Flattening Breast Cancer by Removing the Breasts: Protecting a Woman's Right to Choose Reconstruction of an Aesthetic Flat Chest After a Mastectomy

Amelia Landenberger*

Abstract

Breast cancer takes away women's choices. Many women decide to regain control of their bodies and prevent future cancer or follow-up surgeries by having a double mastectomy without any reconstruction, leaving a flat chest. When their doctors refuse to perform this surgery or their insurers refuse to cover this form of chest reconstruction, women are traumatized by their loss of choice in a system that clings to the outdated idea that women cannot be feminine without breasts. The Women's Health and Cancer Rights Act of 1998 was intended to protect women facing cancer from the second trauma of being unable to afford their breast reconstruction. New York has passed legislation making it explicit that flat chest reconstruction is breast reconstruction and must be covered. Other states should follow suit, especially in the face of the surge in anti-trans legislation banning gender-affirming surgeries for trans men, which could further limit women's options by banning the surgical creation of flat chests for cancer patients. In the absence of such state legislative action, insurers and courts should read the Women's Health and Cancer Rights Act to include reconstruction of both protruding breasts and flat chests in order to make women whole again after cancer.

* Assistant Professor, Law Library, University of Akron School of Law. This article is dedicated to all the women who went flat before it was cool, and to the women who will be empowered to make this choice in the future.

INTRODUCTION

A woman should have the right to have a mastectomy in order to decrease her high risk of cancer. She could then choose to have reconstruction of her breast(s) or choose to only reconstruct the breast area without protruding breasts (going flat).[1] A woman should have this right even if—and especially if—her choice might not be the most popular choice or what her surgeon would choose for themself. All stages of this reconstructive surgery should be covered by her insurance, just like her mastectomy.

Women's choices regarding their cancer treatment have been limited in the past. In 1971 Babette Rosmond discovered she had breast cancer. The standard medical treatment at the time was the "extremely disfiguring" radical mastectomy.[2] The decision to mutilate women's bodies in this way was typically made

1. *See infra,* I(C).

2. Barron H. Lerner M.D., *The Right to Choose Your Cancer Treatment*, N.Y. TIMES (June 13, 2012), https://perma.cc/QYT9-5SGG ("It so happened that Ms. Rosmond had two friends with breast cancer,

while the women were unconscious in the operating room, and some doctors didn't take the time to explain it to women ahead of time.[3] This horror-movie scenario[4] seems like a relic of the Dark Ages, if the Dark Ages had included reliable anesthesia.

As medicine advanced, women were still denied proper care. In 1997, Janet Franquet was denied breast reconstruction because her insurer considered it cosmetic.[5] Janet's story inspired the Women's Health and Cancer Rights Act of 1998 (hereinafter WHCRA) which prevents insurance denials for post-mastectomy reconstruction.[6] Janet died in 1999, at 33.[7] Because of her advocacy, the WCHRA spares some women from the pain of battling cancer and insurers. But the WCHRA has not always been enough, and insurers still fight to avoid paying for certain procedures.

In 2009 Anne Marie Champagne chose to have a flat closure after a mastectomy and her doctor seemed to have changed the plan for the surgery while she was unconscious, leaving her with odd-looking flaps of skin instead of her choice of a flat chest.[8] She stated:

> Even though I went into surgery thinking we were in agreement on the closure," Champagne says. "I had made my wishes clear. To this he replied that in his experience all breast cancer survivors reconstruct within six months. When I heard his words I felt profound grief, a

---

both of whom had experienced psychological and physical side effects from radical mastectomy, the extremely disfiguring operation routinely used by surgeons to treat the disease. The operation removed not only the cancerous breast, but the underarm lymph nodes and both chest wall muscles on the side of the cancer, leaving women with hollow chest walls and swollen arms." *Id. See also* Ms. Rosmond's book on the topic, written under a pen name: ROSAMOND CAMPION, THE INVISIBLE WORM (1972). She wrote about her friend's experience: "She had a bad time for the simple reason that no one ever really explained to her the trauma that often follows a radical mastectomy. . . . 'The thing they never even thought of telling me about–much less the definition of 'radical mastectomy'—is the pain. The nerves in the stump of pectoral muscle are screaming, the burned area gets hot and itchy after the X-ray treatment and develops a thick, reptilian hide that sheds grayish-purple flakes for a year. They tell me the cramps and vomiting are psychological. Maybe. All I know is, I was supposed to have a 'topflight' surgeon and a 'topflight' radiologist. Now, nearly four years after the operation, I still have an immensely swollen right arm and a chest that sheds gray flakes. And I can't really type. You know what that means when you think you're a writer. . . ."'*Id*. at 13.

3. Lerner M.D., *supra* note 2. *See also* Rosmond/Campion, *supra* note 2 at 28 ("For nearly a century, radical mastectomy, with or without irradiation, has been the accepted treatment of breast cancer in almost every hospital in the United States. But there have been recent developments that raise a dramatic question: is it morally acceptable for doctors to go ahead with something so drastic without fully informing the patient of all possible answers? One top-ranking surgeon in a first-rate clinic has dared to differ in his opinion of treatment: he believes that in cases in which a lesion is tiny and discovered very early, removal of the lump itself and examination of surrounding tissue are all that is necessary. (Obviously, this would not apply to a large cancer or to one that has already spread.)").

4. *Id*.

5. 144 CONG. REC S12810-39 (daily ed. Oct. 21, 1998).

6. *Id*.

7. Tom Demoretcky, *Janet Franquet, Pushed Law for Cancer Patients*, NEWSDAY, May 6, 1999, at 63.

8. Fran Kritz, *Some Women Want Flat Chests after Mastectomy. Some Surgeons Don't Go Along.*, WASHINGTON POST (June 16, 2022), https://perma.cc/6ATP-3USK.

> combination of heartache and anger. I couldn't believe that my surgeon would make a decision for me while I was under anesthesia that went against everything we had discussed—what I had consented to.[9]

It is hard to believe that in 2009, a physician might contradict his female patient's right to bodily autonomy and make that decision while the patient was unconscious. In addition to the women who face outright denial of their choice to go flat, many other women find that their physician doesn't explain all of their reconstruction options or that their insurer might only pay for certain choices.

To contrast Anne Marie's and Janet's experiences, consider the mastectomy and reconstruction of another woman: the very wealthy and famous actress Angelina Jolie.[10] Ms. Jolie, a BRCA mutation carrier with a very high risk of breast cancer, had a preventative double mastectomy with breast reconstruction.[11] The cost of the procedure would be minimal compared to her income, so we can presume she didn't need to fight with her insurer to cover her procedures. She made her choices with the advice and support of physicians[12] and achieved a surgical result that matched her choice to return to her pre-surgical silhouette.[13] Ms. Jolie felt empowered to take control of her medical decisions. She wrote about her experience and ended her op-ed by saying that "[l]ife comes with many challenges. The ones that should not scare us are the ones we can take on and take control of."[14]

Babette had to fight her way to a satisfactory outcome. She demanded to be a part of her own medical care. She discovered that there was an alternative to radical mastectomy and, through stubborn persistence, was able to choose this less-disfiguring, more targeted surgical treatment.[15] Her doctor told her she was a "very silly and stubborn woman," but her surgery was successful and the cancer never came back.[16] Anne Marie, almost fifty years later, was denied the right to make her medical decisions, while Angelina was able to consult multiple doctors and generated a surgical plan that she appreciated enough to write about in the

---

9. *Id. See also* Hester Hill Schnipper, *Breast Reconstruction - Is It the Right Choice for You?*, BETH ISRAEL DEACONESS MED. CTR (Aug. 7, 2019), https://perma.cc/PV3H-8XPU.

10. Richard Corliss, *Mighty* Maleficent*: Why Angelina Jolie Is the World's Highest-Paid Actress*, TIME (June 2, 2014), https://perma.cc/L5J5-KV87.

11. Angelina Jolie, *My Medical Choice*, N.Y. TIMES (May 14,2013), https://perma.cc/YM5P-YE9H.

12. *Id.* Two years later, when Ms. Jolie had a bilateral salpingo-oophorectomy, she described her level of medical care in detail: "I have spoken to many doctors, surgeons and naturopaths. There are other options. [. . .] There is more than one way to deal with any health issue. The most important thing is to learn about the options and choose what is right for you personally. In my case, the Eastern and Western doctors I met agreed [. . .]". Angelina Jolie, *Angelina Jolie Pitt: Diary of a Surgery*, N.Y. Times (Mar. 24, 2015), https://perma.cc/QU5W-RYN4.

13. Jolie, *supra* note 11 ("They can see my small scars and that's it. Everything else is just Mommy, the same as she always was.").

14. *Id.*

15. Babette Rosmond (writing as Rosamond Campion), *The Right to Choose*, 1972–02 MCCALL'S 64, 66, 158 (1972).

16. ROSMOND/CAMPION, *supra* note 2, at 33. *See also* Lerner M.D., *supra* note 2.

New York Times. She hoped that awareness of her choices might help other women facing similarly difficult decisions.[17] We cannot all be movie stars, but all high-risk women should be presented with the available options for reconstruction and allowed to make the relevant treatment choices themselves.

This article focuses on the experiences of cisgender women because of the way societal norms about women, femininity, and breasts may affect surgeons' and legislators' opinions and the way they understand, describe, and conscribe women's choices. Though trans men, cisgender men, and trans women can also experience breast cancer,[18] I did not find trans voices or male experiences represented in the legislation, caselaw, or articles I drew on to write this piece. I welcome future scholarship focusing on the impact of cancer and mastectomies on trans people and on men.

This Article promotes a woman's right to make the decision to have a flat closure following a mastectomy which was prompted by a high risk of cancer. *Section I: Aesthetic Flat Closure* covers how high-risk women are identified, why they may choose mastectomy instead of frequent screening, what the menu of reconstruction options is, and why they may increasingly choose a flat closure rather than the other possibilities for breast reconstruction. *Section II: Challenges in Access to an Aesthetic Flat Closure* covers the harm caused by flat denial and the reasons a physician might oppose the decision: denying women's choices, ignorance of the technique, or bias towards other options. It also discusses the issue of insurance companies which refuse to cover the procedure. *Section III: Solutions* covers the WHCRA and delves into the issues of defining the breast, following the stated purpose of the act by considering the legislative history, and understanding the small bit of caselaw interpreting the WHCRA. *Section III* then covers a recent New York law explicitly requiring that insurers cover aesthetic flat closure equally with breast reconstruction and notify patients of that option in addition to the other available reconstructive choices.[19] Finally, it covers non-legislative solutions like litigation, social change, and other methods of increasing awareness of flat closure. Women deserve to be fully informed about their options, and deserve to be able to choose the post-mastectomy reconstruction that is right for them. They deserve to be made whole.

I. AESTHETIC FLAT CLOSURE

A. HIGH-RISK WOMEN AND THEIR GENETIC MUTATIONS

While both high-risk women and cancer patients have mastectomies, I have chosen to focus on high-risk women who have preventative mastectomies because cancer patients must sometimes choose from a more limited menu of

17. Jolie, *supra* note 11.

18. *See Male Breast Cancer, Abramson Cancer Center*, PENN MEDICINE, https://perma.cc/NE2B-ZRK2.

19. N.Y. INS. LAW § 3216 (McKinney 2024).

options—the necessities of cancer treatment drive the surgical or reconstructive choices.[20] Women who undergo a preventative mastectomy because they do not yet have cancer should have the full range of options and time to consider them, so they are the simpler case-study from which to discuss reform to the set of options women are offered for their post-mastectomy reconstruction.

A note on terminology: I have used the word *women* throughout this article but wish to be respectful of the fact that these issues may be experienced very differently by cisgender and transgender women. While all humans, male and female, cis and trans, are susceptible to breast cancer, I wanted to address the specific ways in which societal expectations of gender affect how a woman's choices regarding the shape of her chest are heard and respected or unheard and ignored. While I hope that this work may be helpful to all readers, I recognize that these societal expectations of gender may be different for trans women than for cis women, and the sources I have found do not speak to the trans experience of these issues. I welcome future scholarship that will explore these intersections in more detail and represent more voices than I have been able to quote in this piece.

A high-risk woman is one who has a genetic mutation or family history that makes her far more likely to get breast cancer and more likely to get breast cancer when she is young.[21] While there are many mutations that can cause a woman to be high-risk, the two best-known and most prevalent are BRCA1 (BReast CAncer gene 1) and BRCA2 (BReast CAncer gene 2), which produce proteins that help repair damaged DNA."[22] They "are sometimes called tumor suppressor genes because when they have certain changes, called harmful (or pathogenic) variants (or mutations), cancer can develop."[23] This Article will focus on BRCA1 because this mutation has been widely studied and the resulting data shows a staggering risk of breast cancer.[24]

The average woman has a 13% chance of getting breast cancer in their lifetime; as a fraction, that percentage becomes roughly one in eight women.[25] Luckily for

20. *See* Ellyn Winters, *I'm as Flat as a Pancake since My Mastectomy, but I'm Not Afraid to Wear Revealing Clothes*, GLOBE & MAIL (Jul. 23, 2022), https://perma.cc/A3T7-U9TZ ("When I first met with my surgeon, we discussed a variety of reconstruction options. Due to the size and distribution of the tumours in my left breast, a lumpectomy was quickly ruled out. But there was the possibility of an oncoplasty, where my surgeon would work hand-in-hand with a plastic surgeon to remove the cancer and remake me a pair of smaller boobs. If radiation was not required, a mastectomy with immediate reconstruction using implants was also on the table. Alas, a subsequent MRI revealed yet another tumour, and a mastectomy with deferred reconstruction was the only pathway forward. So, in good Canadian fashion, I opted for a double-double.").

21. *BRCA Gene Mutations: Cancer Risk and Genetic Testing*, NAT'L CANCER INST., https://perma.cc/GZ6F-XX34.

22. *Id.*

23. *Id.*

24. Jae Yeon Cheon, Jessica Mozersky & Robert Cook-Deegan, *Variants of Uncertain Significance in BRCA: A Harbinger of Ethical and Policy Issues to Come?*, 6 GENOME MED. 121, 1 (2014).

