



Aesthetic Society News

Quarterly Newsletter of the American Society for Aesthetic Plastic Surgery

Volume 13, Number 1 Winter 2009

From the Aesthetic Surgery Journal:

ASJ Now Indexed in MEDLINE/PubMed

(Editor's note: Stanley A. Klatsky, MD, former editor of the Aesthetic Surgery Journal and current Editor-Emeritus, published the following Editor's Note in the November/December, 2008 issue of ASJ.)

It gives me extreme pleasure to announce that Aesthetic Surgery Journal has been accepted for indexing in MEDLINE/PubMed (www.pubmed.gov). Indexing using the National Library of Medicine's (NLM) advanced MESH terminology will be retroactive, beginning with the January/February 2008 issue of the journal. While pre-2008 content will not be indexed using MESH terms, content from 1995-2007 will be included in PubMed search results and retrievable for all typical purposes.

As you probably know, MEDLINE is the U.S. National Library of Medicine's (NLM) premier bibliographic database that contains references to journal articles in the life sciences with a concentration on biomedicine. The database contains citations from 1950 to the present, with some older material. PubMed includes over 18 million citations from MEDLINE and other life science journals. It includes links to full text articles and other related resources.

Our acceptance for indexing in MEDLINE/PubMed represents the achievement of a long-time goal. Until now, ASJ has been indexed in a number of databases including two of the worlds most comprehensive indexing and abstracting databases—EMBASE and Scopus. However, these databases are available by subscription only and, therefore, are not widely accessible to clinicians and

researchers. In contrast, PubMed is freely accessible and is the most widely used medical database. Achieving recognition by PubMed means that the contributions of authors submitting their work to ASJ will be viewed and cited more widely than ever before.

In the past, there have occasionally been authors who were reluctant to publish their work in ASJ, despite their high regard for the Journal's quality and wide readership (ASJ has subscribers in more than 80 countries), simply because it was not indexed in MEDLINE/PubMed. With the Journal's inclusion in MEDLINE/PubMed, concerns about accessibility are no longer a factor. We anticipate that our indexed status will have a very positive impact on manuscript submissions as well as international readership. Most important, clinicians and researchers around the world will have the opportunity to increase their knowledge and understanding of safe and effective aesthetic surgical practices and techniques, thus enhancing patient care. We eagerly look forward to the full and rapid inclusion of ASJ in MEDLINE/PubMed.

In Other ASJ News:

Jeffrey M. Kenkel, MD Named Associate Editor

Dr. Michael F. McGuire, Chair of the Aesthetic Society's Publications Committee and President-Elect of ASPS announced the unanimous decision to appoint Jeffrey Kenkel, MD as Associate Editor of ASJ. The Associate Editor position is a voluntary one within the Society.

Dr. Kenkel is Professor, Vice Chairman, and Director of The Clinical Center for

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What happens in Vegas won't stay in Vegas this year!

There's still time to register online for the premier educational event in Aesthetic Surgery, **The Aesthetic Meeting 2009** taking place at the Mandalay Bay Hotel in Las Vegas! Our program of scientific sessions, teaching courses and special presentations will help aesthetic surgeons at all stages of their careers stay current with the latest techniques, practices and science available today. Our faculty of thought leaders draws from some of the best surgeons in the world and Las Vegas provides plenty of opportunities for leisure activities as well. To see the "week at a glance" please go to page 18 of this issue. To register online, please visit <http://www.surgery.org/meeting2009/>



ASAPS 2008 Annual Statistics Now Available

As this issue of ASN goes to press, the Communications Commission is pulling together the final numbers for our annual procedural statistics. Please refer to *surgery.org* in the next week to obtain your copy.

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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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Send address changes and membership inquiries to Membership Department, American Society for Aesthetic Plastic Surgery, 11262 Monarch Street, Garden Grove, CA 92841. Email asaps@surgery.org



The American Society for
Aesthetic Plastic Surgery



The Aesthetic Surgery Education
and Research Foundation

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April 4, 2009

Patient Safety in Body Contouring and Aesthetic Surgery of the Breast

The New York Athletic Club,
New York, NY

Endorsed by ASAPS

Contact: Francine Leinhardt
212.702.7728



June 13–20, 2009

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www.surgery.org/cruise2009

Play the Winning Hand



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April 29–May 2, 2009

SPSSCS 15th Annual Meeting

Mandalay Bay Resort

Las Vegas, NV

Contact: SPSSCS at 800.486.0611
spsscs.org

August 26–29, 2009

25th Annual Breast Surgery & Body Contouring Symposium

Eldorado Hotel, Santa Fe, NM

Co-Sponsored by ASAPS/ASPS

Contact: ASPSP at 800.766.4955

November 29– December 3, 2009

5th World Congress of IPRAS

New Delhi, India

Contact: Conference Secretariat

Tel: 91.11.23231871

desk@ipras2009.org



May 2–7, 2009

The Aesthetic Meeting 2009

Mandalay Bay Resort

Las Vegas, NV

Contact: ASAPS at 800.364.2147

surgery.org/meeting2009



Learning from the Masters

“There are no great limits to growth because there are no limits of human intelligence, imagination, and wonder.”

—Ronald Reagan—

40th president of US (1911–2004)

Although there's no question that the current economic downturn has affected all aspects of the economy, including our surgical practices, it is very important to remember that the investments made in your plastic surgery training and education provide excellent long term rewards. It is my belief that if this investment is given the opportunity to grow and flourish, the returns will only increase.

Here at the Aesthetic Society, we have a compendium of opportunities coming up to help you keep your state-of-the-art skills and protect your practice from current and possibly future economic uncertainty. A few of them are outlined below:

The Aesthetic Meeting 2009

Can there be a better time to invest in your aesthetic surgery education? Evidence such as the increased focus on demonstrated outcomes, the plethora of new injectable and laser treatments and an undiminished media interest in plastic surgery (our Communications Office reports that from July 1 to December 31, 2008, ASAPS, its members, and statistics were featured nationally and internationally with confirmed media placements reaching an audience of almost 73 million), all suggest that interest in our services and expertise remains high.

This year's meeting, under the excellent direction of Drs. Jeffrey Kenkel and Jack Fisher offers opportunities in didactic, hands-on and collaborative learning that will give you the ammunition to compete

on knowledge, competency and training—not gimmicks, discounts and other short sighted strategies that will not serve us well in the long term.

Although patient census may be down, the demands of staying current in the specialty are not. In order to allow as many members as possible to attend our meeting, registration fees have been frozen at the 2008 level. Members can register online by visiting www.surgery.org/meeting.

Your ASAPS Membership

If you are like the majority of board-certified plastic surgeons, cosmetic surgery is still the most important growth area of your practice, particularly in the areas of non-surgical procedures and injectables. As the only national organization devoted exclusively to aesthetic plastic surgery education, ASAPS membership gives you exposure and access to some of the greatest teachers and practitioners working in our specialty today; a feature that can only enhance both your professional and personal growth.

What you may not be aware of is the wide range of value-added services available to all ASAPS members as a benefit of dues. These include:

A webinar scheduled for March 16, 2009; “How to manage your practice in challenging times”

Under the direction of Practice Relations Committee Chair Daniel C. Mills, II, MD, this hour and a half program will give you practical advice on topical issues such as:

- How to reduce overhead without compromising quality
- How to further refine your internal marketing; such as offering existing patients fee concessions without

discounting your prices and undermining your reputation

- How to navigate your way through what seems like an endless stream of new “marketing opportunities”

Faculty for this event includes Aesthetic Society members Drs. Mills, Michael Edwards, (Practice Relations Committee Vice Chair), Renato Saltz (President-elect) and Mark Codner, (Communications Commissioner).

Other speakers include Dr. Dan Dubin, an advisor to institutional investors and corporate life sciences clients, and Marie Czenko Kuechel, long time consultant and consumer advocate to the aesthetic surgery community.

Practices of Office Safety

This online program, introduced as a benefit of dues to all Aesthetic Society and ASPS members last year, is a staff training tool covering all aspects of patient safety and communication, with self-quizzes and situational simulations. Many of you have taken advantage of this excellent program. If you haven't, I urge you to visit <http://www.practicesofficesafety.org> and sign up.

Beauty for Life

The joint ASAPS/ASPS Beauty for Life program has been widely discussed in both meetings and here in the pages of ASN; however, for those not aware of the program, its features bear repeating. Among the member benefits are:

- A consumer website, www.beautyforlife.com, that leads the user through distinct stages of achieving beauty goals at any age, gives a beauty quiz, supplies accurate information on plastic surgery and positions the plastic surgeon as the “go to” physician in cosmetic medicine.

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Being Attacked on the Web? Think First, Proceed With Caution

By Mark A. Codner, MD

Many of us go through this scenario every day: a patient comes in for a consultation. He or she is given a full examination; we listen to their aesthetic goals, and perform the procedure to the best of our ability concentrating on a safe, positive outcome for their surgery and follow-up with appropriate after care.

For most of our patients, that's the end of the story. We have some people who return for other procedures or repeat visitors for injectable treatments. Or we might need to do an additional or revision procedure if the patient isn't fully satisfied or if further work is necessary. Usually that's where the story ends; usually but not always.

We've all had disgruntled patients, the ones who, no matter what you do, are never quite satisfied, started with unrealistic expectations we failed to foresee or just didn't understand the limits as well as the opportunities of aesthetic surgery.

As we have noted in the pages of *ASN* previously, these patients now have an international forum to voice their complaints and potentially cause harm to your practice—the Internet.

