



# Aesthetic Society News

Quarterly Newsletter of the American Society for Aesthetic Plastic Surgery

Volume 12, Number 4 Fall 2008

## Society to Begin on-line CME Project in Peri-operative Patient Safety

### Pilot Program to Launch in Spring, 2009

In an effort to provide verifiable benchmarks to the plastic surgeon's practice and improve outcomes and process, the Aesthetic Society has begun implementation of a web-based education module for reducing risk of hypothermia in the office-based practice.

This program, modeled after successful programs at the University of California and other Centers of Excellence, follows a simulation model to implement simple, but effective remedies for the avoidance of hypothermia over-layered with "Lean" healthcare principles that can improve process and safety in every aspect of the surgeon's work.

"As part of our Patient Safety Committee charge, we started looking at the issues of process and utilization improvement and how they could benefit our colleagues" said Felmont (Monte) Eaves, III, MD, Chair of the peri-operative subgroup and Vice President of ASAPS. "We started learning about the Toyota Production System model and its application to medicine called Lean Healthcare. Our group thought it could be a tremendous value to members to have a self-learning option that addressed a potentially dangerous consequence of surgery, hypothermia, and apply Lean principles to its correction."

Lean Healthcare, as described by industry expert Mark Graban at the recent Aesthetic Meeting, 2008 Joyce Kaye

### Culture of Safety

Lecture, "is a system about developing talent and building people's skills and problem solving abilities." Hospitals (and free standing surgical suites) would do well to adopt a similar goal—"building people before treating patients." While

buildings and equipment are important, healthcare is ultimately about people.

One example of a Lean method is called "Standardized Work." There is a systems and tools component—defining and agreeing upon the ONE BEST WAY of doing any activity, and of course doing in a safe, high quality manner. Today's standardized work is just the starting point for future improvement, what we call "kaizen."

We say standard-IZED (emphasize on the IZED) because our goal is not to have people robotically following a "cookbook" process. Remember, it's the THINKING production system... there are times when judgment is necessary, but we standardize what we can at the right level of detail. Finally, standardized work is not forced on people. To gain acceptance, it must be written by the people who do the work, not some outside expert."

One example comes from Aesthetic Society member Dr. John B. Tebbetts. Dr. Tebbetts took it upon himself to study Lean, finding innovative applications to his own practice—quality and efficiency

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## Aesthetic Surgery Training in the United States:

### Taking Back Our Identity

By Jeffrey M. Kenkel, MD



As many of you are aware, the guidelines for training in aesthetic surgery are sorely outdated for our residency programs and virtually nonexistent for our aesthetic

fellowships. At the recent Aesthetic Society Strategic Planning Session, I was charged by ASAPS President Alan H. Gold, MD, to put together a task force to evaluate this serious issue and make recommendations as to how we might be able to secure a better future through education.

I have learned that the Residency Review Committee is in the process of updating requirements for residents, which leaves us to focus on fellowship training. At this time there is no model or standard; although there are 23 fellowships offered in Aesthetic, Body, and Breast surgery, 75% of these are one year programs with 68% having an academic affiliation.

Any proposal should involve some type of a graduated 12 month education. What can ASAPS offer?

In 2000, a fellowship committee was

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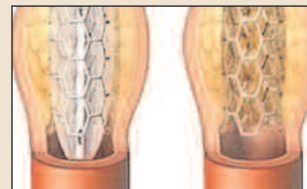
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## Aesthetic Society News

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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## November 1, 2008

### Breast/Body Contouring Pre-Meeting Symposium

Chicago, IL

Co-Sponsored by ASAPS/ASPS

Contact: ASPS 800-766-4955

## November 13 – 17, 2008

### Advances in Aesthetic Plastic Surgery: The Cutting Edge VII

The Hilton New York, New York, NY

Endorsed by ASAPS

Contact: Francine Leinhardt

212-702-7728

## January 15, 2009

### Second Annual Oculoplastic Symposium

InterContinental Hotel, Atlanta, GA

Endorsed by ASAPS

Contact: Susan Russell

435-729-9459 or [srussell@gunnerlive.com](mailto:srussell@gunnerlive.com)

## January 16 – 18, 2009

### 25th Annual Breast Surgery Symposium

InterContinental Hotel, Atlanta, GA

Endorsed by ASAPS

Contact: Susan Russell

435-729-9459 or [srussell@gunnerlive.com](mailto:srussell@gunnerlive.com)

## January 23-25, 2009

### Expanding Horizons—New Paradigms in Aesthetic Surgery of the Face and Breast

Wynn, Las Vegas, NV

Co-Sponsored by ASAPS/ASPS

Contact: ASPS 800-766-4955

## February 5-7, 2009

### 43rd Baker Gordon Symposium on Cosmetic Surgery

Hyatt Regency Miami, Miami, FL

Endorsed by ASAPS

Contact: Mary Felpeto

305-859-8250

## February 20-23, 2009

### American-Brazilian Aesthetic Meeting

Yarrow Hotel, Park City, UT

Jointly Sponsored by ASAPS

Contact: Luanna Squerzi via

email at [americanbrazilian](mailto:americanbrazilian)

[aestheticmtg@gmail.com](mailto:aestheticmtg@gmail.com)

## March 4-8, 2009

### 12th Annual Dallas Cosmetic Surgery Symposium and 26th Annual Dallas Rhinoplasty Symposium

Westin Galleria, Dallas, TX

Endorsed by ASAPS

Contact: Giau Nguyen at

214-648-9280

Email: [dallasRhinoplasty@](mailto:dallasRhinoplasty@)

[utsouthwestern.edu](mailto:utsouthwestern.edu)

## May 2 – 7, 2009

### The Aesthetic Meeting 2009

Mandalay Bay Resort

Las Vegas, NV

Contact: ASAPS

800-364-2147

[surgery.org/meeting2009](http://surgery.org/meeting2009)

## June 13-20, 2009

### Aesthetic Surgery on the Eastern Mediterranean—Biennial Cruise

(Greek Isles and Turkey)

Co-Sponsored by ASAPS/ASPS

Regent Seven Seas Navigator

Contact: ASAPS at 800/364-2147

[surgery.org/cruise2009](http://surgery.org/cruise2009)



## Just the Facts

There's no question, with the upsetting news from Wall Street and elections looming that these are unsettling economic times for all of us. It's easy to get caught up in the latest headlines, see open spaces on our surgical calendar and think the worst. While economic realities can't be refuted, I would like to offer some solid facts that, I suggest, help balance out the equation:

1. According to our own annual statistics, there has been a 456 percent increase in the total number of cosmetic procedures performed between 1997, when we began gathering these data to 2007, the date of our last report. This includes economic downturns in the late 1990's and the after-effects of the 9/11 tragedy. The interest in improving and maintaining one's personal appearance and reducing the telltale signs of aging remains strong in our society and continues to increase globally.
2. The burgeoning growth of laser therapies and injectables provides an attractive lower cost, although more limited and temporary, option for some patients than surgical intervention, and can additionally augment your practice through a slackening in consumer spending.

