



Aesthetic Society News

Quarterly Newsletter of the American Society for Aesthetic Plastic Surgery

Volume 15, Number 2 Spring 2011

Aesthetic Society Annual Statistics Almost 9.5 Million Cosmetic Procedures in 2010; Surgical Procedures Account for 17 Percent of Total

The ASAPS Annual Statistics, conducted since 1997, showed that plastic surgery procedures increased almost 9% last year. The overall number of cosmetic procedures has increased 155 percent since the tracking of the statistics first began. Almost

9.5 million cosmetic surgical and nonsurgical procedures were performed in the United States in 2010. The most frequently

performed surgical procedure was breast augmentation and the most popular nonsurgical procedure was injections of Botulinum Toxin Type A (including Botox and Dysport).

Cosmetic surgical procedures increased almost 9 percent, with over 1.6 million procedures in 2010. Surgical procedures accounted for 17% of the total numbers of procedures performed representing 61% of total expenditures. The top five surgical procedures were:

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Patient Safety and the Plastic Surgeon Brand: An Industry Perspective

By **Hani Zeini**



During the recent ISAPS meeting held in San Francisco this past August, I had the privilege of participating as an industry representative during the Global Patient Safety Summit. Many key points and opinions were discussed and debated in this regard, and I want to take this

opportunity to similarly share with you our perspective.

To fully appreciate the environmental conditions, one must fully appreciate the fast moving progression of the past decade. In the last 10 years, the world of plastic surgery witnessed two remarkable and course-changing milestones:

- “Patients” became “Consumer Patients”
- Democratization of plastic surgery procedures

Thus, yielding what I term “disturbances” to the Plastic Surgery Ecosystem.

The health and sustainability of this Ecosystem depends on its balance. When presenting the elements of this Ecosystem, it is often misunderstood that I am espousing a monolithic isolationist view of plastic surgeons and the specialty. In reality, the Ecosystem not only allows for co-existence with other specialties and organisms, but, it demands it

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Society Announces New Endorsed Member Services

By **Michael C. Edwards, MD**

On behalf of the Aesthetic Society, I am pleased to announce that Keane Insurance Group, Touch MD and the surgical garment company Medelita are the latest participants in the ASAPS Endorsed Member Services Program. Companies who are part of this program are required to pass stringent requirements for quality, efficacy and value by Aesthetic Society Committee members and must be voted on for inclusion in the program by the ASAPS Board of Directors. Discounts on



their services and stipends back to the Society are requirements for participation.

Keane Insurance Group is a medical malpractice carrier in business since 1995. They currently provide coverage to more than 5,000 physician clients and serve as brokers to a variety of carriers. Their corporate offices are located in St. Louis, MO.

Touch MD is a combination of hardware and an easy to navigate patient

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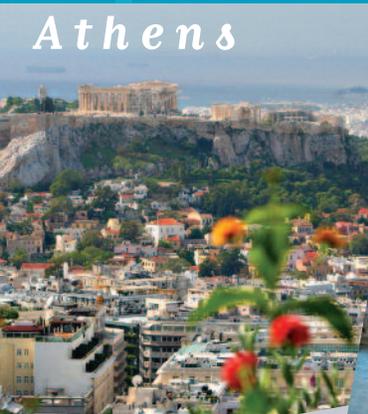
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May 6, 2011

The 16th Annual Meeting of The Rhinoplasty Society

Boston, MA
Contact: Jean Hodges:
904.786.1377
www.rhinoplastysociety.org
Jointly Sponsored by ASAPS

May 6 – 11, 2011

The Aesthetic Meeting 2011 Affirming the Science of Aesthetic Surgery

Boston Convention & Exhibition Center, Boston, MA
Contact: ASAPS 800.364.2147
562.799.2356
asaps@surgery.org
www.surgery.org/meeting2011
Endorsed by ASAPS

June 9 – 11, 2011

Summit in Aesthetic Medicine Symposium

Dana Point, CA
Contact: Sylvia Reitman
973.568.1751
s.reitman@globalacademycme.com
Endorsed by ASAPS

June 10 – 12, 2011

Plastic Surgery/Anti-Aging Medicine: The Next Generation Symposium

New York, NY
Contact: Francine Leinhardt:
347.266.7887
fleinhardt@earthlink.net

June 22 – 26, 2011

7th Annual Vegas Cosmetic Surgery 2011—An International Multi-Specialty Symposium

Las Vegas, NV
Contact: Nicholas Carson
877.673.3272
Email: nick@multi-specialty.org

July 6 – 10, 2011

2011 Plastic Surgery Congress

Broadbeach, Queensland Australia
Contact: Congress Secretariat
Tel: 61. 2. 9431. 8632
Email: 2011psc@conferenceaction.com.au
Website: <http://plasticsurgerycongress.org.au/>

August 6 – 13, 2011

Aesthetic Surgery on the Adriatic

Contact: ASAPS
Tel: 562.799.2356
Email: asaps@surgery.org
Website:
<http://www.surgery.org/cruise2011>

August 24 – 27, 2011

Breast Surgery and Body Contouring Symposium

Santa Fe, NM
Contact: ASPSP
847.228.9900

October 20 – 23, 2011

QMP 7th Aesthetic Surgery Symposium

Contact: Andrew Berger
Tel: 314.878.7808
Email: aberger@qmp.com



Aesthetic Society News

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

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The American Society for
Aesthetic Plastic Surgery



The Aesthetic Surgery Education
and Research Foundation

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ASAPS Website: www.surgery.org

ASERF Website: www.aserf.org



Stem Cells in Aesthetic Surgery: Evidence Trumps Marketing

We've all seen the ads: "Stem Cell Face Lift—Cutting Edge Surgery Without The Cutting!" "Stem Cell Breast Augmentation." Even "Stem Cell Therapy Cream." But having a savvy publicist, being featured on a news program, funding a big marketing budget, or theories on a web site does not amount to scientific proof that these procedures are safe or effective. Board certified plastic surgeons and their patients deserve better evidence and should demand better evidence.

Task Force formed:

There is no doubt that the potential future of stem cell therapies is bright in many areas of medicine, none more than plastic surgery. However the emotional abuse of patients by enticing them with unsubstantiated claims not only harms and deceives patients, but also potentially tarnishes the reputation of the specialty and of stem cell therapies themselves. Based on these concerns and a growing deluge of marketing claims concerning stem cell therapies in plastic surgery, ASAPS and ASPS banded together in the creation of a joint task force in the spring of 2010. The joint task force is chaired by Dr. J. Peter Rubin, co-director of the Adipose Stem Cell Center and Chair of the Division of Plastic Surgery at the University of Pittsburgh.

Systematic Review Completed:

Under Peter's direction, an exhaustive systematic review of the world literature related to stem cell therapies in aesthetic surgery is nearing completion. Peter and his team examined thousands of publications, and found very little published literature to currently support claims of safety or efficacy for aesthetic

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applications. Those publications that have been identified are being subjected to careful methodological review and ranking of the level of evidence (LOE) to assess scientific validity.

According to Phil Haeck, MD, current ASPS President, "this systematic review brings into sharp focus the fact that the marketing around stem cell therapies in aesthetic surgery is pushing far ahead of the current science." Indeed much of the currently available "evidence" related to stem cell treatments is anecdotal, but simply creating more "anecdotal evidence" does not create scientifically valid evidence. More and better research is necessary to find out not only if the stem cells work in the intended ways, but to standardize the methods of collecting, concentrating, or manipulating the cells. And of course most importantly the safety of these treatments must be documented.

What kind of evidence will be necessary to "prove" safety and efficacy? Consider for a moment what appears to be generally termed a "stem cell face lift;" this typically combines some sort of method to concentrate, "enhance," or "activate" stem cells which are then injected along with harvest fat, either alone or in combination with other surgical interventions. However

it is always difficult to assess the results of such "combined" therapies as the fat grafts alone may be responsible for most if not all of the observed results. So how do we know if the "stem cell" procedure is better, the same, or worse than our standard techniques? For this kind of question, only studies with side-by-side comparisons of fat grafting alone and fat grafting with the stem cell component can truly give us that answer. To be the most valid, such studies should be well designed, have adequate predictive power, and be prospective and blinded. No such study currently exists.

Another issue to be aware of is that some types of cell therapy or the devices that may be developed and marketed to use in stem cell collection or treatments may fall under the regulatory authority of FDA. For example, automated devices that can separate stem cells from adipose tissue are available as research tools, but not approved by the FDA for human use.

Joint Statement to be released at Aesthetic Meeting in Boston:

Based on a full examination of the current science of and literature related to stem cell treatments, ASAPS and ASPS will be voting to approve a joint position statement on stem cells in aesthetic surgery during the first week of May, 2011, and anticipate releasing the position statement during the ASAPS Annual Meeting in Boston. While we remain enthusiastic about the future potential for stem cell therapies and eagerly await good quality research, this position statement will provide current guidance for our members and help us communicate our evidence and safety message with the public and media.