25. *BRCA Gene Mutations: Cancer Risk and Genetic Testing*, *supra* note 21.

women, most breast cancers happen after age 50[26] and the one in eight statistic includes all women: the beautiful younger women featured in Komen Breast Cancer Awareness ads[27] and the older women who might discover a slow-growing breast cancer at 90, choose not to treat it, and die of old age at 95.[28]

For women with BRCA1 mutations, dying of old age at 95 may feel fanciful—they don't expect to live that long. Instead of a 13% chance, women with a BRCA1 mutation have a 55%–72% chance of getting breast cancer.[29] Instead of one in eight, a BRCA1 mutation carrier has a one in two chance—or nearly as high as a three-in-four chance—of getting cancer. Women with BRCA1 mutations do not just get breast cancer more often, they get it when they are younger, too.[30] They may also have cancer that is harder to detect early and faster-growing tumors.[31]

The only positive for women who discover they have a BRCA1 mutation is that their awareness of this risk allows them to make choices to prevent cancer. Increased awareness also demystifies and destigmatizes the mutation. There are often landmark moments in awareness of a particular disease which was previously kept secret. The turning point for general breast cancer destigmatization was in 1974 when former First Lady Betty Ford publicly revealed her diagnosis.[32] For BRCA1, the shift in public awareness came in 2013, when the actress Angelina Jolie revealed her mutation and her choice to have a mastectomy in a New York Times Op-Ed.[33] Her op-ed was so influential that this gene is

26. *What Are the Risk Factors for Breast Cancer?*, CTRS. DISEASE CONTROL & PREVENTION (Jul. 25, 2023), https://perma.cc/MKX7-Z2C7.

27. Julia Markham Cameron, *Painting the Capitol Pink: The Breast Cancer Research Stamp and the Danger of Congressional Cause Marketing*, 27 UCLA WOMEN'S L.J. 17, 27 (2020). Cameron describes the deceptive positivity of breast cancer marketing: "the ad posits that the fight against breast cancer is a joyous one: breast cancer is not about taxing rounds of chemotherapy, unending medical bills, and painful operations; rather, it is about sisterhood, togetherness, and love." *Id.* at 25.

28. Sharon Reynolds, *Study Adds to Debate about Mammography in Older Women*, NAT'L CANCER INST. (Sept. 12, 2023), https://perma.cc/RER2-2YLJ. *See also* Mehra Golshan, *I'm a Breast Cancer Surgeon. Here's What I Think of the New Screening Guidelines.*, N.Y. TIMES (May 16, 2023), https://perma.cc/N6SJ-MY4R ("We also know that if a woman is diagnosed with cancer in her 40s, it is more likely to be a more aggressive type of breast cancer. This is the kind of cancer that is best to catch early because the treatment will need to be more intensive as it progresses — likely requiring a combination of surgery, radiation and drugs like chemotherapy. This isn't the same situation as a woman who comes to me with an early-stage cancer at age 80; we are having different conversations about treatment, because *the cancer may not ultimately affect how long she lives*.") (emphasis added).

29. BRCA Gene Mutations: Cancer Risk and Genetic Testing, *supra* note 21.

30. *Id.*

31. S. Pilgrim & S. Pain, *Bilateral Risk-Reducing Mastectomy Is the Safest Strategy in BRCA1 Carriers*, 40 EUR. J. OF SURGICAL ONCOLOGY 670, 670 (2014) ("In addition to this, tumours in young BRCA1 mutation carriers are believed to grow quickly. A three dimensional MRI study estimated that the volume of breast tumours doubles in 46 and 52 days for BRCA1 and BRCA2 mutation carriers respectively, twice as fast as other high risk non-mutation carriers.").

32. *Betty Ford and the Stigma of Discussing Cancer*, NPR (Dec. 28, 2006), https://perma.cc/DX9Z-S2HL; *see also* Peggy Orenstein, *Our Feel-Good War on Breast Cancer*, N.Y. TIMES (Apr. 25, 2013), https://perma.cc/3S3L-7Q72.

33. Jolie, *supra* note 10. For a discussion of the impact of Angelina's article, *see* Denise Grady, Tara Parker-Pope & Pam Belluck, *Jolie's Disclosure of Preventive Mastectomy Highlights Dilemma*, N.Y. TIMES (May 14, 2013), https://perma.cc/3BUE-L3D7.

sometimes referred to as the "Angelina gene" or "Jolie gene," and the increase in women considering prophylactic mastectomy after 2013 has been called the "Angelina effect."[34]

Finding a BRCA mutation can be a future-shattering event for a young woman. Today some women might find a mutation accidentally through direct-to-consumer testing like 23 and Me,[35] but for most of the time since the BRCA mutations were discovered, a woman would be tested for one of two reasons: either a family history of breast or ovarian cancer or a personal diagnosis of breast or ovarian cancer.[36] This means that most women who find out that they carry a BRCA mutation have already faced the trauma of cancer either personally or through their loved ones.

Cancer is not merely a hypothetical future for most BRCA1-positive women; it is a part of their past.[37] This plays out in the choices they make: high-risk women closely touched by the horrors of cancer are more likely to choose surgical prevention methods rather than surveillance.[38] For example, in Ms. Jolie's op-ed describing her mastectomy, she began by sharing that her mother passed away at age 56 after a ten year battle with cancer.[39] Two weeks after the op-ed was published, Ms. Jolie's maternal aunt died of breast cancer.[40] When describing the motivations that led her to have a salpingo-oophorectomy, Ms. Jolie related that in addition to her mother and aunt, she had also lost her grandmother to cancer.[41] Though this volume of loss in one family is shocking and tragic, it is also unremarkable in families affected by the BRCA1 gene.

Screenwriter Alena Smith wrote how finding her BRCA mutation felt like her future was re-written in an instant with a new cancer-focused plot:

> I had a BRCA1 hereditary gene mutation, which meant I had an 80 percent chance of getting the aggressive breast cancer that had killed my grandmother when she was just three years older than I was then, and a 40 percent chance of developing an undetectable ovarian cancer that was likely to be fatal as well. It would be smart for me to have all

34. Carole Cadwalladr, *What Happened When I Had My Genome Sequenced*, GUARDIAN (June 8, 2013), https://perma.cc/H3GQ-2976.; Andrew Gregory, *NHS in England to Offer Pioneering Cancer Drug to Patients with 'Jolie Gene,'* GUARDIAN (Apr. 6, 2023), https://perma.cc/7WAK-3L24; Alice Park, *The Angelina Effect*, TIME (May 27, 2013), https://perma.cc/2LMB-YGYS.

35. *Do You Speak BRCA?*, 23ANDME, https://perma.cc/DK39-MS7G.

36. *BRCA Gene Mutations: Cancer Risk and Genetic Testing*, *supra* note 21.

37. Marleah Dean, *"It's Not* If *I Get Cancer, It's* When *I Get Cancer": BRCA-Positive Patients' (Un)Certain Health Experiences Regarding Hereditary Breast and Ovarian Cancer Risk*, 163 SOC. SCI. & MED. 21, 25 (2016).

38. Catheleine M. Van Driel, Yassir Eltahir, Jakob de Vries, Jan P. Japsers, Jan C. Oosterwijk, Marian J. Mourits, and Geertrudia H. de Bock, *Risk-Reducing Mastectomy in BRCA1/2 Mutation Carriers: Factors Influencing Uptake and Timing*, 77 MATURITAS 180, 181–82 (2014).

39. Jolie, *supra* note 11.

40. Sam Jones, *Angelina Jolie's Aunt Debbie Martin Dies of Breast Cancer*, GUARDIAN (May 27, 2013, 9:27 AM), https://perma.cc/QTM5-ZU6B.

41. Jolie Pitt, *supra* note 12.

> my sexual organs (breasts, ovaries, fallopian tubes, possibly uterus) removed as soon as possible—but first, I should hurry up and get pregnant. Click. There's the plot. Enough for multiple seasons. Be careful what you wish for.[42]

BRCA forces women to make incredibly difficult and personal decisions, often quickly and under the strain of knowing that a wrong decision could lead to death. BRCA mutation carriers sometimes refer to themselves as previvors to differentiate from cancer survivors and from the rest of the population with a normal risk of cancer.[43] Though "[t]raditionally, society categorizes individuals as either healthy or sick," previvors inhabit the space between sickness and wellness.[44]

Previvors may be grateful for the knowledge which allows them to have preventative surgery while also grieving the loss of their normal bodies and normal lives before learning of their BRCA mutation. Taylor Harris described this dichotomy beautifully:

> It can't be healthy to hide behind gratitude without acknowledging that sometimes I feel like the subject of a Cubist portrait—a woman made of fragments pieced together, almost recognizable as her own. I'm looking for space, as a previvor, to mourn. A space where I can stop and consider that my scars are signs of relief but also collateral damage from a choice I made. I am fortunate and disappointed, indebted and sad.[45]

The measures which might allow a high-risk woman to prevent cancer will equal trading "the risk of developing one disease state for another."[46] This leaves doctors in a position where they cannot predict what will happen and there is no clear standard of care, so the woman herself is the only one who can choose the right course of action.[47]

B. PROPHYLACTIC MASTECTOMY VERSUS SCREENING

Why would a woman choose to amputate her breasts rather than screening for breast cancer every six months? Some women may make this choice for financial reasons, some because of anxiety related to cancer screenings, and some out of a desire to reduce uncertainty.[48]

---

42. Alena Smith, *A Previvor's Tale*, N.Y. TIMES (Dec. 4, 2022), https://perma.cc/97HE-PXJW.

43. Valerie Gutmann Koch, *Previvors*, 49 FLA. ST. U. L. REV. 643, 644 (2022).

44. *Id.* at 657. *See also* Soumya Karlamangla, *Not Quite Healthy, Not Quite Sick, Women at Risk of Hereditary Cancer Can "Fall through the Medical Crack,"* L.A. TIMES (Apr. 8, 2018, 5:00 AM), https://perma.cc/UA2R-VF4Y.

45. Taylor Harris, *After a Mastectomy, Moving Between Gratitude and Grief*, N.Y. TIMES (Jan. 25, 2022), https://perma.cc/LG93-QFVF.

46. Gutmann Koch, *supra* note 43 at 655.

47. *Id.*

48. Gutmann Koch, *supra* note 43.

Cancer screening can be very expensive. Some insurers may choose not to cover earlier cancer screening for high-risk women. The recommended screening for high-risk young women, the M.R.I., is only wholly covered for 25% of high-risk women.[49]

Screening can also be very stressful. Aside from the physical discomfort associated with mammography and the claustrophobia of M.R.I. tubes, waiting for the results can also be miserable. Ms. Jolie described her anxiety while waiting for results of ovarian testing: "I passed those five days in a haze, attending my children's soccer game, and working to stay calm and focused."[50] Since the standard procedure for high-risk women is to have a mammogram and an M.R.I. every year past the age of 30, women may reasonably choose not to pass a week every six months in a terrified haze, waiting for scan results.[51]

High risk women may choose prophylactic mastectomy because the uncertainty of their risk of cancer and death feels impossible to live with. Valerie Guttman Koch, Assistant Professor and Co-Director of the Health Law & Policy Institute at the University of Houston Law Center, has written about previvors and how the uncertainty inherent in genetic mutation fails to fit into the old informed consent model.[52] She argues "all those who test positive for a deleterious genetic variant that increases one's risk of developing a disease share a fundamental element: uncertainty."[53] In the old informed consent model the doctor was the one with the information and it was intended to flow from him to his patient; if it did not, he had failed to properly inform the patient.[54] But a doctor cannot tell a previvor if she will get cancer—the best medical knowledge today can only give her an approximate risk of cancer.[55] Therefore, "previvor decision making around risk and prophylactic interventions are based on more than medical factors; they often include psychosocial factors. For example, one may seek 'peace of mind' due to increased confidence that the individual will not develop the

49. Leah Pierson & Emma Pierson, *Genetic Risks for Cancer Should Not Mean Financial Hardship*, N.Y. TIMES (Nov. 26, 2021), https://perma.cc/Z6Z5-QXRW.

50. Pitt, *supra* note 12.

51. *Breast Cancer Screening Tests for Women at Higher Risk*, SUSAN G. KOMEN (Dec. 27, 2023), https://perma.cc/8Y6E-H5SW.

52. Gutmann Koch, *supra* note 43, at 687.

53. *Id.* at 651.

54. *Id.* at 669 ("Often, during 'normal' medical circumstances, a patient will receive a diagnosis based on symptoms, and then the physician will consider and recommend a course of treatment based on diagnosis and prognosis, refer the patient to a specialist if necessary, make the appropriate medical disclosures and obtain the patient's informed consent, and generally lead the patient through the course of treatment. Significantly, the informed consent process has traditionally been the forum for the patient to learn about the risks and benefits of a proposed course of treatment from the physician. The legal doctrine of informed consent is premised on ameliorating the information (and therefore power) asymmetry inherent in the physician-patient relationship. The doctor-patient relationship is often considered to be fiduciary in nature in order to ensure that physicians meet their disclosure and care obligations.

55. *Surgery to Reduce the Risk of Breast Cancer Fact Sheet*, NAT'L CANCER INST. (Aug. 12, 2013), https://perma.cc/9V6W-KLZA.

illness as a result of his or her genetic predisposition."[56] Women may find a sense of closure or resolution in having completed the mastectomy and reduced their risk of breast cancer by 90% or more.[57]

Ideally, Professor Koch says, doctors must engage in shared decision making:

> Rather than focusing on what the objective reasonable patient would find material to a voluntary medical decision, shared decision making is subjective and patient specific, relying on the medical evidence, the provider's clinical expertise, and the unique attributes of the patient and his or her family, including cultural factors and factors that affect patient-clinician interactions.[58]

The utter dismissal of shared decision-making is the most haunting part of Babette Rosmund's story of choosing a lumpectomy over a radical mastectomy in 1971. Babette's doctor, frustrated that she had refused to sign the consent for a radical mastectomy before the surgery to determine if her lump was cancerous, told her, "'You ask too many questions. I could have performed the mastectomy while you were under, and you would not have to go through this trauma twice and everything would have been fine.'"[59] He went on to threaten her with the possibility of imminent death: "'There are times when a woman is better off not knowing too much. She must put her faith and trust in her surgeon. *He knows best*. No. You can't wait more than a week.'"[60] Rosmund ultimately saw him as an executioner, not as a trusted physician. She described waking from her surgery: "I was aware of [the doctor] standing over me. I smiled at him (perhaps Mary Stuart in her scarlet gown smiled at the man bending over her, too), and then—much later—I became aware that I was in the recovery room."[61] Ideally women should feel that their physicians are empowering them to make the right choices, not threatening them with death and dismissing their opinions and emotions.