There is much evidence to support this conclusion, including data available to all members through the joint Aesthetic Society/ASPS Cosmetic Medicine Taskforce; you can find this data at [www.surgery.org](http://www.surgery.org) in the members only section.

We are also implementing a customer survey through our relationship with the consumer site [www.realself.com](http://www.realself.com) that asks beauty consumers directly where their spending will go within the next twelve months. Results of the survey

3. Economists and business experts alike all recommend careful pricing strategies over fire sale discounting

According to a report published by international consulting firm McKinsey & Company careful strategies based on your total patient value proposition augmented with selective services and market-bearing price will consistently weather any business through an economic downturn. In other words, augment more expensive procedures with less invasive, less expensive alternatives, and remember to be mindful of the "value proposition" of the patient's experience.

### Your Aesthetic Society Membership: more valuable than ever

I may be biased but, in all the years I have attended Aesthetic Society Meetings, they have consistently grown in quality, content and clinical relevancy, and you seem to agree with me. According to our most recent member survey, more than 92 percent of ASAPS members thought that our current educational offerings met their needs. And this year, registration fees for The Aesthetic Meeting 2009 will be frozen at last year's rates.

Education is, of course, the cornerstone of our organization. However, we also have product offerings, both as member benefits and available for sale, that you can use in your practice today. Among them are:

- Practices of Office and Patient Safety, [www.practicesofofficesafety.org](http://www.practicesofofficesafety.org) an online staff training program free of charge to all ASAPS and ASPs members. To sign up your staff just enter "ASAPS" or "ASPS" as the password and you're ready to go.

- The Cycle of Care Resource Book, our joint product with ASPs, containing all pre and post operative patient information forms, worksheets, letters and other documents for aesthetic and reconstructive procedures. This product is also available through and fully integrated with the NexTech practice management software.
- A variety of practice marketing brochures and patient consultation worksheets
- Enhanced Practice Profile web pages that provide effective Internet exposure to your practice and introduces you to additional prospective patients are available to all members for a nominal fee
- Resources and signage from the Physicians Coalition for Injectable Safety, [www.injectablesafety.org](http://www.injectablesafety.org)
- Resources and new products from the Aesthetic Society/ASPS Beauty for Life program, available through [www.surgery.org](http://www.surgery.org) in the members only section and on [www.plasticsurgery.org](http://www.plasticsurgery.org). Make sure to visit the site [www.beautyforlife.com](http://www.beautyforlife.com), where this program, a benefit of member dues, is showing significant traffic in the "find a surgeon" function.
- An exciting new offering through a recent agreement with the popular consumer website [www.realself.com](http://www.realself.com):

RealSelf has agreed to create a message board/blog site exclusively for ASAPS members where you can go and answer questions directly from consumers about a variety of plastic surgical procedures and injectables. RealSelf will identify you as an ASAPS member and create a profile page for you with your website address—providing another source of referrals.

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# Working with the Community of Plastic Surgery

By Renato Saltz, MD



When I became a member of the Aesthetic Society in 1994, the world of the aesthetic surgeon was very different than the one we face today. For example:

- Silicone breast implants were banned by the FDA except in clinical trials or for reconstructive uses
- Botulinum Toxin type A (BOTOX Cosmetic) was nowhere near FDA approval, not entering the market until 2002
- Most patients considering plastic surgery wouldn't dream of having a procedure performed by a gynecologist, dentist, internist or any other specialty except for a properly trained plastic surgeon
- Medi-spas didn't exist
- The internet was in its infancy

Clearly, much has changed. Now, instead of competing with other plastic surgery specialties for patients, we're competing with just about anyone who calls themselves a "cosmetic surgeon." Aggressive advertising campaigns and the reach of the Web have confused patients and muddled our position as highly

credentialed, experienced ABMS Board-certified surgeons.

Today, it can be argued, we as members of the Aesthetic Society, have much more in common with our colleagues in Facial and Ocular surgery, and Dermatology than ever before. It's true that all these groups have differing scopes of practice and organizational views. However, as the Aesthetic Society's President-Elect, I would like to ask something radical:

## Should we work more closely with them?

We already have a successful model of collaboration with the Physician's Coalition for Injectable Safety ([www.injectablesafety.org](http://www.injectablesafety.org)), where two of these groups, AAFPRS, ASOPRS and now ISAPS, the International Society of Aesthetic Plastic Surgeons, and the Canadian Society for Aesthetic (cosmetic) Surgery, have joined forces with us to inform the public about unsafe injectable practices and help members eradicate the proliferation of off-shore injectables. When

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we, as organized plastic surgery, come together for specific objectives like patient safety or legislative advocacy, we can only be stronger with our messages together than apart.

Perhaps this could extend to educational opportunities as well. While I am not suggesting that we invite physicians who are not aesthetic surgeons to our Annual Meeting, there are a number of "core" educational venues of high quality where we could learn from each other.

Corporative efforts could be a strong antidote to the proliferation of "weekend courses" geared towards everyone from Family Practitioners to Dentists trying to enter the aesthetic arena; lowering standards, compromising patient safety and confusing the public. I would be very interested in your opinion on this issue: are we better off working with Board-certified plastic surgeons in different specialties but all with years of training and education or going it alone in our struggles with so-called "Cosmetic Surgeons" or "Cosmetic Doctors" who in many cases, have little or no training at all?

Please direct your thoughts to [rsaltzmd@surgery.org](mailto:rsaltzmd@surgery.org); everyone on the Executive Committee is here for the membership and we need your views on this important issue.



# Why I became involved in the Aesthetic Society.

By Robert W. Kessler

I finished my plastic surgery residency and began my career as an active duty plastic surgeon with the US Air Force. I was excited about being a plastic surgeon and wanted to be an ASPS member. I knew nothing about the Society but wanted to be a member of this prestigious group that I had worked so hard to become a part of.

Shortly thereafter I learned about the Aesthetic Society, which had further requirements beyond board certification. I was interested in cosmetic surgery and so I worked to meet the requirements of this subspecialty Society.

The military was supporting me during this time and I was comfortable in my position. The Society rules and regulations did not concern me as I found them quite easy to follow in my institutional role. In addition to this, my dues were subsidized by the government, which meant no out of pocket expense to me. I was just along for the ride.