PROJECT Beauty.

By Daniel C. Mills, II, MD

At last year's Aesthetic Meeting in Washington, DC, we introduced you to a new product that utilizes the exciting concept of Video on Demand (VOD) to deliver important news, information and entertainment to a segment of the population that may not yet be considering aesthetic surgery. The name of this product is Project Beauty.

Since that time, many exciting things have developed with this product. Among them are:

- 10,400 registered users, acquired through very successful contests and promotion. This gives us a core community of consumers that we can leverage in the future.
- An established presence on Twitter, Facebook and YouTube. Recent tweaking of these efforts has resulted in greater numbers: we currently have over 1,000 fans on Facebook, have retooled our YouTube presence to have a solid channel of video leading back to the Project Beauty site, and more than 510 Twitter followers.
- An iPhone app that is being widely disseminated thanks to the efforts of Task Force member Sanjay Grover, MD. This will increase both the reach and influence of the project.
- A web site that is both robust and beautiful. Redesign and back end enhancements have led to better streaming and a more consumer-friendly site. The videos themselves have maintained that high quality.
- A platform for the voicing of issues important to the Society; for example the recent issues surrounding breast implants and ALCL.

- Approximately \$60,000 in revenue, a little less than half of the project's operating budget.
- Our blog which has become one of the top three viewed portions of the site.
- Our new preferred vendor relationship with TouchMD that will get Project Beauty into every participating members practice.
- A relationship with The Society of Plastic Surgical Skin Care Specialists which provides us with interesting commentary and consumer interest.

As the Anniversary of our launch, I can think of no better time to let you know of some exciting new developments for the future of Project Beauty. They include:

- A re-focus of our information to only include subjects directly applicable to plastic surgery, skin care, and non-invasive products,
- The ability for all members to submit their own video to Project Beauty as long as they adhere to editorial guidelines (to come via blast email),
- The inclusion of the popular Find a Surgeon and Ask-a-Surgeon features

from www.surgery.org,

- The ability to use any Project Beauty video on your own site to augment your patient education efforts,
- The possibility of geographic search on the Project Beauty portal for Find a Surgeon.

Project Beauty is the ONLY tool available to membership through the Society to reach the elusive "thinking about it" patient, the ONLY visual, interactive arm of our public education outreach efforts and the ONLY voice organized plastic surgery has to educate in an entertaining way. Please help to support your project by announcing it via your regular patient correspondence, Facebook or newsletter. Please use it, support it and send any ideas you may have for it to our staff liaison John O'Leary at john@surgery.org

Daniel C. Mills, II, MD

is an aesthetic surgeon practicing in Laguna Beach, CA. He is Chair of the Communications Commission and of the Project Beauty Task Force.



Project Beauty, the Society's Video on Demand (VOD) product, has almost 11,000 registered users since our July, 2010 launch to the public—but we need your help to reach our next milestone!

Invite your patients, past patients, contacts, and office staff to join the "Elite" membership category of **Project Beauty** and enter to win a state of the art HP LCD touch screen monitor—a \$1,000 retail value!

Just have ten of your contacts sign up for **Project Beauty**. As "Elite" members, they'll be given an exclusive first opportunity to participate in product give-aways, special promotions and the opportunity to participate in group discussions.

For every ten of your contacts who sign up, you'll be awarded one ticket to win the flat screen monitor for your waiting or consultation room; the more of your contacts that sign up, the more chances to win. The winner will be announced on the last day of the Aesthetic Meeting in Boston; however you don't need to attend to win.

ENTER TODAY! For further details, please contact media@surgery.org or call our Communications Office at 212.921.0500.

An Industry Perspective

Continued from Page Cover

for its survival, if and only if, it is done in a balanced manner that protects its equilibrium. Given that plastic surgeons historically have been in the lead and at the top of the value chain within this Ecosystem, the specialty is responsible and accountable to lead and maintain that leadership as it relates to the consumer patients, their safety and quality of care. This must serve as our foundation if we desire continued healthy growth.

These previously mentioned disturbances have resulted in “plastic surgery” no longer being synonymous with “plastic surgeons.” I consider this seismic change as one of the most devastating failures, due to the fact that it has had a remarkable and far reaching negative implication on our Ecosystem. One of the critical factors that contributed to this failure, is the lack (some might argue non-existence) of a well-conceived, highly valued and easily translatable global brand to define exactly what a ‘Plastic Surgeon’ is.

Over the past decade, I have heard countless times from many plastic surgeons, that due to the specialty’s educational,

clinical and certification background, considering patients should be seeking them. This assertion is based on what should be perceived as the value delivered by a plastic surgeon and the safe manner in which the procedure is delivered. Unfortunately, the big disconnect in that view is that this assertion was more befitting when the specialty dealt with a “patient” versus the now “consumer patient.”

Unfortunately the explosion of internet marketing and advertising, coupled with the advent of social networks and the numerous credible/non-credible available resources have all resulted in a confused consumer patient. Research has shown, time and again, that these consumer patients are neither capable of distinguishing between a plastic surgeon and a cosmetic/aesthetic surgeon, nor are they capable of differentiating between the values delivered by either.

Hence, the most challenging dilemma we currently face within our Ecosystem, is that plastic surgery is no longer synonymous with plastic surgeons.

The consumer patient is researching and focusing on their individual expecta-

tions and desires which can be defined as follows:

Consumer Expectations = Safety of Procedure + Value of Outcome

So, how do we re-create that plastic surgeon brand value that can be translated into consumer patient value?

Let us examine that previous equation about ‘Consumer Expectations’ and I will start with the ‘Value of Outcome.’ From a consumer patient perspective it can be simply defined as follows:

Perceived Value = $\frac{\text{what I get}}{\text{what I want}}$

The smaller the gap is between the ‘get’ and the ‘want,’ the higher the perceived value in the eye of the consumer patient. It is incumbent on us, as leaders of this Ecosystem, to work tirelessly on measuring, analyzing and reporting the continuous advancements made to bridge this gap and increase the consumer delivered value. This is one of the two critical dimensions in building the global brand value for plastic surgeons.

The other dimension is ‘Patient Safety,’ which is repeatedly presented as the difference between plastic surgeons and the other specialties when it comes to these procedures. There are many definitions and declarations about safety and what it means from various perspectives. However, I suggest to you, a consumer patient centric equation that is much simpler:

Safety = $\frac{\text{outcome of procedure}}{\text{risk of complications}}$

Over the past decade we have done a good job in fine tuning and improving the delivery of procedures. Ground breaking, evidence-based work, has been done by Dr. Andrea Pusic and her colleagues with validated, patient-reporting systems such as BreastQ, FaceQ and BodyQ. This metrics-based, validated, evidence-supported system is critical because it directly addresses the consumer patient perceived value and not ‘our’ evaluation of it.

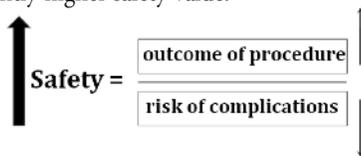
What we continue to need, and are currently lacking, is the same rigor when it comes to metrics-based, standardized, global



An Industry Perspective

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systematic collection, measurement, analysis and reporting of complication risks related to these procedures. There is a wealth of data available globally that can and should be interconnected to demonstrate the validity of the assertion that plastic surgeons do it better and safer. We can successfully build on this baseline, by prospectively collecting data from our continuing experiences, and documenting the work product of the efforts to collectively reduce (and in certain cases eliminate) the risks of complications associated with these procedures. This will provide a quantitatively documented, validated and unquestionable dataset which links the value of plastic surgeons to safety outcomes for the procedures consumer patients are seeking. The reduction in risk complications while at the same time improving outcomes will yield a significantly higher safety value.



The result will be a remarkable, documented, and demonstrative patient safety edge that shows the differentiating value of a plastic surgeon. In turn, this can and should be monetized into the value of the plastic surgeon brand equity, and becomes a tipping point in the decision making process of a considering consumer patient.

It is my unwavering belief that building a global plastic surgeon brand based on quantitative outcomes of safety and value is critical for our future. Achieving this differentiation will result in the restoration of the plastic surgeons leadership position within our continuously growing and evolving Ecosystem.

Hani Zeini, is the founder, president and chief executive officer of Sientra, Inc., a Santa Barbara-based Plastic-Surgery-focused company that offers a broad portfolio of implantable devices for aesthetics and reconstructive surgery. Additionally, the company is currently seeking FDA market clearance for its Silimed brand silicone gel breast implants.



Medical Ethics & Social Media

Ryan Miller

Many surgeons today are still a little fuzzy around the edges when it comes to Facebook, YouTube, Groupon and Twitter. Even so, it's easier than you might think to get a handle on ethics in the social media space, and develop an approach that protects you and your practice in this era of ever-increasing connectivity.

