

# Facial Plastic TIMES

AMERICAN ACADEMY OF FACIAL PLASTIC AND RECONSTRUCTIVE SURGERY, INC.

## MUSIC CITY HOSTS THE 2016 AAFPRS FALL MEETING

**FACIAL PLASTIC SURGERY**  
AMERICAN ACADEMY OF FACIAL PLASTIC AND RECONSTRUCTIVE SURGERY, INC.

October 6-8, 2016 • Nashville, Tennessee

### FALL MEETING

**Meeting Director**  
Phillip R. Langsdon, MD

**Program Chairs**  
Rami K. Batniji, MD  
Samuel M. Lam, MD

This year's co-chairs have radically redesigned the program by creating topic-focused tracks such as rhinoplasty, facelift, eyelid surgery, the aging face, non-surgical aesthetics, and more. Phillip R. Langsdon, MD; Rami K. Batniji, MD; and Sam M. Lam, MD, collaborated to give you what you asked for—new speakers, new presentations, and a new format.

Instructional courses have been eliminated and the entire three-day program is organized according to themes. Redundant talks were reduced, while creating focused lectures containing facts, new technology, and emerging trends.

"We have worked tirelessly to structure a beneficial program that is all-inclusive and maximizes the use of time," says Dr. Lam. "Whether or not you've attended an AAFPRS Fall Meeting before, this year will set the new standard for meetings," Dr. Lam adds.

To be held at the Music City Center in Nashville, this meeting promises to be an unforgettable educational experience.

The preliminary program is included in this issue of *Facial Plastic Times*. Register early to get the early-bird rate and book your hotel accommodations at the beautiful Omni Nashville Hotel—which is adjacent to the Music City Center—before rooms run out. ■

**MAY/JUNE 2016**  
**Vol. 37, No. 4**

**BOARD OF DIRECTORS**

Edwin F. Williams, III, MD, MD\*  
*President*

Stephen S. Park, MD\*  
*Immediate Past President*

Fred G. Fedok, MD\*  
*President-elect*

Minas Constantinides, MD\*  
*Secretary*

William H. Truswell, MD\*  
*Treasurer*

Richard E. Davis, MD+  
*Group VP for Education*

Theda C. Kontis, MD\*  
*Group VP for Membership & Society Relations*

Wm. Russell Ries, MD\*  
*Group VP for Public & Regulatory Affairs*

Sam P. Most, MD+  
*Group VP for Research, Development, and Humanitarian Programs*

Harrison C. "Chris" Putman, III, MD+  
*Treasurer-elect*

Paul J. Carniol, MD+  
*Group VP for Membership and Society Relations-elect*

Andres Gantous, MD  
*Canadian Regional Director*

Patrick J. Byrne, MD  
*Eastern Regional Director*

John S. Rhee, MD  
*Midwestern Regional Director*

Phillip R. Langsdon, MD  
*Southern Regional Director*

David W. Kim, MD  
*Western Regional Director*

Anthony P. Sclafani, MD  
*Director-at-Large*

Lisa M. Ishii, MD  
*Young Physician Representative*

Theresa A. Hadlock, MD  
*Eastern Regional Director-elect*

Travis T. Tollefson, MD  
*Western Regional Director-elect*

Stephen C. Duffy+  
*Executive Vice President*

\*Member of the Executive Committee  
+ Ex-officio member of the Executive Committee

*Executive Editor:* Stephen C. Duffy  
*Medical Editor:* Steven H. Dayan, MD  
*Managing Editor:* Rita Chua Magness  
*Freelance Writer:* Lynnette Simpson  
Facial Plastic Times is published by the American Academy of Facial Plastic and Reconstructive Surgery (AAFPRS) 310 S. Henry St., Alexandria, VA 22314; Phone: (703) 299-9291; Fax: (703) 299-8898 E-mail: info@aafprs.org; www.aafprs.org.

Articles signed by their authors express the views of those authors only and do not necessarily express official policy of the Academy. The Academy does not necessarily endorse the products, programs, and services that appear in paid, non-AAFPRS advertisements.



## PRESIDENT'S MESSAGE:

I realize this message is politically charged. However, for those of you who know me well, I'm not one to mince words. The Affordable Care Act (ACA) as it stands is unsustainable and needs to be replaced or radically altered. To understand how we ended up with the ACA, I encourage you to read Steve Brill's book, *America's Bitter Pill*. Brill is a terrific writer and journalist who has written for the *New York Times*, *New York Magazine*, and the *American Lawyers* to name a few.

In the book, he sheds light on the historical perspective of health insurance, which I found informative, before reporting on the "blow by blow" accounts of what actually occurred leading up to the signing of the Affordable Care Act, in March of 2010, by President Obama.

Unfortunately, physician representation was not at the table; neither was organized medicine nor the American Medical Association involved in the background negotiations. As the saying goes, "If you're not at the table, you get eaten for lunch." Where did we—as physicians and patient-advocates—fail at this process? I guess it begins when we first allowed the healthcare system to start referring to us as "health care providers" in the late 1990s. Really, where did the patient-doctor relationship go?

Brill does a great job at keeping the book very objective and apolitical. His "fly on the wall" approach is not only entertaining, but also makes it very difficult to put the book down. Clearly, the health care system was ripe for change with 30 million Americans not covered by health insurance, and anecdotal stories of Americans who thought they had adequate health insurance only to be devastated when a family member had a catastrophic illness. Additionally, by the 1990s to 2000s, the cost of health care had continued to rise between 15 to 20 percent annually and by all accounts was not financially sustainable. However, while there was much made to do about the 30 million Americans who were "not covered." I must say in all of my years of practice, I'm unaware of a patient who presented to the emergency room who was turned away because of their inability to pay. Furthermore, in all my years of being involved in trauma and our fellows' involvement at Albany Medical College, patients were given tertiary level care regardless of their health insurance status. When we became aware that a patient did not have insurance or was unable to pay, we wrote off the balance. That's just how we did things. Additionally, for the working middle class who did have health insurance, the system clearly worked with reasonable copays and coinsurances. Despite the naysayers, the United States still is considered to have some of the best health care in the world. I have friends and colleagues who travel here from Europe to receive their executive physicals or any other health care that they may need.

In retrospect, what occurred with the passage of the ACA is essentially a one trillion dollar expansion of health care over the subsequent 10 years, once the ACA was to be implemented. The potential winners and players at the table were pharma, health insurance companies, large hospital health systems, and naturally the U.S. government that would be the recipient and distributing agent for the multitude of hidden taxes and fees for the 9,625-page document governing the ACA. While the intention of the ACA was to hold everyone getting paid accountable for their actions in delivering health care, at the eleventh hour, a huge concession was made to get the legislation passed, which included scrapping tort reform. Senator Harry Reid was adamantly opposed and

# WHERE DO WE GO FROM HERE WITH THE ACA?

given his influence, it was clear the Affordable Care Act would not be passed if malpractice and tort reform were included. A necessary concession to scrap this piece occurred in apparently a tenuous discussion between Rahm Emanuel and Harry Reid.

In the months and years following the passage of the ACA, stock prices of health care companies continue to rise with the promise of more Americans not only covered, but also unlike Medicare payment and negotiations for medications, a concession was made that the new system would allow payment for everyone at "list" rates versus negotiated rates currently in existence for CMS with drugs.

Health insurance and hospital executives were giddy over the thought that everyone would be covered with health insurance as a result of the original mandate. And while the aggressive consolidation occurred within the industry, stock prices for health insurance rose and many health insurance executives profited handsomely on speculation the insurance industry stood to collect their share of this one trillion dollar expansion. Health insurance executives cashed in on their stock options and many of them walked away extremely wealthy despite consolidation and loss of their jobs. While many health insurance executives continued to complain about the regulations, restrictions, and consolidation, many of these same executives were thrilled about the promise of more control, revenue, and salaries unforeseen in the previous "broken system."

