

Facial Plastic TIMES

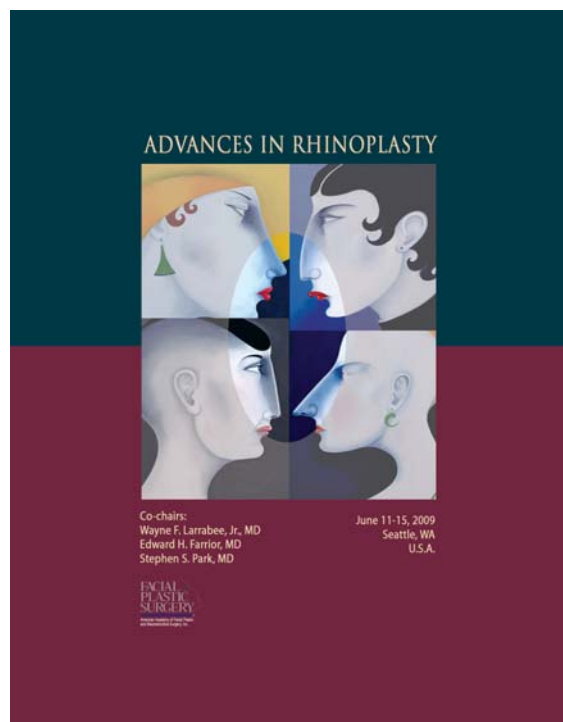
AMERICAN ACADEMY OF FACIAL PLASTIC AND RECONSTRUCTIVE SURGERY, INC.

UNRIVALED PRESENTATIONS AND SCENERY AT RHINOPLASTY COURSE

The AAFPRS Foundation is proud to sponsor *Advances in Rhinoplasty*, June 11-15, 2009, in Seattle. This renowned course is replete with highly skilled faculty from diverse specialties that will provide an enriching and comprehensive experience. Co-chairs Wayne F. Larrabee, Jr., MD; Edward H. Farrior, MD; and Stephen S. Park, MD, have organized a learning experience you will not want to miss.

Experts within their related fields will lead participants from the initial consultation to the management of the most challenging reconstructive rhinoplasty cases via didactic lectures. Attend panel discussions, video presentations, and a cadaver dissection lab for opportunities to interact with distinguished faculty.

On Thursday, panels include the following topics: Nuances of the Consultation; Choreography of a Rhinoplasty: What I do When and Why; Functional Septo-rhinoplasty; and Ask the Experts. Managing the Nasal Tip Skin: The Thick and Thin; the Cleft Lip Nose; and another session of Ask the Experts will be presented on Friday. Saturday panels feature Osteotomies in Rhinoplasty, Ethnic Rhinoplasty, and Pediatric Nasal Surgery. On Sunday, there



are five panels, including Total Nasal Reconstruction; Profile-plasty; Tip Techniques in the Closed Approach; Revision Rhinoplasty; and So You Want to do Rhinoplasty: How I've Been Humbled.

Take advantage of the assembled expertise by submitting your patients' photographs and a brief history prior to the course. This opportunity to receive expert advice is only available to participants that register and submit cases early.

Panel members will review the patient histories and photographs provided by the participants and

See Sounds of Seattle, page 12

DR. ALAM MAKES HISTORY; U.S. FACE TRANSPLANT

Daniel S. Alam, MD, helped make medical history this fall as a member of the Cleveland Clinic's surgical team that performed the first facial transplant in U.S. history. As the team's only facial plastic surgeon, Dr. Alam



was handpicked by Maria Siemionow, MD, the surgical team leader, because of his microvascular expertise and comprehensive training in the head and neck. "This was what my training prepared me for," relates Dr. Alam, a 2002 AAFPRS fellow of Gregory S. Keller, MD. "Although this operation was the culmination of Dr. Siemionow's life's work and five plastic surgeons were already part of the team, she realized the importance of having a microvascular surgeon whose training reflected a mastery of the

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PRESIDENT'S MESSAGE:

Over the past decade, there has been a trend for more physicians to choose to not join or renew their membership in medical organizations: I'll call this "dis-association." Perhaps younger physicians, (dare I say Generation X doctors?) feel even less need for formal peer group associations than their elders. But even the most loyal lifetime members question the value of paying dues in their senior years.

Why? Perhaps more physicians just don't see much value in belonging. Maybe it's the money, especially in a tight economy. Perhaps in the age of increased individualism and independence, we feel more self-sufficient. After all, we practice in an era of dedicated Web sites and personal blogs; we own our own "foundations" and can create our own institutes. We can "associate" with people on FaceBook and Plaxo. Hey, I have my own personal empire; what else do I need?

Forgive the tired political question: Are you better off than you were four years ago? I would paraphrase it to ask: Are you better off than you were before your Academy association?

Question: As facial plastic surgeons, what do we get from the Academy that is unique or valuable?

Education? Well, the number of educational opportunities today has never been greater, whether it comes from seminars or DVDs or on-line offerings. Even commercial companies are offering medical training. Legal representation? I can hire my own whenever I need one. Public Relations? Publicists and public relations firms are plentiful in almost every community. FACE TO FACE: International? Foreign medical trips can be arranged through other organizations, can't they?

So who needs the Academy, anyway? Wouldn't I be just as well off to dis-associate? I mean, I would save all that money...and 2008 was a rough year!

As I take a look back on my Academy association, I see that it has been filled with benefits that, while not on the official list, I will value forever. Like many of you, my "facial career" began with an otolaryngology residency. In addition to my immediate faculty, I first met surgeons like Richard D. Holt, MD; Richard L. Goode, MD; M. Eugene Tardy, Jr., MD; Ted A. Cook, MD, and others. I was encouraged by professors like John "Mac" Hodges, MD, and Charles Gross, MD, to take my training to the next level with a fellowship in facial plastic surgery, since that was my interest. And when E. Gaylon McCollough, MD, accepted me, he became my next mentor, introducing me to talented physicians like Jack R. Anderson, MD; Richard C. Webster, MD; Robert L. Simons, MD; and Norman Orentreich, MD. Here, I met "fellow" fellows; one with a New York accent but a yearning for Big Sky country, and another from Stanford who played Rachmananoff and flew Cessnas for fun. Raymond Konior, MD, and Steven Denenberg, MD, remain good friends.

As I entered practice, hungry for more knowledge, I was introduced to other stalwarts such as the legendary Leslie Bernstein, MD, DDS, and indefatigable Richard D. Farrior, MD. At an aging face meeting in St. Louis in the mid '80s, I was asked to work with Peter A. Adamson, MD; Edwin A. Cortez, MD; Jim C. Denny, MD, and others to build a new examination that would rival the quality of ABMS certification exams. Little did I know about exams, except taking them, but soon I would learn. These associations became the fertile fields where not only exams, but also lifelong friendships, grew. I'll forever remember the graciousness of the late Larry D. Scheonrock, MD, and his wife Diane, chartering

DIS-ASSOCIATION

a bus for an unforgettable winery dinner for the BOD in those early days!

Don't great memories qualify as real benefits?

Step by dogged step, we learned how to build a board certification and examination process. Where else would I have learned this? Soon, I would be associating with other oral examiners of the ABFPRS, striking (some) fear into the minds of those who dared to sit for the examination each June in Washington, D.C. This ritual has continued for 20 years, and now we have 900 board-certified graduates, sort of like our family of really smart people. (It definitely was better to give rather than to receive a message not lost on the examinees.)

Hey, I was feeling better off by this point, as were others.

It was with the Academy that I learned more about the association of business and medicine. Public relations, medical legal, staff development...here I attended my first unforgettable Karen Zupko seminar.

Each committee led to another, and one by one, I met other colleagues making their way in the world. Some were young Turks; and others, more senior, I admired for what they knew and how they seemed to carry themselves. I was associating with some very interesting people.

