



# Aesthetic Society News

Quarterly Newsletter of the American Society for Aesthetic Plastic Surgery

Volume 10, Number 2 SPRING 2006

## PATIENT SAFETY ALERT:

The Aesthetic Society (ad hoc) Mesotherapy Committee has issued the following position paper on the use of mesotherapy; a download of the document is available at [www.surgery.org/members](http://www.surgery.org/members)

### Mesotherapy Position Statement

#### History and Current Practice:

Mesotherapy was developed by Michel Pistor in France in 1952 and is recognized in that country as a separate medical specialty. Pistor believed that the injection of various compounds into the dermis—in high local concentrations—could produce positive physiologic effects on the vascular and lymphatic systems. Injection solutions have historically contained various combinations of substances that may include vitamins, minerals,



stimulants, plant extracts, vasodilators, hormones, enzymes, and drugs such as NSAIDs, theophylline and isoproterenol. Mesotherapy has been recommended for a wide range of conditions including pain management, sports injuries, cellulite,

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### Aesthetic Surgery Journal Featured on Today Show Segment

When the combination is sex and cosmetic surgery, you are bound to have media interest.

When the subject is a clinical article suggesting a link between sexual satisfaction and cosmetic surgery, you get on the Today Show.



That, at least, was the experience of primary author Guy M. Stofman, MD when his article titled: "Better Sex from the Knife? An Intimate look at the Effects of Cosmetic Surgery on Sexual Practices" appeared in the most

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## Countdown to Aesthetic Meeting 2006

The Aesthetic Meeting 2006, *Pursuit of Artistry and Science in Aesthetic Surgery* is less than one month away. If you have not registered for the event yet, please be advised that pre-registration ends March 31st. You can register online at [www.surgery.org/meeting2006](http://www.surgery.org/meeting2006)

### Some special meeting features to consider:

#### The 2006 Opening Ceremonies

Please join us in a welcome to the 2006 Aesthetic Society meeting. This year, we will be honoring all winners of the scientific achievement awards, paying

special tribute to the founders of the Flying Doctors of East Africa and the Image Reborn Foundation, and featuring a special presentation by former NASA astronaut Story Musgrave, MD.

#### Hot Topics

This year Hot Topics is shaping up to be hotter than ever. Scheduled discussion items for this year include: Surgi-wire incisionless dissector, Clinical trial of Evolence (porcine collagen) injectable filler vs. Restylane, Survival of fat grafts based on harvesting and preparation techniques—what the real science suggests, and

Medical legal implications of non-invasive technology—legal press on previously presented hot topics. See all the Hot Topic presentations on Friday, April 21st from 12:30 PM to 4:30 PM.

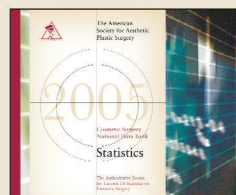
#### The First Annual Women Plastic Surgeon's Luncheon

Coordinated by the ASAPS Women's Health Advocacy Committee this Mentor sponsored event is designed to provide insight on the clinical practice and lifestyle issues uniquely affecting women surgeons. The discussion will take place from 12:15 pm to 1:45 pm on Saturday, April 22nd.

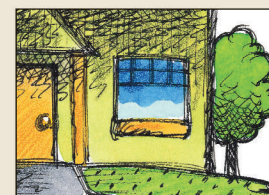
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## Aesthetic Society News

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

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The American Society for  
Aesthetic Plastic Surgery



The Aesthetic Surgery Education  
and Research Foundation

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ASAPS Members Forum: [www.surgery.org/members](http://www.surgery.org/members)

ASAPS Website: [www.surgery.org](http://www.surgery.org)

ASERF Website: [www.aserf.org](http://www.aserf.org)

## March 31 - April 1, 2006

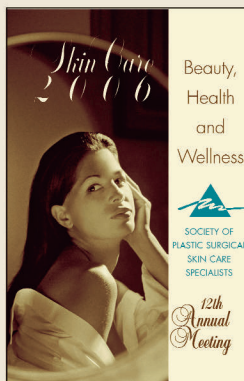
### Body Contouring After Massive Weight Loss Symposium

Co-sponsored by ASAPS/ASPS/PSEF  
Dallas, TX  
Contact: PSEF 800.766.4955

## April 17-20, 2006

### SPSSCS 12th Annual Meeting

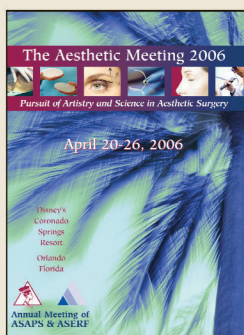
Orlando, FL  
800.486.0611  
For more information, log on to:  
[www.spsscs.org](http://www.spsscs.org)



## April 20-26, 2006

### The Aesthetic Meeting 2006

Disney's Coronado Springs Resort  
Orlando, FL  
Contact: ASAPS  
800.364.2147 or 562.799.2356  
E-mail: [asaps@surgery.org](mailto:asaps@surgery.org)  
For more information, log on to:  
[www.surgery.org/meeting2006](http://www.surgery.org/meeting2006)



## July 21-23, 2006

### Anti-Aging Skincare and Non-Invasive Cosmetic Procedures

Boston, MA  
Co-sponsored by ASAPS/ASPS/PSEF  
Contact: PSEF  
800.766.4955

## August 23-26, 2006

### 21st Annual Breast Surgery & Body Contouring Symposium

Santa Fe, NM  
Co-sponsored by ASAPS/ASPS/PSEF  
Contact: PSEF  
800.766.4955

## October 23-26, 2006

### Breast Surgery & Body Contouring Symposium

San Francisco, CA  
Co-sponsored by ASAPS/ASPS/PSEF  
Contact: PSEF  
800.766.4955

## November 12-16, 2006

### Advances in Aesthetic Plastic Surgery—The Cutting Edge

Sherrell Aston, MD  
Thomas Rees, MD  
New York Hilton Hotel, NY, NY  
Contact: Francine Leinhardt  
212.702.7728





## Focus on Philanthropy

**This issue of Aesthetic Society News will be my last one as President. I want to thank all members, staff and colleagues for giving me an incredible year, one of the most satisfying of my professional career.**

Aesthetic Surgery has many unsung heroes, physicians who provide medical care and respite to those most needing it. This year, at the Opening Ceremonies of the Annual Meeting, we will be recognizing two very different programs developed by ASAPS members. Very different, but exemplifying what humanitarianism is all about.

The Image Reborn Foundation ([www.imagerebornfoundation.org](http://www.imagerebornfoundation.org)) was conceived from a very basic idea: women dealing with the complexities of breast cancer needed a rest stop—somewhere they could go to renew the spirit, access healthcare professionals, learn about nutrition and alternative therapies—without taking on any additional financial burdens. Image Reborn provides this haven, a safe place to talk with other women dealing with cancer, to reflect on the changes in one's life, or simply to enjoy the fantastic Rocky Mountain location.

Society member Renato Saltz, MD saw this need in his own practice. "As a plastic surgeon, I can reconstruct a woman's breast and make it look very natural" said Saltz. "But there's more to feeling 'whole' again than just the physical aspect. A lot of what these patients need is to reconnect with themselves, and sometimes this is easier in a supportive group setting among people who understand what the cancer experience is like," he added.

The Image Reborn Foundation offers, at no cost to the women, support groups, medical education, advice on nutrition and exercise, massage therapy and simple relaxation. To date, over 300 women have participated.