I knew I was not destined for a military career and separated from the Air Force to complete an aesthetic fellowship and begin private practice. By my second year in private practice, I began to question what I was paying Society dues for as finances became tight. I began to feel certain aspects of the code of ethics were restricting my ability to compete with non-plastic surgeons infiltrating our "turf." In addition to this, I was feeling very isolated in my solo practice and missed the camaraderie of my plastic surgeon colleagues.

I found myself in discussions with fellow young plastic surgeons complaining about the relative ineffectiveness of the Societies in competing with the "cosmetic surgeons" and the perceived lack of interest in helping young plastic surgeons develop their practices.

I decided rather than sit back and complain about how the Societies failed to help me, I would get involved and learn more. I thought if there was a way, I would try to work within the system to implement changes which would benefit me and my peer group.

With minimal outreach beginning at the last ASAPS meeting, I found senior members of the organization willing to discuss all aspects of business and advertising, not to mention the free exchange

of ideas on surgical technique and help with difficult cases. I found the camaraderie among colleagues which I have missed since leaving the Air Force. I also realized the leadership is acutely aware of "my" concerns and is acting upon them at all levels from regional to national.

The more I reach out to the senior membership, the more I appreciate the depth and diversity of our profession and the quality of the people in our group. These positive experiences have encouraged me to become more involved. I have developed an appreciation for our Societies and the role they play. Like so many things in life, the more effort you put into something the greater your reward.

So I expressed interest in becoming involved in the Society and was soon appointed to a position on the Electronic Communications Committee.

In the short time I have been on the Committee I have seen firsthand the value of our Society in the practice management arena, how our leadership gathers and proactively addresses issues which affect each of our practices on a daily basis, and the enormous effort that goes into protecting the rights of the members which are always at the forefront.

I have seen how truly aware our leaders are of the obstacles which face our profession and the thought which is going into helping the membership meet the challenges of the future.

The system is not perfect but it can be changed with your involvement. There is no doubt in my mind that collectively we are stronger than we are alone. There are formidable challenges ahead for us. Our greatest chance for success is to be proactive and speak with one voice. Our Society is the vehicle. Our leadership is open to ideas to help meet the challenges. Don't leave the Society complaining that it does nothing for you; join and help make the changes you know will benefit our profession.

*Robert W. Kessler, MD is an Aesthetic Surgeon in private practice in Newport Beach, California and a member of the ASAPS Electronic Communications Committee.*



## 2009 PhRMA Marketing Code

### Say Goodbye To Your Free Pens

**Bribe: payment made to a person in a position of trust to corrupt his judgment**

#### The Problem

No one likes the word, but it sums up the problem neatly. Device and pharmaceutical manufacturers have come under heightened government and media scrutiny for their marketing practices with physicians, and thus two leading trade associations have been leapfrogging (PhRMA 2002, AdvaMed 2003, PhRMA 2009) to develop ever more stringent codes of conduct, with AdvaMed being expected to match PhRMA, possibly by January, 2009.

These marketing codes are not entirely altruistic: even though compliance is voluntary, the Department of Health and Human Services will benchmark PhRMA 2009 in its investigations. In other words, industry is attempting to outrun the whip, i.e. self-regulate, before HHS does it for them.

#### It Takes Two to Tango

When HHS finds improper marketing practices, they automatically find physicians on the receiving end. Consequently, it is in ASAPS' members interests to both understand and support PhRMA 2009; extensive Q&A is provided at [www.phrma.org](http://www.phrma.org). Furthermore, any individual or organization resisting compliance will likely be subjected to heightened HHS scrutiny, because the implied goal of eliminating bribes is unassailable:

**“A healthcare professional’s care of patients should be based, and should be perceived as being based, solely on each patient’s medical needs and the healthcare professional’s medical knowledge and experience.”**

**When HHS finds improper marketing practices, they automatically find physicians on the receiving end. Consequently, it is in ASAPS' members interests to both understand and support PhRMA 2009**

#### Culture of Influence.

PhRMA 2009 makes sweeping changes to correct the existing culture of influence in every arena, including industry use of patient data, marketing perks, CME relationships, and corporate support. If losing your Pfizer flash drive seems like overkill, remember that while HHS treats bribes case by case, PhRMA 2009 is designed to eradicate the entire disease of corruption. Read *PhRMA 2009 By Topic* for a full explanation of how you and your colleagues will be affected. Skip to **What You Will Notice** for the highlights only.

#### PhRMA 2009 By Topic Presentations by Field Reps and Managers

**Permitted:** Must be in-office or in-hospital, conducive to informational communication, and modest meals.

**Prohibited:** Restaurants, resorts, entertainment, recreation, spouses and take-out.

#### Presentations by Consultants and Speakers

**Permitted:** Conducive to informational communication and modest meals; restaurants ok, field reps can be present.

**Prohibited:** Resorts, entertainment, recreation, spouses and take-out.



#### Entertainment and Recreation

**Permitted:** None, even when associated with an educational event

**Prohibited:** Everything, including tickets to the theater, sporting events and equipment, leisure or vacation trips, and resorts

#### CME Support

**Permitted:** Bona fide educational programs

**Prohibited:** Fake CME as an inducement to prescribe or recommend treatment, meals and costs of travel, lodging or personal expenses of non-faculty

#### ASAPS/ASPS

**Permitted:** Financial support to third-party scientific and educational sponsors

**Prohibited:** Financial support for travel, lodging or personal expenses of non-faculty healthcare professionals attending the meeting, except for scholarships (see below)

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## 2009 PhRMA Marketing Codes

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### Consultants at Company Sponsored Meetings

**Permitted:** Reasonable (fair market) compensation, travel, lodging, modest meals for bona fide consulting arrangements, as shown by a written contract, legitimate need and number of consultants and meetings, directly relevant selection criteria, detailed records, and disclosure to formulary committees

**Prohibited:** Entertainment, recreation and resorts; honoraria or travel or lodging expenses to non-faculty and non-consultant healthcare professional attendees

### Speaker Programs

**Permitted:** Reasonable (fair market) compensation, travel, lodging, modest meals for bona fide speaking arrangements, including extensive training, which provides a valuable service to the company, reasonable number of engagements and disclosure to formulary committees

**Prohibited:** Fake speaker arrangements as an inducement to prescribe or recommend treatment; entertainment, recreation and resorts

### Scholarships

**Permitted:** Financial assistance for medical students, residents and fellows to attend educational conferences

**Prohibited:** Selection of the scholarship recipient (selection by the academic or training institution is okay)

### Non-Educational Items

**Permitted:** Samples

**Prohibited:** Everything else, including pens, note pads, mugs with logos, flowers, art, CDs, tickets, cash, gift certificates

