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Dr. Scott Hultman



Dr. Brian Coan



Dr. Cynthia Diehl



Dr. Michelle Brownstein



Dan Shannon

Cosmetic Changes

A lively discussion about plastic surgery

Four surgeons – three specializing in plastic surgery – met recently at *Chapel Hill Magazine's* office for a roundtable discussion about the state of cosmetic surgery. They covered a lot of ground, from exploring the motivations of patients to the cost of implants to improvements in Botox to plastic surgery-addicted patients. The following is an edited transcript of the conversation.

The panelists included:

Dr. Scott Hultman, in addition to heading UNC's plastic surgery group, trained at UNC's Plastic Surgery Residency; Emory University General Surgery Residency and Fellowship in Surgical Critical Care; University of North Carolina, M.D.; University of Pittsburgh.

Dr. Brian Coan maintains a private practice on the Durham-Chapel Hill border called CARE Plastic Surgery (www.careplasticsurgery.com). Dr. Coan trained at Duke University Medical Center and the University of Texas Southwestern Medical Center.

Dr. Cynthia Diehl is a plastic surgery resident finishing her training at UNC in June. She is a board certified general surgeon but found greater satisfaction in the aesthetics of reconstructive and cosmetic surgery, so she returned to train in plastic surgery. She will start a reconstructive and cosmetic private practice, Diehl Plastic Surgery, in Raleigh this summer.

Dr. Michelle Brownstein, a columnist for *Chapel Hill Magazine* and a retired surgeon, and *CHM* Editorial Director **Dan Shannon** moderated the discussion.

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SHANNON: Let's start. The top three [surgical] procedures nationwide are liposuction, eyelid surgery [blepharoplasty] and breast augmentation. The most popular non-invasive are Botox injections, laser hair removal and injectable

fillers. Does that sound right for Chapel Hill?

DR. COAN: That sounds just about right for our area, as well.

DR. HULTMAN: The cosmetic surgery

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we do at UNC is a little different than [those] trends. We do a lot of reconstructive surgery; in my own practice I do a lot of cosmetic surgery on burn patients. Likewise, we do a lot of body contouring surgery on patients who have lost a massive amount of weight from having their stomach stapled, gastric bypass and the like. Chapel Hill's unique in that we have every kind of [plastic surgery] practice.

SHANNON: All to the good from a patient's viewpoint.

DR. COAN: Yes, it's a very friendly community of [specialists]. Everyone supports one another, regardless of specialties.

DR. BROWNSTEIN: From the readers' perspective, how would you advise they sort through the wealth of different [plastic surgery] options in the area?

DR. COAN: How to choose a doctor is a complex process. The most important is your rapport: Do you like your doctor and does he or she like you? Do they have the ability to communicate their goals with you? And do they have the right training?

DR. HULTMAN: It's particularly critical to have great communication with cosmetics patients because they – the patients – dictate what their goals are. With other types of health care, it's more straightforward. If you have a ruptured appendix, you take it out; if your gall bladder is infected, you remove it. If someone has signs of aging or desires to have enhancement, then you have to really be able to communicate with your patient to determine [his or her] goals and objectives.

SHANNON: The self-selection of your

patients is a unique aspect of your field, but I get it. I'm 56 years old, and if I were in the job market right now I would consider coming to you and asking if it would make sense for me to try to look a bit younger, for example. Another patient might come to your office and just say, "I want to look prettier." How do you assess?

DR. DIEHL: That's so tough. You have to nail down precisely what bothers the patient. Of course, sometimes they want you to tell them what's "wrong" with them.

SHANNON: How do you do that?

DR. DIEHL: I ask them to define what they think their issues are and then we discuss those specific issues. To have them stand there and say, in effect, "Fix me up," is not the way to proceed.

Aside from the obvious problem of my

	
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saying, “So, you’d like me to work on your lips,” and they then say, “I love my lips!” (*Laughter*)

DR. HULTMAN: You ask the patient to define their goals first. You never take the first step.

DR. COAN: In addition to their issues or goals, we need to ascertain the patients’ motivation. That’s the way to get to the heart of the matter in a non-judgmental way. We’ll ask, “What brings you here? Is it your idea or someone else’s?”

SHANNON: For example?

DR. COAN: Say an estranged spouse is motivated to have [cosmetic surgery] in order to win back her husband. That’s a motivation that would raise warning flags.

DR. BROWNSTEIN: So you’re on the lookout for motivations that may not be healthy?

DR. COAN: Exactly.

SHANNON: To win back your spouse? That’s not a healthy motivation?

DR. COAN: I would say no. It’s important to me that their whole support structure supports what they are doing.

DR. HULTMAN: Brian’s absolutely right. There’s an art and science to cosmetic surgery, and the art is trying to understand their motivations. And then trying to match our own skill set to their needs. As doctors, we will recommend to them what we can accomplish. Most plastic surgeons would agree that it’s not about changing someone’s looks but it’s about making them look younger or more refreshed. It may be about correcting certain deficits, like a crooked nose or a chin that’s been broken, but by and large we’re not striving to alter one’s looks.

SHANNON: It sounds a bit judgmental, if I may say so. If, say, a 45-year-old woman is having marital problems and she thinks cosmetic surgery will help, isn’t that a good enough reason?

DR. DIEHL: It’s hard enough to give people the results they want, cosmetically. It’s even harder to get that husband back. We don’t have any idea what was behind that. You have to measure their expectations and assess what’s realistic and what’s not.

