Feature Article

‘Jack of All Trades’...Master of ASAPS!

During the recent BAAPS Annual Meeting held in London at the end of September, I was fortunate enough to meet the very charismatic Dr. Jack Fisher, the current President of the American Society of Aesthetic Plastic Surgeons (ASAPS), who hails from Nashville, USA.

Dr. Fisher was kind enough to allow me to ‘quiz’ him on some of the differences between practices, trends and experiences of surgeons in the USA, in comparison to the UK and Europe.

Many of the comments were very insightful and showed a clear distinction in how things are ‘done’ across the pond. I hope you will enjoy this interview as much as I did.

Lorna: I’d like to talk about breast implants. Historically in America there was a ban on silicone implants, with them coming back to market in 2006. I also see from the ASAPS annual statistics that you actually publish percentages for the use of silicone versus saline breast implants which last year showed 72% silicone use. There has also recently been the FDA approval for the marketing of the Sientra/Silimed brand of silicone implants. So I wondered if your perception is that basically that’s the end for saline use in America? I mean we really don’t use them much in the UK.

Jack: Right, well let’s start out with a misconception. Gel implants were never banned in the United States, they had restricted use.

Someone like myself, who did a lot of breast reconstruction or congenital breast deformities, we were allowed to use gel implants throughout that entire period but we had to do them in studies, for the collection of data.

I even hear my colleagues in the US say they were banned. There was never a ban.

But what has happened is we are following what has happened in Europe. I am one of the individuals that have always felt gel implants are superior to saline and have a lot of benefits; feel, appearance, especially in thin individuals. Saline implants have a lot of problems.

Because you all had access to gels, or alternate access to gels quicker than we did I think there was a quicker conversion. 90% of the implants I put in are gels, only 10% are saline.

Again I’ll still see the occasional patient who is worried about it, even though I’ll give them the science. And also some of it is cost. Saline implants are half the price of silicone gel implants. But as I tell my patients I’ve never had anybody come back to me with gel implants and say ‘*I wish I had salines*’. But I have a certain percentage with salines who come and say, ‘*you know you were right, I’ve got wrinkling, they don’t look quite as natural*’, and they switch to gels.

So I think there’s a place for saline implants. We do have a restriction in the United States, which makes no sense, but in a purely cosmetic patient they have to be 22 and older to put in gels.

Now if it’s someone with breast marked asymmetry or who never developed a breast on one side, we can use gels in those patients. So in someone

Dr. Jack Fisher is a plastic surgery specialist in Nashville, Tennesse, USA, with more than 30 years of experience.

His many years of service to the American Society for Aesthetic Plastic Surgery (ASAPS) culminated in his becoming president of the organisation in April of 2013. Previously, he served as head of education, treasurer, and vice-president of ASAPS and acted as president-elect through 2012.

Dr. Fisher is a well-known and respected surgeon. He has been invited to speak at a number of surgical conferences throughout the world particularly on breast and aesthetic surgery. He is also an Associate Clinical Professor of Plastic Surgery at the prestigious Vanderbilt University Medical Center in Nashville, Tennesse.

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who's doing a younger patient population they will use more salines. Because I'm getting old, so are my patients! So I'm seeing less of the really young patient population but primarily its gels.

When I give my patients the pros and cons, the vast majority say '*yes let's use gels*', and I use the European experience and tell them the vast majority…95% at least, I'm sure use silicone over saline in Europe. So I tell people that in Europe they hardly use salines and they haven't been for years. It gives them a sense of reassurance, plus I know the science between gels and a lot of the hysteria in the United States.

We must remember that what happened in the early 90's with gel implants, a lot of that was lawyers and it made some people very, very wealthy because of what happened with the litigation.

L: We all know that we live in a multicultural society now so maintaining ethnicity in terms of aesthetic plastic surgery is always an important factor for surgeons; for example with operations like a rhinoplasty in a Caucasian individual versus an African American, we know there are issues there in terms of maintaining the required shape of the nose. However, I wanted to touch on the concept of *westernising surgery*. There has recently been the story of Julie Chen, the American TV news anchor, who admitted to having eye surgery to reduce her oriental eyelids.

I wondered if ASAPS have their own stance or protocols in terms of how they advise aesthetic surgeons on the dichotomy between maintaining ethnicity and the idea of people wanting to westernise themselves?

J: It's a very good question because in Korea now, it is an incredibly common operation to have the eye surgery. As a matter of fact it's their number one procedure in Korea. So we don't have a lot of experience with that, there are different areas in the United States where you might have a higher Asian population like California.

It's something I have no personal experience with, certainly as an organisation we have no public or consistent recommendation but I think my colleagues who are well trained, who have a sense of ethics and standards at least would inform a patient of the pros and cons.

The most common thing we see really is more rhinoplasty related then eyes and it has to do with the African American population as you said. I call it the 'Michael Jackson Syndrome' where essentially he didn't have a nose prior to his unfortunate death, it was over operated on.

Those are very difficult procedures to do and to do well because there are a lot of structural components with different noses.

I think in the United States it's (westernising surgery) not as much of an issue and I have to be quite honest I don't understand it personally, what is going on in Korea, where they're having the high incidents of surgery. Sometimes you wonder what is a fad? And what is a pure sense of aesthetics?

In the United States we're seeing a lot of buttocks augmentation. When I grew up everybody wanted a small butt!