Fast forward to January 2016, the system is clearly more broken now than ever and the patient-doctor relationship continues to be strained even more. What do I mean by this? As a small business person who provided excellent health care benefits to our 50+ staff, I can no longer afford

the 30 to 50 percent proposed increases in providing the same health insurance my outstanding staff is accustomed to receiving. Because we've had to cap the increases at 15 percent, my hard-working, middle-class staff either pay the additional increases or consider opting for the NYS public option that is a bit more affordable. Those who have chosen the increases frequently have considerably higher deductibles. This has resulted in a feeling of resentment; my staff often has difficulty paying for their deductible for a needed service only to see a patient who has a system-sponsored version of Medicare or Medicaid with very little or no copays. Who has won here?

As head of a household and a person who pays their own health insurance, I've seen triple-digit increases in my high deductible plan over the past three years. Currently, we pay approximately \$15,000 annually for a family of six with a \$10,000 deductible. At times, I honestly feel like I can't keep up with the doctor bills given this high deductible plan that costs me a small fortune. While I personally can afford the doctor bills, many middle and upper middle class families simply cannot.

There was a recent editorial in the *Wall Street Journal* written by a gentleman who expressed his feelings. He makes \$110,000 annually at his job and pays for a \$10,000 deductible policy. He now has a policy where he can barely afford the premiums and certainly cannot afford the deductible should he be required to use his insurance for a minor family illness or hospitalization. Who won here? Clearly, not the middle class.

As a shareholder in a surgery center that has been marginally profitable over the past 15 years and saved the health insurance industry a small fortune as compared to performing surgery in a hospital, the center lost

money last year. What we are observing is the middle class choosing to defer on elective surgery at a record rate because of the high deductibles and their inability to afford outpatient procedures. Meanwhile, insurance co-sponsored Medicaid patients who have no copay are much more likely to sign up for elective surgery that is financially crippling the surgery center. The surgery center, which represents a considerable amount of cost savings to the system, is now faced with either dropping insurance altogether and focusing on only "cosmetic" cases or continued insolvency. Who won in this deal?

The health insurance companies are now wondering what happened to them. Because they were lured by the huge pot of additional revenue associated with covering 30 million additional Americans in the individual mandate, things have not worked out favorably for them at all. As a result of the high cost of compliance associated with the Affordable Care Act, and the low

*See Patient-Doctor, page 12*

## 2016 AAFPRS Clinical Investigation Award Deadline

The deadline to apply for the AAFPRS Clinical Investigation Award is June 1, 2016. This award is intended to provide funding to AAFPRS members who don't normally participate in research projects but demonstrate an interest in furthering the profession. These grants are meant to foster career development and provide mentorship to members. The purpose of these awards is to encourage young surgeons to pursue valid ideas by providing grants to offset expenses. To learn more, or to apply go to [www.aafprs.org/research/](http://www.aafprs.org/research/).

## PR TIPS: WAYS TO USE

The latest infographic from the American Academy of Facial Plastic and Reconstructive Surgery (AAFPRS) can, and should, help kickstart your marketing and media engagement efforts. Released in early April 2016, the new infographic breaks down the top trends spotted in our annual member survey. And while the graphic itself is eye candy, it contains a lot of meat that can be expounded upon, shared, and repurposed.

Here are six ways to use the infographic to help promote your practice, talents, and our specialty.

### Spin it on social media

Infographics are great social media fodder. Post it. Tweet it. Feed your followers. Infographics tend to be among the most shared type of content across all social platforms. Thank followers for sharing or commenting, as we know that engagement is social media gold.

### Dissect it for spare parts

Each “factoid” in the new infographic is substance for your blog. Consider a post on new fixes for tired looking eyes or share your take on the desire for that “undone” look when it comes to nose jobs. Video blogs (vlogs) cater to prospective patients who would rather watch than read; and downloadable podcasts also resonate well.

### Share it with your media contacts

Everyone loves a pretty infographic—especially beauty bloggers and reporters. Send ours along. Let your contacts know you are available for interviews on any and all of the trends highlighted in the new infographic. This may be especially appealing for local media looking to put a down-home spin on national news and trends. For example, 64 percent of AAFPRS members saw an increase in cosmetic surgery or injectable treatments in patients under 30 due to social media and selfies. Does this mirror what you are seeing in practice? If so (or even if not), that's your way in.

### Learn from it

Look at what the infographic is telling you about patients, and use the trend



## THIS INFOGRAPHIC

data to better plan in-office events and target your marketing efforts. More than 70 percent of AAFPRS report that combining surgical and non-surgical procedures are in high demand.

Should this be something you offer (if you don't) and promote more vigorously (if you do offer)? Lips are also on trend, according to the AAFPRS member survey. Consider an in-office event discussing all the ways that you can add volume and contour to the lips in 2016.

### Update your Web site

Your practice Web site says a lot about you and the procedures that you offer. It is likely a prospective patients' first foray into your sphere. Yes, they will look to credentials and education, but they will also want to know that you perform the very procedures they want. More than 50 percent of facial plastic surgeons report an uptick in patients asking to get their cheekbones back. Do you have the latest information on cheek enhancement on your site? If not, it may be time to update this section.

### Blast it out to your mailing list

If a picture is worth a thousand words, an infographic is worth at least 10,000. Include ours in your newsletter to break up the text with a bright and colorful image. We know that different patients consume information in different ways. Some like to read, some like to see it, and others like to hear it.

Enjoy the process and reap the benefits. ■

Remember to like us on Facebook (AAFPRS) and to follow us on Twitter and Instagram (@AAFPRS).

KELZ PR is eager to hear about your dynamic patient cases that they can share with the media. If you have a story to share, please e-mail Patty directly at [pattymathews@kelzpr.com](mailto:pattymathews@kelzpr.com).

*Editor's note: This column was prepared by the Academy's public relations firm, KELZ PR.*

# Face Lift Retractor with Reverse Handle



Detail of blade with teeth



Detail of blade with 4mm teeth

**ASSI®-ABR 53926R, 80 x 16mm**  
with fiber optic, suction and adapter

**ASSI®-ABR 43926R, 80 x 16mm**  
with fiber optic and adapter

**ASSI®-ABR 43526R, 80 x 16mm**  
without fiber optic or suction

**ASSI®-ABR 531026R, 120 x 16mm**  
with fiber optic, suction and adapter

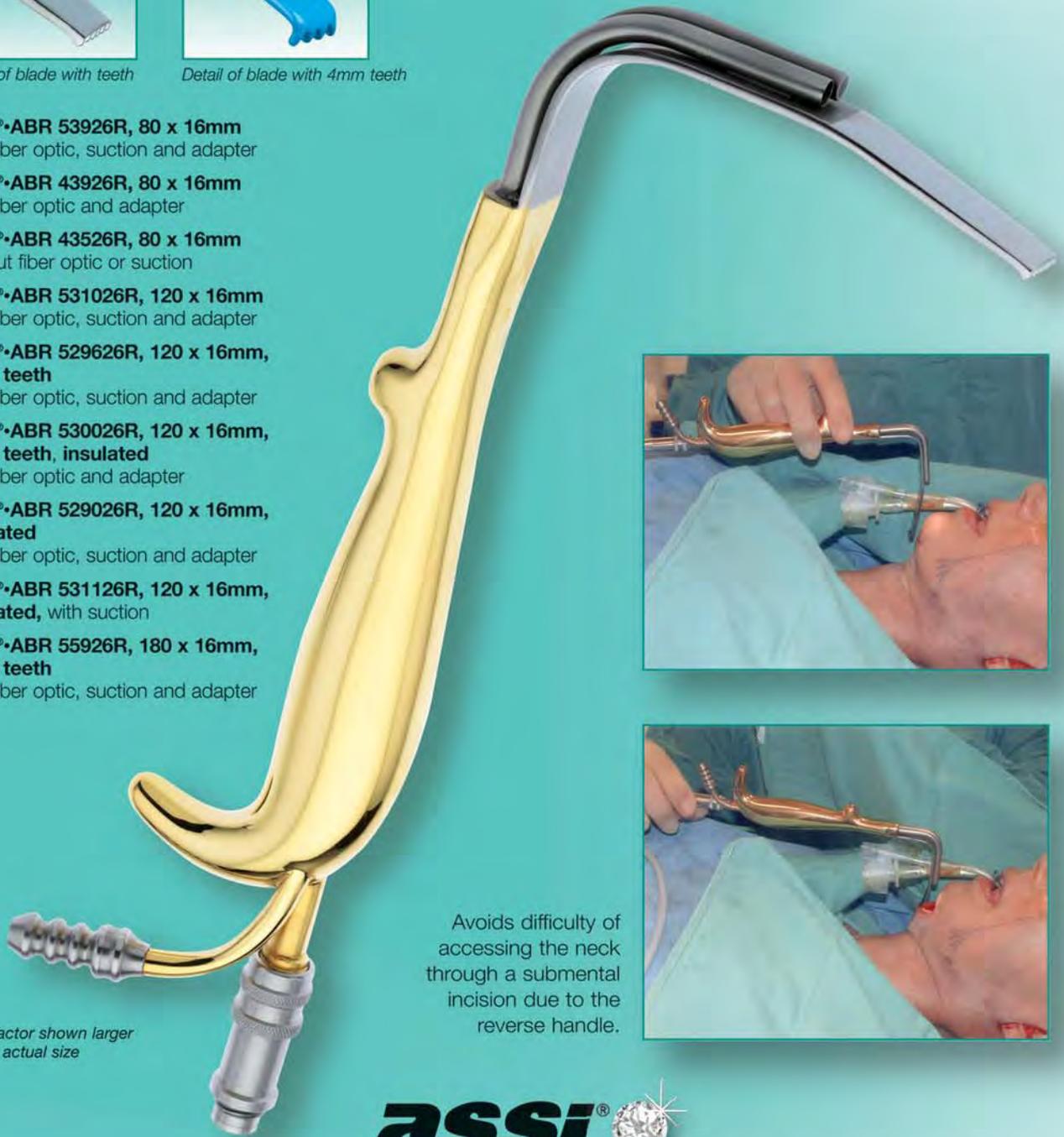
**ASSI®-ABR 529626R, 120 x 16mm, 4mm teeth**  
with fiber optic, suction and adapter