I recently went through this experience in my own practice and, while it certainly isn't pleasant, it's not the end of the world either. Listed below are some of the things I learned along the way, and some advice that might be useful to others going through the experience:

- **Attacks of this kind are a one-sided equation.**

There seem to be limitless blog sites where patients can share their “experiences” with others and, under their first amendment rights to free speech, can say just about anything—to a point.

“Dr. Smith is a jerk” is an opinion, fully protected under our Constitutional right to free speech. “Dr. Smith operated on my face without authorization” is a statement of fact that, if not true, is subject to libel and slander laws.

Most webmasters will remove libelous information if asked. (Remember, never speak in a threatening tone to the owner of a website or think that any conversation is confidential. You'll more than likely see your conversation on their site, further fueling the issue.) A reputable site will not want to be publishing information that is blatantly untrue or illegal.

- **When you are nearly bursting to respond to an attack—don't.**

Most sites allow participants to blog using an alias—your response would be published as John Smith, MD. In other words you might know who you are responding to, but no one else on the blog site will. This is a fight that, in my opinion, you can't win and your response will only escalate the situation.

- **Make sure your malpractice attorney is involved.**

If there's a chance that the patient in question could file a claim, make sure your carrier is notified immediately. Remember, if in the heat of the moment you go onto the blog site and mention the patient by name, you have just violated HIPAA and patient confidentiality laws—another reason NOT to respond to anonymous attacks.

- **Watch your own website Google rankings.**

If a Google search of your name comes up with “Dr. Smith butchered me” or “don't trust Dr. Smith for breast implants” consider developing a couple press releases of your own. Your search

optimization company can help you with strategies for this; some simple approaches would be a brief release on any subject-related talks or papers you have given, a release on your interest in the procedure involved, (Dr. Smith has been performing successful rhinoplasties for 20 years) or any involvement in philanthropic endeavors (Dr. Smith visits South America for Project Smile).

There are also several steps you can take as “pre-emptive strikes” to prepare for possible web-bashing. Among them are:

- Consider creating a “patient comment” book for your office where patients can express their opinions; you can ask patients with positive experiences and outcomes to post these observations on popular blog sites
- Consider changes to your informed consent documents. Many practices are now asking patients to sign forms stating that they will not comment on any blog sites, that they will only use Board Certified Plastic Surgeons if an experience does result in litigation and that claims will not be filed in small claims court.

Most importantly, remember, this too shall pass. There are literally millions of websites that swallow up content in a matter of minutes. The hot topic today is forgotten tomorrow.

Mark A. Codner, MD, is an Aesthetic Surgeon in private practice in Atlanta. He is Chair of the Aesthetic Society's Communications Commission.

MANAGING YOUR PRACTICE IN CHALLENGING TIMES



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HOW TO:

- Eliminate unnecessary expenses and renegotiate existing contracts and agreements
- Incentivize staff to achieve greatest efficiencies
- Explore insurance plans and reconstructive surgery options
- Use internal and external marketing strategies to distinguish your practice at minimal cost
- Incorporate cosmetic medicine into your practice to boost revenues

**In 2008, 25% of surgeries were performed on prior surgical patients:
are you capturing this business?**



Daniel B. Dubin, MD

Vice Chairman and a Director at Leerink Swann, a leading healthcare and biotechnology investment banking firm, former instructor in Dermatology at Harvard Medical School



Mark A. Codner, MD

Chair, Communications Commission, The Aesthetic Society, aesthetic surgeon in private practice, Atlanta, GA.



Marie Czenko Kuechel

A nationally recognized consumer advocate, and practice consultant; author and expert in health, beauty and aesthetic medicine.



Michael C. Edwards, MD

Vice-Chair, Practice Relations Committee, The Aesthetic Society, aesthetic surgeon in private practice, Las Vegas, NV



Renato Saltz, MD Moderator

President-elect, The Aesthetic Society, Co-Chair, Cosmetic Medicine Taskforce, aesthetic surgeon, private practice, and owner, Spa Victoria, Salt Lake City, UT



Daniel C. Mills, II, MD

Chair, Electronic Communications and Practice Relations Committees, The Aesthetic Society, aesthetic surgeon in private practice, Laguna Beach, CA

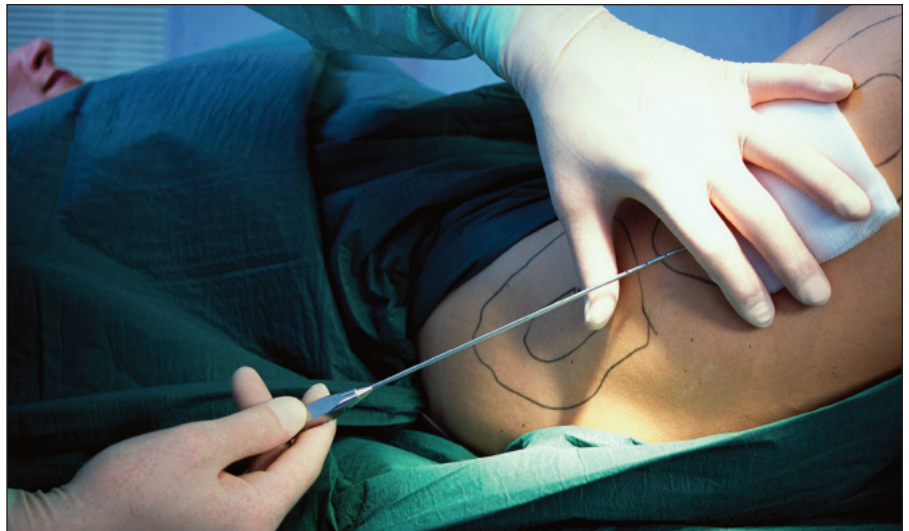


Fast and Furious Field of Plastic Surgery

Upon completion of my plastic surgery residency at Brown University in June 2004, I felt that I was on the cutting edge of aesthetic and reconstructive plastic surgery. After a well-balanced and comprehensive residency program, I was ready to implement all those hours of training and therefore launched a solo private plastic surgery practice in Bloomington, Illinois.

It wasn't long into my solo practice that I realized it doesn't take long to not be on the cutting edge of technology. The first realization came during my first week of practice when I had a phone call from a patient to see if I injected lips with a new substance called Restylane. I had another patient call to see if I performed the "feather lift." Suddenly, the young, confident plastic surgeon who felt comfortable addressing Leforte 3 fractures and mangled hands was learning from the patients. I was frustrated by the fact that I barely knew of the substance, let alone know how to inject it. It was at this point that I had an epiphany—this feeling was going to be quite common since the field of plastic surgery is fast and furious. I always proclaimed that it was the dynamic nature of the field that attracted me to plastic surgery and I have now truly experienced the magnitude of that sentiment.

It was at this juncture that I realized extreme effort and enthusiasm would be necessary for me to be a life-long disciple and provider of the most advanced plastic surgery care. I began reading as many journals and websites as I could. I contacted pharmacy and company representatives to learn more about new products and the proper techniques. I found myself traveling and visiting many prominent plastic surgeons across the country. I ordered many DVDs and watched "live" surgical



techniques. I attended national conferences, anatomy lab courses and seminars throughout the country. I finally came to the conclusion that it will not be easy to always be on the cutting edge. There may be times in my career when I feel I'm more on the cutting edge than other times. I soon realized that it is essential to not become complacent with the status quo and to constantly maintain an eagerness to advance and broaden our discipline.

The non-surgical advancements have been the most difficult to keep current within my 4½ years of practice. Soft tissue fillers have now become the second most common non-surgical procedure performed in the country. I realized that this would be the first of many things that I will have to learn during my practice as opposed to learning in residency. We have many substances, both temporary and permanent, that can be injected in many ways and in many different areas. Furthermore, we are pushing the envelope where Botox can be injected. Since I began practice, it is now

FDA approved for non-cosmetic purposes including hyperhidrosis. This, as well as the other off-label areas, requires additional training and another learning curve. All the firming, cellulite machines, and lasers hitting the market were all new to me as I was never exposed to these during residency. Later I understood why so many of these become obsolete so rapidly. I quickly learned that I had to be very careful and patient before embarking on a new procedure/product for the fear of tarnishing my reputation in the community. For example, recent reports suggest the FDA is now looking further into the risks associated with the soft tissue fillers. FDA scientists will soon present an advisory panel with data on 823 patients who suffered "serious and unexpected" reactions after treatment with fillers between 2003 and September 2008. Paying close attention to patient safety reports and FDA rulings/investigations is imperative during this rapidly advancing era. Keeping current with patient safety

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reports will continue to modify my practice and make me think twice about using products in an off-label manner.

Endoscopic plastic surgery continues to evolve as well. Technology is rapidly advancing on what tissues should be released and how they should be fixated.

Consequently, there are many more expensive instruments available with each different technique described. I currently dissect my brow lifts and fixate them completely different than I learned as a resident 5 years ago.

The less invasive surgery trend has then lead into minimal incision facelifting and cable suture suspension techniques. I now perform smaller incisions for my facelifts than I learned in residency. I also dissect and fixate the SMAS differently than I was originally taught. Furthermore, I'm injecting much more fat to volumetrically sculpt the face than I ever did as a resident. I'm now cautiously watching the fat injection pioneers as they begin to inject fat into other controversial areas such as breasts.

Finally, with the FDA recently approving silicone breast implants again, a whole brave new world opens up again, especially for recent residency graduates. Not only is there a learning curve on using the implant itself, one must also decide if it is truly better to place it subglandular or subpectoral and whether a shaped/round and smooth/textured implant should be used. Once we feel comfortable using these, we'll then have to become familiar with addressing the secondary issues.

