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“Landmark Plastic Surgeon Advocacy within the Federal Government: Four Case Studies”

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Running head: History of Plastic Surgeon Advocacy

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Abstract:

Background:

Throughout history, plastic surgeons have advocated for the protection of the specialty and for better care for their patients. Whether through efforts to support and move legislation through Congress or through preventative advocacy in the form of lobbying against legislation, plastic surgeons have often used their expertise in the political sphere to shape patientcare. We hope to inspire current and future plastic surgeons to be politically active and to devise ways in which their expertise can be used within the legislative system to better care for their patients.

Methods:

The following manuscript highlights four historical examples of plastic surgeon led advocacy within the federal government: *The U.S. Flammable Fabrics Act*, ASPRS and the Federal Trade Commission -1979, the *Women's Health and Cancer Rights Act*, and the *Breast Cancer Patient Education Act*.

Results:

We hope that plastic surgeons will – like Dr. Crikelair, Dr. Wider, and the members of ASPS/ASPRS – continue to play an active role in the shaping of the legislative system for our profession and ultimately our patients.

Conclusion:

To ensure the best care for their patients, plastic surgeons must continue to maintain their relationship with public health and legal professionals and legislators. Through relationships with patients and a firm understanding of their stories, plastic surgeons can make great impacts in all local, state, and national political spheres.

Introduction

Plastic surgeons bring a unique perspective to the American legislative ecosystem. Like all physicians, they carry a deep understanding of their patients' experiences in addition to a firm comprehension of data, trends, and statistical analysis. Although the legal, legislative, and political systems can feel foreign to plastic surgeons, there is crossover between items important to healthcare administrators, congressional leaders, and plastic surgeons, including patient outcomes, risk -to-benefit ratios, and cost. Each of these aspects and participant perspectives must be considered and utilized in a way that is productive and data driven to produce policy changes that help patients to ultimately receive the best care.

There are many avenues by which plastic surgeons can become involved in advocacy. These can include direct participation within government via running for office, serving on task forces and regulatory entities at the state and federal level, or testifying in front of Congress; grassroots-level initiatives such as having conversations with or writing to politicians about pertinent issues, joining protests, signing petitions, raising money, or talking to the public; and through academia by performing groundbreaking research and educating the next generation of physician-leaders. Though each of these options carry varying levels of commitment, each provides a pathway for change.

Through four specific historical examples, we showcase how different plastic surgeons navigated these systems to utilize their expertise for the betterment of patients. We seek to demonstrate that the plastic surgeon perspective is critical to advocacy for patients, no matter the method or depth of participation.

The U.S. Flammable Fabrics Act

In the late 1940s and early 1950s there were a number of children and women who were tragically burned to death wearing rayon pajama sets, sweaters, and dress-up materials. Congress responded to these frequent incidents by enacting the *U.S. Flammable Fabrics Act of 1953*, allowing the Federal Trade Commission (FTC) to regulate and ultimately prohibit the creation of highly flammable attire using brushed rayon.¹ These items were cited to be ‘so highly flammable as to be dangerous when worn by individuals’² and were even known to ‘explode into flames in the presence of a lighted match or a cigarette’³.

Even with this increased regulation of clothing, it was estimated that as many as 150,000 people per year were victims of fabric burns well into the 1960s.² Dr. George Crikelair, the chair of Plastic Surgery at Columbia-Presbyterian Medical Center in New York at the time, noticed a pattern among his child and adolescent patients seeking burn care treatment. His patients were often treated while still in their cotton pajamas, costumes or playwear that were subsequently found to be the provocateur of the burn.⁴ He decided to engage within his local political sphere to advocate for tighter regulation of flammable clothing. He began by involving other local burn surgeons, textile industrialists and government officials in the issue of clothing-related burns.⁵

