



Aesthetic Society News

Quarterly Newsletter of the American Society for Aesthetic Plastic Surgery

Volume 11, Number 2 Spring 2007

Celebrating 40 Years of Aesthetic Education

Why I joined the Aesthetic Society A conversation with Peter McKinney, MD

By Julius Few, MD



Peter McKinney, MD



Julius Few, MD

Dr. Peter McKinney has had a rich career in plastic surgery and continues to exert his influence today. In addition to having served as a Founding Member and President of the Rhinoplasty Society, he is a Past President of the Aesthetic Society, has authored five books and 158 Scholarly Articles and mentored scores of residents, including me.

In addition to his professional

accomplishments, Peter credits his wife, two children and three grandchildren as being the best and most important part of his life. I recently caught up with Peter to ask him why he chose to focus on aesthetic surgery when the norm at the time was reconstructive, how he obtained clinical information at the time, why he joined the Aesthetic Society and how he chose to focus on Rhinoplasty. I know his witty and insightful answers will delight you as much as they did me.

Dr. Few: Peter, it's such a pleasure to catch up with you. I'd like to ask you a few questions. First, what led you to aesthetic surgery when reconstructive was the predominant sub-specialty at the time?

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Aesthetic Surgery in the Media: A Ten Year Perspective

Shannon Leeman

I remember the first time I was invited to watch a plastic surgeon operate. It was a breast augmentation, I leaned against the farthest wall away from the patient, swaying sickly, praying for it to be over. A dozen years and many operations later, I have my own scrubs and secretly think I am an attending.

I am a surgery groupie.
I have been writing on Cosmetic

Surgery and Anti-aging for more than a decade. The first piece I wrote on the subject was an A- list Top surgeon type piece that infuriates most doctors but goes down extremely well with the few names that make the list. The scarcity of reliable information at the time made a feature like that a 'tear out and save' reference. I remember my editor at the time loved the

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From the Editor Julius F. Few, MD

This issue of ASN finds us with much to celebrate. Forty years is a significant milestone in the life of any organization but the changes we have seen, not only in our Society but in our specialty, give us much to be proud of.

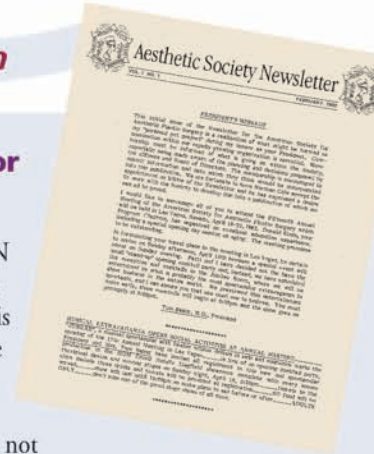
We have produced a special edition of ASN for our Spring issue that both celebrates our past, looks at our present and provides a window into our future. Among the highlights are:

Is Cosmetic Medicine the new paradigm? Industry pundit Marie Kuechell puts a socio-economic model to the emerging trend of cosmetic medicine.

Why did you become an ASAPS member? We posed this question to life member Peter McKinney, MD and new member Michelle Zweifler, MD. The commonality of their answers may surprise you.

ASAPS is a solid source for media information, but how has cosmetic surgery reporting changed over the years? To find out, we went to one of the most respected sources in the business. London-based Shannon Porter Leeman, a frequent contributor to W Magazine traces the shifts in plastic surgery reporting over the last ten years.

Also in this issue: our new slate of candidates, Benchmarking Your Practice by Allergan's Mark Craze, and the Aesthetic Meeting Week at a Glance—2007 and 1969, when our meetings first began.



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East	21	26.3%	26
South	27	33.7%	33
Midwest	10	12.5%	10
West	22	27.5%	30
			99

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Aesthetic Society News

The American Society for Aesthetic Plastic Surgery
The Aesthetic Surgery Education and Research Foundation

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The American Society for
Aesthetic Plastic Surgery



The Aesthetic Surgery Education
and Research Foundation

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April 19-24, 2007

The Aesthetic Meeting 2007— Annual Meeting of ASAPS & ASERF

Javits Convention Center
New York, NY

Contact: ASAPS

Tel: 800-364-2147

May 19-20, 2007

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Cruise Dates: July 21-28, 2007



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www.surgery.org/cruise 2007

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November 14 – 17, 2007

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Contact: Francine Leinhardt

212.702.7728

November 30 – December 2, 2007

QMP Third Aesthetic Surgery Symposium

Hyatt Regency, Chicago, IL

Endorsed by ASAPS

Contact: Andrew Berger

314.878.7808

aberger@qmp.com



Looking Forward

It has been an honor and highlight of my professional career to have served as President of the Aesthetic Society for the past year. As we celebrate our Fortieth Anniversary and prepare for another outstanding educational event via our Annual Meeting, I would like to take this opportunity to give a strictly personal view of where our organization and our specialty may be headed:

On the Aesthetic Society's Mission

Our founding members built ASAPS on a strong mission of providing cosmetic surgical education. Today we excel at educational venues, both to members and to the public. We also provide members with a large portfolio of practice and educational products, co-sponsor or endorse symposia on topics ranging from massive weight loss surgery to rhinoplasty and provide to our colleagues with a close knit network of members who have often become friends.

On the Health and Growth of ASAPS

The Aesthetic Society has always taken a prudent course towards financial health and member growth. Our Annual Meetings, which provide roughly half of our revenue, have shown a steady and encouraging increase in attendance that both reflects the popularity of our specialty and the growth of the organization. As we all know, large membership numbers were never the goal at ASAPS. All members must be sponsored, meet strict practice and educational requirements and adhere to our code of ethics. I am happy to report

that nothing has changed this picture: we are financially sound, discerning in who can join our ranks, and are large enough to offer a wide range of educational venues from New York City to the Baltic Sea.

On Cooperative Efforts with ASPS

Several years ago, the ASPS and the Aesthetic Society met to see where we could be joining forces on projects, how we could support each other on important advocacy and scope of practice issues and how we could generally work in closer corporation as two of the leading voices in organized plastic surgery.

The result of this meeting was the formation of the Cosmetic Surgery Alliance, or CSA. The CSA is building a strong foundation of mutual respect and trust among our organizations and, to date, has worked in concert on such issues as the approval of silicone breast implants, patient advisories on issues such as Medi-spas and fat grafting to the breast, joint patient education brochures and joint symposia. I feel that this cooperative spirit is an excellent and healthy sign for anyone who cares about our specialty. I support their on-going work and am confident that President-Elect Foad Nahai, MD will regularly report on its progress.

On where the specialty is going

No one has to tell an ASAPS member the wide range of challenges we face on issues such as scope of practice, the growth of non-surgical specialties performing both surgical and non-surgical procedures and the explosion in new treatments and

technologies. What I would like to share is what we are helping you do about it.

The Cosmetic Medicine Task Force, another joint project of ASAPS and ASPS, conducted through the Cosmetic Surgery Alliance, is taking a hard look at the burgeoning area of cosmetic medicine and all its implications: financial, environmental, societal, etc. This group, co-chaired by Renato Saltz, MD and Richard A. D'Amico, MD will be reporting its findings in the coming months and providing guidance to our members on this important topic.

Market forces aside, I would be remiss if I did not say what a great position we are in today as Aesthetic Surgeons. Better educated, highly respected, our activities are reported on in professional meetings the world over and mentioned in important media from the New York Times to CBS News. It gives me great pride to be an aesthetic surgeon. And it is with great confidence that I hand over the reins to my friend and colleague Foad Nahai, MD. Foad is one of the most respected educators in the world. I look forward to his term as President and the innovation he will undoubtedly bring to the organization.



Financial Benchmarking for the Cosmetic Practice

By Mark Craze

Successful cosmetic practices are diligent in gathering, measuring and managing information. In addition, these practices routinely compare or benchmark actual operating results to prior periods, budget forecasts, and/or available industry benchmarks. This process focuses the practice on continually improving workflow processes, while enhancing physician and staff productivity.

The process of benchmarking should enable a practice to compare and measure results against better performing "like kind" practices. For most cosmetic practices, this often proves to be a difficult exercise. Useful specialty specific data has generally not been available.

Types of Benchmarking

Methods of benchmarking vary but three are commonly recognized: internal, competitive and functional. Internal benchmarking involves studying and comparing operating results and work processes within a practice in order to identify areas of opportunity for performance improvement. This method of benchmarking requires minimal investment of time and expense and absent availability of external benchmarks can prove very beneficial. Internal benchmarking is a good place to start for practices with little experience with quality improvement initiatives. Competitive benchmarking entails looking outside to compare with the industry's better-performing practices. This process will often reveal strengths and weaknesses, and the amount of "distance" that may need to be made up in order to achieve better results. Finally, functional benchmarking involves comparing a specific work operation or task with an organization considered to be a leader for that function or service. This is a very challenging exercise because it is often difficult to find within our sphere of influence. As such, functional

benchmarking often involves an analysis of work performance measures in other industries, thereby leading to new solutions or ideas never previously considered.

The Allergan/BSM Consulting Database

In 2005 the Allergan Practice Consulting Group working closely with BSM Consulting initiated a financial benchmarking program designed to offer an analytic tool for cosmetic practices that would assist in evaluating practice performance along certain key measurements. The program results allow us to provide a useful set of metrics that enable cosmetic practices the ability to compare operating results to those practices participating in our database. As the program expands, we expect to report results for what we would consider the better performing practices. It is expected that the program will provide an external data source to facilitate competitive benchmarking and assist in the process of developing quality improvement initiatives. **Table 1** provides a list of key statistics presently being tracked.

Table 1: The Key Statistics General Financial and Practice information

1. Net Collected Revenue per Full-time Equivalent (FTE) MD/DO
2. Revenue Rate per Hour per MD/DO
3. Number of FTE Support Staff per FTE Provider
4. Net Collected Revenue per FTE Support Staff
5. Operating Expense Ratio
6. Non-Provider Payroll Ratio
7. Rent Expense Ratio
8. Marketing and Advertising Expense Ratio

Sources of Information

Participating physicians complete an initial survey, which provides us with basic background information on the practice. In addition, we receive financial statements (balance sheet and income statement), tax returns, and employee census data as well as computer generated physician productivity reports. In most cases, we receive two to three years of historical information.

BSM is in its second year of providing database results with 80, 99, and 66 participating practices in 2003, 2004, and 2005, respectively. **Table 2** provides a geographic breakdown of participating practices.

Table 2: Geographic Breakdown of Participating Practices

	2003	%	2004	%	2005	%
East	21	26.3%	26	26.3%	20	30.3%
South	27	33.7%	33	33.3%	23	34.8%
Midwest	10	12.5%	10	10.1%	11	16.7%
West	22	27.5%	30	30.3%	12	18.2%
Totals	80	100.0%	99	100.0%	66	100.0%

In addition, the benchmark data originated from a number of different specialties competing in the cosmetic marketplace. Practices had to derive over 50% of their annual revenues from cosmetic fee-for-service work in order to be considered for inclusion in the cosmetic database. **Table 3** provides a specialty breakdown of participating practices.