**ASSI®-ABR 530026R, 120 x 16mm, 4mm teeth, insulated**  
with fiber optic and adapter

**ASSI®-ABR 529026R, 120 x 16mm, insulated**  
with fiber optic, suction and adapter

**ASSI®-ABR 531126R, 120 x 16mm, insulated, with suction**

**ASSI®-ABR 55926R, 180 x 16mm, 4mm teeth**  
with fiber optic, suction and adapter



Retractor shown larger than actual size

Avoids difficulty of accessing the neck through a submental incision due to the reverse handle.



ACCURATE SURGICAL & SCIENTIFIC INSTRUMENTS®

For diamond perfect performance™

accurate surgical & scientific instruments corporation

800.645.3569 516.333.2570 fax: 516.997.4948 west coast: 800.255.9378 www.accuratesurgical.com

©2009 ASSI®

# MESSAGE FROM THE MEDICAL EDITOR: "HYDROCODON-PHONE," A 21ST CENTURY DRUG

By Steven H. Dayan, MD, Medical Editor, *Facial Plastic Times*



An Australian company has developed a smartphone app that remotely records cardiac rhythms. It can capture atrial fibrillation, a wide complex QRS, and maybe even an early MI.<sup>1</sup> A smartphone saving a life isn't the only medical app that is paving the way for the future of medicine. The monitoring and treating of diabetes, hypertension, and PTSD is also now available. According to industry estimates, 50 percent of the more than 3.4 billion smartphone and tablet users will have a mobile health app by 2018.<sup>2</sup> Growing at 20 percent a year, both consumers and physicians recognize the value of consumer medical apps for improving health and increasing compliance.<sup>3</sup> However, to every yin there must be a yang.

My yang came about a month back, when I was in the Guatemala rainforest getting in touch with my explorer side and I realized I lost my phone. Has that ever happened to you? I panicked. What was I going to do? How would I get back? How would I take pictures? But mostly, I feared private information, access to my bank accounts, and passwords being compromised. It is hard to believe that for 30 years of my life, I travelled and survived without a cellular phone but now it felt like I had lost my wallet or worse. Fortunately, about an hour later a taxi returned with my phone. "Muchas gracias," I said in my poor accented Spanish. I was thankful, but it made me stop and think: How has the smartphone changed my life and the world?

As a third-year resident, I got my first mobile phone. It made my life a lot easier; now if paged, I

could immediately call back and not have to stop at a phone booth. (Millennials: Note, phone booths were the glass-enclosed closets located on street corners. We would put quarters into a pay phone and make a call to a landline. See Superman video.<sup>4</sup>) But I was embarrassed to talk in public on a cell phone; it seemed rude. So, I would politely step outside, even if it was below freezing, to take a call. To this day, I still feel uneasy talking on the phone publically. I would contrast this to the loud smacking power broker sitting next to me on the plane who has no concerns letting the whole aircraft know about his indigestion from the French onion soup he had for lunch.

Over the last decade, the phone has morphed from a device designed for remote verbal communication to a self-contained entertainment, information, and pleasure toy. Early phones had primitive messaging, but the insemination of the phone by the Internet has birthed the smartphone. I would venture to guess it is probably the single most identifiable device responsible for changing the world the most over the past 50 years. I remember 15 years ago, travelling through the rural country side of an Eastern Bloc country after the fall of communism, and local village people curiously gathered around me to see what I was doing on a hand-held Blackberry. Fast forward to the present, and regardless of age, culture, religion, color, or creed, the smartphone has become a staple appendage even in the most remote corners of the earth. It connects all, highlighting the similarities between all humans. When 23rd century historians look back, how will they categorize the impact the smartphone has had on society and the profession of medicine?

There has been enormous strides made in humanity, safety, information gathering, dissemination, and education, all because of the smartphone; however, could the smartphone also be the strongest mood altering substance since opium? I am going to suggest the "hydrocodon-phone" is a 21st century drug, with dangerously addictive properties. Look no further than the 1.6 million car accidents per year and nearly 4,000 deaths per year attributed to those who "DUIphone," (drive while texting).<sup>5</sup> And, if you think that mature, reasonable adults are capricious with their phones...try pulling one out of the hands of a teenager. All struggle with discipline and moderation when it comes to primitive urges; but, it can be especially wrenching for tweens who lack maturity of temperance.

The hydrocodon-phone has all the elements of an addictive drug: mood altering, increasing tolerance, and withdrawal symptoms. The hydrocodone phone offers the perfect escape for an uncomfortable or socially awkward moment. And nowhere is this more apparent than when getting into an elevator. Today, not only is it rare to get an acknowledgment or a "hello," but a troubling invisibility is approaching. Politely engaging in conversation about the weather or staring blankly up into space is no longer necessary; now, we can take a hit from a four-inch screen satisfying an urge to feel immediately at ease. And for those who need a quicker high, a screen can be wrist mounted for quicker delivery of soma.

Like any drug that has medicinal value, if abused, it can lead to destruction. And the isolated cocoon weaved to protect an awkward back side, may diffuse into an uncontrollable self-indulgence that can destroy. See *Effective Communication*, page 11

# We've Mastered the Art of Chin Implants



Leader in  
silicone, ePTFE  
and patient-specific  
facial implants.

***Implantech***<sup>®</sup>  
Superior Patient Aesthetics

For more information about our facial or  
body contouring implants, visit us or call:  
**[implantech.com](http://implantech.com) | 800.733.0833**

# SUMMER FPST: IMPROVE FORM AND FUNCTION

**D**o you have a strategy for informing your current and potential patients on the latest techniques, technologies, and surgeries that you offer? How often do you update your Web site with fresh, engaging content? The Academy provides its members with *Facial Plastic Surgery Today (FPST)*, a newsletter for consumers. If you are not a subscriber, now is your chance to order your digital copy of the upcoming summer issue. You can print the newsletter with your practice information for your waiting room or e-mail it to your patients. Additionally, you can post the articles on your Web site.

The summer issue will capture readers' attention with the

cover article, "News Flash: Men are Having Facial Plastic Surgery." The month of June is men's health awareness month; for many men, this will include a visit with a facial plastic surgeon. This article will review the motivation behind cosmetic improvement and what procedures are trending among men.