Although some of my experiences are different because I am a solo practitioner in a community-based setting, I think most beginning plastic surgeons would agree that it doesn't take long to begin modifying techniques learned in residency. I remember some of my attendings at Brown University telling me that most, if not all, of their techniques were learned as a practitioner and not as a resident. Residency provides us the foundation, principles, and critical thinking skills on which to build upon. It is where we learn the necessary and proper habits to be a life-long learner and to constantly critique

our results and ultimately push ourselves to do better. Ironically, as we get further along into our practice, we also run the risk of losing what we gained throughout residency thereby losing our diversity. Maintaining a broad-based plastic surgery practice obviously not only helps serve our patients better, but it also helps serve our fellow colleagues better who can always count on you. It is also this diversity that becomes our strength during economic hardships like the present.

Although some of my experiences are different because I am a solo practitioner in a community-based setting, I think most beginning plastic surgeons would agree that it doesn't take long to begin modifying techniques learned in residency.

We chose to deal with these issues when we chose to practice the discipline of plastic surgery. I often wonder if other plastic surgeons had so many new surgical and non-surgical options to choose from so early in their careers. Or are we a unique generation since aesthetic surgery has become much more popular in the last 10 years? After analyzing my current techniques, I have determined that these are not just techniques I learned at a seminar or from one particular professor; rather, it is a synthesis of all the techniques I have absorbed throughout the years. I have somehow incorporated them into my own style that I feel comfortable with as a surgeon and one that I believe continually produces safe and long-lasting results; that is, until something new is introduced.

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Cosmetic Laser Treatment, holds the Rod J. Rohrich, MD Distinguished Professorship in Wound Healing and Plastic Surgery at the Department of Plastic Surgery of University of Texas Southwestern at Dallas, and is the Chair of the Aesthetic Society's Education Commission as well as Secretary of the Society.

"All of the final applicants for the Associate Editor position are leading educators and clinicians in the plastic surgery community and the final selection was extremely challenging for the Committee" said Dr. McGuire. "In our opinion, Jeff represents one of the best of the new generation of plastic surgery educators and physicians."

"Dedicated to evidence-based medicine and pursuing new methods and modalities for treating our patients both surgically and non-surgically, Dr. Kenkel will play a pivotal role in helping ASJ achieve even greater relevancy and scope," said Editor-in-Chief Foad Nahai, MD. On behalf of the Editorial Board, I would like to welcome Jeff to his new position."

Melissa Knoll New Managing Editor

Melissa Knoll has been hired on the Aesthetic Society staff as the new Managing Editor for *ASJ* replacing Paul Bernstein who will stay on the publication in a consulting capacity from his home base in New York.

Melissa's most recent experiences include Associate Editor (Promotion) at the Nemours Children's Clinic, writing a monthly health column for Jacksonville Magazine (FL) and serving as Managing Editor, for the American Journal of Ophthalmology. Please join us in welcoming her to her new position. Melissa can be reached at the Society Central Office number; 562.799.2356 Ext. 302, or by email at Melissa@surgery.org



Guidelines for Plastic Surgery Tourism

Prepared by the International Society of Aesthetic Plastic Surgery (ISAPS) and The American Society of Aesthetic Plastic Surgery (ASAPS)

By Professor James Frame and James A. Matas, MD



Co-author's Note:

Medical Tourism is experiencing exponential growth. Patients can have very good results at a fraction of the cost and in an environment which is conducive to bonding the family on vacation. Few reports have hit the literature about the disasters; perhaps because of subjudice, or patient embarrassment, or perhaps it is a time bomb or slow fuse and an explosion will be inevitable.

The complications from all surgical tourism procedures is close to twenty percent and the expense and diversion of medical attendees to deal with these problems is considerable. Medical Tourism is a multi-million pound industry, unregulated and, largely, in the control of entrepreneurs but is increasingly being supported by accreditation by some of the world's leading "Ivy League" medical care providers.

The ethics of surgical tourism are related to:

- Exposing the vulnerable patient to physical, mental and financial disaster.*
- Exposing the vulnerability of the human psyche and the surgeon to temptations that contradict the Hippocratic Oath.*
- High profit and an easy life are an offer to the unscrupulous.*
- The jackals of the insurance and legal professions, tourism associations, hotel groups, hospital groups, paramedical and non-medical entrepreneurs, have already identified the weakness and vulnerability of the patients and target them via glossy magazines, media and the internet.*

The standards of surgical care should include:

- Pre-operative (counseling)*
- Peri-operative (informed consent)*
- The management of complications at home or abroad need clear and informed pathways including, but not limited to:*

- The additional cost of managing complications*
- Continuity of care in the patient's home country (accredited liaisons needed).*
- Obligations of the initiators of the surgical tourism process.*
- Standards and techniques of surgery and quality of prostheses needed.*
- The standards of employed surgeons; qualification and experience (Revalidation and Certification).*
- Medical negligence insurance and patient reimbursement programmes.*
- Facility guarantees to continuous care.*

For all of these reasons, we at ISAPS are delighted to work with our colleagues at the Aesthetic Society, particularly ASAPS Secretary Jim Matas, MD on developing new consumer guidelines for plastic surgery tourism with the goal of protecting even one patient from suffering serious complications or adverse events. Our suggestions appear below:

Kind Regards,

Jim Frame

Chair, ISAPS Medical Tourism Committee

ISAPS and ASAPS advocate that employers, insurance companies and all other entities that facilitate or incentivize either inbound or outbound plastic surgery care adhere to the following guidelines and share these with their patients and customers.

1. Plastic surgery care either inbound or outbound must be voluntary.
2. A complete consultation including physical examination, alternatives to treatment, risk assessment, potential complications, and an informed consent must be provided by the operating surgeon prior to actual treatment and preferably prior to travel for ultimate surgery.

3. Financial incentives for either inbound or outbound plastic surgery care should not influence or limit the diagnostic and therapeutic alternatives offered to patients or in any way restrict treatment or referral options.
4. Surgeons and/or their qualified staff should advise patients of all fees prior to travel, including cost of different materials and implants, as well as options for these materials.
5. Patients are strongly urged to use institutions or facilities that have been inspected and accredited by recognized international accrediting bodies such as the Joint Commission (www.jointcommission.org) or the American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (www.aaaasf.org). Patients should ask their surgeon about the accreditation of their facilities before making any commitment. If in doubt, they should be advised to cross check accreditation claims by consulting accrediting bodies' websites.
6. Patients should be well aware of any staff language barriers during their pre- and post-operative periods.
7. Patients are entitled to and should ask for full disclosure of the treating physician as well as staff credentials including possible use of junior plastic surgery trainees prior to travel.
8. Follow up care in the patient's home town is a critical element of any medical tourism decision. Prior to travel, local follow-up care facilities and consulting physicians must be determined and coordinated with clear discussion, understanding and acceptance of all fees.

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Guidelines

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9. In the event of a complication, clear information should be provided to the patient prior to treatment including the responsibilities of all parties, a reasonable estimate of costs for recommended treatment of complications including ICU (ITU) care, as well as possible care by other specialists.
10. Prior to any commitment to travel for surgery, patients should be made aware of the significant variations in physician responsibilities and liability coverage for adverse events in other countries. In addition, in the event of medical errors, patients should know in advance what their recourse options are under a different country's legal system.
11. Physician licensing and procedural outcomes data as well as facility accreditation and its outcomes data should be provided to all patients both inbound and outbound, prior to departure.
12. The transfer of patient medical records to and from facilities outside the US should be consistent with HIPAA guidelines and provided by the overseas physician in the spoken language of the patient's country of origin.
13. Patients choosing to travel for their plastic surgery care should be provided with detailed information about the potential risks of combining surgical procedures with long airplane flights. Recommendations for how long the patient should remain in the country where the operation is performed should be established and confirmed in advance, and appropriate arrangements made for an extended stay.

Professor James D. Frame FRCS, FRCS (Plast), is chair of the International Society of Aesthetic Plastic Surgery's Surgical Tourism Committee and senior consultant surgeon at the Springfield Hospital, Chelmsford. (UK)

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



Aesthetic Surgery Journal Call for Manuscripts

Aesthetic Surgery Journal, now indexed in MEDLINE/PubMed, is inviting manuscripts meeting the following general criteria:

- Original research and review articles on topics relevant to the safe and effective practice of aesthetic surgery including anatomical studies, outcomes of clinical techniques, and patient safety
- Original articles outlining technical details of established and developing aesthetic surgical and non-surgical treatments for enhancement of the face, body and skin
- Important research and techniques in reconstructive surgical procedures having a highly significant aesthetic component
- Scientific evaluation and commentary regarding the effects of aesthetic surgical and nonsurgical interventions on such measures as quality of life, psychological and social functioning, and self-esteem in diverse gender, age and cultural contexts

Aesthetic Surgery Journal is a peer-reviewed, international journal. It is an official publication of the American Society for Aesthetic Plastic Surgery, and the official English-language journal of 10 international plastic surgery societies. The Journal has subscribers in more than 80 countries, and it is available in print and online.

Submit your manuscripts online at
www.aestheticsurgeryjournal.com

For information or assistance, contact Managing Editor
Melissa Knoll, Melissa@surgery.org, or call 800.364.2147
(or 562.799.2356) ext. 302



What Should You Do at a Time Like This?