Limitations

There is admittedly selection bias in the survey because participating practices were identified by the Allergan Practice Consultants and therefore, this was not a random sample. In addition, there is a lack of consistency in data reporting. Although, as noted, we receive source documents such as tax returns, financial statements, and practice productivity reports, we

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Table 3: Specialty Breakdown of Cosmetic Practices

	2003	%	2004	%	2005	%
Plastic Surgery	50	62.5%	56	56.6%	33	50.0%
Facial Plastics	10	12.5%	15	15.1%	12	18.2%
Oculoplastics	2	2.5%	2	2.0%	2	3.0%
Dermatology	18	22.5%	26	26.3%	19	28.8%
Totals	80	100.0%	99	100.0%	66	100.0%

acknowledge the fact that practices use different data tracking and reporting systems. It is also important to point out that we use an arbitrary benchmark of hours worked (1,600 per annum) in

Participating physicians complete an initial survey, which provides us with basic background information on the practice. In addition, we receive financial statements (balance sheet and income statement), tax returns, and employee census data as well as computer generated physician productivity reports.

determining the number of full time equivalent physicians in a practice. Finally, data reporting is based upon the cash method of accounting. From an accounting

standpoint, the cash method (recognizing revenue earned when cash is received and expenses incurred when actually paid) has the potential to distort

operating results. Since the vast majority of practices use the cash method for both tax and management reporting purposes, we believe it is best to measure results along this same line.

Results to Date

The average physician in our database generated approximately \$1,420,000 in collected receipts in 2005. This is up slightly from previous years. The average revenue rate per hour for 2005 was \$887. The average practice in our database spends in operating costs approximately 64% of every dollar of collected revenue. Expenses include all cost of running the business with the exception of depreciation and provider compensation (salaries, bonuses, and retirement plan contributions). The average practice in our database also spends around 15.6% of collected receipts on the gross payroll of rank and file staff, 5% on space rental, and around 4% on marketing and advertising.

In addition, our database shows that the average practice employs 5.35 employees per FTE physician and spends \$234,550 in gross wages, or an average of \$43,841 per employee. The average practice in our database generates nearly \$300,000 in collected receipts per FTE staff member. This result has been relatively stable over the three years of reported data.

A summary of performance indicators is set forth in **Table 4** providing the mean and median values.

Competitive Benchmarking

The results presented in **Table 4** can be compared to your own practice performance provided your computations are consistent with those used in constructing the database. Definitions and formulas for computing the performance indicators are provided below to facilitate accurate comparisons.

About the author: Mark Craze is a senior manager with the Allergan Practice Consulting Group. He is based in Dallas, Texas. Contact him at craze_mark@allergan.com.

Table 4: BSM/Allergan Financial Benchmarking Performance Indicator

Performance Indicator	2003		2004		2005	
	Mean	Median	Mean	Median	Mean	Median
Net Collected Revenue per FTE MD/DO (1)	\$1,291,647	\$1,182,042	\$1,403,227	\$1,334,942	\$1,419,660	\$1,355,438
Revenue Rate per Hour per FTE Physician	\$807	\$739	\$877	\$834	\$887	\$847
No. of FTE Support Staff per FTE Provider	4.88	4.51	5.31	4.95	5.35	5.04
Net Collected Revenue per FTE Support Staff	\$309,786	\$279,955	\$315,401	\$289,310	\$298,352	\$286,848
Operating Expense Ratio	65.5%	67.9%	63.8%	65.0%	63.9%	63.9%
Non-Provider Payroll Ratio	14.9%	13.8%	15.1%	14.4%	15.6%	15.5%
Rent Expense Ratio	5.6%	4.8%	4.9%	4.6%	5.1%	4.6%
Marketing and Advertising Ratio	4.2%	3.6%	3.8%	3.2%	4.2%	3.6%



Cosmetic Medicine: The New Paradigm?

By Marie Czenko Kuechel

Among plastic surgeons, there seems to be talk of a new paradigm: cosmetic medicine. How this will co-exist with aesthetic plastic surgery is the prevailing question. To answer that requires consideration of the marketplace, economics, the present and the future.

“Cosmetic” and “aesthetic” have two very distinct definitions. One is about substances like lipstick—it covers, temporarily, what exists. The other is about beauty—it is pleasing in appearance. Appropriately, cosmetic medicine includes a lot of temporary fixes, from injectables to skincare to lasers. If you stop using these things the “fix” will eventually wane. Aesthetic plastic surgery has, for forty years, been something that endures: a one time, permanent fix that results in a pleasing appearance.

Aesthetic medicine is the nucleus from which cosmetic medicine has been born. And like any anthropological original, over time aesthetic surgery must evolve. In these evolutionary times I see two possibilities:

- **aesthetic plastic surgery as a slice of cosmetic medicine, or**
- **aesthetic plastic surgery as the core of cosmetic medicine.**

The decisions made today regarding issues such as the marketplace, industry challenges, politics and economics will result in either aesthetic plastic surgeons taking a slice of the pie, or taking position as the core entity from which cosmetic medicine is prescribed.

Personal Spending

The U.S. Federal Reserve defines the wealthiest 10 percent of Americans as having an income of \$256,000 annually. Near-affluence is a new category among economists, defined as an income of \$100,000 to \$256,000.

Personal spending among these groups is high and growing. The top four categories in personal spending among affluent and near-affluent Americans in 2006 were:

- 1) Automobiles
- 2) Clothing
- 3) Watches
- 4) Cosmetics/beauty products which includes “cosmetic medicine.”

One might argue that, in today’s times, you need a car, clothing and watch. But clearly, brands such as Bentley, Hermes and Breitling are not a need, they are wants that connote luxury.

Like these brands, cosmetic medicine is a want. And, like any indulgence, one may be willing to spend a significant portion of income to get it. Where cosmetic medicine differs most significantly from these other examples of “wants” is that it involves not only money but also time, discomfort and the stress of an unknown outcome. Unlike that car, there are no warranties or guarantees.

Consider that the average of all surgical fees in 2006 was \$4157. Patients in the near-affluent group spend 1/25th of their annual gross income on surgical fees alone.

The average price of a non-surgical, cosmetic medicine treatment in 2006 was \$777. Therefore a consumer of near affluence is spending about 1/200th of gross income on something that he or she must repeat in order to continue to reap the benefits.

Is personal income a factor in consumer choices for aesthetic surgery and/or cosmetic medicine?

Slice: Aesthetic surgery is a luxury and those who want it will buy it.
Core: Cosmetic medicine offers greater variety and chance to test drive or taste of what aesthetic surgery might offer.

Luxury

It may commonly be defined as indulgent, expensive and non-essential, but most succinctly luxury is defined by expectation. Depending on one’s income, luxury is highly variable. Cosmetic medicine and

aesthetic surgery may be labeled as such, but do they deliver luxury? And who is defining the expectations?

Brand loyalty among near affluent and affluent Americans in luxury categories rates as follows, with the following reasoning:
1) Automobiles “I drive a lot.” “Safety I trust.”
2) Cosmetics/beauty products “It goes onto or into my body.”

Bottom line? Brand loyalty is about trust.

A spa is a luxurious place to be pampered. As of yet, medi-spas have not been defined by luxury or self-pampering, but rather by non-surgical, cosmetic medicine treatments. Some may offer luxury and pampering, others offer nothing more than medically based treatments with a business model no different than a \$19.95-per-visit to a hair salon.

Is luxury essential to aesthetic plastic surgery and/or cosmetic medicine?

Slice: Luxury is defined by label.
Core: Luxury is not defined by product, it is defined by experience

Brand Loyalty

Travel is a lot like cosmetic medicine: you don’t know what the outcome or the experience will be until you’ve completed your journey. Among the leaders of brand loyalty in luxury markets is the Four Seasons Hotel group. Bill Gates loves it so much he bought it. People who stay there once return again and again. Small children behave because they love it there, and they become adults who choose the Four Seasons. Patrons are defiantly loyal, and while the rest of the hotel market rewards loyalty in upgrades and points, the Four Seasons offers neither.

What they do provide is the service and experience you expect for the price you pay. They cannot guarantee the weather, the ways of the world or what happens to you outside their properties. But what brings Four Season’s guests back time and again is the consistency of service and quality offered by their brand, among many unpredictable variables in the world.

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Cosmetic Medicine: The New Paradigm?

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Should aesthetic plastic surgery and/or cosmetic medicine compete on price and convenience, or service and value?

Slice: Price breeds loyalty

Core: Service and quality breed trust, trust breeds loyalty

New Treatment Options

Non-surgical treatments are not new. But there certainly are many more non-surgical treatments and those treatments that truly demonstrate results account for the majority of what is being called “cosmetic medicine”.

Based on the ASAPS 2006 statistics the ratio of non-surgical vs. surgical procedures is roughly 7:1. Many would argue that surgical procedures are dwindling in a world where cosmetic medicine is growing. Surgical procedures did in fact decline in 2006 overall, but this was statistically due to steep declines in lip and chin augmentation, eyelid surgery and forehead lift.

Conversely, in the non-surgical segment, dermal fillers saw rapid growth in 2006 (used to augment the lips and chin). Yet overall, non-surgical procedures as a category demonstrated only 3 percent growth in the ASAPS statistics, a compilation of procedures provided by board certified plastic surgeons, dermatologists and otolaryngologists. Cosmetic medicine suppliers and Wall Street numbers would clearly dispute that the market is flat. And they would be correct. The disparity in reported numbers is simple: The number of core providers has not changed. Surgery has not changed. Therefore unless plastic surgeons are working a lot more, non-surgical procedures as performed among them are not going to change. Non-core providers, in no formalized setting or specialty who are statistically abstract and generally unquantified, account for the growth in cosmetic medicine.

Should aesthetic plastic surgeons innovate, advance and prescribe cosmetic medicine treatments?

Slice: Only if these impact specific surgical procedures

Core: Choice, service and quality breed trust and loyalty

New Service Models

Since the GI's returned from World War II, medical specialties are defined by their focus. Dermatologists treat skin. OB/Gyns act as primary care health providers to women. These are simple and well-known service models among medical specialists.

Cosmetic medicine is, of course, not a specialty; it is a new paradigm whose service model is confusing at best. The models are so diverse that they include everything from core providers to employed non-core physicians, nurses and aestheticians, from core physician administered procedures to core physician prescribed, physician-supervised, off-site physician supervised, no physician supervision and even physician “directing” of cosmetic medical services. Confusing at best!