In 1957, three plastic surgeons, Thomas D. Rees, MD, Michael Wood, MD and Archibald McIndoe, MD, drew up their plans to provide medical assistance to remote regions of East Africa. The question they had was: "how?"

To find out, these visionary physicians consulted none other than Albert Schweitzer, the pioneer doctor in Africa. How, they asked, can we reach the 80% of rural Africans who live beyond the reach of urban medical facilities? "Use the tools of the time," was his answer. Airplanes and radios, the tools of the time, became the basis of their new organization, the Flying Doctors of East Africa.

From the beginning, Tom Rees was operating on kitchen tables in remote villages, treating people from far different cultures than his own (one anecdote Tom tells is treating the child of a tribal leader who was upset because the child would live and his cow would die), and raising funds for what would become the African Medical and Research Foundation ([www.amref.org](http://www.amref.org)) the largest non-governmental health agency in Africa, with 85 percent of its staff native Africans. Of course Tom also found time to establish one of the most successful and respected practices in the United States and provide training to countless numbers of residents.

I think you will enjoy meeting these two gentlemen and hearing more about their meaningful work, in and out of the surgical suite.

This has been a wonderful year for ASAPS in which we have made progress by working together to address important issues affecting the Society and to work on opportunities that will benefit us in the future. It has been an honor to serve as the 37th president of the Aesthetic Society.

I look forward to seeing you in Orlando and, as always, please feel free to contact me at [mjewellmd@surgery.org](mailto:mjewellmd@surgery.org) with questions or comments.

# The Aesthetic Practice: 2006 and Beyond

By Marie Czenko Kuechel, MA



Marie  
Czenko  
Kuechel

The data released from the American Society for Aesthetic Plastic Surgery's Cosmetic Surgery National Data Bank certainly provides much needed information for media and consumers. But what do these numbers mean for the Aesthetic Surgery practice? The numbers allow for forecasting of industry trends. But forecasting has little value without defined strategies for addressing the trends that may influence your practice.

## Trends

Breast augmentation continued its rise in 2005, despite the belief that women are waiting for the option of silicone implants. This increase strengthens the notion that when most women want something, they want it now. The question remains, will silicone launch a new trend?

Botox® usage is up as is the use of injectables. There is no surprise to this trend: Botox® injections offer little down-time, are inexpensive and show measurable results.

Microdermabrasion and chemical peels are down after years of booming numbers. The reason for this is not the treatment itself but rather a new trend: the plethora of over-the-counter options makes it easy for patients to garner results at home. At home solutions are more convenient, generally less expensive, and while the results may not be similar, they still do offer improvement.

The vast majority (nearly 88%) of laser skin resurfacing was performed with non-ablative lasers, a relatively new category of treatment. Yet the numbers for laser resurfacing overall are down. What do these trends mean? Consumers are looking for less down-time, we know. But many non-ablative lasers don't produce results that parallel ablative resurfacing, making their investment a cautious one for physicians and consumers alike. Yet technology keeps refining current modalities and introducing new options.

Add to this the trend in science-based skincare and you have to question where the trend in laser skin resurfacing or tightening will go next.

Liposuction continues its lead in surgical procedures. Why the trend? It's effective, safe and offers dramatic results to a nation of body and health conscious people.

The average age of those who spend \$12.4 billion dollars on cosmetic procedures was between 35 and 50. Clearly, this group has the highest disposable income, is in a competitive stage of life, and is the most likely to be showing (and hoping to deny) the signs of aging. But the patients in the immediate younger and older age groups together equaled the 35-to-50 age group. The trend? Beauty knows no age.

## Strategies

You don't have to be trendy to succeed in today's aesthetic market, but you do need to have strategies that link your goals and the desires of those with buying power. You are an aesthetic plastic surgeon, but your practice is a business. With so

many influences, advancements and competitors in your marketplace, your business plan, whether you choose to offer trendy treatments or not, should address these trends.

## Silicone

The hot topic and anticipated big trend is clearly the approval of silicone implants for breast augmentation. Even in the state of pre-market approval, questions about availability have been numerous.



How will your practice address silicone? If you are an investigator, "we already do" is not a strategic response. The anticipated approval of silicone gel breast implants means that something investigational is now to be public: advertised. It also means that something once controversial is again in the news. Whether you presently offer silicone in controlled studies, whether you have made the decision to be among the first certified in silicone, or even if silicone is not at the top of your list, you still need a silicone strategy.

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## The Aesthetic Practice: 2006 and Beyond

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Your office is going to get calls from prior and prospective patients about silicone no matter the status on silicone or where it fits in your practice mix. You may even get calls from the media. Prepared, consistent communications should lead your strategies:

- Have a defined position statement on silicone readily available to offer callers, web visitors and in-house patients. The primary focus of that position should be aligned with the position of the Aesthetic Society, one that defines silicone as an option for women seeking breast enhancement. Your position should encourage a dialogue between patient and plastic surgeon for any woman with questions and it should be timely to access (access meaning the status of FDA approval). Define the point person in your office to contact for more information or a consultation, and/or referral to a colleague who offers silicone if you don't.
- Make your position well known to all office staff. Your front line (the reception staff) should have specific talking points to answer questions about the approval and availability of silicone.
- While your focus may be past and prospective patients, don't overlook proactive communication with your referral sources, namely referring physicians. Give them the information and tools to direct good candidates to you.
- Don't hold yourself out to the media to talk about silicone unless you are media trained. The Society and the implant companies all have good resources of information but you must remember that the message you carry may not be for the moment. Silicone has a history, and what you say will add to that history. Also keep in mind that in the silicone trend, you are not just representing yourself you are representing a profession and an industry.

There has been speculation that a high number of revision surgeries to

replace saline filled implants will occur once silicone is approved. Things to consider in your strategies to address revision surgeries:

- Define your position on revision surgery and make that position clear to your office staff and those past and prospective patients who inquire. Your position should clearly define the appropriate reasons to undergo revision surgery, and offer anyone with questions a direct resource within your office to answer individual questions and determine if a consultation is warranted.
- Your position or marketing strategies should not devalue the choice women made in earlier years to enhance their breasts with saline implants. It should balance the option women have in saline or silicone through clear, unbiased, direct information.
- Define a means to track the inquiries you receive about revision surgery and follow-up annually with those patients who have inquired. Revision may not be warranted today, but in the coming years it may be. Make certain you remain the point of contact to that patient.

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**You don't have to be trendy to succeed in today's aesthetic market, but you do need to have strategies that link your goals and the desires of those with buying power. You are an aesthetic plastic surgeon, but your practice is a business. With so many influences, advancements and competitors in your marketplace, your business plan, whether you choose to offer trendy treatments or not, should address these trends.**

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- Don't overlook your referring physicians, or those who are potential referral sources in defining your strategy. Extend your position, your professionalism and offer information. Within that information, invite them to refer their patients with questions about revision to you.
- A rush of silicone revisions may make for a healthy bottom line, and it will impose on resources (time and staff) as well. Your practice is a business, and all businesses have financial goals. If your strategy is to capitalize on revisions, consider this: once the rush of revisions is over, how will you maintain the income your practice is now accustomed to, and how will you continue to maximize your resources?

The market introduction of silicone will require certification for you, and the option of silicone will require a new administrative process for your practice. If you accept the silicone trend, you accept these responsibilities.