One particularly tragic example of a clothing-related burn involved the daughter of a prominent Washington reporter who was severely burned after her flannel pajamas caught fire while she was playing. Her father took the charred remains of her pajamas to the Textile Bureau of the FTC as evidence for prosecution. However, according to the current legislation, her pajamas were simply not flammable.⁶ This increased the movement’s momentum and led Dr. Crikelair to pursue national political involvement. He began to testify before the Senate about the morbidity and mortality of the fabric burns affecting patients like this young girl, and the

economic impact of the utilization of hospital resources/supplies in the treatment of fabric burns. During his testimony he stated, “*We know that even when burn victims survive, our techniques for the reconstruction of damaged hands and deeply scarred ears and noses are still less than the perfect that we’d like. The answer is obviously prevention.*”⁶ This testimony proved to be pivotal and in 1967, Congress amended the *U.S. Flammable Fabrics Act of 1953* to include any fabric or material used in apparel or interior furnishings to be properly labeled and to be held to a mandatory flammability standard.¹

Dr. Crikelair subsequently helped to create and became the chair of the Information Council on Fabric Flammability (ICFF), which eventually fell under the Federal Consumer Product Safety Commission. The ICFF began establishing safety standards for carpets and rugs in 1970, followed by mattresses and mattress pads in 1972 and children’s sleepwear between 1971-1974.^{1,5}

Because Dr. Crikelair was conscientious of his patient’s stories and needs, he was able to enact change that would protect and promote the safety of future generations. His expertise and his willingness to become politically engaged ultimately led to safer textiles for all U.S. citizens and prevented countless injuries. Though he passed away in 2005, his legacy of promoting patient safety and advocating for legal protections for patients will continue to inspire future generations.

ASPRS and the Federal Trade Commission -1979

In the 1970s, the Federal Trade Commission (FTC) took a stand against certain current medical practices and organized medicine entities, beginning with the American Medical Association (AMA). When the AMA was founded in 1847, a line within their Code of Ethics argued that advertising medical services was “derogatory to the dignity of the profession” and

was consequently banned.⁸ In 1975, the FTC brought this issue to the forefront in *Goldfarb vs. the Virginia State Bar*. The lawsuit claimed that physicians were “restraining trade” by not advertising. It presented the FTC with the theoretical hope that ‘doctoring—like any trade—would become better and cheaper if incited by competition’.⁹ Ultimately the court sided with the FTC and determined that medicine should be treated the same as a goods/services market, which included allowing advertising.¹⁰ Interestingly, several years after the passing of this law, a study demonstrated that physician advertising in the yellow pages had increased dramatically, and that 12% of these advertisements were made by “specialists” without a board certification in fields like hypnosis and nutrition.¹¹

Then, continuing their focus on regulations of the medical industry, the FTC specifically targeted what was then known as the American Society of Plastic and Reconstructive Surgeons (ASPRS), now ASPS¹², and the American Board of Plastic Surgery (ABPS), claiming that board certification was forcing increased prices and creating an unfair market. The leader of the FTC at the time, Commissioner Michael Pertschuk, stated that the “standards in plastic surgery were unnecessarily high” and that they were “self-serving, exclusive, and potentially acting to restrain trade”.¹³ Plastic surgery was singled out because it was one of the smallest medical societies, as well as there were many complaints by physicians who were not board certified, and because it was now a more visible specialty because advertising was legally permitted. To combat this threat, Dr. Mark Gorney, the chief of plastic surgery at St. Francis in San Francisco (ASPRS president 1982-1983), made the decision to initiate a special dues assessment of \$400 to all members of ASPRS practicing in the United States in order to challenge the FTC complaint. Within two months, 81% of members had paid, as well as retired members and members from Canada. Additionally, plastic surgeons weren’t the only ones to donate; members of other

medical societies donated to the cause knowing that the ASPRS was likely the first of many other medical societies to be targeted by the FTC. With this funding, ASPRS was able to create a national movement based on the idea that blurring the line of physician competency puts patients at risk. Several media outlets also joined the movement, with *Reader's Digest* publishing multiple articles on the topic, and *60 Minutes* and *The Today Show* airing segments about the harm caused by those claiming to be plastic surgeons.¹⁴