Organized plastic surgery took the lead in defining the appropriate model for ambulatory surgery by mandating accreditation and establishing standards.

Should organized plastic surgery formalize the cosmetic medicine service model?

Slice: Existing practices are too diverse among core providers to set standards

Core: Service, quality and safety are paramount to standards that breed trust and loyalty, and can endure

Politics

Some would argue that cosmetic medicine doesn't injure anyone other than the naïve consumer, so caveat emptor is all that is needed. However, how can a buyer

beware in a diverse and complicated world of treatment categories, providers, federal, state and local governments all with different agendas?

The potential categories of cosmetic medicine alone are confusing—do skin-care, supplements and lymphatic massage constitute cosmetic medicine?

The politics of cosmetic medicine are presently lacking three things:

- 1) clear definitions for the various categories of cosmetic medical treatments
- 2) safety and research standards for treatments

- 3) an easy means to identify qualified, well-trained providers.

Accomplishing this requires simple rules, supported by unbiased data, networked by core providers and the public alike through all levels of government and the insurance industry.

Is regulation of cosmetic medicine necessary to uphold public safety?

Slice: So long as it doesn't restrict my practice

Core: Take the lead among appropriate providers and work together toward the common goal of protecting the public interest

Economics

A basic law of economics: If demand is high and supply is limited, raise your price. A basic law of commerce: If demand is high and supply is limited, market an alternative. Another law of economics: If you are a monopoly, you can fix your price.

The “supply” of board certified plastic surgeons has not grown much over the past decade. Surgery overall is not growing. Non-surgical treatments are growing, but not necessarily among core providers. There's an economic dilemma here and it is simple: Treatment may be more convenient for consumers somewhere else. It's not a matter of price wars; the commercial goods necessary for cosmetic medicine are largely at a fixed price. (Truly how much variation exists in the cost of one IPL device to another?)

Are the laws of economics valuable in shaping a new paradigm?

Slice: Surgery is not growing, do not add more plastic surgeons

Core: We need more leaders who are qualified to prescribe cosmetic medicine and who can manage various providers in the new paradigm

New Providers, New Treatments, New Competition

Among many specialties of medicine it's clear—there are defined providers that carry out basic care as prescribed and supervised by the specialist.

Such a paradigm does not exist among the current core providers of cosmetic medicine: plastic surgeons, dermatologists, or otolaryngologists.

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Whether considering starting a medical spa or looking for ways to rejuvenate your existing business, this workshop promotes responsible spa operation by including relevant information on ownership models, staffing, marketing, measurements for success, legal considerations, best practices and more.

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Why I joined the Aesthetic Society

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Dr. McKinney: I think the thing that really cemented this for me was the combination of third party insurance issues and patient demand. For instance, aesthetic surgery is really old-fashioned medicine. In Plastic Surgery at Rush and Northwestern, we always emphasize to the students the correlation between the doctor-patient relationship and good outcomes. We have all seen excellent aesthetic results yet the patient is furious, and conversely, we have seen poor results and the patient loves it.

Dr. Few: Yes, absolutely.

Dr. McKinney: So it's the personal contact. Once you got insurance involved—and never mind the insurance compensation because at first it was reasonable—the physician-patient relationship changed. For me, this relationship was really the most fun. In addition you had patient demand. Patients would ask for aesthetic surgery as it became more popular. Interestingly, I had more patients go out of their way to express gratitude with aesthetic surgery than I did with reconstructive.

Dr. Few: Dr. McKinney, you significantly impacted the lives of many of your students and colleagues over the years and really when you started in aesthetic surgery, there wasn't that much available in terms of teaching. How did you go about educating yourself in the discipline?

Dr. McKinney: Well, in the 60s, the education in aesthetic surgery was sparse and often trivialized. I trained with Dr. Herbert Conway¹, who did a lot of face and eye surgery but not many rhinoplasties. This generated my initial interest in the field. In addition, observing a closed rhinoplasty was like watching a magic show, and I just had to know the answers. Although Dr. Gustave Alfricht² used to lecture us as residents and Dr. Conway did occasionally, rhinoplasty was not as sophisticated as it is today. Until the Aesthetic Society developed, teaching in aesthetic surgery was limited. In the 60s you didn't see it on the program at the meetings of the Association or the Society and it was something that you did not really talk about or admit that you performed. For

example, in 1965, Dr. Conway gave two papers at the New York Surgical Society, one on facial rejuvenation and one on reconstruction after melanoma. After the presentation, the press asked him only about the face lift procedures. The academic structure at that time positioned the Chief of Surgery with unlimited powers and Dr. Conway was only the Section Chief. In those days, you could not advertise or get your name in the paper much less talk about 'cosmetic' surgery. Dr. Frank Glenn, the Chief of Surgery at The New York Hospital saw this in the newspaper and called him on the carpet, so to speak, and it was a very awkward moment for our Section Chief. The first comprehensive book we had came out in '65 (1st edition of Converse). There were other smaller individual books but we had virtually no contact with aesthetic surgeons other than Dr. Alfricht.

Dr. Few: So really the paucity of exposure, in particular for rhinoplasty, was really a calling for you to investigate...

Dr. McKinney: The closed rhinoplasties that were done by Dr. Conway were approached from a general surgical background and they were done under local anesthesia. Dr. Conway was a brilliant surgeon, but he had little patience. Local anesthetic was always the choice as it was felt that general was too dangerous.

He would start by taking a needle and aiming it toward the tip of the nose with the patient's eyes crossing as they followed the needle. As it hit the nasal tip, the patient's fears were confirmed and, of course, the blood pressure went up. Then he would insert powdered cocaine on a cotton tip applicator and the patient would sneeze, effectively expelling the medicine. Dr. Conway wouldn't wait, for the epinephrine or the anesthesia to fully engage and by then the blood pressure was even higher. The immediate incision only exacerbated the situation. None of us went to the lab to do dissections at that time so our understanding of the anatomy was very limited.

Dr. Few: When did you first come to hear about the Aesthetic Society?

Dr. McKinney:

There was discussion about it in the mainstream of Plastic Surgery, but the leadership of Plastic Surgery and most academic chiefs considered it a fringe group.

Dr. Morrison Biers, a founding member from Chicago invited me to the first scientific meeting, a cruise from Vancouver. Although I couldn't go because of other conflicts, my interest in the group increased. The more I investigated, the more I realized that's where the education was. Aesthetic Surgery was not discussed in any of the major societies' symposia or programs in the 60s and 70s.

Dr. Few: I imagine when you ultimately did attend one of the early meetings, there was pressure not to be involved especially from your Chief or peers at the time?

Dr. McKinney: My Chief was very understanding but I could tell he was not enthusiastic about it. He never did join in spite of the fact that he was the head of a major teaching program for 25 years.

Dr. Few: Interesting.

Dr. McKinney: He had his own feelings about it, but he was very tolerant of my activities. The Aesthetic Society took the majority of my papers and the leadership was extraordinarily friendly. I recall one of the early programs for a face lift symposium in Dallas which the Aesthetic Society co-sponsored with the PSEF. I was presenting the anatomy of the great auricular nerve. This was really the first time that Aesthetic Surgery was beginning to reach the mainstream of Plastic Surgery. I was alone at the meeting, but on the way to dinner, Dr. Bernard Kaye, a founder and former president, whom I knew only by reputation, invited me to join him at his table.

Dr. Few: I definitely shared a similar experience from my first meeting and I think that tradition holds true today. What would you say is your most memorable experience that you could share with us regarding your membership to the Aesthetic society?

Continued on Page 10

Why I joined the Aesthetic Society

Continued from Page 9

Dr. McKinney: The exchange of information in Aesthetic Surgery. This was something you could not obtain from the other societies.

Dr. Few: The Society at the time, and I think it's probably true now, was willing to think outside the box.

Dr. McKinney: Absolutely.

Dr. Few: What would you say is the biggest change in aesthetic surgery if you compare where you started as compared to now?

Dr. McKinney: Education is the greatest change. I give credit to the Aesthetic Society for most of this. I remember particularly Drs. Kaye, Tom Baker Tom Rees, Gene Courtiss, Richard Stark, Gil Gradinger, George Peck, Jack Sheen, Jack Gunther and so many others lifting the veil of mystery for me in their teaching courses. The other change I see is advertising. Before 1979, you had to get clearance from your local Medical Society to even appear on the news, as advertising had been banned by the AMA when it was formed in 1848. Historically, medicine did not advertise as it was considered detrimental to the patient. There were few physicians and many patients. There were many entrepreneurs advertising their 'cures,' so ads were banned. Now that

Aesthetic Surgery is very popular and ads legal, the 'cures' are reappearing. So are physicians going to be more reclusive and secretive with their knowledge or will we continue to teach the competition our trade secrets? Recall the family in England who had the secret to obstetrical forceps for about 100 years. They had a lock on obstetrical practice in London for the entire 18th century, as they wouldn't show their colleagues the design of the instrument. Patients did not benefit from this.

Dr. Few: The other big issue or change that I think we are facing today is with individuals who have not trained in the traditional way of plastic surgery. How do you think that will impact our presence as an educating body?

Dr. McKinney: It's very simple—do it better. However, we can also learn from them. For example, a lesser trained physician may perform a face lift and have a very happy patient. Sometimes we overdo things with complicated surgery for a simple problem. Just because we can, doesn't mean we should. It will only elevate us if we are inclusive and keep focused on excellence.

Dr. Few: What's your opinion of the growth of 'cosmetic medicine'?

Dr. McKinney: Oh, I think it's neat. The reason I do is it can be of enormous benefit for the patient. Dr. Tolbert Wilkinson told me that some years ago he was offering face creams with an aesthetician and a full time manager. When physicians develop a medi-spa, they have an opportunity to help a lot of people with guidance on nutrition, lifestyle, smoking, drinking, exercise, etc. Aesthetic patients are very motivated when they have correct information.

Dr. Few: Last question. Do you have any advice for surgeons establishing their practice?

Dr. McKinney: Exercise patience and focus. Keep your integrity with patients, yourself and your colleagues. It can be annoying to see another surgeon claiming "I developed," "nationally acclaimed," "inventor of the... technique," etc. when in fact they contribute to the press rather than to medicine. Such things may get a lot of notice, but integrity will gain so much more.

1. *Herbert Conway, MD was Chairman of the Department of Plastic and Reconstructive Surgery at New York Hospital and a professor at Cornell Medical School. New York Hospital*
2. *Dr. Gustave Alfricht was a native of Budapest, Hungary, treating wounded soldiers during the war, studying with the leading practitioners in Europe and arrived in New York in 1923.*

An Alert from the Membership Committee

By Malcolm D. Paul, MD

The Aesthetic Society's Membership Committee had to reject an alarmingly high number of applications this year. The primary issue? Website advertising and hyperbolic claims of excellence that couldn't be factually verified, as required by 2.I.G.7 of our Code of Ethics. The Code provides a great deal of information on permissible advertising. Unfortunately, it provides no examples of what is forbidden. We hope to rectify this situation by producing a brochure with guidelines on what to avoid in advertising and promotion.