Women choose bilateral mastectomies in order to be finished with surgery, and they largely do not regret that choice.[62] While today's prophylactic mastectomy is not the brutal, disfiguring radical mastectomy of Babette Rosmund's day, it is

---

56. Gutmann Koch, *supra* note 43, at 681.

57. *Preventive Surgery to Reduce Breast Cancer Risk*, AMERICAN CANCER SOCIETY (Dec. 26, 2021), https://perma.cc/VA7S-HVNF.

58. Gutmann Koch, *supra* note 43 at 683 (internal citations omitted).

59. CAMPION, *supra* note 3, at 33.

60. *Id*. at 41 (emphasis in original).

61. *Id*. at 31; *Mary, Queen of Scotland*, Britannica (Feb. 4, 2024), https://perma.cc/Q76Q-TLG9 ("Mary was executed in 1587 in the great hall at Fotheringhay Castle, near Peterborough; she was 44 years old.").

62. Amanda Deliere, Deanna Attai, David Victorson, Kristine Kuchta, Catherine Pesce, Katherine Kopkash, Mark Sisco, Akhil Seth, & Katharine Yao, *Patients Undergoing Bilateral Mastectomy and Breast-Conserving Surgery Have the Lowest Levels of Regret: The WhySurg Study*, 28 ANN SURG ONCOL 5686, 5686 (2021).

nevertheless a serious surgery, and it is an amputation of a body part. The National Cancer Institute lays out these risks rather like the rapid-fire warning statement at the end of a drug advertisement:

> "As with any other major surgery, bilateral prophylactic mastectomy and bilateral prophylactic salpingo-oophorectomy have potential complications or harms, such as bleeding or infection. Also, both surgeries are irreversible. Bilateral prophylactic mastectomy can also affect a woman's psychological well-being due to a change in body image and the loss of normal breast functions. Although most women who choose to have this surgery are satisfied with their decision, they can still experience anxiety and concerns about body image. The most common psychological side effects include difficulties with body appearance, with feelings of femininity, and with sexual relationships. Women who undergo total mastectomies lose nipple sensation, which may hinder sexual arousal."[63]

These are not small side notes of a woman's life. A mastectomy may affect her self-image, her relationships with others and her mind. These are some of the fundamentals of life. In addition, there are changes to the experience of motherhood: women who have a double mastectomy as a preventative measure against cancer will not be able to breastfeed afterwards.[64] While some women are more self-aware than others, there is no way to truly know how all of this may feel until a woman is living inside her post-surgery body, and once the surgery is done, it is irreversible. It is not a choice to be taken lightly.

Women who make the choice to have a mastectomy might be trading one uncertainty for another, i.e., *I will not get cancer but I might experience feelings of loss and sadness over the changes to my body's shape and feeling*.[65] Because there is so much additional uncertainty in the reconstruction process, as will be discussed in Section C below, women who choose flat closure may be reducing uncertainty by decreasing the number of surgeries they must undergo and having a more limited number of likely outcomes regarding the ultimate shape of their chest.

C. RECONSTRUCTION CHOICES

When a woman chooses a mastectomy, she must also consider the menu of reconstructive choices. Three broad categories of reconstruction are offered today: silicone or saline implants, own-tissue reconstruction (including DIEP and TRAM flaps), or flat closure. There is no single correct choice. Each option has significant drawbacks and therefore the right choice for a particular woman

63. *Surgery to Reduce the Risk of Breast Cancer Fact Sheet*, *supra* note 55.

64. *Breastfeeding History*, BREASTCANCER (Jan. 4, 2023, 11:01 AM), https://perma.cc/Q3SL-WRML.

65. Gutmann Koch, *supra* note 43.

depends on her values and risk tolerance. In more technical terms, "[b]reast reconstruction falls into the category of what has been described as 'preference-sensitive care.' When multiple treatment paths are available and clinically appropriate, the decision process should incorporate and be sensitive to patient preferences about the various treatment options."[66]

To understand why a doctor cannot make this choice for women, consider four hypothetical women facing a high risk of breast cancer.

May is an artist in her mid-twenties. She's very image-conscious and focuses on the shape of her body. She knows that her confidence in future romance will be tied to the way she perceives her own attractiveness. She does not want to have a flat chest and is willing to have multiple surgeries but wants the option with the most minimal scarring. She will choose a nipple-sparing mastectomy with implant reconstruction done by a skilled plastic surgeon who can minimize the scarring.

Anna is a mid-thirties mother of two children. She wants to alleviate the kids' fear that their mother might die. She wants reconstruction so that her children will consider their mother unchanged, but she's hesitant about having multiple surgeries to replace her implants in the future and she's ok with having scars as long as she can cover them up with a simple one-piece swimsuit. Anna will choose a mastectomy with flap reconstruction.

Elizabeth is an extreme introvert who would prefer to avoid surgery. She has a strong belief in the immutability of fate. She feels confident that she'd rather treat breast cancer *if* it comes in the future rather than deal with all of the hassle and fuss for something that might never arrive. She chooses biannual screening rather than mastectomy and enlists a more outspoken friend to come with her to her screenings to make the experience less stressful.

Louisa is in her mid-thirties and is very independent. She makes her decisions quickly but is typically untroubled by regret. When she finds out about her high-risk status, she almost immediately settles on a mastectomy with aesthetic flat closure. When she takes off her bandages for the first time, she sobs at the loss of a body part she didn't anticipate she'd miss. But by the next day, she has no regrets, and she is confident that she'll never need another breast surgery.

No physician constrained by hourlong appointments can be expected to know May's views on the ideal female form, or that Louisa usually doesn't regret her choices, or that Elizabeth should bring a friend to her appointments because she sometimes struggles to speak up for herself. But without knowing small details about these women's self-image, personal preferences, life goals and personality traits, a doctor might decide that all four should have silicone implant reconstruction, because that's what she would choose for herself. And she would be making the wrong choice for three of her four patients.

---

66. Beth Aviva Preminger, Koiana Trencheva, Catherine S. Chang, Austin Chiang, Mahmoud El-Tamer, Jeffrey Ascherman, & Christine Rohde, *Improving Access to Care: Breast Surgeons, the Gatekeepers to Breast Reconstruction*, 214 J. AM.COLL. SURGEONS 270, 270 (2012).

1. Implant Reconstruction & Self-Tissue Reconstruction

Some people may try to make women feel better about the mastectomy by telling them that their reconstructed breasts will give thema "boob job,"[67] slang for the augmented breasts popularized by models and actresses.[68] This focus on the breast, not the woman, obscures the negative feelings a woman may have about her reconstructed breasts.

When first hearing their menu of choices, women may be drawn to the familiar. Most women are aware of breast implants because of models and actresses who popularized cosmetic breast implants unrelated to mastectomies. However, women should look beyond that first instinct and carefully consider their options. There are many drawbacks to implants, including the need for tissue expanders, the feel of the implant for the woman, the risk of rupture, the specter of breast implant illness, and the requirement that the implants be replaced in the future.

Implant placement following mastectomy is typically a two-step process, meaning two surgeries are required.[69] The first surgery involves inserting tissue expanders, which are then filled with saline over a number of appointments until the temporary implants and surrounding skin are the appropriate size for the more permanent implants.[70] Then a second surgery is performed to replace the temporary tissue expander implants with more permanent ones.[71] Young, healthy women with small breasts can sometimes have an implant inserted directly after a mastectomy, but for the majority of women, implant reconstruction is a lengthy ordeal.[72]

While silicone implants have some of the appearance and a similar tactile feeling to natural breasts from the outside, the exterior tissue is typically incapable of feeling sensations.[73] Therefore, the reconstructed object may look like a breast and feel like a breast to others but does not feel like a breast to the body's owner.[74]

---

67. Tracy E. Tyner, Wyona Freysteinson, Stephanie Evans & Jennifer Woo, *"My Body, My Choice": A Qualitative Study of Women's Mastectomy with Flat Closure Experiences*, 46 BODY IMAGE 419, 425 (2023).

68. Leslie Smith, *11 Things No One Tells You About Getting a Double Mastectomy,* SELF (Oct. 19, 2016), https://perma.cc/LN2X-NPYV.

69. *Breast Reconstruction After Mastectomy*, NAT'L. CANCER INST. (Feb. 24, 2017), https://perma.cc/XGY8-DGMU.

70. *Id.*

71. *Id.*; *Breast Reconstruction Using Implants*, AM. CANCER SOC'Y (Sept. 19, 2022), https://perma.cc/47DH-HP52 .

72. *Breast Reconstruction Using Implants*, *supra* note 71.

73. Roni Caryn Rabin, *After Mastectomies, an Unexpected Blow: Numb New Breasts*, N. Y. TIMES (Jan. 29, 2017), https://perma.cc/4NNA-RSZQ.

74. *Id.* ("Doctors often promise patients that their reconstructed breasts will look even better than the breasts they had before. But they often describe the potential consequences of the surgery in ambiguous terms. Women say the fact that sensation and sexual arousal will not be restored is not made clear. The main problem is using the word 'feel,' said Dr. Clara Lee, an associate professor of plastic surgery at Ohio State University who does reconstructive breast surgery. Surgeons who use a woman's own tissue to recreate a breast might tell the patient that it will 'feel' like a natural breast, referring to how it feels to someone else, not the woman.").

Some women report that their implants are also always cold, reinforcing the feeling that the implant is an alien presence, not a body part.[75]

Doctors who are promising "boob jobs" might be promising too much. The likely aesthetic outcome of implant reconstruction post-mastectomy is different from the desired aesthetic outcome when women are seeking breast augmentation.[76] In an augmentation, the woman's original breast tissue cushions the implant and makes it look more natural.[77] Post-mastectomy women have no breast tissue left, and there is a very thin layer of skin covering the implant.[78] With either type of implant, silicone or saline, there is a danger that the implant could break through this thin skin.[79] The implant can be placed under the pectoral muscle, but this can have other undesirable side effects such as abnormal bulges and contortions of the implant when the muscle is used.[80] Women who are expecting large, taut, perfect super-model breasts post-mastectomy may be disappointed to find thin, rippled skin covering their implants.[81]

In addition to the feel and aesthetics of implant reconstruction, there is another danger: implant rupture.[82] When saline implants rupture, the saline (saltwater) can be absorbed by the body, and the woman's breast will appear deflated.[83] She would need to schedule a surgery to replace the ruptured implant.

Silicone implant rupture is more concerning because it may be impossible to detect without an MRI or other screening, and because silicone is very different from saltwater.[84] Many people would be disconcerted by the idea of this foreign

---

75. Ida Emilie Steinmark, *Goodbye Silicone? A New Era of Breast Reconstruction Is on the Horizon*, OBSERVER (Jul. 3, 2022), https://perma.cc/N3ZB-WXGJ ("Having an ice pack strapped to your chest – that's how some describe the experience of taking a walk in cold weather when you have breast implants. Silicone only slowly reaches body temperature once out of the cold, so that icy feeling can persist for hours. As well as being uncomfortable, for breast cancer survivors it can be an unwelcome reminder of a disease they would rather put behind them.").

76. Dr. Minas Chrysopoulo & Courtney Floyd, *Implant Breast Reconstruction vs Breast Augmentation: What's the Difference?*, PRMA PLASTIC SURGERY CTR (Jul. 20, 2020), https://perma.cc/8WHX-EJ4N.

77. *Id.*

78. Daniel Schmauss, Hans-Günther Machens & Yves Harder, *Breast Reconstruction after Mastectomy*, 2:71 FRONT SURG 1, 2 (2016).

79. *Breast Reconstruction After Mastectomy*, *supra* note 69.

80. Amy S. Colwell, *Correction of Suboptimal Results in Implant-Based Breast Reconstruction*, 40 AESTHETIC SURGERY J. S38, S41 (2020). This issue is called an animation deformity. *Id.*

81. Mario Faenza, Giuseppe Lanzano, Elisa Grella, Sara Izzo & Giuseppe Andrea Ferraro, *Correction of Rippling in Implant-based Breast Reconstruction with Serratus Fascia Flap*, 11 PLAST RECONSTR SURG GLOB. OPEN e4862, 1 (2023).

82. *Breast Implant Rupture*, BREASTCANCER, https://perma.cc/N4FL-KMTX; Neal Handel, M. Emily Garcia & Roger Wixtrom, *Breast Implant Rupture: Causes, Incidence, Clinical Impact, and Management*, 132 PLASTIC AND RECONSTRUCTIVE SURGERY 1128 (2013).

83. *Breast Implant Rupture*, *supra* note 82.

84. Handel, Garcia & Wixtrom, *supra* note 82 at 1129. ("Rupture of breast implants can be either overt (clinically evident) or silent (detectable only by means of imaging modalities). Most ruptures are silent, and the sensitivity of plastic surgeons to diagnose rupture has been estimated to be approximately 30 percent. Of the various imaging techniques used to detect rupture (including mammography and ultrasound), magnetic resonance imaging is considered the criterion standard. New high-resolution ultrasound methods are currently being evaluated in the hope that they will provide a more cost-

substance moving amidst their internal organs. Because of this danger of rupture, "[t]he U.S. Food and Drug Administration (FDA) recommends that people with silicone breast implants receive breast MRI screening for silent rupture three years after having breast implant reconstruction surgery and every two years after that."[85] Women who want to avoid frequent screening for cancer may also wish to avoid perpetual screening for implant rupture.