Inside the issue, "Reconstructive Surgeries to Improve Form and Function," will explore the various types of reconstructive surgery: cancer reconstruction, nasal airway reconstruction, cleft lip repair, cleft palate repair, face transplants, facial paralysis, facial trauma reconstruction, microtia repair, and scar revision.

"Ask the expert" will tackle carboxytherapy and how it can be used to treat dark, under eye circles.

Did you know that there is a link between the levels of air pollution and the formation of dark spots on the skin (lentigines)? The "What's new?" section will highlight a largescale study that concluded that for women older than 50, exposure to nitrogen dioxide was significantly associated with more lentigines on the cheeks.

Patients will be reminded to seek advice before committing to the latest trend in the "Health Tip." New products, procedures, and techniques are popularized in the media every day. It is important—especially for products

YOU CAN STILL RECEIVE THE SPRING ▲ ISSUE OF *FPST* (AS SEEN ABOVE), AND YOU CAN GET IT AT NO-CHARGE, IF YOU START YOUR ANNUAL SUBSCRIPTION ON OR BEFORE JULY 15, 2016. SEE ENCLOSED SUBSCRIPTION FORM.

that are not approved by the Food and Drug Administration—that they seek your expertise before forging ahead.

Exciting research in the *Proceedings of the National Academy of Sciences* is exploring the aging process. "The Speed of Aging," on the back page, will highlight this study of nearly 1,000 participants, who were followed from age 26 to 38, across 18 measures to show how quickly they were aging. Factors typically linked to aging were included such as, blood pressure, lung function, cholesterol, body mass index, inflammation, and the integrity of their DNA. They repeated the testing at 32 and 38 years of age and then calculated the pace at which each person was aging. This is an excellent way to track whether anti-aging treatments work or not.

Start your annual subscription with the summer issue. Order your copy today. Refer to the enclosed form in this issue of *Facial Plastic Times*.

## Silence On Hold?

**Let Commercials On Hold Help You:**

- ✓ **DEFINE** Your Practice
- ✓ **LIFT** The Mood
- ✓ **INJECT** Information
- ✓ **PLUMP** Your Profits

**Call Now For A FREE Demo!**  
**800-832-4653**

**TRANSMEDIA**  
**COMMERCIALS ON HOLD**

Visit Our Website: [commercialsonhold.com](http://commercialsonhold.com)

# MR. TONY BULL...SURGEON, TEACHER, VISIONARY, FRIEND

By Wayne F. Larrabee, Jr., MD

Our friend and colleague Tony Bull, MD, met an untimely death last month; we are all still absorbing this great personal and professional loss. Tony worked, taught, and entertained us from his iconic office at 107 Harley Street seemingly forever. For those who didn't know him personally, it is impossible to summarize his charisma, humor, and wisdom—but there was no one like him. He was a giant in our specialty and along with Claus D. Walter, MD, the “glue” that bonded the North American and European facial plastic surgery communities.

Tony was a consultant surgeon at the Royal Throat Nose and Ear Hospital, The King Edward VII's Hospital for Officers, the Charing Cross Hospital, and a senior lecturer at the Institute of Laryngology and Otology Royal Free Hospital. His surgical skills were legendary as seen in the long queues of international patients traveling to have him perform their rhinoplasties at the London Clinic. Rhinoplasty was his single largest passion; but unknown to many, he was also an equally talented stapedectomy surgeon and seemed to switch effortlessly between the two skill sets. It is of note that Bill Wright, MD, one of the great rhinoplasty surgeons in the United States, also continued to do otology. These two pioneers chose operations that required great precision and craft.

Most of us first met Tony as a teacher. His lectures on rhinoplasty and “bat ears” were immensely entertaining; but beneath the wit and irreverence, there was a deep understanding of the art and craft of our specialty. His gravelly voice was unique and immediately recognizable to all. His sayings such as “spot on” and “first rate” still echo in my mind. I remember when he



and Jill joined us at a meeting in Morelia, Mexico, and he told me he had developed a unilateral vocal cord paralysis. That never left him but only added to the character of his voice and presentations.

Tony was one of the founders of the European Academy of Facial Plastic Surgery. This grew from the Joseph Society that he Dr. Walter, had organized. He served as secretary from 1977-1988 and president from 1989-1994. He helped me organize the International Federation of Facial Plastic Surgery Societies and served as president in 1998.

I have a special fondness for his role, along with M. Eugene Tardy, Jr., MD, in founding the *Facial Plastic Surgery Monographs*. I served on his editorial board for

many years and this journal was essentially the first credible international publication in facial plastic surgery. J. Regan Thomas, MD, and I launched the *Clinics in Facial Plastic Surgery* later, based to a large degree on this foundation. Our peer reviewed *Archives of Facial Plastic Surgery* (now *JAMA Facial Plastic Surgery*) also was possible because of his pioneering work and the demonstrated audience.

The most important legacy of Tony Bull is his kind and generous support to all of us for whom he was a mentor. When I was studying eye plastic surgery at the Moorfield's Eye Hospital during the 80s with Mr. Richard Collin, I would go on Fridays to watch Tony operate. He didn't just allow me to observe, but became a good friend. We would go to his favorite pub afterwards to continue the conversation. When I decided to start a practice in London, Tony welcomed me warmly. He offered to allow me to see my consultations in his personal rooms at 107 Harley Street and then wouldn't consider any payment in return. He was a great man, a great friend, and I will miss him very much. ■

Plan now to attend

## Advances in Rhinoplasty 2017

The course promises to be an exciting, interactive learning experience for students of rhinoplasty at all levels.

The faculty represents the best rhinoplasty surgeons in the world, coming from multiple continents to provide up-to-date information on rhinoplasty.

A promotional graphic for a course titled "Advances in Rhinoplasty 2017". The background features four stylized profiles of human faces in shades of blue and white. A large red diamond shape is overlaid in the center, containing the course title and details. The text inside the diamond includes: "May 4-7, 2017 // Chicago, IL USA", "SHERATON CHICAGO HOTEL AND TOWERS", "ADVANCES IN RHINOPLASTY", "CO-CHAIRS Peter A. Adamson, MD; Sam P. Mast, MD; and Orafi Friedman, MD", and the logo for "FACIAL PLASTIC SURGERY".

# FACE TO FACE UPDATE: VIETNAM AFTER 40 YEARS

I was 17 years old when my family left Vietnam and settled in Lansing, Mich. I earned a medical degree from the University of Tennessee, Memphis. I met John M. Hodges, MD, during a clinical rotation in the ENT program and we developed a close relationship. I was very impressed with Dr. Hodges' personal character and professionalism; and based on his recommendation, I pursued the ENT program.

In October of 1998, I was scheduled to give lectures during the FACE TO FACE trip to Vietnam, but was unable to attend due to my father's illness. He passed away in December of that year. I moved my family to Atlanta, and started my practice in ENT and facial plastic surgery, with the focus on Asian blepharoplasty and rhinoplasty. I remained in contact with Dr. Hodges, and on occasion, sought his advice. Dr. Hodges continued to give lectures at several hospitals in Vietnam after 1998. He invited me to travel with him throughout the years; unfortunately, due to family and work obligations, I was unable to attend.

In October of 2015, I was inducted into the Legacy Society Club at the University of Tennessee and was reunited with Dr. Hodges. Again, Dr. Hodges extended the invitation to go with him to Vietnam in December as a teacher. I was very happy that my circumstances allowed me to accept his invitation this time. An invitation immediately followed from Tran Phan Chung Thuy, MD, the director of the ENT Hospital in Ho Chi Minh, to give lectures at a plastic and reconstruct surgery workshop, December 3-4, 2015. I gladly accepted.

## Preparation

Along with the help of my wife, Linh, we started to prepare for the long journey. I was a bit anxious regarding presenting the lectures in Vietnamese. Even

though I can speak the language fluently, all of my medical training has been in English. The English-Vietnamese dictionary became my best friend! In some instances, I combined both languages and hoped that the Vietnamese physicians could understand.

## The course

After five days of touring the country, I returned to Ho Chi Minh City. As I entered the gates of the ENT hospital, I became very emotional. There were numerous patients waiting outside, hoping to be seen. The hospital is old, but in much better condition than I had expected. Dr. Tran Thuy welcomed me and asked me to give an opening speech for the workshop. I was humbled by the privilege to teach at a hospital in my birth country after 40 years. I was glad that I could still communicate with the Vietnamese physicians in the same language.