L: It's the Beyoncé factor isn't it?

J: Yes, but I think those actually are more temporary trends that come and go. I think for most of us there are basis aesthetic criteria of what enhances a person's appearance, versus what is almost a short term trend. Who knows in a decade in Korea if people will still be having that procedure or if you'll see buttocks augmentation in the United States?

Part of that's regional in the USA too. You see a lot of that (buttock augmentation) in Florida and other parts of the country. You go to Minnesota which is all Norwegians and Swedes they won't even know what you're talking about.

So there are a lot of regional differences but to really answer your question in what I think is a logical manner we have to separate the norms of what we consider beauty and aesthetics from something that is almost a fashion trend; that I think is very short term.

L: We all know the horrible fact that sometimes cosmetic surgery goes wrong. We have issues in this country whereby if somebody goes into a private practice to have a treatment or they go abroad to continental Europe and then something goes wrong, because we have a nationalised health system invariably they will end up in Accident & Emergency and the tax payer picks up the bill for treating them.

Some of the news stories that I read from the United States include illegal buttock augmentations that happen in the back streets, particularly in the transgender or Latino communities in America with devastating consequences. I therefore wonder how that actually manifests in terms of those people getting help in the USA. Is there 'pro-bono' help, what happens?

J: That's a very good question. We're seeing more and more patients that are going outside the United States for aesthetic surgery. Some of it is probably pretty reasonable but the best surgeon is going to have complications.

One of my mentors favourite line was 'the only way to avoid complications in surgery is to never operate'. It is part of the human condition; you can get an infection; you can have problems. So, it is a real problem and again it's regional.

I have a friend in New Orleans who has seen a lot of people coming from South America who then come with complications and expect that somebody should take care of them for free, and don't go back to the country of origin where the surgery was.

We have a case in Nashville where a young lady went abroad for skin reduction; these people who've had massive weight loss. She had horrible complications.

Fortunately a lot of our members (ASAPS) are willing to take these on pro-bono, the problem is that the hospitals won't.

So a lot of these patients are actually trapped because the hospitals are not going to start doing free surgery on these people. If it's something simple that can be done in the clinic or the doctors own operating room that's possible. But yes, there are these disasters and it's a real problem especially if somebody comes back with an infection that cannot manifest itself for two or three weeks after the original surgery.

So you're better off in this country because at least your national health care system will take care of them. Private insurance in the United States will not, so these people can be trapped.

L: I see. So even if they have a health care insurance provision…

J: The insurance company will say sorry. We even have a problem in the U.S. where if they have aesthetic surgery in the U.S. and have a complication their health insurance may still deny treating that complication because it was outside the scope of their policy.

Now we do have a policy that is available in the U.S., and I use it. I have all my patients acquire the policy. It's a thirty day policy that will cover any post-op surgical complication and it's very cheap, it's like $140. It's a great idea and it will cover them because a lot of the private companies in the U.S. will say '*sorry you paid for that yourself we're not going to cover the problem*'.

L: I think if the NHS put their foot down in this country, we may well find insurance provision like that comes here.

J: Yes. Has anybody looked at how big a problem it is here in Great Britain?

L: There are studies by departments in regional NHS hospitals who have evaluated the number of patients who come in with complications following cosmetic surgery from abroad and poorly administered dermal fillers mostly.

J: That would be fascinating to know and also to find out what the financial burden is on these institutions. Some of these people are very sick and you spend a great deal of money on them and it may not just be one or two procedures, it may be a protracted amount of care that you have to deliver to them.

L: With the NHS, generally, they will patch up. So if you turn up at the emergency department with a chronic infection they will treat that but they will not then take that forward with any restorative surgery; or any further correction after that. They will just get you better again.

J: Then the person goes abroad again and then comes back.

L: Absolutely, we have a huge problem with cosmetic surgery tourism, mainly due to the cost.

J: I'm going to write a book entitled '*smart people making dumb decisions*'.

L: As you said earlier on today in the Press briefing, when referring to cosmetic injectables, it is unfortunate that the public think that going for an injectable treatment is like having a makeover. Similarly, they think that going for cosmetic surgery is not a big deal and they don't think of it as medical.

We have all sorts of issues with dermal fillers, in that we want better regulation, because unlike with the FDA where you have only about a dozen approved fillers available, we have the European CE marking which unfortunately lets hundreds through into the marketplace as the restrictions aren't so tight.

In the UK we're currently going through a regulatory shake up on who can and can't administer them too so I think in the next year or so we'll have a better idea of the future landscape.

J: The big problem is that these events are rarely scientific and more likely they're political. Until you get the politicians behind it there's very little you can accomplish.

For more information on the American Society of Aesthetic Plastic Surgeons (ASAPS), including international membership, please visit www.surgery.org.

Lorna Jackson

Lorna has been Editor of The Consulting Room™, the UK's largest aesthetic information website, for over a decade, since 2003.

She has become an industry commentator on a number of different areas related to the aesthetic industry, collating and evaluating statistics and writing feature articles, blogs, newsletters and reports for The Consulting Room™ and various consumer and trade publications, including *Cosmetic News, Journal of Aesthetic Nursing, Aesthetic Medicine* and *Aesthetic Dentistry Today.* Lorna has also been asked to present at various industry events, including Smart Ideas, BACN and Merz Aesthetics Business Workshops, the FACE Conference and the Clinical, Cosmetic & Reconstructive Expo.
