Facial plastic surgeons celebrate 40 years of surgical excellence and quality patient care at the Fall Meeting, September 21-24, 2004 in New York City. You won't want to miss the exceptional scientific program. In addition, you will be challenged and entertained by our John Conley and Jack Anderson Lectureships.

Mehmet C. Oz, MD, as the John Conley Lectureship will be speaking on, Complementary and Alternative Approaches: Are They Ready for Primetime?

Dr. Oz is vice-chair of surgery and professor of cardiac surgery at Columbia University. He directs the Cardiovascular Institute and is a founder and director of the Complementary Medicine Program at New York Presbyterian Medical Center. He has authored over 350 original publications, book chapters, abstracts, and books, and has received several patents. His books, Healing from the Heart won the prestigious Books for a Better America Award (1999) and Minimally Invasive Cardiac Surgery was elected as a Best Health Science Book by Doody's Review Journal (2000).

Dr. Oz received his undergraduate degree from Harvard University (1982) and obtained a joint MD and MBA (1986) from the University of Pennsylvania School of Medicine and Wharton Business School. He has appeared on NBC, ABC, and CBS news, and on 60 Minutes, Oprah, McNeil-Lehrer, 48 Hours, Turning Point, Dateline, Good Morning America, the Today Show, CNN, Discovery, PBS documentaries, and over two-dozen other shows. In April 2003, he was featured in Current Biography as one of the nation's foremost cardiothoracic surgeons. On October 20, 2003, his show, Second Opinion with Dr. Oz, premiered on the Discovery channel receiving critical acclaim.

Tom得益生，Esq.

As this year's Jack Anderson Lectureship, Thomas Rhodes, Esq., will present, The Neuroendocrinology of Laughter and Other Serious Topics. Mr. Rhodes plans to enlighten the membership as he discusses insights he has gained from representing facial plastic surgeons for over two decades. Mr. Rhodes was the trial counsel in the case of Anderson versus Georgia Society of Plastic Surgeons, where Dr. Jack Anderson recovered a substantial verdict against a group of surgeons that had disparaged his credentials as a facial plastic surgeon. Dr. Anderson's generous donation of those funds made possible the examination given annually to the Foundation's fellows and applicants for certification by the American Board of Facial Plastic and Reconstructive Surgery. The donation also endowed the annual Anderson Lectureship.

Mr. Rhodes graduated from Davidson College and the University of Virginia Law School.
Facial plastic surgery is a subject that traditionally piques public interest and the media, in turn, capitalizes on this curiosity. This past year we have seen unprecedented coverage of our specialty, which for the most part has been positive. Unfortunately, there have been several visible and well-publicized occurrences that have raised concerns about the safety of cosmetic plastic surgery procedures. Our Academy is choosing to be proactive in addressing these concerns and establishing guidelines to further promote quality patient care.

At the Spring Meeting the Academy Board of Directors voted to require all members who perform office-based surgery utilizing Level 2 and above anesthesia have their facilities accredited by one of the generally accepted accrediting agencies.

We feel this is a natural progression in our continued efforts to advocate safety in the surgical setting. The theme for this year’s Annual Meeting, *Facial Plastic Surgery Celebrates 40 years of Surgical Excellence and Quality Patient Care*, will show that historically, we have placed a high priority on safety education and accreditation of facilities. We were one of the first professional specialty organizations to recognize the importance of sponsoring of the Accreditation Association for Ambulatory Health Care (AAAHC). Years ago, we established an Ambulatory Surgery Committee (ASC) to educate our members on the importance of accreditation of our facilities, stressing the value of this process in improving the overall quality of our services, and the benefits to our patients. We have incorporated this into our fellowship programs by requiring all of our fellowship directors to have their facilities accredited by the various recognized accrediting agencies.

Congress and many state legislatures have also had concerns about the safety of office-based surgery and have introduced numerous bills to regulate its conduct. The Patient Safety and Quality Improvement Act passed the House of Representatives this spring by a large margin and the Senate version is a priority bill for this year. While this legislation does not directly address accreditation of outpatient surgical facilities, it does encompass quality and safety issues and calls for reporting of medical and surgical errors. Passage this year is not certain because of election politics, but this bill will certainly resurface in the future, regardless.

Ten states have proposed legislation regulating office-based surgery (AL, CT, IA, KS, MA, MD, MN, MS, NJ, NY). While some of these bills are dead for this legislative session, we can be certain that they will resurface again next year, and most assuredly in additional state legislatures. Many of these states are looking at Certificate of Need (CON) or state licensure as a means of controlling safety in outpatient surgery. They will almost certainly be looking at the criteria established by accreditation organizations when determining the standards. Compliance will be easily attainable if we are already adhering to these guidelines.

The anesthesia classification levels are outlined below (Table 1). This will guide you in determining if certification will be required for your surgical facility. Keep in mind that there are several organizations you can work through for certification and licensing. This would include state licensure or Medicare certification for ambulatory surgical centers, or the Accreditation Association for Ambulatory Health Care (AAAHC).
the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF) for office based facilities.

The timetable and implementation details are being formulated with the expected finalization at the fall Board meeting in New York. Every effort will be made to educate and assist our members who operate in office facilities to obtain the appropriate accreditation in a fair time frame. I welcome your comments and suggestions regarding this process.

It is clearly the right time for the Academy to take this step. Our patients look to organizations like ours to champion their interests and by taking this initiative we are fulfilling the trust they place in us as facial plastic surgeons.