I gave a lecture on Asian blepharoplasty and Dr. Hodges lectured on rhinoplasty after his arrival the first morning. He performed two surgeries later that afternoon, a rhinoplasty reconstruction for a cleft lip patient and a lower lip scar repair/reconstruction for another. We then attended a welcome dinner at the Majestic Hotel attended by the director and staff from the hospital. We enjoyed scrumptious food accompanied with live Vietnamese music and traditional dance. The next morning was especially thrilling for me because I performed and taught a live surgery of Asian double eyelid with local anesthesia. Then I was requested to perform an impromptu live upper and lower eyelid surgery on a doctor who was attending the class. Dr. Hodges performed and taught a live facelift and another cleft lip rhinoplasty in the

other surgery room. The afternoon of the second day was dedicated to lectures. I spoke on Asian augmentation rhinoplasty and complication, and Dr. Hodges lectured on reconstruction of facial defects. We attended a private dinner that evening with the chair of the Plastic and Reconstructive Surgery Department of Cho Ray Hospital.

We were invited to visit the beaches at Vung Tau the following day, but Linh and I decided to spend our last two days in Ho Chi Minh City. We spent them visiting with relatives and friends and also visited the hospital to follow up with the patients. Both of my patients had gone home, and Dr. Hodges' patients were fine and ready to be discharged from the hospital. We had a wonderful farewell dinner on our last night at Quan Dong Restaurant.

We left Vietnam and arrived safely back in the United States. The experience and the memories of this trip have left a gigantic imprint on our lives, and we are already looking forward to our next return to Vietnam in the near future.

*Editor's Note: This article was written by Khuong Van Nguyen, MD (seen here with his wife), a colleague of Dr. Hodges (right) and a friend of the Academy.*



# MAINTAIN EFFECTIVE AND MEANINGFUL COMMUNICATION

From *Medical Editor*, page 6

relationships. As we are transported to a virtual world instantly connected to all others minute-by-minute, we become occupied but not present in the moment. The phone today is an amazing advancement in long-distance connections, allowing instant sharing of a story with hundreds if not thousands of people around the world and maintaining ties with family and friends overseas. The irony is that nothing steals an intimate moment from the one closest to you than a phone. How hurtful or insulting when a phone is placed face up at the dinner table? Your meaningful story can be swiped out and dismissed by a confidant more interested in the next Facebook alert. According to researchers at Baylor University, nearly 50 percent of respondents have felt insulted by “phubbing,” a new word meaning being snubbed by a loved one because of phone interruption. At least 23 percent felt it had a negative impact on the relationship, even leading to feelings of depression in over one-third.<sup>6</sup>

How we communicate has changed more in the last five years than in the 2,000-year leap it took to go from hieroglyphics to alphabet letters. We have an emerging generation that communicates better in 140 characters, emoji’s, and acronyms than in spoken words. Although I am sure the early 1900s had comparative dilemmas when the telephone encroached on the written word, there is something so uniquely one dimensional about communicating via the smartphone that it cannot be overlooked. Texting and social media allow communication within a time frame that best fits one’s schedule, as opposed to a phone conversation that forces engagement in the moment. It is impossible to have a one-way phone conversation. I have to admit, I am a fan of the “communicate when you wish” aspect of texting, a great tool for multi-

taskers. It allows a say when we feel like it... and if we want to fire off a quick note and selfishly not wait for a response, we can do that too. For the ADD and those always needing to get in the last word, what could be better? It seems that human culture has finally caught up with them. Nevertheless, what will be the impact on human interaction and socialization when the influence of the smartphone is fully realized?

Will the disuse atrophy of interpersonal communication skills and an inability to be alone with our thoughts slowly erode our evolutionary advantage to reason, actively ponder, reflect, and imagine? From Einstein to Freud to Jobs, many of the greatest advancements in human culture stem from those who learned to experiment with detailed thoughts in their minds to create, manipulate, and extend the boundaries of science.

Closer to the here and now, how does and will the smartphone impact aesthetic medicine? For many, it is already providing an important added measure of comfort allowing an ability to see postoperative concerns in real time. Soon it may be an acceptable standard for performing imaging and virtual consults from anywhere in the world. And just as orthopedic surgeons are reporting a burgeoning business of carpal tunnel phone syndrome, there is some thought that aesthetic physicians will be seeing more patients with NWPS (neck wrinkle phone syndrome), secondary to looking down to view a phone.<sup>7</sup> Perhaps the phone will be able to determine where skin damage lies, measure laxity, and help to virtually schedule a laser or chemical peel. Perhaps a phone will allow patients to capture and create an idealized 3-D image of a nose that can be printed and delivered to offices only needing to be inserted under the nasal skin in a quick

procedure. A smart-phone doing surgery is fortunately hard to conceptualize; thankfully so, as if it could, we might be out of a job. Yet crazier things have happened. The future of how the phone will affect our field is fascinating to consider.

While we continue to praise the phone and its aid in medical convenience, diagnostics, and monitoring, we have to be cautious. In aesthetics as in life, the most important contributor to well-being and patient satisfaction distills down to effective and meaningful communication.

Embracing the emerging value of the smartphone to the advancement of our field is prudent. However, equally critical is not to overlook the need to master the art of empathetic face-to-face communication. Maybe it is time to occasionally put down the phone and better engage with those in front of us. How we interact, treat, and advise those who rely on us may be the keystone not only to securing the future of our profession, but also to maintaining a sense of serenity as well. ■

---

## References

- <sup>1</sup>[www.alivecor.com](http://www.alivecor.com)
  - <sup>2</sup>[www.fda.gov/MedicalDevices/DigitalHealth/MobileMedicalApplications/default.htm](http://www.fda.gov/MedicalDevices/DigitalHealth/MobileMedicalApplications/default.htm)
  - <sup>3</sup>[www.modernhealthcare.com/article/20151128/MAGAZINE/311289981](http://www.modernhealthcare.com/article/20151128/MAGAZINE/311289981)
  - <sup>4</sup>[www.youtube.com/watch?v=p0B1ufjXODs](http://www.youtube.com/watch?v=p0B1ufjXODs)
  - <sup>5</sup>[www.textinganddrivingsafety.com/texting-and-driving-stats](http://www.textinganddrivingsafety.com/texting-and-driving-stats)
  - <sup>6</sup>[www.huffingtonpost.com/entry/cell-phone-hurts-relationships-phone-snub\\_us\\_560c0cdee4b0dd85030a1c4e](http://www.huffingtonpost.com/entry/cell-phone-hurts-relationships-phone-snub_us_560c0cdee4b0dd85030a1c4e)
  - <sup>7</sup>[www.aafprs.org/media/press-release/20150324.html](http://www.aafprs.org/media/press-release/20150324.html)
-

# PATIENT-DOCTOR RELATIONSHIP IS FIRST AND FOREMOST

From President's Message, page 3 enrollment by individuals seeking "private" or non-state sponsored programs, most health insurance companies are losing money at record rates and are now on an unsustainable path. Aetna, historically one of the largest providers of health insurance, recently announced they are considering an exit of health insurance altogether in 2017. In the *Wall Street Journal* at the time of this writing, May 5, 2016, health insurance giant United Healthcare is also entertaining a withdrawal from all but a handful of states where private health insurance is sold. Who wins here?

As a physician/surgeon, I've always taken pride in the fact that while we could afford to drop care for insured patients, to the chagrin of our consultants, we've always participated with essentially every health insurance company including Medicaid. Over the years, I've just felt as a member of the community that it was my obligation to do so. As of May 2016, I will no longer participate with any health insurance given the associated hassle, compliance cost, declining reimbursement, and frustration. Who won here?

For all physicians, change is in the air and unfortunately, it is not favorable. The underpaid primary care physicians were promised increased compensation with the implementation of the Affordable Care Act. That has not happened thus far. Additionally, they have been rewarded with additional compliance costs, further regulations, and the associated frustration. This also holds true for surgical sub-specialties. Many surgical practices have been absorbed by the hospital system with the lure of a stable salary and protection. The result again has been more regulation and loss of autonomy. While compensation has been reasonable, most experts agree

surgical sub-specialists can expect to see compensation decreases between 20 to 30 percent over the next five years.