Women may also be concerned about the possibility of breast implant illness: there are a range of negative symptoms reported by some women with breast implants which have not ruptured.[86] While this is not an official medical diagnosis, many of the women with these symptoms report that their symptoms improve after implant removal.[87]

Saline (saltwater) implants, while arguably more natural than implants filled with silicone, are firmer than silicone implants.[88] Therefore, they may have a less-natural feel to the external observer or manipulator. To the person whose body contains the implants, the same issues arise as with silicone implants: the exterior tissue is incapable of receiving sensation, as the nerves have been cut in the mastectomy.[89]

Over time, scar tissue may form around the implant.[90] Most importantly, eventually the implant will need to be replaced, which means women who choose implants are signing up for future surgeries.[91] For women traumatized by the uncertainty of waiting for cancer, the uncertainty of waiting for an implant to fail may be hard to stomach.[92]

2. Self-Tissue Reconstruction

Own-tissue or self-tissue reconstruction, where tissue from other parts of the body fill the space left by the mastectomy, increases the area of the body affected by the surgery and may increase the time necessary to heal.[93] While women may feel more comfortable using their own tissue rather than a foreign object, that

---

effective alternative to magnetic resonance imaging."); *Id.* at 1130 ("Risk factors for rupture include excessive force to the chest, for example, during closed capsulotomy (strongly advised against), seat belt contusion injury, blunt trauma, compression during mammographic imaging, or severe capsular contracture. Case reports of implant damage as a consequence of mammography were associated primarily with thinner shell, earlier second-generation devices.").

85. *Breast Implant Rupture*, *supra* note 82.

86. J. W. Cohen Tervaert, N. Mohazab, D. Redmond, C. van Eeden & M. Osman, *Breast Implant Illness: Scientific Evidence of Its Existence*, 18 EXPERT REV. CLIN IMMUNOL 15, 16 (2022).

87. *Breast Implant Illness (BII): What It Is, Symptoms & Treatment*, CLEVELAND CLINIC, https://perma.cc/TS7W-8GCJ.

88. Karen Horton, *Silicone vs Saline Breast Implants*, AM. SOC'Y OF PLASTIC SURGEONS (July 14, 2017), https://perma.cc/ZYN7-GN6L.

89. *See* Rabin, *supra* note 73.

90. *Breast Reconstruction After Mastectomy*, *supra* note 69.

91. *Id.*

92. *See* Gutmann Koch, *supra* note 43.

93. *Breast Reconstruction Using Your Own Tissue (Flap Procedures)*, AM. CANCER SOC'Y, https://perma.cc/E7AZ-X4JU.

does not guarantee long-term success. There is the potential that the tissue flap can die.[94]

Even with a successful reconstruction, there can be issues at the part of the body the flap came from, including "abdominal bulging, muscle damage or weakness, and contour distortions such as dimpling of the skin."[95] Women who are seeking to eliminate future uncertainty will not be happy with the idea that they may reconstruct their breasts by damaging their abdomen and risking future abdominal weakness and hernias.[96]

3. Flat Chest Reconstruction/Aesthetic Flat Closure

While some might consider aesthetic flat closure to be the absence of breast reconstruction, it is most accurately a type of reconstruction: reconstruction of the chest wall rather than of protruding breasts. This semantic difference matches the statutory change recently made in New York:[97] a simple and elegant way to frame aesthetic flat closure within the existing structure of healthcare law and insurance coverage. Some medical experts also follow this trend, explaining to patients: "[m]any think of reconstructive surgery as breast reconstruction with tissue flaps or implants. But aesthetic flat closure—considered the gold standard for going flat—is also a form of reconstructive surgery."[98]

A flat closure avoids much of the uncertainty inherent in other reconstructive choices. It does not include foreign objects and is less complicated than a self-tissue reconstruction.[99] Finally, there is no decrease in quality of life for women who choose chest wall reconstruction over breast reconstruction.[100]

Whatever choice a woman makes here, it is important that it is her own informed choice. A physician cannot weigh how it will feel to this particular woman. Additionally, Hester Hill Schnipper, an Emeritus Program Manager in Oncology and Social Work at the Beth Israel Deaconess Medical Center, says that in all her time working with women with cancer,

---

94. *Breast Reconstruction After Mastectomy*, *supra* note 69.

95. *Breast Reconstruction Using Your Own Tissue (Flap Procedures)*, *supra* note 93.

96. Nicholas T. Haddock, Abby J. Culver & Sumeet S. Teotia, *Abdominal Weakness, Bulge, or Hernia After DIEP Flaps: An Algorithm of Management, Prevention, and Surgical Repair with Classification*, 74 J PLAST RECONSTR AESTHET SURG 2194, 2195 (2021).

97. 2022 N.Y. Sess. Law News Ch. 571 (A. 8537) (McKinney's).

98. Kristine Conner, *About Aesthetic Flat Closure*, BREASTCANCER, https://perma.cc/N724-JR9D.

99. *See Breast Reconstruction Using Your Own Tissue (Flap Procedures)*, *supra* note 93; Jennifer L. Baker, Don S. Dizon, Cachet M. Wenziger, Elani Streja, Carlie K. Thompson, Minna K. Lee, Maggie L. DiNome & Deanna J. Attai, *"Going Flat" After Mastectomy: Patient-Reported Outcomes by Online Survey*, 28 ANNALS SURGICAL ONCOLOGY 2493, 2496 (2021) ("When asked to describe their top two reasons for forgoing reconstruction, avoidance of a foreign body was selected by 39.9% of respondents, followed by a lower complication rate (34.9%).").

100. Clara Lee, Christine Sunu & Michael Pignone, *Patient-Reported Outcomes of Breast Reconstruction after Mastectomy: A Systematic Review*, 209 J. AM. COLL. SURG. 123, 129 (2009) ("The two largest and higher-quality studies found no significant differences in quality of life between mastectomy with reconstruction and mastectomy only.").

> I have known only two women who regretted what they had done and both were able to alter their first choice. One, who had opted for no reconstruction, went back two years later to have that surgery. The second, who had chosen reconstruction, opted later to have the implants removed and go flat. . . . We always know ourselves better than anyone else knows us, and I think that our instincts are reliably correct.[101]

While it is possible for a woman to regret the choice to go flat, most often she will not. Conversely it is also true that many women do not regret the choice to reconstruct their breasts. Physicians must respect either choice.

D. THE INCREASING POPULARITY OF AN AESTHETIC FLAT CLOSURE

What is driving the rise in interest in aesthetic flat closure? There is no data on how many aesthetic flat closures are performed each year, but the idea seems to be rising in the public's awareness, and physicians have noted an increase in interest.[102] It is likely due to a combination of factors: women choosing to decrease uncertainty by avoiding further surgeries, increased visibility of the procedure in media and social media, and a rise in gender-affirming care which may inspire high-risk women towards a similar aesthetic end result as that of trans men undergoing chest surgery.

1. Media Coverage of Women's Flat Closure Choice

The idea of a flat closure has been gaining ground in traditional and social media. In 2016, the *New York Times* published an article about the choice to go flat which contained photos of the chests of women who had had flat closures.[103] This is notable because the article itself, while not featuring a star as famous as Angelina Jolie, nevertheless reached the wide readership of the *New York Times*.

However, the *New York Times* struggled with the decision to publish photos of women's bare, flat post-mastectomy chests in their 2016 article, '*Going Flat' After Breast Cancer*.[104] In an article discussing the journalism behind the *Times*' story, the author noted that "without a compelling reason, The Times typically would not publish a photo of a woman with a bare chest. And most women don't want their chests photographed, fully clothed or otherwise."[105] Ultimately the Times editors determined that "the photos were respectful to the women involved and essential to telling a complete story."[106] Since social media posts are reviewed by algorithms rather than a team of experienced and thoughtful editors,

---

101. Schnipper, *supra* note 9.

102. Kritz, *supra* note 8.

103. Roni Caryn Rabin, *'Going Flat' After Breast Cancer*, N.Y. TIMES (Oct. 31, 2016), https://perma.cc/Q8CW-9SCQ.

104. *Id.*; Roni Caryn Rabin, *The Women Who Showed Their Breast Cancer Scars*, N.Y. TIMES (Nov. 4, 2016), https://perma.cc/R3BS-D8KP.

105. Rabin, *supra* note 104.

106. *Id.*

these proud going-flat posts are thrown out along with the bathwater of pornographic and exploitative photos of women's chests.[107]

2. The Impact of Social Media

While it is nearly impossible to measure the reach of the flat chest movement across social media, the existence of groups such as "Not Putting on a Shirt" and "Flat and Fabulous" have raised awareness of this reconstruction option.[108] In one study of women's flat closure experiences, a participant named Jennifer described, "I didn't even know it (flat closure) was an option until I stumbled across it online."[109] The study goes on to summarize that "[n]avigating flat closure websites or private Facebook groups provided women access to needed information and photos of flat closure outcomes. The women in this study wanted support and flat closure education from their clinicians. The majority of women reported receiving little to none of this."[110]

However, social media can be limited in its effectiveness because policies intended to exclude female nudity may limit exposure to photos of post-mastectomy flat chests. When women who have undergone preventative or cancer-treatment mastectomies post photos of their post-mastectomy flat chests, they are often flagged as inappropriate on social media.[111] One going-flat advocate, Stephanie Germino, was banned from TikTok six times within her first year of posting and now keeps the form necessary to contest TikTok's decision bookmarked on her phone.[112] She says, "[i]t's not just that I'm showcasing my body. I'm showcasing an option [to do an aesthetic flat closure]."[113]

Social media can also harmfully spread misinformation about cancer and add to the impression that cancer can be "beat" with more pink merchandise and optimistic thoughts.[114] Long before social media, Babette's friend discovered the danger of "pinkwashing" the horrors of cancer: "I found out the hard way that there are two kinds of reading matter on this subject. One is meant for ladies, put out by magazines, newspapers and the American Cancer Society. It is full of pretty untruths. The other kind is written for surgeons. There aren't all that many women surgeons."[115] Modern writers have argued that American women are so

107. Savannah Kuchar, *When social media censorship gets it wrong: The struggle of breast cancer content creators*, USA TODAY (Sept. 13, 2023), https://perma.cc/TDR7-R5QY.

108. Kritz, *supra* note 8.

109. Tyner, Freysteinson, Evans & Woo, *supra* note 67, at 424–25.

110. *Id.* at 425.

111. Kuchar, *supra* note 107.

112. *Id.*

113. *Id.*

114. Elia Ben-Ari, *The Challenges of Cancer Misinformation on Social Media*, NAT. INST. HEALTH (Sept. 9, 2021), https://perma.cc/WXA4-X57J; Peggy Orenstein, *supra* note 32.

115. ROSMUND/CAMPION, *supra* note 2, at 13; Orenstein, *supra* note 32 ("The ribbon has come to symbolize both fear of the disease and the hope it can be defeated. It's a badge of courage for the afflicted, an expression of solidarity by the concerned. It promises continual progress toward a cure through donations, races, volunteerism. It indicates community. And it offers corporations a seemingly

hyper-aware of breast cancer that they are unnecessarily terrified by it.[116] And increased awareness may simply lead to cancers being caught earlier, but not actually change outcomes for women.[117]

3. The Visibility and Acceptance of Gender-Affirming Care for Trans Men

It is possible that a rise in gender-affirming care is also inspiring awareness of flat chests as a post-mastectomy option. Anne Marie Champagne[118] attributes the rise in awareness of the procedure to seeing photos of "transitioning transgender men's post-mastectomy flat chests."[119] She said her friends helped inspire her choice:

> I had several friends who transitioned in the years leading up to my diagnosis and surgery, and saw what their flat chests looked like, which made me feel like I had more options," she says. "Societally we've become more open to a wider array of body expressions."[120]

It is concerning to note the rampant attempts to limit this gender-affirming care for trans men. In addition to the much larger harms to people who will be directly impacted by these limits on care, there are also smaller negative side effects on high-risk women: they may feel stigmatized by anti-trans rhetoric, they may be afraid of being mistaken for trans men when they are happily female, and they may have less-experienced doctors if these surgical techniques are not in high demand.

Furthermore, women with flat closures may be mistaken for trans men and experience some of the discrimination and vitriol which is unfortunately sometimes directed at trans people. One woman with a flat closure was concerned that "I heard about a flat woman who was chased out of the pool locker room. Somebody just took one look at her and assumed she was a trans male. I was worried. It made me nervous."[121]

---

fail-safe way to signal good will toward women, even if, in a practice critics call "pinkwashing," the products they produce are linked to the disease or other threats to public health.").

116. Orenstein, *supra* note 32 ("There is so much 'awareness' about breast cancer in the U.S. I've called it breast-cancer overawareness. It's everywhere. There are pink garbage trucks. Women are petrified.").

117. Orenstein, *supra* note 105 ("It has been four decades since the former first lady Betty Ford went public with her breast-cancer diagnosis, shattering the stigma of the disease. It has been three decades since the founding of Komen. Two decades since the introduction of the pink ribbon. Yet all that well-meaning awareness has ultimately made women less conscious of the facts: obscuring the limits of screening, conflating risk with disease, compromising our decisions about health care, celebrating 'cancer survivors'" who may have never required treating. And ultimately, it has come at the expense of those whose lives are most at risk.").

118. *See supra* Introduction.

119. Kritz, *supra* note 8.

120. *Id.*

121. Tyner, Freysteinson, Evans, & Woo, *supra* note 67, at 425. Another woman shared, "I don't wanna say discrimination, but I do worry about, you know, how judgments might affect future job prospects or opportunities." *Id.* at 427.

Anti-trans legislation may make physicians less inclined to suggest flat closure, either because they are afraid their patients will experience discrimination or because they do not understand how a cisgender woman might choose to go flat but not be trans.

Furthermore, doctors who might be motivated to specialize in aesthetic flat closures for trans men and high-risk women might avoid this area of practice for financial reasons if this surgical technique is limited to cancer-related surgeries and not widely performed as a part of gender-affirming care.