Indeed, you have already learned all you need to know to behave responsibly and ethically as you extend your practice into and engage your patients with social media. Here are the key components of an ethical approach:

- Be honest, avoiding statements that are false, exaggerated or misleading.
- Be transparent, disclosing your identity, affiliations and bias.
- Be accountable, understanding that the immediacy of social media makes mistakes more likely and the permanence of the Web makes their impact more pressing.
- Be sensible, recognizing when overstepping personal and professional boundaries could impact your reputation or tarnish your entire profession.

The ethical questions you will encounter extend beyond you to your staff, your practice, your vendors and your patients. To the extent that these other parties are speaking on your behalf or at your direction, they must be given ethical training and procedural guidance. Remember that social media is a true “web” of interactions, and keep in mind all of the people and entities who can affect your reputation as you extend your ethical knowledge into social media.

Yourself

The ethical framework you have learned and adopted offline is immediately applicable online in general and in social media in particular. While the technology of social media is certainly new, the idea behind it really isn't. We've all heard of “word of mouth” and “the grapevine,” and now those types of social interactions are occurring in a new platform. But while it may be a new platform, you can still use

time-tested strategies to apply moral judgment about what is right and wrong.

- Maintain separate social media profiles for your personal use and your practice. Do not accept patients or staff as friends on your personal social media profiles and lock down those profiles from public view.
- When posting content in public forums, consider your personal boundaries in advance—will you share photos that depict you drinking, use vulgar language or post content that reveals religious or political affiliations?
- Do not answer personal medical questions in public social media; you may create an implied patient relationship with all of its ethical and legal complications. Refer those questions to a private consultation.
- Be honest and disclose any bias. Do not overstate benefits or understate risks of procedures and consider whether to disclose your financial interests before offering online endorsements.
- Avoid anonymous postings. It's just too easy to disrespect a patient or colleague when hiding behind anonymity.

Your Practice

As a business entity, you need to establish procedures and guidelines to protect the privacy of your patients and the reputation and security of the enterprise.

- Preserve patient privacy. Get consent before posting images or information related to your patients and avoid sharing identifying information.
- Establish a formal, written policy for social media. The Ohio State Medical Association provides a beautiful example in their report titled Social Networking and the Medical Practice online at <http://www.osma.org/tools-resources/running-a-practice/legal-standards-and-guidelines/social-media-policy>.
- Monitor what is said by and about your practice in social media. It isn't just interesting or prudent, it may be mandatory to demonstrate that you are enforcing your own policy.

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Boomers: Demographic Good News for Plastic Surgeons

Karen Zupko, and Sheila Hall, MS, MBA

The first wave of Baby Boomers turns 65 at about 7,000 people a day in 2011. Don't miss this opportunity. Practices stuck on stereotypes and bogged down by ageism, with websites almost exclusively featuring models in their 20s and 30s clad in Cosmo fashions and sporting looks that alienate affluent 50- or 60-year-old prospective patients are a Boomer turn-off. Practices that continue marketing only to credit-challenged youths are unlikely to fill their surgery schedules. Meanwhile, a swelling population of people intent on looking youthful, that acts younger than their actual age, are savvy about financial planning, and who intend to keep working, sound like ideal customers for plastic surgeons.

What stands between you and Boomer patients?

As a generation, Boomers have the reputation of being comfortable spending money on themselves. However, the current recession has left some tightening their belts as they wonder if their assets will recover enough to allow for a comfortable retirement. Plastic surgery practices were not surprised when sales of lower-cost enhancements such as injectable and laser treatments showed a recessionary uptick. It's in your best interest to pay more attention to injectables and other minimally invasive therapies. Look at the recently released ASAPS statistics, the proof is in the statistics.

Start with the ASAPS statistics. Look carefully at facelift volumes of patients having facelifts. Compare that figure to the competitive specialty numbers for less expensive procedures that women, and yes, men, are having. In 2010 only 127,512 facelifts were performed in comparison to the 2,437,165 Botox procedures. Face it, not everyone is eager for a facelift. Yet, Boomers are still flocking to plastic

surgeons for a variety of procedures. 2011 ASAPS data shows that people 51-64 account for 28% of total plastic surgery procedures, and that people 65 and older account for 7.3% of procedures. With Boomers making up over 35% of the consumer base for plastic surgeons, it benefits to cater to them.

So, let's look at how to attract and retain Boomer and near-Boomer patients.

Small type: Youthful graphic designers are fascinated with unreadable microscopic fonts. However, you can't blame the designer if you approve their work, so keep 45- to 65-year-old potential patients in mind when making design decisions. Why irritate Boomers who can comfortably read type that is 12 points or larger by making them reach for their 1.5 magnifier glasses? Take a cue from consumer product companies who are using larger fonts. For instance, Arm & Hammer has enlarged the font on their cat-litter packaging by 20% over the last five years (WSJ). Modifying simple design elements will avoid annoying Boomers.

Experience: The Boomer Project reports that this group wants to spend money on experiences, not just objects. A practice can use this desire to its advantage by making the patient's consultation and treatment experience a differentiating factor. If your waiting room is full and your staff is overwhelmed, and it feels like an internal medicine or gynecology office – you've set the wrong mood. Offer all procedures in a luxurious, pampering environment. Offer amenities like a thick luxury robe (that's the right size for the patient), a comfortable chair, and soft washcloths. Boomers want the appointment to feel like a treat, not a chore. Make it feel more like a spa than an internist's office.

Ensuring consistency of the patient experience takes effort. As an example,

some practices exude an image of luxury on their website and in their surgery suite, but the patient coordinator uses worn out, 3-ring binders that hold outdated before-and-after photos of patients. We recommend replacing old binders with new photobooks, which can easily be created using Snapfish, Shutterfly, iPhoto, or other photograph managing sites. Make sure the type describing the pre- and post-operation pictures is large enough to read. If you provide Boomers with a reliably positive experience, they will return for future treatment and send their friends.

Time Management: According to the Boomer Report, this group values their time as much as younger people. After all, Boomers spearheaded the success of drive-through services. Demonstrate that you value your patients' time by maintaining an on-time schedule and make sure staffing levels are adequate.

Female-Only Focus: The time has come to extend a welcome to men. To gauge the potential growth in the men's services segment, take a look at other vanity trends. For example, from 1999 to 2010, the rate of men 50 to 64 who color their hair grew from 3 percent to 10 percent according to the research company Multi-Sponsor Surveys. Not convinced? According to an autumn article in the New York Times, the sale of men's skin care products, such as facial cleansers and moisturizers, grew by a factor of five from 1997 to 2009. Men now account for 15% of the injectables market and 26% of the skin rejuvenation market. On this point, include men in your portfolios of before and after photos. Men are a small but growing demographic in the aesthetic market. Some Southern California plastic surgeons tapped into the "his" and "hers" facial rejuvenation market years ago.

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Boomers

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It's not just what you do; it's how you do it

Boomers are reinventing what it means to age, and according to AARP they are “refusing to grow old.” They see themselves as younger than they are. In fact, Rod Stewart’s “Forever Young” might just be the Boomers’ theme song. So, while you should include Boomer patients and photos in your marketing, make sure your models do not look “old.” Boomers, on average, feel nine years younger than their chronological age, according to Pew Research. This means you’ll be on target by featuring people in their early 50s, or even a bit younger, because Boomers and almost-Boomers will best identify with them.

On a similar note, experts quoted in the Wall Street Journal do not recommend using age to target messages to Boomers. Simply make things convenient for them without drawing attention to their age. National retailers such as Walgreens and Sherwin Williams made revisions to their lighting and packaging, making them Boomer-friendly. Interestingly, the companies realized the changes made buying easier for customers of all ages.

Demographer Cheryl Russell points out that many Boomers own their homes free and clear of payments, leaving them with more liquid assets than members of Generation X who came after the Boomers. Gen Xers may be an attractive demographic in your practice because they are younger (30 to 50 years old); however, according to Pew Research, 60% of this group was classified as “losing ground” during the recent Great Recession. In contrast, only 30% of Boomers are considered to have lost ground, supporting the point that Boomers are less affected by the recent economic downturn. Russell recommends practices market to Boomers by being health-oriented and appealing to their desires to keep up and be youthful.

Boomers want experiences that feel effective and are in line with how they see themselves. You don’t have to be a top sales rep to know people are more comfortable buying from people they identify with and trust. Put this principle to work in your practice by rethinking the 25-year old

patient coordinator who talks with older face-lift patients. She may be a match for younger breast augmentation patients, but possibly off-putting for Ms. Boomer whose daughter may be older than the patient coordinator. Think “mature” for your next patient coordinator, or find a way for patient coordinators to specialize in different procedures and services.