- Take advantage of the new administrative process to review your current patient tracking and communication. Silicone may require annual follow-up with silicone patients, but regardless of the procedure or device, annual communication with your patients is always good practice. The ASAPS/ASPS Cycle of Care product offers you form letters designed for patient follow-up, retention and referral.

### Injectables

There is no denying that the trend of injectables is going to continue to grow. And while the industry wrestles with issues of imported and illegal injectables, unqualified providers and patient safety in this rapidly growing market segment, you need defined strategies that weigh in on industry issues and mesh with your own practice. The growth in approved injectable options makes it even more confusing for consumers to understand what is safe, and what the

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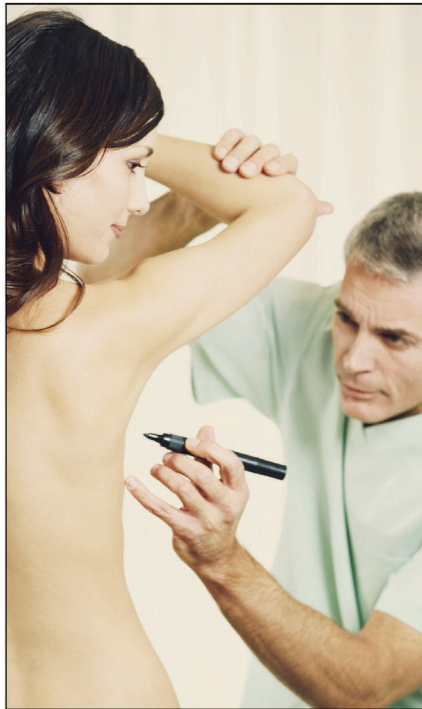


trade-offs among injectables include.

- Your position on injectables, must be more than simply defining whether you offer certain injectables as an option to your patients, or not. You must have a position that defines safe and available market options. Why you choose and use certain injectables should be foremost, but also what is accepted by the industry that you don't use may help your patient to make educated choices if he or she turns elsewhere. Your strategy should be to never turn a patient focused on injectables away without solid information, nor to turn him or her away for services you don't provide without referring that patient to a trusted colleague.

Injectables are an easy revenue stream, but they also expend your resources, namely time. To define your injectable strategy, look at how injectables fit into your practice, and the value they bring.

- Building on the trend of injectables means more than attracting new patients. First look at your retention of existing patients and the value of expanding services to existing patients. It's less taxing on your resources to enhance services to your existing patients than to attract new patients.
- Marketing injectables on price, whether competing with less qualified sources, offering rebates, discounts and VIP programs, means your patients will learn to shop for injectables on price. Your training, experience and outcomes all contribute to value and rather than discounting injectables, offer a reward system that allows your patients the bonus of added services.
- As an aesthetic surgeon, the traffic created by injectable patients should fuel your surgical practice. Even if you have a nurse injector or PA providing service, regular communication from the doctor is an important strategy. Make it policy that once per year injectable patients spend a few moments with you, the aesthetic surgeon and expert, to review personal appearance goals. These few moments of your time can be scheduled at the time of treatment and easily



translate to a lot of goodwill and possibly added services.

- When you consider a nurse injector, first define the needed return on investment, meaning the number of injections she or he must perform monthly to pay for salary and the administrative overhead. Add to this any value in freeing more of your time. Then consider whether your market will accept a nurse injector and how you will communicate that person's value to your patients and prospective market. If you have a nurse injector, an annual audit is essential to review and revise your strategies.

### Technologies and Treatments

Trends move, sometimes quickly. And most often, new treatments and technologies experience growth spurts due to marketing and media. Whether you offer them, market them, or shy away, these trends can impact your practice.

- New technology or services are not always practice builders; if they were, they would replace surgery. In fact new technologies are more appropriately strategized as practice complements:

enhancing, refining or delaying the results of surgery. When you invest in a new technology, focus on how it will complement your practice mix, and what it may also replace. Your return on investment calculation includes more than the time it will take for service fees to pay for the equipment. It includes the cost of resources (people, time and overhead) and it includes the loss of fees from technologies or treatments it may be thought to replace.

Look carefully at how you position and communicate new technologies. People want options, they want less down time, but they also want value for the time and money invested, and they want visible results.

- Don't promise what you cannot deliver. New technologies marketed to substitute surgery create a glut of interest and a letdown in results. Rather than fueling your surgical practice, this may leave a negative impression. Be clear on what technologies offer, and what they cannot, define the complements and the alternatives.
- If you choose not to offer new technologies, be careful about negating their value to your patients. A position statement that clearly defines what these new technologies offer and what they don't is essential to uphold your role as the aesthetic surgeon and industry expert. Referral to a colleague who does offer a treatment your patient is set on trying will offer goodwill, where sending them out the door without answers will not.

### Your Surgical Core

The mainstay of your practice is aesthetic surgery, and despite innovations and changes in the industry, the desire for surgery continues to grow.

- Don't become complacent with what works. In the same manner you evaluate your communications, position statements, policies and even your return on investment with new introduction to your practice, you should re-examine your core as well. You may find room to improve on a good thing.

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## Unhappy Campers

Unhappy patients used to have only three arrows: talk to the surgeon, complain to the medical board, or file a lawsuit, all of which would only reach a few dozen listeners with astronomical litigation expenses. Thanks to the internet, patients' quivers now include websites, web *logs* [blogs] and forums with the ability to reach millions for only \$350/ year. Though not yet as common as unhappy patients, internet sites expressing personal and professional dissatisfaction are quickly becoming the irritant *de jour* for our members.

Lawsuits have not fallen into disfavor, but the uncertainties of litigation, such as the 9-3 jury verdict in favor of Allergan and Arnold Klein over his injections of Botox® into Irena Medavoy, make the web both a cost-contained and cost-effective method of criticism. Plastic surgeons, of course, are not the only profession with unhappy patients sponsoring internet sites.

Dentalfraudinflorida.com, Worstdentist.com, Baddentist.com, BosleyMedical.com and BosleyMedicalViolations.com are aggressive websites attacking dentists and the Bosley Medical Institute. Hairtransplant.net and Hair-restoration-info.com are examples of forums for commentary, both positive and negative.

Naturally, we become considerably more sensitive when the arrow hits closer to home. Awfulplasticsurgery.com is

celebrity focused and thus, relatively generic, but some of our members have become direct targets for their former patients and actively solicit other patients for negative feedback. From the surgeon's perspective, internet attacks constitute libel, while from the patient's perspective, they constitute free speech. These issues have been tested in court.

When the material posted is factual or opinion, free speech wins. For example, the dentists attacked at Dentalfraudinflorida.com filed a lawsuit against their former patient and claimed her site was slanderous [technically libel], a public nuisance, and a violation of Florida law making disciplinary complaints confidential if they are dismissed. On the eve of a motion to dismiss by the ACLU, the dentists dismissed first, then ended up being ordered to pay their patient's \$20,000 in legal fees on the grounds that they and their lawyers should have known of the patient's constitutional right to free speech. Similarly, Bosley sued his former hair restoration patient for using his registered trademark, i.e. Bosleyinstitute.com as a domain name, but in 2005 the 9th Circuit held that noncommercial use of a trademark as a website domain name to post consumer commentary does not constitute infringement. [Comment: the wrongful use of a domain name for either commercial gain or to extort a purchase price is known as cybersquatting;

in contrast, the wrongful effort to prevent lawful use of a domain name is known as cyberbullying.]