While bans may hurt trans women and women at high risk of cancer, a wider acceptance of flat closures for women following mastectomies may lead to more coverage for individuals wishing to have gender-affirming care. A New Jersey statute prohibiting Hospital Service Corporations from discriminating against individuals on the basis gender identity or expression prohibits:

> (4) denying or limiting coverage, or denying a claim, for services including but not limited to the following, due to a covered person's gender identity or expression or for the reason that the covered person is a transgender person:
>
> (a) health care services related to gender transition if coverage is available for those services under the contract when the services are not related to gender transition, including but not limited to hormone therapy, hysterectomy, mastectomy, and vocal training; or [. . .] N.J. Stat. Ann. § 17:48-6oo (West)

This would mean that any insurer covering aesthetic flat closure for women having preventative mastectomies should also cover the same surgery for individuals in the process of a gender transition. However, such laws will likely be geographically limited for some time. In the current political climate, such a law would be unlikely to pass in Florida or Texas.[122]

II. CHALLENGES IN ACCESS TO AN AESTHETIC FLAT CLOSURE

A. A PHYSICIAN'S FAILURE TO SUGGEST OR AGREE TO AN AESTHETIC FLAT CLOSURE

If a woman wants an aesthetic flat closure, why wouldn't a physician perform one? Physicians may not know how to perform the surgery, they may feel that a flat closure will be taken as a failure on their part to convince the patient of the benefits and availability of breast reconstruction, or they may have their own biases about femininity and the presence of breasts.

---

122. Patricia Mazzei, *Florida Legislature Passes Bill Banning Gender-Transition Care for Minors*, N.Y. TIMES (May 5, 2023), https://perma.cc/3V72-2CQ3; David Montgomery & J. David Goodman, *Texas Legislature Bans Transgender Medical Care for Children*, N.Y. TIMES (May 18, 2023), https://perma.cc/6YPD-CB68; Francesca Paris, *See the States That Have Passed Laws Directed at Young Trans People*, N.Y. TIMES (June 5, 2023), https://perma.cc/2PKK-QJG8.

1. Flat Denial

As discussed above, women have multiple reconstructive choices.[123] What happens when a physician merely closes the surgical wound without any attempt at aesthetics? Women often feel mutilated and ugly. This is a cruel outcome for a woman already traumatized by cancer or fear of cancer.

The misery of losing breasts through mastectomy can be compounded by the failure of a physician to agree to or to properly perform an aesthetic flat closure or an aesthetic protruding breast reconstruction. Surgical removal of breasts through mastectomy can be a difficult loss for many women. The U.S. Government has recognized this loss as comparable to the loss of a foot or hand in its wartime disability compensation statute.[124] As difficult as it may be to accept the loss of the body part, what women most often regret is not their choice to undergo a mastectomy but their choice of surgeon.[125]

A recent study found that among women who underwent mastectomies and had not intended to undergo reconstruction, the biggest issue they encountered was flat denial: physicians refusing to agree to women's desire to go flat or failing to actually make women flat.[126] The study was pointed in its desire to educate surgeons of the harm they could be causing their patients: "Our study found that a high level of flat denial was the strongest predictor of dissatisfaction with surgical outcome. Surgeons should become aware of this communication point given the important negative consequences."[127]

---

123. *Supra* Section I:C.

124. 38 U.S.C.A. § 1114 (Westlaw through P.L. 118-30) ("(k) if the veteran, as the result of service-connected disability, has suffered the anatomical loss or loss of use of one or more creative organs, or one foot, or one hand, or both buttocks, or blindness of one eye, having only light perception, has suffered complete organic aphonia with constant inability to communicate by speech, or deafness of both ears, having absence of air and bone conduction, or, in the case of a woman veteran, has suffered the anatomical loss of 25 percent or more of tissue from a single breast or both breasts in combination (including loss by mastectomy or partial mastectomy) or has received radiation treatment of breast tissue, the rate of compensation therefor shall be $96 per month for each such loss or loss of use independent of any other compensation provided in subsections (a) through (j) or subsection (s) of this section but in no event to exceed $3,327 per month; and in the event the veteran has suffered one or more of the disabilities heretofore specified in this subsection, in addition to the requirement for any of the rates specified in subsections (l) through (n) of this section, the rate of compensation shall be increased by $96 per month for each such loss or loss of use, but in no event to exceed $4,667 per month;").

125. Amanda Deliere, Deanna Attai, David Victorson, Kristine Kuchta, Catherine Pesce, Katherine Kopkash, Mark Sisco, Akhil Seth & Katharine Yao, *Patients Undergoing Bilateral Mastectomy and Breast-Conserving Surgery Have the Lowest Levels of Regret: The WhySurg Study*, 28 ANN. SURG. ONCOL. 5686, 5686 (2021).

126. Baker, Dizon, Wenziger, Streja, Thompson, Lee, DiNome & Attai *supra* note 99 at 2494 ("The experience of flat denial was measured using a second 5-level Likert scale derived from three statements related to preoperative counseling about the option to go flat and whether respondents felt their surgeon supported their decision to go flat: ''my doctor performed the surgery we agreed upon''; ''my doctor offered me the option to go flat''; and ''my doctor was supportive of me going flat.'' On this scale, a lower score was associated with a greater experience of flat denial.").

127. *Id*. at 2497.

A botched aesthetic flat closure or a simple wound closure without any regard to aesthetics can be painful as well as ugly.[128] Even a properly executed flat closure can leave women with sensitivity in their scars, and a closure which leaves hanging flaps can cause pain daily.[129] A study of women's experiences with flat closure asked women to describe how they felt after viewing their post-surgical bodies. Some of the women had optimal outcomes and others had what may be euphemistically called "suboptimal aesthetic outcomes."[130] In addition to physical pain caused by remaining skin flaps or bulges, women in that study experienced strong feelings of distress simply looking at their bodies in the mirror.[131] The researchers asked each woman, "[t]ell me about the experience of looking at your chest wall in the mirror for the first time after your flat closure surgery."[132] Evelyn, a woman in the study who was very displeased with her outcome, "described her mirror viewing experience stating: 'I was pretty scared before looking, and then I saw a monster. I had become a carnival freakshow.' She was 'shocked' and 'distraught' with her image. Her outcome did not resemble anything remotely flat."[133] Pam, another woman in the same study, described disgust and anger at the way her body looked after surgery: "I looked like Frankenstein. They took two boobs and gave me four in place of it. I've got two giant baseballs in my armpits. I don't know what the hell they did. I hoped to be wonderfully and beautifully flat, but instead, he screwed me up and shit on my dreams. I'm like beauty and the beast."[134]

There are two fairly simple solutions which led to positive outcomes for women: "having adequate preoperative information to make an informed decision and having a surgeon who specialized in breast surgery."[135] While the WHCRA requires annual notice to insured women of their coverage for mastectomy reconstruction, since it does not specifically mention aesthetic flat closure by name and because notification by statutorily-required postcard is insufficient to cover the multitude of details of surgery, women may not be adequately informed of their choices unless they educate themselves.[136] And surgeons, being human, may be hesitant to admit what they cannot do, and may not refer patients to breast-surgery specialists even when that option would be best. Women who

128. Tyner, Freysteinson, Evans, & Woo, *supra* note 67, at 428.

129. *Id.* ("The large flaps under my arms after about three hours get really sore. I have to wear a bra to contain them. I want these flaps gone."); For visual examples of these mangled chests, *see* Photo Gallery, NOT PUTTING ON A SHIRT, https://perma.cc/62NM-6G6D; *Id.* ("These images are hard to look at, but the fact is that images make the case in a way that words never can. All of these women clearly and unequivocally asked to be flat.")

130. Tyner Freysteinson, Evans, & Woo., *supra* note 67, at 426.

131. *Id.* at 420.

132. *Id.* at 422.

133. *Id.* at 425.

134. *Id.*

135. Baker, Dizon, Wenziger, Streja, Thompson, Lee, DiNome & Attai, *supra* note 99, at 2496.

136. 29 U.S.C.A. § 1185b (West current through P.L. 118-41).

want the optimal experience of being operated on by a specialized breast surgeon may need to find their doctors themselves.

2. Physician Ignorance

In a mastectomy with reconstruction, typically one surgeon performs the mastectomy, and a plastic surgeon performs the reconstruction. While most surgeons can manage the closure part of aesthetic flat closure, it is the aesthetics which require an experienced surgeon, perhaps a specialized plastic surgeon.[137] Otherwise, rather than a flat chest, a woman may be left with lumps, bumps, and more extensive scars than necessary.[138] In addition to experience gained performing aesthetic flat closures on cancer patients and high-risk women, surgical techniques developed or practiced during female-to-male gender affirming surgery can be used to create an aesthetic flat closure following a mastectomy.[139] Surgeons may refuse to present flat closure as an option because they don't know

137. Kristine Conner, *Talking to Your Surgical Team About Going Flat*, BREASTCANCER.ORG (Sept. 24, 2023), https://perma.cc/92R2-L7XD. ("Plastic surgeons have a skill set that cancer surgeons may not necessarily have and can offer advice about advanced reconstruction techniques that cancer surgeons might not even know about. Additionally, not all general surgeons or even all breast surgeons have experience in performing aesthetic flat closure. Having a plastic surgeon present when you have a mastectomy can improve your chances of getting an optimal flat closure and help you avoid additional surgery. Physical features — such as breast size, body mass index (BMI), degree of sagging (also called ptosis), amount of skin under the arms, and position of the breasts relative to the rib cage — can make it more challenging to achieve an excellent flat closure. Scarring from radiation therapy also can present challenges during an aesthetic flat closure. In these more complex situations, having a plastic surgeon present is a good idea.").

138. Kristine Conner, *supra* note 98. ("Aesthetic flat closure requires proficiency with certain surgical techniques, such as:

- making incisions that avoid bulges of extra skin under the arm (dog ears) and in the chest area (most prefer two incisions rather than one long incision across the chest, although in some cases, one long incision is required; different body types may require different incisions)
- using fat grafting or tissue transfer techniques to achieve a smoother contour and avoid a scooped-out look
- using local tissue flaps to smooth out uneven areas
- knowing how to remove all extra skin and tissue, including in the areas above and below where the breasts were and under the collarbone.");

see also, Kerry A. Morrison & Nolan S. Karp, *Not Just a Linear Closure: Aesthetic Flat Closure after Mastectomy*, 10 PLAST RECONSTR SURG GLOB OPEN e4327 (2022) ("(1) judicious lateral de-fatting is necessary to mitigate dog ears, specifically, aggressive lateral fat direct excision can be performed while ensuring that the flaps are not too thin; (2) axillary liposuction can be utilized to contour the lateral chest wall to provide smooth definition to the final flat chest closure; (3) tailor tacking is key in these patients in order to ensure that there is no lateral dog ear, and to obviate the need to extend the lateral chest incisions onto the back, which is aesthetically displeasing to patients.").

139. Michelle Djohan, Rebecca Knackstedt, Tripp Leavitt, Risan Djohan & Stephen Grobmyer, *Technical Considerations in Nonreconstructive Mastectomy Patients*, 26 BREAST J. 702, 704 (2020) ("As the end goals of this surgery are similar to those desired in female-to-male mastectomies (FTTM), lessons learned from that field and from breast reduction surgery were applied to this surgical dilemma to allow for an easy, reproducible, and aesthetic result.").

how to do it well: "[s]urgeons may be less confident that they can provide a cosmetically acceptable result for patients who desire a flat chest wall."[140]

3. Physician Bias & Pressure towards Traditional Reconstructive Methods

In many of the "flat denial" stories in the news, surgeons are the villains who disfigure their patients instead of allowing them to go flat.[141] However, surgeons who do not suggest flat closure may be responding to past pressure to provide women with all possible choices, especially "vulnerable populations based on racial, geographic, and socioeconomic factors."[142] This thought-framing causes physicians to see flat closure as a failure to meet the patient's needs, when in fact the failure they are performing is the failure to properly educate their patients and seriously discuss all possible options.

New York's law requiring physicians to give their mastectomy patients a list of reconstruction options was inspired by studies showing that a lack of information was exacerbating unequal outcomes.[143] In the Justification section of the bill jacket, the legislators listed the study by Caprice Greenberg, Knackstedt, Leavitt, Djohan, and Grobmyer. demonstrating that "the greatest predictor of reconstruction was a documented discussion about reconstruction between the breast surgeon and patient. This critical discussion is not taking place often enough."[144]

Physicians may also be stuck in a bias towards the old model of physician-patient relationships, where the physician has all of the information and must educate the patient. But many women who decide to go flat have done their own research and are in a position of educating their physician: "[women] reported that they discovered the option to "go-flat" via their independent research and recalled receiving a lack of understanding or empathy from their surgeon on their interest in going flat, with some even describing these interactions as paternalistic."[145] Physicians may also be more likely to discuss the list of reconstructive options when there are "language, educational, or cultural barriers."[146]

---

140. Baker, Dizon, Wenziger, Streja, Thompson, Lee, DiNome & Attai, *supra* note 99, at 2497.

141. *See* Kritz, *supra* note 8; *see also* Sara Goldenberg, *Breast Cancer Survivor Fights Cleveland Clinic over Surgery Results (Graphic)* 19 NEWS (*Jun. 20, 2018, 11:12 PM)*, https://perma.cc/MLM2-L9CP; *see also* Catherine Guthrie, *These Cancer Patients Wanted to Get Rid of Their Breasts for Good. Their Doctors Had Other Ideas*, COSMOPOLITAN (Sep 6, 2018), https://perma.cc/3HPR-L9S7.

142. Baker, Dizon, Wenziger, Streja, Thompson, Lee, DiNome & Attai, *supra* note 99, at 2943, 2497 ("Perhaps an unintended consequence of accreditation standards and legislation set forth to ensure that surgeons provide access to reconstruction may be that it biases surgeons toward this approach and creates discomfort when their patients choose to go flat.").