Ambitious practices realize that Boomers who had plastic surgery procedures when they were younger are likely to return for “freshening.” Replace breast implants and breast lifts for middle-aged ptosis on the agenda. Patients who have relocated to a different region of the country or who received care from a now retired surgeon are all candidates for a new relationship. Marketing the fact that plastic surgery enhancements require some maintenance as people age, will attract Boomers needing an update.

Having confronted strong cultural changes from the Vietnam War to the mid-2000s, Boomers feel it is never too late to reinvent themselves, according to the Boomer Project. This is a key characteristic for plastic surgeons to understand and benefit from. Practices may have historically targeted the younger market, but now is the time to focus on where potential patients are.

Ms. Zupko is President, KarenZupko & Associates, Inc. (KZA), a practice management consulting and training firm based in Chicago, Illinois. KZA has worked with thousands of plastic surgeons nationwide.

Ms. Hall, MS, MBA is a KZA writer and researcher, focused on the intersection of business and medical communications to improve practice operations and patient health.

Address correspondence to: Karen Zupko, KarenZupko & Associates, Inc, 625 N Michigan Ave, Suite 2225, Chicago, IL 60611 (tel, 312-642-5616 ext 220; fax, 312-642-5571; e-mail, kzapko@karenzupko.com; Web site, www.karenzupko.com).

Face the Boomer Fact

For the next 18 years, Baby Boomers will be turning 65 at a rate of about 10,000 a day according to Pew Research.

Who is a Boomer?

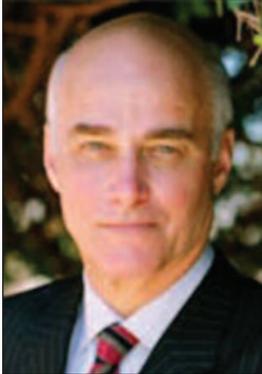
The U.S. Census Bureau considers Baby Boomers (Boomers for short) as individuals born from 1946-1964. This cohort is 78 million members strong, so their interests and purchasing habits have significant impact on the U.S. economy as a whole—they make up 28% of it.

Who else is paying attention to Boomers?

The TV industry recognizes that Boomers outnumber younger generations as the coveted demographic to attract. Boomers watch more television than any other generation, making them a powerful target audience. Networks are retooling their television programming to appeal to the affluent Boomer audience.

Fashion has not forgotten the power of Boomer spending either. Designers have noticed that the demand for hip blue jeans that fit middle-age bodies has risen greatly in recent years since women 55 and older are the fastest growing group of denim buyers. Fashion designers are now gladly accommodating the roughly 76 million Boomers that account for half of all consumer spending.

References on Page 22



THE AESTHETIC SURGERY EDUCATION AND RESEARCH FOUNDATION

The Aesthetic Surgery Education and Research Foundation (ASERF) has awarded the following grants during the past year:

Ernest Chiu, MD

The use of Adipose Stem Cells in Breast Surgery: Friend or Foe?

Anand K. Deva, MD

Use of Antibiotic mesh in a Pig Model to Prevent Capsular Contracture.

Mark Granick, MD

Patient Education: Are we Getting the Message Across?

Jeffrey Kenkel, MD

Effects of Facial Topical Lidocaine Application on Serum Levels of Lidocaine and MEG-X

Michael Neumeister, MD

Skin Regenerative Potential of Adipose Derived Skin Cells (ADSCs) in an In Vivo Nude Mouse Model

We look forward to receiving the preliminary findings of these projects and their subsequent publication (if accepted) in the *Aesthetic Surgery Journal*.

New portal streamlines grant submission process:

The new ASERF Grant Analysis Program will be launching soon to expedite the grant submission and approval process. This new feature allows for Internet base updating the roster of the Research Committee Members (Figure 1) and Email announcement of new grant submissions. (Figure 2) The Committee Members can then log into the system and review all of the grants, providing grades for each grant. (Figure 3) The system automatically resubmits Emails to members who have not completed their grant grading in a timely fashion. All of the collated scoring and comments are readily visible to the Chairman to facilitate timely decision making about submitted grants.

We are hopeful that this system will streamline the process and make grant analysis easier.

Increases in membership

This year, ASERF was fortunate to see a rise in annual membership by nearly 20%. The active membership is up to 450 members. While this number represents about 25% of Society members it is still a sharp increase for the Foundation.

With each additional member ASERF has the ability to increase its research which is important for all of plastic surgery. Increased research can lead to increased patient safety and efficacy which assists all plastic surgeons in their own offices.

If you haven't joined ASERF this year or would like to know more, stop by the booth at The Aesthetic Meeting in Boston or visit the website aserf.org. Beyond membership, there are other ways to become active and support research: Start a Grateful Patient Campaign, make a donation in honor of someone, or consider a planned gift. Thank you for allowing me to be your ASERF President this year. V. Leroy Young, MD will be taking the reins and steering ASERF with steady and capable hands.

Geoffrey R. Keyes, MD is an aesthetic surgeon practicing in Los Angeles, CA, and the current President of ASERF.

Figure 1

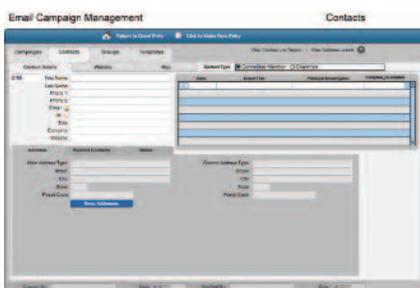


Figure 2

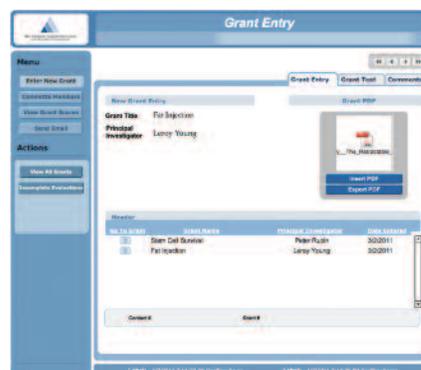
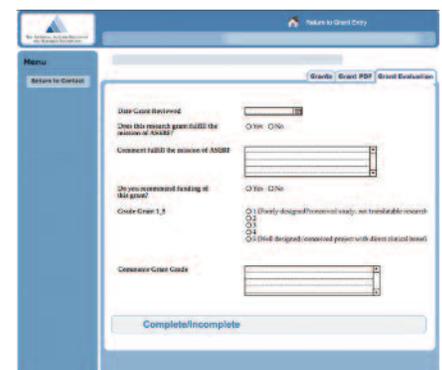


Figure 3



Membership Deadline: July 1



Membership in the Aesthetic Society Today, more important than ever!

With never-ending news reports of charlatans, fake boards and desperate consumers undergoing risky procedures without regard to health or safety, membership in The Aesthetic Society is more important than ever.

ASAPS can assist you in growing your aesthetic surgery practice with our expert practice management solutions. Our nationally recognized CME programs allow you to benefit from the experiences of your colleagues, discovering the evidence behind the hype. ASAPS membership gives you both the knowledge and tools you need to stay one step ahead of the rest.

The Benefits of Membership:

Education:

- ASAPS remains the **ONLY** organization whose sole Mission is **aesthetic surgery education of the face and body**. Our educational program is not fettered by ancillary programs or conflicting interests.
- Members receive registration discounts for The Aesthetic Meeting resulting in substantial cost savings to this premier educational event.
- Webinars are regularly delivered free of charge to members on subjects ranging from breast implants to injectables to practice management.
- The indexed and peer reviewed *Aesthetic Surgery Journal* keeps you up-to-date on the latest techniques, practice management pearls and research germane to aesthetic surgery interests.

Conduit for Change:

- Members wanting an opportunity to participate in Society Committees all have an opportunity to take part in this interactive method of influencing change and giving back to the Specialty.

Practice Management:

- A **NEW** office procedural manual to help with office accreditation requirements "The Aesthetic Society Policies & Procedures Manual."
- The "Safety with Injectables Workbook" containing informed consents and documents including the latest injectable products.
- The "Practices for Office and Patient Safety" - an on-line program for training of office staff in all aspects of office safety with self-quizzes and a certificate of completion (certificate available for a nominal charge).
- Free video content via Projectbeauty.com to optimize and enhance your website.
- **Find-a-Surgeon, Enhanced Practice Profile (EPP) Web Pages, and Ask-a-Surgeon, located on Surgery.org, produce approximately 40,000 referrals per month.** (EPP Pages at additional charge)



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For a list of membership requirements and full instructions on how to apply, please contact the central office at 562.799.2356 or visit www.surgery.org/membership



The International Traveling Professor and Interna

The Aesthetic Society's new programs for international education have proven
We thank Sientra for their generous

The International Traveling Professor

Foad Nahai, MD

United Kingdom, March 2011

I very much appreciated the opportunity of being the first ASAPS International Traveling Professor, which included visits to three separate institutions with a series of formal lectures and informal meetings with trainees.