DR. HULTMAN: Take a weight-loss patient that’s lost a couple of hundred pounds and wants to look the way they did before they gained the weight. As

‘There’s an art and science to cosmetic surgery, and the art is trying to understand their motivations ... it’s not about changing someone’s looks.’

surgeons we can help them with that. The woman you described, I think it would be perfectly reasonable to offer her various procedures – for example, a tummy tuck or a breast lift or facial rejuvenation – that would make her feel good about herself. That’s a sound motivation. But if she’s doing it for someone else, that’s a problem.

DR. COAN: Also, I worry when a patient imagines their whole world is going to change because of body contouring or cosmetic enhancements. Their personality or degree of confidence may change, and then they can go out and deal with the world on their terms.

DR. BROWNSTEIN: On another topic,

what are your insights on Botox versus facelifts? Can you elaborate on options patients have to get that refreshed look?

DR. HULTMAN: There are invasive and non-invasive options. What we’ve seen over the past couple of years is that the demand for the more invasive surgical procedures has been flat or even fallen a little bit while demand for rejuvenative non-invasive procedures has increased quite a bit.

DR. BROWNSTEIN: To what do you attribute those trends?

DR. HULTMAN: In part because of the economy, but also these [newer] ancillary procedures combined can produce results almost as good as, if not better, than a facelift.

DR. BROWNSTEIN: But they’re temporary treatments.

DR. HULTMAN: Yes.

SHANNON: Also, I’m told there are varying levels of quality of Botox. Who knew?

DR. HULTMAN: Botox has become a commodity. I’ve always been surprised at how much patients like Botox.

DR. DIEHL: Well, \$400 for Botox versus thousands of dollars [for a facelift].

DR. COAN: I have very happy patients that use Botox.

DR. BROWNSTEIN: Of course patients have to come back [for treatments] every four to six months. What happens when they stop? All of a sudden they have their old face back.

DR. DIEHL: Botox is probably one of the only treatments that is preventative. It atrophies muscles, and atrophied muscles aren’t going to form wrinkles as effectively as non-atrophied muscles.

DR. HULTMAN: Fillers now are far superior to what they were in the past.

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They're lasting two years now as opposed to six months. For a 42-year-old woman, say, she can get a really good result from Botox and fillers, whereas in the past we might have considered a facelift.



SHANNON: Can we talk about insurance and plastic surgery? The perception is that it's a wonderful luxury, but an *elective* luxury, if you will. Is that the case?

DR. DIEHL: Very complicated topic.

Take rhinoplasty or blepharoplasty, for example. There are functional, specific reasons why people might need [a nose job or an eye job] and those reasons could justify coverage by insurance. For example, if skin is hanging over your eyes and obstructing your vision, there might be a sound medical reason to remove that skin.

DR. COAN: There are a lot of reasons to undergo plastic surgery that might be covered by insurance. Inability to breathe adequately during exercise, obstructions of the nose, sleeping with your mouth open all the time because you can't breathe through your nose. These are some reasons why patients might have a rhinoplasty consultation.

DR. HULTMAN: Another example is breast reconstruction after cancer. We will often need to do another procedure on the other side that may be considered elective, but it is [covered by] insurance. So breast reductions, breast lifts and breast augmentations can be covered by insurance.

SHANNON: But absent cancer, breast

reductions, breast lifts and breast augmentations are not typically covered by insurance, correct?

DR. COAN: Correct. But sometimes it's frustrating. My first case as a private practitioner involved a woman who had a very large pendulous breast on one side and a nearly absent breast on the other side – a congenital malady – and she was denied by her insurance company.

SHANNON: That's an outrage.

DR. BROWNSTEIN: How much does plastic surgery cost for a breast aug-

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mentation or reduction?

DR. COAN: I believe that the average cost for a breast augmentation or reduction, according to industry studies, is \$6,000 to \$10,000. And maybe one-third to one-half of that is the surgeon's fee.

I'd like to add – price is not the way to select a plastic surgeon.



DR. BROWNSTEIN: What about the patient who is never satisfied with the results? Or is addicted to [plastic surgery]?

DR. HULTMAN: We've all seen addicted patients.

DR. COAN: Sometimes you miss it, though. We're not perfect, which emphasizes the need for great communication with the patient.

SHANNON: Look at Michael Jackson. What kind of ethical surgeon would work on him?

DR. BROWNSTEIN: Short of that extreme, you must run into patients who are never satisfied with the outcome.

DR. HULTMAN: What I tell my patients [pre-procedure] is if they are not happy with the result, we will be able to address some of their concerns. If some-

thing's a little uneven, we can do touch-ups; that's part of what we do.

DR. BROWNSTEIN: But there's always the patient who sees things that are crooked that no one else sees.

DR. COAN: You use your documentation, photographs, your education and, ultimately, you sometimes just have to say, "I can't operate on what I can't see."

DR. DIEHL: Sometimes I mention to women that nothing is perfectly symmetrical; I tell them to think of their breasts as sisters, not twins.



SHANNON: Last question. Have *you* had plastic surgery?

DR. COAN: Yes, I've had Botox treatments as part of my training and I've used it afterwards.

DR. HULTMAN: No, nothing. Wait. Ten years ago I had microdermabrasion on my face to see what it was like.

SHANNON: Okay. Cynthia?

DR. DIEHL: Maybe. **CHM**