After multiple negotiations between ASPRS and the FTC, the FTC claimed they would be launching their legal complaint in mid-July of 1979. However, because of the pressure from plastic surgeons around the world and the public, that date passed, and no legal proceeding was ever opened. As this fight came to a close, ASPRS president and the chair of University of Pennsylvania at the time, Dr. Peter Randall, stated *"The overall changes in their position are favorable, but we must remember very clearly that even though the tide has changed, there comes a time, as surely as the moon will rise, when the ebb tide will stop and the flood tide will begin again."*¹⁴

The willingness of ASPRS members to get involved, both locally and abroad, and collaboration with other large medical societies made this protection possible. It is important to note that substantial financial capital can greatly enhance advocacy, particularly when utilized and strengthened through large, professional societies.

The Women's Health and Cancer Rights Act

In 1997 Dr. Todd Wider, a plastic surgeon in New York, was taking care of a 32-year-old nurse with newly diagnosed breast cancer requiring a major resection. Using his expertise, he recommended that Ms. Janet Franquet undergo a transverse rectus abdominus myocutaneous (TRAM) flap for coverage after her cancer resection.

Ms. Franquet had union-based self-insurance through her husband's employment. During this time in the late 1990s, some U.S. states, including New York, had passed laws requiring insurance companies to cover breast reconstruction costs, but often the union-based plans were exempt from requiring this coverage. Because of this, Dr. Wider had frequently run into issues with obtaining insurance coverage for breast reconstruction. Ms. Franquet's case, he felt, was uniquely justified due to the size of the area requiring coverage. After applying for pre-authorization for the procedure, the insurance company denied the medical necessity and cost of a TRAM flap. At this point, he requested to speak with the medical director of the insurance company. The medical director recommended Dr. Wider "perform a skin graft" as it was much more cost-effective for the company, despite having no inherent medical basis. Dr. Wider refused, stating "*that might be OK in 1935, but not in 1998*".¹⁵ Eventually, Dr. Wider ended up performing Ms. Franquet's breast reconstruction for free.¹⁶

Following this encounter, Dr. Wider reached out to his local senator, Alfonse D'Amato (R-NY), who was already a substantial proponent of policies aiding the fight against breast cancer, having secured over \$900 million in federal money for breast cancer research.¹⁷ Senator D'Amato, after hearing about Ms. Franquet's case, then called the same medical director at the National Organization of Industrial Trade Unions Insurance to demand coverage for her breast reconstruction. The medical director was then quoted as stating, "*Replacement of a breast is not medically necessary and not covered under the plan. This is not a bodily function and therefore cannot and should not be replaced.*"¹⁵ Senator D'Amato responded by introducing a bipartisan bill to Congress, known as the *Women's Health and Cancer Rights Act (WHCRA)*, which provides coverage for group and individual health plans for all stages of reconstruction on which mastectomy has been performed, any surgery required on the contralateral breast to produce

symmetry, prosthetics, and for treatment of all complications of mastectomy including lymphedema.¹⁸ This bill was signed into federal law on October 21, 1998, by President Bill Clinton and is now presently recognized as “Janet’s Law.”¹⁹

Studies have since concluded that this act is at least partially responsible for doubling the breast reconstruction rate from 1998 to 2008.²⁰ Without Dr. Wider and other passionate plastic surgeons listening, understanding the hardships of his patient, and initiating conversations with key legal personnel, this act would not have been possible. This crucial act, aimed at improving the options for breast reconstruction for patients with breast cancer, reiterates the importance of plastic surgeon involvement in healthcare, insurance, and governmental decision-making.