Consider accrediting your office surgery center today. Contact any one of the following accrediting organizations for more information:

- Accreditation Association for Ambulatory Health Care (AAAHC)
  Phone (847) 676-9610; www.aaaac.org
- Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
  Phone (630) 792-5731; www.jcaho.org
- American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
  Phone (847) 949-6058; www.aaaasf.org

The AAFPRS has a video called Office Operating Room Facility Accreditation which you may purchase for $80. If you'd like to order this video, please contact Rita Chua Magness at the AAFPRS office, (703) 299-9291, ext. 227 or fax you order and credit card number to (703) 299-8898.

**Table 1** (Source: American Society of Anesthesiologists, 1999)

<table>
<thead>
<tr>
<th>Level</th>
<th>Responsiveness</th>
<th>Airway</th>
<th>Spontaneous Ventilation</th>
<th>Cardiovascular Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>Minimal Sedation (anxiolysis)</td>
<td>Unaffected</td>
<td>Unaffected</td>
<td>Unaffected</td>
</tr>
<tr>
<td></td>
<td>Moderate Sedation/analgesia “conscious sedation”</td>
<td>No intervention required</td>
<td>Adequate</td>
<td>Usually maintained</td>
</tr>
<tr>
<td>Level 3</td>
<td>Deep Sedation/analgesia</td>
<td>Intervention may be required</td>
<td>May be inadequate</td>
<td>Usually maintained</td>
</tr>
<tr>
<td>Level 4</td>
<td>General Anesthesia</td>
<td>Intervention often required</td>
<td>Frequently inadequate</td>
<td>May be impaired</td>
</tr>
<tr>
<td></td>
<td>Unarousable even with painful stimulus</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

President's Appeal Update

Dr. LaFerriere likes to get things accomplished. That is why he made the first donation to the President's Appeal to assist in paying off the mortgage for the AAFPRS building in 2005. We need to raise $150,181 to own the building. As of June 25, 2004 the President’s Appeal has raised $41,500. The following have been most generous:

- Dr. and Mrs. Keith A. LaFerriere
- Mrs. Kaye M. Curry
- J. Kevin Duplechain, MD
- Dr. and Mrs. H. Devon Graham, III
- Sam Rizk, MD
- David B. Rosenberg, MD
- Joseph K. Wong, MD

Please contact Ann Holton at aholton@AAFPRS.org for details on how to add your name to this list.
By Jon Mendelsohn, MD

As injectable filler options grow, so do their power to offer patients a more youthful look. The evolution of materials and the demand for the “perfect” substance that is “painless, lasts forever, offers no risks, and no downtime” has yet to be discovered. In the meantime, patients are very fortunate that the hyaluronic acid products such as Restylane® and Hylaform® are currently available in the United States. This article will review these materials and their practical uses for the treatment of facial wrinkles, folds, and augmentation procedures.

RESTYLANE

Restylane (Medicis) is the trade name for a product that was originally produced by Q-med in Sweden and used in over 60 countries. The final FDA approval was given in December, 2003. This completely natural substance is found in the human body and therefore requires no skin testing. It provides fullness and volume to the areas on the face wherever it is used.

The hyaluronic acid in Restylane is a clear gel called NASHA, or Non-Animal Stabilized Hyaluronic Acid. It is not made from animal products (like Hylaform). Hyaluronic acid is composed of a dimeric, linear polysaccharide and has a hydrophilic or “water-loving” feature that adds to its uniqueness. By binding water molecules, the material offers longer-lasting results despite the materials absorption over time. While this is biosynthetically produced, it is almost identical to that existing naturally in all living organisms.

HYLAFORM

Hylaform (Inamed and Genzyme) has been approved more recently in the United States (April, 2004). Unlike Restylane, Hylaform is a modified form of hyaluronan, which is derived from rooster’s combs. Therefore, this material should not be used in those patients who have a history of allergies to avian proteins. However, there is no allergy testing required as hyaluronan is biologically identical in all species.

Like Restylane, this material is clear and viscous, although slightly less viscous than Restylane. The preparation and technique are the same when using Hylaform. The material is injected through a ½” 30-gauge needle and comes prepared in a syringe with 0.7cc of material. Unlike the device prepared for Restylane, the Hylaform device does not have that little, adjustable swivel part (for the index and middle finger to hold), that makes it easier to position the bevel of the needle when injecting. However, the “feeling” of this injection is very smooth, likely the result of lower viscosity. The material is injected very slowly as the needle is inserted and threaded through the mid-dermis (bevel up unless injecting in a more sebaceous area such as the glabella, where the bevel is often facing down to avoid the material escaping through the skin). Once the needle has reached its desired location, it is gently and smoothly withdrawn as additional (and the majority) of it is infiltrated. On occasion, it is noteworthy that air may be injected creating a diffuse, whitish appearance that may be noticed.

SUCCESSFUL SOFT TISSUE COURSE

Over 50 residents and fellows attended the Soft Tissue Course at the Department of Otolaryngology-Head and Neck Surgery, University of Illinois at Chicago (UIC) College of Medicine, this past February 28, 2004.

All aspects of facial soft tissue surgery were covered including wound healing, suture techniques, local flaps and grafts, and scar revision techniques. Participants shared both didactic lectures and hands-on lab sessions. The UIC interactive computerized video program in soft tissue surgery was also introduced to the participants and used during the lab exercises.