I had no experience with board meetings, governance, lengthy agendas, and sometimes, super big egos. But over time, I began to understand although tricky, it was possible, with the help of our central office staff, to skillfully manage a diverse surgeon organization with only two meetings and a few conference calls a year.

About 1995, I heard a FACE TO FACE lecture by Lawrence Marentette, MD, who had just returned with a team from war-torn Croatia. Not long after that, I was headed there too, in the

company of Wayne F. Larrabee, MD; Peter A. Hilger, MD; John L. Frodel, MD; and Craig S. Murakami, MD. The best benefit was deepening my friendship with these highly skilled and personable people.

Again, clearly I was better off for my association.

Lest it sounds like everything is beautiful, there have been problems, as well. The ongoing legal challenges that erupt like wildfires from state to state, the attacks on our specialty by miscreants, intra-Academy rivalries and politics, educational meetings with sometimes uneven content, navigating perilous financial waters, and, sadly, issues that occasionally resulted in a colleague losing their membership. These all have to be addressed. I have even learned a bit of law-and-order from our lawyer, Tom Rhodes such as, "Once the toothpaste is out of the tube, its very hard to get it back in."

As I survey the landscape of the Academy, I reflect on how much I have learned not just about the surgical technique and new technology, but just as important, my lessons about people, coping with unexpected challenges, finding solutions, maybe in an early morning board meeting room, or perhaps over a late night beer.

Whether it has been sharing a joke with William E. Silver, MD; eating chili fries with J. Regan Thomas, MD; getting a ski lesson from Jonathan M. Sykes, MD; losing golf balls with Sheldon S. Kabaker, MD; sipping Russian vodka with Ritchie A. Younger, MD; co-chairing a meeting with S. Randolph Waldman, MD, and Wallace K. Dyer, MD; where else could I receive so much from my



associations? My dues did not cover these benefits.

If I had dis-associated, could I have learned, developed, matured as the Lone Ranger without the Academy? Maybe. But I doubt it.

As we look ahead to 2009 and beyond, with whom will you associate? Where will these associations lead? We have a full agenda set for the coming year. We are addressing initiatives that involve wounded veterans,

See Member Benefits, page 7

IN BRIEF

Sam Rizk, MD of New York, was featured in the Concierge 2008-2009 issue of *Avenue: An Ultimate Insiders Guide to Manhattan*. He was noted in the Top Beauty Docs section for neck and face lifts and rhinoplasties.

Michelle R. Yagoda, MD of New York, was featured in the December issue of *Remedy Magazine* in an article called, "Face Facts," and in the September issue of *Elegant Bride* with tricks for the bride for under eye circles and puffiness. ■

PRACTICE TIPS: WHAT TO KNOW WHEN YOU BUY A LASER

By James R. Shire, MD

If you have purchased a laser, IPL, or other machine recently or considering a new purchase, there are a few things you should know other than the technical specifications and functions of the machine. After your research and you have selected the right techno-box, spoken to the sales rep and the sales manager, you have been told what you want to hear, promises have been made, the price has been negotiated, and you now must sign a contract. But not so fast...



Contracts are relatively standard with all companies and are all written for the benefit of the company, not you, the purchaser. We have all heard about reading "the fine print," but it is important to understand what the fine print means to you. Consumers should be aware of the following four areas: governing law clauses; arbitration clauses; additional or inconsistent terms; and limited warranty and claims clauses.

All contracts will have a clause titled, **Governing Law**. This states if there is a problem that requires legal action, it must be filed in a designated venue. Any process or problem that one may encounter is determined by that state's laws. This means that you do not have a practical remedy, and you must play in their ballpark. Any action taken must be filed in the designated state indicated where the laws favor the company and, if the purchaser does not live in or near that state, it would increase the expense and challenge of long distance litigation.

Most contracts today have an **Arbitration Clause**. Arbitration is a hearing with an arbitrator, not a judge, who will decide the case. The arbitrator can be anyone: an attorney, a retired attorney, a businessman, usually selected by the company. Therefore, if you sign an arbitration agreement in a contract, you are giving up your right to sue. You must use the arbitrator as the only remedy for your dispute. What is wrong with arbitration? It can be expensive because you must pay a fee; and the arbitrator, in addition, gets paid by the hour. Arbitrations are in geographical and legal locations that benefit the company. You are less likely to win with an arbitrator.

Another clause in a contract is usually titled, **Additional or Inconsistent Terms**. This clause may contain many pertinent and devious restrictions. As an example, a very common item states that no matter what has been told, implied, guaranteed, or promised to you, if it is not written specifically in the document, it is not binding. For example, let's say you are told that you will get 100,000 flashes from a handpiece, but in reality, the handpiece only maintains its power to 40,000 flashes. Or, you were prom-

ised that this machine was the platform of the future and all improvements and upgrades will be based on that machine, but one year later, a completely new machine, which is not compatible with previous products, is released...too bad!

Limited Warranty and Claims clauses are standard in all contracts but the wording can be deceptive in many incidences. This clause is the extent and timeframe of the warranty. As an example, a company may warrant a handpiece to remain within 10 percent of the manufacturer's specifications for a period of one year from the date of shipment. This means that as long as the handpiece functions (flashes) it does not necessarily have to work (improve pigmentation, wrinkles, redness), as long as it is within 10 percent of the specs. The company must also be notified within a restricted timeframe of delivery of any damages (usually 72 hours). Beware of Friday deliveries. You also may have a limited time allowance (10 days might be the timeline) to determine if the machine is functioning properly. A common phrase is "we disclaim all warranties, expressed or implied, including any warranty of merchantability or fitness for a particular purpose." This means that you will be limited to the terms of any written warranty, which likely will only allow you to seek repair costs and then only for a limited time.

When dealing with most light-based technology, the machines are expensive to purchase. However, the most important aspect of the product is the maintenance agreement. These are always required to maintain the warranty and always very expensive. They can be anywhere from five to 20 percent of the purchase price per year. The maintenance contract is where many companies generate their profits, perhaps more than the profits from the sale of the actual machine. These maintenance contracts must be aggressively negotiated.

These are but a few examples of the most common contract issues that routinely occur. Most importantly, one must always be aware and alert of hidden agendas that may be part of the "boilerplate." While most companies offering lasers and other skin treatment devices are reputable and work hard to offer exciting, therapeutic, and beneficial technologies, this technology comes with a price; and there is a "business side" that we as physicians need to understand. Therefore, when you want a shiny new machine, negotiate price and equipment, but do not forget to negotiate the "standard contract" and bring your attorney always. ■

Disclaimer: The article above expresses the opinions and experiences of the author, and is not meant as a legal document. When making legal business decisions, the reader is advised to seek legal advice that relates to the specifics of his or her own practice.

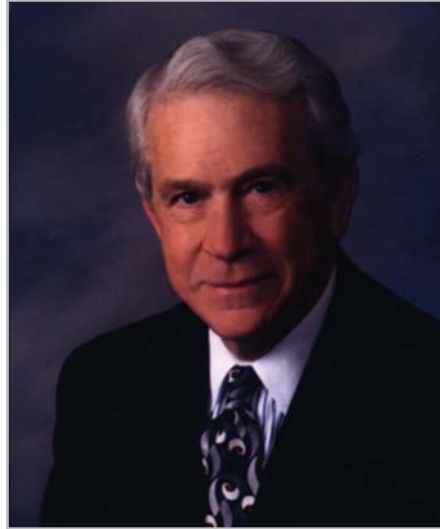
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FACES OF THE ACADEMY: LOUIE PATSEAVOURAS SHARES

This new column, *Faces of the Academy*, was launched in the November/December issue of *Facial Plastic Times*, which featured Howard W. Smith, MD, DMD. In this issue, we are pleased to honor Louie L. Patseavouras, MD, of Greensboro, N.C., for his long and loyal membership, his many contributions to the Academy, and for his leadership over the years.