In the meantime, we would like to remind all members and candidates that self-promotion without factual backup is prohibited. Hint: adjectives are usually the culprit, because they are opinions. Bothersome examples include:

- the absolute best
- the best of the best
- There is no one else who can do what I do
- Gender induced superiority
- Ethnic induced superiority
- Listing in ad with use of ASAPS logo, before active membership
- Misleading board status, not representative of the American Board of Medical Specialties

Please maintain the standards of professionalism and clinical excellence that are synonymous with being an ASAPS member by reviewing your own ads before we are asked to do so. Thanks for your help.

Dr. Paul is Chair of the Membership Committee and a Past President of ASAPS.

The Society of Aesthetic Surgeons First Annual Meeting, February, 1969

The Aesthetic Society Meetings may have started off small but they certainly contained a full and ambitious program for the time. From Rhinoplasty to Face

Lifts, this first meeting presented the foremost minds in Cosmetic Surgery generously sharing their knowledge and techniques with their colleagues.

This tradition of generosity continues today. Please turn the page for the Aesthetic Meeting 2007 Week at a Glance 2007.

THE SOCIETY OF AESTHETIC SURGEONS

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MONDAY, FEBRUARY 3, 1969

4:00 P.M. - 6:00 P.M.
REGISTRATION Gazebo - Main Lobby

4:00 P.M. EXECUTIVE COMMITTEE MEETING (Officers and Chairmen of Committees) Royal Suite, Third Floor, Tower Four

6:30 P.M. - 7:30 P.M. (Sharp)
WELCOME COCKTAIL PARTY (INFORMAL)

TUESDAY, FEBRUARY 4, 1969

8:00 A.M. - 10:30 A.M.
REGISTRATION Gazebo - Main Lobby

8:30 A.M. - 9:00 A.M.
COFFEE AND HOSPITALITY - Pan American Room, Tower Four

9:00 A.M. - 9:30 A.M.
WELCOME BY PRESIDENT AND LOCAL ARRANGEMENTS COMMITTEE - Pan American Room, Tower Four

9:30 A.M. - 12:30 A.M.
John R. Lewis, Jr., M.D., Chairman
SCIENTIFIC SESSION - Pan American Room, Tower Four

9:30 A.M. Thomas J. Baker, Jr., M.D., Howard L. Gordon, M.D.
CHEMICAL FACE PEELING FOR PIGMENTATION PROBLEMS OF THE FACE

10:00 A.M. Morrison D. Beers, M.D.
UTILIZATION OF MATTRESS AND FIXATION SUTURES IN CORRECTIVE OTOPLASTY.

10:30 A.M. Richard C. Webster, M.D.
A TECHNIQUE OF OTOPLASTY

11:00 A.M. Bernard L. Kaye, M.D.
OTOPLASTY BY THE MATTRESS SUTURE TECHNIQUE

11:30 A.M. John E. Alexander, M.D.
THE RUNNING W-PLASTY - A STUDY IN CONTOUR

12:00 - 12:30 P.M. DISCUSSION OF PAPERS

12:30 - 1:30 P.M. BREAK FOR LUNCH

1:30 P.M. - 4:00 P.M. Michael M. Gurdin, M.D., Chairman
SCIENTIFIC SESSION - Pan American Room, Tower Four

1:30 P.M. Stephen R. LoVerme, M.D.
NASAL RECONSTRUCTION IN RHINOPHYMATOUS PATIENTS - COMPARISON WITH OTHER SURGICAL PROCEDURES

2:00 P.M. SECONDARY NASAL SURGERY - Richard C. Webster, M.D.

2:30 P.M. Joseph Safian, M.D.
PROGRESS IN NOSE AND CHIN IMPLANTS

3:00 P.M. Salvador Castanares, M.D.
PARTIAL OR TOTAL LOSS OF CARTILAGINOUS SEPTUM - A MODIFICATION OF RHINOPLASTY

3:30 P.M. Richard E. Straith, M.D.
RHINOPLASTY AS SEEN THROUGH NASAL SCAR EXCISION SITE

9:00 A.M. - 4:00 P.M. PRESS - Royal Suite, Third Floor, Tower Four

WEDNESDAY, FEBRUARY 5, 1969

8:00 A.M. - 10:30 A.M.
REGISTRATION Gazebo - Main Lobby

8:30 A.M. - 9:00 A.M.
COFFEE AND HOSPITALITY - Pan American Room, Tower Four

9:00 A.M. - 12:00 P.M. Simon Fredricks, M.D., Chairman
SCIENTIFIC SESSION - Pan American Room, Tower Four

9:00 A.M. THE SURGICAL FACE LIFT - Herbert Conway, M.D.

9:30 A.M. John R. Lewis, Jr., M.D.
THE SEGMENTAL APPROACH TO FACE LIFTING

10:00 A.M. AGING IN THE MALE - Michael M. Gurdin, M.D.

10:30 A.M. FOREHEAD LIFTS - Richard E. Straith, M.D.

11:00 A.M. Mar W. McGregor, M.D.
COMPLICATIONS AND PROBLEMS OF FACE LIFTING

11:30 A.M. DISCUSSION OF PAPERS

12:00 - 1:30 P.M. BREAK FOR LUNCH

1:30 P.M. - 3:30 P.M. Thomas J. Baker, Jr., Chairman
SCIENTIFIC SESSION - Pan American Room, Tower Four

1:30 P.M. Salvador Castanares, M.D.
BLEPHAROPLASTY FOR THE AGING LIDS

2:00 P.M. THE SUBCUTANEOUS MASTECTOMY - Simon Fredricks, M.D.

2:30 P.M. Claude Dufourmental, M.D.
MAMMOPLASTY BY THE LATERAL METHOD

3:00 - 3:30 P.M. DISCUSSION OF PAPERS

3:30 P.M. BUSINESS MEETING (Active Members Only)

9:00 A.M. - 4:00 P.M. PRESS - Royal Suite, Third Floor, Tower Four

7:00 P.M. - 8:00 P.M. COCKTAIL HOUR

8:00 P.M. ANNUAL DINNER (Semi-Formal)

Week-at-a-Glance

Thursday, April 19, 2007

- 6:30am-4pm** Registration Open at Javits Convention Center, South Concourse
Committee Meetings
ASAPS Board of Directors Meeting
ASERF Board of Directors Meeting
- 7:30am-1pm** **Special Pre-Meeting Cadaver Workshops**
S1 Endoscopic Technique in Facial and Forehead—A Cadaver Workshop
Instructors: Renato Saltz, MD, Grady B. Core, MD, Felmont F. Eaves, III, MD, & Richard J. Warren, MD
- 7:30am-11:30am** **S2 Barbed Sutures: Theory and Use**
Instructor: Gregory L. Ruff, MD
- 2-6pm** **S3 Open and Closed Precision Rhinoplasty—A Cadaver Workshop**
Instructors: Joe M. Gryskiewicz, MD, Paul H. Izenberg, MD & Robert M. Oneal, MD
- 2-6pm** **S4 Hair Transplantation for Alopecia Following Facelifting**
Instructors: Alfonso Barrera, MD & Carlos O. Uebel, MD
- 2-6pm** **S5 Facial Rejuvenation by MACS Lift—A Cadaver Workshop**
Instructors: Mark L. Jewell, MD, Patrick L. Tonnard, MD, & Alexis M. Verpaele, MD

Friday, April 20, 2007

- 6:45am-5pm** Registration Open at Javits Convention Center, South Concourse
Special Seminars
Badges and tickets were mailed to U.S. surgeons. Seminars at the Marriott.
- 7:45am-5pm** **S6 Rhinoplasty Symposium: Improving the Results of Primary and Secondary Rhinoplasty**
Co-Chairs: Ronald P. Gruber, MD & Robert M. Oneal, MD
- 8am-5pm** **R Residents & Fellows Forum**
Co-Chairs: Julius W. Few, MD & Clyde H. Ishii, MD
Made possible by an educational grant from Allergan Medical.
- 8:30am-5:30pm** **S7 Advances in Minimally Invasive Face & Body Rejuvenation Featuring Live Patient Demonstrations**
Co-Chairs: Jeffrey M. Kenkel, MD, Clifford P. Clark, MD, Steven Fagien, MD & Rod J. Rohrich, MD
Made possible by educational grants from Allergan Medical, Artes Medical, BioForm Medical, Lumenis, Medicis Aesthetics, Sanofi-Aventis/Dermik and Thermage.
- 8am-5pm** **S8 Advanced Cardiac Life Support (ACLS) Provider Course**
Instructor: Charles Bortle
- 8am-5pm** **S9 Medical Life Drawing and Sculpture**
Instructor: Grant R. Fairbanks, MD
- 8am-12noon** **S10A AAAASF Inspector Training Workshop**
Instructors: James A. Yates, MD, Alan H. Gold, MD, Gary M. Brownstein, MD, David D. Watts, MD, Harlan Pollock, MD, Geoffrey R. Keyes, MD, Michael F. McGuire, MD, Jeff Pearcy, Theresa J. Griffin, Pamela Baker, John D. Newkirk, MD, and Rachele Springer
- 8am-12noon** **S11 Gel Breast Implants: Use, Efficacy and Safety**
Chair: Richard A. D'Amico, MD
- 8am-12noon** **S12 Practice Management—The Critical Elements for Success**
Co-Chairs: Mark L. Jewell, MD & Robert Singer, MD
- 12:30pm-4:30pm** **S13 Hot Topics/Emerging Technology in Plastic Surgery**
Moderators: William P. Adams, Jr., MD, Joe M. Gryskiewicz, MD, & V. Leroy Young, MD
- 1pm-6:30pm** **S14 Cosmetic Rehabilitation of the Post-Bariatric Patient**
Co-Chairs: Al Aly, MD & Jeffrey M. Kenkel, MD
- 1pm-5pm** **S10B AAAASF Medicare Inspector Training Workshop**
Instructor: Michael F. McGuire, MD
- 2pm-6:30pm** **S15 Basic PowerPoint® and Basic Patient Imaging**
Instructors: Samuel J. Beran, MD and Joshua Greenwald, MD
- 2pm-6:30pm** **Optional Courses**
- 7pm-10pm** **Videotape Theater**
- 7-8pm** **Women's Martini Hour**
Sponsored by Mentor Corporation.