Given the sacrifices associated with medical school and surgical training, the Affordable Care Act quite honestly is a tough sell and I'm not sure it makes good financial sense. If I am in need of a neurosurgeon at some point in my life, I want the best and brightest to be attracted to neurosurgery and not to Wall Street. Who is winning here?

Being the eternal optimist, I hope you understand this message is not intended to be a downer but to cause a call for action by all of us. We are now experiencing a record number of physicians pursuing an MBA over the last five years and I'm specifically calling to action each and every one of us—but specifically our newly minted MD/MBAs. Given the current financially unsustainable mess we are facing, I am challenging those physicians to use their influence and resolve to put the patient-doctor relationship front and center in each and every discussion related to health care reform.

Medicine is truly a noble profession. There's definitely some type of psychological transformation that occurs as you go through a residency training program. One slowly becomes acutely aware of the responsibility bestowed upon you and the trust a total stranger will place in you simply because you are their doctor. It is a trust I committed to never take advantage of; I believe most good physicians feel the same way. This is why we cannot simply rely on others with a deep-rooted agenda to rectify the shortcomings of the ACA or how we practice our profession.

In the interest of not spoiling the book, in *America's Bitter Pill*, Stephen Brill comes to many of my same conclusions. I continue to remain hopeful for our young residents, medical students, and

aspiring physicians as I look them in the eye and assure them that caring for someone as a physician or surgeon will give them the fulfillment not achievable by any other profession.

To the next generation of physicians, given what is at stake, we need your lifelong commitment more than ever to become involved and stay invested.

Edwin F. Williams, III, MD

## ACADEMY AWARDS

The AAFPRS is still accepting nominees for the following Academy awards: Residency Travel, William Wright, Mark Rafaty, John Dickinson, and Community Service awards for presentation at the 2016 Fall Meeting in Nashville, Tenn.

For more information, contact Glenda Shugars at the Academy office at (703) 299-9291, ext. 234, or visit the AAFPRS Web site, AAFPRS Foundation, the Research Center: [www.aafprs.org/research/awards/](http://www.aafprs.org/research/awards/).

## CLASSIFIED AD

Practice Opportunity San Francisco Bay Area  
40-year-old, accredited office-based surgery facility, facial plastic surgery practice including hair transplantation, available for fellowship trained FPS or equivalent. Immediate association available and early practice acquisition/transfer/sale. Contact Sheldon S. Kabaker, MD, for further details and information regarding practice and timeline. The practice is located in the San Francisco Bay Area community of Oakland, California, only 20 minutes from downtown San Francisco. E-mail requests to: [OaklandFPS@aol.com](mailto:OaklandFPS@aol.com).

Did you know it took her **144** days to finally make a decision?

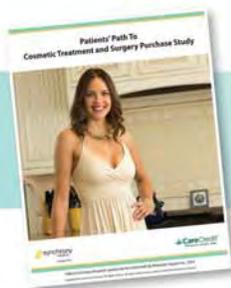
*If only you could get inside her head.*

**Now you can.** A compelling new study on patient decision-making.

An in-depth study on how cosmetic patients make decisions reveals the process takes about 144 days, and addressing cost concerns early with financing options like the CareCredit credit card can help them move forward. Two key findings from the research:

- ▣ **86%** research cost/financing both offline and online
- ▣ **49%** visit the office regarding cost, and the majority make multiple consults

Find more insights to help you attract and convert more patients in the "Patients' Path to Cosmetic Treatment and Surgery Purchase" Research Report.



**FREE REPORT: Download at [carecredit.com/pro](http://carecredit.com/pro) or call 800-300-3046.**  
Mention code **FPT2016CA**.

**CareCredit**<sup>®</sup>  
Making care possible...today.

\*Path to Purchase research conducted for CareCredit by Rothstein Tauber, Inc., 2014.

FPT2016CA

# LEVELING THE PLAYING FIELD BETWEEN OUT OF NETWORK

**B**y definition, a "level playing field" is a concept about fairness where all players play by the same set of rules. The underlying assumption is transparency and consistency of the rules, their definition, and their interpretation. In other words, a playbook that all players have access to and understand. Unfortunately, in today's reimbursement world for out of network providers (OON), the field is sorely off balance leading to potentially hundreds of thousands of dollars unclaimed and uncollected.

## The players

Insurance companies: For the most part, insurers are corporate giants with deep pockets that have mastered the art of creating processes on top of processes. A

• Web of red tape at every turn  
• causes members and providers alike to feel stuck and out of control. This is the image of today's insurers. An exaggeration? You be the judge.

• Out of network providers:  
• Long gone are the days of private practice physicians seeing patients with little concern about insurance reimbursements. Today, being in private practice, and one who is an out of network provider, carries with it huge risks and daily unknowns. Professionals, who were trained to treat patients, but not necessarily run a business, are forced to face-off daily with their large-scale counterparts on matters directly affecting the bottom line. The result? Physicians must manage the rising costs of business in a medical climate they have very little control over.

The claims auditing and appeals process itself gets overburdening, and without knowing the specific plan outlined in a patient's Summary Plan Description (SPD), providers are unable to take action against claims offers that are unfair and sometimes even downright insulting. Even a large practice rarely has the internal ability and resources to effectively manage this process.

**The playbook**  
Summary Plan Description: For every health insurance plan that is written, there is a Summary Plan Description (SPD) that goes along with it and is given

• to the member when he or she enrolls. In most cases, it is solely the insurer who interprets and executes the terms in the SPD, and controls the claims process every step of the way. Therefore, it is ultimately up to them to determine the level of difficulty, clarity, and consistency of each claim handled.

• The language in an SPD is typically ambiguous, unclear, and wide open to interpretation. Terms such as "usual and customary," and "allowable amount," are examples of ways insurers keep control of specific claims. The ambiguity allows for interpretation, and usually this interpretation is done solely on the insurer side. For example, what is usual and customary, and who determines that? Further, who determines the allowable amount and when can it change?

• Why does this keep the claim negotiations one-sided? Because the member rarely keeps or reads the SPD and the provider only has access to it if the member gives him the right. If the provider does not see the SPD, they are unable to determine if what the insurer is offering is outside the scope of what is fair for each claim.

## The answer?

With knowledge, comes power.  
ERISA—Most insurance policies are governed under ERISA (Employee Retirement Income Security Act), and therefore have strict regulations regarding disclosure of terms and administration of policies. Specifically, ERISA guarantees each member a full and fair review of plan documents and all evidence, methodology, and fee schedules relied upon to determine the reimbursement amount. The key to OON providers receiving more, if not all, of the reimbursement in accordance with each member's policy, is to take a systematic approach and work with the law under ERISA for each claim.



**The 2016 Portland Rhinoplasty Course**  
Oregon Health & Science University

A unique opportunity to expand your knowledge in rhinoplasty is being offered in Portland, Oregon July 29th—31st, 2016.

Each day the course will feature structured panel discussions, faculty/student workshops, didactic presentations, and case analysis with expert faculty. This course is appropriate for all rhinoplasty surgeons interested in advancing and refining their knowledge of this most challenging procedure.

Participants in the laboratory portion of the course will have the opportunity to dissect fresh cadaver specimens.

**Accreditation**  
Oregon Health & Science University School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

**Credit**  
OHSU School of Medicine, Division of CME, designates this live activity for a maximum of 19.5 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity

**For more information please visit—**[www.ohsu.edu/pdxrhinoplastycourse](http://www.ohsu.edu/pdxrhinoplastycourse)

**Course Directors & OHSU Faculty**—Tom D. Wang, MD & Michael M. Kim, MD; Myriam Loyo Li, MD; Timothy Smith, MD; Henry Milczuk, MD; & Ted Cook, MD.