143. Public Health Law-Breast Reconstructive Surgery, 2010 Sess. Law News of N.Y. Ch. 354 (A. 10094-B).

144. N.Y. Bill Jacket, 2010 A.B. 10094, Ch. 354.

145. Michelle E. Wakeley, Collette Bare, Rebecca Pine & Catherine Dube, *A Social Media Survey of Women Who Do Not Pursue Reconstruction after Mastectomy for Breast Cancer: Characterizing the "Going Flat" Movement*, 26 BREAST J. 1455, 1456 (2020).

146. Caprice C. Greenberg, Eric Schneider, Stuart R Lipsitz, Clifford Y Ko, Jennifer L Malin, Arnold M Epstein, Jane C Weeks & Katherine L Kahn., *Do Variations in Provider Discussions Explain Socioeconomic Disparities in Postmastectomy Breast Reconstruction?*, 206 J. AM. COLL. SURGEONS 605, 613 (2008).

Optimally, physicians should address all of the options with each patient, including flat closure.[147]

Physicians may not present the option of going flat because it may not seem beautiful to *them*. Plastic surgeons are trained to focus on aesthetics and may not consider a woman's choice to be as important as the aesthetic result. Unfortunately for the patient, aesthetics is in the eye of the beholder.

> "We don't always mean what's important to the patient," Dr. Lee said. "Our focus has been on what women look like," said Dr. Andrea L. Pusic, a plastic surgeon at Memorial Sloan Kettering Cancer Center who specializes in breast reconstruction and studies patients' quality of life after breast surgery. "What it feels like to the woman has been a kind of blind spot in breast surgery. That's the next frontier."[148]

Even when surgeons are not focused on creating the sort of body that's typically featured in women's magazines, they may still have strongly held beliefs about what is "normal" for women. Catherine Guthrie, who wrote a book about her experience going flat, was told by a doctor: "Most women want to look normal in clothes."[149]

Physician bias is not the only negative bias for women. Societal biases about breasts also affected the WHCRA. A congressional cynic might argue that one purpose of the act was also to make breast cancer easier for men: the husbands of breast cancer patients. One woman whose story was used in support of the WHCRA explained that she needed to stay in the hospital after her mastectomy because her loving husband could not have dealt with the gory sight of her drains and wounds.[150] Professor Tweedy noted that the "emotional appeal" that kept reconstruction in the WHCRA as many other provisions were cut. "was partially fueled by societal stereotypes of womanhood and concomitant demands upon women to be available to–and pleasing to–heterosexual men."[151]

---

147. *Id.* ("Physicians should systematically address the issue of reconstruction, starting with whether or not the patient is a reasonable candidate based on the clinical situation, with all patients rather than relying on patients to inquire about it.").

148. Roni Rabin, *After Mastectomies, An Unexpected Blow: Numb New Breasts*, N.Y. TIMES (Jan. 29, 2017), https://perma.cc/4NNA-RSZQ.

149. Susan Gubar, *Flat Out: Rejecting Breast Reconstruction*, N. Y. TIMES (Oct. 18, 2018), https://perma.cc/ZQS6-BR4A.

150. 143 CONG. REC (daily ed. Jan. 30, 1997), S886 (1997), https://perma.cc/4QHT-MMMW ("'When I was in the hospital after my surgery . . . [the nurses] actually cringed [the people responsible for taking care of me] and looked upset when they changed my dressing. I spoke candidly to my husband, who is loving and caring and goes with me to most of my medical appointments, and he felt that he could not have handled the emotional or the clinical responsibility of helping with drains and bandages. The appropriate length of stay is critically needed and the language in the bill to ensure that the appropriate stay for each individual is met is vital.' What she is saying is that if she had been discharged, her husband could not have taken care of her. And you just simply cannot set a time limit.").

151. Ann E. Tweedy, *Insuring Breast Reconstruction*, 66 UCLA L. REV. 2, 14 (2018).

B. INSURANCE COVERAGE

A lack of insurance coverage or low reimbursement rates may prevent women and surgeons from choosing aesthetic flat closures. Surgeons might not want to perform aesthetic flat closures or any other kind of post-mastectomy reconstruction because the insurance reimbursement rates are much lower than for purely cosmetic procedures.[152] Insurance companies who are required by the WHCRA[153] may not cover aesthetic flat closure or know how to bill for it.[154] Some physicians may in fact avoid using the word aesthetic to seek to avoid issues with insurers classifying the procedure as cosmetic rather than as a reconstruction.[155]

In addition to failure to pay for the procedure, there is some danger of future outright bans. As noted above,[156] women seeking reconstruction may be inspired by transgender men's post-mastectomy flat chests.[157] It is possible that the current attempts to limit gender-affirming care for transgender people could include statutory or regulatory language which would also limit the ability of high-risk women and breast cancer survivors to access aesthetic flat closures. Even if statutory or regulatory language is not clear, it might have a chilling effect on physicians' willingness to perform the procedure. If more states follow New York and specifically require insurers to offer aesthetic flat closures as a form of reconstruction, it should clarify insurance coverage and offer some protection against this sort of accidental legislative limiting.

III. SOLUTIONS

A. THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 ALREADY ENCOMPASSES AESTHETIC FLAT CLOSURE

The purpose of the WHCRA was to give women back their breasts, to make women whole, and make women aware of the guaranteed coverage for their reconstructed bodies so that women considering mammography or cancer treatment would not need to worry about a mutilated body afterwards. All of these

152. Christine Grogan, The Women's Health and Cancer Rights Act (WHCRA) and Breast Reconstruction Policy: An Evaluation of Physician Attitudes and Perceptions, 29 (Jan. 1, 2022) (Ph.D. dissertation, Medical University of South Carolina) (MEDICA)).

153. *see infra* Section III:A

154. Conner, *supra* note 98 ("Thanks to the Women's Health and Cancer Rights Act of 1998, most health insurance plans cover breast reconstruction with tissue flaps and implants, as well as other reconstructive procedures needed to achieve balance (symmetry). Still, it's essential to know that there is currently no procedure code specific to flat closure that doctor's offices can use when submitting paperwork to health insurance companies. So, it's a good idea to call your health insurance company to confirm whether your plan covers aesthetic flat closure.").

155. Conner, *supra* note 137 ("Ask if your surgical consent form can specify aesthetic flat closure, as defined by the National Cancer Institute. Some surgeons prefer the term flat closure reconstruction and leave out the word aesthetic, so it's clear that the surgery is reconstructive and not cosmetic. Ask your surgical team what they recommend.").

156. *See supra* Section I.D.

157. Kritz, *supra* note 8.

purposes are served by a reading of the WHCRA that encompasses aesthetic flat closure.

The WHCRA required insurance providers in group health plans to cover post-mastectomy reconstruction if they cover mastectomy.[158] Specifically, the law requires:

> A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits with respect to a mastectomy shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for—
>
> **(1)** all stages of reconstruction of the breast on which the mastectomy has been performed;
>
> **(2)** surgery and reconstruction of the other breast to produce a symmetrical appearance; and
>
> **(3)** prostheses and physical complications of mastectomy, including lymphedemas;
>
> in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter.[159]

While this seems rather comprehensive and clear, the intervening twenty-five years have generated some new questions about the text of the statute such as: How should "*breast"* be defined? Does the WHCRA cover lumpectomies and flat closures as well as mastectomies and breast mound reconstruction? What are the limits of the WHCRA?

1. Defining the "Breast"

The WHCRA requires insurers to cover reconstruction of breasts if they cover mastectomies,[160] but what is a "breast"? The WHCRA does not define this body part, nor does the case law interpreting this statute. However, courts have needed to interpret the word "breast" in other statutory areas, including sexual abuse

158. 29 U.S.C.A. § 1185b (Westlaw through Pub. L. No. 118-30).

159. *Id.* at (a).

160. *Id.* at (a)(1)" ("A group health plan, and a health insurance issuer . . . that provides medical and surgical benefits with respect to a mastectomy shall provide, in a case of a participant . . . who is receiving benefits with a mastectomy and who elects breast reconstruction with such mastectomy, coverage for (1) all stages of reconstruction of the breast on which the mastectomy has been performed; . . .").

cases involving very young female children.[161] Courts have examined dictionary definitions to determine that statutes may encompass multiple shapes and development stages of the breast area simply by using the word breast.[162] In short, a breast is a breast, no matter how small.

When interpreting statutes defining criminal sexual abuse, courts have found that touching the chest of an eight-year-old female child, whether the chest was developed or not, could constitute sexual contact with a breast.[163] Courts have also looked to the dictionary definitions of "chest" to determine if that term also includes an individual's "breast," as in *Arroyo v. State*.[164] In *Arroyo*, the court needed to determine whether the witness's use of "chest" was sufficient for a jury to conclude that the defendant violated a state statute prohibiting the indecent touching of a minor.[165] *Arroyo* neatly summarizes the logic in an earlier case, *Nelson*, where a minor similarly described the touching of her chest.[166] At the time of *Nelson*, it was criminal for someone with "lascivious intent to intentionally [. . .] place his or her hand [. . .] upon the breast of a female."[167] The *Nelson* court had to determine whether her testimony about her chest supported a conviction when the statute exclusively used the term *breast*:

> After looking at dictionary definitions of "breast" and a definition of "chest," the Court concluded that "the definition of 'chest' is broader than the definition of 'breast' and includes a larger area of the body than that encompassed by the latter."[14] One of the definitions of "breast" was "either of the two protuberant milk-producing glandular organs situated on the front of the chest or thorax in the human female." The other definition described "breast" as "[t]he fore or ventral part of the body between the neck and the abdomen, the front of the chest." The definition of "chest" was "the part of the body enclosed by the ribs and the breast bone.[168]

Although the *Nelson* court considered the various dictionary definitions of "breast," the court held that the use of "chest" was insufficient to support a finding that the defendant violated the statute.[169] Ultimately the court in *Arroyo*

161. *See, e.g.*, Russell v. Chenevert, 621 F. Supp. 3d 104 (D. Me. 2022).

162. *Id.* at 109 (citing the dictionary definition of "breast" to include the "front part of the body from the neck to the abdomen).

163. *Id.* ("As Rule 415(a) is meant to apply to sexual contact with all children, the Court concludes that Rule 415(a) incorporates both definitions [of "breast," including a more general definition].")

164. Arroyo v. State, 559 S.W.3d 484 (Tex. Crim. App. 2018).

165. Id. at 485.

166. Id. at 487 (citing Nelson v. State, 505 S.W. 2d 551-52 (Tex. Crim. App. 1974)).

167. Nelson v. State, 505 S.W. 2d 552 (Tex. Crim. App. 1974).

168. *Id.*

169. *Nelson*, 505 S.W.2d at 552 ("The State cites a number of cases in which this court has affirmed fondling convictions where the victim has used words different from those in the indictment to describe the area of the body fondled. . . We have reviewed these decisions, and while the victims therein did not use the precise words set forth in the indictments, their testimony was sufficient to identify the area of the

distinguished itself from the *Nelson* decision and decided the case without "address[ing] the larger question of to what extent 'breast' may be synonymous with 'chest.'"[170] The court found that it was clear from the legislative history that the Texas Legislature had intended to make the statute applicable to females at any stage of development.[171] The statute had historically only applied to "the breast of a female 10 years or older" but had been amended to remove the references to age and gender.[172]

In a similar case of an adult touching a child's upper-front body, the defendant argued "that the term 'female breast' is not defined in the statute, and maintain[ed] that the words 'female breast' have two reasonable meanings: 1) the breast of any female regardless of her age or degree of physical maturity, and 2) the breasts of fully developed, mature women."[173] The court rejected the defendant's argument that these two meanings of the word breast render the statute unclear.[174] Rather, the court found that both meanings were meant to be applicable and the defendant's conduct was criminal whether it was done to a "fully developed, mature woman" or to a child.[175]

Interpreted in this way, the word "breast" in the WHCRA must include flat breasts which have been reconstructed with an aesthetic flat closure. The word "breast" does not mean only mature breasts or large breasts or the breasts on the body of a woman over twelve. In the absence of such limiting language, the word "breast" applies to all breasts at any stage of development. The ideal end result of a flat closure is a breast like that of an undeveloped or prepubescent girl (though without nipples).[176] This breast is flat, not protruding, and very importantly, an aesthetic flat closure is not concave. The WHCRA's requirement of "reconstruction of the breast" must therefore be read to encompass reconstruction of flat breasts as well as protruding breasts.

Furthermore, not all mature women have protruding breasts. Some women's breasts are naturally flat or nearly flat.[177] The WHCRA could have specified that

---

body . . . violated. . . . [Here,] [t]he testimony 'He rubbed my chest' is insufficient proof to sustain the . . . indictment . . .").

170. *Id*. at 488.

171. *Id*.

172. *Id*.

173. Stephan v. State, 810 P.2d 564, 565 (Alaska Ct. App. 1991).

174. *Id*. at 567 ("Beyond the fact that Stephan cites no legislative history or case law supporting his interpretation, his argument makes no sense bearing in mind the statute's central purpose—to protect children under age thirteen from becoming the objects of adults' sexual gratification.").

175. *Id*. ("Based on the language and statutory history . . . it is apparent that the legislature intended that the term 'female breast' be applied according to its plain meaning—referring to all females regardless of age or degree of development.").

176. Tyner, Freysteinson, Evans, & Woo, *supra* note 67 at 426 ("The women expected their chest wall to be as flat as a "10-year-old boy" or a "pre-pubescent girl.").

177. *See* Arne Estler, Eloisa Zanderigo, Daniel Wessling, Gerd Grözinger, Sahra Steinmacher, Adrien Daigeler, Cristina Jorge, Adelana Santos Stahl, You-Shan Feng, Vincent Schipperges, Konstantin Nikolaou, & Stéphane Stahl, *Quantification of Breast Volume According to Age and BMI: A Three-Dimensional MRI Analysis of 400 Women*, 47 AESTH. PLAST. SURG. 1713, 1716 (2022) (finding

only women who were not flat-chested to begin with could have reconstruction, but there is no language limiting the shape of women entitled to reconstruction under the statute. Some women choose to complete reconstruction with larger or smaller breasts than when they began.[178] Insurers do not and should not be able to draw an arbitrary line and only cover reconstruction of B-cup breasts and refuse reconstruction to women who began as an AA-cup (which add less than an inch to the circumference of the chest).[179] Insurers should not be able to deny women the opportunity to become AA-cups through aesthetic flat closure.