### Educational Items

**Permitted:** <\$100 value, occasionally given, with zero non-professional use (anatomical models, for instance)

**Prohibited:** Items with non-professional use, such as DVD players

### Prescriber Data

**Permitted:** Responsible company use of prescriber data, i.e. confidentiality

**Prohibited:** Company use of such data when healthcare professional denies permission

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**ASAPS has formed a task force to identify and, to the extent reasonably possible, remedy marketing inequities among our vendors, exhibitors and corporate supporters, while preserving their important function of keeping you educationally current on the latest scientific and practice information.**

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### What You Will Notice

Pens, key chains, note pads and all “reminder gifts” will be history, along with 5 star dining, resorts, virtually all office gifts and absolutely all recreation and entertainment perks. Industry won't be paying for your spouse (who can't even be present at informational gatherings), meals will be modest, and when provided by field reps, will only be in your office or hospital. Technically, CEOs can still take you to nice restaurants (this part of the Code applies to field reps and their immediate managers, not CEOs), but don't count on it; you're more likely to hear from industry, “We wish we could, but...” in order for them to avoid even the appearance of corruption.

### What Won't Change

Advertising and corporate sponsorship (now called corporate “support”) will likely be unaffected, because money given to organizations which benefits all attendees equally is specifically permitted. Company sponsored CME at ASAPS meetings will also likely be unaffected, because PhRMA 2009 merely matches existing ACCME requirements that CME content be independent of industry influence.

### Why PhRMA 2009 Seems Unfair.

This is a situation similar to ASAPS' Code of Ethics: you can't advertise raffles, but your competitor can. Same here: these codes don't affect non-PhRMA and non-AdvaMed members, such as website

designers, insurers, software makers and publishers, all of which exhibit at our meeting. Accordingly, the ethical marketing playing field is not yet level, because only the device and pharmaceutical manufacturers are currently taking the high ground.

### How You Can Help

In order to fully implement the spirit of PhRMA 2009, i.e. intellectual objectivity in patient care, you can do your part by understanding the marketing limitations of PhRMA 2009, supporting the efforts of your device and pharmaceutical field reps to comply, and understanding that if you take the bait from industry, HHS will reel you both in.

### What The Aesthetic Society is Doing

ASAPS has formed a task force to identify and, to the extent reasonably possible, remedy marketing inequities among our vendors, exhibitors and corporate supporters, while preserving their important function of keeping you educationally current on the latest scientific and practice information. A further step would be to inquire whether ASAPS' membership would favor revising the Bylaws and Code of Ethics to adopt PhRMA's language:

**“A healthcare professional's care of patients should be based, and should be perceived as being based, solely on each patient's medical needs and the healthcare professional's medical knowledge and experience.”**

The Aesthetic Society continues to raise the educational bar for its aesthetic plastic surgeons; it is logical we should continue to raise the ethical bar as well. Send your thoughts to [aicher@sbcglobal.net](mailto:aicher@sbcglobal.net); your input is both welcome and vital to your Society's mission.

# Surgical Tourism: New Practice Paradigm or Business as Usual?

By James A. Matas, MD and Michael F. McGuire, MD

Medical and surgical tourism are being promoted to the public as never before. According to a recent report by the consulting firm Deloitte Center for Healthcare Solutions, in 2007 an estimated 750,000 Americans traveled abroad for medical care, a figure estimated to increase to six million by the year 2010.

Of course, surgical tourism is nothing new, either inbound or outbound. Major academic medical centers such as Massachusetts General Hospital, Johns Hopkins, Duke and the University of Chicago have had major outreach efforts to foreign countries for years. And some major American universities have recently developed formal relationships with foreign hospitals.

## From the New York Times, 1996:

### Hospitals Looking Abroad To Keep Their Beds Filled

*Not long ago, most foreign patients at the New England Medical Center were wealthy Europeans and Latin Americans. But now a patient from overseas is more likely to be someone like Gladys Soto Pilone, a 62-year-old retired schoolteacher, whose health plan in Argentina agreed to pay for breast cancer surgery in Boston last summer.*

*Reaching beyond their longstanding international clientele of royal potentates, celebrities and wealthy people, top-drawer medical centers including the Mayo Clinic, the Texas Heart Institute, the Cleveland Clinic and New England Medical are helping to fill their beds and pay their bills by wooing groups of less affluent foreign patients.*

*Famous medical centers still welcome heads of state from time to time, of course. Sheik Zayed bin Sultan al-Nahayan, president of the United Arab Emirates, checked into the Mayo Clinic in Rochester, Minn., for neck surgery in September. He brought an entourage of 140 people and stayed five weeks. Still, a push for more foreign patients*



International destinations invest heavily in medical tourism.

*has led hundreds of research and teaching institutions to create package deals and offer other inducements to attract private and government health plans in Latin America and the Middle East, as well as a small but growing number of patients from the Pacific Rim.*

This foreign desire for surgery in the U.S. continues today, and is based on obtaining the highest quality care, rather than seeking a “bargain” or a stay in some exotic resort.

However, with the recent trend in surgical “vacations” to locations such as Costa Rica and Brazil (among others) and “patient recruitment congresses” being held in several American cities, it appears that the pendulum may be swinging from royal potentates coming here for State of the art, premium healthcare to average Americans shopping for lower priced procedures overseas.

The question at hand is: do these new developments create a potential patient census concern or is this unlikely to be a significant threat to American medicine?

Information gathered by the Deloitte Healthcare report as well as information presented at the recent World Medical Tourism and Global Health Congress<sup>1</sup> suggests the following:

- “Third world” countries are creating hospitals with first world facilities, including physicians trained in the United States and Europe, state of the art equipment and a focus on customer service and patient satisfaction that rivals and at times exceeds anything to be found in a state-side hospital.
- The governments of Korea, United Arab Emirates, India, Brazil, Columbia, and Costa Rica are investing major promotion and infrastructure dollars in these programs.
- However, major managed care players don’t seem to be buying it; In fact, one major payor revealed that they see this foreign threat more as a possible way to lower reimbursement in this country.

From those presenting at the recent

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## Surgical Tourism

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**“Third world” countries are creating hospitals with first world facilities, including physicians trained in the United States and Europe, state of the art equipment and a focus on customer service and patient satisfaction that rivals and at times exceeds anything to be found in a state-side hospital.**

Congress, issues of continuity of care, case management, after care, credentialing, potential medical/legal liability for the facilitators and insurers, and outsourcing of US jobs were all raised as major concerns.

