

## Foreword



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*Consulting Editor*

Pancreatic surgery, and to some degree the surgeons who specialize in pancreatic surgery, has had an almost mythical—if not mystical—quality imbued to it. The oft quoted warnings about staying away from the pancreas and the general jitters that some people get when confronted with these problems have served to reinforce the idea that there is something fundamentally different about the pancreas. I cannot say that I have witnessed any concerted effort to dispel such notions, and I may have seen a few people try very hard to reinforce the idea. And in some ways that may have been a good thing.

Our understanding of how the pancreas works, how it fails to function properly, who is at greater risk for developing pancreatic disorders, and who is best capable of treating people who have pancreatic diseases continues to unfold at a refreshingly rapid pace. In this issue, an excellent series of reviews are provided that should well acquaint the reader with what we currently believe to be true regarding benign disorders of the pancreas. For those of you who like to hear the other shoe drop, we expect to include in a future issue a similarly comprehensive review of what we know about malignant disorders of the pancreas.

Over the past twenty years or so, there have been tremendous advances in our capacity to diagnose and treat patients who have pancreatic disorders. Along with this increase in knowledge, there has been a concerted effort to “centralize,” (for lack of a better word) by some and to limit the care of these patients to certain locations. The motivations of those who have supported this effort, in my opinion, have been to maximize benefit to the

individual patient and to the collective group of patients at large. Yet, there are some who could look upon this “centralization” as a “restraint of trade” issue. And since the practice of medicine and delivery of health care are still private industries, legislative fiat is limited in how much it can do to enforce such matters.

The evolution of thinking on who should deliver complex and unusual services for patients who have pancreatic diseases has moved along in parallel track to the development of our improved understanding. For a period of time it was suggested that institutional volume was the sole determinant of who could best provide care. Subsequently, it would appear that individual volume (of surgeons, at least) is probably a better predictor, though we don’t really know what the actual volume of patients should be.

It never made sense to me that a surgeon who has a high volume pancreatic experience in one facility would become less capable if he or she moved to another facility. Nor did it make sense that if a hospital had a high overall volume of a given procedure that a “low volume” surgeon would derive “institutional benefit” for performing procedures infrequently unless the operative part of the patient’s care was not really that important. It would therefore stand to reason that there are probably some features of surgeons that are important (something I think most people who perform these procedures often would agree with), and there are some institutional features that are important, as they may influence not only the care of the patient in “non-operative” situations but may also impact the ability of the surgeon to develop a high volume practice.

The traditional concept of the general surgeon has been one of an “in-charge”, individually responsible physician. We construct our training that way. The American Board of Surgery still instructs those of us who give the certifying exams to tell the candidates that “their consultants are all unavailable.” But the more realistic viewpoint is that we are all parts of a system in which overall system performance is becoming, if not already, more important than individual performance. Surely, the weak link in the chain theory holds true in such cases, but one link does not make much of chain—strong link or otherwise. We as surgeons are most likely at a point where, if we want better operative outcomes for either individual patients or for collective groups of patients, we shall need to expend as much energy trying to improve the system lines that we work in as much as improve our own skill sets.

Pancreatic surgery lends itself well to these challenges. The discipline relies heavily on diagnostic imaging, endoscopic evaluation and treatment, metabolic and physiologic support, behavioral counseling, operative expertise (not just from the surgeon but from the entire operative team), anesthetic care, and, in some cases, perioperative critical care. Many of these associated disciplines have their own volume-to-expertise ratios that have to be considered as well. All of these disciplines are associated with fixed basal costs to maintain appropriate staffing and equipment capitalization

to offer competitive quality services. The availability of adequate patient volume and revenue generation to sustain a full-time supra-critical mass of all the key clinical elements in a service-line model for the care of patients who have pancreatic diseases is probably the major determinant of where pancreatic surgery could be practiced. Maintaining adequate resources to achieve outcomes that are competitive with the “best practices” that are available at a finically acceptable burden will probably be the major barrier for most institutions to clear in order to participate in this type of care.

Individual focus and study as well as concentrating the challenging problems in the hands of fewer people who are willing to fully commit to their best solution for the patient has carried us a long way. As much as some of us might like to think that the discipline of pancreatic surgery is best characterized as “one riot, one ranger” (the motto of the Texas Rangers,) the reality is that we need to be a part—an important part, no doubt, but a part of a larger team if we expect to be competitive with the best performing groups.

The issue that Dr. Behrman has assembled should well familiarize the reader with the current state of understanding of benign pancreatic disorders. I am personally grateful to him for assuming the duties of editing this issue, as he did it on short notice as a favor. I would also like to acknowledge his other contributions to our country through his service in the United States Navy while activated as a reservist during the initial phases of this current military conflict. His efforts as well as those of his colleagues have helped countless suffering persons during tragic times.

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