FROM LEFT TO RIGHT ARE: STEPHANIE A. JOE, MD (UIC FACULTY MEMBER); RAYMOND J. KONIOR, MD; DEAN M. TORIUMI, MD (UIC); AMITA A. BAGAL, MD (PRIVATE PRACTICE); STEVEN H. DAYAN, MD (UIC); AND J. REGAN THOMAS, MD (UIC). OTHER FACULTY MEMBERS NOT IN THE PHOTO INCLUDE: DAN DANAHAY, MD, NORTHWESTERN UNIVERSITY; MANUEL LOPEZ, MD, (UIC FELLOW); AND JOHN WESTINE, MD, (UIC FELLOW).
ADVERTISEMENT ON PRINTED COPY
Every year the AAFPRS surveys its membership to learn the latest trends in facial plastic surgery. Survey results offer members insight within the industry as a whole and allow members of the media to track and report the latest findings. Below is a breakdown of survey highlights as well as tips on how you can capitalize on the findings in your own area.

The membership survey is implemented to garner media coverage for the Academy and its membership. In addition, the membership is encouraged to use these findings in their local market for individual coverage. An interesting angle members can take with their local news outlets is the impact of reality television shows like Extreme Makeover™ and how they have increased the public’s awareness of plastic surgery options. This has corresponded with an increased desire for people of all ages and backgrounds to undergo facial plastic surgery.

The survey shows that in 2003, facelifts have increased by an overwhelming 46 percent compared to 2002, with an increase of 45 percent seen in women and 12 percent in men. A new finding this year is the increase in procedures seen in women under 40. This group increased 25 percent in invasive and non-invasive facial plastic procedures. Rhinoplasty showed filler injections are up 39 percent, fat injections are up 191 percent (354 percent in women alone), and Botox injections are up 44 percent. In 2003, the most popular cosmetic surgical procedures overall were facial/neck liposuction, up an astonishing 173 percent and scar revisions, up 142 percent. In addition, non-surgical cosmetic procedures saw significant increases as well with laser resurfacing, up 171 percent and microdermabrasion, up 90 percent.

As predicted, women continue to be the most likely candidates for facial plastic surgery (71 percent of all surgical procedures and 87 percent of all non-surgical procedures). Specific increases among women include IPL laser resurfacing (up 339 percent), facial/neck liposuction (up 189 percent), microdermabrasion (up 97 percent), and otoplasty (up 73 percent). Top procedures among men included neck/face liposuction (up 66 percent), microdermabrasion (up 45 percent), and laser resurfacing (up 30 percent).

Questionnaires were mailed to 520 members in February. A total of 109 members completed the survey. Results were tabulated by IRC in Media, Pa.

What the survey means to you. The member statistics were discussed in detail by AAFPRS president Keith LaFerriere, MD, during his deskside meetings with key national women’s magazines in New York including Vogue, Harper’s Bazaar, and Marie Claire. This survey allows the Academy—and you as a facial plastic surgeon—to translate statistics into national media buzz. By looking at your personal surgery statistics compared to the national averages, you can determine what procedures people are looking for in your area. Let local media outlets know what is hot, and offer to be a contact for information on the latest trends and procedures.

Getting personal. This is an opportune time to have your patients help build your reputation. With this flurry of cosmetic plastic surgery reality shows, magazine features, and news commentaries, people are more willing than ever to share their experiences. Ask a patient to share their experience with a reporter or news station. This will give the reporter a personal aspect to add to the statistics. As an expert in the field, inform news outlets that they can come to you for questions and background information related to anything from safety to questions on the latest trends. The patient/doctor angle is always popular in the news. Your perspective on a procedure, your advice, and answers to a reporter’s questions will help cultivate your reputation as an experienced professional in the field.

Meeting the media. The survey results are a perfect opportunity for you to introduce yourself to your local media or improve your standing relationships. Rather than pitching a story, you can offer a background session on some of the emerging trends in facial plastic surgery. Be prepared to delve into the topic if the reporter decides to take it further and write a story. Establish yourself as a media friendly source of information and a credible expert who can be called for comment on breaking news such as FDA approvals or even celebrity stories.

Congratulations to AAFPRS membership survey winner Marc Zimbler, MD. He was randomly selected among survey respondents and has won free registration to the Fall Meeting this September in New York City.

Enjoy the second issue of the AAFPRS PR newsletter, published by the Academy’s PR firm in New York, Magnet Communications.
PR Corner:

Patient Communications
Putting Your Best Face Forward
Everyone knows the importance of a first impression. Below are strategies and recommendations to help you and your staff put your best "face" forward and help make your patients feel comfortable and welcomed.

Friendly Telephone Manners
The telephone is the first initial interaction between your office and patients, so good telephone manners will go a long way. Staff members should answer the phone in a warm, friendly tone and smile while talking on the phone—a smiling staff member comes across more positive to the caller. We suggest the greeting be similar to “thank you for calling, facial plastic surgery this is Jane, how can I help you?” It is best that the telephone is answered within the first four rings and the caller is not left on hold for longer than two minutes.

Using a message-on-hold recording describing procedures, credentials and accomplishments will help promote your practice. You could also opt for soft soothing music in the background to add to the overall patient experience.

Prompt Service
Patients should always be greeted with a smile. Staff members should be educated on the most common questions about the doctor, office policies, insurance information, etc. and should be prepared to deliver a clear and consistent response. Post a frequently asked questions sheet in the inner office with the appropriate answers for your staff to refer to. In addition, hold in-office seminars for employees on the latest industry news and techniques, as well as standard office practices. And remember, prompt service begins at the top. If you make it a priority to be on-time throughout the day, your staff will follow your lead.