Anecdotal evidence via the recent Congress suggests that some patients are shopping for procedures overseas due to lack of insurance or being under-insured at home. The price of a coronary bypass or hip replacement in India is significantly lower than the usual and customary fees charged by the State-side academic medical center.

The Aesthetic Society and ASPS have developed a joint Taskforce, headed by us to study this issue—before it’s a serious concern we can’t impact. We will be working on it with our colleagues Scott Barttelbort, MD, Robert Singer, MD, Jeffrey Kenkel, MD, Mark Jewell, MD, Foad Nahai, MD, John Canady, MD, Linda Phillips, MD, Greg Evans, MD, Michael Edwards, MD, Renato Saltz, MD, and Fritz Barton, MD. We will submit our findings to a peer reviewed medical journal as a special report. If the readers of ASN have any thoughts on the subject we would love to hear from you. Please send any comments to us via [drmatas@surgery.org](mailto:drmatas@surgery.org).

*James A. Matas, MD is an aesthetic surgeon in private practice in Orlando, FL and Treasurer of the Aesthetic Society*

*Michael F. McGuire, MD is an aesthetic surgeon in private practice in Santa Monica, CA. He is Vice President of Communications for ASPS*

<sup>1</sup> San Francisco, CA Sept. 9-12, 2008

## Media Notes and Quotes

A Sampling of current media coverage on the Aesthetic Society

It’s no surprise I’m not alone in my quest for eternal youth. In 2007 almost 400,000 Botox procedures were done on patients ages 19 to 34, according to the American Society for Aesthetic Plastic Surgery.

Beginner Botox  
**Marie Claire Magazine**  
October 2008

Dr. Alan Gold, president of the American Society for Aesthetic Plastic Surgery, said that for the past year, sagging business has been the talk of cosmetic surgeons. “Everybody talks about it, nobody really has any numbers, so we polled our membership,” said Gold, whose suburban New York office is on Long Island....However, many Botox and filler patients are waiting longer than the usual three to four months between treatments, said Dr. Robert Singer, of La Jolla, Calif.

As Economy Sags,  
Faces Do Too, Cosmetic Docs Say  
**Associated Press**  
October 3, 2008

Even the medical establishment is revisiting the issue: The American Society for Aesthetic Plastic Surgery’s research arm is funding a breast-augmentation study. Patients are being recruited at [ClinicalTrials.gov](http://ClinicalTrials.gov). The cost of fat-grafting procedures for cosmetic breast surgery ranges widely, from \$15,000 to \$30,000 or more depending on the surgeon and clinic.

Stem Cells and Breast Surgery  
**Wall Street Journal**  
August 19, 2008

But these days, the growing number of cosmetic-surgery patients are motivated to quit for other reasons: vanity, and the threat of not being able to get a coveted new face, stomach or pair of breasts. “When someone hears this from an internist or cardiologist who says it’s really bad for you, it increases your risk of lung cancer, it’s bad for your heart,

people tend to blow that off if they’re feeling well,” said Dr. Alan Gold, the president of the American Society for Aesthetic Plastic Surgery. “But if they have a medical problem and are not going for just a routine checkup, they may tend to listen to that advice more.”

Want a Face-Lift?  
First, Better Stop Smoking  
**New York Times**  
August 13, 2008

The report cited American Society for Aesthetic Plastic Surgery (ASAPS) estimates that business is down by more than 50 percent. But, other than the price - there’s at least one other factor contributing to the decrease: recovery time. “They don’t find themselves able to take that kind of recovery period that they would have been able to take before from work - fearful that the job may not be there when they come back,” ASAPS President Dr. Alan Gold told CNN.

American Morning  
**CNN**  
August 13, 2008

Breast augmentation was the most popular cosmetic surgery for women in 2007 (closely followed by lipo), according to the American Society for Aesthetic Plastic Surgery (ASAPS)...“Twenty-five years ago, women weren’t told that implants weren’t permanent,” says Foad Nahai, MD, a plastic surgeon in Atlanta and the current president of ASAPS. “But patients I see now are still surprised. The first thing I tell any new patient is, ‘Please understand, these won’t be your last pair.’”

Terms of Endowment  
**Elle Magazine**  
July 2008



## Hurricane Ike Relief Fund

The Aesthetic Surgery Education and Research Foundation (ASERF) recently appealed to members to help victims of Hurricane Ike, the latest tropical storm to attack the Gulf of Mexico, particularly the city of Galveston, Texas. ASAPS and ASERF members, with their usual generosity, have been contributing to our Hurricane Ike Fund and we will deliver the funds to the Convoy of Hope, a four star rated charity distributing aid directly to Ike victims. My thanks to Mark Jewell, MD for coordinating this effort.



Gulf residents continue to clean up after Hurricane Ike

## Call for Grant Applications

As reported in a previous issue of ASN, The Aesthetic Surgery Education and Research Foundation (ASERF) is seeking competitive grant applications for the Allergan Foundation Breast and Cosmetic Medicine Research Grants. Four grants are available for the dollar amount of \$25,000 each. Eligible researches are limited to Residents, Fellows and Plastic Surgery Faculty in practice for less than two years.

Research projects should be EVIDENCE BASED MEDICINE OUTCOME STUDIES specific to women's issues, including but

not limited to: breast surgeries, Botulinum Toxins, fillers (collagen, HA's etc.) and cosmetics. Grant applications are available at [www.aserf.org](http://www.aserf.org); please submit your application no later than January 31, 2009. Award recipients' will

be announced at the Aesthetic Meeting, 2009 in Las Vegas, NV.

Recipients must be able submit semi-annual research updates, as well as guarantee ASERF the first right to publish research outcomes in various plastic surgery publications (such as The Aesthetic Surgery Journal).

## Have you considered joining ASERF?

Did you know that there is an organization which creates new patient service opportunities for plastic surgeons by proving what works and what doesn't and by investigating what is safe and what is not? Did you know that this organization is your research and development partner and has been funding studies with direct impact in your daily practice? This organization is the Aesthetic Surgery Education and Research Foundation (ASERF).

The fortuitous rise in introduction of new techniques and devices, developed by our colleagues and industry, has created a greater need for ASERF to increase its research activities. It is ASERF's role to study the efficacy and safety of these techniques and products so that you can expand your plastic surgery practice with comfort and confidence.

Every successful industry allocates about 10% of its annual budget to research and development. Even though ASERF plays such a role for the plastic surgeons, its budget is a fraction of the collective revenues of the plastic surgeons. ASERF has directed its resources to those investigations that are most pertinent to your practice. However, with the increase in new technology, ASERF needs to expand its research capabilities.