After obtaining a bachelor's degree in mathematics from the University of North Carolina (UNC) at Chapel Hill, Dr. Patseavouras entered the military where he had his first exposure to medicine in the medical corps of the United States Air Force. Working in the lab doing primarily bacteriology and parasitology, he was exposed to and involved in the care of patients. The physicians at the base saw his interest in the diagnosis and care of patients and encouraged him to attend medical school. Having completed many pre-med courses, Dr. Patseavouras returned to UNC and completed the necessary courses and entered medical school. Upon completion of medical school, he began a post-graduate course in general surgery and after three years in general surgery, he switched to otolaryngology-head and neck surgery. The facial plastic surgery aspect of otolaryngology became the focus of his training. He recalls being greatly influenced by Maurice Cottle, MD, of Chicago, and Irvin Goldman, MD, of New York, whose courses he frequented.

Dr. Patseavoras experienced his first facial plastic surgery meeting as a senior resident. At these meetings, he met many of the "greats" of the day including Richard Webster, MD; Jack Anderson, MD; Leslie Bernstein, MD; and Richard Farrior, MD, just to mention a few, and never stopped attending because of the wealth of informa-



tion that was taught. Fellowships were not available after residency then, but he had the opportunity to visit many of these greats who opened their offices as a learning experience, especially Dr. Webster. Dr. Patseavouras remembers a facial plastic surgery meeting in Palm Beach when at the end of a dinner-dance, Dr. Anderson presented the idea of a fellowship program and enlisted the aid of everyone there for financial support. "I have tried to emulate such leaders by sharing what I have learned with those who sought it," says Dr. Patseavouras.

We asked Dr. Patseavouras the following questions.

Having had many years of experience in practice, what advice would you give the young surgeon on how best to proceed?

The practice of medicine has changed in many ways over the years, technologically and administratively, but for those beginning always remember that it is the patient first. The old axiom "do no harm" means that you have prepared yourself the right way and are capable of executing a plan to achieve the desired outcome. Communication with the patient is paramount in the doctor-patient relationship. Once these are mastered, success follows.

What is the greatest change you have witnessed during your career?

Having begun practice when facial plastic surgery was not fully recognized by many disciplines in medicine and looked upon as a threat to some in similar fields, and having to "fight" the battles on a local level to obtain privileges for facial plastic surgery was a major accomplishment. In the years that followed, those coming out of residences and fellowship programs found it far easier to obtain

Changing the Face of Domestic Violence



▲ Family Service's Julia Nile accepts a \$1500 check from Dr. Louie Patseavouras and his wife Sandy.

What do Botox Cosmetics™ treatments have to do with domestic violence? One local plastic surgeon leveraged the

popularity of Botox to help increase awareness of domestic violence and help its victims last October.

Honoring Domestic Violence Awareness Month, **Patseavouras Center for Plastic & Laser Surgery** donated to Clara House \$50 for every Botox procedure performed during the month of October. These donations totaled \$1500.

"Botox Cosmetics is designed to enhance the appearance of individuals by eliminating lines and wrinkles. We thought that by donating a portion of proceeds to Clara House, we can also enhance the lives of people touched by domestic violence," said Dr. Louie L. Patseavouras, director of the center.

HIS PAST AND HIS ADVICE TO OTHERS

those privileges and now it is a "given." Much is owed to Dr. Anderson and those involved in the legal battles that I feel established the name facial plastic surgery.

What are you most proud of? Outside of the practice that I have developed over 40 years with great patients, much that I feel proud of at this time is the opportunity I have had to serve the Academy. Beginning with the early meetings, I volunteered for committee service and served on many including public relations and ambulatory surgery. My services culminated in being elected vice president of public affairs, which at that time had oversight of over 13 subcommittees. I worked with many chairs that made it a pleasure to serve in my capacity. Most notable during the tenure was the development of new brochures for the Academy. They are still being used and continue to be very profitable for the Academy. It was also at this time we developed the Domestic Violence Program. With the help of Mary Lou DiNardo and her New York marketing firm, the program gained national exposure, placing facial plastic surgery in the limelight. Also, I was privileged to serve the Academy as a representative to the AAAHC for 14 years, during which time I was chair of their Surveyor Training and Education Committee and served on the Executive Committee.

What was your most unusual experience, in or out of the practice of facial surgery?

The practice of facial plastic surgery has provided many memorable experiences. But experiences outside medicine in community involvement have been exceptionally rewarding. My involvement has included the Arts Council (having received the local *O'Henry Award* for this service), chairing the restoration of a historical theatre, teaching the waltz to the Greensboro

Symphony debutants, serving on the opera board, performing with the Greensboro Ballet in the Nutcracker, and ringing the Christmas bell for the Salvation Army. In addition, I owned and operated a kiddie ferris wheel and miniature train for local charities for 20 years. Community leadership roles demonstrate a deeper interest in our fellowman and cultivates trust. Our strength as a group lies in exemplifying public service. I encourage you to become involved.

What is the biggest challenge that our specialty has today? Our specialty today should continue the leadership role that it has established over the years. Strength is not always in numbers but in quality, which is what facial plastic surgery is all about.

Thank you to Dr. Patseavouras for taking the time to speak with us and we wish him the continued success for the coming years. ■

▶ DR. PATSEAVOURAS OWNED AND OPERATED A KIDDIE FERRIS WHEEL AND MINIATURE TRAIN THAT WAS USED FOR LOCAL CHARITIES.



▲ DR. PATSEAVOURAS AND WIFE, SANDY, TAKE TIME TO PARTAKE IN COMMUNITY ACTIVITIES. THE PHOTO ABOVE SHOWS THEIR PARTICIPATION IN THE NUTCRACKER WITH THE GREENSBORO BALLET.



MEMBER BENEFITS, NEW INITIATIVES

From President's Message, page 3 increased member benefits, enhanced educational opportunities, medical malpractice rate analysis, the ongoing bewildering world of aesthetic providers, an expanded international presence, and more.

We will achieve little as individuals or by dis-association. We must do this together. You. Me. Us. Especially during these times.

So I ask you, will you be better

off with or without the Academy this next year?

Not sure where to put your talents? Contact the Academy office in Virginia at (703) 299-9291 or e-mail me directly at DonnChathamMD@mindspring.com. Let's make some history together.

This year, let's associate!

Donn R. Chatham, MD

Donn R. Chatham, MD

DO'S AND DON'TS: WHY AND HOW INTERNET MARKETING

By Andrew Burchard, MD

Perhaps you are an established

facial plastic surgeon who is considering updating and improving your

current Web site. Maybe you are a young facial plastic surgeon who is designing a Web site to develop your practice and showcase your talents. In either case, one question is inevitably asked: "How do I get people to visit my Web site?" The key to increasing traffic to your Web site lies in understanding how search engines work and the concept of search engine optimization.

Although there are many search engines available on the Internet today, one of the most widely used is Google. For the sake of brevity, the following discussion will focus on Google's search engine design.

How Web sites appear on Google

There are three avenues for a Web site to appear on Google's search results when an Internet user performs a Google search. The first avenue is as a paid advertisement. A Web site owner pays Google a fixed monthly fee to constantly display their site as an advertisement when certain specified key words are entered (e.g., facial plastic surgeon and New York). The site will appear at the top of or along the right hand side of the Google search Web page specified as a *Sponsored Link*. Typical costs vary depending on the popularity of the specific key words selected. This represents the most expensive method of appearing on Google.