By Bruce S. Maller

Most pundits would agree that the turmoil seen in the world financial markets the last several months has been unprecedented. Consumers and investors are suffering from a crisis in confidence in our financial system. It has become extremely difficult to predict what will happen from one day to the next. In addition, it is very hard to assess what the “downstream effect” will be on different aspects of the economy. Based on our history of financial cycles, I suspect we are in for a longer-than-expected slow down in economic activity.

Sure, the stock, bond, and commodity markets may very well rebound in the months ahead; however, many people would agree that it could take many years to recover the losses incurred in savings and retirement plans over just the past several months. Clearly, we are left with more questions than answers.

I thought it might be helpful to provide some answers to the most frequently asked questions I have heard from our clients over the past several months. We recognize many of you have other questions and concerns about how these events may impact your practice and personal financial planning. We recommend you consult with your financial advisors to begin to “assess the extent of the damage” and initiate your recovery plan.

Given the current economic climate, what would you recommend for our practice?

- First of all, your staff needs to hear from you. This is a time where the leaders in any organization need to provide reassurance, clarity, and focus. A calm, even hand is essential.
- It is important you be honest in your assessment of how the current economic challenges will impact the practice. No one will be immune from the current contraction in business activity.
- This is a time to refocus on the fundamentals of excellent patient care, staff development, and fiscal responsibility. If viewed as a three-legged stool, the key is to make sure there is proper balance between these elements. During tough times, it is easy to “lose your way” and create an imbalance. During better economic times it is not unusual for practices to get somewhat complacent. Strong physician leaders understand this and are able to provide just the right amount of pressure in the right areas to keep things moving in the right direction.
- Set the tone with staff that we are in for lean times in the foreseeable future and that this presents an opportunity to get better at what we do. More so than ever, the practice will need the dedication and support of each staff member. It is fine to remind staff that they are fortunate to have a good job with a good practice.
- Reevaluate your strategic plan. This would include a review of under-performing offices or service lines. This is a time to focus your limited resources where you can expect the greatest return on investment and to eliminate those assets not providing adequate yield or that do not have other strategic significance. Check out the diagnostic and score your readiness to tackle these challenges.

Are there some specific things we should be doing to safeguard our assets?

- Make sure your bank deposits are in fully insured accounts. The recent TARP bill provides some short-term relief by temporarily extending insurance coverage to \$250,000 per account category and by providing unlimited FDIC insurance coverage for non-interest-bearing transaction accounts of many small businesses. Be sure to review these new FDIC coverage requirements. Don't assume your accounts are insured.
- I recommend you or your financial advisor review the financial statements of your bank. If the bank is a public company, it is easy to obtain current financial statements either by requesting them from the bank or going online and doing a search. In the case of a private institution, request copies of the most recent financial statements. You should be looking for increases in reserves for bad debt as well as non-performing asset categories. Investigate changes in balance sheet values as compared to prior years.
- In order to provide greater efficiency in managing large account balances, consider setting up an account with a discount broker, i.e., Charles Schwab and Company, where you can purchase individual denomination certificates of deposit (for less than the maximum FDIC insurance limit) or U.S. Treasury instruments.
- Some commercial banks participate in the Certificate of Deposit Account Registry Services® (CDARS®) program. This program provides depositors with access to up to \$50 million in FDIC-insurance coverage on certificates of

Continued on Page 11

What Should You Do at a Time Like This?

Continued from Page 10

deposits. The program is normally available to customers free of charge. In essence, CDARS® provides a customer the ability to spread money across a network of FDIC-insured banks through the convenience of their commercial bank.

Do you have other suggestions when it comes to managing our financial affairs?

- If you haven't done so already, scrutinize every line item of expense on your P&L to insure that you are spending funds wisely. Just because you have done things a certain way for years does not mean you should continue this policy. For example, review all of your insurance policies to make sure each is still necessary. In addition, consider putting out for bid all of your policies with several brokers. We have found that it is not unusual to find significant cost savings by shopping your insurance coverage. Another suggestion is to reassess contractual relations with outside professionals, i.e., legal, accounting and consulting that serve the practice. Are you using these resources judiciously? The bottom line is that you cannot afford to be complacent.
- Increase your level of financial oversight. Many physicians have become complacent, relying on others to assume responsibility for managing their financial affairs. Work within the confines of a budget and make sure you are getting the right information in order to make better decisions about the business. Hold off on major capital expenditures unless they are absolutely necessary or it is clear you can obtain an excellent return on investment. Exercise the discipline of completing a break-even analysis for any new capital purchases. Do not rely on an analysis performed by the equipment manufacturer in making your purchase decision.
- Review your internal controls to insure there is appropriate segregation of duties and minimal risk of embezzlement. Too many practices have suffered losses at the hands of dishonest or unscrupulous

employees. If an employee gets defensive about implementing safeguards in this area, this might provide a clue toward possible mishandling of funds. It is recommended a practice have their outside accountant complete an annual review of receipt/disbursement policies in order to insure assets are properly safeguarded.

- Carefully monitor your cash flow. It is recommended you more aggressively manage the accounts receivable cycle. Consider having your financial advisor prepare and maintain a three-month cash flow forecast (set up on a weekly basis) so you can avoid any surprises. This report should be updated at the end of each week and reviewed by management and owner physicians.
- Consider not filling any vacant positions. If a staff member leaves the practice, evaluate opportunities to re-allocate that person's responsibilities to other staff members.
- Review all doctor schedules to insure you are maximizing each provider's template. Each provider needs to take ownership of his or her book of business. This starts with developing a business plan for each doctor. This should include a forecast of doctor work days, patient visits, procedure goals, and payer mix. This will enable you to more accurately predict practice revenue. This will also allow you to make better decisions about resource requirements necessary to meet your financial goals.

We've noticed that many of our patients are very anxious about the current state of affairs. What can we do to alleviate their concerns?

- First of all, it is important to recognize that many patients are more cautious about spending on discretionary items. In fact, many actually feel some measure of guilt in "spending on themselves" during challenging economic times.
- On the other hand, many consumers will seek out cosmetic products and services in order to feel better about themselves. The important thing is for the practice to remain focused on offering practical and cost effective solutions that meet

patient needs. Practices may want to modify their marketing message to better address current patient needs and emotions.

- For staff it is important they maintain a positive and reassuring attitude and demeanor. Patients will appreciate that there is some degree of security and consistency in their lives.
- It is vital to communicate to each patient a "business as usual" attitude. When appropriate, remind them that we have been through many ups and downs with the economy and that history teaches us we will recover and rebound. However, it is always hard to know when.

Over the years, we have focused more attention on growing the aesthetic side of our practice. Would you recommend we take steps to reestablish or grow our reconstructive surgery business?

- As mentioned, this is an opportune time to reexamine one's strategic plan. This would include an assessment of a practice's strength, weaknesses, opportunities, and threats. In addition, the physician owner(s) need to reevaluate personal and professional goals and objectives.
- This exercise should lead a practice down the path of answering this question. Ramping up third-party business requires a thoughtful examination of the resource requirements to do this correctly. Although on the surface this may seem like a good idea, there may be extenuating factors that may make it impractical or unwise. Proactive practices should ask the following questions: Are we participating in the major health plans in the area? Does our billing department have the ability and capability to perform third-party billing? Do we need to rebuild our physician referral network and, if so, do we have a plan to accomplish this task? Is staff adequately trained to discuss new procedures, i.e., reconstructive surgery?

Continued on Page 12

What Should You Do at a Time Like This?

Continued from Page 11

- For many plastic surgery practices that are still doing some amount of reconstructive surgery, it will be easier to shift more attention to this activity. As a general rule, a slowdown in consumer spending tends to have a more significant impact on practices with a heavier concentration in aesthetic services. Diversification of services (between cash and third party) is, in most cases, the preferred route. This approach allows a practice to more easily shift its resources in order to adjust to market fluctuations.

Many physicians have lost a significant portion of their net worth in a very short period of time and feel insecure about the future. What advice would you give them?

- As mentioned, it is important to recognize that the events of the past several months are unprecedented. History tells us that the path to recovery normally begins when things seem to be at their lowest point. The essential thing is to not lose faith in our system. We are in a serious correction from the excesses of the real estate boom that occurred from 2000 through 2006. Unfortunately, a correction of this nature has far-reaching consequences, and it is difficult to predict how long it will be before we see stability and renewed growth.
- Maintain a positive frame of mind. Do not allow yourself to be consumed by things outside your control. Be thankful that you work in an industry that is, in some respects, immune from some of the volatility seen in other market sectors. Yes, some physicians may have to extend their work plans. However, it is critical to recognize that you work in an industry that affords the opportunity to rebuild your net worth.
- Develop a more aggressive plan to retire outstanding indebtedness, both at home and at work. Being debt-free provides the greatest feeling of security and control over one's financial affairs. Don't listen to those so-called experts that

preach the fact that leverage is a good thing and that the interest on your home loan is one of the few remaining tax deductions.

- Focus on areas of opportunity to improve practice efficiency. There are always things practices can do to trim costs and make better use of existing resources. Rally the team around opportunities in this regard.

The most significant thing at this point in time is to not lose perspective on all the good things going on in your lives. As mentioned, many have experienced significant losses in their investment and retirement plans. Be thankful you are in a great profession that rewards you well for what you do and that you have patients that need and value your services.

Bruce S. Maller is the founder and President of BSM Consulting, a nationally recognized health care technology and consulting firm with offices in Scottsdale, Arizona and Incline Village, Nevada.

Mr. Maller is a frequent lecturer for various medical societies and national conventions. He has also been a featured speaker at numerous meetings sponsored by various corporate and business groups and has been instrumental in the design of course content and speaker selection for many of these meetings. He is a frequent contributor to many health care management publications on different facets of practice management.