As President of ASERF, I have made it my mission to build upon what my capable colleagues, Drs. Gold, Lang, and others, have set up and to invigorate ASERF. Please join me to begin a new era for ASERF and to reach my goal of 100% ASAPS member participation in ASERF. There is no application process for becoming a member of ASERF. All you do is pay a membership fee. Please consider joining today.

## Attention Residents and Fellows: Enter our Social Media Contest and you might see your video on surgery.org and Youtube!

By Clyde H. Ishii, MD and Julius W. Few, MD

The Aesthetic Society is reaching out exclusively to Residents and Fellows to bring us further into the brave new world of social media while promoting The Aesthetic Society, patient safety, ABMS Board Certification (or Board eligibility) and realistic surgical expectations. This is an excellent opportunity for you to help the Specialty, support the Aesthetic Society Mission, flex your creativity and show all Board-certified plastic surgeons that you've got the right stuff!

Like any contest, this one has its rules and rewards.

### Let's start with the rules:

- Videos must be no more than two minutes in length and cannot be professionally produced
- Videos may not be posted on Youtube or any other media prior to submission
- You should invest no more than \$300.00 in producing your video
- Please maintain basic standards of good taste
- The contest is open to residents and fellows only
- You must obtain release forms from any talent used in your video. Release forms can be found at [www.surgery.org/youtubecontest](http://www.surgery.org/youtubecontest)
- Entries must be received no later than March 15, 2009

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**This is an excellent opportunity for you to help the Specialty, support the Aesthetic Society Mission, flex your creativity and show all Board-certified plastic surgeons that you've got the right stuff!**

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### Now for the rewards:

- The three to four winning entries will be heavily promoted at the Aesthetic Meeting, 2009 in Las Vegas, included on the [www.surgery.org](http://www.surgery.org) public information website and optimized for Youtube, Metacafe, Google and other social media sites.
- The winners, (residents and fellows only, please!) will receive a scholarship for their pre-approved expenses paid to attend The Aesthetic Meeting, 2009 in Las Vegas next May!

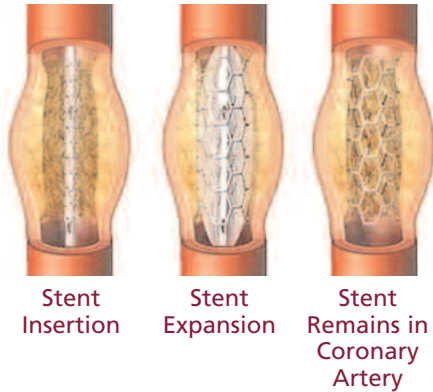
### Voting procedures:

- All entries will be voted on by a panel of Society members.
- High scores go for originality, and strong messages on board certification, value of ASAPS membership and patient safety.
- There are no restrictions on format or materials. Edgy entries are welcomed!

### How to enter:

Just email your entry to [youtubecontest@surgery.org](mailto:youtubecontest@surgery.org). Please include a brief email explaining your project and why your video is best along with your contact information. You can obtain release forms at [surgery.org/youtubecontest](http://surgery.org/youtubecontest). We hope you'll help us with this exciting venture and we look forward to seeing your submission!

*Clyde H. Ishii, MD is an Aesthetic Surgeon in private practice in Honolulu, HI and Chair of the Aesthetic Society's Resident's and Fellows subcommittee. Dr. Julius W. Few is an Aesthetic Surgeon in Chicago and Vice Chair of ASAPS Communication Commission*



## Minimizing Acute Thrombosis Risk in Patients with Prior Coronary Interventions Undergoing Procedures

The following advisory was supplied to *ASN* by Aesthetic Society President Alan H. Gold, MD. The editor gratefully acknowledges the Manhasset and Long Island Jewish Medical Center in New York for their contribution

Patients who have had prior coronary interventions and, in particular, drug eluting stents, create significant challenges when presenting to our operating rooms and procedure suites. There is a small but real risk of stent thrombosis when antiplatelet agents are withdrawn prior to procedures. Stent thrombosis has led to acute fatal myocardial infarctions during and shortly after procedures. This is becoming a widespread problem.

The American College of Cardiology (ACC) has issued clinical guidelines for preoperative preparation and management of stented patients. To help minimize the risk of stent thrombosis, the OR Booking Staff are now asking if patients are taking antiplatelet therapy (especially Plavix) at the time each case is booked. As of

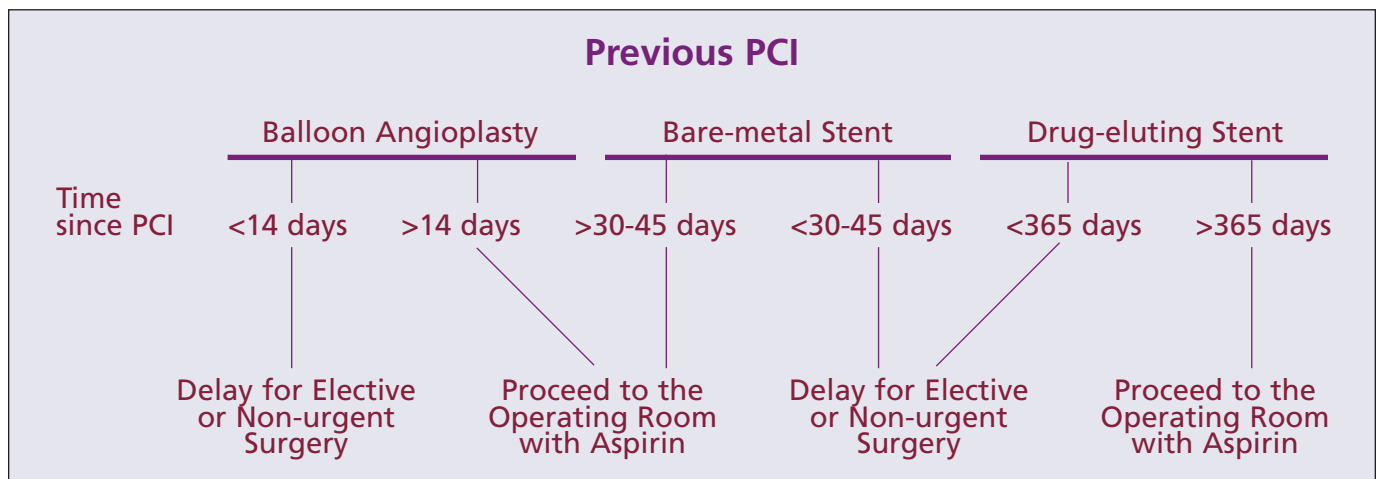
November 1st, 2008, this information will be required in order to proceed with booking. Surgeons and procedurists are encouraged to contact their patient's cardiologists and make a joint plan for management of antiplatelet agents well in advance of elective procedures. A risk benefit discussion should take place prior to the day of procedure with the patient. Their report can be found below.