Front Office FAQs
1. How much does it cost?
2. How long is the recovery?
3. Can I have everything done at once?

Office Décor
Your reception room should be a comfortable, inviting space where patients can feel at-ease before meeting you. We suggest an environment that resembles a living room rather than a sterile medical waiting room. Reading materials should also be available. A comfortable and inviting décor will be appreciated by patients.

Warm friendly wall colors such as peach, taupe, soft blues and greens are calming and relaxing hues and should be considered for the reception areas. Providing beverages such as water, coffee or tea is advisable as well. Fresh flowers are also a welcoming touch. These simple tips will make your office environment inviting and pleasant and guarantee that patients’ experiences are more relaxed and enjoyable.

The results are in! The AAFPRS 2003 membership statistics are now posted on www.aafprs.org. Visit the web site and see how your practice numbers compare to the national averages. Thank you to this year’s survey respondents.
Be Heard – Using the right messages
As part of our ongoing effort to offer you media tips, this issue will explore the key messages members should reference prior to an interview. In order to be a credible source of information for the media, as well as consumers, consistent messages should be used in all areas of marketing, including public relations and advertising. Below are some key points to remember:

• **Trust your face to a facial plastic surgeon** – As the tagline for AAFPRS, this is a very powerful message and simple for both consumers and media to relate to. When linked to the AAFPRS, this statement says that you are the specialist for facial plastic and reconstructive procedures of the face.

• Facial plastic and reconstructive surgery improves self-image and quality of life.

• AAFPRS members are board-certified surgeons specializing in facial plastic and reconstructive surgery.

• The AAFPRS is the world’s largest association of board-certified facial plastic and reconstructive surgeons with 2,600 members. AAFPRS is the only organization dedicated to the advancement of plastic and reconstructive surgery of the face, head and neck.

• Consumers can call toll-free 1-800-332-FACE and receive free brochures about facial plastic and reconstructive surgery procedures and a list of board-certified AAFPRS surgeons in their area.

• Consumers seeking facial plastic surgery should make sure the surgeon:
  • regularly performs the specific procedures
  • has privileges to perform the procedures at a local hospital or ambulatory surgery center
  • has documented education, training and experience performing the procedures

In addition to these key AAFPRS message points, it is important to also develop key messages which relate to your own practice. If you are the only board-certified facial plastic surgeon in your community—make it known. This is an important message to touch upon in all marketing materials. Also if you specialize in a specific procedure, you should highlight that and try to get that message out so you stand out from the rest.

The most important factor to remember when developing your message points and preparing for an interview is to be consistent. Stay on focus with your points and try not to deviate from them. Ideally, you should have 3-5 message points that relate to the topic and 3-5 message points about the AAFPRS and your practice. You will sound more credible – and the more credible you are, the more the media and consumers will turn to you for answers and insight.

Comments
Do you have a story idea or suggestion for us? Or share your local good news with AAFPRS members. Contact Patty Mathews at pmathews@magnet.com or (212) 367-6923. We look forward to hearing about your exciting, local stories.

Attention Members:
If you are not yet listed in Castle Connolly’s “America’s Cosmetic Doctors and Dentists” consumer guide, now is your chance. There is no cost to be listed in the guide. The goal of the book is to help patients identify qualified physicians for cosmetic treatment. Contact Vicky Klukkert at 212-367-8400 to be included.

Did you know...
Eight seconds is the average length of a TV sound bite so be sure to craft strategic messages.
The Academy was honored to have George A. Sisson, MD, as president in 1978. During his presidency, he vigorously sought recognition for our specialty and collaboration with the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) and the international medical scene at large. Dr. Sisson was also a regional vice president from 1972 to 1977. He chaired the 2nd International Symposium on Plastic and Reconstructive Surgery of the Head and Neck, in 1974.

He played a crucial role in the founding of the AAO-HNS and has held the position of president for six of the major organizations in otolaryngology.

In his prolific medical career, Dr. Sisson has edited or written numerous books and contributed chapters; has written 119 papers; filmed seven movies, performed 12 research investigations; and made over 400 presentations.

A paramount contribution for the AAO-HNS, Dr. Sisson spent countless hours compiling the history of the society in his book, The Head and Neck Story (1983, ASHNS). He writes in the forward, “The Head and Neck Story is primarily the tale of a 25-year struggle by a relatively small group of young unknown surgeons whose controversial objective, as they sought to expand the dimensions of their particular branch of medicine, was to change the status quo...This story is unique because this pursuit of excellence in the practice of head and neck medicine has affected, and is increasingly affecting, the methods of educating and training physicians with the end result that there has been a recognized and gratifying improvement in the treatment and care of the head and neck cancer patient.”

Among many, many honors, Dr. Sisson was the John Conley Lecturer in New York City in 1986. Dr. Sisson currently resides in Oakbrook, IL with his wife and is enjoying retirement.

Unpretentious, persistent, and kind still describe him. The Academy is proud to count him as one of its finest presidents and members.

Legal Advise for Over Two Decades

From Cover Story, page 1

Mr. Rhodes is a senior partner specializing in antitrust and trade association practice in an Atlanta law firm, Smith, Gambell, and Russell, where he has practiced for 34 years. He has always made time to represent indigent clients. In 1989, he received an award identifying him as the Atlanta lawyer who “best exemplifies the high ideals of legal services to indigents.” The Boy Scouts of America has awarded him the District Award of Merit for his service as backpacking instructor to inner-city boy scouts, whom he has taken on 50-mile backpacking expeditions.