Saturday, April 21, 2007

- 6:30am-5:15pm** Registration Open at Javits Convention Center, South Concourse
- 7:15am** **Scientific Session**
Celebration DVD—History of the Aesthetic Society
Stanley A. Klatsky, MD
- 7:30am** **Program Chairs' Welcome**
Foad Nahai, MD & Jeffrey M. Kenkel, MD
- 7:45am** **New York Welcome**
Sherrell J. Aston, MD
- 9am** **ASERF Welcome**
Alan H. Gold, MD
- 10:15am** **ASAPS President's Welcome**
James M. Stuzin, MD
- 11am** **Panel—Facial Rejuvenation—A 40-Year Retrospective—What Has Stood the Test of Time?**
Moderator: Robert Singer, MD
Panelists: Sherrell J. Aston, MD, Thomas J. Baker, MD, Fritz E. Barton, Jr., MD, & Bruce F. Connell, MD
- 11:30am** **Panel—Facelift Complications—Distortion, Hematoma and Nerve Injuries**
Moderator: James M. Stuzin, MD
Panelists: Daniel C. Baker, MD, Barry M. Jones MD, & Val Lambros, MD
- 12:15pm** **Special Presentation—The History of the Aesthetic Society—Celebrating 40 Years**
Thomas J. Baker, MD
- 12:15pm-1:15pm** **Coffee in the Exhibits**
- 12:15pm-1:45pm** **Papers**
Interactive Video—Short Scar FAME Technique
Presenter: Sherrell J. Aston, MD
Moderator: Rod J. Rohrich, MD
Discussant: Joel J. Feldman, MD
- 12:15pm-1:45pm** **Lunch in the Exhibits**
- 1:45pm** **Optional Courses**
- 3:15pm** **S18 Research & Innovative Technology Luncheon**
Co-Chairs: William P. Adams, Jr., MD & Joe M. Gryskiewicz, MD
Made possible by an educational grant from Sanofi-Aventis/Dermik.
- 4:15pm** **S19 Women Plastic Surgeons' Luncheon**
Co-Chairs: Susan E. Downey, MD & Linda Goluch Phillips, MD
Sponsored by Mentor Corporation.
- 4:45pm** **Panel: Blending Lid/Cheek Junction—Divergent Approaches Similar Results?**
Moderator: Foad Nahai, MD
Panelists: Sam T. Hamra, MD, T. Roderick Hester, MD, J. William Little, MD, Bryan C. Mendelson, MD, & Edward O. Terino, MD
- 5:15pm** **Panel: Shaping the Upper Eyelid as an Isolated Procedure—Five Consecutive Cases**
Moderator: Charles H. Thorne, MD
Panelists: Mark A. Codner, MD, Steven Fagien, MD, & Glenn Jelks, MD
- 5:30pm** **Coffee Break in the Exhibits**
- 6:30pm** **Papers**
Corporate Sponsorship Awards
Lawrence S. Reed, MD & James M. Stuzin, MD
- 7:30pm** **Panel: Challenges in Male Brow Rejuvenation—Five Consecutive Cases**
Moderator: Fritz E. Barton, Jr., MD
Panelists: Bahman Guyuron, MD, Val Lambros, MD, Z. Paul Lorenc, MD, & Timothy J. Marten, MD
- 9am-4:30pm** **Adjourn**
Welcome Reception—Marriott Marquis
Sponsored by NexTech, Inc.
- 9am-4:30pm** **Special Seminar for Patient Coordinators Only**
S16/S17 Skills for the Successful Patient Coordinator
Instructors: Karen Zupko & Jennifer Bever

▲ Earn 8 Patient Safety CME Credits by attending the entire Scientific Session.

Visit the ASAPS web site for on-line physician registration, hotel reservations and course updates www.surgery.org/meeting2007

Sunday, April 22, 2007

6:30am-5pm **Registration Open at Javits Convention Center, South Concourse**
Scientific Session A

7am **Panel: Silicone Gel Implants—What are the Advantages?**
 Moderator: Foad Nahai, MD
 Panelists: William P. Adams, Jr., MD, Dennis C. Hammond, MD, G. Patrick Maxwell, MD, & Michael Scheffan, MD

8am **Panel: Role of Pedicle Position in Breast Shaping**
 Moderator: Jeffrey M. Kenkel, MD
 Panelists: Olle Asplund, MD, Jack Fisher, MD, Moustapha Hamdi, MD, & David A. Hidalgo, MD

9am **Interactive Video: Circumvertical Augmentation Mastopexy**
 Presenter: Dennis C. Hammond, MD
 Moderator: Elizabeth J. Hall-Findlay, MD
 Discussant: Frank R. Lista, MD

10am **Coffee Break in the Exhibits**

10am **Papers**

11am **Panel: Management of Breast Implant Malposition—An Interactive Panel with Member Submitted Cases**
 Moderator: Jack Fisher, MD
 Panelists: Sharon Giese, MD, James C. Grotting, MD, Roxanne J. Guy, MD, & Scott L. Spear, MD
Made possible by educational grants from Allergan Medical and Mentor Corporation.

12noon **Lunch in the Exhibits—or ASAPS/ASERF Business Luncheon**
Sponsored by MediCredit.

Scientific Session B

7am **Panel: The Role for Barbed Sutures in Facial Rejuvenation**
 Moderator: James M. Stuzin, MD
 Panelists: Nicanor Isse, MD, Malcolm D. Paul, MD, Gregory L. Ruff, MD, & Woffles Wu, MD

8am **Interactive Video: Breast Rejuvenation/Reshaping with Autologous Fat**
 Presenter: Sydney R. Coleman, MD
 Moderator: Scott L. Spear, MD
 Discussant: Felmont F. Eaves, III, MD

9am **Panel: Technical Challenges in the Use of Long Lasting Fillers**
 Moderator: Rod J. Rohrich, MD
 Panelists: Steven R. Cohen, MD, Miles H. Graivier, MD, Rhoda Narins, MD, & Danny Vleggaar, MD

10am **Coffee Break in the Exhibits**

10:30am **Papers**

11am **Panel: Breast and Body Contouring—Procedure Oriented Safety**
 Moderator: Peter B. Fodor, MD
 Panelists: Jeffrey M. Kenkel, MD, Foad Nahai, MD, & V. Leroy Young, MD

12noon **Lunch in the Exhibits—or ASAPS/ASERF Business Luncheon**
Sponsored by MediCredit.

2pm-6:30pm **Optional Courses**

7pm-10pm **Videotape Theater**

9am-12noon **Special Seminar for Patient Coordinators Only**
S20 Advanced Discussions for Patient Coordinator Course Alums
 Instructor: Karen Zupko

Monday, April 23, 2007

7:15am-5pm **Registration Open at Javits Convention Center, South Concourse**
Scientific Session

7:45am **Joyce Kaye Educational Session**
Joyce Kaye Lecture—Patient Safety Panel
 Moderator: Robert Singer, MD
 Panelists: Felmont F. Eaves, III, MD, James C. Grotting, MD, Geoffrey Keyes, MD, & Robert London, MD—anesthesiologist

8:45am **Panel: "Spreading the News"—Role of the Media**
 Moderator: James M. Stuzin, MD
 Panelists: Sarah Bernard, Sanjay Gupta, MD, Edith Updike, Denise Mann, & Max Paul

9:45am **Journalistic Achievement Awards**
 Michael F. McGuire, MD

10am **Coffee Break in the Exhibits**

10:30am **Papers**

11am **Panel: Difficult Primary Rhinoplasty (Member Submissions)**
 Moderator: Bahman Guyuron, MD
 Panelists: Onur Erol, MD, Ronald P. Gruber, MD, Jack P. Gunter, MD, & Rod J. Rohrich, MD

12noon **Interactive Video: Closed Rhinoplasty**
 Presenter: Mark B. Constantian, MD
 Moderator: Jack A. Friedland, MD
 Discussant: Gustavo A. Colon, MD

1pm **Lunch in the Exhibits**

Open Forums

S22 New Member Open Forum
 Chair: Barbara B. Hayden, MD
 Vice Chair: Joe M. Gyskiewicz, MD

S23 Candidate Open Forum
 Chair: Michael C. Edwards, MD
 Vice Chair: Patrick K. Sullivan, MD

Optional Courses

2-6:30pm **VIP Reception**

6:30pm **Videotape Theater**

7-10pm **Presidential Cocktail Reception**

8pm **Presidential Dinner/Dance**
Sponsored by Medicis Aesthetics.

Tuesday, April 24, 2007

7am-12noon **Registration/Information Desk at Javits Convention Center, South Concourse**
Scientific Session

6:30am **New Board of Directors Organizational Meeting**

7:30am **Body Contouring Research Foundation Presentation—Personal Trends in Liposuction—A 20 Year Perspective**
 Introduction: Julio L. Garcia, MD
 Presenter: Richard A. Mladick, MD

8am **Panel: Precision Shaping in Abdominoplasty—Challenging Current Concepts**
 Moderator: Al Aly, MD
 Panelists: Alan Matarasso, MD, Harlan Pollock, MD, Osvaldo R. Saldanha, MD, & Kenneth C. Shestak, MD

9am **Papers**

9:30am **Coffee Break in the Exhibits**

10am **Panel: Role of Autologous Fat in Breast Shaping**
 Moderator: Foad Nahai, MD
 Panelists: Louis P. Bucky, MD, Sydney R. Coleman, MD, Emanuel Delay, MD, & Gino Rigotti, MD

11am **Panel: Problem Cases in Massive Weight Loss (Member Submissions)**
 Moderator: Jeffrey M. Kenkel, MD
 Panelists: Al Aly, MD, Loren J. Borud, MD, Felmont F. Eaves, III, MD, & Dennis J. Hurwitz, MD

12noon **Lunch in the Exhibits**

1:00pm **Panel: Minimally Invasive Body Contouring Surgery**
 Moderator: V. Leroy Young, MD
 Panelists: Diane I. Duncan, MD, Dennis C. Hammond, MD, Karen Kim, MD, & Steven A. Teitelbaum, MD

2pm **Papers**

2:30pm **Special Presentation: Autologous Fat Transfer for Buttock Augmentation**
 Constantino Mendieta, MD

2:45pm **Papers**

3:30pm **Panel: International Perspectives on Facial Rejuvenation—Transition from the 20th to the 21st Century**
 Moderator: Thomas M. Biggs, MD
 Panelists: José Guerrosantos, MD, J. William Little, MD, Ivo Pitanguy, MD, & Frank Trepsat, MD

4:30pm **Adjourn**

5pm **International Reception—Marriott Marquis**

* Registration hours subject to change.

Botox, Restylane, Thermage and Fraxel have created new treatment categories within cosmetic medicine. Many new treatments and categories of varying effectiveness will likely come in the future. Ultrasonic fat reduction without added liposuction is a heartbeat away. Autologous tissue grown in a lab in the form of breasts is reportedly a few years away. And even cosmetic medicine is not insulated from challenge. A true botulinum type A cream is reportedly two years away. Will it be prescription or OTC?