Mr. Maller received his Bachelor of Arts degree from the University of Colorado.

Practice Readiness Assessment

On a scale of 1 to 5, please rate the "readiness" of your practice to tackle the challenges ahead. **1 = Not Ready • 5 = Very Ready**

- ___ I am providing the type and style of leadership necessary to assist my practice in meeting the challenges that lay ahead.
- ___ We have communicated with staff about our current position and have solicited their input and support in meeting our objectives.
- ___ We have reevaluated our strategic plan and have a clear plan of action for the next three to five years.
- ___ We have implemented a practice budget and consistently operate within its parameters.
- ___ We have completed an assessment of all patient "touch points" and feel we are delivering a high level of customer service.
- ___ We have completed a review of cash management procedures and feel we are properly safeguarding our assets.
- ___ We have reevaluated our marketing plan and modified our budget to reflect current market conditions.
- ___ Personally, I have met with my financial advisors to assess my current portfolio and made proper adjustments in my goals and objectives.
- ___ I can honestly say our practice is well positioned to take advantage of the opportunities that lay ahead.

Your Results: Use your TOTAL score to see where you rank.

- 00 – 10 You have lots of work to do.
- 11 – 20 It's time to ramp it up.
- 21 – 30 I guess you are doing OK (but who wants to be just OK?).
- 31 – 40 Congratulations on being ahead of the curve.
- 41 – 50 Maybe you should have run for President!

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ASERF Sponsors First Aesthetic Summit



Many of us have struggled with how to scientifically measure aesthetic outcomes other than clinical incidences or medical errors. It is the root of most surgery education that a “how to” approach is employed, with a positive outcome largely derived from patient satisfaction data.

In the first of what is hoped to be several “C” level summits, ASERF, with a generous educational grant from Ethicon-Endo Surgery, recently assembled an interdisciplinary group to get our arms around this issue and develop scientific measures that look beyond adverse events and anecdotal satisfaction levels from patients.

The group represented some of the best thinkers from anthropology, sociology, psychology, feminism, and facial recognition. Attendees included:

- **Lt. Roy Paschal**, who started the Forensic Art Unit at the South Carolina State Law Enforcement Division in 1985 and has completed numerous facial reconstructions that have led to the identification of unnamed persons.
- **Nina G. Jablonski** is Department Head and Professor of Anthropology at Pennsylvania State University. She is a biological anthropologist and paleobiologist who studies the evolution of adaptations to the environment in nonhuman and human primates.
- **David B. Sarwer, PhD**, is an Associate Professor of Psychology in the Departments of Psychiatry and Surgery at the University of Pennsylvania School of Medicine and a consultant to the Edwin and Fannie Gray Hall Center for Human Appearance.

- **Randy Thornhill, PhD**, Distinguished Professor, The University of New Mexico, who has done extensive research in the areas of evolutionary aspects of social psychology and behavior; developmental stability; sexuality; attraction and attractiveness; cultural and other biodiversity
- **Beth Troutman**, the originator of the non-profit organization, “The Build A Dream Foundation,” founded by her at age 19 to help young adults develop a healthy self-esteem. She received degrees in both Political Science and Women’s Studies from the University of North Carolina at Chapel Hill.
- **Dale Cameron**, a cosmetic industry icon, who rapidly rose through the ranks of the Nordstrom organization where she quickly established herself as an innovator and leader in driving strategy and revenue

The Group was moderated by ASAPS Vice President Felmont (Monte) Eaves, III, MD, who is currently developing a clinical paper for submission to a peer-reviewed, scholarly journal.

Other ASERF News

New grant awarded

A new grant request has recently been funded in the amount of \$10,000 by ASERF. The topic, Anti-inflammatory Properties of Adipose Tissue Derived MSCs was submitted by Summer Hanson, MD of the University of Wisconsin.

Please help us with our new patient satisfaction survey on Botox Cosmetic and Hyaluronic Acids

ASERF has received a research grant to examine patients’ use and satisfaction with BOTOX® Cosmetic and HA dermal fillers through a survey of patients who currently use these products. In collecting this data, we hope to develop a demographic profile or profiles of the average user(s) and determine general user satisfaction with BOTOX® Cosmetic and HA dermal fillers. The survey results will be shared with all ASAPS and ASERF members, to provide additional useful information about the level patient satisfaction, potential concerns and patient demographics. This brief five minute survey would be self-administered in your waiting room either pre or post visit. Please watch for the packet that will be mailed to you in the next several weeks and thank you in advance for participating

Applications being evaluated for Allergan Foundation Breast and Cosmetic Medicine Research Grant

The Scientific Research Committee is currently evaluating applications for the Allergan Foundation Research Grant—awardees will be notified within the next several weeks.

Studies in progress

Two significant directed research projects are currently underway through ASERF, Injection Lipolysis and fat grafting to the breast. Further details will be published in a peer-reviewed journal and in the pages of *ASN*.

Media Notes and Quotes

A Sampling of current media coverage on the Aesthetic Society

"But doctors are free to use fillers as they deem appropriate for individual patients. For example, several medical societies have created injectablesafety.org, which covers both approved and unapproved uses of dermal fillers; the site is financed by grants from BioForm, Artes and Medicis. Dr. Julius W. Few, a plastic surgeon in Chicago, said that ancillary medical personnel and doctors who lack expertise in cosmetic treatments were responsible for most filler complications."

Questions on Using Fillers Near Eyes
New York Times
November 20, 2008

"A simplistic, unscientific analogy—that 'the breast is like a pillow and a pillowcase'—can be useful for patients, says Renato Saltz, president-elect of the American Society for Aesthetic Plastic Surgery and founder of the Image Reborn Foundation, a retreat for breast-cancer survivors in Park City, Utah. 'Remove the tissue—the pillow—and there are lots of ways you can fill the pillowcase.'"

Body Rebuilding
Allure Magazine
October, 2008

"But for those who are seeking wrinkle relief, there may be more options in the near future. Reloxin, another injectable form of the botulinum toxin, from Medicis Pharmaceutical and Ipsen, could be approved by the F.D.A. by early 2009, breaking Allergan's Botox monopoly. 'There may be others to follow,' said Dr. Alan Gold, the president of the American Society for Aesthetic Plastic Surgery, who practices in Great Neck, N.Y. 'So what you'll find is an increased public awareness of the availability of these products.'"

Botox Hits Men Right in the Brow
New York Times
October 15, 2008

"In 2007, The American Society for Aesthetic Plastic Surgery and the American Society of Plastic Surgeons issued a joint statement of caution about fat injections for the breast, noting that they can be effective in enhancing breast appearance after reconstruction or to soften the appearance of implants in place, but not recommending fat injections for augmentation, citing a lack of data and the fear of hindering breast cancer detection."

Are Fat Injections Safe for Breasts
WebMD
October 22, 2008

"Evolence, approved by the FDA in June, has the same plumping effect as the original, but with potential collagen-boosting benefits, too. 'It's more than just injecting a blob to fill an area,' says New York City plastic surgeon Z. Paul Lorenc, MD."

Beauty Antiaging—Lip Service
Elle Magazine
October, 2008

"Among 30 patients who each had three treatments at four-week intervals, circumferential body measurements decreased by an average of one and a half inches (and as much as four inches) by one month after the final session. Body weight was unaffected. Jeffrey Kenkel, professor of plastic surgery at the University of Texas Southwestern Medical Center and vice-chairman of UltraShape's advisory board, is now evaluating its safety and efficacy in 125 patients. 295% more breast augmentation procedures were done in 2007 than in 1997—The American Society for Aesthetic Plastic Surgery."

Scapel News
Allure Magazine
November 2008

"According to the American Society for Aesthetic Plastic Surgery, men had 1.1 million cosmetic procedures in 2007, up 17 percent from 2006—so it's not just Hollywood aiming to look better. More likely, it's the senior vice president of marketing down the hall. But even with this uptick, men account for only about 9 percent of total procedures."

Beauty: Face Time
Forbes
November 24, 2008

"So anyone who is obese and planning a New Year's resolution to shape up and slim down is taking a positive step toward better health. 'The bigger 'horror stories' are someone who's massively overweight and dying of a heart attack or stroke," says Dr. Alan Gold, president of the American Society for Aesthetic Plastic Surgery. Of course, Gold is a plastic surgeon who spends his days helping patients look better, so he feels our readers' pain. Surgery can help with saggy skin, although it can be very expensive. A surgeon's fees alone for a tummy tuck average more than \$5,000, according to ASAPS. Gold notes that some insurance companies do cover tummy tucks, thigh lifts and other body-contouring surgeries for patients who've lost a lot of weight and then develop significant problems like chafing and skin irritation from the excess skin.

Lose Weight, Gain a "Loose Suit" of Skin?
MSNBC
December 23, 2008

"The latest figures from the American Society for Aesthetic Plastic Surgery show that the number of cosmetic surgical procedures performed on youths 18 or younger more than tripled over a 10-year period, to 205,119 in 2007 from 59,890 in 1997. The most frequent procedure, otoplasty, or ear reshaping, costs an average of \$3,000, while rhinoplasty costs \$4,500, according to the American Society for Aesthetic Plastic Surgery. These costs can be twice as much in the New York area. "If parents have bought into the concept, if they're supportive of a procedure for their child, they seem to be going through with it despite the economy," said Dr. Alan Gold, a plastic surgeon in Great Neck, N.Y., and president of the society.

