

# DR. KOTLER'S SPECIAL REPORT

INSIDER'S INFORMATION FROM THE DR.90210 NASAL SURGERY SUPERSPECIALIST

## Why Not All Plastic Surgeons Should Be Performing Rhinoplasty

I would like this report to be precious to you. I want this to have value such that you will say to yourself, "It's a good thing I read this, I sure didn't know that."

Today I want to discuss with you issues that other MDs may not necessarily be as forthright or open about. I am going to tackle somewhat of a controversial subject.

And, I may not win any popularity contests with some other doctors, but that's not important. What's important is what's critical for you.

I have the standing to be a judge and critic. I can help you from the vantage point of having been a board-certified specialist for 36 years and having over 4,000 nasal surgery cases under my belt. A record few other doctors will achieve. My career has included serving a fellowship in cosmetic facial surgery following my residency as well as a military career which gave me enormous experience and depth. Plus teaching in the military and here at both USC and UCLA medical schools.

Right now, up front, here is the statement you need to hear: There are way too many poorly performed cosmetic nasal plastic surgeries. I am embarrassed by it.

Now, you need to know the "why" and how not to be one of the unhappy patients. Here we go.

### Is Every Plastic Surgeon Qualified to Do Nasal Cosmetic Plastic Surgery?

No.

That's the big "pearl" that I want to share with you. Not all plastic surgeons or head and neck/ear, nose and throat surgeons are equipped by training, talent or experience to perform cosmetic and reconstructive nasal surgery. Regardless of what it says on the office door.

It's an inconvenient truth that needs to be told.

What I'm telling you is based on my observations and my involvement over the years in the academic community and in acting as a consultant to the Medical Board of California and to insurance companies and even the City and County of Los Angeles Medical Departments. **Nasal surgery is unquestionably the most complex and challenging of all the surgeries within the world of cosmetic plastic surgery.** You can understand why. The operation is typically done through the nostrils. While it can be done through an external incision, even that still yields a very limited opening through which surgery is done. Contrast that with surgery inside the abdomen, chest or even skull where the exposure or opening is quite generous. In abdominal surgery, three or four surgeons could put their hands inside. You can barely put your pinky inside the opening of the nose when operating.

The nose has complex anatomy and the component structures are interdependent on each other. **In nasal surgery, more than any other cosmetic plastic operation, tolerance for error is very narrow.** Remember, it won't make much difference if there is a little bit of tightness or a little extra scar tissue inside your abdomen after you have your gallbladder removed or your hernia repaired but you sure don't want to have any scar tissue that shows on the outside of your nose after having cosmetic nasal plastic surgery. So the standards for excellence have to be high.

With little room for error in the cosmetic result and the need often to make sure that the patient breathes well, there is a lot of responsibility that comes with picking up the instruments to do cosmetic *rhinoplasty* as well as the surgery to improve the airway known as nasal *septoplasty* and *turbinate resection*. Sometimes, it is even necessary to do some limited sinus surgery if in fact the patient's breathing problems are so bad as to impact upon sinus function.

My point is that just like in orthopedic surgery, where not all orthopedic surgeons are experts in arthroscopic knee surgery, or hand surgery, you have to make sure that you narrow your search beyond just having a board-certified specialist in either head and neck surgery or plastic surgery because both of those fields cover a lot of ground.

In plastic surgery, for example, there are 137 operations that the American Board of Plastic Surgery considers within its domain and expects its graduating residents to have familiarity with and be capable of performing. But there is no way any plastic surgeon could master all those operations. Certainly *rhinoplasty*, as difficult as it is technically to

perform, cannot be fully mastered in just a couple years of residency. It takes many more years. Because the route to excellence is long and demanding and comes from great teaching, and broad experience and the desire for mastery.

### Current Problems with Training and Education of Cosmetic Surgeons

Speaking of training, you need to understand the current state of American post-graduate medical education, the residency system.

Nearly 100 years ago, the U.S. established the world's premier and most sophisticated postgraduate physician training system. All this was the result of formalization of specialties which began in 1916 with the formation of the American Board of Ophthalmology. My specialty, head and neck surgery, was the second certifying board founded several years later. Since then, there have been 23 recognized specialties, each conducting its own residency programs leading to credentialing known as "board certification."

