

Foreword



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The continuing mission of this series is to inquire into and discuss the topics that are relevant to general surgeons. One of the more ever present themes is what is it that makes a general surgeon a general surgeon. In previous issues, we have presented topics that one could argue represent specialized skills and others could state represent a limitation of scope of practice. In this issue, we come back to this dynamic of what “belongs” to general surgery and what doesn’t.

My original mentors in surgery were vascular surgeons. Surgeons such as Dr. H. Brownell Wheeler and Dr. Clement Hiebert made the beginnings of their very successful careers by operating on arteries. They were in the mix when the first carotid endarterectomies were done and coronary artery bypass grafting was coming into wide use. The discipline of vascular surgery, as we were taught it, was exciting and terrifying, and it was (and still is) extremely demanding and fairly unforgiving. Also, it was a timed game; neither bleeding nor ischemia is particularly understanding of our prior time commitments. This added another layer of challenge and reward to these operations.

The field of vascular surgery is virtually unrecognizable in practice compared to those days but its fundamental principles remain beautifully similar. The concepts of “inflow, outflow, conduit” and “achieve proximal and distal control” will still carry you a long way, no matter where you are and what you have to work with.

Which brings us to the original point: what does vascular surgery have to do with general surgery? Is it a completely separate specialty or a basic

component of general surgery? The answer, as it turns out, is probably yes. And the reason the answer to an “either /or” question is yes is because the answer changes upon local workforce structure and health care integration policies and arrangements. It may also change with weather and geopolitics.

We continue to face a debate in the United States about how to deliver health care and how to pay for it. In my opinion, the debate is being poorly conducted and mostly consists of obfuscation in order to preserve temporary perceived advantages; but that is one surgeon’s opinion and I have been known to be wrong before. The parts of the story that are somewhat beyond debate is that we have a nonhomogenous distribution of resources and a disconnect between risk sharing and cost sharing. Some of this disconnect is economic, some is geographical/spatial, and some is political.

Vascular surgery is an excellent example of a tiered response system. It has a range of services from very basic repair of acute minor vascular injuries and straightforward restoration of blood flow that could be done in a tent, to complicated interventional techniques requiring expensive dedicated procedure suites that require highly specialized personnel and broad system support such as intensive care units, dialysis capability, and “open” operative support. Also, the range of costs of recruiting and retaining personnel to these differing centers is very broad.

We in the military have a significant history of managing widely varied levels of resources in various spatial configurations, from state of the art facilities in peaceful, secure areas to barely sheltered soft “facilities” in extremely austere environments. Despite an extremely gifted and dedicated transport system of air evacuation in hostile environments, time still dictates that life and limb salvage must be undertaken with limited resources and with great frequency. For those of us who were a little older, it was clear under those conditions that the comfort level of recently graduated trainees with vascular surgery being a part of general surgery was a bit less than with those who trained prior to the creation of the American Board of Surgery Vascular Surgery Board as a separate board.

The flip side of this coin is the disparity in training required to be maximally effective in an environment that has every resource. By way of example, I was recently asked to see a patient in an emergency room because he had a rigid abdomen and was in shock. I took him to the OR and started the operation to control and repair his ruptured abdominal aortic aneurysm while our vascular surgeon came in and we finished it together—good fun actually; it went well, and my colleague was responsible for the postoperative care. Our editor for this issue, Dr. Starnes, and I were talking on the phone a day or two later and I relayed the story to him. He asked me if I had considered fixing the aneurysm endovascularly. I told that even if I had wanted to, I would not have known how. And since the patient was fairly close to dying, I did not think that was a good time to learn.

Our conversation made it clear to me that state-of-the-art vascular surgery has become so evolved that it cannot be just a “part” of general

surgery. Yet basic “keep them alive with their limbs on” vascular surgery probably has to remain an important part of general surgery. We simply cannot afford nor would we probably accept a system that would have to change adequately to respond to the global needs of our patients if we limited vascular surgery to surgeons who only perform vascular procedures. Furthermore, we could not project this level of sophistication to every acute facility and expect enough clinical volume to maintain system and individual proficiency.

I can think of no more qualified person to have edited this issue. Dr. Starnes has extensive experience in working in environments as austere as Forward Surgical Teams in Afghanistan to the cutting edge environment he currently works in at the University of Washington. He and his colleagues have assembled a truly magnificent collection of articles that should be relevant to any general surgeon.

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