**Guest Faculty**—Amit Bhrany, MD; Richard D. Davis, MD; Oren Friedman, MD; Grant Hamilton, MD; Fausto Lopez, MD; Benjamin Marcus, MD; Jose Montes, MD; Sam Most, MD; Charles Shih, MD; & Brian Wong, MD

Room block at discounted rate available through June 28th at River's Edge Hotel under—"OHSU Department of Otolaryngology—Head & Neck Surgery".

# PROVIDERS AND INSURANCE COMPANIES

## Leveling the field

Ensure all patients sign a DAR (Designated Authorized Representative) form on initial visit. A critical starting point as this allows the providers to "step into the shoes" of the patient. Without a DAR, providers have no rights, as health insurance is a contractual agreement between the member and the insurance company. Once signed, however, the provider has all the rights and protections afforded under the patient's policy and the law. By exercising the member's rights under ERISA, providers are able to appeal, negotiate directly, clarify terms, and ultimately hold the insurance companies to the fairest interpretation of the SPD possible under the law.

*Exhaust the written appeals process.* This process includes all the administrative remedies required before a claim can move on to litigation. It is a tedious process complete with red tape, denials, and delays, and can take six months or longer. Many providers and members give up and accept whatever they are offered at this point—usually well below what they are entitled to.

*Request an SPD.* Legal intervention begins with a request for a Summary Plan Description. Providing the SPD is required under ERISA, and a refusal or a delay in doing so has severe fines.

*Take legal intervention and action.* Once the member's SPD is received, a careful analysis can identify language to be challenged and proven inconsistent. It is these inconsistencies, ambiguities, or buried promises that can lead to a clarification of the terms, a re-evaluation of the current payment, and ultimately a favorable result. Many times, claims can be settled prior to litigation with demand letters. However, as a last resort, insurers will be taken to court, many times resulting in a settlement in the early stages of litigation.

## No pain, no gain

Obviously, this sounds simple but can be difficult and sometimes impossible for busy medical practices to implement. Historically, insurers have realized this too and brought in outside help. In many cases, it is beneficial for providers to consider doing the same. A designated resource that works specifically on the claims auditing and appeals process and insurer negotiations can keep the process moving to a favorable outcome—ultimately leaving much less money on the table. These resources can work on one or several parts of the process, on current claims, or provide a complete analysis of historical claims with potential benefits.

The only constant in today's medical climate is that things continue to change. Keeping up with the changes, and staying on top of claims processes are critical to maintaining a successful practice. It might be a difficult and sometimes painful part of business, but one that is not going away. The positive impact on the bottom line can be a constant reminder that it is a long-term investment in a difficult business. ■

### *Editor's Note:*

*The Law Offices of Cohen & Howard grants permission to the American Academy of Facial Plastic and Reconstructive Surgery (AAFPRS) to print this article in the May/June 2016 issue of Facial Plastic Times. The writer, Leslie Howard, Esq., will speak on this topic at the upcoming Fall Meeting in Nashville during the Practice Management Session. Leslie is a founding member of The Law Offices of Cohen & Howard, a New Jersey based firm that works with non-participating medical groups (out of network providers) to help drive up reimbursements from insurance companies by focusing on an underutilized area of the law (ERISA).*

## CLASSIFIED AD

VECTRA H1 3D imaging and consultation system for sale. We are selling a new Vectra 3D imaging system. Improve your consult to surgery conversion rates with visual communications. The VECTRA H1 handheld imaging system brings clinical quality 3D imaging to any practice. It delivers precision optics for high-resolution 3D images in an intuitive, lightweight, and easy to handle image capture system. Ideal for facial aesthetics, clinical documentation, and more; it's completely self-contained with integrated flash and ranging lights. The VECTRA H1 is ready to go with minimal staff training. Contact Ryan Menachof at [RyanM@advancedentdenver.com](mailto:RyanM@advancedentdenver.com), (303) 792-3242.

## CLASSIFIED AD

Cosmetic clinical assistant in New York City needed. Responsible for management of facial plastic surgery department by focusing on medical and surgical patient care and development of the cosmetic practice. Duties include assisting physician in performing examinations and procedures, educating patients on procedures and options, maintaining cosmetic inventory, and assisting in cosmetic marketing and events. Candidate should be able to initiate and convert patients from general ENT to facial plastic surgery.

The applicant must have knowledge of infection control, medical/cosmetic procedures, OSHA and HIPAA regulations, medical safety protocols, software systems including Excel, Word, Epic, Greenway, and Televantage systems or ability to learn.

Please send your resume to [mes3003@med.cornell.edu](mailto:mes3003@med.cornell.edu).

## A RECAP OF A HOLLYWOOD SUCCESS

For four days, top facial plastic surgeons, plastic surgeons, dermatologists, and oculoplastic surgeons convened at the Beverly Wilshire to present and learn about the hottest techniques through dynamic panels, workshops, and first-ever dueling live surgery sessions for the *Facial Rejuvenation: Master the Techniques* event. For those of you who do not know, this meeting is a reboot of the meeting formerly known as *Rejuvenation of the Aging Face*. The faculty, the program, the hotel, and the host city were all of the reasons why this meeting was very well attended; attendees came from all over the world, including Brazil, England, France, Lebanon, Saudi Arabia, and Kuwait.

One meeting feature was a full-day injection course demonstrating innovative off-label techniques. Another highlight to the program was "dueling" live surgeries: two surgeons demonstrating different approaches and techniques to address the same issue. For instance, Stephen W. Perkins, MD, and Andrew J. Jacono, MD, each performed their facelift/necklift surgical procedures at the same time and these surgeries were broadcast live to the Beverly Wilshire ballroom where a moderator, panelists, and attendees discussed the differing techniques.

Celebrity speakers included Paul S. Nassif, MD, and Michael Westmore, both giving interesting anecdotes about their experiences in Hollywood.

Thirty-six companies jam-packed the exhibit hall, where the lunches, breaks, and cocktail receptions were held. Exhibitors were pleased with the traffic of nearly 300 surgeons daily.

Members of the media took advantage of the insightful presentations. The AAFPRS issued passes to 15 credentialed journalists. Many attended the

opening reception and enjoyed mingling with the AAFPRS leadership and presenters.

Media coverage was earned in various outlets, such as a top television segment with Associated Press TV, which will air soon. In addition, press clippings include beauty and celebrity blogs and trade journals like *PRIME* and *Modern Aesthetics*. The event was pre-promoted via various calendar listings especially in the trade magazines and Web sites like Plastic Surgery Practice and *Modern Aesthetics*. Finally, a wrap-up press release titled, "What's Trending in 2016, AAFPRS members reveal 'The Next Big Thing,'" was distributed to media contacts after the event.

Beverly Hills is an ideal location for a facial rejuvenation meeting. Interestingly, this meeting is the first major plastic surgery society meeting held in the iconic Beverly Wilshire Hotel. Attendees had a full immersion experience in Beverly Hills, with Rodeo Drive across the street from the hotel. ■



THE CO-CHAIRS (FROM LEFT), DRS. BATNIJI, PERKINS, AND KONTIS, ON THE RED CARPET IN FRONT OF THE STEP-AND-REPEAT, WHERE ATTENDEES GATHERED FOR SELFIES.



## NAVIGATION TABS MADE CLEAR

Check out the updates to the left hand navigation tabs on LEARN, the Academy's educational portal. The following changes have been made to allow viewers an easier browsing experience.

- We have added a Practice/Job Opportunities tab. This tab will be activated in the coming months.
- The John Dickinson Library Videos tab has been renamed to Surgical Videos to be consistent with the Academy's Web site.
- The Core Lectures tab has been renamed Keynote Speakers. These are videos from past Fall Meetings.
- The Member Only John Dickinson Library Videos tab has been revised to Free Surgical Videos for Members.
- The Research tab is now AAFPRS Grants and Awards.
- There is a sub-section to the Fellowship tab, providing easier access to Free Instructional Videos for fellows.
- The Journal tab is renamed JAMA Facial Plastic Surgery.
- The capability to go directly from the LEARN home page to the AAFPRS Web site is added.