In the golden era of medical education which in my opinion began at the end of World War II and continued into the early 1980s, surgeons-in-training, had ample opportunity to amplify their skills. "Teaching cases" were plentiful since there were many patients who would come to the university hospitals and be willing to have their surgical procedures done by the novice surgeons under supervision of the professors and other faculty members. This was possible because then universities had fat budgets for teaching. As you can imagine, residents take longer to do procedures than sophisticated faculty or other veteran specialists in practice. Yet, the budgets allowed for that prolonged operating room time. The system worked very well for many, many years. The large inflow of patients allowed young surgeons to feel quite comfortable with their skills when they graduated from the residency programs. I know that the teachers in our residency program at the University of Illinois felt that way.

Another negative consequence of the constriction of funds for teaching was that the corps of voluntary doctor teachers began to shrink. In my residency program, most of the teachers were unpaid, volunteer faculty. They felt a duty and responsibility to give back to the University that trained them. So, many would devote one day per week, 20% of their workweek to be with us at the University. But as the doctors felt the pinch from the insurance companies on their practice home front, they could no longer afford to be away from their practice a day a week. That hurts training programs.

At the university hospitals, the full-time faculty is struggling with administrative and financial issues. The university requires full-time faculty to generate a certain amount of research including the writing of research papers. Also, in order to support the institution financially, faculty is required to bring a certain number of paying patients to the university. All this means that doctors spend a lot more time doing administrative functions including battling with insurance companies so that both they and the university are paid for services performed. Less time for teaching.

All of the above current problems and burdens within the residency training system were not the case in the "golden era" of medical education where the attention and focus was directed on producing competent practitioners with a large volume of experience during the residency program.

The times run against great training programs for other reasons you may not have considered. **Further heightening the abilities and talents of today's superspecialists, the most experienced and specialized surgeons, was that nearly all of us served in the military.** I served as Major, Medical Corps, U.S. Army and was a faculty member in the Walter Reed Army Medical Center's residency program at our hospital. For many of us who had completed our residencies and were fully trained and qualified specialists, it was a rich and rewarding opportunity to hone our skills and at the same time, of course, give back serve the country in a meaningful manner. Most of today's young surgeons have not had the privilege and honor plus the benefits of the experience that come with military service.

You might ask why the young doctors are not pursuing additional training in cosmetic surgery after those long residencies. One explanation is that doctors today decide against further training and education to further perfect their skills to the highest level because they cannot afford to further defer their entrance into practice. Traditionally this was done by either joining the military or electing to take a fellowship. Today, many graduate from medical school saddled with huge debt; some private medical schools now charge \$60,000 a year for tuition! So it is possible that young graduates - before they start their six to seven-year residency - are in debt as much as a quarter million dollars. And while residents are paid during their long period of apprenticeship, little money is left over to begin to pay down the loans. It is an untenable situation for many families of these young, struggling doctors in training. Rather than concentrate on moonlighting to earn extra money, these young doctors need to keep their focus on reading medical journals, studying textbooks and preparing for the demanding life of a MD.

### How Insurance Companies Helped Weaken Medical Education

As usual, economics trumps all. In the early 1980s, the complexion of medical practice changed as insurance companies began to reduce payments for all medical services. The bottom line is that over a period of time, teaching hospitals - like all hospitals - became financially squeezed as insurance company payments were continually ratcheted down and as the expense of providing care went up. Budgets in university hospitals were under such a tight rein that the residency programs began to suffer from it. Some hospitals even gave up training certain residents and fellows (fellows are post - residency subspecialty trainees, say in cardiology) because government stipends were diminishing parallel to the decline in insurance reimbursements.

So how did this all affect the training of residents? The answer is that the opportunities to perform elective surgery drastically diminished. **Residents today often graduate from some training programs with a very poor background in cosmetic surgery. They are stronger in reconstructive surgery**, whether in the head and neck or the rest of the body. The reason is that reconstructive surgery is always medically necessary and patients come to the hospitals with some form of insurance. The hospitals still keep the Welcome Wagon out for hand surgery, burn care, reconstruction after cancer, correction of birth defects. These are reconstructive plastic surgeries staples. But hospital administrators loathe to tie up an operating room for an entire day, for less compensation than a reconstructive case, for a young surgeon trying to learn how to do a facelift.