The WHCRA does not define the breast, and neither does it define mastectomy nor reconstruction of the breast. Professor Ann Tweedy of the University of South Dakota has shown how the WHCRA was clearly intended to cover lumpectomy though the text of the law and statements in the legislative history almost never use that term.[180] Rather, the bill's sponsors referred to mastectomies "and other breast cancer related procedures."[181] She conducts a substantial analysis and concludes that "the legislative history of the WHCRA, contemporaneous dictionary definitions, and state law sources examining similar issues all lead to the conclusion that the term 'mastectomy' in the WHCRA should be interpreted to include a partial mastectomy when the patient and her physician conclude that reconstruction is warranted."[182] Though she is focused on reconstruction of the breast, not flat closure, Professor Tweedy also notes that "[w]hile reconstruction is not the right choice for every breast cancer patient, under the WHCRA, it is the patient's choice, in consultation with her physician, whether to pursue it."[183]

2. The Intent of the Act: Making Women Whole

The WHCRA was intended to make women whole following their cancer treatment. The bill was first introduced in the spring of 1997 and merited a mention in that year's State of the Union Speech.[184] President Clinton compared outpatient

---

that the smallest breast sizes measured by the study were 64 and 55ml, roughly equivalent to two ounces).

178. Krista M. Nicklaus, Thao Bui, Mary Catherine Bordes, Jun Liu, Deepti Chopra, Aubri S. Hoffman, Gregory P. Reece, Summer E. Hanson, Fatima A. Merchant, & Mia K. Markey, *Goldilocks Principle: Preference for Change in Breast Size in Breast Cancer Reconstruction Patients*, 12 FRONTIERS PSYCH. 1, 3 (2021).

179. Bra cup sizes are determined by taking the circumference of the chest below the bust and at the fullest part of the breasts. A B-cup breast is roughly two inches greater in circumference than the chest below the breasts. An A-cup has a difference of one inch, and an AA-cup has no difference between the two circumferences. *See How to Measure Your Bra Size at Home*, REAL SIMPLE (Oct. 4, 2023), https://perma.cc/4K2Q-BS2R.

180. *See* Tweedy, *supra* note 151, at 23.

181. *Id.* (emphasis in the original).

182. *Id.* at 33.

183. *Id.*

184. President William J. Clinton, State of the Union Address (Feb. 4, 1997), https://perma.cc/5X2K-A7VX ("Just as we ended drive-through deliveries of babies last year, we must now end the dangerous and demeaning practice of forcing women home from the hospital only hours after a mastectomy. . . I ask your support for bipartisan legislation to guarantee that a woman can stay in the hospital for 48 hours after a mastectomy. With us tonight is Dr. Kristen Zarfos, a Connecticut surgeon whose outrage at this

mastectomies to "drive-through deliveries of babies," highlighting the larger trend of insurance companies putting cost-cutting measures above patient needs.[185] At the time, California already mandated coverage of reconstruction after mastectomies, but nationwide 84% of women were denied coverage for reconstruction, leading Senator Feinstein to call for "a national standard, covering all insurance policies."[186]

In the legislative history of the WHCRA, the statement of Senator D'Amato makes clear that the law was inspired by the troubles of a woman named Janet Franquet.[187] In his telling, "Mrs. Franquet's insurance provider, the National Organization of Industrial Trade Unions (NOITU) Insurance Trust Fund refused to cover the reconstruction of Mrs. Franquet's breast. Imagine the shock and horror of being told by your HMO [Health Maintenance Organization] that surgery following the removal of your breast is cosmetic. That is outrageous."[188] During the floor debate, one of the bill's sponsors, Senator Snowe, focused on the outrage of being denied medical coverage at such a horrible time in a woman's life:

> Consider for a moment what it must be like to face a cancer diagnosis. Then imagine what a woman with breast cancer goes through when she loses a breast to this disease. A mastectomy patient may endure great pain resulting from the surgery, and has a large wound with drainage tubes which must be properly cared for. She must also face the emotional pain of losing part or all of a breast, and may struggle with her fear of cancer and what lies ahead. Then try to imagine if she is released from the hospital within hours of surgery.[189]

---

practice spurred a national movement and inspired this legislation. I'd like her to stand so we thank her for her efforts. Dr. Zarfos, thank you. . .").

185. *Id.*; *see also* Vicki Lawrence MacDougall, *Medical Gender Bias and Managed Care*, 27 OKLA. CITY U. L. REV. 781, 881–82 (2002) (quoting Leslie Laurence & Beth Weinhouse, Outrageous Practices: How Gender Bias Threatens Women's Health xvi (1997)) ("Managed care companies frequently assert that they are protecting women by limiting access to the surgical procedures that were performed unnecessarily in the past under pay-for-service plans, for example, hysterectomies, and cesarean sections. 'What these companies don't say is that while unnecessary or unproven surgeries are being reduced, so are necessary ones. Some managed care companies, for instance, define reconstructive surgery after mastectomy as cosmetic rather than medically necessary and refuse to cover it. Or they pay for the first part of the procedure–the operation to recreate the breast mound–but not subsequent procedures, such as the nipple reconstruction or surgery to adjust the opposite breast so it matches the new one. Even more galling, the same managed care companies that deny breast reconstruction sometimes cover penile implant surgery.' Managed care has been relentless in the reduction of the number of in-patient hospital days. There has been a reduction in in-patient days of forty percent per thousand patients. Notable examples are the famous "drive-by deliveries," outpatient mastectomies, and discharging women after gynecological procedures with catheters in place.").

186. 143 CONG. REC S889-90 (daily ed. Jan. 30, 1997) (statement of Senator Feinstein). *See* CAL. HEALTH & SAFETY CODE § 1367.6 (West, Westlaw through Dec. 31, 1999); *see also* Cal. Ins. Code § 10123.8 (West, Westlaw through Dec. 31, 1999).

187. 144 CONG. REC S12825 (daily ed. Oct. 21, 1998) (statement of Senator D'Amato).

188. 144 CONG. REC S12825 (daily ed. Oct. 21, 1998) (statement of Senator D'Amato).

189. 143 CONG. REC S820 (daily ed. Jan. 29, 1997) (statement of Senator Snowe).

Sponsors also rejected the idea that breast reconstruction would not be covered while ear or testicle reconstruction would be covered.[190] "Looking normal is medically necessary. Breast reconstruction is important to recovery."[191]

It is clear from the legislative history that one of the main purposes of the WHCRA was to reduce women's fear of cancer screening by promising that they would be made whole after a diagnosis and treatment for cancer. One of the earliest legislative comments by Senator Snowe explained that "studies show that the fear of losing a breast is a leading reason why women do not participate in early breast cancer detection programs. If women understand that breast reconstruction is widely available, more might participate in detection programs."[192] In 1998, women were dying of breast cancer at a rate of 44,000 per year and so an increase in participation in detection was a motivating factor in protecting reconstruction.[193]

While introducing the bill, Senator D'Amato discussed his concern that Health Maintenance Organizations (HMOs) were punishing doctors.[194] He read recent testimony by the Chief Breast Cancer Physician at Sloan Kettering Memorial Hospital that rather grandly stated that "[]he point is that there is a holy alliance between the doctor and the patient, and the entire structure of medicine is because of that holy alliance" and he, the doctor, was not being permitted to treat the patient in the correct way because the HMO was refusing to cover the chosen treatment.[195]

It is clear from these legislative statements that the intent of the bill was to make women whole and to get insurance companies out of the business of limiting women's reconstructive options by refusing to pay for them. Furthermore, the insurance company's insistence on preserving the bottom line got in the way of the "holy alliance" between a woman and her doctor and prevented the doctor from using their best judgment. While the congresspeople in 1997 and 1998 may

190. 143 CONG. REC S886 (daily ed. Jan. 30, 1997) (statement of Senator D'Amato recounting a conversation with Mary McCarthy, then executive director of the American College of Obstetricians and Gynecologists of New York, "[i]f you lose an ear or a testicle, or part of your face to cancer, there is no question that reconstruction is covered. Yet denials for breast [cancer] reconstruction are serious and they are rising."); *see also* 143 CONG. REC E159 (daily ed. Feb. 5, 1997) (statement of Rep. Molinari discussing that "[i]ronically, insurance companies do not deny reconstructive surgery for an ear that is lost due to cancer. Insurance companies are simply not being sensitive to the needs of breast cancer patients, and this bill seeks to ensure a breast cancer patient's access to an appropriate hospital stay as well as reconstructive surgery.").

191. 144 CONG. REC S4648 (daily ed. May 12, 1998) (statement of Senator Diane Feinstein rebutting a statement by Joseph Aita, then executive vice president and medical director of Life Guard, an insurance company).

192. 143 CONG. REC S820 (daily ed. Jan. 29, 1997) (statement of Senator Snowe).

193. 144 CONG. REC S12825 (daily ed. Oct. 21, 1998) (statement of Senator D'Amato).

194. 143 CONG. REC S885 (daily ed. Jan. 30, 1997) (statement of Senator D'Amato, "Every physician would have the freedom to prescribe longer stays when necessary, and the confidence that insurers will not punish them for practicing sound medical treatment.").

195. *Id.* at S886.

not have imagined that women of 2023 would be made whole by being made beautifully flat, it is clear that the intent of the bill would support this outcome.

3. "In a Manner Determined in Consultation with the Attending Physician and the Patient"

There is very little case law interpreting the WHCRA, and most of it focuses on whether it creates a private right of action against insurers.[196] *J.L.F. v. Arizona* touches on what type of outcome a woman may expect and how a coverage decision can be made about reconstructive options.

J.L.F. had a covered mastectomy and a covered reconstruction surgery, both performed by the same surgeon.[197] After the second surgery she felt that "her left breast was "flatter and smaller" than the right one."[198] Her original surgeon wrote in his notes that he only considered there to be "maybe about half a centimeter difference between the two sides. It's so subtle, that I don't think it's worth the risk of going back in, reoperating, and risking infection and loss of the implant [. . .] I can't promise that I can make them exactly symmetric. I never have done that."[199] He refused to operate on her breasts again.

She sought out a second physician who was willing to operate, but he wrote in his notes that he could only make a slight improvement.[200] J.L.F.'s insurer read this note and denied the operation, concluding "that surgery to correct mild mammary asymmetry appears to be for cosmetic reasons."[201]

After a series of hearings and appeals, her case was heard by the court of appeals of Arizona. The court concluded that "J.L.F.'s breasts are within the range of normal human form and symmetry" and agreed with the prior decision of the Director of the Arizona Health Care Cost Containment System (AHCCCS) that "[t]he average human body in its normal state is not perfectly symmetrical."[202] The court looked at the plain language of the WHCRA:

> The statute does not provide a definition of symmetrical appearance or, indeed, any measure or guidance to determine whether a symmetrical appearance has been achieved. J.L.F. insists that her breasts do not have a symmetrical appearance, and she argues that the Act implies that deference should be given her and her treating physician to decide if a symmetrical appearance has been achieved and how to proceed if it has not been attained.[203]

196. Howard v. Coventry Health Care, of Iowa, Inc., 293 F.3d 442, 445 (2002).

197. J.L.F. v. Arizona Health Care Cost Containment System, 91 P.3d 1002, 1003 (2004).

198. *Id.*

199. *Id.* (internal quotations omitted).

200. *Id.* ("Dr. Gitt acknowledged that J.L.F.'s breasts showed only a "slight asymmetry" and that her appearance would be improved only "slightly by increasing the left-sided fill.") (internal quotations omitted).

201. *Id.*

202. *Id.* at 1006, 1004.

203. *Id.* at 1005.

The court considered the legislative history of the statute and concluded that although the language of the act required decisions about hospital stays and breast reconstruction to be done "in a manner determined in consultation with the attending physician and the patient," the focus was on the first part: "the necessity of consultation was only emphasized with regard to the first purpose of the Act and not to the second purpose. The first concern was to ban "drive-through mastectomies[.]"[204] However, the court noted that there was a second concern: "to bar health insurers from categorizing reconstructive surgery following a mastectomy as cosmetic and denying coverage."[205] Nevertheless, the court in J.L.F. upheld the decision of J.L.F.'s insurer to deny her coverage under the theory that her surgery was merely cosmetic and not determined in consultation with her physician.[206]

While the court was focused on returning her to "the range of normal human form and symmetry," the WCHRA is more specific than that. In fact, breast asymmetry is quite common outside of the context of mastectomy: "up to 94% of women have one breast larger than the other."[207] However, the WHCRA specifically requires insurers to cover breast reconstruction including "surgery and reconstruction of the other breast to produce a symmetrical appearance [. . .] in a manner determined in consultation with the attending physician and the patient."[208] This means that J.L.F.'s real failure was in not seeking a third opinion. Her first physician didn't want to try a third time and her second physician was wishy-washy, telling her that he could probably improve the situation but writing his doubts into his notes. If she could have found a third physician willing to write a more confident opinion of the outcome, her insurer would likely have covered the surgery. The court notes that while the AHCCCS Director ruled against covering a revision surgery, J.L.F.'s insurer, Mercy Healthcare, "also agreed that it would not object if J.L.F. sought a third opinion at its expense, perhaps an opinion from a plastic surgeon."[209] The court made it clear that it considered J.L.F.'s wish for a third surgery to be a unilateral and unfounded decision:

> "The spirit and purpose of the Act was to provide a woman with insurance coverage for reconstructive surgery "to produce a symmetrical appearance" of her breasts following a mastectomy with the "manner" of the procedure "determined in consultation with the treating physician and the patient." This does not equate to the unrestricted provision of coverage for a subjective, autonomous decision by the patient without objective support."[210]

204. *Id*.
205. *Id*. at 1006.
206. *Id*. at 1007.
207. Linzi Kinghorn, *Breast Asymmetry: Women in Dorset Share Their Experiences*, BBC (June 13, 2023), https://perma.cc/D7C8-QSNW.
208. 29 U.S.C.A. § 1185b(a) (Westlaw through P.L. 118-39).
209. *J.L.F*., 91 P.3d at 1007.
210. *Id*. at 1006.