### Preparation for Patients with Previous Coronary Interventions Being Scheduled for Noncardiac Surgery

Patients who require noncardiac surgery after percutaneous coronary intervention require special consideration. Coronary stent thrombosis in the perioperative setting, has become an emerging life threatening complication of surgery when antiplatelet agents have been withdrawn prior to surgery. The type of surgery, the timing since coronary stenting, and the type of coronary stent placed all factor into

the decision regarding stopping antiplatelet agents. The American Heart Association and American College of Cardiology have recently published new guidelines for the evaluation and care of such patients scheduled for noncardiac surgery.

When the risk of surgical bleeding is considered low, patients should be continued on aspirin and plavix throughout the perioperative period. The algorithm noted below serves as a guideline for the timing and medical preparation of patients with previous coronary interventions. Completely elective surgery, in patients with a drug eluting stent, should wait at least 12 months, before withdrawing plavix. Aspirin should ideally be continued. The risk of stent thrombosis does not disappear at 12 months. A risk/benefit discussion needs to occur between cardiologist and surgeon regarding individual patient needs and surgical demands prior to scheduling surgery.



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## On-line CME project

Continued from Cover

improvements that greatly benefit patients. His example shows that it is possible to take general Lean concepts, combined with tenacity and ingenuity, and to apply them to an area that many might argue could not be standardized: surgery.”

“Our program is remarkably simple in design and we hope will be effective” continued Dr. Eaves. “By taking information from the literature on the avoidance of hypothermia in the surgical suite and illustrating this information via simulations, quizzes and scenarios based on Lean principles, we hope to give members a roadmap to improve clinical outcome and process efficiencies. We have assembled a team from within and outside of the specialty to develop the program for us and make the learning experience as exciting and interactive as possible.”

*Current members of the peri-operative team include Dr. Eaves, V. Leroy Young, MD, Durward K. Sobek, II, Associate Professor, Dept. of Mechanical and Industrial Engineering, Montana State University, Elizabeth Skousen, PhD candidate, also at Montana State, Maurice Hitchcock, Professor and Director of Medical Education at University of Southern California (USC) School of Medicine, Tiffany Grunwald, Aesthetic Society Candidate with a specialization in medical education and online learning experiences, and other authorities as required by the project.*

## Aesthetic Surgery Training

Continued from Cover

created, chaired by Drs. Larson and Cunningham. They developed guidelines for post graduated education and a proposed curriculum which was really an extension of what the RRC published.

Currently ASAPS lists the fellowships on its website.

Our task force could help in the following ways:

- Update curriculum/criteria for all aesthetic fellowships (face, body, breast)
- Distribute information about programs to applicants
- Encourage academic and nonacademic programs to participate/create fellowships
- Standardize the application process
- Consider accreditation of programs
- Consider providing certification
- Publish yearly case numbers for fellows and residents benefit
- Provide an educational resource... *ASJ*, meeting reductions, separate “Fellows” forum
- Corporate sponsored fellowships through ASAPS (already an interest by EES)

It is time for us to take back our specialty by focusing on quality education. Our newly formed taskforce, Residency and Fellowship Guidelines for Training in Aesthetic Surgery, will get to work on this seminal issue and report on our progress at the May, 2009 Aesthetic Society Meeting.

*Jeffrey M. Kenkel, MD is a Professor and Vice Chairman of the Department of Plastic Surgery at The University of Texas Southwestern Medical Center at Dallas. He is Secretary of the Aesthetic Society and Chair of the Education Commission.*

## President's Report

Continued from Page 3

Content from [www.surgery.org](http://www.surgery.org) will be included in the site, giving greater credibility to your ASAPS membership among beauty consumers—the information also links back to our site. This is an outstanding opportunity available exclusively and free of charge to all members

- There are a variety of other practice marketing and education products in the member's only section of [www.surgery.org](http://www.surgery.org) ; I urge you to have a look at them and as always, we're here to help.

### Looking Ahead

The Aesthetic Meeting in Las Vegas May 2- 7, 2009 is shaping up to be one of our best meetings ever under the guidance of Jeffrey Kenkel, MD, Chair of the Education Commission and Jack Fisher, MD, Vice-chair. They have asked me to urge all members to consider submitting abstracts for the meeting; the deadline for submission is November 1, 2008. Abstracts will be grouped by topic, to include face, breast, body contouring, rhinoplasty, International Hot Topics, and miscellaneous topics. You may submit as many abstracts as you like; however, each presenter will be limited to only one presentation per topic. Each abstract must be a completed study and as extensive as possible to permit accurate review. Abstracts can be submitted online at <http://www.surgery.org/abstracts/>

### And Finally...

This is still a great time to be an aesthetic surgeon. Our specialized training, commitment to continuing education and life-long learning, our dedication to our patients and their safety, and the great satisfaction we get from providing them with increased self- esteem are things will remain constant...as will ASAPS' commitment to you.

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## Update on the Aesthetic Surgery Journal

### Final interviews for Associate Editor position to be held at Plastic Surgery, 2008 Meeting in Chicago; Editorial Office to move to Atlanta

The ASAPS Publications Committee has narrowed down an extensive list of highly qualified candidates for an Associate Editor to replace in-coming Editor-in-Chief Foad Nahai, MD to four exemplary finalists. These members, all published, thought and opinion leaders in aesthetic surgery with active practices, will be invited to present their vision for *ASJ* and philosophies on the Associate Editor role to a sub-group of the Committee at the Chicago ASAPS meeting. When final presentations are completed, a recommendation will be made to the Aesthetic Society Board of Directors and, if accepted, the new *ASJ* Associate Editor will commence work in January, 2009. An announcement of the Board Decision will be announced to all Aesthetic Society members.

In other *ASJ* news, the editorial offices, formerly housed in our New York Communications Office, will be moving to Atlanta also commencing in January, 2009. The move will allow the in-coming Editor-in-Chief to work directly and hands-on with Journal staff. This follows the model of numerous medical publications including *Plastic and Reconstructive Surgery*. The Journal team will continue to be employees of the Society, reporting to the Central Office.

### From the Pages of *ASJ*:

## Breastfeeding May Not Have an Adverse Effect on Breast Appearance

### Study shows age, body mass index, smoking among risk factors for sagging breasts

Findings from a study published in the September/October 2008 issue of the *Aesthetic Surgery Journal* show that, contrary to popular belief, breastfeeding is not a likely cause of post-pregnancy drooping of the breasts. As a growing number of women turn to plastic surgeons to counteract the effects of pregnancy on their bodies, one common postpartum complaint is sagging breasts, also known as breast ptosis, which many believe to be linked to breastfeeding. However, as this new study demonstrates, it appears that other factors, including older age, higher body mass index (BMI) and a history of smoking, are responsible for the breast sagging experienced by some women after pregnancy.