The second avenue is called pay-per-click. A Web site owner pays Google a fixed amount each time period (e.g., day, week, or month) determined by the Web site owner creating an account



balance. Google then includes the site as a *Sponsored Link* when specific key words are entered. When an Internet user clicks on the *Sponsored Link*, the Web site owner will be charged a fee.

Based on the economic theory of supply and demand, it is not surprising that more popular key words, such as "plastic surgery" and "surgeon" cost more than less popular key words. Once the Web site owner's balance for a given timeframe is used, the link is removed until the balance is renewed. This allows site owners to better control costs while still appearing as a *Sponsored Link*.

The third and most common avenue is through Google's standard search. Google performs an algorithmic search to identify the Web pages most relevant to the Internet user's search terms. This is provided free of charge and includes any Web page on the Internet.

How Google searches the Internet

It is well known that the higher a Web page appears on Google's search list, the more likely it is to be visited by an Internet user. So, how do you get your site to appear higher on Google's search list without paying for expensive Internet advertising? The answer to this question lies in understanding how Google performs its search.

When an Internet user performs a search, computer programs check the Google index to determine the most relevant search results. Three distinct processes create the Google index. The first process is called crawling. A program appropriately called Googlebot fetches or crawls billions of pages on the Internet to find new or updated pages to be added to the Google index and uses an algorithmic process to assess them. The crawl process begins with a list of Web page addresses from previous crawls, in addition to the data provided by the Web site owners' sitemaps.

Googlebot visits each site, detects links on each page, and adds them to the list of pages to crawl. New sites, changes to existing sites, and dead links are all used to update the Google index. It is important to note that this process is not affected by paid advertising with Google.

The second process is called indexing. Googlebot processes each of the Web pages it crawls to compile a massive index of all the words it sees and their location on each page. It is able to process most, but not all, content types. For example, text within images or dynamic Web pages are not processed, and therefore, not included in the Google index.

The third process is called serving results. The Internet user enters key words to search, and Google searches its index for matching pages and returns the most relevant results. Search relevancy is determined by over 200 factors. For example, page rank for a specific Web page is a measure of the importance of a Web page based on incoming links from other Web pages. Each link to a Web page on your site from another site adds to the rank of your Web page. Google attempts to improve its users' experience by identifying spam links and practices that negatively impact search results. Sites that utilize such techniques risk being blacklisted by Google, and subsequently blocked from appearing on any Google searches.

Search engine optimization

Obviously, it is extremely important to make sure that search engines can crawl and index your site correctly to rank well in search results. Search engine optimization (SEO) is the best technique to accomplish these goals. SEO can be performed by consultants who are hired for optimization projects on behalf of a client or by employees in your practice with Internet webmaster experience.

There are certain guidelines recommended by Google to ensure that your Web site is properly found, indexed, and ranked. When designing your Web site, make sure it has a clear hierarchy and text links. Offer a sitemap to your users with links to the important parts of your Web site. Create a useful, information rich Web site. Anticipate the words users would type to find your Web page and make sure that your Web site utilizes these words. Use text instead of images to display important names, content, and links as Google does not recognize text contained within images. Keep your Web site current with frequent updates. This will not only improve your ranking with Google, but also give your patients a reason to consistently visit the site. Further technical and quality guidelines are also recommended and are described in detail on Google's Web site, but they are beyond the scope of this article.

Internet marketing is becoming an increasingly important tool to reach your patient base. Understanding how search engines, such as Google, are designed will assist you in developing an effective Web site that will allow you to reach a wider share of the market in your practice area. SEO is a technique that will ensure that you create a search engine friendly site as a means to that end. ■

The information in this article was obtained from Google's Webmaster Help Page (www.google.com/support/webmasters). Please visit this sight for further information.

If you have a specific subject matter or topic that you would like addressed in this column, please e-mail Rita Chua Magness at the AAFPRS office: rcmagness@aafprs.org.

PR COLUMN: A NEW YEAR, NEW BUSINESS, NEW YOU

As celebrated American author and scientist Isaac Asimov said, "The only constant is change, continuing change, inevitable change; that is the dominant factor in society today. No sensible decision can be made any longer without taking into account not only the world as it is, but the world as it will be." Like everyone else in the world, each and every member of the AAFPRS has experienced the recent tides of change. Now, it is more important than ever to work together to raise awareness among the media and consumers about the latest news and information in facial plastic surgery and the importance of trusting your face to a facial plastic surgeon.

In January, AAFPRS members will be sent the annual trend survey, and we are counting on you to help strengthen our collective message. As the Academy is compiling its 2008 Statistics on Trends in Facial Plastic Surgery, we are looking to you to provide information about trends and unique findings that will distinguish the Academy from the rest of the organizations vying for the media's attention. With compelling statistics and newsworthy patient stories, we will increase our chances of securing media coverage, and ultimately, leading patients to your practice.

During the first quarter of 2009, we will continue our multimedia public relations campaign with the key message of *Trust Your Face to a Facial Plastic Surgeon*. As part of the program, we developed a multimedia news release (MNR), an interactive news release with video, audio, still images and text, as well as a physician locator offering, which will be distributed globally to thousands of top national broadcast, print and on-line media, including influential social networks and consumers.

The rest of 2009 is packed with several exciting AAFPRS news and events, including the FACE TO FACE trip to China, the Winter Symposium in January, the *Advances in Rhinoplasty* in June, the annual Fall Meeting in October, and the release of the updated *Face Book*. These markers of growth and success indicate a promising and exciting year for the Academy and its members.

If you are contacted by the media, we encourage you to keep the AAFPRS key message points and activities top-of-mind, particularly during these times when consumers are tightening their belts and scrutinizing every penny they spend. As an expert in your field, it is important to convey confidence in your practice, treatment offerings, and the intrinsic restorative properties of both cosmetic and reconstructive surgery.

As always, Behrman Communications will work tirelessly to pique media interest, position the AAFPRS as the authority when it comes to facial plastic and reconstructive surgery, and keep prospective patients knocking on your doors. ■

NOMINATIONS DUE FEBRUARY 1, 2009

The deadline for nominations for the Academy awards is fast approaching. Nominate your colleagues for the following awards: William K. Wright Award, Community Service Award, F. Mark Rafaty Memorial, and John Dickinson Teacher Award.

Visit the AAFPRS Web site: www.aafprs.org/physician/awards_grants/awards_nom.pdf. Complete the form and fax it to Michelle Busey at (703) 299-8898.

TRAINING AND FOCUS LEAD TO A SUCCESSFUL LIFE-GIVING

From Cover Story, page 1
facial skeleton and soft tissue areas of the head and neck. She had to fight to get me on this team, but in the end, having a head and neck microvascular surgeon became a matter of necessity," Dr. Alam says.

The Cleveland Clinic's facial transplant team trained together for months to perfect this procedure, but Dr. Alam wrote the actual protocol for the facial transplant operation while he was attending the AAFPRS Fall Meeting in Chicago. "I was writing the protocol while I was at the Palmer House attending meetings and courses. Ironically, not long after I finished the protocol and returned from Chicago, the call came through that a perfect donor match had been found for our patient." The 23-hour ground breaking surgery was about to begin.

"Before the actual transplant could be performed, our first responsibility was to ensure that the patient had enough healthy blood vessels to be able to sustain the transplant. Because she had had previous reconstructive surgeries that did not yield significant results, there was a lot of scarring. After using a cat scan blood vessel map, we were able to find critical blood vessels necessary to ensure tissue survival. The entire team was excited, optimistic, and ready to move on to the next phase," says Dr. Alam.

"It was time to bring down the donor and we were ready and well prepared," he confides. "But when the moment comes to put all your planning and your expertise into the procedure itself, adrenaline courses through your veins and it's hard to calm down. I found myself thinking, once more, about what it meant to the donor's family to surrender their loved one's face. Could I do that? Before the first incision was made, the magnitude of the donor's gift set

in again," he confesses. "Then I thought of our patient and what this donor's face would mean to her. She was counting on us," Dr. Alam stresses.