My objective was twofold. First, I wanted to teach the trainees aesthetic surgery, not just procedures, but also patient selection and patient management. The second was to find out the current state of aesthetic surgery education in the United Kingdom. I feel the visit was successful on both accounts.

The Chelsea and Westminster Hospital, a unit of Imperial College School of Medicine, University of London:

The first institution I visited was the Chelsea and Westminster Hospital, a unit of Imperial College School of Medicine, University of London. During my afternoon and evening there, I interacted with 23 medical students, 27 junior doctors (trainees who intend to go into plastic surgery) and 17 plastic surgery trainees. In addition, there were 13 consultants (attendings). The audience was comprised mostly of plastic surgeons, but because my lecture was on blepharoplasty, the ophthalmology division was invited and they were also in attendance.

I had the opportunity to hear presentations from a final year medical student and two plastic surgery trainees on their assessments of aesthetic surgery training in the UK. The case presentations that followed were both interesting and challenging.

My lecture that evening was entitled

“Contemporary Blepharoplasty: Patient Evaluation.” The entire scientific session was well received with plenty of interaction between the residents, trainees, their attendings and me. The evening concluded with a social hour where I had the chance to informally interact with the medical students and trainees, which was a great way to end the visit.

The Queen Mary University of London and Barts and The Royal London Medical School and Hospitals:

The second visit was an entire day spent at the Queen Mary University of London and Barts and The Royal London Medical School and Hospitals. I had the opportunity to meet with another group of plastic surgical trainees, approximately a dozen or so, during the morning where I joined them in their state of the art microsurgical training laboratory. We discussed aesthetic surgery training, the role of aesthetic surgery within plastic surgery and their exposure to aesthetic surgery.

In the afternoon, I spent a very profitable couple of hours with the trainees. Our discussion centered on the practice of aesthetic surgery, the training required, and the management of aesthetic surgical patients.

That evening I participated in a series of lectures covering the social and psychological aspects of aesthetic surgery. More than 50 trainees, medical students and consultants attended the evening series. The discussion that followed my presentation on “Managing Expectations in the Aesthetic Surgery Patient” was most interesting and illuminating.

Discussions centered on aesthetic surgery training continued that evening at dinner with Professor Jim Frame of Anglia

Ruskin University and Professor Simon Myers of London University.

Post Graduate Medical Institute Anglia Ruskin University:

The third part of my visit was a full two days at Anglia Ruskin University in Chelmsford. These two full days were the busiest and most intense of the traveling professorship.

My visit coincided with the official opening of the Post-Graduate Medical Institute (PMI) of Anglia Ruskin University. As part of my visit a special full day symposium on aesthetic plastic surgery was planned for all trainees in Southeast England, (The Pan Thames Meeting) attended by over 120 plastic surgery trainees.

The day began with an informal meeting with the trainees, an opportunity to discuss training in aesthetic surgery, management of the aesthetic surgery patient and dealing with dissatisfied patients. This was followed by a full day symposium on aesthetic surgery where I presented a two-hour keynote lecture on facial rejuvenation.

That evening I delivered the inaugural lecture at the Post-Graduate Medical Institute entitled “Beyond the Surface.” I traced the origins of plastic surgery, its emergence through two world wars and then the rapid growth and changes during my 30 years in practice. In addition to the trainees, the lecture was attended by University officials and lay members of the public. Prior to the lecture, I presented a copy of the second edition of my three-volume “Art of Aesthetic Surgery” to the Vice-Chancellor of the University. He

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tional Fellow Programs Report on their first year:

to be a great success from the perspective of both professor and fellow. support of this important initiative.



Cutting Edge Facial Surgery: Aesthetic Applications

Aina VH Greig MA, PhD, FRCS(Plast)—London, UK

Editor's note: Aina Greig was the recipient of the Society's first International Fellowship Award. The following is her report.

The primary goal of facial aesthetic surgery is to restore, enhance and rejuvenate the face, achieving balance and harmony. My training has been in cleft and cranio-facial surgery and my aim from the ASAPS International Fellowship was to visit high volume practitioners and pioneers in facial aesthetic surgery with a particular focus on surgery to improve facial balance. The features of the nose, lips and chin define a person's profile and give the essence of character to the face. Skeletal implants or osteotomies can be used to address profile deficiencies due to congenital, traumatic or aging factors.

In order to learn about chin implants for balancing the profile (eg post rhinoplasty), I visited Drs. Michael Yaremchuk (Boston) and Edward Terino (Agoura Hills, California), and the following specialists in rhinoplasty including Drs. Bahman Guyuron (Cleveland, Ohio), Nicolas Tabbal (New York), Rollin K. Daniel (Newport Beach, California), Anthony Griffin, Raj Kanodia, Paul Nassif and Jay Calvert all in Beverly Hills, CA. Dr. Daniel had very innovative solutions for various nasal deformities and showed me his systematic approach to rhinoplasty. I am also grateful to Dr. Bruce F. Connell (Santa Ana, California) for his teaching about facial aesthetic analysis and facial anatomy.

Soft tissue face lifting techniques are essentially two dimensional, whereas skeletal augmentation is three dimensional in nature and represents surgery at the deepest plane of the face. Skeletal augmentation can be achieved by using either facial osteotomies or facial implants. Drs. Yaremchuk and Terino were exceptional teachers who showed me their approach to mandibular, midface and periorbital augmentation with facial implants.

It was fascinating to then visit Drs. Dale Bloomquist and Gary Feldman in Seattle who focus on balancing facial appearance using the Le Fort I osteotomy and bilateral sagittal split osteotomies of the mandible.

What I found to be most stimulating was the opportunity to visit surgeons and find out about new ideas and techniques which complemented those that I learned during my craniofacial fellowship in New York and to see how all of these can be applied to aesthetic surgery.

I would also like to thank the following physicians for their knowledge and generosity: Joseph G. McCarthy, Stephen M. Warren, Charles H. Thorne, Barry M. Zide, Barry H. Grayson and Court B. Cutting at NYU Langone Medical Center; Drs. Henry K. Kawamoto, Jr., James P. Bradley and J. Brian Boyd at UCLA; Andrew Wexler at Kaiser Permanente Los Angeles; Dr. Mark M. Urata at Children's Hospital Los Angeles; Drs. Joseph S. Gruss and Richard A. Hopper at Seattle Children's Hospital and John B. Mulliken, John G. Meara and Bonnie L. Padwa at Boston Children's Hospital, whom I also visited.

I would also like to thank Dr. Lawrence Bass (New York) from whom I learned about cutting edge innovations in facial rejuvenation using lasers and fillers. A big thank you to Dr. W. Grant Stevens (Marina Del Rey, California), an innovator in internet marketing who gave me fascinating insights in how to run a practice. Also, I very much appreciated Garth Fisher (Beverly Hills, California) for showing me his approach to body contouring and facial rejuvenation surgery.

My aim is to become an innovator and leader in the field of facial aesthetic surgery using the full gamut of craniofacial and aesthetic techniques. This fellowship allowed me an amazing opportunity to make international connections and meet new mentors. The ideas and techniques I have learned will be useful to both my aesthetic and reconstructive patients and will have relevance for years to come. I would like to thank ASAPS and everyone involved for giving me this opportunity.



Felmont F. Eaves, III, MD
President of the Aesthetic Society

A Discussion Between Two Presidents



Jonathan M. Sykes, MD
President of the American
Academy for Facial Plastic and
Reconstructive Surgery

Editors Note: In recent years board certified plastic surgeons have been working more closely with other ABMS surgery groups engaged in aesthetic surgery and cosmetic medicine with the goal of cooperating on areas of patient safety and truthful description of training and credentials, among other topics.

Two recent ASAPS member surveys, one in 2009 and the second in 2010, demonstrated that the vast majority of ASAPS' members support such cooperation. We are pleased to present a recent exchange between Dr. Jonathan M. Sykes, President of the American Academy for Facial Plastic and Reconstructive Surgery (AAFPRS) and ASAPS President Dr. Felmont F. (Monte) Eaves, III.

Why do you think it's important that core aesthetic surgery groups work together?

Dr. Eaves: In the past, different groups doing aesthetic surgery were often bitter rivals. However as we have seen an ever-increasing incursion of non-core physicians moving into the aesthetic surgery arena, we have come to realize that we share many common goals and backgrounds, especially along the lines of patient safety. Because ASAPS and AAFPRS members are all surgically trained in aesthetic surgery within their ABMS board certification, we both recognize the need for excellent training, qualification by an ABMS board which includes aesthetic surgery, and that physicians should practice within their scope of training.

Dr. Sykes: At the core of both ASAPS and the AAFPRS is to promote the highest quality of plastic surgery (and facial plastic surgery) through education and training. We respect our colleagues in

ASAPS and have admired the educational work ASAPS has done for many years. As with any organization, sometimes we lose sight of important goals and focus on less important turf issues.