The Breast Cancer Patient Education Act

After the passage of the WHCRA, patient education regarding breast reconstruction remained an issue. A study published in the *Journal of the American Medical Association* in 2014 found that only 42% of women undergoing mastectomy chose to undergo breast reconstruction. Of the 58% of patients who did not, 20% reported a complete lack of knowledge of the procedure and their rights to reconstruction. Another 20% of patients foregoing breast reconstruction also struggled with misinformation, believing that reconstruction would alter their breast cancer disease state and recurrence detection later in life.²¹ Alarming, further research proved that there was a large disparity between black patients and nonblack, non-Latina patients in the choice to undergo breast reconstruction.²²

With this information, the American Society of Plastic Surgeons (ASPS) authored the *Breast Cancer Patient Education Act* (BCPEA) in 2012 with Senators Leonard Lance (R-NJ) and Roy Blunt (R-MO). This act would require the Secretary of Health and Human Services (HHS) to develop and implement an educational campaign about breast reconstruction options

and insurance coverage.²³ This bill gained most of its support through grassroots efforts and in-person meetings held between plastic surgeons and congressional staff that were coordinated by ASPS and largely executed in conjunction with its ASPS Regional Fly-Ins. This grassroots initiative reached a crescendo at the start of 2015, when over 85 in-person meetings were held with individual legislators and over 125 letters were sent to Congress regarding the BCPEA over a six-month period. As a result, 12 additional legislators signed on to the bill as cosponsors and increased bipartisan support for the bill by 41%.²³ Eventually, in 2015, the *Breast Cancer Patient Education Act* was passed, and educational materials were created by a joint effort between the office of HHS, the ASPS and the National Cancer Institute (NCI).²⁴

The educational campaign produced by the BCPEA has touched the lives of millions of American women. Although difficult to measure, it is likely that the annual incremental increases in breast reconstruction rates are at least in part due to the BCPEA's educational initiatives and the dispelling of misinformation among patients regarding their reconstructive options. Additionally, HHS has officially named March 21st Breast Reconstruction Advocacy and Education (BRAVE) Day, with the hope to educate breast cancer survivors about their recovery options.²⁵ Without the support and gathering of plastic surgeons around the United States, this act would not have been possible. Because of the collective effort of the ASPS and its members' willingness to get involved for the sake of their patients, women with breast cancer in the United States now have a federally mandated right to education regarding their options of breast reconstruction.

Conclusion

To ensure the best care for their patients, plastic surgeons must continue to maintain their relationship with public health and legal professionals and legislators. Be it through Dr. Crikelair's approach of recognizing patient safety concerns and reporting them to local politicians, or through advocating for insurance coverage and patient education like Dr. Wider and ASPS members in 2015, there will always be a part for plastic surgeons to play in the crafting of legislation in the United States. Because of their unique perspective, plastic surgeons have a duty to use their expertise to bring more attention to healthcare issues that are affecting millions of their patients. Through relationships with patients and a firm understanding of their stories, plastic surgeons can make great impacts in all local, state, and national political spheres. Though this paper focuses on examples within the United States, it is important to note that there are examples of plastic surgery advocacy in many other countries, and all plastic surgeons should advocate for their patients regardless of their location.

There are multiple ways for plastic surgeons to serve as an advocate for patients, including involvement in ASPS's Legislative Advocacy Committee (LAC) branch of the ASPS and the PlastyPAC, its political action committee. Both organizations are plastic surgeon-run and are always seeking out members and donations. Additionally, the PlastyPAC invites all plastic surgery attendings, fellows, and residents to the Advocacy Summit each year in May. Current LAC and PlastyPAC members are listed online, so another option is to connect with a member who is located near your respective region. On a different scale, meeting with local legislators about important health policy that affects patients is another avenue in which to advocate. In addition, social media is growing as a way for plastic surgeons to communicate directly with patients about educational information and health policy. There are also many civil

organization and non-profits plastic surgeons can collaborate with to raise awareness of patient issues and gather funding for advocacy efforts, like the Komen foundation. Regardless of the avenue, it is essential that plastic surgeons add a component of advocacy to their practice.

We hope that plastic surgeons will – like Dr. Crikelair, Dr. Wider, and the members of ASPS/ASPRS – continue to play an active role in the shaping of the legislative system for our profession and ultimately our patients.

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