Free speech is not without limits. Regrettably, between fact and defamation is opinion, which is protected, but webmasters routinely monitor postings in forums which cross the line, such as Hair-restoration-info.com which removed the thread critical of Dr. Barry White and The National Hair Institute after giving "Graft Boy" 48 hours to clean up his act or be barred from the site. [Comment: a link on Google may be currently unavailable, i.e. deleted, but click on "cached" and a snapshot of the original website will appear.] Webmasters are also open to your direct contact: in the case of one of our members who was libeled with swastikas, postings from the forum were immediately removed, because website hosting services have no desire to become defendants themselves when alerted to clearly defamatory content. Unfortunately, e-mails are not monitored.

Regardless of its legality, internet criticism can be consuming. If you know one of our members being targeted, do not hesitate to express condolences and support for your colleague. One of our Society's core values could well be collegiality, and it is best to express it well before you *need* it.

# Members to Vote on Slate of Candidates

Active members of the American Society for Aesthetic Plastic Surgery (ASAPS) will hear reports on Society business; vote on proposed changes to the Bylaws and elect new officers for 2006–2007 during the ASAPS Annual Business Luncheon. All active members are invited to attend on Sunday, April 23.



**President**  
**James M. Stuzin, MD**  
Automatically ascends to President.



**President-Elect**  
**Foad Nahai, MD**

Atlanta, GA  
Private Practice  
**Current Board Position:** Vice President  
**ASAPS Committee work:** Education Commission (current chair), Program Committee Chair (since 2005) and Representative to the ASPS Scientific Program Commission, Patient Safety Steering Committee ad hoc, Strategic

Planning Committee (current chair)  
International Committee, *Aesthetic Surgery Journal* (Associate Editor), Teaching Course Subcommittee (Past Chair)  
**National Affiliations:** ASAPS, AAPS, ACS, ASERF, ASPS  
**Training:** University of Bristol; General  
**Surgery Residency:** The John Hopkins Hospital, Baltimore, MD and Emory University Affiliated Hospitals, Atlanta, GA; Plastic Surgery Research Fellowship and Plastic Surgery Residency: Emory University Affiliated Hospitals  
ABPS certification: 1980



**Vice President**  
**Alan H. Gold, MD**

Great Neck, NY  
Private practice; Clinical Associate Professor of Surgery, New York Hospital-Cornell University Medical Center  
**Current Board Position:** Treasurer  
**Past Board Positions:** Historian, Parliamentarian  
**ASAPS Committee work:** Administration Commission (Past Chair), Communications Commission (Past Vice Chair), Public Education (Past Chair), Symposia, Traveling Professor  
**National Affiliations:** ASAPS, AAAASF, ASERF, ASPS, PSEF  
**Training:** State University of New York Downstate Medical Center; General  
**Surgery Residency:** North Shore University Hospital, Manhasset, NY; Hand  
**Surgery Fellowship:** Nassau University

Hospital, East Meadow, NY; Plastic  
**Surgery Residency:** State University of New York-Kings County Hospital Center, Brooklyn, NY  
**ABPS certification:** 1979



**Treasurer**  
**V. Leroy Young, MD**

St. Louis, MO  
Private Practice; Chief of Surgical Services at Barnes-Jewish West County Hospital, St. Louis, MO  
**ASAPS/ASERF Committee work:** Non-Surgical Procedures and Breast Surgery Immediate Response Committees (current chair). Emerging Trends Task Force for the Aesthetic Surgery Education and Research Foundation (ASERF) (current chair), Associate Editor of *Aesthetic Surgery Journal*.  
**National Affiliations:** ASAPS/ASERF, ABPS, ASPS  
**Training:** University of Kentucky School of Medicine; General Surgery Residency; Washington University Barnes-Jewish Hospital; Plastic Surgery Residency  
**ABPS certification:** 1981

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## Members to vote on Slate of Candidates

Continued from Page 8



### Secretary Renato Saltz, MD

Salt Lake City, UT  
Private Practice; Adjunct Professor,  
University of Utah School Of Medicine  
**Current Board Position:** Secretary  
**ASAPS Committee work:** Symposium  
Committee (current chair), International  
Committee, Clinical Editor of *Aesthetic  
Surgery Journal*.

**National Affiliations:** ASAPS, AAPS,  
ACS, ASPS, PSEF

**Training:** Universidade Federal Rio  
Grande do Sul School of Medicine;  
General Surgery Residency: Jackson  
Memorial Hospital, University of Miami,  
Miami, FL; Plastic Surgery Residency:  
University of Alabama, Birmingham, AL

**ABPS certification:** 1992



### Member-at-Large Laurie A. Casas, MD 3-year term



### Member-at-Large Mark A. Codner, MD 3-year term



### Member-at-Large James W. Fox, IV, MD 3-year term



### Member-at-Large Paul D. Faringer, MD 1-year term

(completing the term left vacant by Dr. Young)

Society members will  
also vote on the  
following candidates  
for office

Trustee  
(3-year term) –  
Malcolm D. Paul, MD

Ethics Committee  
(3-year term)

Northwest  
Linda J. Leffel, MD

Midwest  
A. Jay Burns, MD

Judicial Council  
(3-year term)

Southeast  
T. Roderick Hester, MD

North Central/Canada  
Richard J. Warren, MD

Membership Committee  
(3-year terms)

Northeast  
Richard S. Fox, MD

Midwest  
Julius W. Few, MD

Far West  
Bryant A. Toth, MD

Canada  
Trevor Born, MD

## Patient Safety Alert

Continued from Cover



wrinkles, alopecia, psoriasis, weight loss, and body contouring.

For decades, mesotherapy was largely a French, European, and South American phenomenon. During the past few years, however, it has been embraced in the U.S. under a variety of names. The English-language peer-reviewed literature contains no reports on traditional mesotherapy (except for complications) and only a few on injections of phosphatidylcholine for reducing fat deposits. Most who offer mesotherapy in the U.S. provide only vague descriptions of the ingredients used, in what dosages, and for which indications. It seems that mesotherapy practitioners have their own formulas, which are often kept secret or revealed only through fee-for-service courses.

In traditional mesotherapy, the ingredients are injected into the deep dermis or mesoderm, but the mesoderm is not precisely defined. In treatments with Lipodissolve (in which the primary ingredient is phosphatidylcholine), the injections are made into the subcutaneous fat. In both cases, the depth of injection is critical to prevent damage to fascia and muscle, as well as deliver treatments to the proper location. Although 27-30 gauge needles and small syringes can be used to perform injections, the need for speed and precision has led to development of devices called mesoguns to insure the proper depth and dose of injection.

Mesotherapy practitioners claim that mesotherapy injections can “dissolve unwanted local accumulations of fat.” Such claims, of course, are appealing to

Americans, and mesotherapy treatment centers are opening around the country. To our knowledge, those who advertise mesotherapy treatment do not specify the ingredients, or combinations thereof, used to “melt fat.” Some say their mesotherapy formula contains drugs such as theophylline, isoproterenol, or collagenase that have been approved by the FDA for other uses (theophylline for bronchodilation; isoproterenol for treatment of asthma, shock, pulmonary hypertension, and bradycardia; collagenase for debridement of chronic dermal ulcers and severe burns).

These drugs, which can act as beta-adrenergic agonists, are purported to stimulate enzyme systems that break down the triglycerides contained in adipocytes into free fatty acids. These free fatty acids are then mobilized from the fat cells and eliminated by the liver, kidneys, or gastrointestinal tract. However, this proposed scenario is contrary to the accepted principles of lipid metabolism.