Seeking Self-Esteem Through Surgery
New York Times
January 15, 2009



Medical Spa Task Force Report

Medical spas have been studied by a Task Force created in Massachusetts in 2006. Eight recommendations were presented January 12, 2009 <http://www.massmedboard.org/public/pdf/MedSpaFinalReport.pdf> with input from the Boards of Registration of Cosmetology, Electrology, Nursing and Medicine, as well as individual dermatologists, plastic surgeons, nurses and consumers.

Recommendation 1

Classify Medical Aesthetic Procedures by Regulation. The Task Force recommends classifying all potential aesthetic medical procedures as Level I, II and III according to patient risk and need for higher levels of education, training and supervision. Level I (hair, massage, skin and nail care) would be performed by manicurists, electrologists, aestheticians and cosmetologists. Level II (laser, light and energy based devices and tissue alteration) would require RN or APN practitioners, except for electrologists who could perform laser hair removal. Level III (ablative and vaporizing laser, photodynamic therapy, injectables, dermabrasion, chemical peels) would require physician or nurse in collaboration with a physician practitioner. However, the Task Force recommends a new category called Advanced Aesthetician to perform Level I ultrasonics, dermaplane exfoliation and non-invasive cellulite treatment treatments, and Level II non-ablative laser (hair removal and skin treatment), intense pulsed light therapy, all radio frequency devices, dermaplane exfoliation, and lymphatic drainage treatments.

Recommendation 2

Medical spa procedures should be performed only by individuals licensed

by an appropriate Board of Registration.

The Task Force is calling each Board of Registration to establish scope of practice restrictions, for example so that MD's not specifically trained in dermatologic procedures would be prohibited from offering laser skin procedures without additional training.

Recommendation 3

Medical Spas should be licensed by the Department of Health in a manner similar to hospitals and clinics. This recommendation includes proposed legislation to create Level I, II and III facilities. However, Level II and III facilities can avoid Medical Spa licensure if it is a physician, nurse or electrologist owned facility, and the owner is actively practicing on site at all hours of operation and qualified to perform and supervise all treatments offered. Exemption also means the facility cannot use the phrase "Medical Spa" to imply it is so licensed.

Recommendation 4

The Board of Registration in Medicine should amend its policy prohibiting the sale of non-durable goods by physicians. Massachusetts currently prohibits product sales, except for patient care items, such as crutches, and recommends they be provided at cost. The Task Force adopted the North Carolina Medical Board's policy, which permits limited sales of durable medical goods or aesthetic products, but never displayed in examination, consultation or treatment rooms.

Recommendation 5

The Board of Registration in Medicine should amend its definition of laser hair removal as the practice of

medicine. Electrologists safely use lasers for superfluous hair removal. Any other purpose (tattoo removal, age spots) should remain the practice of medicine.

Recommendation 6

The Legislature should establish by law a separate Board of Registration in Aesthetics. Aestheticians in Massachusetts are currently regulated by the Board of Cosmetology. The Task Force believes skin care is sufficiently different from nail care and hair treatments as to be separately regulated. The Board of Cosmetology disagrees.

Recommendation 7

The Commonwealth should establish an advanced aesthetician license. The Task Force believes aestheticians with additional training can safely perform certain Level II procedures that are "essentially cosmetic, non-diagnostic in nature and involve no removal of tissue." This recommendation is not part of the proposed legislation.

Recommendation 8

Prior to any laser or other light-based skin procedure, patients must be assessed by a physician, a physician's assistant, or an APRN or RN practicing in compliance with BORN's advisory ruling on nursing practice related to Non-Ablative Laser and Non-Laser Light Sources Device Use. The Task Force believes treating age spots or blemishes merely as cosmetic issues, instead of evaluating them as potentially serious medical conditions, places patients at risk.

The link above to the Task Force report provides additional and exhaustive recommended categorization of procedures, personnel, training and facilities.

The Aesthetic Meeting 2009

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Week-at-a-Glance

Saturday, May 2, 2009

6:30am - 6pm **Registration Open**
Mandalay Bay Convention Center South—Mandalay Bay Foyer

Special Pre-Meeting Workshops

7:30am - 5:30pm **S1 Cosmetic Medicine: The Spectrum of Non-Surgical Options for Face and Body Rejuvenation: What's Available, What's New, What's on the Horizon—Featuring Live Patient Demonstrations**

Co-Chairs: Jeffrey M. Kenkel, MD and Clifford P. Clark, III, MD
Educational grants provided by Allergan, BioForm Medical, Canfield Imaging Systems, Dermik Aesthetics, Eclipse Medical, Lumenis, Medicis Aesthetics, Mentor Corporation, Obagi Medical Products, OrthoDermatologics Aesthetics, Palomar Medical, Reliant Technologies, and Sciton, Inc.

7:30am - 1pm **S2 Endoscopic Technique in Forehead & Mid-Face—A Cadaver Workshop**

Instructors: Renato Saltz, MD, Grady B. Core, MD, Felmont F. Eaves, III, MD, Kiya Movassaghi, MD, & Richard A. Warren, MD

8am - 5pm **S3 Medical Life Drawing & Sculpture**

Instructors: Grant A. Fairbanks, MD & Grant R. Fairbanks, MD

2pm - 6pm **S4 Open and Closed Rhinoplasty: The Complete Basic Steps of Rhinoplasty: A Cadaver Workshop**

Instructors: Joe M. Gryskiewicz, MD, Paul H. Izenberg, MD, Robert M. Oneal, MD, & Daniel Sherick, MD

S5 Facial Rejuvenation by MACS Lift—A Cadaver Workshop

Instructors: Mark L. Jewell, MD, Alexis M. Verpaele, MD, Glenn W. Jelks, MD, Kiya Movassaghi, MD, & Thomas L. Roberts, III, MD

Sunday, May 3, 2009

6:30am - 6pm **Registration Open**
Mandalay Bay Convention Center South—Mandalay Bay Foyer

ASAPS Board of Directors Meeting

ASERF Board of Directors Meeting

Special Seminars

7am - 6:00pm **S6 Cosmetic Medicine: Business Strategy in a Challenging Economy**

Co-Chairs: Renato Saltz, MD & Richard A. D'Amico, MD
Co-sponsored by The Aesthetic Society and The American Society of Plastic Surgeons

7:30am - 5pm **S7 Conjoint Rhinoplasty Symposium: Technique and Artistry in Rhinoplasty—A Joint Presentation of The Rhinoplasty Society and The American Society for Aesthetic Plastic Surgery**

Co-Chairs: Jack A. Friedland, MD & Mark B. Constantian, MD

8am - 2pm **R Residents & Fellows Forum**

Co-Chairs: Clyde H. Ishii, MD & Kiya Movassaghi, MD
Supported by Allergan

8am - 12Noon **S8A International Hot Topics in Aesthetic Surgery**

Co-Chairs: William P. Adams, Jr., MD & João Carlos Sampaio Goés, MD

S9 AAAASF Inspector Training Workshop

Instructors: Lawrence S. Reed, MD, Gary M. Brownstein, MD, David D. Watts, MD, Harlan Pollock, MD, Geoffrey R. Keyes, MD, Jeff Percy; Theresa J. Griffin-Rossi, CAE, Pamela Baker; John D. Newkirk, II, MD, & John Pitman, MD

S10 Strategies for Re-Designing Your Practice

Co-Chairs: Mark L. Jewell, MD & Robert Singer, MD

12:30pm - 4:30pm **S8B Hot Topics/Emerging Technology in Plastic Surgery**

Co-Chairs: William P. Adams, Jr., MD, Joe M. Gryskiewicz, MD, & V. Leroy Young, MD

OPTIONAL COURSES (Pages 20 - 23)

Residents & Fellows Forum Reception

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Monday, May 4, 2009

6:30am - 5:30pm **Registration Open**
Mandalay Bay Convention Center South—Mandalay Bay Foyer

Scientific Session

7:45am **Aesthetic Society Welcome** —Alan H. Gold, MD

ASERF Welcome —Bahman Guyuron, MD

Canadian Welcome —Yvan Larocque, MD

ASPSN Welcome —LuAnn Buchholz, RN, CPSN

Program Chairs' Welcome —Jeffrey M. Kenkel, MD & Jack Fisher, MD

8am **Panel—Etiology and Prevention of Unnatural Results in Rhytidectomy**

Moderator: Foad Nahai, MD

Panelists: Sam T. Hamra, MD, Val Lambros, MD, H. Steve Byrd, MD, & Daniel C. Baker, MD

9:15am **Panel—Overcorrection/Undercorrection and the Iatrogenic Deformity of the Neck Following Rhytidectomy**

Moderator: Fritz E. Barton, Jr., MD

Panelists: Joel J. Feldman, MD, William J. Little, MD, Foad Nahai, MD, & Alexis M. Verpaele, MD

10:30am **Coffee Break in the Exhibits**

11am **Papers**

11:30am **Special Presentation—Aesthetic Interdependence of the Eyebrow and the Mid-Face and Orbit: Refining Our Aesthetic Goals for Age Appropriate Rejuvenation of the Forehead and Brow**

Presenter: Timothy J. Marten, MD

Moderators: Rod J. Rohrich, MD & Bryan C. Mendelson, MD

Lunch in the Exhibits

12:15pm - 1:45pm

12:15pm - 1:45pm

12:15pm - 1:45pm

12:30pm - 1:30pm

12:30pm - 1:30pm

1:45pm

3pm

3:30pm

4pm

4:30pm

4:45pm

6pm - 7pm

7pm

8:00am - 12Noon

1:30pm - 5:30pm

9am - 4:30pm

S14 Research & Innovative Technology Luncheon (Page 24)