Can a new paradigm manage the growing and undefined world of providers, treatments and competition?

Slice: Surgeons exist to operate
Core: Aesthetic plastic surgery must evolve

Marketing and Communications

The web. Advertising. Media. Gossip. When it comes to aesthetic surgery or cosmetic medicine, these are pervasive, accessible and influential and they can also be inaccurate, make false claims and come from poor sources. With such a doctrine, it's easy to understand why some view marketing and communications as Pandora's box.

Freedom of speech applies to cosmetic medicine. So does the freedom not to speak. The conflict arises when only one voice speaks.

From a micro-view, marketing is measured by ROI (return on investment): the number of procedures tracked to an ad or effort must cover the cost of that ad or effort, at a minimum. Even if you don't

advertise, messages affect your practice; for example, radio spots for a revolutionary non-surgical facelift by a competitor. Your office gets calls asking for the procedure. You can turn away callers, find yourself forced to debate the value of the latest gimmick.

From a macro-view, new societies with pseudo-credentials are growing both in the number of members and in the number of groups that exist. One unhappy patient or political crier can open the floodgates with a web site or blogging that lives in Google's top ten. One unproven innovation can influence the spinmasters resulting in morning news programs that look like infomercials. A company can fly beauty editors to the Caribbean for a beauty weekend before a treatment receives FDA approval and suddenly the women's books are filled with promise and anticipation.

Continued on Page 21

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Why I Joined the Aesthetic Society

By Michelle J. Zweifler, MD

It is a privilege to be a member of the American Society for Aesthetic Plastic Surgery.

I am so honored to have been asked to contribute this article since I too will be celebrating my fortieth birthday this year. Birthdays are a time to reflect back on our past accomplishments, assess where we are now, and plan for the future.

The journey to become a member of ASAPS has been both challenging and exciting.

Residency training, studying for board examinations (can we ever forget the blue case books), and the oral examinations are initial criteria for membership. The beginning years of practice and collecting the necessary aesthetic cases have enabled us to become members of this prestigious society. I feel that we are a part of an impressive professional community. We distinguish ourselves by educating our residents in the art of aesthetic surgery and fostering their involvement in research and technology.

ASAPS offers excellent scientific conferences to allow for peer exchange of ideas and the learning of new techniques in aesthetic surgery. Communication with our colleagues via ASAPS is outstanding. One of the reasons I wanted to be part of ASAPS was to have the opportunity to collaborate with and learn from the masters of aesthetic surgery.

We need to unite with colleagues in other specialties as well and work as a team to provide the highest level of care to our

One of the reasons I wanted to be part of ASAPS was to have the opportunity to collaborate with and learn from the masters of aesthetic surgery.

patients especially in the areas of injectables and non-invasive surgical techniques. After educating the FDA, we are now able to provide silicone gel implants to all our augmentation patients, giving patients a choice about available options.

Education of the public is exceedingly important as people need to be more enlightened in order to make informed decisions regarding their bodies. Nip/Tuck and blogs should not be the providers of patients' knowledge of cosmetic surgery.

Nip/Tuck and blogs should not be the providers of patients' knowledge of cosmetic surgery

We need to make society aware of the importance of patient safety. ASAPS members are held to the highest ethical standards and educate patients about realistic expectations.

The use of an accredited surgical facility needs to be emphasized for quality patient care and safety. The name of ASAPS should be recognized by the public

as the forefront of aesthetic plastic surgery.

I often refer to myself as a psychiatrist with a scalpel since we as aesthetic surgeons need to be able to communicate to our patients the risks, benefits and limitations of cosmetic surgery as well as the ultimate rewards. This will help us as members of ASAPS maintain our high professional standards with our patients.

We often hear "age before beauty," but due to our scientific advances and expertise it is now often difficult to differentiate between beauty and age.

The society is at the vanguard in the areas of the business practices of plastic surgery, as well as, patient education and well being.

Keeping with our 40th birthday celebration, we need to meet the demands of society while continuing to maintain the highest ethical standards. We need to assist one another, our young members and the future generations in order to keep alive the goals of our founding fathers. And most importantly, we need to ensure that the next forty years will be as successful and influential as the first.

Happy Birthday to all of us!

Michelle J. Zweifler, MD, FACS

The Aesthetic Surgery Education and Research Foundation

The Beginnings



On Patriots' Day, April 20 1993, Dr. Simon Fredricks, Dr. Robert Singer and Aesthetic Society Executive Director Bob Stanton discussed details for the development of a charitable, not-for-profit organization based upon advancing the practice of aesthetic surgery by providing for the enhancement of patient and public welfare, research, public service, public education, plastic surgery education and the public image of the professions.

The Aesthetic Surgery Education and Research Foundation (ASERF) would be the first plastic surgery organization to include lay persons and the only plastic surgery organization where 100 percent of its funding would go to directed research.

The ASERF Board would have up to four members-at-large positions available to non-surgeons. It was recognized that several of our constituencies did not have the opportunity to share in the educational programs provided by the organized plastic surgery community. Many people who might consider plastic surgery as a career did not have access to the information that could assist in their decision-making process. Many office staff members work in an aesthetic practice although they have had few opportunities for professional development.

It was decided that the first program developed would provide an educational lecture to staff members of aesthetic surgery facilities and that the program would be created in honor of Mrs. Joyce Kaye who had helped pioneer the practice management classes and lectures available to plastic surgeons.

The Joyce Kaye Annual Memorial Lecture became a rallying point for plastic surgeons and lay persons who supported the need for such endeavors. The fund for the Lectureship expanded to \$13,050 and the first lecture was given at no charge to an audience of approximately 475

attendees, including members of the Plastic Surgery Administrative Assistants on Wednesday, April 20, 1994 in Dallas, Texas. The panel was moderated by President Simon Fredricks, M.D. and panelists included: Fritz E. Barton, Jr., M.D., (Dallas, TX), Norman M. Cole, M.D. (Louisville, KY) and Gustavo A. Colon, M.D., (Metairie, LA).

In the first year of the Foundation 436 Charter Members joined, contributing \$52,983. Mentor and McGhan became the first two Corporate members of the ASERF contributing \$2,000 each. Representatives of Corporate members, under the Bylaws, were given the right to vote and to hold office.

The ASERF awards program consists of annual awards of:

- a \$750 prize to the resident who makes the best aesthetic surgery presentation at a plastic surgery meeting,
- a \$750 award to the aesthetic surgeon whose philanthropic surgical assistance to citizens of less fortunate countries best exemplifies humanitarian service,
- a Tiffany crystal trophy for the best scientific presentation at the Aesthetic Society Meeting,
- \$750 and a crystal box for the best panelist at the Aesthetic Society meeting,
- \$1,000 for the best video presentation at the Aesthetic Society meeting,
- a plaque for the best scientific exhibit at the Aesthetic Society meeting,
- a certificate for the best scientific exhibit by a resident at the Aesthetic Society meeting, and
- \$1,000 for the best aesthetic surgery journal article.

Other awards are for Teaching Course Excellence (a bust of Queen Nefertiti), Distinguished Service Award (trapezoidal crystal trophy) and for Special Merit an engraved silver bowl are presented for

extraordinary service and are not required to be given on an annual basis.

In December 1993, the ASERF was invited to become a member of the National Advisory Council on Family Violence. Dr. Marie Christensen (Minneapolis, Minnesota) was appointed chair of the Foundation's Domestic Violence Committee.

Since then ASERF has awarded grants on such important topics as:

- Histologic Effect of CO2 Laser Resurfacing on Skin Pretreated with Retin-A
- An Analysis of Growth Factors Responsible for Adipocyte Proliferation
- Evaluation of Pulmonary Function Changes Following Breast Reduction Surgery in Patients with and without Pulmonary Disorders
- Breast Augmentation Patient Survey: Patient Satisfaction and Breast Augmentation Patient Survey: Informed Consent and Follow-up
- In Search of Safety: Lidocaine Disposition in Large Volume Liposuction

Today, Aesthetic Society members continue this tradition of research, philanthropy and community involvement. ASERF has grant monies available to any member who has a legitimate research protocol and is willing to have it reviewed by the ASERF Research Committee. We have expanded our awards to include the Ted Lockwood Award for Excellence in Body Contouring and special Community Service Awards for those members who have taken volunteerism to a greater level. As ASERF works for even greater expansion of its research mission, we thank those who envisioned this Foundation and commend those who continue its growth and relevancy for the Specialty.

The Aesthetic Society Education and Research Foundation

A tradition of strong leadership in Education and Research

We would like to thank the following physicians for devoting their time and effort to starting ASERF and maintaining its mission:

ASERF Board Members 2006–2007

Alan H. Gold, MD – President
Laurie A. Casas, MD – Vice President

Mark L. Jewell, MD – Treasurer
Jeffrey M. Kenkel, MD – Secretary

James M. Stuzin, MD – ASAPS President
Foad Nahai, MD – ASAPS President-Elect

1993/1994

Simon Fredricks, MD – President
Norman M. Cole, MD – Vice President
Lawrence L. Ketch, MD – Secretary
Frederick M. Grazer, MD – Treasurer
Sherrell J. Aston, MD – ASAPS President
Robert Singer, MD – ASAPS President-Elect
James L. Baker, Jr., MD – ASAPS Vice President

1994/1995

Simon Fredricks, MD – President
Norman M. Cole, MD – Vice President
Lawrence L. Ketch, MD – Secretary
Frederick M. Grazer, MD – Treasurer
Robert Singer, MD – ASAPS President
James L. Baker, Jr., MD – ASAPS President-Elect
Gustavo A. Colon, MD – ASAPS Vice President
Mr. James McGlothlin – Member-at-Large

1995/1996

Simon Fredricks, MD – President
Norman M. Cole, MD – Vice President
Lawrence L. Ketch, MD – Secretary
Frederick M. Grazer, MD – Treasurer
James L. Baker, Jr., MD – ASAPS President
Gustavo A. Colon, MD – ASAPS President-Elect
Lawrence B. Robbins, MD – ASAPS Vice President
Mr. James McGlothlin – Member-at-Large

1996/1997

Simon Fredricks, MD – President
Norman M. Cole, MD – President-Elect
Robert Singer, MD – Vice President
Francis G. Wolfort, MD – Secretary
Jeffrey Lang, MD – Treasurer
Gustavo A. Colon, MD – ASAPS President
Lawrence B. Robbins, MD – ASAPS President-Elect
John G. Penn., MD – ASAPS Vice President
Mr. James McGlothlin – Director

1997/1998

Norman M. Cole, MD – President
Robert Singer, MD – President-Elect
Jeffrey Lang, MD – Vice President
Robert W. Bernard, MD – Treasurer
Francis G. Wolfort, MD – Secretary
Lawrence B. Robbins, MD – ASAPS President
John G. Penn., MD – ASAPS President-Elect
Fritz E. Barton, Jr., MD – ASAPS Vice President
Simon Fredricks, MD – Trustee
Lawrence L. Ketch, MD – Trustee