The idea of dissolving fat via injections seemed to be taken more seriously after 1999, when Patricia Rittes, a Brazilian dermatologist, published a case series describing injections of phosphatidylcholine into the fat pockets of the lower eyelids in 15 patients. Also called Lipostabil, phosphatidylcholine (PPC) is approved in Europe to treat lipid abnormalities, coronary plaque, and cirrhosis of the liver. It has also shown promise in shrinking lipomas through subcutaneous injections.

Rittes' before and after photos seem to show impressive shrinkage of the lower lid fat pockets after one to four injections, and she has subsequently shown clinical examples of Lipostabil injections in the abdomen, flanks and thighs that demonstrated improved contour and fat loss.

In 2004, the California dermatologists Albon and Rotunda conducted a similarly-designed study of 13 patients who received open-label injections into their lower eyelid fat pads. Their results were similar to those of Rittes, and their peer-reviewed paper was well done and appropriately cautious.

By 2003, talk about mesotherapy began to spread rapidly through the American media (television and print) as various outlets began reporting on the “miraculous” new injections that could dissolve fat. The most noteworthy publicity probably came from singer Roberta Flack, who told ABC's 20/20 program that she had lost 40 pounds through mesotherapy, although she also dieted and exercised.

### Terminology Confusion

The combination of phosphatidylcholine and deoxycholic acid injected into subcutaneous fat is now popularly grouped under the name of mesotherapy. However, the movement of these drugs into the mesotherapy “tent” has somewhat confused the terminology. When we first heard about mesotherapy as part of Hot Topics several years ago, its possible ingredients sounded like a kind of “snake oil” remedy for fat deposits. At that point, the injection of phosphatidylcholine and deoxycholate acid into the subcutaneous fat was not considered part of mesotherapy treatments. To distinguish their approach from the rather unorthodox ingredients of standard mesotherapy, some practitioners using PPC injections began to refer to their treatments with terms like Lipodissolve, Lipostabil, injection lipolysis, or dermatoliposclerosis. Today, however, all the various terms seem to be used interchangeably, although mesotherapy alone has clearly entered the public vernacular. A recent Google search for “Lipodissolve” returned

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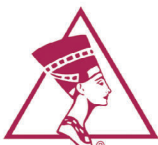
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The Cycle of Care Resource Book covers aesthetic and reconstructive procedures, operating room, and general consent forms, disclosures, and patient letters. It is designed for the busy surgery practice with a CD based color coded compendium of all necessary forms for breast, body, face and reconstructive procedures. A loose leaf binder with all letters and forms is available for reference.



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340 listings, while “mesotherapy” produced 329,000 listings.

The growing recognition of terms like mesotherapy and Lipodissolve among the general public, which has been encouraged through advertising, has led to the formation of societies, such as the American Society of Aesthetics and Mesotherapy, that are dedicated to teaching injection procedures. Their published formulas contain ingredients such as phosphatidylcholine, lidocaine, collagenase, and hyaluronidase, among others. (See [www.mesotherapy-us.com](http://www.mesotherapy-us.com).) Courses designed to train physicians in mesotherapy are held frequently around the country and appear to be open to all MDs regardless of training or board certification. Rumors suggest that some MDs then train spa staff to perform mesotherapy treatments “under medical supervision.” The Centers for Disease Control has even reported on mesotherapy being done in homes, hotels, and “clinics” by people with no credentials of any kind.

Mesotherapy protocols vary, but the most standard involves drawing a 1 to 1.5 cm grid on the area to be treated and injecting each square with an identical technique. Typically, a series of injections is separated by 2 to 8 weeks, depending on the injection formula. Although the improved body contour results are attributed to the injections, diet and exercise are often recommended as part of the treatment plan.

### Complications

The lay press and internet sites dedicated to mesotherapy and Lipodissolve rarely report complications. However, there are numerous reports of complications documented in the medical literature, including atypical mycobacterium infection and granulomas. Urticaria pigmentosa following mesotherapy with procaine and plant extracts has also been documented. In addition, there are reports of injections done by lay people causing localized necrosis when extremely high doses are injected superficially in a small area.

### Theory of Action

Phosphatidylcholine and deoxycholate are both phospholipids and surfactants. Phosphatidylcholine is a zwitterionic molecule with both polar and nonpolar ends. It is the most abundant phospholipid in cell membranes. Deoxycholate is an ionic phospholipid found in bile.

Theoretical mechanisms by which these drugs could potentially result in mobilization of fat include direct toxic effects on adipocytes, surfactant effects, and activation of lipase. Histologic sections of biopsy specimens following injection of PPC and deoxycholate show the mechanism of action to be a direct toxic

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**Phosphatidylcholine and deoxycholate acid are both approved by the FDA for use as surfactants and drug carriers. However, there is no FDA approval of either drug for subcutaneous injection for any purpose. The FDA has occasionally issued warnings to some physicians advertising mesotherapy on their websites and demanded that the information be removed because the FDA has approved no such treatment.**

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effect on the cell membrane that induces necrosis, but not apoptosis. This is confirmed by the presence of inflammation, the fact that many contiguous cells are involved, and the development of neovascularization. In apoptosis, cells die a “silent” death, unmarked by a local inflammatory reaction. New data show that macrophages arrive at the site and remove the cell debris. Although apoptosis caused by surfactant effects is a theoretical mechanism of action, it is unlikely to play a significant role because the dominant histological picture is consistent with necrosis. Physicians who claim that injections cause apoptosis seem to be using the term loosely to mean cell death.

Both phosphatidylcholine and deoxycholate are known to cause cell death on direct contact without selectivity for fat cells. They can therefore induce necrosis of fascia and muscle as well. This means that injections must accurately place the agents in the superficial to mid-layer of fat and far enough away from muscle and fascia so that only fat cells are killed. The dose should be limited to a maximum of 2500 mg of phosphatidylcholine per treatment session to avoid systemic toxicity.

There are reports of patients complaining of erythema and itching after the injections, which could be a manifestation of lipase activity or histamine release. However, there is no objective proof of lipase activity. Because the erythema and itching occur immediately after injection, these symptoms are almost certainly due to histamine release.

Some advocates of Lipodissolve therapy have claimed that the “disappearing” fat is eliminated via the urine or GI tract. This seems physiologically impossible unless a negative energy balance is also induced by diet and exercise. Fat is stored in adipocytes as triglycerides, and the body manages triglycerides and fatty acids in two ways: they are burned or they are stored. They are not excreted.

### Regulatory Status

Phosphatidylcholine and deoxycholate acid are both approved by the FDA for use as surfactants and drug carriers. However, there is no FDA approval of either drug for subcutaneous injection for any purpose. The FDA has occasionally issued warnings to some physicians advertising mesotherapy on their websites and demanded that the information be removed because the FDA has approved no such treatment. The agency has also issued warnings to people known to import products such as Lipostabil on the same grounds. Yet advertising for mesotherapy/Lipodissolve continues to grow, and the ingredients are easy to purchase from compounding pharmacies. Since it is difficult to tell what, exactly, is being injected in a mesotherapy treatment,

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## Patient Safety Alert

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regulation seems an impossible task. This particular genie is already out of the bottle, and the FDA will not be able to control it unless, perhaps, tragic consequences result from mesotherapy.

Despite all the claims that mesotherapy/Lipodissolve treatments can safely and effectively eliminate unwanted subcutaneous fat deposits, this remains clinically unproven. There are no published peer-reviewed scientific reports of properly performed blinded and controlled prospective trials to confirm either safety or efficacy. Furthermore, we have no objective data on how these treatments produce the reported effects.