Dr. Alam and the surgical team



DR. DANIEL ALAM, PICTURED ON THE RIGHT, AT THE CLEVELAND CLINIC DURING THE FIRST FACIAL TRANSPLANT IN U.S. HISTORY, ASSISTED BY DR. ROBERT LOHMAN, ALSO A MEMBER OF THE TEAM, WHO IS PICTURED ON THE LEFT.

divided into halves. Dr. Alam's half of the team began the difficult task of donor procurement and the other half remained with the patient to continue the preparatory work necessary for the patient to receive the transplant. Dr. Alam did all the soft tissue dissection and microvascular work for the procurement while Frank Papay, MD, Plastic Surgery Chief at the Cleveland Clinic, did all the bone cuts and eventual bone plating. Procurement for this procedure even included the bony palate. "Since the surgical rooms for the donor and the patient were side by side, both teams spent the next nine hours crossing between the two rooms and working together to utilize each surgeon's unique expertise to the individual procedure," Dr. Alam says. "Because this near full face transplant included extensive bony framework in addition to massive soft tissue transfer, everyone's expertise shaped its final form," he adds.

After Dr. Alam neared completion for the vessel dissection, the

team finished the necessary bone cuts to free the face from the donor. Dr. Alam stressed the spirituality of the moment. "As the final blood vessels were tied, the face took on a ghostly quality and it turned ashen gray. I placed a surgical towel over the face and carried it over to the recipient patient's operating suite."

The team was now working within a very limited time frame to complete the operation before the tissue became nonviable. "There were five security guards outside the door," Dr. Alam relays. "It was a surreal atmosphere and we all knew that time was precious." Dr. Alam turned the face over to the craniofacial team to begin fitting it into the patient's existing

skeletal structure. He was able to snatch about an hour's worth of rest, but he knew that the ultimate success of the surgery depended upon what was about to happen in the next phase.

"The craniofacial team finished with their inset and I started sewing vessels together. I had to sew the vessels together perfectly with suture much finer than human hair. In microvascular operations such as this, the integrity of these vessels would ultimately determine the survival of the transplanted face," Dr. Alam states.

Needless to say, Dr. Alam and the team retained their intense focus in the remaining hours of the surgery and the primary vessels were sutured. "I was again struck by the spirituality of this watershed moment," he admits. "The time had come to release the clamps on the blood vessels that had restricted the blood flow until we had completed our work. In fact, the photo (above) at the beginning of this article was taken just before the magical moment the clamps were

released," Dr. Alam adds. "I opened the clamp and watched as the blood coursed through the vessels. The face that had been ashen gray became pink. You could actually see life coming back to transform the donor's face into a new face for this deserving recipient. It was a humbling moment."

The surgery has been over for weeks now and Dr. Alam confides that the patient is doing extremely well. The surgical team is excited about their patient's chance to get her life back after it had been so cruelly altered. "I have performed 400 facial reconstructions," Dr. Alam mentions, "but nothing is ever perfect or virginal about a reconstruction. You can always tell that a face has been altered after extensive reconstructive work has been performed. With a transplant, it's different. Transplants have the potential to make people feel and look more normal. For complex structures like our lips and nose, facial transplants look better than anything we could reconstruct. I just hope the current economic realities don't outweigh the potential to offer this life giving procedure in the future," he concludes.

Dr. Alam went to medical school at Johns Hopkins University School of Medicine in Baltimore and completed his otolaryngology residency at Harvard University in Boston in 2001. Dr. Alam continued his medical training via an AAFPRS fellowship with Dr. Keller at UCLA in 2002. Dr. Alam was the winner of the ABFPRS *Jack Anderson Prize*, awarded for achieving the highest score on the 2002 ABFPRS examination, and he attained ABFPRS certification in 2005. He is currently Head of the Section of Facial Aesthetic and Reconstructive Surgery in the Head and Neck Institute of the Cleveland Clinic and is an AAFPRS Fellowship Director of Facial Plastic Surgery at the same institution. ■

NEW BROCHURE SHOWCASES LIP ENHANCEMENT OPTIONS

After months of anticipation, the Lip Enhancement brochure is now available to add to your display of patient education brochures. Beautifully illustrated with comprehensive text, this brochure will answer questions, clarify doubts, and compel patients to obtain treatment. Written by Publications Committee chair Terry L. Donat, MD, the brochure covers types of enhancements, understanding the procedures, deciding on a type of enhancement, and what to expect after treatment.

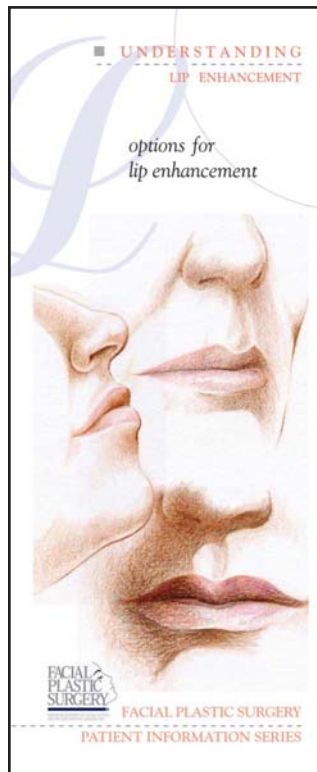
The brochure has a strong emphasis on lip augmentation; however, lip reduction is also mentioned in reference to congenital deformity, illness, trauma, or prominence associated with ethnicity. Patients will feel at ease

after reading through *Understanding Lip Enhancement*. "While there are a number of minimally invasive techniques and treatments available, the potential patient is assured that they can trust their face to a facial plastic surgeon to provide expert advice and guidance in deciding on a specific treatment," says Dr. Donat. Available options are safe, successful, and performed in a private setting.

Making a Decision for a Specific Therapy highlights the evolution of materials and techniques for augmenting the lips, while also stating that preferences for specific materials will vary between surgeons. Common injectable and permanent fillers are discussed with advantages and techniques presented.

What to Expect After Treatment, is very important to the patient. They want to know the side effects, details of the recovery, and when they can resume normal activities.

Order your copies by contacting the Academy's Publications Department at (703) 299-9291, ext. 234 or by completing the form below. ■



The adjacent article on Dr. Alam was written by Laurie Wirth, Executive Director of the American Board of Facial Plastic and Reconstructive Surgery.

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SOUNDS AND WONDERS OF SEATTLE

From Cover Story, page 1

then share these cases via Ask the Experts. These case evaluations will reinforce information presented during the didactic sessions.

Rhinoplasty video presentations will be offered throughout the course at the Academy's Video Learning Center. The featured surgeon will be available after each viewing to further discuss the surgery and answer any questions. This is another example of how the course co-chairs have ensured that attendees have every possible opportunity to interact with the faculty.

A dissection course will be offered on Monday, June 15. Raymond D. Cook, MD; Edward W. Chang, MD; and Samuel P. Most, MD, will be coordinating the lab with all faculty invited to participate. Attendees will benefit from supervised hands-on experience.

While there, take time to visit this amazing city. Sheraton Seattle will be our host and guests will enjoy magnificent views of the city and access to all the best sights and sounds of Seattle. You and your family must take in the panorama from the world-



famous Space Needle. Another must-see site is the Pike Place Market. It is the oldest continually operating farmers market in the nation and boasts a splendid variety of seafood and produce stalls, restaurants, crafts, and international foods. Take a stroll along the waterfront for shops, restaurants, excursion boats, and maritime sightseeing. You can also check out the Aquarium and Odyssey Maritime Discovery Center. Extend your stay to visit one of the 35 wineries in the Puget Sound Region or walk through Olympic Sculpture Park, where visitors can enjoy art outdoors and views of the Olympic Mountains, Puget Sound, and Seattle's cityscape.