1998/1999

Norman M. Cole, MD – President
Robert Singer, MD – President-Elect
Jeffrey Lang, MD – Vice President
Robert W. Bernard, MD – Treasurer
Francis G. Wolfort, MD – Secretary
John G. Penn., MD – ASAPS President
Fritz E. Barton, Jr., MD – ASAPS President-Elect
Daniel C. Morello, MD – ASAPS Vice President
Simon Fredricks, MD – Trustee
Lawrence L. Ketch, MD – Trustee

1999/2000

Norman M. Cole, MD – President
Robert Singer, MD – President-Elect
Jeffrey Lang, MD – Vice President
Robert W. Bernard, MD – Treasurer
Francis G. Wolfort, MD – Secretary
Fritz E. Barton, Jr., MD – ASAPS President
Daniel C. Morello, MD – ASAPS President-Elect
Malcolm D. Paul, MD – ASAPS Vice President
Simon Fredricks, MD – Trustee
Lawrence L. Ketch, MD – Trustee

2000/2001

Norman M. Cole, MD – President
Robert Singer, MD – President-Elect
Jeffrey Lang, MD – Vice President
Robert W. Bernard, MD – Treasurer
Francis G. Wolfort, MD – Secretary
Daniel C. Morello, MD – ASAPS President
Malcolm D. Paul, MD – ASAPS President-Elect
Franklin L. DiSpaltro, MD – ASAPS Vice President
Simon Fredricks, MD – Trustee
Lawrence L. Ketch, MD – Trustee

2001/2002

Robert Singer, MD – President
Jeffrey Lang, MD – President-Elect
Francis G. Wolfort, MD – Vice President
Alan H. Gold, MD – Secretary
V. Leroy Young, MD – Treasurer
Malcolm D. Paul, MD – ASAPS President
Franklin L. DiSpaltro, MD – ASAPS President-Elect
Robert W. Bernard, MD – ASAPS Vice President
Norman M. Cole, MD – Trustee
Simon Fredricks, MD – Trustee

2002/2003

Robert Singer, MD – President
Jeffrey Lang, MD – President-Elect
Francis G. Wolfort, MD – Vice President
Alan H. Gold, MD – Secretary
V. Leroy Young, MD – Treasurer
Franklin L. DiSpaltro, MD – ASAPS President
Robert W. Bernard, MD – ASAPS President-Elect
Peter B. Fodor, MD – ASAPS Vice President
Norman M. Cole, MD – Trustee
Simon Fredricks, MD – Trustee

2003/2004

Robert Singer, MD – President
Jeffrey Lang, MD – President-Elect
Franklin L. DiSpaltro, MD – Vice President
Alan H. Gold, MD – Secretary
V. Leroy Young, MD – Treasurer
Robert W. Bernard, MD – ASAPS President
Peter B. Fodor, MD – ASAPS President-Elect
Mark L. Jewell, MD – ASAPS Vice President
Norman M. Cole, MD – Trustee
Simon Fredricks, MD – Trustee

2004/2005

Jeffrey Lang, MD – President
Alan H. Gold, MD – President-Elect
Franklin L. DiSpaltro, MD – Vice President
V. Leroy Young, MD – Treasurer
Rod J. Rohrich, MD – Secretary
Peter B. Fodor, MD – ASAPS President
Mark L. Jewell, MD – ASAPS President-Elect
James M. Stuzin, MD – ASAPS Vice President
Bahman Guyuron, MD – Director
Jeffrey M. Kenkel, MD – Director
Robert Singer, MD – Trustee
Norman M. Cole, MD – Trustee
Simon Fredricks, MD – Trustee

2005/2006

Jeffrey Lang, MD – President
Alan H. Gold, MD – President-Elect
Franklin L. DiSpaltro, MD – Vice President
V. Leroy Young, MD – Treasurer
Rod J. Rohrich, MD – Secretary
Mark L. Jewell, MD – ASAPS President
James M. Stuzin, MD – ASAPS President-Elect
Foad Nahai, MD – ASAPS Vice President
Bahman Guyuron, MD – Director
Jeffrey M. Kenkel, MD – Director
Robert Singer, MD – Trustee
Norman M. Cole, MD – Trustee
Simon Fredricks, MD – Trustee

Members to Vote on Slate of Candidates

Active members of the American Society for Aesthetic Plastic Surgery (ASAPS) will hear reports on Society business; vote on proposed changes to the Bylaws and elect new officers for 2007–2008 during the ASAPS Annual Business Luncheon. All active members are invited to attend on Sunday, April 23.



President
Foad Nahai, MD

Atlanta, GA
Automatically ascends to President.



President-Elect
Alan H. Gold, MD

Great Neck, NY
Private practice; Clinical Associate Professor of Surgery, New York Hospital-Cornell University Medical Center
Current Board Position: Vice President, ASERF President
Past Board Positions: Historian, Parliamentarian
ASAPS Committee work: Administration Commission (Past Chair), Communications Commission (Past Vice Chair), Public Education (Past Chair), Symposia, Traveling Professor

National Affiliations: ASAPS, AAAASF, ASERF, ASPS, PSEF
Training: State University of New York Downstate Medical Center; General
Surgery Residency: North Shore University Hospital, Manhasset, NY; Hand
Surgery Fellowship: Nassau University Hospital, East Meadow, NY; Plastic
Surgery Residency: State University of New York-Kings County Hospital Center, Brooklyn, NY
ABPS certification: 1979



Vice President
Renato Saltz, MD

Salt Lake City, UT
Private Practice; Adjunct Professor, University of Utah School Of Medicine
Current Board Position: Secretary
ASAPS Committee work: Symposium Committee (current chair), International Committee, Clinical Editor of *Aesthetic Surgery Journal*.
National Affiliations: ASAPS, AAPS, ACS, ASPS, PSEF
Training: Universidade Federal Rio Grande do Sul School of Medicine; General Surgery Residency: Jackson Memorial Hospital, University of Miami, Miami, FL; Plastic Surgery Residency: University of Alabama, Birmingham, AL
ABPS certification: 1992



Treasurer
Felmont F. Eaves, III, MD

Charlotte, NC
Private Practice
Current Board Position: Treasurer
ASAPS Committee Work: Patient Safety Committee (current chair), Administrative Commission (current chair), Strategic Planning Committee, Body Contouring Committee (current chair), Editorial Board, Aesthetic Surgery Journal.
National Affiliations: ASAPS, ASPS, PSEF, ACS, AMA
Training: University of Tennessee School of Medicine; General Surgery Residency; University of Texas, Southwestern Medical Center; Plastic Surgery Residency; Emory University School of Medicine; Post Graduate Fellowship; Endoscopic and Minimally-Invasive Plastic Surgery, Emory University School of Medicine
ABPS certification: 1996

Continued on Page 19

Members to vote on Slate of Candidates

Continued from Page 18



Secretary

Jeffrey M. Kenkel, MD

Private Practice; Chairman, Department of Plastic Surgery, The University of Texas Southwestern Medical Center

Current Board Position: Member at Large

ASAPS Committee Work: Finance and Investment Committee (current chair), Time and Place Committee (current chair), Education Commission (current vice-chair), Program Committee (current vice-chair), ASERF Secretary.

National Affiliations: ASAPS, ASPS, PSEF,AMA, A4M

Training: Georgetown University School of Medicine; Georgetown University School of Medicine; General Surgery Residency; Plastic Surgery Residency, University of Texas Southwestern Medical Center

ABPS certification: 1998



Member at Large Julius W. Few, MD Three-year term



Member at Large Charles H. Thorne, MD Three-year term



Member-at-Large Paul D. Faringer, MD 3-year term



Trustee Three-year term Jeffrey Lang, MD



Ethics Committee Canada and North Claudio Delorenzi, MD Three-year term



Southwest Brandon Kallman, MD Three-year term



Judicial Committee/ West Lorne Rosenfield Three-year term

Membership Committee All three-year terms



Northwest: Richard Baxter, MD



Florida: Onelio Garcia, MD



Southern California: Susan Downey, MD



Shannon Leeman

Aesthetic Surgery in the Media

Continued from Cover

response the piece received and said “We must do another plastic surgery piece in a year or so.” What a difference a decade makes! Today it is impossible to open any woman’s magazine or newspaper without being bombarded with best lists, horror stories and surgery do’s and don’ts. Until recently journalists were reporting almost exclusively on face and eyelid lifts, breasts, liposuction and the occasional chemical or laser peels.

Ten years ago Botox was still in it’s “whisper, nudge, nudge” phase. Plastic surgery was perceived as something the rich and famous did. *Town and Country*, *Vogue* and *W* magazines all championed the surgeons who understood discretion and rarely spoke with the press. Basically, plastic surgery had not yet filtered down to the malls of America. Every town had it’s own “best surgeon” well before the ubiquitous smile clinics and drop-in Botox centers erupted across the country. Surgeons were pillars of their local communities and women quietly bragged about whom had “done” their faces. Women (at the time, plastic surgery was almost exclusive to women) saved up for their face lifts and planned them like a military operation. It was a right of passage that women who drank martinis, and met their husbands at the door after work, maintained was their due. Surgery was a privilege, not a right. The cosmetic surgery menu was shorter and the consumer was offered fewer options. Face lifts were the gold standard. Reporting on plastic surgery was in its infancy and although a solid ground swell of interest was building, I could never have imagined daily programming and reporting on the subject. Surgeon Dr. Gerald Imber suggested to me at the time that I might want to look into some sort of broadcasting work on cosmetic surgery. The idea was revolutionary and I thought it would never sell.

And then came 9/11. My work writing on plastic surgery almost dried up over night. Suddenly it felt foolish to be worried or write about sagging breasts when our country was under attack and so many had lost their lives. Our surgical self-obsessions went underground. I couldn’t sell an editor on the subject for a good year, and though many doctors were loathe to admit it, the trend must have been reflected in surgeons’ waiting lists. As the threat of attack started to fade, the blackout on plastic surgery reporting was slowly lifted.

The new millennium saw big changes in the way the media reported on Cosmetic Surgery. The amount of infor-

reported on all of it, only to do an about face the following year, reporting on how dangerous or outdated the latest innovation or technique was. Anti-Aging technology was booming and the public was hungry for the information.

I remember dermatologist, Dr. Arnie Klein saying to me at the time “the reason there are so many different fillers is because none of them ticks all the boxes!” A plethora of hucksterism misinformed and confused the public.