Outside the practice of law, Mr. Rhodes spends much of his time at his camp in a remote mountain valley. He is married to Ann Bloodworth Rhodes, a noted artist. They have two grown children.

The Academy is pleased to have Dr. Oz and Mr. Rhodes attend our meeting as our invited guest speakers. We look forward to their lectures.
**Women in Facial Plastic Surgery: Networking**

*By Cynthia M. Gregg, MD*

As a member of the Women in Facial Plastic Surgery Committee, I was invited to share my experiences with networking.

After leaving academics, my first exposure to the private practice arena was in Nashville, where I participated in an organization called Tennessee Women in Medicine (TWIM). This organization was started by a small group of female physicians in private practice in Nashville and grew to incorporate both female physicians and PhDs from the medical and scientific communities of Nashville including Vanderbilt University. Tennessee Women in Medicine held quarterly dinner meetings usually hosting nationally recognized speakers. A particularly memorable meeting for me featured Christiane Northrup, MD, an author and practicing obstetrician/gynecologist who spoke on balancing her career and family life.

I opened my solo practice several years ago in North Carolina. Shortly afterward, I started meeting with several other female physicians for lunch and these gatherings continue on a regular basis. The group includes the physicians and their office staff and the specialties represented include plastic surgery, dermatology, ophthalmology, dentistry, and gynecology. We meet quarterly for lunch and discuss both medical and business issues with topics ranging from medical innovations to marketing strategies. We occasionally include women from non-medical businesses that provide services such as printing, banking, interior design, and marketing.

One aspect of academic medicine that I miss is the availability of formal and informal consultations among different specialties and sub-specialties. In academics, this included both formal interdisciplinary conferences and informal “curbside consultations.” The relationships developed with the other female physicians provide a similar avenue for both patient referrals and informal consultations.

As a female solo practitioner who is also a wife and mother, my opportunities to socialize with other professional females often seem limited. I look forward to our meetings as a regularly scheduled opportunity to meet with other women who find themselves in a similar situation.

I highly recommend starting a similar group in your area. Begin by contacting female physicians and plan a lunch or dinner meeting. Schedule the first meeting several weeks if not months ahead to accommodate everyone’s busy schedule.

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**Do’s and Don’ts: Personal Marketing**

*By Paul E. Kelly, MD*

Marketing for the facial plastic surgery practice has evolved from little time and effort spent, to investments of significant resource. Advertising which was once considered taboo among physicians has now become a necessary process, especially for the younger physician initiating his or her “elective” plastic practice. As an effort directed by the Academy’s Public Information Committee, a regular column will present marketing strategies, in honesty and sincerity, used by committee members that have been either helpful, hurtful, or with no reward. I hope to offer my personal strategies used in both the saturated market and in the market where exposure to the world of facial plastic surgery was limited.

One’s efforts are generally directed toward specific goals, with the primary goal of growing a practice through recruitment of appropriate patients that can afford your services. There are many methods to accomplish this task with your own specific environment dictating which will be most effective.

As explained by my mentor Russell W.H. Kridel, MD, whether practicing in a large city or in a small community, distinguishing yourself as unique is perhaps the most vital component for any successful bid for new patients. Joining the masses, however, should not be discounted because of its ability to provide name recognition among consumers. While advertising with the masses in either the newspaper or local journals may not lead to a significant number of new patient consults for the surgeon, he or she splits his efforts especially early on in his career between ENT and facial plastic work may find great benefit in establishing his label as a facial plastic surgeon through this marketing technique.

When opening in a new community, I have found that a four to eight month blitz of the local paper and a few advertorials in free journals to be very effective in “joining the group.” Failing to do so in a saturated market such as a big city, may find you with more time than patients in your initial set-up phase.

Even more effective in generating new patient consults was offering an educational CME seminar to the OR nurses on, *Advances in Facial Plastic Surgery*. A captivated audience allowed me to digress, albeit briefly, to explain how my training course is clearly superior and focused, as compared to those who don’t specialize in facial procedures. Never underestimate the referral power of the nurses in your hospital or operating room—they are frequently queried about who to see for elective surgery. Be on your best behavior in the OR from day one, educate and teach during your cases, and provide the OR
PECTIVES FROM THE BIG CITY TO THE SMALLER TOWNS

team with follow-up photos of cases in which they participated. Your reputation will quickly grow.

While most effective in the smaller communities, a very personal approach to meeting other physicians or merchants is to take an afternoon each week and go knocking on doors. I chose those who held overlapping interests and found this to be most effective. Never forget how important physician referral is for your business--be certain to provide those you meet with a short biography about you and your training, and even a procedure list outlining areas of your greatest interest. Make your visits quick and to the point, trying not to interrupt their patient care days. Send a quick note in follow-up again outlining services offered and reassure quick appointments and excellent care.

Capitalizing on your unique training and credentials, regardless of your market, is becoming increasingly more effective as the standard consumer is becoming better educated. The distinctive training requirements and focused face and neck base of the facial plastic and reconstructive surgeon clearly sets him ahead of his peers. Educated consumers are allocating appropriate weight to the training factor when deciding on a physician to re-shape their nose or lift their face. If you are to capitalize on your board certification, it is important to state clearly your primary board being the American Board of Facial Plastic Surgery — Head and Neck Surgery, as well as to announce certification by the American Board of Facial Plastic and Reconstructive Surgery if you hold this title. Advertising laws vary by state, with most requiring declaration of a primary ABMS board in conjunction with any non-ABMS certification announcement. Outlining both board certificates will avoid unnecessary hassles with your local plastic surgeon competitors.