“It is widely assumed that breastfeeding will adversely affect the appearance of the breasts, and this has been a major reason cited by women who choose not to breastfeed,” said Brian Rinker, MD, a plastic surgeon in Lexington, Kentucky and lead author of the study. “However, there has been very little objective data to support or deny that this is, in fact, the case. With this study, we hope to shed some light on the subject and correct any misconceptions.”

The current study set out to identify risk factors for the development of breast ptosis and to determine if there is a correlation between breastfeeding and breast aesthetics using data from 93 patients who had sought aesthetic breast surgery between 1998 and 2006. All patients had a history of at least one pregnancy. The degree of breast ptosis was determined from preoperative photographs in the patient’s medical charts, and ranked on a

scale from zero to three. Each patient was interviewed and medical charts were reviewed to collect information on potential risk factors for breast ptosis, including age, number of pregnancies, history of breastfeeding, duration of breastfeeding, BMI, pre-pregnancy bra cup size, history of smoking and amount of weight gain during pregnancy.

Fifty-eight (58%) of the patients studied had a history of breastfeeding one or more children; 39 patients had never breastfed. Weight gain during pregnancy across both groups ranged from five to 45 kilograms and 39% reported a history of smoking. Fifty-one respondents described an adverse change in breast shape following pregnancy. BMI and weight gain during pregnancy were both significantly higher in the non-breastfeeding group.

Analysis of this information showed that greater age, higher BMI, greater number of pregnancies, larger prepregnancy bra cup size, and history of smoking were all significant risk factors in the development of sagging breasts. Breastfeeding, however, was not—even as duration of breastfeeding increased.

“Patients need to be armed with objective data rather than broad assumptions when making important health decisions,” said Alan H. Gold, MD, President of ASAPS. “While further study in larger numbers of patients is necessary to assess the effects of breastfeeding on the breasts versus other factors, this study is a good start in providing information for those who are concerned about the potential aesthetic effect of breastfeeding.”

The full text of this article can be found in the current issue of *ASJ*.

# Update on: Physician's Coalition for Injectable Safety

Recent member survey confirms Mission and Goals of Coalition [www.injectablesafety.org](http://www.injectablesafety.org)

A recent survey conducted among member organizations of the Physicians Coalition for Injectable Safety revealed that providing consumer education on safe choices for cosmetic injections (91%), providing clinical education on cosmetic injectables (86%) and targeting counterfeit injectables (69%) are the top three goals members want the Group to achieve. The web-based survey was conducted over the summer and included members of the Aesthetic Society, The American Academy of Facial Plastic and Reconstructive Surgery, The American Society of Ophthalmic Plastic and Reconstructive Surgery and The International Society of Aesthetic Plastic Surgery. Since the survey closed, two additional international societies have joined the group, the International Federation of Facial Plastic Surgery Societies (IFFPSS) and the Canadian Society for Aesthetic Plastic Surgery (CSAPS).

Member physicians over-all have a high awareness of the Coalition's activities, with 96% being aware of the "injectables are not cosmetic" artwork, 95% awareness

of the Coalition's statement on the ethical use of Injectable products and 93% aware of its consumer newsletter.

## Perceptions of the injectables market

Members were asked their perceptions of the current injectables market. 40% of respondents view it as "an important component of complete rejuvenation," and 25% view it as "an important complement to surgical procedures." These are consistent with findings of the joint ASPS/ASAPS Cosmetic Medicine Taskforce.

## Member physicians still do the majority of injections

When asked "Who administers injectables in your office or medi-spa?" the majority of respondents, 69%, indicated physicians, with 20% responding a nurse, nurse practitioner or physician's assistant did the administration under the physician's supervision. Of those who did not always do their own injections, 61% responded that they are always on-site but not always in the room.

On the issue of non-physician injectors, respondent's opinions were divided. 50% of respondents thought that nurses and PA's should be allowed to inject botulinum toxin with direct-on-site physician supervision, with 22% stating that these allied health professionals should not be allowed to inject.

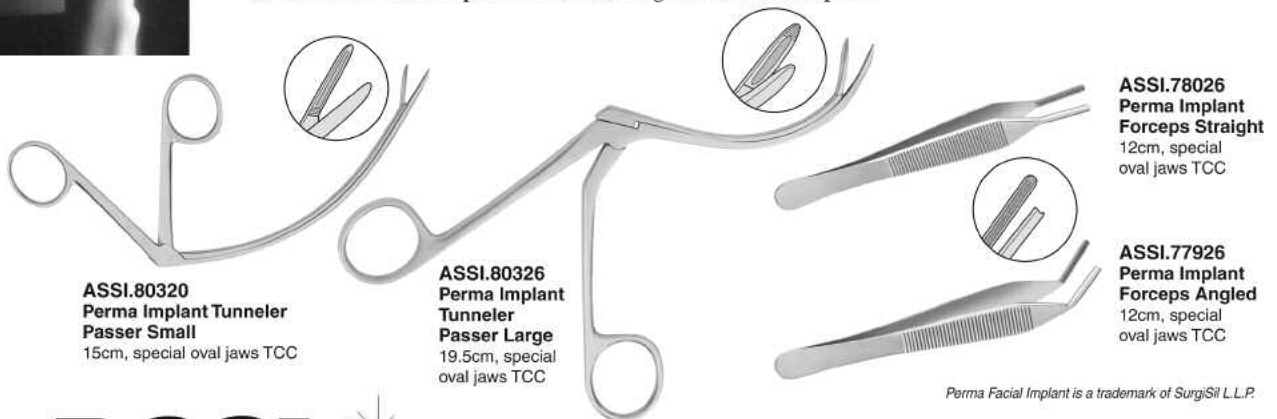
On the question of temporary dermal fillers, the group had stronger opinions. When asked "Do you believe that nurses (RN) and physician's assistants should be allowed to inject dermal fillers with a duration of less than six months," 45% responded yes, with direct on-site supervision, 26% responded no, they should not be allowed to inject, and an equal number—26%—thought they should be allowed to inject with physician supervision from a remote location.

*The Coalition sends out semi-annual surveys to gage the opinions of its members and be sure it is meeting member's expectations. The group is sponsored, in part, through unrestricted educational grants from Artes Medical, Medicis, Inc., BioForm, inc, and Mentor. We thank them for their support.*



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