N early 10 years ago, when plastic surgeons in California engaged in long and hard-fought legislative battles to mandate third-party coverage of appropriate reconstructive procedures, we included a definition of reconstructive and cosmetic surgery in the bill to minimize misinterpretation:

“Reconstructive surgery” means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: (1) to improve function, or (2) to create a normal appearance, to the extent possible. “Cosmetic surgery” means surgery that is performed to alter or reshape normal structures of the body to improve the patient’s appearance.\(^1\)

The resulting legislation is still one of the most comprehensive and effective in the nation. Innumerable patients have received necessary and appropriate treatment as a result of this landmark legislation, which is a great benefit to society and, ultimately, a great benefit to the specialty of plastic surgery. Notably, plastic surgeons still retain the right to choose whether to participate in third-party payer plans.

After the California victory, Federal legislation in the form of the Women’s Health and Cancer Rights Act of 1999 required third-party payers to cover breast reconstruction after mastectomy on a national level. Unfortunately, that bill was not as comprehensive as the California law, specifying “post-mastectomy reconstruction” rather than “reconstruction following treatment for cancer or other disease of the breast.” Since the legislation was passed by Congress and signed into law, the treatment of breast cancer has increasingly changed. A greater emphasis has been placed on breast conservation therapy when appropriate, on the basis of the nature of the malignancy. However, the resulting deformities are often significant, and breast reconstruction may be greatly complicated by the frequent use of adjuvant radiation therapy. Indeed, the reconstructive challenges posed by these patients can make an aesthetic result more difficult to achieve than in a patient who has undergone mastectomy. In addition, the expectations of patients undergoing conservation therapy are often greater, because they understood that their treatment would minimize the postoperative deformity and give them a more aesthetic outcome.

In many cases, third-party insurance companies deny reconstruction for these patients, using a very narrow interpretation of the Federal law. This is unacceptable, and we must advocate for a broader, more appropriate law that includes all patients needing reconstruction after any treatment for breast cancer or other breast disease. Legislation must reflect the changes that occur in society and in medical care over time; it is essential that the Women’s Health and Cancer Rights Act be updated and expanded.

Why should surgeons who perform primarily aesthetic surgery get involved in this advocacy issue? First, there is more that unifies aesthetic and reconstructive surgery than divides it. There is always an aesthetic component in plastic surgery, regardless of the operation. Whether it is a cleft lip, a nasal defect after ablative cancer surgery, or a breast deformity after mastectomy, reconstructive surgery is not focused solely on “closing the hole,” but on doing so with like tissue, having an acceptable color and texture match, and restoring form. The goals of symmetry, pleasing shape, minimally noticeable scarring, and the least evident donor scars are all aesthetic in nature. Moreover, many of the cosmetic procedures that we perform actually combine aesthetic and reconstructive surgery, including abdominoplasty with diastasis repair, and rhinoplasty with septoplasty, turbinate reduction, or spreader grafts. And, in my opinion, the quality of aesthetic surgery is enhanced by the knowledge and experience acquired in doing reconstructive surgery on the same anatomy.

But beyond this, there are important reasons why aesthetic surgeons must participate in the efforts to gain appropriate third-party coverage for procedures that are reconstructive in nature, even when the approach to

---

Dr. McGuire is an Associate Clinical Professor of Surgery at UCLA, Los Angeles, CA.
these problems includes aesthetic concerns. The article in this issue of *Aesthetic Surgery Journal*, “Aesthetic Outcomes in Breast Conservation Therapy,” by Wang et al, demonstrates that, in the authors’ study, 28.3% of women undergoing breast conservation therapy were dissatisfied with their cosmetic result and therefore were more likely to have a negative change in body image when compared with patients who were satisfied with their cosmetic result.\(^2\) The article also states that rates of breast conservation therapy may, in some instances, be as high as 47% of eligible patients. The implications are that a significant population of women find themselves with significant breast deformities following disease treatment, yet they may have no opportunity to undergo plastic surgery procedures that could restore a more normal and aesthetic appearance of their breasts. As physicians and surgeons, we must consider this situation untenable.

Laws with language similar to that incorporated into the California legislation are needed in every state to prevent inappropriate denials of necessary reconstructive surgery. In addition to the issue of breast reconstruction after any treatment for breast disease, plastic surgeons are fighting on the Federal level to secure passage of the “Children’s Access to Reconstructive Evaluation and Surgery Act,” the CARES Act. This bill has been proposed for several years and has received significant support in Congress, but it is opposed by the insurance industry. We must continue to advocate for this legislation until it is passed.

Historically, a “professional” has been defined as a member of one of the learned occupations who assumes the obligation to defend the rights of the most vulnerable members of society. As medical professionals and plastic surgeons, it is our obligation to advocate for our patients as their spokespersons and defenders so that “aesthetic reconstructive surgery” is available to all who need it. ☀

DISCLOSURES

The author has no disclosures with respect to the contents of this article.

REFERENCES