Finally, giving to your community through involvement in a socially concerned fashion adds a fourth dimension for you in the eyes of others. My personal cause is skin cancer prevention, detection, and reconstruction. I have initiated in both the big city and a smaller community a free skin-screening program; it was very well received in both venues and clearly serves a great purpose. Local news agencies have found the material news worthy and will frequently provide camera crews or reporters to cover the event. Appropriate phone calls and office-generated press releases served me well in securing coverage. I also found local elementary schools very interested in my Practicing Safe Sun Kids Program; it was originally developed for my daughter's fourth-grade class and ultimately presented to a number of different elementary classes and schools. Take home bags with information on how to stay safe in the sun mixed with practice information and contact numbers reaches an entire set of patients and families.

The majority of strategies I have presented require a relatively limited advertising budget. The large public relations firms certainly have their place in developing a niche for the facial plastic surgeon, but local community exposure is best in my opinion handled in a local fashion. Give to your community and they will give back to you.

IN BRIEF

J. David Holcomb, MD of Sarasota, Fla., was a guest speaker at the Annual Awards Dinner of the Sarasota County Dental Society, May 20, 2004. He discussed current trends in facial plastic surgery and addressed the impact the field of dentistry has had on aesthetic analysis of the face.

Prof. Pietro Palma, MD of Milano, Italy, was elected president of the Italian Society of Facial Plastic Surgery from 2004 to 2007.

Thomas Romo, III, MD of New York, was appointed chief of facial plastic and reconstructive surgery at the Department of Otolaryngology at Manhattan Eye, Ear, and Throat.

Lee E. Smith, MD of Princeton, WVA, was elected to serve as chair-elect of the Federation of State Medical Boards. The Federation, which represents the nation’s 70 state medical boards, enhances public protection by developing and promoting high standards for physician licensure and practice. Dr. Smith will become chair in 2005.

Michelle R. Yagoda, MD of New York, and her medical spa—Rejuvenessence™— were featured on NY1 News on several dates and at several times in April 2004. Reporter Shazia Khan highlighted lymphosuction™, a therapeutic massage technique for firming and smoothing skin.

Marc E. Yune, MD of Atlanta, was featured on CNN as an expert on plastic surgery during the Fountain of Youth segment in October 2003. He made another live appearance on CNN in April 2004 to address and educate viewers on the popularity and safety of plastic surgery. Dr. Yune also filmed a charitable reconstructive case with the FACE TO FACE program, which was featured on the Discovery Health Channel.
By David Reiter, MD, DMD, Medical Editor, Facial Plastic Times

The public demands it. The payers pay for it. So what is it? According to Sackett (the youngest father of EBM), evidence-based medicine is “…the integration of clinical expertise, patient values, and the best evidence into the decision making process for patient care.” He advises us to “target [our] reading to issues related to specific patient problems. Developing clinical questions and then searching current databases may be a more productive way of keeping current with the literature.”

Further, “[evidence-based medicine] converts the abstract exercise of reading and appraising the literature into the pragmatic process of using the literature to benefit individual patients while simultaneously expanding the clinician’s knowledge base.” In other words, we should target our reading to topics and issues of direct relevance to our patients rather than reading everything that crosses our desks.

Now there’s a novel concept. Who would have thought that reading about what we do could improve the quality of care we deliver? I thought the research we do and the presentations and publications it stimulates were only supposed to get us promoted or to enhance the marketability of our practices. Who would have imagined that we could actually improve care by knowing the comparative outcomes of management alternatives?

OK, OK, despite my cynical observation about what’s what under the sun, society has embarked on a new crusade. If the right responses will improve both patient care and our lots in life, I’m all for it—and I think I can suggest one. You and I both know that “outcomes research” is just another word for application of the scientific method to clinical care; it’s the controlled evaluation of the results of an intervention based on well-grounded observations and hypotheses. And that’s been the nature of published research since paper was invented, no? Well, almost...

From my point of view, there are three major reasons for the public’s perception that we do not practice evidence-based medicine. First, much so-called research and the publications it spawns do not conform to high scientific or journalistic standards. There is little consistency in the criteria and methods used to analyze data, and even less in the quality of information generated by those analyses. The high cost of support for clinical trials further weakens the research infrastructure, and studies seem to be pared down to the minimums necessary to generate a paper when the costs of an optimal study cannot be covered. Common problems include sample sizes too small to generate useful comparisons and statistical methods so numerous that any data sets can be “compared” with statistical significance regardless of their clinical significance. Contributing to this is the increasing drive to publish, resulting in editorial in-boxes filled to capacity despite an increased number of medical journals.

Second, I do not believe that working knowledge of pertinent current literature is as common today as it should be. Despite the plethora of marginal publications, there are some very fine studies every month in the literature of every specialty. In my current position as medical director of a major academic hospital, I encounter dozens of clinicians in all specialties every day and I do not sense that most have sufficient awareness, knowledge, and understanding of the fine and useful articles available to them.

Third, we physicians still cling to the idea that we are all better as individuals than the mean performance measures for us as a group. One of my goals is to see the medical staff at my hospital achieve performance at or better than the mean for all University HealthSystem Consortium (UHC) hospitals for all parameters measured by UHC. Those specialties that are significantly worse than UHC means all offer the same reason, namely, “Our patients are sicker.” UHC analyses are adjusted for case mix index; in other words, indicators of severity (e.g., comorbidities) are used to adjust the data so it’s comparable from place to place despite differences in patient populations. Beyond this, it turns out that our patients are not any sicker than those at most other UHC institutions.