Both organizations actually have more in common—excellent educational programs and members committed to patient safety and the highest outcomes—than we have differences. If we are able to work together, these outcomes and programs will only improve.

How have the Academy and the Society been working together?

Dr. Sykes: Our groups first started working together closely in the Physicians Coalition for Injectable Safety along with other board-certified groups including dermatologists and oculoplastic surgeons. This group has been a great success in promoting safe practices in injectables as well as appropriate training and oversight. Beginning in 2010, we also started working on integrating evidence based medicine into the entire specialty of aesthetic surgery and cosmetic medicine, and this project is ongoing.

Dr. Eaves: In addition, the “core four” groups—ASAPS, AAFPRS, the American Society for Dermatologic Surgery (ASDS), and the American Society of Oculoplastic and Reconstructive Surgery (ASOPRS)—have created a coalition to work together on issues of patient safety and other concerns that we share in common. This group, the Physicians Aesthetic Coalition, (PAC) will be meeting again this summer in Las Vegas to continue to grow our efforts in this regard.

It's been widely noted that the public at large is not only confused about Board Certification but can't distinguish real boards from fake ones. Is this an issue the PAC will be working on?

Dr. Sykes: It is certainly true that the public is often confused about specialty training and board certification. We support genuine board certification. The public gains useful knowledge about a physician from learning about the physician's certification by a genuine board. We've always believed ACGME training and ABMS examination form the “gold standard.” Our Academy requires appropriate and complete ACGME training and appropriate ABMS certification for fellowship. The certifying board in facial plastic surgery requires those ACGME and ABMS prerequisites and requires a further two-day examination in facial plastic surgery. We believe genuine certifying boards fit that model. I believe it is important for us to work with state organizations to assure truth in advertising. This will educate the public and make them better consumers. Patient safety and physician education and quality are our goals.

Dr. Eaves: I agree with Jonathan—this is a critical area for public safety and for integrity in medicine. Fortunately several states are recognizing issues of truthful depiction of credentials. I think we are also starting to see some interest in dealing with the problem of physician drift—when doctors practice in an area different than that of their training—and thus there is no board overlooking and certifying the training or ongoing education. This is a particular concern in aesthetic surgery and cosmetic medicine.

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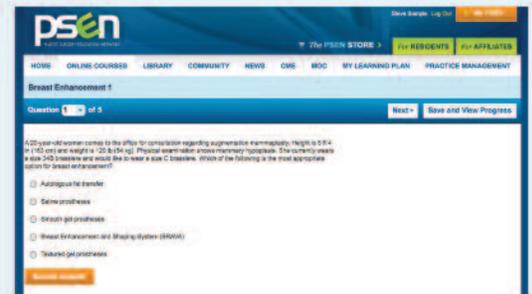
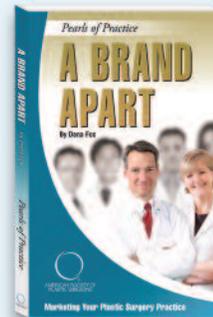
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Taking Back Control of Your Online Reputation

By Tom Seery, CEO, RealSelf.com

Your online reputation isn't determined by consumer reviews alone—it's also influenced by the message you put forth.

Among plastic surgeons, there's no consensus opinion of online doctor reviews. Some loathe them, some grudgingly accept them, and others embrace reviews as an opportunity to market their practice.

Regardless of your feelings on the topic, one thing is certain: as more and more prospective patients use the web to evaluate and choose a doctor, the importance of cultivating a positive online reputation can't be ignored.

Fortunately, your online reputation isn't exclusively determined by patient reviews. An individual searching for more information about a doctor or a cosmetic procedure wants to know more than simply what anonymous poster "Jane Doe" thinks.

They want to know who you are: your thoughts, your approach to medicine, and what distinguishes you from other physicians. **A desire for a strong, trusting relationship with their doctor or surgeon means that they are going to look beyond patient reviews before deciding on a physician.**

While you can't really control what other say about you online, you can control the message that you put forth. Dr. Bryan Vartabedian, a pediatric gastroenterologist at Baylor (and a blogger) puts it:

1. You have no control over what people say
2. You have 100% control of the story you create

Your own story

When a prominent Google executive was asked about the fairness of online reviews (which can be negative or patently untrue), he replied: "The only answer to bad speech is more speech."

In other words, staying silent online isn't an option. Google isn't going to remove information from its search results, even if it's completely false or defamatory. So the only way to build and protect your reputation against negative comments and reviews is to put as much of your own messaging and content out there.

8 Tips offered to our doctors active in RealSelf Q&A

Online readers skim... they don't read

1. **Highlight keywords**
2. **Create meaningful headlines (not "clever" ones)**
3. **Use lists—bulleted or numbered**
4. **Keep to one idea per paragraph**
5. **Start with the conclusion, the answer (the inverted pyramid style of writing)**
6. **Edit yourself. Use half the word count (or less) of conventional writing**
7. **Avoid vague answers. If you don't want to answer, skip it.**
8. **Use spell check before posting**

It's how you say it, not how you post it

Many surgeons I've met tell me that they're inundated with suggestions that they should blog or post videos on YouTube in order to reach out to new clients. They get caught up in how they're going to deliver their message, as opposed to figuring out what their message is.

As the famous ad-man David Ogilvy once noted, "What you say in advertising is more important than how you say it."

Prospective patients focus directly on *what* you have to say—about your practice and who you are as a doctor—instead of *how* you say it.

Giving the consumer what they want

Based on our experience at RealSelf.com in engaging a community of millions, we've found that consumers are looking for two distinct things from their online queries.

First, they want more than basic descriptions about a plastic surgery procedure. Generic content can be found on tens of thousands of sites—and people are tired of seeing it! Instead, they want to know specific details about a procedure, ranging from affordability to risks to recovery.

Both ASAPS and RealSelf offer expert Q&A that helps doctors communicate this valuable information to potential patients online.

Second, consumers prefer doctors who can explain complex medical information simply, and *in their own words*. A person doing research on the web wants to know about you—the physician—and how well you know your stuff (not how effective you are at hiring content writers for your website).

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Your Online Reputation

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Sharing your expertise in your own voice, and expressing your own personality allows potential clients to gain confidence in you as a person and as a doctor.

Say things imaginatively, originally, freshly

If all your web messaging is boring, stale, or simply not “you” then it won’t do anything for your online reputation. Standing out from the crowd and getting noticed requires a little finesse.

Former advertising executive, Bill Bernbach, sums up this concept well:

The truth isn't the truth until people believe you, and they can't believe you if they don't know what you are saying, and they can't know what you are saying if they don't listen to you, and they won't listen to you if you are not interesting, and you won't be interesting unless you say things imaginatively, originally, freshly.

So what are you waiting for? It's time to introduce prospective patients to the doctor they've been searching for—you.

Tom Seery is the CEO and Founder of RealSelf.com, a social media community and ASAPS partner that connects plastic surgeons with consumers who wish to learn more about cosmetic procedures. For a custom social media consultation or to apply to join our growing community, visit www.realslf.com/doctor

Annual Statistics

Continued from Page Cover

- Breast augmentation (318,123)
- Liposuction (289,016)
- Eyelid surgery (152,123)
- Abdominoplasty (144,929)
- Breast Reduction (138,152)

Cosmetic minimally-invasive procedures decreased almost 9 percent, with nearly 8 million procedures in 2010. Nonsurgical procedures accounted for 83% of the total number of procedures performed representing 39% of total expenditures. The top five minimally-invasive procedures were:

- Botulinum Toxin Type A (2,437,165 procedures)
- Hyaluronic acid (1,315,121 procedures)
- Laser hair removal (936,270 procedures)
- Laser skin resurfacing (562,706 procedures)
- Chemical peel (493,896 procedures)

Women had almost 8.6 million cosmetic procedures, 92% of the total. The number of cosmetic procedures for women increased over 164% from 1997. The top five surgical procedures for women were: breast augmentation, liposuction, breast reduction, abdominoplasty, and eyelid surgery.

Men had over 750,000 cosmetic procedures, 8% of the total. The number of cosmetic procedures for men increased over 88% from 1997. The top five surgical procedures for men were: liposuction, rhinoplasty, eyelid surgery, breast reduction to treat enlarged male breast, and cosmetic ear surgery.

Americans spent nearly \$10.7 billion on cosmetic procedures in 2010. Of that total almost \$6.6 billion was spent on surgical procedures; \$1.9 billion was spent on injectable procedures; \$1.8 billion was spent on skin rejuvenation procedures; and almost \$500 million was spent on other nonsurgical procedures including laser hair removal and laser treatment of leg veins.