Unfortunately for J.L.F. and women in similar situations, physicians may be wary of promising perfect symmetry out of a fear of overpromising aesthetic outcomes. So, women must make their decision in consultation with a treating physician, but physicians are wary of promising positive outcomes, which may leave the patient as the only person willing to believe that a better outcome can be achieved.

By refusing treatment for this reason, the insurer placed the burden back on J.L.F. to find a new doctor willing to promise more. For financial and geographical reasons, this amounts to limiting the best care to the women who live close to the best doctors, or women who can afford to see many doctors to find one who will care for them properly. Limiting the WCHRA in this way risks exacerbating the inequalities that the legislation was designed to prevent.

The broader and more positive applicability of J.L.F. is this: while the WHCRA may not require insurers to cover surgery to revise asymmetry in situations where the patient and physicians do not concur about the likelihood of success, it is clear that insurers must cover surgery to repair breast asymmetry caused by poorly completed breast surgeries following mastectomies. This means that women who have had negative outcomes following flat closures, particularly in cases where surgeons did not know the techniques required to make the breasts flat without flaps, lumps, or wrinkles, should be able to have further revision surgeries covered by the symmetry provisions of the WHCRA.

Further, the court's focus on the "range of normal human form" suggests that a flat closure should be covered by the WHCRA.[211] A completed aesthetic flat closure is well-within normal human form; although it is not the average form for an adult human female's breasts, it is perfectly normal for some girls, boys, and adult males to have flat chests.

4. The Limits of Breast Reconstruction Under the WHCRA

Despite the clear intent of the WHCRA to make women whole, doubtless insurers will still seek to exclude procedures in order to save money, as in *J.L.F.* They may argue against a more expansive reading of the words "breast reconstruction" in the WHCRA by attempting to take it to its most extreme ends. What if a woman wishes to have four or six reconstructed breasts? What about women who wish to have nipples tattooed over their reconstruction scars? What about future women who wish to have lab-grown pieces of their own tissue implanted rather than silicone or saline implants? (This is not currently a possibility, but it seems like a plausible direction of future innovation.)

Insurers may draw the line at constructing the six-breasted alien from Star Wars because this unnatural chest configuration is not a natural human form.[212] This shape cannot be *re*constructed because it has never existed in nature. It can

211. *Id.*

212. *Yarna d'al' Gargan,* STARWARS, https://perma.cc/TL28-6LR3.

only be constructed, not reconstructed, and insurers can rightfully reject this conceit as purely cosmetic.

However, other advances which may have seemed like science fiction in 1998 should be covered. The WHCRA did not address nipple tattooing, likely because it wasn't widely done in 1998, or perhaps because the idea of repeating the words "nipple" and "areola" on the Senate floor might have been too scandalous. Nevertheless, the intent of the WHCRA was to make women whole, and tattooing the semblance of nipples and areolas onto reconstructed breasts is a part of reconstruction and should be covered.[213] Finally, future innovations in reconstruction should not be limited because they are not specifically named in the WHCRA. The legislators wisely chose "breast reconstruction" not "silicone implant reconstruction" or "DIEP flap reconstruction" so future innovations in reconstruction should be covered by insurers under the WHCRA.

B. NEW YORK'S LAW MANDATING COVERAGE OF AESTHETIC FLAT CLOSURE AS A RECONSTRUCTION OPTION

One simple and neat solution to ensure access to aesthetic flat closure is to amend the law to require insurers to cover aesthetic flat closures equally with other forms of post-mastectomy reconstruction. While many insurers in other states may choose to cover the procedure without aesthetic flat closure being specifically named in a state statute, New York has become the first state to explicitly require this coverage. New York has the unhappy distinction of being above the national average rate of breast cancer among its populace, but the state is at least also a trailblazer in terms of treatment and insurance coverage.[214]

Like the WHCRA, New York's 2022 addition to these protections was inspired by the stories of individual women. In this case, the bill's sponsor, Stacey Pheffer Amato, said:

> I have seen their scars, heard their stories and it is through their experiences, not only through surviving breast cancer but dealing with the aftermath that I am pushing this bill. After a mastectomy, every woman deserves to have a body that they are happy with and we are on the way to ensuring that this will happen.[215]

New York's law is almost perfectly simple: in every location where the law mentioned post-mastectomy reconstruction of the breast, the 2022 law added an

---

213. Caitlin Kiernan, *A Tattoo that Completes a New Breast*, N.Y. TIMES (June 3, 2014, 5:00 AM), https://perma.cc/N25Y-ANQF/.

214. *Quick Profiles: New York*, STATE CANCER PROFILES, https://perma.cc/C8CK-NRGM; Memorial Sloan Kettering Cancer Center in New York City is ranked second in the nation by the U.S. News and World Report. *Best Hospitals for Cancer,* U.S. NEWS, https://perma.cc/5ZJP-WAHH.

215. *NYS Assembly Passes Pheffer Amato's Aesthetic Flat Closure Bill: Gives Women the Option on How Their Body Will Look Post-Mastectomy*, ASSEMBLYWOMAN STACEY PHEFFER AMATO (May 11, 2022), https://perma.cc/9WRY-KFYE.

explicit mention of reconstruction of the chest wall.[216] It also specifies that "[c]hest wall reconstruction surgery shall include aesthetic flat closure as such term is defined by the National Cancer Institute."[217] This means that insurers who were required to cover breast reconstruction now must also cover aesthetic flat closure, and hospitals which are required to inform patients about their choices must include aesthetic flat closure in that list of choices.[218] This amounts to an increase in coverage and an increase in awareness of the procedure.

C. LEGALLY MANDATED NOTICE OF ALL RECONSTRUCTION OPTIONS

In addition to being a leader in requiring insurers to cover aesthetic flat closure as a reconstructive choice, New York is also a leader in raising physician and patient awareness of this possibility. In 2008, an article published in the Journal of the American College of Surgeons showed discrepancies in access to post-mastectomy reconstruction was largely determined by physician-patient communications.[219] The article noted discrepancies in care based on demographic and socioeconomic factors and concluded, "Optimally, clinical decisions in such cases should reflect individual patient preference and not bias on the part of physicians. This requires that a discussion of potential options be presented to the patient in an informative and comprehensible manner regardless of race, education, insurance or primary language spoken."[220] In 2010, New York passed a law making these conversations mandatory.[221]

Since 2011, hospitals in New York providing mastectomies have been required to give patients substantial information about their choices in writing.[222] This notice law was amended in 2022 to include aesthetic flat closure as an option.[223] Today, the information given to a woman contemplating mastectomy must include:

> (a) a description of the various reconstructive options and the advantages and disadvantages of each. Such description shall include aesthetic flat closure as such term is defined by the National Cancer Institute;
> (b) a description of the provisions assuring coverage by public and private insurance plans of the costs related to reconstructive surgery under federal and state law;

---

216. 2022 Sess. Law News of N.Y. Ch. 571 (A. 8537) (McKinney).
217. *Id.*
218. *See* infra III:C
219. Greenberg, Schneider, Lipstiz, Ko, Malin, Epstein, Weeks & Kahn, *supra* note 146. The article explained: "(1) patient-provider discussions of the option of reconstruction occur less frequently in vulnerable populations; (2) there are differences in qualitative aspects of patient-physician communication during these discussions, potentially based on language, educational, or cultural barriers; and (3) age-based and ethnic or cultural differences in patient preferences regarding reconstruction." *Id.*
220. Greenberg, Schneider, Lipstiz, Ko, Malin, Epstein, Weeks & Kahn, *supra* note 146.
221. 2010 N.Y. Sess. Laws Ch. 354 (A. 10094-B) (McKinny).
222. *Id.*
223. 2022 N.Y. Sess. Laws. Ch. 571 (A. 8537). (McKinney).

(c) a description of how a patient may access reconstructive care, including the potential of transferring care to a facility that provides reconstructive care or choosing to pursue reconstruction after completion of breast cancer surgery and chemo/radiotherapy, if warranted;
(d) such other information as may be required by the commissioner.[224]

The effects of this law on reconstruction rates are already clear: rates of reconstruction have increased, particularly in certain populations: older women and women of color.[225] Now that the law includes aesthetic flat closure in the menu of required options, it is reasonable to expect to see an increase in this choice among newly informed patients.

While this law requires hospitals to give information in writing to patients, this law should not just be beneficial to patients. It will also help with physician awareness of the various options and the importance of offering all the options to their patients. It also solidifies the presence of aesthetic flat closure as one of the various reconstructive options.[226] Physicians might not be ready to perform the procedure personally, but they must be prepared to give the patient a list of the advantages and disadvantages of this choice, and at the least they should be prepared to discuss what is written.

D. NON-LEGISLATIVE SOLUTIONS

1. Medical Malpractice Litigation

Some readers may question why malpractice litigation is not a primary solution to this issue. It does not seem to be the correct answer to drive broad societal changes and overcome gender stereotypes. Judges and juries may hold many of the same cultural biases as the doctors who denied aesthetic flat closure, i.e. that breasts equal femininity and no "natural woman" would choose a flat closure. Therefore, these may not be winning malpractice cases even when a woman has been harmed through a breach of the standard of care. Indeed, in a case from Minnesota in 2008 where the plaintiff alleged that the physician had disregarded her instructions to leave a flat chest and instead performed a skin sparing

224. N.Y. PUB. HEALTH LAW § 2404 (McKinney, Current through L.2024).

225. Rose H. Fu, Onur Baser, Lu Li, Paul Karlansky, Jessica Means & Christina H. Rohde, *The Effect of the Breast Cancer Provider Discussion Law on Breast Reconstruction Rates in New York State*, 144 PLASTIC & RECONSTRUCTIVE SURGERY 560 (2019). ("The aim of the Breast Cancer Provider Discussion Law is to improve breast reconstruction rates through provider-driven patient education. . . Our study reveals a significant change in reconstruction rates following law passage seen most acutely in ethnic minorities and those in the lower median income bracket. . . This demonstrates that the law is effective in improving awareness of both reconstruction options and the federal mandate for insurance coverage, and more importantly for reversing health care disparities among those patient subpopulations that normally fall victim to poorer standards of care. Further examination of public and provider awareness of this law may further clarify its role on this observed trend in breast reconstruction. The New York State Breast Cancer Provider Discussion Law can provide a template for other states to model legislation geared toward patient-centered improvement of health outcomes.").

226. N.Y. PUB. HEALTH LAW §2404 (McKinney, Current Through L.2024).

mastectomy (leaving skin for a future reconstruction) the jury found that the physician was not negligent.[227] It would be unwise to speculate based on a single case more than a decade in the past, but it would also be unwise to hope for a sudden surge in successful litigation of this type to drive broad social change.

2. Social Change and Increased Awareness

Advocacy organizations like Not Putting On a Shirt are raising awareness and helping women to find physicians who will respect their wishes and who are skilled at reconstructing flat chests.[228] The organization has a list of flat-friendly physicians and connects women with peer support from a Facebook group called Fierce, Flat, Forward.[229]

CONCLUSION

Janet Franquet, whose struggles inspired the WHCRA, was actually able to have a mastectomy with reconstruction before the legislation was passed. Her physician, Dr. Wider agreed to cover the surgery free of charge, but even that wasn't the end of her battle.

> Mrs. Franquet and her family were left to pay for the procedure out of their own pocket. The procedure cost approximately $16,500. Luckily, her doctor, Dr. Todd Wider, agreed to forgo payment for this life saving surgery. But recently, the insurance fund agreed to pay for the surgery—only after a lengthy appeal before the Board of Directors with lawyers and doctors testifying as to the medical necessity of the surgery. I ask you, Mr. President, how many other Janet Franquets are out there? Will they be lucky enough to have a Dr. Wider to take care of them, or will they be forced to forgo this lifesaving surgery so that insurance companies can cut costs and save money?[230]

What happens to these other Janets, indeed? Wealthy women like Ms. Jolie will be able to find responsive surgeons and move on from BRCA1 with their bodies and self-image intact. Women with less means will be mutilated and scarred, some of them left unwilling to look at their own bodies, or too afraid to have surgery, rolling the dice on dying from breast cancer. Unless the intent of the WHCRA is followed and physicians fully inform women and then respect their choices, this inequality will persist and worsen.

---

227. Thompson v. Mitchell, 2012 WL 1641746 (Minn. Dist. Ct., 2012); Complaint, Thompson v. Mitchell, 2012 WL 1641746 (Minn. Dist. Ct., 2012) (No. 73-CV-09-7061).

228. *Mission & Values*, NOT PUTTING ON A SHIRT, https://perma.cc/ZH6A-DAFR.

229. *Flat Friendly Surgeons Directory*, NOT PUTTING ON A SHIRT, https://perma.cc/9FA4-E5MQ; *Peer Support: Fierce, FLAT, Forward*, NOT PUTTING ON A SHIRT, https://perma.cc/A4WC-XWA4).

230. 144 CONG. REC S12825 (daily ed. Oct. 21, 1998).

In her article describing her choice of a less-drastic, less disfiguring breast surgery, Babette Rosmund summarized her ordeal in fighting with her physicians quite poetically:

> The basic truth of the matter is this: No woman on earth is exactly like any other woman. Even in the thrall of a dread disease, she is unique and must be paid by her doctor the compliment of being allowed to be a partner, within the proper framework of her illness, in deciding what is the best solution for her own special, or even eccentric needs.[231]

Women who choose a flat chest must be respected whether or not their doctors find their needs or choices to be eccentric and should receive the same insurance coverage as women who choose a more traditional protruding breast reconstruction. Women can be empowered to make this choice through more careful reading of the breast reconstruction requirement of the WHCRA, new legislation in the states, and increases in awareness of this option by patients and physicians.

231. Rosmund/Campion, *supra* note 15, at 158.