
Discussion

Achieving a Predictable 24-Hour Return to Normal Activities after Breast Augmentation: Part I. Refining Practices by Using Motion and Time Study Principles

by John B. Tebbetts, M.D.

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I read with great interest Dr. Tebbetts' review of his current and past practices in performing augmentation mammoplasty. Although the subject of this paper is a relatively simple one, the article itself is fairly complex. There are two major themes in this article and several other minor themes.

As best as I can discern, the first major theme is that Dr. Tebbetts has developed a method of performing augmentation mammoplasty that he believes is faster and more efficient than his previous techniques of a decade or longer ago. The second major theme is that these same techniques have created the environment for a speedier and more predictable patient recovery postoperatively. On the basis of the evidence presented in this article, both of these hypotheses are well supported.

There are some more specific minor themes within this reference as well. The author has developed surgical techniques and a philosophy that require a smaller amount of both intraoperative and postoperative drug therapy that he believes hastens the recovery process. The shortened operative time also results in a shortened time interval for general anesthesia, which the author believes also facilitates a quicker postoperative recovery. The shortened operative time, while facilitating a quicker postoperative recovery, also facilitates an increase in surgeon productivity, allowing for a shorter work day or for more surgery within the same work day. Lessened surgical trauma is believed by the author to result in a reduced requirement for postoperative drug therapy and for a

relaxation of the prohibition against medications previously associated with postoperative bleeding. Finally, a decrease in operative time and drug dosage results in a reduced cost to both the patient and the surgeon, which is to everyone's benefit.

Knowing the quality of Dr. Tebbetts' surgery and his knack for accuracy and precision, I have no doubt that all of the above principles are valid. What is more interesting to me, however, are the more global issues that this sort of article brings to mind. My sense of things is that young surgeons will be particularly interested in this type of paper because many of them will not have well-established work patterns, and they therefore will be more likely to adopt this recipe as the template for their own approach to surgery. On the other hand, I expect that more senior surgeons will look on this paper as simply another surgeon's list of preferences and that more senior surgeons will therefore be less inclined to adopt this program in its entirety, but may rather pick and choose a few things that might improve their own current approach to surgery.

What was also interesting to me is that when I compared my personal approach to surgery to that of Dr. Tebbetts, I found a remarkable degree of similarity. For example, breast augmentation surgery in my practice is very much a choreographed operation in which almost all the surgical steps could be written down in advance such that the surgeon, the assistant, and the scrub nurse should all know precisely their individual parts and what is coming next.

On the same theme, much of the surgery can be set up in advance, and this includes the preparation of implants and the preparation of the fill tubes so that the surgeon does not need to wait for those things to happen during his portion of the operation. I also believe in atraumatic surgery with a bloodless field and minimal surgical trauma. Finally, within the last year or two I had independently moved toward ibuprofen rather than narcotics in the recovery phase for both patients undergoing augmentation mammoplasty and many other patients of plastic surgery who are at low risk for bleeding. Similar to Dr. Tebbetts, I have found that most of my patients after augmentation mammoplasty make a very quick and speedy recovery and are usually quite functional within a day or two of surgery. However, I confess that I do not routinely use a stopwatch in the operating room to check speed.

At present, I have a fairly broad plastic surgery practice and do both reconstructive and cosmetic surgery. My practice includes such things as transverse rectus abdominis musculocutaneous flaps, latissimus flaps, free transverse rectus abdominis musculocutaneous flaps, tissue expanders, abdominoplasty, primary and secondary breast augmentation procedures, mastopexy procedures, face lift, blepharoplasty, brow lift, otoplasty, rhinoplasty, and other primary and secondary procedures. It would be interesting to think how efficient I might become if I only did one or two operations and avoided complex or secondary procedures of either my own or other surgeons. The practical problem that most surgeons eventually confront is that even if we script and choreograph our operations to fine detail, we have a hard time keeping our surgery teams working at the same efficient pace. This is true in hospital and outpatient operating rooms where turnover of staff and sharing of staff is a

necessity of life. It is also true in office operating rooms where staff turnover is probably the bigger problem. When you add in the multitude of various procedures we do and the variability of procedures, particularly when we are dealing with secondary operations or complex combination operations, it is hard for the staff or even the surgeon to stay on script perfectly.

From a philosophical point of view, it is also interesting to ask, do many of us really want to have our surgery careers so precisely choreographed that we only do one or two operations and only do those same operations exactly the same way every single time, even to the point to which we reject patients who have more interesting or complex variants of the same basic problem? In the short run, many of us might be pleased with such a limited and focused practice. On the other hand, would this limited and focused practice provide the right amount of intellectual stimulation over a 25- or 30-year professional career?

To put it another way, although motion-time studies can improve our productivity, is an individual surgeon's practice fully analogous to an automobile assembly line?

In summary, Dr. Tebbetts presents us with convincing evidence that with the proper attention to detail and planning, a gifted surgeon can improve efficiency and productivity while at the same time improving patient recovery and outcomes. The ultimate danger in this sort of analysis, however, is the temptation to reduce plastic surgery to a two-dimensional assembly line activity in which intellectual stimulation and professional career satisfaction are diminished.

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