How the numbers are calculated:

A paper-based questionnaire was mailed to 22,000 Board-Certified physicians (8,500 Dermatologists, 8,000 Otolaryngologists, and 5,500 Plastic Surgeons). An online version of the questionnaire was also available to these physicians. A total of 938 completed and valid responses (420 Plastic Surgeons, 331 Dermatologists, and 187 Otolaryngologists) were received in time for tabulation.

Final figures have been projected to reflect nationwide statistics and are based exclusively on the Board-Certified Plastic Surgeons; Otolaryngologists; and Dermatologists. The findings have been aggregated and extrapolated to the known population of 24,500 physicians who are Board Certified in these specialties. Though the confidence intervals change by procedure, depending on the grouping's sample size and the response variance, the overall survey portion of this research has a standard error of +/- 3.14% at a 95% level of confidence.

Some Surprises:

The surgical increases may surprise some members whose practices are still suffering the effects of the recent recession. However, the statisticians suggest that, as the recession had impacted some regional areas before others, the same could hold true for the recovery.

Injectable Numbers:

Compared to other published statistics and publicly available reports from the manufacturers, our statisticians were concerned that the procedure numbers for cosmetic injectables appeared low. The group concluded that the wording of this question excluded procedures performed by the surgeon's nurse injector. The question will be re-worded in future surveys.

Questions?

If you have an questions on how to use the annual statistics in your practice, please contact the Communications Office at media@surgery.org

What you must consider if you're a Hospital Employee or if your practice is acquired by a Hospital

David B. Mandell, JD, MBA
R. Paul Wilson, CRPC®

Each month, we speak with physicians across the country, many of them specialists like orthopedists and orthopedic surgeons, who are hospital employees and are frustrated with the type of tax and retirement planning options they have, compared to their colleagues in private practice. At the same time, a common trend in the medical landscape today is the acquisition of medical practices by hospitals – so more and more specialists are becoming hospital employees everyday. If you are a presently a hospital employee or one who is considering the move, this article is a must-read.

If You're a Hospital Employee Now

As you know well if you are currently a hospital employee, one of the significant downsides of being an employee of a large institution is that you have virtually no control of the tax-saving retirement plans, benefit plans, fringe benefit plans or other write-offs. Compare this to an orthopedist in a practice he/she owns, where all of these important financial options are available. Over a career, these tools can mean the difference between an early or later retirement or the quality of that retirement financially. The case study below will be valuable for you to understand, since it illustrates what you are now giving up (though you may not have realized it) and how you can improve your benefit offering at the hospital.

If You May Become a Hospital Employee—Practice Acquisition

If you are not presently a hospital employee, but are considering joining a hospital, there are a few alternatives to outright acquisition of a medical practice by the hospital (such as joint ventures). However, since the vast majority of trans-

actions are outright acquisition—where the physician becomes a hospital employee—we will focus our discussion here on that model.

The traditional outright acquisition model has distinct positives and negatives for the doctor. The principal positives are the following:

- A. Reduced legal exposure for the doctor, as he/she is now a hospital employee
- B. Reduced overhead expenses—most often, rent, administration and liability insurance
- C. In some circumstances, increased financial security for the practice—as the hospital may support it financially or guarantee it a certain flow of patients

The significant negatives include:

- A. Loss of autonomy—the physician is now an employee that must report to hospital executives
- B. Loss of control of his/her financial package—including qualified plan and other benefit planning

While the first negative may be more frustrating on a personal level, the second negative can be quite costly to the doctor over his/her career.

Case Study: Orthopedic Surgeon Oscar Sells Out to Hospital

At 45 years old with a healthy practice, Oscar would likely have either one, or both, of the following Qualified Retirement Plans to help him save for retirement, and reduce his current taxable income. These plans would include:

A Defined Contribution Plan, also referred to as a “Profit Sharing Plan.” In this plan, Oscar can defer up to \$49,000 in 2011. This contribution limit is typically increased each year to keep pace with inflation. Oscar’s investment will accumulate

on a tax-deferred basis as well, but every dollar withdrawn in retirement will be taxed as income.

A Defined Benefit Plan is also funded with tax-deferred dollars. The annual contributions are calculated each year based on conservative growth assumptions, and a specific amount to be attained at a specific age, for example, \$1,000,000 at age 62. For the purposes of our case study, let’s say Oscar is making tax-deferred annual contributions of \$45,000 into his Defined Benefit Plan. These funds will also accumulate on a tax-deferred basis, and withdrawals during retirement will be taxed as income.

For purposes of the analysis below, we will assume that Oscar maximizes his profit-sharing contribution but does not presently take advantage of a defined benefit plan in addition. More savings-motivated physicians will give up even more by becoming a hospital W-2 employee.

When Oscar becomes a hospital W-2 employee, he will lose the more tax-beneficial qualified plans above—both the profit-sharing plan and/or the defined benefit plan. Even in a “likely hospital scenario,” Oscar would have access to a 403b, which will allow him to defer only \$16,500 in 2011. In a “best case” hospital scenario, Oscar would also have access to a 457b plan, which is very similar to a 403b, and would allow Oscar to defer another \$16,500 in 2011.

In addition to his Qualified Retirement Plans, as a practice owner, Oscar also enjoys the ability to deduct business related expenses, such as a portion of his car lease and home office expenses.

Let’s say Oscar pays \$800/month for his car lease, and claims he uses his vehicle for business purposes 70% of the time. The business portion of his lease payment will be deductible to the extent allowed against his business income. However, as a W2 employee, Oscar can only take that

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Hospital Employees

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deduction to the extent his employee business expenses along with other miscellaneous deductions exceed 2% of his AGI

Oscar would also be able to deduct business related expenses, such as computer and electronic equipment, software, office furniture, office supplies, travel expenses, etc. For this example, we'll assume Oscar is deducting \$4,000/year for these expenses. *As a W-2 employee of the hospital, Oscar will also lose the ability to deduct these expenses unless they exceed 2% of AGI*

Assuming Oscar's gross annual income is \$500,000, let's look at how the two scenarios currently compare below. Again, we will assume here that Oscar only participates in a profit-sharing plan—for doctors who also have a defined benefit plan, these numbers would likely look even more dramatic:

Oscar's Private Practice Scenario			Oscar's Scenario as a W-2 Employee -- Best Case		
	Gross Annual Amount	Income Tax Savings @ 40% Tax Bracket		Gross Annual Amount	Income Tax Savings @ 40% Tax Bracket
Deferred Contribution into Profit Sharing Plan	\$ 49,000.00	\$ 19,600.00	Deferred Contribution into 403b Plan	\$ 16,500.00	\$ 6,600.00
Office Expense Deductions	\$ 4,000.00	\$ 1,600.00	Deferred Contribution into 457b Plan	\$ 16,500.00	\$ 6,600.00
Total Annual Savings	\$	\$ 21,200.00	Total Annual Savings	\$	\$ 13,200.00

Oscar's case is not unique. In fact, it is quite typical. The reality is that a physician gives up most of the benefit of being a business owner when he/she becomes a hospital employee (some expenses can still be deducted, but only to the extent they exceed 2% of AGI). As above, the ability to implement aggressive retirement plans, fringe benefit plans, and the tax savings that goes along with them has a direct impact on a physician's long-term wealth creation. Giving that ability up is significant—whether the hospital falls into a “likely” or “best” case scenario.

A Potential Solution: A Hybrid Benefit Plan Ideally Suited For Hospitals

While the reality of what Oscar gave up may be startling, there is good news. Hospitals around the country are beginning to learn about, and adopt, a particular type of benefit plan that can provide Oscar with a way to capture all of his lost benefits, and

more. Further, this plan costs the hospital nothing! It is not surprising that hospitals are starting to see the fit here—it helps their existing and soon-to-be-recruited doctors significantly and costs them nothing. A major teaching hospital in Ohio, in fact, is in the process of layering this plan into their benefits package as this article goes to press.

A few brief facts about this type of benefit plan:

- This benefit plan is authorized by a particular section of the Internal Revenue Code (“IRC”) that has been in the IRC for over 30 years, an extremely long and stable legislative history.
- Nearly five years ago, a Revenue Procedure was issued which created safe harbor rules for calculating the economic benefits to be included as taxable compensation under the plan. This should give any hospital counsel or HR office comfort to move forward with the plan.

The hospital can offer this plan in addition to their 403(b) or other qualified retirement plan.

- The hospital can decide to offer this to all employees, just physicians, or some other classification tied to employment
- The plan is asset protected at the highest level in many states and can be designed for solid asset protection in all states.

While a full description of all the tax and retirement benefits are beyond the scope of this article, feel free to contact the authors for more on this at (877) 656-4362.