Finally, we are working on the concept of a Virtual Exhibit Hall. Check future issues of *Facial Plastic Times* for updates. If you have any questions regarding how to navigate the LEARN site, contact Karen Sloat, [ksloat@aafpsr.org](mailto:ksloat@aafpsr.org). ■



**AAFPRS and ZELTIQ  
at the America's Cup World Series in NYC  
on May 7, 2016**



**History was Experienced  
Friends and Families Gathered  
Food and Drinks Enjoyed  
We Missed You!**

**Join us at our next regional event**



# MEET YOUR SPONSORSHIP COORDINATOR

By Rachel Hardy, OFPSA President

**W**e are looking forward to connecting with new members and familiar faces at the upcoming Fall Meeting in Nashville, October 6-8, 2016. We hope that you have made arrangements to join us; the program this year is going to be outstanding.

In preparation for the Fall Meeting, we would like to introduce Chelsea Berendsen, an OFPSA officer who serves as our sponsorship coordinator. Her energy, creativity, joyful spirit, along with her diligence and hard work, has made her an incredible asset to the OFPSA. Chelsea works as lead administrator and surgical services coordinator at Cascade Facial Surgery and Aesthetics in beautiful Mount Vernon, Wash. She was kind enough to share some insight into her practice life in the following interview.

**Q:** How long have you been with your practice and how did you start in facial plastics?

**A:** I started working with Jonathan Grant, MD, when he opened the doors of his private practice in January 2014. With his educated background, professional mannerism, and passion for wanting to help people look and feel their best, I knew he was genuine. Before I met Dr. Grant, I worked for one of the community hospitals at a dialysis center. My passion for medical care is greatest when I see real changes. I stopped working there knowing that I wanted to work as a part of the patient experience before, during, and after treatments that produce changes you can see. Nothing compares to being able to see the results-driven outcome you work so hard to achieve.

**Q:** What is your practice like?

**A:** When you walk into our reception area, you first see flowers sitting on the counter above our fountain, which is

located right at our front desk where patients check in. Behind the front desk, we strive to have a smiling staff member always present to greet and assist our patients as they walk through our doors. At Cascade Facial Surgery and Aesthetics, we pride ourselves on providing world-class service in every aspect of our practice. From cutting-edge techniques and high standards for surgical safety and efficiency to concierge service and individual, personalized care, our aesthetic and medical specialists have the advanced skills to support our nonsurgical as well as surgical patients, both facial plastic and reconstructive. Dr. Grant is double-board certified and specializes in cosmetic surgery, reconstruction surgeries (including skin cancer reconstruction), and nonsurgical procedures that can improve both appearance and function and reduce the signs of aging. Our clinical aesthetic nurse and master certified aesthetician work as the ideal extension of him and offer services that complement our surgeon's procedures. The entire team works well together to help our patients look and feel their best. We use the Canfield Mirror imaging software whenever possible to simulate anticipated changes with sur-

gery. This helps our patients feel more confident about their choice of procedure.

**Q:** What is your role in the practice?

**A:** I have evolved into the lead administrator and surgical services coordinator. I play a large part in helping run the day-to-day operations, as well as coordinate surgical services. My experience working with our surgeon provides me with the greatest understanding of the quality care he gives to his patients, both in and out of the operating room. We have highly qualified professionals working on our team who are passionate about providing exceptional patient outcomes. Working with this highly talented group of individuals makes my job easier and all the more gratifying.

**Q:** What is your favorite part of your job?

**A:** Being with our patients when they see their result for the first time is my favorite part of what I do. When I hear a woman complaining of her protruding ears—she had never been able to wear hats and wouldn't go swimming with her family because her wet hair accentuated her ears—and then I am part of the process to get her the outcome she desires, it is easy to see why I work in this field! Patients often



Cascade Facial Surgery and Aesthetics  
Reception Area



look in the mirror and smile, or shed happy tears, and say, "Wow!" Our procedures are life changing for people. When a man walks into our clinic that has lost his entire nose from skin cancer, you get to be part of the team that gives him a nose again. When his wife says, "Wow! That looks better than the nose you had before!" That is why I do what I do. Anyone who works in this industry is very blessed to be part of something so special.

**Q:** What is the most stressful part of your job?

**A:** The most stressful part of my job has been helping to establish a team fit for a growing practice. There are many details to growing a business. When you are in the business of taking care of people, every aspect of what we do is vital to giving the patient the best experience and the best care. Establishing a team within our clinic that pays attention to those small, but important, details as we have grown has been the key to our success. Every patient outcome shows this. Needless to say, the stress has been worth it.

**Q:** Any other fun facts about you that you would like to share?

**A:** Being a young female that wore cowgirl boots growing up and that has always been a fan of hunting and fishing, I never saw myself working in the field of plastic surgery. I would say my perception was definitely wrong about the field. The surgeon I work for has a natural aesthetic and treats his patients as he would treat his own family. We are changing lives, helping our patients feel better about the way they look, and I find that very gratifying. I also enjoy getting to know my colleagues that work in this specialty. Networking in other areas of the country is a piece of my job that is very



## FACIAL PLASTIC TIMES MAY/JUNE 2016

### 2016

#### MAY 7

AAFPRS FUNDRAISER ON THE HUDSON  
New York, NY  
Chair: Edwin F. Williams, III, MD

#### MAY 11-14

8TH WORLD CONGRESS OF FACIAL PLASTIC SURGERY  
Rio de Janeiro, Brazil  
Sponsored by the IFFPSS

#### MAY 18

ESSENTIALS IN FACIAL PLASTIC SURGERY  
Chicago, IL  
Director: Stephen S. Park, MD

#### MAY 18-22

COMBINED OTOLARYNGOLOGY SPRING MEETINGS (COSM)  
Chicago, IL  
Co-chairs: Robert M. Kellman, MD, and Lisa E. Ishii, MD

#### MAY 21

\*HEMANGIOMAS AND VASCULAR ANOMALIES  
Charleston, SC  
Director: Marcelo Hochman, MD

\*ENDORSED BY THE AAFPRS

#### JUNE 23-25

\*AESTHETICA SUPER SYMPOSIUM  
Washington, DC

#### JUNE 25-26

ABFPRS EXAMINATION  
Washington, DC

#### JULY 29-31

\*2016 PORTLAND RHINOPLASTY COURSE  
Portland, OR  
Director: Tom D. Wang, MD

#### OCTOBER 5

AAFPRS COMMITTEE MEETINGS  
Nashville, TN

#### OCTOBER 6-8

FALL MEETING  
Nashville, TN  
Program Director: Phillip R. Langsdon, MD  
Co-chairs: Samuel M. Lam, MD, and Rami Batniji, MD

### 2017

#### MAY 4-7

ADVANCES IN RHINOPLASTY  
Chicago, IL  
Co-chairs: Peter A. Adamson, MD; Sam P. Most, MD; and Oren Friedman, MD

special to me. I am always looking for ways to increase efficiency in the personalized care that we provide. I am honored to be on the OFPSA Board for the sister organization of the AAFPRS.

Thank you to Ms. Berendsen for sharing about herself and her practice. We hope to highlight another OFPSA officer soon. And, we would like to hear your story

too. Please feel free to send me an e-mail anytime at [rachel.hardy@hsc.utah.edu](mailto:rachel.hardy@hsc.utah.edu).

Don't forget to ensure that everyone in your office is a member of OFPSA; the cost is \$175 and covers the whole office for an entire calendar year. To sign up, visit the OFPSA Web site: [www.aafprs.org/ofpsa/become-member](http://www.aafprs.org/ofpsa/become-member). ■

Enclosed in this May/June issue of *Facial Plastic Times* are the Fall Meeting Preliminary Program and FPST Subscription Form.

# VECTRA<sup>HI</sup>

3D: SMART • FAST • SIMPLE



Assess.  
Communicate.  
Document.



VECTRA<sup>XT</sup>



VISIA<sup>®</sup>



Reveal<sup>®</sup>



VEOS<sup>®</sup>



IntelliStudio<sup>®</sup>

IMAGING EXCELLENCE FROM  
 **CANFIELD**

[www.canfieldscientific.com](http://www.canfieldscientific.com) | [info@canfieldsci.com](mailto:info@canfieldsci.com) | phone +1.973.276.0336 | (USA) 800.815.4330

VECTRA, VISIA, Reveal, VEOS, and IntelliStudio are registered trademarks of Canfield Scientific, Inc.