New York Plastic surgeon, Dr. Daniel Baker only recently commented “I am spending a lot more time with my patients today as they have so much information,



mation foisted on the public exploded as a result of television, radio, editorials, infomercials and advertising. Shows like, *Extreme Makeover*, *the Swan* as well as daily news programs created an almost circus-like atmosphere which many doctors denounced as the accuracy and realistic expectations were often in question or abandoned.

Writers were flooded with press releases from surgeons and cosmeceutical companies touting their latest makeover machines. Press packs landed on my desk daily, without a medical degree it was hard to discern what was worth reporting on and what was bunk. Words such as Yag, Co2, IPL, minimally invasive, lunch time procedures, and short scar lifts became part of our vernacular. In general we just

and need to sort out the hype from reality. Overall though I think journalists have become much more knowledgeable.”

As the number of annual surgery numbers increased so too did the analysis and criticism by the press. Plastic surgery was rapidly becoming show business, with personalities emerging from behind their surgical masks, which became a dangerous business as surgeons were laying themselves open for criticism and writers followed the scent of scandal.

Surgeon Dr. Gerald Pitman remarks, “Many in the entertainment media have sensationalized and trivialized plastic surgery with such programs as *Extreme Makeover*.” Many print journalists, on the other hand, have dug in and educated

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Aesthetic Surgery in the Media

Continued from Page 20

themselves in the details and nuances of plastic surgery. I have seen many more quality pieces which do a real service to the public in presenting not just the latest and sexiest new procedures, but also the perils and pitfalls.”

Notwithstanding the volume of sensational journalism, there are a number of writers whom have become much more educated on the subject. Journalists such as Joan Kron from Allure Magazine, Natasha Singer of the New York Times, Sarah Brown of Vogue, Lois Johnson of More, as well other reputable journalists, have consistently proven that unbiased and well-researched pieces on cosmetic surgery is possible. Pitman believes “some of their pieces are sometimes as detailed and substantive as articles in the Science section of the New York Times.” In my writing career I have endeavored to steer clear of unconstructive, negative pieces. I feel the public is looking for the best in reporting not cynical derisive journalism.

It's taken me years to really appreciate that 'new are not always good' and there should be a period of critical analysis. New procedures may only be adding to the size of the menu of options rather than genuinely benefiting the patient. The press office at ASAPS has been an incredible source of solid non-sensational information for me over the years. I have come to rely on them and all the members for reliable quotes and I have learned to temper my impulses to write up every new fad. Journalists are always looking for the latest, greatest injection, product, therapy or surgery. I have tried always to take an honest look at the benefit versus the perils. The pieces I write today are focused more on non-surgical procedures following the national trend. My readers are younger and include one of the biggest growth sectors, men. Statistics show and editors follow statistical trends, that men are the fastest growing and potentially lucrative group interested in staying young and vital.

So what's the secret to getting good press?

Though it might seem obvious, be charming, helpful, modest, yet very confident in what you offer. Give the journalists something unique to build a feature

around. Persistence does pay off even though editors hate to admit it, the squeaky wheel theory does work. Slow, or no news days are the nightmare every editor dreads, so be creative, and use interesting anecdotes to relate the story you want to get across. Amusing, innovative, heart rending stories are gold dust to a writer. Feel free to ask journalists what they are looking for and how you can help. If you can offer up a good story we need you. Be accessible. I tend to use the same doctors again and again for quotes and opinions as well as recommendations, if I can get through and speak directly with the doctor, or the office manager responds knowledgeably, remembers my name and gives and takes good messages. (The doctors I quote in this piece returned my messages on the same day). Being a good source for topical quotes effectively makes you the first person to call!

I often check doctor's websites to view their work and update my information. Think of your website as your waiting room. It tells potential clients a lot about you and an informative, easy to navigate site will reap rewards. Better to be looked over than over-looked. All of these trends have developed exponentially; websites are now the norm, as is cosmetic surgery.

To keep one step ahead or on a par with your peers you need to keep us, the journalist in the loop and have something exciting to offer.

I am a surgery advocate. I love the business, the operations and hopefully the results. If I can guide one person to the right doctor for their needs my job has been well done. We work together, not at odds.

Shannon Leeman has been writing at the highest level for journals and magazines for over a decade on the subjects of anti-aging, health, beauty and cosmetic surgery. She has won journalistic awards for her research and writing and has gained the respect of not only her colleagues but from the doctors and therapists to whom she refers.

Ms. Leeman has been a contributing editor to the Sunday Times, W magazine and Tatler magazine. She has consulted with numerous television series on style, anti-aging and cosmetic surgery and is writing a book on the subject.

Cosmetic Medicine

Continued from Page 14

Must aesthetic plastic surgery address marketing and communications?

Slice: Cater to them, ignore them or try to compete

Core: Connect to the right partners and media players who uphold your values, reach the masses and appeal to individual consumers

Evolution or revolution

It's happening all around the country. Cornfields are popular sites for new housing. Teardowns are equally in the spotlight. It's an odd mix of people and architecture in the neighborhood when the split-levels and raised ranches are being leveled in favor of more traditional construction. Yet in some neighborhoods, the old brownstones and three flats of prior decades are being renovated into single-family homes, with plenty of room for our near-affluent and affluent appetites.

Cosmetic medicine is not much different from housing. Medi-spas are cropping up anywhere. Might they become the teardowns of the future? If the paradigm is too trendy, no doubt they will.

Does aesthetic plastic surgery need to be torn down and rebuilt into cosmetic medicine?

Slice: Historical landmarks are often the target of rebels, rebuilding is only a matter of time.

Core: Preserve the original structure, but make room for today and anticipate tomorrow.

Marie Czenko-Kuechel is a consultant to the plastic surgery community including private and university-based practices worldwide, and an advocate for consumer safety in cosmetic medicine. She is the author of the practice management guide "Aesthetic Medicine: Practicing for Success" and the author, contributor and editor of numerous consumer and practice management books and articles. She has appeared nationally on CNN, Good Morning America, Today and other programs, is editor-at-large to "NewBeauty" magazine and a regular contributor to the NBC local television stations group.

The "Anatomical Lady," the body-based guide to clinical education online, stands ready to assist Aesthetic Society Candidates, 24/7



How It Works

Click on any section of her anatomy, and a "Results Page" shows clinical educational content available on that topic. For example, a click on her nose displays a "Results Page," which lists rhinoplasty and associated videos from recent annual meetings.

Some of these presentations are the "Interactive Videos" from the meetings: The surgeon/speaker shows a videotaped surgery and stops the action at key places to give more information and answer questions. Candidate Dr. Alper Sari of Mersin, Turkey, writes, "It is really a [privilege] to have the opportunity to reach all these master-class videos..."

Other Options

In addition, there are even more options now available for Candidates. Scroll down, below the image of the "Anatomical Lady" and search for clinical education content by procedure, speaker, keyword, and Patient Safety CME.

Aesthetic Society Candidate, Charles Perry, MD, Sacramento, CA, summed it up beautifully, "This is fantastic news. Thank you for including us."

Do you have a favorite speaker? Is there a surgeon's outcome that you admire? Do you want to examine Mark Codner's blending of the lid/cheek juncture, observe Bruce Connell's invisible stitching technique around the ear or watch a close-up video of a complicated surgical technique? Now, it is possible with a simple Internet connection.

Candidates, Residents, and Chiefs of aesthetic surgery residency programs received an e-mail announcement in December 2006, stating that they will be allowed to view the online education features which had been in the members-only section. Dr. Sam Bartholomew, Davis, CA, writes, "I wanted to give you feedback on the ASAPS website clinical library to which I was recently granted access. It is amazing. I am a plastics resident and have found the resource incredibly helpful. Thanks!"

Satisfying Educational Needs

Aesthetic Society President, Dr. James M. Stuzin, welcomed the Board decision to open up this key educational area to candidates and residents:

"It is vitally important that the Society maintain its leadership position in the field of Aesthetic Surgery education. What better way than to use web-based technology to provide education in a convenient, easy-to-use format for the plastic surgeons who are in the beginning years of their careers. It just makes good sense to open the clinical education library to these physicians and to assist them further with their training. Education is the primary mission of the Aesthetic Society; and in my opinion, the key to both patient safety and consistent results in cosmetic surgery is quality aesthetic surgery education."

There is a lot to discover for Aesthetic Society Candidates at www.surgery.org/members/clinicaleducationlibrary.php

Category 1 CME Credits

There are also many CME credits available online. The credits are free for all text-based educational activities. Articles from the Aesthetic Surgery Journal, which have been repurposed online, are designated for CME Category 1 credit. There is the convenience of online and immediate scoring of CME exams, providing instant feedback and, if necessary, the chance to retake the exam. Additionally, you have the option to automatically send the passed exam to the Society headquarters with the click of your mouse. The CME exam results are recorded and forwarded to The ASPS on a quarterly basis.

Additionally, Category 1 CME Credit was assigned to several annual meeting videos. Watching these videos is complimentary, but if the CME Category 1 credit option is desired, there is a nominal fee to help defray the costs of operating the system.

As you watch the various videos, the size of the window in which the video plays may not be adjustable to full screen. This will change as the streaming technology improves. For now, the windows are optimized to be as large and adjustable as possible while ensuring a smooth video streaming image, which translates to an even, movie-like, seamless viewing experience.

Candidates continue to voice their appreciation for having this access. "I looked at the site... This is exactly what I was hoping to find," Mary Powers, MD., Long Beach, CA. Moreover just as Newport Beach, CA's Dr. Lavinia Chong expresses that she is confident that "...this link has great utility in my daily practice," —So are we!

Feedback Is Welcome

Call Distance Education Manager, Darlene Oliver at 800-364-2147 or email Darlene@surgery.org for assistance.

FIRST IMPRESSIONS ARE EVERYTHING

Before Extreme Makeover



DRLANDSMAN.COM

After Extreme Makeover



Before Extreme Makeover



SOUTHBAYPLASTICSURGERY.COM

After Extreme Makeover



You only have one chance to make a great first impression

In today's digital world, your website is often a patient's first introduction to your practice. To successfully convert prospects into patients, your practice website needs a state-of-the-art image and good quality patient education information. To continue creating great first impressions for website visitors, the average website needs to have its image updated every 18-24 months. Are you ready to bring your website to the next level with an Einstein Medical Extreme Website Makeover?

Video customized websites

The next generation's websites are now available at Einstein Medical. Ask about customized video productions for your practice website!

A commitment to excellence makes us #1

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Cosmetic Medical Practices and Medical Spas**

Data conversion is available from Data Medic®, Inform Solutions®, Ivy®, Lytec®, Medical Manager®, WebMD® Medical Manager, Misys®, Medic®, and numerous others.

For a demonstration CD, or to inquire about our module-based pricing, please contact
NexTech at: **800.490.0821** email: sales@nextech.com ~ www.nextech.com

New NexEMR, NexASC & NexSpa Modules!

ASPS® Consent Forms now included with NexForms!