The ASAPS Mesotherapy Committee has contacted the FDA regarding their requirements for an ASERF-funded clinical trial of phosphatidylcholine and deoxycholic acid injections. The FDA stated that any study involving subcutaneous injection of these drugs requires FDA approval of an investigational new drug (IND) application plus IRB approval. The FDA is well aware that mesotherapy/Lipodissolve injections are growing in popularity but the agency thus far has not exercised its enforcement power to restrict its use.

### What Needs To Be Done

News about mesotherapy/Lipodissolve is spreading rapidly throughout the country with huge numbers of patients receiving treatments. This is occurring in the absence of proper studies to document its safety and efficacy, not to mention the absence of FDA approval. In the interest of patients' safety, we need to conduct a prospective blinded, placebo-controlled, multi-center study designed to evaluate the safety and efficacy of these treatments, as well as potential complications. The Mesotherapy Committee of ASAPS has developed a research protocol and ASERF has provided funding for the study. The formula to be used for injections is the same as that reported by Albon and Rotunda: 5 g of phosphatidylcholine, 4.75 g of deoxycholic acid sodium salt (to solubilize the PPC), 0.9 mL benzyl alcohol (as preservative and antimicrobial), and 100 mL sterile saline (as carrier).

Currently, the Mesotherapy Committee is in the process of filing the paperwork for FDA approval of the IND application, which is necessary before IRB approval can be finalized. The goal is to have these in place to begin the study in the spring of 2006. It is estimated that 6 to 8 months will be needed to complete the study, at which point the results will be analyzed and published in the *Aesthetic Surgery Journal* and presented at the annual ASAPS meeting.

### Recommendations for Aesthetic Society Members

ASAPS does not endorse the injection of phosphatidylcholine, deoxycholate or any other drugs, vitamins, plant extracts, hormones, etc. into subcutaneous fat as practiced in mesotherapy/Lipodissolve treatments. At present, these therapies lack objective proof of safety and efficacy. They also lack FDA approval. Members should therefore refrain from adopting these procedures until the results of the ASERF study are available to provide proof of safety and efficacy, or lack thereof. If and when patients ask about these treatments, the scientific reality that currently exists should be explained to them, along with the caution to wait until something definitive is known. Until then, patients should be warned about seeking treatments from people who may not be qualified to administer large numbers of injections that require very precise placement.

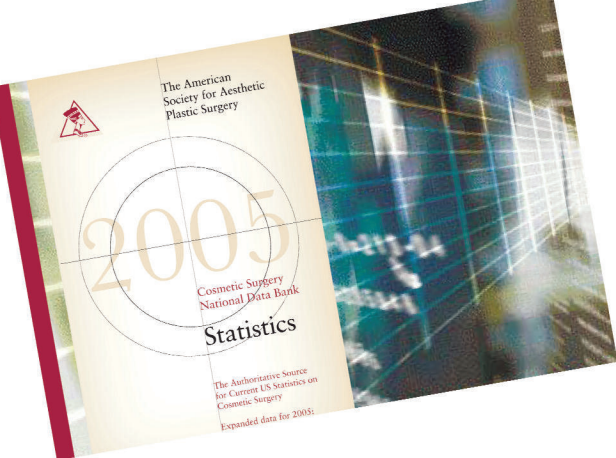
## The Aesthetic Practice

Continued from Page 5

- Look at your own surgical and patient statistics and define trends for your practice. Define the ages; the common procedures of certain age groups in your patient populations. Survey the weak and the strong groups to learn whether you've met their expectations, or if you have room to grow.
- Regularly measure how your patients come to find, and choose you. Look closely at repeat patients, the relatives of prior patients, and carefully collect and track referrals from other patients and from your best referral sources.
- Don't overlook marketing (this does not mean advertising alone). The visibility generated by marketing is important to keep your name, and ideas fresh in the minds of your potential patient populations and referral sources. Your best potential referral sources are past patients; at the very least your marketing strategies should include annual contact with these happy, fulfilled ambassadors to your practice. Consider this: if no one advertised, if there were no in-office materials to highlight cosmetic solutions, if there were no web and if the media did not cover cosmetic enhancement, where would interest and traffic come from? Referral from happy, past patients, of course.

Marie Czenko Kuechel, MA is an aesthetic practice and consumer education consultant and author of *Aesthetic Medicine: Practicing for Success*, two consumer guides to plastic surgery, and serves as the editor-at-large to *NewBeauty* magazine. She has taught courses in practice management at The Aesthetic Meeting since 2005 and can be reached at [marie@czenkokuechel.com](mailto:marie@czenkokuechel.com).





# Aesthetic Society Releases Annual Statistics

Nearly 11.5 million cosmetic surgical and nonsurgical procedures were performed in the United States in 2005, according to statistics recently released by the Aesthetic Society.

Compared to 2004, surgical procedures increased 1% to 2.1 million, while nonsurgical procedures declined 4% to 9.3 million. The Aesthetic Society which has been collecting multi-specialty procedural statistics since 1997 says the overall number of cosmetic procedures has increased 222% since the collection of the statistics first began. The most frequently performed procedure was Botox® injections and the most popular surgical procedure was liposuction.

“The surgical portion of the statistics show interesting results in the breast augmentation and breast lift areas,” said Aesthetic Society president Mark L. Jewell, MD. “While some procedures are down, these areas continue to increase; breast augmentation by 9 percent and breast lift by 23 percent. This also marks the first year that we have segmented the device used for breast augmentation, saline or silicone. This should give us significant trending data when silicone devices are approved by the FDA.”

## TRENDS AND DEMOGRAPHIC DATA

### Top surgical and nonsurgical cosmetic procedures among ALL AMERICANS in 2005:

| Surgical            | # procedures | Nonsurgical                           | # procedures |
|---------------------|--------------|---------------------------------------|--------------|
| Liposuction         | 455,489      | Botox®                                | 3,294,782    |
| Breast augmentation | 364,610      | Laser hair removal                    | 1,566,909    |
| Eyelid surgery      | 231,467      | Hyaluronic acid (Hylaform, Restylane) | 1,194,222    |
| Rhinoplasty         | 200,924      | Microdermabrasion                     | 1,023,931    |
| Abdominoplasty      | 169,314      | Chemical Peel                         | 556,172      |

### Top cosmetic procedures for WOMEN:

| Surgical            | # procedures | Nonsurgical                           | # procedures |
|---------------------|--------------|---------------------------------------|--------------|
| Liposuction         | 402,946      | Botox®                                | 2,990,658    |
| Breast augmentation | 364,610      | Laser hair removal                    | 1,334,669    |
| Eyelid surgery      | 198,099      | Hyaluronic acid (Hylaform, Restylane) | 1,149,228    |
| Tummy Tuck          | 164,073      | Microdermabrasion                     | 939,508      |
| Breast Reduction    | 160,531      | Chemical Peel                         | 533,009      |

Women had 91 percent of cosmetic procedures. The number of procedures (surgical and nonsurgical) performed on women was nearly 10.5 million, a decrease of 2 percent from the previous year. Surgical procedures increased 2 percent; nonsurgical procedures decreased 3 percent.