### **Today, Is It Wise to Go to a Teaching Hospital?**

Thanks to the Internet, today's patients are very sophisticated. A different world than that of my training days. Today's patients know a lot and they also know that perhaps the teaching hospital is not the place to go for their surgery because that is where the surgery is done by trainees. Patients are reluctant to have elective cosmetic plastic surgery done by inexperienced surgeons. So that keeps people from going to the hospitals and that **diminished inflow reduces the surgical load and learning opportunities for the surgeons in training**. In addition, teaching hospitals offer little privacy and personalized service. Further, of course, in hospitals there is a greater risk of infection and other complications that strike fear into patients and surgeons alike.

### **Some Surgeons Learn to Do Cosmetic Surgery on Their Patients**

The consequences of changes in training programs are significant for today's patients. If residents graduate from a residency program with nearly all training in reconstructive plastic surgery and little experience in performing cosmetic plastic surgery such as rhinoplasty, for example, they have to learn it on their patients in private practice. Such "on the job training. Not exactly what patients expect or want for their hard-earned money.

**We hear of surgeons who go into practice and advertise that they perform cosmetic nasal surgery and yet have done two or three rhinoplasty cases in their residency.** Their web site shows one or two before and after photos. Are these doctors kidding themselves? Worse, are they kidding their patients?

You need to think about all these things when you make your decision particularly concerning nasal cosmetic surgery which is by far the most technically demanding and sophisticated of all the cosmetic surgery procedures.

### **Why Before and After Photographs Are the Best Clue to the Doctor's Experience, Degree of Specialization and Surgical Talent**

There is no better telescope into the nature of a cosmetic surgery practice than the volume and quality of the before and after photographs that are made available to prospective patients. I almost chuckle when I see some surgeons with such a limited number of rhinoplasty cases on their website. They may have more breast augmentations or liposuctions but even those numbers are very small. So if a surgeon has such a small library of before and after pictures, doesn't it seem that their surgical experience would also be limited?

I love websites that have hundreds of before and after photographs because it is much easier for the prospective patient to identify someone, somewhere on that site that had similar needs and aspirations that they have. So don't forget to ask about before and after photographs when you go for consultation and if there are no photographs that can be shared with you, I would suggest that you say "Oops, I think I have a cell phone call. I must leave now", and politely head for the door.

### **The Single Smartest Decision You Can Make: Seek the *Superspecialist***

To summarize, what I'm suggesting to you is that if you are considering having nasal surgery, you must search for the ***superspecialist***. The doctor at the top of the totem pole. A master nasal surgeon. Not one who says, "Oh yes, I do those too", as if it's OK for you to have an operation considered a sideline!

You want a surgeon who has narrowed his practice down to a very limited number of procedures among which nasal surgery is extremely prominent and who has the focus such that he has excluded many other procedures from his practice, even though he may have once been quite capable of well-performing. The educational background that one seeks is to have graduated from a residency program and passed the board examination and then gone on for additional ***fellowship*** training in facial plastic surgery which will always have nasal surgery as a key component. Remember, fellowships are Medicine's finishing schools.

Look for fellowship training the doctor's *Curriculum Vitae* (professional resume). Also, you need to ask **how long the doctor has been doing nasal surgery and how many cases he has done over a period of years**. Do the calculation that shows how many are performed each year. Any surgeon who is performing fewer than **100 nasal cases per year** is probably not at the top of the totem pole.

Remember, you have the right to ask these questions, you have the means to do your homework. As you know from seeing patients who have had unsatisfactory nose surgery, the stakes are high.

Do your homework. Read. Visit websites. Talk to your friends.

After all, you want to do it right the first time.

I hope this helps you. If you want more information, call us; we always welcome questions.

Robert Kotler, MD, FACS

PS: **Take advantage of our many remote patient services;** you can consult with us from the privacy of your own home. Whether here in Southern California or anywhere in the world. We can arrange a **personal, confidential SKYPE CONSULTATION with me** and if you send us digital photos (see the website's section on Computer Imaging) we can morph them on our office computer system and send to you, via e-mail, the **photos that show the predicted result of your procedure!**

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