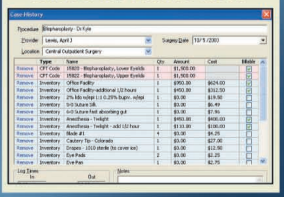
SKIN CARE INVOICING



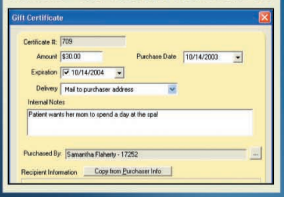
INVENTORY & BAR CODE SCANNING



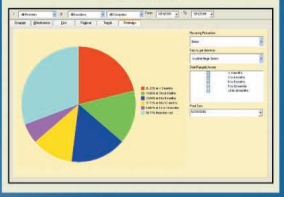
AMBULATORY SURGERY CENTER



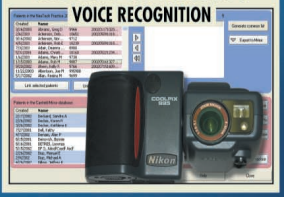
NEXSPA - MEDICAL SPA MANAGEMENT



MARKETING



LINK DIGITAL PHOTOGRAPHY & VOICE RECOGNITION



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