### Top cosmetic procedures for MEN:

| Surgical              | # procedures | Nonsurgical                           | # procedures |
|-----------------------|--------------|---------------------------------------|--------------|
| Liposuction           | 52,543       | Botox®                                | 304,124      |
| Rhinoplasty           | 45,945       | Laser hair removal                    | 232,240      |
| Eyelid surgery        | 33,369       | Microdermabrasion                     | 84,423       |
| Male breast reduction | 17,730       | Hyaluronic acid (Hylaform, Restylane) | 44,994       |
| Facelift              | 13,041       | Laser Skin Resurfacing                | 43,083       |

Men had 9 percent of cosmetic procedures. The number of procedures (surgical and nonsurgical) performed on men was nearly 1 million, a decrease of 15 percent from the previous year. Surgical procedures decreased 9 percent; nonsurgical procedures decreased 18 percent.

### Frequency of cosmetic procedures by AGE GROUP:

| Age          | % of total | # procedures | Top surgical procedure | Top nonsurgical procedure |
|--------------|------------|--------------|------------------------|---------------------------|
| 35-50        | 47%        | 5.3 million  | Liposuction            | Botox®                    |
| 51-64        | 23%        | 2.7 million  | Eyelid Surgery         | Botox®                    |
| 19-34        | 24%        | 2.7 million  | Breast Augmentation    | Laser Hair Removal        |
| 65 and over  | 4%         | 530,139      | Eyelid Surgery         | Botox®                    |
| 18 and under | 2%         | 174,851      | Rhinoplasty            | Laser Hair Removal        |

## Racial and Ethnic Distribution

Racial and ethnic minorities accounted for 20 percent of all cosmetic procedures in 2005. Hispanics again led minority racial and ethnic groups in the number of procedures: Hispanics, 9 percent; African-Americans, 6 percent; Asians, 4 percent; and other non-Caucasians, 1 percent.

## Location and Fees

Just over forty-eight percent (48.3 percent) of cosmetic procedures in 2005 were performed in office-based facilities; 27.9 percent in freestanding surgicenters; and 23.8 percent in hospitals. Americans spent just under \$12.4 billion on cosmetic procedures; \$8.2 billion was for surgical procedures, and \$4.2 billion was for nonsurgical procedures.

See page 4 for information on how the statistics relate to your practice.



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# Beware the Number One Myth of Asset Protection: Physicians CAN Lose Assets in a Medical Malpractice Lawsuit

David B. Mandell, JD, MBA

As the author of two leading asset protection books for physicians, including *Wealth Protection, MD*, and as a lecturer at many medical meetings across the country, I have spoken with thousands of physicians. In my experience, I have encountered many dangerous misconceptions about asset protection planning.

A partial list of the articles we have written to dispel myths about asset protection includes:

- Why it doesn't make sense to put money in a spouse's name
- Why joint ownership with a spouse is mediocre protection at best, and
- Why your medical malpractice policy and Professional Corporation may not shield you from claims.

Though these are only a few of the topics that many physicians concerned with protecting personal and practice assets must address, it is more important that every physician recognize the need to at least consider asset protection planning as part of a comprehensive Wealth Preservation Plan.

The truth is that the majority of physicians will go through their entire careers without ever going to trial to defend themselves in a medical malpractice lawsuit. Of those that do go to trial, many result in favor of the physician. Of those that end in favor of the plaintiff, many are covered by traditional \$1million/\$3 million medical malpractice coverage.

Though the odds are in your favor that you will never be faced with a judgment above coverage limits, the truth is that some physicians can, and do, lose their homes, brokerage accounts or other personal assets from lawsuits every year. The most common and dangerous misconception physicians have is: "Asset Protection planning is not important because physicians don't lose assets to lawsuits."



In this short article, I hope to open your eyes and dispel this myth. Even more, I hope it will show you that the benefit to engaging in this type of planning is that, even if you are right and you never lose a large lawsuit, the benefits your family receives from this planning will far outweigh the cost of such planning. For this reason, even if the risk of such a financial catastrophe is extremely small, it is still well worth the time and effort to move forward with the planning.

There are a number of key issues in this analysis to review. I will take each one individually:

## 1. Finding proper data is difficult

Those of you who have spoken to me, read my book, or read my other articles, know that I am not someone who uses extremes. I, like you, like to see data before I make judgments or form opinions. However in this area, tracking how many physicians who lose personal assets in malpractice actions is very difficult, if not impossible to obtain. That is because the legal system publishes filed cases and judgments rendered, but they do not publish the collections of those judgments. In other words, any lawyer can consult his or

her own local litigation reports and see on a monthly, quarterly, or annual basis what the medical malpractice judgments in his location were. There may be many judgments for the defense, some small judgments for the plaintiff, and some very large judgments for the plaintiff, beyond coverage limits. After that, we are stuck.

There are no reports that publish what happens once a judgment is rendered. Did the plaintiff, with a judgment in excess of coverage limits, simply settle for the amount of the medical malpractice insurance?

Did the plaintiff and his attorney pursue the personal assets of the physician and his family to satisfy any excess judgments? These are questions for which there are no answers in the published materials. Therefore, it is almost impossible to find data on a local or national basis.

I practice law in New York and California. Every week in the malpractice reports I review, there are numerous malpractice actions decided in both places. Most decisions are for the physician defendant, some are small judgments for the plaintiff and a few, every week, are very large judgments for the plaintiff. This may be the same in your location as well. Nonetheless, we can only hypothesize about what will occur once these very large judgments are rendered. It seems that many physicians and their advisors simply assume that their plaintiffs in these cases will walk away from very large judgments and simply settle for the malpractice insurance coverage. Let's look at a couple of reasons why this may not be so.

## 2. Payments, Not Evictions

A common theme in speaking to physicians and their advisors around the country on this topic seems to be that "I

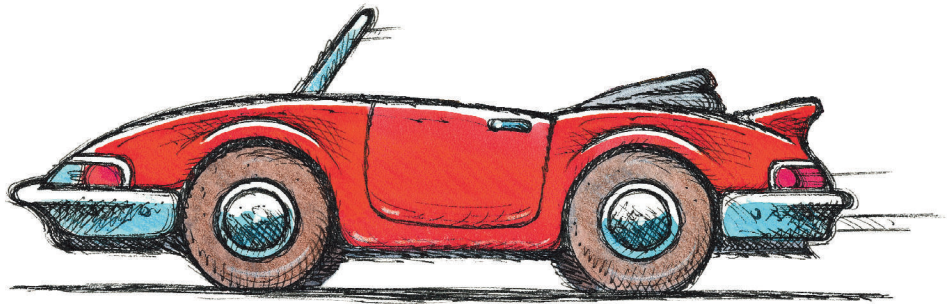
**Continued on Page 17**



have never personally heard of anyone losing their home to a lawsuit,” and therefore the conclusion is that it doesn't happen. And like them, I have not heard of a physician losing their home outright or being evicted by a lawsuit plaintiff. However, if one understands the goal of litigation and the plaintiffs, this certainly isn't surprising. What does occur instead of eviction, is that the plaintiff with the judgment will file a lien on real estate, levy bank accounts or put liens on them and essentially put levies or liens on any assets of the physician to the amount of the judgment owed to them. The goal is not to kick the physician out of their home, but to make the doctor take a loan against the home to pay off the excess judgment. And this, I can assure you, happens with great regularity.