Moderators: William P. Adams, Jr., MD & Joe M. Gryskiewicz, MD

S15 Women Plastic Surgeons' Luncheon (Page 24)

Co-Chairs: Susan E. Downey, MD & Linda G. Phillips, MD

"Friends of Bill W" Meeting

OPTIONAL COURSES (Pages 25 - 27)

Panel—What Was I Thinking? Reassessing Your Unsatisfactory Breast Augmentation Results

Moderator: Jack Fisher, MD

Panelists: William P. Adams, Jr., MD, Barbara B. Hayden, MD, Michael Scheffan, MD, & W. Grant Stevens, MD

Special Presentation: In the Beginning...The Evolution of Breast Implants

Presenter: Thomas A. Biggs, MD

Coffee Break in the Exhibits

Papers

Corporate Sponsorship Awards

Al Aly, MD & Alan H. Gold, MD

Panel: Surviving Complications After Cosmetic Surgery—Hindsight is 20/20—Why it Happened and How I Managed

Moderator: Robert Singer, MD

Panelists: Bryan Mendelson, MD, Felmont F. Eaves, III, MD, Jack P. Gunter, MD, & Dennis C. Hammond, MD

S16 Cocktails and Complications (Page 27)

Faculty: Fritz E. Barton, Jr, MD, James H. Carraway, MD, Franklin L. DiSpaltro, MD, Jack Fisher, MD, Glenn W. Jelks, MD, Jeffrey M. Kenkel, MD, Timothy A. Miller, MD, Foad Nahai, MD, & Rod J. Rohrich, MD

Welcome Reception

Mandalay Bay Convention Center—Mandalay Bay Ballroom I - L

Special Seminars

S11A Physician Extender Injector Competence Training Level 1—Basic

Co-Chairs: Clifford P. Clark, III, MD, Mark A. Codner, MD, & Julius W. Few, MD

S11B Physician Extender Injector Competence Training Level 2—Advanced

Co-Chairs: Clifford P. Clark, III, MD, Miles H. Graivier, MD & Z. Paul Lorenc, MD

S12/S13 Skills for the Successful Patient Coordinator

Instructors: Karen Zupko & Isabel Stoltzman

Tuesday, May 5, 2009

- 6:30am - 5pm** **Registration Open**
Mandalay Bay Convention Center South—Mandalay Bay Foyer
- 8am** **Scientific Session A**
Panel—Congenital Breast Deformities: Transitioning from a Reconstructive to Cosmetic Algorithm
Moderator: James C. Grotting, MD
Panelists: João Carlos Sampaio Goés, MD, G. Patrick Maxwell, MD, Brian D. Peterson, MD, & Scott L. Spear, MD
- 9:15am** **Interactive Video—Short Scar Breast Lift**
Presenter: Frank R. Lista, MD
Moderators: Elizabeth J. Hall-Findlay, MD & Albert de Mey, MD
- 10am** **Coffee Break in the Exhibits**
- 10:30am** **Papers**
- 11am** **Live Demonstration: Do Different Techniques Demand Different Designs?**
Moderator: Scott L. Spear, MD
Discussant: Steven A. Teitelbaum, MD
Panelists: Jack Fisher, MD, Elizabeth J. Hall-Findlay, MD, & Dennis C. Hammond, MD
- 12Noon** **Lunch in the Exhibits or ASAPS/ASERF Business Luncheon**
- 8am** **Scientific Session B**
Panel—Aesthetic Control of the Lower Lid: What's Important to Successful Shape
Moderator: Mark A. Codner, MD
Panelists: Glenn W. Jelks, MD, Charles H. Thorne, MD, Thomas L. Roberts, III, MD, & Graeme J. Southwick, MD
- 9am** **Panel—Complications of Injectables—Etiology, Treatment, and Prevention**
Moderator: Renato Saltz, MD
Panelists: Sue Ellen Cox, MD, Z. Paul Lorenc, MD & Rod J. Rohrich, MD
- 10am** **Coffee Break in the Exhibits**
- 10:30am** **Papers**
- 11am** **Panel—Fractional Resurfacing—Should We Believe the Hype?**
Moderator: Jeffrey M. Kenkel, MD
Panelists: Fritz E. Barton, Jr., MD, A. Jay Burns, MD, Steven R. Cohen, MD, & Robert Weiss, MD
- 12Noon** **Lunch in the Exhibits—or ASAPS/ASERF Business Luncheon**
- 8am - 6:30pm**  **NURSES TRACK (Page 13)**
ASPSN 6th Annual Aesthetic Symposium of the American Society of Plastic Surgical Nurses
- 2pm - 6:30pm** **OPTIONAL COURSES (Pages 28 - 32)**
- 6:30pm - 7:30pm** **Women's Martini Hour**
Supported by Mentor Corporation

9am - 11am **Special Seminar for Patient Coordinators Only**
S17 Advanced Discussions for Patient Coordinator Course Alums
Instructors: Karen Zupko & Isabel Stoltzman

Wednesday, May 6, 2009

- 7am - 5pm** **Registration Open**
Mandalay Bay Convention Center South—Mandalay Bay Foyer
- 7:30am** **Scientific Session A**
Panel—Best of Hot Topics
Moderators: William P. Adams, Jr., MD & Joe M. Gryskiewicz, MD
Panelists: Selected by popular vote
- 8:30am** **Panel—Liposuction 20 Years Later: Precision in Shaping, Prevention and Correction of Contour Irregularities**
Moderator: V. Leroy Young, MD
Panelists: Arturo Prado, MD, Sydney Coleman, MD, Claudio Calabrese, MD, & Simeon H. Wall, Jr., MD
- 9:45am** **Coffee Breaks in the Exhibits**
- 10:15am** **Papers**
- 10:45am** **Special Presentation—Nutritional Assessment in the Massive Weight Loss Patient—Impact on Outcomes**
Presenter: J. Peter Rubin, MD

- 11am** **Interactive Video—Expanding the Role of the Mini Brachioplasty—A Critical Review**
Presenter: Lawrence S. Reed, MD
Moderators: Alan H. Gold, MD & Al Aly, MD
- 11:30am** **Panel—Defining the Risks of Body Contouring Procedures: Methods for Reduction of Complications**
Moderator: Franklin L. DiSpalatro, MD
Panelists: Al Aly, MD, James C. Grotting, MD, Geoffrey R. Keyes, MD, & V. Leroy Young, MD
- 12:30pm** **Lunch in the Exhibits**
- 7:30am** **Scientific Session B**
Panel—Rhinoplasty—New and Better Solutions to Old Problems
Moderator: H. Steve Byrd, MD
Panelists: Mark C. Constantian, MD, Ronald P. Gruber, MD, Jack P. Gunter, MD, & Bahman Guyuron, MD
- 8:45am** **Panel—Ethnic Rhinoplasty—Creating Shape While Preserving Ethnicity**
Moderator: William P. Adams, Jr., MD
Panelists: Nazim Cerkes, MD, Julius W. Few, MD, Jose Guerrerosantos, MD, & Susumu Takayanagi, MD
- 10am** **Coffee Break in the Exhibits**
- 10:30am** **Papers**
- 11am** **Interactive Video—Closed Rhinoplasty: Limited Access Without Compromising**
Presenter: Mark B. Constantian, MD
Moderators: Ronald P. Gruber, MD & Sherrell J. Aston, MD
- 11:45am** **Interactive Video—The Role of Chin Augmentation in Achieving Facial Harmony**
Presenter: Edward O. Terino, MD
Moderators: Bahman Guyuron, MD & Joe M. Gryskiewicz, MD
- 12:30pm** **Lunch in the Exhibits**
- 12:30pm - 1:30pm** **S19 Candidate Open Forum (Page 33)**
Chair: Jennifer L. Walden, MD, Vice-Chair: Robert Whitfield, MD
- 12:30pm - 1:30pm** **"Friends of Bill W" Meeting**
- 2pm - 6:30pm** **OPTIONAL COURSES (Pages 33 - 37)**
- 6:30pm** **VIP Reception**
- 7pm** **Presidential Cocktail Reception**
- 8pm** **Presidential Dinner Dance**
Supported by Medicis Aesthetics

Thursday, May 7, 2009

- 7am - 12Noon** **Registration Open**
Mandalay Bay Convention Center South—Mandalay Bay Foyer
- 7:30am** **Scientific Session**
Body Contouring Research Foundation Presentation
- 8am** **Annual Meeting Awards**
Jeffrey M. Kenkel, MD, Jack Fisher, MD, & Alan H. Gold, MD
- 8:15am** **Panel—Managing Web-Based Assaults on Your Practice**
Moderator: Robert Singer, MD
Panelists: Robert Aicher, Esq., Mark B. Constantian, MD, Jack P. Gunter, MD, & Neil R. Reisman, MD
- 9:15am** **Panel—Avoiding Complications in the Lower Eyelid: Clinical Pearls**
Moderator: Daniel C. Mills, II, MD
Panelists: Mark A. Codner, MD, Val Lambros, MD, Foad Nahai, MD, & Patrick K. Sullivan, MD
- 10:30am** **Coffee Break in the Exhibits**
- 11am** **Panel—Speak Up or Forever Hold Your Peace—Breast Surgery**
Moderator: Jack Fisher, MD
Panelists: Member submissions
- 12Noon** **Lunch**
- 1pm** **Panel—"I Don't Want Surgery"—Non-Surgical Options for Facial Rejuvenation**
Moderator: Jack A. Friedland, MD
Panelists: Trevor Born, MD, Claudio De Lorenzi, MD, Barry E. DiBernardo, MD, & Z. Paul Lorenc, MD
- 2:15pm** **Papers**
- 3:00pm** **Adjourn**



A Conversation with Dr. Stefanie Feldman of Interplast

Many Aesthetic Society members are familiar with the excellent work being done by California-based Interplast, the philanthropic organization founded in 1969 by plastic surgeon Dr. Donald R. Laub, former chief of plastic and reconstructive surgery at Stanford University Medical Center.