So what do we do about the disconnect between centuries of published research and the demand for evidence-based medical care? The above discouse suggests that we neither generate sufficient information of sufficient quality and clarity to optimize clinical care nor make the best use of the best information we have available to us now. Further, the media search for and focus on preliminary information not ready for prime time, which sells newspapers rather than that which gives perspective on the information contained therein. And no more than half of any group can be better than their mean. Further, no more than five percent can be “significantly” better using the most common statistical standards for evaluation.

Let’s stop generating marginal literature and focus on the quality and utility of what’s left. Those of us under academic pressure to publish can accommodate that need without major
compromise by asking simpler questions in our research. A clear, scientific answer to a simple, relevant question is of far more value than a complex investigation into an obscure area of personal interest. Premature or poorly supported conclusions are of less value than a statement of purpose reflecting the need for independent corroboration before conclusions can be drawn and recommendations for care offered.

It’s easier than ever to remain current with the literature. Let’s get back to it. Find controlled studies to guide the treatment you offer. Learn to evaluate the literature and you won’t find yourself in disagreement with it. There is no valid reason to believe that your treatment for a given problem should differ from recognized standards unless you can demonstrate superiority of your outcomes in a controlled and scientific manner that withstands external scrutiny. If you think you have a better mousetrap, prove it with sound, scientific investigation.

And a footnote to all you editors and reviewers out there: Be sure you know you’re correct before passing judgment on the work you review. I’ve seen many uninformed statements in reviews of my own submissions. Perhaps the most memorable was, “I do not see the findings described by the author and would suggest having this reviewed by a competent pathologist.” This was a review by a clinician of work done by me with the chief of surgical pathology at my institution. Our microscopic findings were verified by immunohistochemistry and electron microscopy, and the work was reviewed for us by Dr. Batsakis at my request.

I’ve also read many articles that virtually duplicated previously published work of which the authors and the editors should have been aware. This was understandable when the literature was hidden in dusty library stacks. A skillful Medline search can now obviate this concern.

Let’s respond to the demand for evidence-based medicine by generating and using the literature more skillfully, supporting our decisions scientifically when they differ from others’, conforming when the evidence is contrary to our current practice, and avoiding marketing hype with no scientific basis or purpose. If you prove it, they will come.

FACE TO FACE: INTERNATIONAL ... Their Visit to China

Linyi was the destination for six AAFPRS members (John “Mac” Hodges, MD; Steven J. Pearlman, MD; David Hamlar, MD; Andrew Campbell, MD; Shane Zim, MD; and Glen Porter, MD) for the fifth FACE TO FACE trip to China. They traveled to Linyi in early April to participate in presenting lectures, video sessions and demonstration surgeries. More than 108 surgeons from China attended and the Linyi People’s Hospital once again graciously hosted the educational exchange. The Director of the Hospital, Dr. Chuangui, wrote, “The lectures were well outlined with excellent explanations and the surgery was performed and demonstrated in a way that was understandable by all of the participants.” Dr. Hodges, the team leader for the trip stated, “It is an honor to travel with fellow AAFPRS members as we work side by side with our colleagues in Linyi. The sharing of knowledge and cultures is what makes the FACE TO FACE trips so successful.”

If you are interested in participating in FACE TO FACE: Vietnam in November 2004 please contact Ann Holton at aholton@AAFPRS.org or please feel free to attend the FACE TO FACE Committee meeting at the Annual Fall Meeting on Monday, September 20, 2004 9:00am-10:30am at the Marriott Marquis in Times Square.
**Now is the Time to Secure Your Gala Tickets**
Add Your Name to the Executive Committee or to the General Committee!

**40th Anniversary Gala**
*Surgeons Children: Bringing Art to Life*

Thursday, September 23, 2004
7:00 pm - 11:00 pm
at Noche in Times Square

Honored Guests will Include:
Marta Sahagun de Fox (First Lady of Mexico)
and Placido Domingo

Chairs: Dr. and Mrs. Norman J. Pastorek
Vice-Chairs: Dr. and Mrs. Philip J. Miller

Executive Committee: Dr. and Mrs. Russell W.H. Kridel
Dr. and Mrs. Keith A. LaFerriere
Dr. and Mrs. William H. Truswell

General Committee: Dr. and Mrs. Mark V. Connelly
Dr. and Mrs. Gerald C. Edds
Dr. and Mrs. John M. Hodges
Dr. John W. Pate
Dr. and Mrs. Louie L. Patseavouras
David Rosenberg, MD and Jessica Lattman, MD
Drs. Angelo Reppucci and Maria Saketos
Dr. Sigmund L. Sattenspiel and Candy Langan, RN

**FALL MEETING UPDATE**
The updated Fall Meeting Program will be mailed to the membership in July. The free papers have been added to the program and some instruction courses were re-scheduled (although their instruction codes remain the same). The Face Lifting Lab Workshop was cancelled and the Skin Care course title was changed.

Please register early and do not forget to make your hotel reservations at the Marriott Marquis; housing deadline is August 20, 2004. The ITS Housing form should be used to make your hotel reservations.