I am part of a national network of advisory firms to physicians called the Wealth Protection Alliance (WPA). When I was doing research for this article, I emailed all members across the country and asked them to give me anecdotal stories of physician clients of theirs who had been successfully sued for large judgments. I received over 20 stories of advisors whose clients had been sued successfully, the judgment had been beyond coverage limits, and the plaintiffs have gone after the doctors assets, not looking for eviction, but looking for payment of the excess judgment. In every case, the physician was forced to take loans against assets, liquidate retirement accounts and sell various assets to pay the judgment off. Of course, none of these cases hit the papers and thus any kind of data in any study.

Consider this situation: a true story from my own practice. In New York, I had a couple come to see me three years ago. He was a Plastic Surgeon and she an OB/GYN. They consulted with me and I made a number of recommendations for tax, estate planning and asset protection. While they implemented some of the planning, they did not choose to do anything to protect their home, which at the time had over \$1.5 million of equity. I received a call from the plastic surgeon nearly a year ago. He said that his spouse, the OB/GYN, had just been successfully sued for a bad baby case in which the



judgment rendered against her was \$4 million, \$2 million more than her personal malpractice coverage. I told him at the time that there was nothing else I could do since there was already a judgment. While I have not spoken to the client since, I ask you, do you think that the plaintiff and their attorney who rightfully won a \$4 million judgment would simply settle for the \$2 million of insurance coverage when they could put a lien on the \$1.5 million of equity in the defendant's home in a matter of two hours with the cost to the attorney being about \$500? If you think that the plaintiff and their attorney would not come after the physician's personal assets in this way, either because you don't think they would kick the doctor out of their home or because of some kind of good will plaintiffs have towards physicians, consider the next point.

### 3. The Legal Obligation of the Plaintiff Attorney: Get the Cash

As above, there seems to be an underlying assumption by attorneys who represent physicians and advise them that asset protection isn't important, that plaintiffs and their attorney will not go after physicians' personal assets because it is "distasteful" or for some other reason. But put yourself in the shoes of the plaintiff and the attorney. In fact, the plaintiff's attorney has a professional and ethical obligation to represent his or her client with their best interest to the fullest extent of the law. If as an attorney, I represented a plaintiff who had a \$4 million judgment and only \$2 million was paid by insurance and I knew that the defendant had millions of dollars of assets

that were unprotected that I could attack in order to get my client paid in full, I would have to do this. In fact, if I didn't pursue those assets, I would be liable for malpractice to my client, and rightfully so.

### 4. Why Would You Protect Assets

As I noted above, if you have ever read my materials or heard me speak, you know that I am not someone who says the "sky is falling." Even with all the statements that I made in this article, it is still statistically relatively low risk that you will lose personal assets in a malpractice action, regardless of your specialty. However, the point that we make with our clients and in our books and articles is that asset protection planning can actually benefit you in many ways beyond lawsuit protection. In fact, most of the asset protection we do for clients is relatively low cost and has numerous financial, tax and estate planning benefits as well. Thus the question becomes "if asset protection planning can protect you in many ways and can cost relatively little, why wouldn't you do it...when there is even a slight chance that you will lose personal assets at some time during your career?"

Think of it this way: Consider colon cancer and getting a colonoscopy. Colon cancer is one of the most preventable forms of cancer we know about. In order to prevent it, patients simply need to get a colonoscopy performed on a regular basis. The medical field spends its time motivating and educating patients about getting a colonoscopy. And even though the chance of cancer may be slight, we know that

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## ASJ on Today Show

Continued from Cover

recent issue of the *Aesthetic Surgery Journal*. Stofman, a Society member in practice in Pittsburgh, PA was interviewed by Today's Alex Glick and was joined by psychotherapist Robi Ludwig.

Doctor Stofman is well aware of the power public education efforts can hold. However, he made special note of the importance these efforts have on the Society and the cosmetic surgery specialty: "There was a lot of PR in and around the article itself and the *Aesthetic Surgery Journal* was mentioned often. This is really a great opportunity for public awareness, and I thought it was excellent for plastic surgery. It was amazing in one day, getting calls from all over the country in a positive way, what an impact the media has," he said.

For more information please contact the Aesthetic Society communications office at 212.921.0500.

## Asset Protection

Continued from Page 17

getting that colonoscopy is the wise thing to do. Nonetheless, many patients still get colon cancer because they don't get colonoscopies done because it is an uncomfortable and perhaps for some, scary procedure.

This seems to be many peoples attitude with asset protection planning. However, when they realize that proper asset protection is not overly complicated, not overly expensive and often benefits them in many other ways, they will move forward even with the knowledge that the chance of being sued is very small.

Ask yourself: how many patients would get colonoscopies done if by getting the colonoscopy procedure they would instantly lose 20 pounds of fat and look ten years younger? You would have patients lining up around the block to get a colonoscopy. If only physicians would realize that asset protection planning can benefit them in so many

ways, they wouldn't be paralyzed by the improper assumption that asset protection isn't needed because they would never lose assets in a lawsuit.

I hope that you will become more educated on what proper comprehensive planning is all about. Feel free to contact me or one of the WPA members around the country to learn more.

For a 40% discount on Jarvis & Mandell's new book, *Wealth Protection M.D.*, or for an audio CD on *Asset Protection* please call (800) 554-7233 or email [info@wealthprotectionalliance.com](mailto:info@wealthprotectionalliance.com)

David B. Mandell, JD, MBA is an attorney, lecturer, and author of the *Wealth Protection, MD*. He is also a co-founder of The Wealth Protection Alliance (WPA)—a nationwide network of independent financial advisory firms whose goal is to help clients build and preserve their wealth. He is speaking at this year's Annual Meeting.

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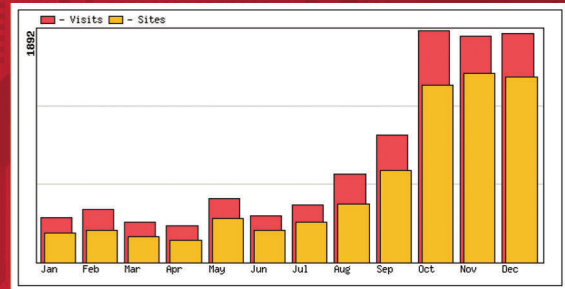
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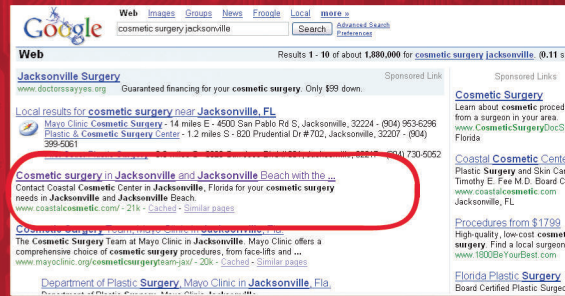
# Search Engine Optimization (SEO)



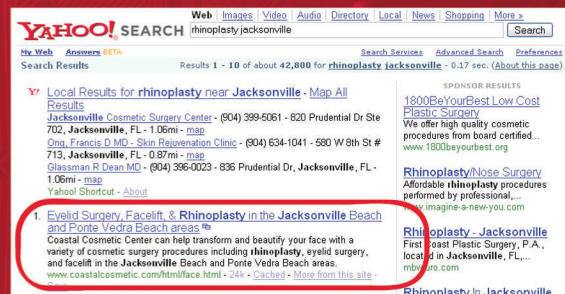
CoastalCosmetic.com - This Einstein site has been optimized to perform under targeted searches.



SEO can radically improve traffic



Google search result COSMETIC SURGERY JACKSONVILLE



Yahoo! search result RHINOPLASTY JACKSONVILLE

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