Case Study: Oscar's Hospital Offers This Benefit Plan

Let's return to Oscar's situation above. Now let's assume that Oscar's hospital adopts this benefit plan as part of their package and offers it to Oscar as a hospital doctor employee. Now, in addition to the 403(b), he is able to contribute another \$50,000 into this benefit plan. He funds this plan for 5 years and then stops. How does Oscar now benefit? Let's see:

- This plan saves him an additional \$8,000 in taxes per year—for a total of \$30,000-\$40,000 in tax savings over the 5 years.
- The contributions into his plan grow totally asset protected under his state's law.
- If Oscar ever leaves the hospital employment, he takes 100% of his funds in the plan with him, the hospital will receive nothing.
- Presuming an 8% return in the market, Oscar would be able to take out \$38,531 per year *tax free* in retirement, ages 65 thru 84. These numbers would be even larger if he waits longer to retire.
- All of the above benefits (and others) Oscar will enjoy—in addition to the hospital's 403(b) and/or 457 plan that he also funds.

Given the implementation of this plan, let's take another look at Oscar's Scenario Comparison:

Oscar's Private Practice Scenario			Oscar in "Best Case" Hospital Scenario		
	Gross Annual Amount	Income Tax Savings @ 40% Tax Bracket		Gross Annual Amount	Income Tax Savings @ 40% Tax Bracket
Deferred Contribution into Profit Sharing Plan	\$ 49,000.00	\$ 19,600.00	Deferred Contribution into 403b Plan	\$ 16,500.00	\$ 6,600.00
Office Expense Deductions	\$ 4,000.00	\$ 1,600.00	Deferred Contribution into 457b Plan	\$ 16,500.00	\$ 6,600.00
Total Annual Savings	\$	\$ 21,200.00	Deduction Based on \$50,000 Contribution into the Hybrid Plan	\$	\$ 17,512.00
			Total Annual Savings	\$	\$ 20,204.80

With the Hybrid Plan, Oscar has been able to reduce his “lost deductions” by \$17,000+ per year, getting him almost to “even” with his deductions when he owned his practice. Even more importantly, the plan contributions are flexible. In other

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words, Oscar could contribute up to \$100,000 per year into the Hybrid Plan, in addition to the 403(b) and 457 plans, giving him another \$17,000+ of deductions. By doing this, not only would he then be better off deduction-wise than he was in his practice, but he would be funding a plan that was asset protected in his state and acts as a tax hedge against future income and capital gains tax increases.

Conclusion

If you are presently a hospital employee, or you may become one—and increasing your deductions as well as tax-beneficial retirement income and asset protection is important to you—then you should work with your other physicians, the board and the HR department to get this benefit plan added to the hospital’s benefit package. As noted above, this plan can be structured with no cost to the hospital, so it shouldn’t

be hard to get approved. The authors welcome your questions. You can contact them at (877) 656-4362 or through their website www.ojmgroupp.com.

SPECIAL OFFER: For a free (plus \$5 S&H) copy of For Doctors Only: A Guide to Working Less and Building More, please call (877) 656-4362.

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International Education

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accepted it graciously and commented that it would be the cornerstone of their yet to be developed medical library at the PMI. The inaugural lecture was very well received.

That evening I had dinner with several of the senior consultants (attendings) as well as the Vice-Chancellor and other senior members of the leadership of the Anglia Ruskin University. This was an opportunity for me to discuss the role that aesthetic surgery plays, not only within plastic surgery and medicine, but also in society. They were most attentive and did not hesitate to share their own thoughts with me. Based on my two days with them at Anglia Ruskin University, they have invited me to become an honorary visiting professor.

The second day at Anglia Ruskin was spent in the operating room with Professor Jim Frame, Professor of Aesthetic Surgery at Anglia Ruskin University. Incidentally, he is the only Professor of Aesthetic Surgery in the entire United Kingdom. We spent the day with his trainee in the operating room, who is the only designated full time trainee in aesthetic surgery.

Impressions and Conclusions:

I interacted with over 200 trainees, 40 or 50 medical students and 40 or so consultants at three separate institution, two medical schools in London and the Post Graduate Medical Institute of Anglia Ruskin University in Chelmsford. All were appreciative that ASAPS had sponsored the visiting professorship and felt that it was a worthwhile effort, which should continue. I did acknowledge that the Professorship was sponsored through a generous educational grant from Sientra.

At each institute, I briefly described who we are, the ASAPS commitment to Aesthetic Surgery Education, patient safety and International cooperation. I promoted our *Aesthetic Surgery Journal* and its goals and distributed over 60 copies of the publication. There was considerable interest in our Society and Journal. I know of several manuscripts that will be submitted as a result of the visit.

A Universal Theme:

I was not surprised to learn that, when it comes to training in Aesthetic surgery, trainees in the UK have similar concerns as their American counterparts—lack of organized teaching and operative experience. In the UK, this is compounded by the European 48-hour workweek for trainees and the restriction on cosmetic surgery within the National Health Service (NHS).

Concerns over fellowships in aesthetic Surgery and job opportunities were also similar to those in the US. There is no question that these concerns over training are universal and not restricted to the UK and USA. I therefore strongly recommend that we continue this International Visiting Professorship program. It demonstrates our leadership in worldwide Aesthetic Surgery and a desire to share that expertise with trainees across the globe. Beyond the altruistic goals, it will bring intangible benefits to the Society and continued International recognition of the Society and our Journal.

On a more personal level, I am deeply grateful to the Society and Sientra for the honor and the opportunity to revisit where I grew up and went to Medical School.

Foad Nahai, MD is an aesthetic surgeon practicing in Atlanta. In addition to being the Society's first International traveling Professor, he is Editor-in-Chief of the Aesthetic Surgery Journal and a Past-President of the Aesthetic Society.

Two Presidents

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Do you think there are opportunities for educational collaboration?

Dr. Eaves: Certainly education is one of the areas that we could—and should—cooperate, especially between ASAPS and AAFPRS, where both groups have very similar practices related to treatments in the head and neck region, covering all aspects of aesthetic surgery and cosmetic medicine. Sharing our divergent backgrounds and experiences only makes us all better surgeons.

Dr. Sykes: I agree. No specialty has a monopoly on knowledge. Every time I have attended a plastic surgery meeting I learn something new and get exposed to a new point of view. I am sure the same is true when an ASAPS member attends an AAFPRS meeting. Cross fertilization of education can only be positive for both organizations.

Dr. Sykes, I understand you will be presenting at the Aesthetic Meeting this year. What is your topic?

I will be speaking on a panel on “Altering the bony nasal pyramid.”

Is there anything else you would like to share with our readers?

Yes. I'd just like to say how much better I feel about a new model for our relationship built on collaboration rather than competitive turf battles. For our part, we're much more comfortable focusing on patient care than competitive concerns. Working together can realize the goals of improving educational programs and promoting patient safety.

Medical Ethics

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- Identify whether your medical malpractice coverage extends to damages related to social media; distress, which is a common claim for social media cases, is often not covered.
- Remember that you may be liable for posts made by your employees and partners.
- If you compensate third parties to comment on your practice in social media with cash or services, mandate that your support be disclosed.

Your Staff

You can dictate how your employees as employees use social media. However, employment law and good sense will prevent you from restricting how employees use social media off the clock. That said, you must convey to your team that while they are free to express themselves in their personal time, they are not free of professional consequences. What employees can do is be transparent and authentic and avoid betraying the trust of a patient or colleague.

- Caution employees about sharing feelings about patient interactions online.
- Actively teach your team about their obligations under HIPAA and the need to protect patient privacy.
- Remind your team that they are responsible and accountable for their postings, and that they must disclose their identity and affiliations if they are posting on behalf of the practice.

- Set boundaries to prevent non-medical staff from delivering clinical advice in public forums.

Your Vendors

Some of your practice's greatest liability in social media may come from your chosen vendors (see the recent story about JC Penny and the actions of their advertising vendor). For practices covered under HIPAA, you are required to install a Business Associates Agreement. And you would be wise to give your chosen social media vendors a crash course on medical ethics.

In Conclusion

While you are well-versed in ethics, social media mandates that you consider new implications and extend training and ethical guidelines to your staff and vendors. It's almost a certainty that social media will change the face of medicine in the coming years, and practices that have a thoughtful, ethical approach to their interactions within this space are in the best position to grow and prosper.

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Endorsed Member Services

Continued from Cover

software interface that resides in the exam room. A touch screen is placed in the exam room easily accessible to the patient, allowing the patient to view topic driven educational information about a particular process or procedure. The doctor can use the product to fully explain a procedure. The product also gathers patient information that will be stored in a database allowing the surgeon to effectively market their services to patients after the visit. The patient will have the ability to review the Patient Education Information at home via a web portal. This allows the patient to relive the visit at the doctor's office and potentially share this information with friends or family that did not attend the doctor visit.

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Boomers

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4. Each winner will receive an iPad with the sessions from The Aesthetic Meeting 2011 in Boston
5. Each winner's paper will be published in 2011 in *ASJ* and will have special designation.

So let's see what you've got!

Please contact Managing Editor Melissa Berbusse at Melissa@surgery.org with any questions or comments.

Thank you!