We hope to see you and your families in Seattle for this bi-annual course. Please see the enclosed brochure and turn in your registration today. ■



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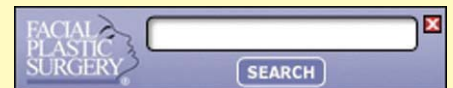


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The AAFPRS Web site has a Physicians Buyers Guide that keeps growing. Make sure you utilize this guide when making purchases for your practice.

It takes just seconds to download a helpful search window from the directory.

Simply access the directory's main search page online [Hyperlink to page]. You'll note that there is a selection of titles in the band just below the main directory title banner and directly above the search window criteria. These titles include *Add or Edit Your Listing*, *Desktop Search* and *Create RFI* from left to right. Click on the words *Desktop Search*. This will take you to an instruction page. The page offers two quick ways to download the search window: you can either click on the words *Download Setup*, the picture of the desktop search window, or the words *Get Started Now*. The toolbar will load directly to your computer giving you instant, one-click access to the Vendor Guide and the association Web site at any time--even if you are not logged on to an Internet browser.

The small, noninvasive, search window is there on your desktop whenever you need to perform your targeted search, and it is easily removable at any time. ■

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FACE TO FACE MISSION TO LINYI, CHINA

By Albert J. Fox, MD

FACE TO FACE recently traveled to Linyi People's Hospital in Linyi, China. This hospital is located in Southern China, approximately 500 miles south of Beijing. The mission to Linyi has allowed our FACE TO FACE members to share knowledge with local surgeons and to help the people of Linyi. It was a successful surgical and educational mission. Participants in the mission included John M. Hodges, MD (Memphis); Scott A. Tatum, MD (Syracuse, NY); Shan R. Baker, MD (Michigan), Albert J. Fox, MD (Dartmouth, MA); Mark Hamilton, MD (Indianapolis); Philip Young, MD (Seattle); William H. Truswell, MD (Northampton, MA); and Laura Ziegler, MD (Philadelphia).

Our host physicians included Dr. Chen Guanping and Dr. Ma from Linyi Hospital. Our mission included participating in the First International Yemen Symposium for Head and Neck, Maxillofacial & Plastic Surgery. Our surgeons provided lectures to over 100 local and visiting surgeons from around China. Physicians from the departments of oral and maxillofacial surgery, department of otolaryngology, and the department of plastic surgery participated in the lectures, creating a truly multi-disciplinary conference.

The people of Linyi have made great strides. The People's Hospital of Linyi is transforming into a more modern hospital. A new 26-story building has been built to accommodate their population and the ever increasing need for medical care. With this modernization has come a need for more knowledge and expertise. The People's Hospital of Linyi has made a strong effort to invite groups like FACE TO FACE to help provide the expertise needed for the best possible care for members of their community.

Upon arrival to Linyi Hospital,

we evaluated several patients. Many of the patients had cleft nasal deformity, congenital nasal deformity, scars, as well as cleft lip and palate. We also had a patient with aging face changes. We were able to perform cleft rhinoplasty, cleft lip and palate repair, fistula repair, scar revision, as well as blepharoplasty and a trichophytic brow lift.

Performing surgery in a foreign country and hospital can be very challenging. The hospital resources were limited. We mixed our own lidocaine and epinephrine for local injections. We made our own nasal vasoconstrictors with epinephrine and saline. The OR staff of Linyi Hospital was extremely helpful, kind, and gracious.

Our patients did not have hospital gowns; many wore the same clothes day after day. They were placed under anesthesia in their full clothing, draped, and after surgery taken to the recovery area.

During this FACE TO FACE mission, I am reminded that we have a lot to be thankful for here in the United States. While our medical system and providing care for our citizens is not perfect, I feel we are fortunate for the easy access to excellent equipment, the variety of specialists, and the overall high quality of care and cleanliness we are able to provide our patients.



As a group of physicians from different surgical backgrounds, we are not only teaching the surgeons in Linyi, but we were also learning from them. There was a great sense of camaraderie and many new friendships were made both here and abroad.

While traveling to China and to our final destination in Linyi,



PICTURED HERE ARE THE FACE TO FACE TEAM WITH LINYI PHYSICIANS. ▲

we were able to enjoy the beauty and marvels of such a vast country. Our team toured the Great Wall and visited China's many treasures such as the Forbidden City. We were also fortunate to visit the Olympic Village with its famous Bird's Nest stadium. We took a gondola ride and hike to Taishan Mountain, the home of Confucius.

As a group, we would like to thank Dr. Hodges for helping to organize this mission to Linyi. It is his dedication and devotion throughout the years that has made FACE TO FACE the success that it is today. I encourage all members to participate in our Academy's humanitarian programs. The reward of giving of yourself, to share your knowledge and to share your skills is immeasurable. The sharing of knowledge benefits everyone, to make our world a better place, one patient at a time. ■

◀ SCOTT A. TATUM, MD, WITH CLEFT LIP PATIENT.

MESSAGE FROM THE MEDICAL EDITOR: CME CHANGES

By David Reiter, MD, DMD, Medical Editor, *Facial Plastic Times*

The Accreditation Council for Continuing Medical Education (ACCME) has revamped its requirements for accredited programs, and the implications are far reaching for us all. In combination with a growing number of states that require continuing medical education (CME) for continued licensure, the new ACCME standards will mandate change in the way we get and use CME if we wish to remain licensed physicians.



The ACCME has defined three essential areas in CME:

- 1) purpose and mission
- 2) educational planning
- 3) evaluation and improvement.

New and critical elements of these areas include clear definition of the "expected results of the program," use of needs assessment data to plan the program, evaluation of the effectiveness of the program in meeting the identified needs, and achieving the expected results. It will now be necessary to show a "change [in] competence, performance, or patient outcomes" as a result of participation in a CME program in order to qualify for credit. This means that accredited CME providers will have to "...[gather] data and [conduct] a program-based analysis on the degree to which the CME mission of the provider has been met through the conduct of CME activities interventions." It will no longer be sufficient to attend Grand Rounds and take a few simple courses at an Academy meeting in order to meet CME requirements. It will be necessary to demonstrate a positive change in our behavior and outcomes as a result of the activity in order to qualify for CME credit.

ACCME is more clear on how they think the above can be

achieved than they are on overcoming the practical obstacles to doing so, to wit:

"[The provider of CME will incorporate] the learner's needs into assignment (needs can be practice, individual, community or population based). Needs (topics to be reviewed or learned) are derived from an assessment of current practice—using identified performance measures. Participating physicians are actively involved in data collection and analysis."

"[To measure the effectiveness of the activity,] the learner summarizes all practice, process and outcome changes that resulted from conducting the performance improvement activity."

The adoption of electronic medical records will greatly enhance the ability of most physicians to meet CME requirements by enabling activities such as those described immediately above. But most of us are far from being able to do these things today. Yet the new CME standards will apply within two years, unless they are modified or the deadline pushed back.

ACCME continues to support their already-defined "learner centered approach" to CME, which holds as its basic principle that "...'What the learner does' will vary across the various formats but in each there is a 'learning project' that is the basis for an 'activity,' similar to the activity built around a journal article that develops into a journal-based continuing medical education activity." In other words, everything we do for CME will have to be structured as a project, with a goal, a plan for improvement, and a measurement system to document achievement. These quotes from the ACCME document *New Formats in Continuing Medical Education* are perhaps less clear and concise than we would like—but they are the words of the organization that enables us to receive

CME credit, so we'd best know and understand them (insofar as that is possible). From discussions with my colleagues on committees and medical school faculties, it seems clear that ACCME is feeling its way through this time of change; the vagueness we perceive reflects uncertainty on all parts.