According to the Interplast website (www.interplast.org), Dr. Laub's philanthropic work "was inspired by Antonio, a 13-year-old boy who had come to Stanford from his home in Mexicali, Mexico to receive surgery to repair his cleft lip and palate. Antonio was being raised by his grandmother, living apart from his parents and six siblings. He had never attended school, and rarely had opportunities for social interactions with other children. Father James Poggi, a local priest, arranged for Antonio to come to California. Dr. Robert Chase, working with then-plastic surgery residents Dr. Leo Keoshian and Laub, performed the surgeries to repair Antonio's lip and palate.

Laub became determined to find a means of helping these children, and set about establishing a program designed to provide surgeries regularly in a charity hospital in Mexicali.

This act of charity was revolutionary for plastic surgery and set in motion the establishment of the first organization to provide free reconstructive surgery in developing countries—Interplast."

Since that time, Laub's vision has grown into one of the most significant charities in organized plastic surgery, supporting 12 permanent Surgical Outreach Centers in 9 countries, where 4,500 surgeries are performed per year. Other developments include the creation of a Medical Scholars Program to bring foreign

Something I find personally interesting about the group is the the countries we work in and the new emphasis on burns in India including acid burns of women. I personally have been to Nepal Myanmar (Burma), Brazil, Honduras, Ecuador, Peru, and India but they have traveled in the past to some remote places such as Mongolia, Laos and Ghana. Other sites they participate in now include Mali, Ethiopia, Bangladesh, Bolivia, Vietnam, China, and Shri Lanka.

doctors and other medical professionals to the United States for multi-month training fellowships, and a Visiting Educator Program, which enables medical experts to travel to developing countries and provide knowledge, training, and experience to developing world doctors and nurses who then help their fellow citizens. As of 2005, Interplast has provided over 60,000 operations for those in need.

Aesthetic Society member Stefanie Feldman, MD, is representative of the next generation of Interplast leadership. An assistant clinical professor of surgery at the University of Southern California and a practicing plastic surgeon in Woodland Hills, CA, Dr. Feldman has been very active with Interplast over the years, serving on the surgery, quality improvement and medical services committees. She has also volunteered as a surgeon on seven trips beginning in 1988, including two as team leader. *ASN* recently caught up with this busy member to hear more about her work with Interplast and how her aesthetic training has helped her help others.

ASN: How long have you been involved in volunteer work?

Dr. Feldman: I started doing volunteer work in high school with Amigos De Las Americas (a volunteer immunization group that, at that time, was going door to door in South and Central America). It was with them that I got my introduction to volunteer medical work.

ASN: What drew you to Interplast?

Dr. Feldman: In the late 70s, I did a plastic surgery clerkship at Stanford and it was there that I first learned of Interplast and was inspired to get involved.

Founded in 1969, the organization was still relatively new and had a completely new concept: provide reconstructive surgery to those in need in developing countries using medical volunteers. Interplast was the first organization of its kind to help those with clefts, disabling burns and hand injuries—restoring hope for productive lives filled with possibilities. Interplast has since provided nearly 75,000 life changing surgeries and it seemed to really motivate me to a career in plastic surgery, as I too wanted to make a difference in people's lives.

ASN: What one deed or activity do you think best exemplifies Interplast?

Dr. Feldman: Interplast's Mission is to provide free reconstructive surgery for people in developing countries, and to help improve health care worldwide. Interplast's goals are to provide direct patient care (reconstructive surgery and ancillary services) to those with no other resources; to provide educational training and medical interchange; and to assist host-country medical colleagues to medical independence.

The goals of education and creating medical independence really make the difference for me. They represent most

Continued on Page 21

Focus on Philanthropy

Continued from Page 20

what I think is best about Interplast: partnering with volunteers and overseas medical colleagues to educate and empower local communities so that medical access is available year-round now and for generations to come.

Interplast builds year-round surgical capacity where none previously existed, in some of the most underserved regions of the world.

Interplast still conducts volunteer medical team trips, but developing world surgeons (operating in their own communities with Interplast oversight and support) perform 76 percent of all Interplast surgeries now.

This focus on empowerment in the Global South also has allowed Interplast to more than double the number of surgeries it can provide annually—and for only a 22 percent budget increase.

ASN: How long have you been in practice; do you still maintain an active aesthetic practice?

Dr. Feldman: I have been in practice at Kaiser Permanente for going on 20 years. We do the full realm of plastic surgery. Our cosmetic program is on hold at the moment, since we are short one surgeon until July. Our Kaiser facility here in Woodland Hills actually started this program some 14 or so years ago offering full-scale aesthetic surgery to our members including rhytidectomies, facial cosmetic including endo brow lifts, abdominal and body contouring, post bariatric cosmetic surgeries and injectables. We hope to start it back up late this summer.

ASN: What part of your aesthetic training do you think is most beneficial to Interplast?

Dr. Feldman: So much of the aesthetic training is helpful since many surgeries we perform such as congenital ptosis, cleft lip and palate, facial reconstruction and burn reconstructive surgery necessitates the fine aspects of the aesthetic surgery that we learn, as well as the functional aspects. The real answer is in the details, the balance of the proportions and beauty. The beautiful repaired cleft lip is the real aesthetic challenge!



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President's Message

Continued from Page 3

- In addition to the website is a consumer brochure and a series of monographs on how members can include cosmetic medicine into their own practice—many members have found that the inclusion of injectable, laser and spa treatments have been a great help in keeping practice revenues healthy.

Focus Forward

President Regan's words quoted above certainly apply to the intellectually curious, scientific and artistic minds of aesthetic surgeons. Among the decisive issues we have debated over the years is aesthetic outcomes, and how to measure them beyond adverse clinical events and anecdotal satisfaction surveys.

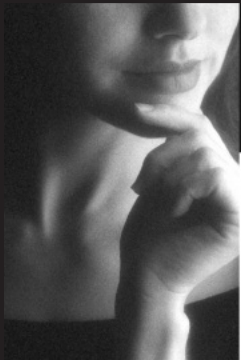
To try and put metrics to the methods, a summit was convened in late January titled *Defining Beauty: Outcomes and Metrics in Aesthetic Medicine*.

Conducted by ASERF under the direction of ASAPS Vice President

Felmont (Monte) Eaves, III, MD and funded by a generous educational grant by Ethicon-Endo Surgery, the summit included academics, scientists and physicians who engaged in two days of open exchange and dialog covering anthropology to FBI forensic reconstruction—for more details on the program please see the ASERF article from Dr. Eaves in this issue of ASN.

Other Issues:

Being president of the Aesthetic Society is not only a great honor but a great educational experience as well. Not a day passes that I don't learn both personally and professionally from my colleagues in all facets of the organization. Thank you for giving me this opportunity and for entrusting me with the leadership of your Society.



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Patient Safety: From the literature

New Long-term Follow-up Study Suggests Lower than Average Risk of Breast Cancer in Women with Cosmetic Implants



Contributing to the aesthetic surgeon's armamentarium on cancer and breast implants comes a new study published *International Journal of Cancer*¹ suggesting that women with cosmetic breast implants consistently have a lower than average risk for breast cancer.

The analysis was based on 6,222 women in Sweden and Denmark, 80% of which had silicone-gel implants, and represents the longest follow up of women with cosmetic breast implants to date. Nearly 85% of the women were followed for over 10 years and over 50% of the women were followed for more than 15 years, the longest follow-up being 37 years.

As most know, in 1992 the US Food and Drug Administration (FDA) restricted the use of silicone gel implants to controlled clinical trials due to questions about their

long-term safety. Saline implants are also tested for safety, but deemed less risky because rupture or leakage would release salt water instead of silicone gel into the body.

After extensive research and debate, they approved the use of silicone implants in November 2006 from two companies: Allergan Corp, Irvine, CA and Mentor Corp, Santa Barbara, CA. FDA approval came with many conditions, including conducting a large post-approval study following 40,000 women for 10 years after their surgery.

While this study is smaller in size than the projected FDA study on silicone gel implants, the length of the follow-up is unprecedented and gives very positive results.

Based on general population rates, the researchers expected 115.62 women out of the group to have breast cancer, but only 84 cases showed. Other cancer levels were on par with the expected average, showing no statistical increase except for lung cancer, which is explained by the significantly higher number of smokers among Swedish and Danish women, compared to previous Canadian and US studies.

The researchers thought the lower number of breast cancer incidence might be equated to certain characteristics of the patients in the study, such as younger age at first birth, higher parity and lower body mass index. Most studies do not include this type of data, but even after the numbers were adjusted to take this into account, the reduction was still substantial.

According to the 2007 Statistics from ASAPS, almost 400,000 women chose breast augmentation in the US, making it the second most popular surgery after liposuction. Both breast augmentation and reconstruction have been proven in numerous studies to have psychological and physical benefits for women who choose these procedures.

This study in addition to the many others that consistently support the safety of silicone gel and saline implants is an important reassurance to surgeons, as well as patients that there is no association between breast implants and cancer.

¹ International Journal of Cancer, Volume 124 Issue 2, Pages 490 - 493, Published Online: 11 Nov 2008

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