**NOCHE SIGN-UP FORM**
Seating is limited and reservations will be honored as received.

☐ **Executive Committee**
To be on the Executive Committee, a donation of $2,500 is required. This will make you a BENEFACCTOR.
( ) Yes, please add my spouse and me to the Executive Committee. Enclosed is our payment for $2,500 for a total of four (4) tickets. (To receive recognition in the program gala, please respond by July 15, 2004.)

☐ **General Committee**
To be on the General Committee, a donation of $1,000 is required. This will make you a PATRON.
( ) Yes, please add my spouse and me to the General Committee. Enclosed is our payment for $1,000 for a total of two (2) tickets. (To receive recognition in the program gala, please respond by July 15, 2004.)

☐ **Standard Tickets to the Gala**
The standard cost of each ticket is $275 per person. This ticket will cover your attendance to the gala which will include dinner and dancing.
( ) Yes, please send me _______ tickets at $275 each.

Please print or type name(s) as you wish for it to appear on the invitation.

Name ______________________________
Address ______________________________
______________________________________
Phone ________________________________
Fax __________________________________
E-mail ________________________________

If buying tickets for guests, please list their names here: __________________________
__________________________________________
__________________________________________

Please charge my credit card for a total of $______________.
☐ American Express  ☐ Visa
☐ MasterCard  ☐ Diners Club
Card No. ______________________________
Exp. Date _______ Billing Zip _____________
Name on Card ___________________________
Signature ______________________________

Mail or fax this form to: Ann K. Holton, Director of Development, AAFPRS Foundation, 310 S. Henry Street, Alexandria, VA 22314. Fax (703) 299-8898. Phone (703) 299-9291, ext. 229.
ADVERTISMENT ON PRINTED COPY
From New Technologies, page 4 appearing area beneath the skin. To avoid this, a small amount of material is expressed through the needles prior to the injection.

The results achieved with Hylaform are typically good to excellent. The site typically reveals a slightly raised area with minimal erythema. Typically, no complaints of pain or discomfort are made although on occasion some patients state it burns briefly. Patients are quite pleased with the results when the goals are improvement in the melolabial folds or upper lip rhytids where it is expected to last about six months (although results may range from four to eight months). While it is not approved for lip augmentation, its use in this region yields about a three to four-month result.

On occasion small raised areas may be noted. Conservative injections using smaller amounts of the material will help to avoid this problem. When palpated, the treated area feels quite natural. Over a two to four-day period a small ridge that sometimes results seems to smooth out very nicely.

Both of these materials offer patients an excellent option for the treatment of lines, wrinkles, and folds in the face. While these substances can be used without complications for lip augmentation, materials like Perlane® will likely be of more value. At this time, we continue to use both products frequently as their demand is high and their results are consistently better than other materials currently available.

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**OPTION FOR WRINKLE TREATMENT**

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**FACIAL PLASTIC TIMES**
**JULY 2004**

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**2004**

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| SEPTEMBER 21-24 | FALL MEETING  
Co-chairs: Devinder S. Mangat, MD and Philip J. Miller, MD  
New York City, NY |
| SEPTEMBER 23 | 40TH ANNIVERSARY CELEBRATION  
SURGEONS AND CHILDREN, BRINGING ART TO LIFE  
Chairs: Dr. and Mrs. Norman J. Pastorek  
Vice-chairs: Dr. and Mrs. Philip J. Miller  
New York City, NY |
| OCTOBER 22-23 | THE PENN RHINOPLASTY COURSE:  
AESTHETIC AND FUNCTIONAL RHINOPLASTY  
Director: Daniel Becker, MD  
Philadelphia, PA |
| OCTOBER 29-NOVEMBER 1 | ART OF RHINOPLASTY  
Director: Leslie Bernstein, MD, DDS  
San Francisco, CA |

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**2005**

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| FEBRUARY 19-23 | WINTER SYMPOSIUM ON THE LATEST ADVANCES IN FACIAL PLASTIC SURGERY  
Snowmass, CO |
| FEBRUARY 19-26 | 34TH ANNUAL OTOLARYNGOLOGY UPDATE  
Director: Leslie Bernstein, MD, DDS  
Honolulu, HI  
Maul, HI (Feb. 23-26, optional) |
| MAY 13-17 | SPRING MEETING (WITH COSM)  
Boca Raton, FL |
| JUNE 18-19 | ABFPRS EXAMINATION  
Conducted by the American Board of Facial Plastic and Reconstructive Surgery  
Washington, DC |
| JUNE 26-30 | ADVANCES IN RHINOPLASTY  
Co-directors: Dean M. Toriumi, MD; Ira D. Papel, MD; and M. Eugene Tardy, Jr., MD  
Chicago, IL |
| SEPTEMBER 22-24 | FALL MEETING  
Los Angeles, CA |

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International Federation of Facial Plastic Surgery Societies Meeting  
Third Biennial International “Milano Masterclass”  
In Quest of Excellence  
➤ Sinonasal & Skull Base Endoscopic Microsurgery  
➤ Advanced Rhinoplasty & Pearls of Facial Plastic Surgery  
March 3 - 9, 2005; Milano, Italy  
Directors & Organizers: Paolo Castelnuovo, MD; Pietro Palma, MD  
Info: Prof. Pietro Palma, MD, Milano, Italy  
Fax: +39 02 6361.8770  
E-mail: mail@pietropalma.it  
Web site: www.milanomasterclass.it

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Paid advertisements appear on pages 5, 9, and 15.  
Enclosed in this July issue are:  
Annual Fund Envelope and  
40th Anniversary Announcement.