Accredited CME providers can now designate credit for "Internet searching and learning, test item writing, manuscript review, and performance improvement activities, in addition to live activities (including some committee work), enduring materials and journal based continuing medical education." So it should still be possible to earn CME credit from solitary activity, if that activity has sufficient structure and pre-post performance measurement to show improvement as a result of having participated. ACCME offers a framework for journal-based CME that includes:

- The reading of an article (or adapted formats for special needs)
- A provider stipulated/learner directed phase [that may include reflection, discussion, or debate about the material contained in the article(s)]
- The completion by the learner of a pre-determined set of questions or tasks relating to the content of the material as part of the learning process

So there are avenues to CME that remain accessible to us with some imagination and more than a modicum of hard work. Will this make us better doctors? I firmly believe it will. But it will have to be accomplished in a way that is both affordable to and adoptable by busy practicing doctors whose budgets are being strained by the economic realities of the early 21st century. We cannot and should not resist adoption of the laudable goals of the ACCME. But we must remain actively involved in the planning and implementation processes to comply with the new regulations. ■

VACCINE FOR INTERNET LIBEL: A SOLUTION

When the Internet exploded, few anticipated how it would be used. Emerging as one of the fastest growing healthcare applications is doctor bashing or—as it is euphemistically described—physician ratings.

If done properly, what harm could there be in letting the ultimate "customer," the patient, describe their experience? To start, healthcare is not the same as buying a toaster. While many treatments can be reduced to reproducible processes, care is, more often than not, complex. In addition, physicians are bound by state confidentiality laws and HIPAA to hold their tongue. Physicians are forbidden from defending against reputational assaults by posting the medical record as a correction. Finally, most of the ratings sites have a handful of posts per physician. This sampling lacks statistical significance and is not actionable.

General ratings sites, such as www.ratemds.com and www.vitals.com, allow individuals to vent anonymously. There is no quality control and it is impossible to tell if the rater is a patient, a disgruntled employee, an ex-spouse, or a competitor. Further, even positive ratings have limited utility; the glowing comments might be the anonymous prose of the physician himself.

Such anonymity makes it very difficult to identify and then sue the poster for defamation. Under traditional legal principles, one who is defamed can sue not only the originator of the libelous comments, but also the distributor—such as a newspaper or a television station. Using that analogy, another natural target would be the digital distributor, the Internet Service Provider. But, in 1996, Congress foreclosed that option by granting broad immunity to Internet Service Providers for the tort of defamation. In

general, physicians have few practical after-the-fact remedies against Internet assaults on their reputation.

Here is the good news. There is a solution. Since 2002, Medical Justice (www.medicaljustice.com) has worked to keep physicians from being sued for frivolous reasons. In 2007, the company launched its Web Anti-Defamation Program as a value added service for its members.

The service is a three step program.

1) Step one is a "reputational vaccine." Patients, when first seen, are asked to sign a copyright-protected contract of mutual privacy. Plan members are licensed to use this document in their patient intake forms. The patient and the doctor agree to maintain reasonable confidences. Doctors grant additional privacy protections to patients above and beyond that mandated by law. For the patient, they are foreclosed from postings on the Web about the doctor's care without the doctor's permission. This system is maximally effective if implemented as a matter of policy for most, if not all, patients. Patients are free to discuss their care with other doctors, family, friends, licensing boards, attorneys, etc. The Internet and broadcast media are the only limitations.

Will patients sign such agreements? Yes. Patients sign agreements all the time. Most patients are interested in one thing, getting better. So, for most patients, preserving the right to vent in public is less important than good health. And for the few patients who must retain their right to defame, if they have no interest in participating in a meeting of the minds, feel free to refer them to your competitor.

2) Step two warns rating sites against interfering with pre-existing contracts. The program proactively notifies various physician rating sites which plan members are licensed to use the

agreements. This notification is done on a regular basis. The service provides continued value to plan members by increasing the effectiveness of the "vaccine."

3) Step three actively searches physician rating sites. This automated service queries the various physician rating sites to verify that sites are not allowing posts on plan member physicians.

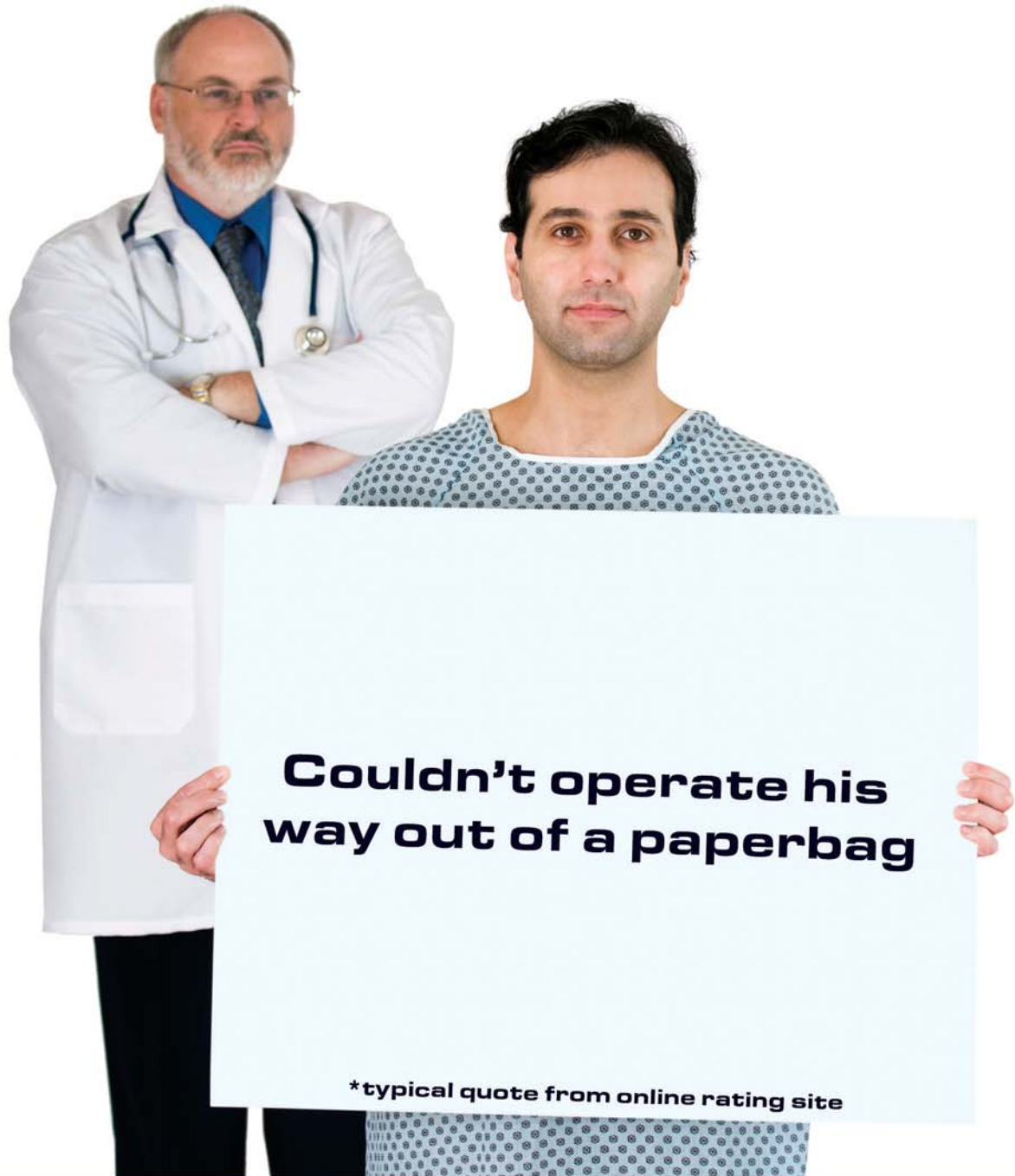
Over the next decade, physicians will likely be held accountable on measures that matter; for example, infection rates, mortality, and length of time to return to work. One challenge, among many, is normalizing the risk of different patients to make such measures meaningful. And when we understand how to define true outcomes, talented physicians will welcome being graded fairly. The current crop of physician ratings sites are a step backwards for that noble goal. And, for now, this is a better solution than just putting your head in the ground and hoping for the best.

Medical Justice is offering dues paying AAFPRS members its Anti-Defamation Program at no cost for one year. To protect your on-line reputation for free for one year, go to www.medicaljustice.com/anti-defamation-trial.aspx and enter promo code: AAFPRS. ■

MEMBERSHIP DIRECTORY

The AAFPRS 2009 *Membership Directory* was mailed to all members in late December. If you would like to order an extra copy for your front office, please contact Michelle Busey at the AAFPRS office either by phone at (703) 299-9291, ext. 234 or by e-mail at mbusey@aafprs.org. Each copy is \$30 for AAFPRS members.

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AMA REPORT: RESIDENT AND FELLOW SECTION

By Scott Chaiet, MD, AMA RFS Delegate

The Resident and Fellow Section (RFS) of the American Medical Association (AMA) held its interim meeting in Orlando last month in conjunction with the Interim 2008 House of Delegates. I was privileged to serve our American Academy of Facial Plastic and Reconstructive Surgery again at this meeting as its delegate to the RFS. The section elected a chair-elect and endorsed nominees for Board of Trustee and council members, as well as 13 other items of business.



The RFS debated seven resolutions and six reports in Orlando. One resolution and one report were forwarded immediately to the House of Delegates (HOD).

Those worthy of mention affecting facial plastic and reconstructive surgery, otolaryngology, and the interim HOD include:

- RFS Resolution 6 - Eliminating personal questions from the

- residency and fellowship process. This would include questions regarding marital status, dependents, plans for marriage or children, sexual orientation, and religion. Since current House policy exists against these questions, but ample testimony showed their persistence, the resolution was amended to work with interested parties to eliminate potentially inappropriate questions, with a report back in January 2009.

- RFS Resolution 5 (HOD 842) - Affirming radiation oncology is not an ancillary service as it is currently designated in the Stark Laws. The resolution was immediately forwarded for consideration and the resolution was referred for decision.

- RFS Report H (HOD 610) - Compared and contrasted president-elect Obama's health care plan to the AMA plan, finding language absent in AMA policy on requiring health care for children. This was brought to the house and adopted as amended.

- Other RFS resolutions that were debated dealt with interoperability of medical devices, membership issues of U.S. citizens studying abroad, mentoring

- of RFS members, calorie labeling in restaurants, and a resident bill of rights. Other RFS reports include Sunsetting Resolutions, Credentialing of Physicians with Transfers During Residency, Expanding Minority Voices in the RFS, and Bylaws Changes for Updating Voting Mechanisms for Sectional Delegates.

The House also debated two resolutions and two reports sent earlier by the RFS:

- Resolution 822 - Recognizing the adverse effects of defensive medicine (Reaffirmed)

- Resolution 914 - Patient prescriptions labeling (adopted!)

- CME Report 4 - Securing medicare CME funding for research and ambulatory non-hospital-based outside rotations during residency (adopted as amended)

- CME Report 5 - Use of at-home call by residency programs (adopted as amended)

I look forward to representing the specialty in Chicago at the annual RFS meeting, at which time we will be conducting elections for our Governing Council and presenting our new resolutions to the House of Delegates. ■

Six Years Later and the Foundation's Bottom Line is Healthier ... Thanks to Dr. Ira Papel

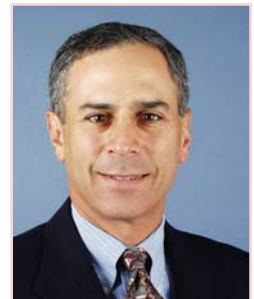
Ira D. Papel, MD, authored the second edition of *Facial Plastic and Reconstructive Surgery* published by Thieme Medical Publishers in New York.

In the summer of 2002, when the book first went to press, Dr. Papel decided to donate any royalties he received under authorship to the AAFPRS Foundation.

Six years later, the Educational Publications Department (a part of the Foundation) is \$40,000 stronger, thanks to Dr. Papel.

The encyclopedic book contains full coverage of topics including endoscopic surgery, microvascular reconstruction, laser resurfacing, and a special chapter on ethics in facial plastic surgery. The book has more than 1,800 illustrations and nearly 1,000 pages of referenced text. It is an excellent study guide for residents and fellows preparing for exams, as well as an essential clinical reference for informed facial plastic surgeons.

The book has gone back to print since its first release. You may order your copy by contacting Thieme Medical Publishers directly at (212) 760-0888 or 1-(800) 782-3488; www.thieme.com.



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NEW DVDS

The AAFPRS Foundation is pleased to announce the addition of three new DVDs to our John Dickinson Memorial Library. The otoplasty and browlift DVDs are authored and generously donated by Peter A. Adamson, MD of Toronto, ON, Canada. The DVD on cleft is authored by Jonathan M. Sykes, MD of Sacramento.

To purchase these DVDs, please complete the form below.

Cosmetic Otoplasty by Peter A. Adamson, MD (R/T: 35:00; Cat. #905). This video illustrates a well-established technique for correction of the congenitally protruding ear in a middle-aged woman. The procedure consists of a Furnas setback of the prominent conchal bowl by excision of post-auricular soft tissue. Unfurling of the antihelix is corrected utilizing horizontal mattress sutures according to the Mustarde technique.

Direct Browlift by Peter A. Adamson, MD (R/T: 45:00; Cat. #215). This video illustrates the use of the direct browlift to elevate ptotic brows in a middle-aged man who by choice has a shaven head. The technique employed includes excision of super-brow skin, fixation of the orbicularis muscle to the periosteum, and vertical mattress suture closure. The finer details of the technique and results are shown.

Unilateral Cleft Lip Repair and Tip Rhinoplasty by Jonathan M. Sykes, MD (R/T: 48:00; Cat. #1227). Dr. Sykes performs a unilateral cleft lip repair using a modified Millard technique with tip rhinoplasty on a three-month-old with a complete unilateral cleft lip. He discusses the types of repairs, the advantages and disadvantages of the Millard repair, and the anatomy. This video clearly demonstrates the local injections, marking and measuring of the landmarks of the lip and nose, the flap incisions, checking of lip length, lip



FACIAL PLASTIC TIMES JANUARY/FEBRUARY 2009

2009

JANUARY 15-19

WINTER SYMPOSIUM ON THE LATEST ADVANCES IN FACIAL PLASTIC SURGERY

Co-chairs: Edwin F. Williams, III, MD; Jonathan M. Sykes, MD; and Sam P. Most, MD
Telluride, CO

JUNE 11-15

ADVANCES IN RHINOPLASTY

Co-chairs: Wayne F. Larrabee, Jr., MD; Edward H. Farrior, MD; and Stephen S. Park, MD
Seattle, WA

JUNE 27-28

BOARD EXAMINATION

Administered by the AAFPRS
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OCTOBER 1-3

FALL MEETING

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2010



Symposium Chair: Shan R. Baker, MD
Program Chair: Philip J. Miller, MD

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Web site: www.eafps.com

closure, and tip rhinoplasty. After completion of the case, pre- and post-operative comparisons are made. This video comes in

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Enclosed in this January/February issue of *Facial Plastic Times* are the:
Call for Abstracts; Advances in Rhinoplasty Brochure; and Annual Fund Envelope.
Paid ads appear on pages 5, 13, and 19.