

Foreword



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For most general surgeons, operations involving the great vessels, aortic arch, or heart are not part of our everyday routine—in fact, these operations are rarely part of our routine on any day. But a working knowledge of the problems and solutions dealt with by cardiac surgeons is, in my opinion, potentially invaluable to any surgeon.

Cardiac surgery has afforded us with one of the best models for scientific inquiry and practical adaptation that medicine has known, second perhaps only to the study of gastric pathology and its solutions, although I will admit my bias in this matter. Cardiac surgery may also serve us even better as a model of the trajectory of surgical intervention within many fields, as it is also an example of a “canary in a coal mine.”

Historically, cardiac surgery has been afforded tremendous visibility in the public eye and a great deal of latitude in development (experimentation) because of the devastating consequences associated with myocardial infarction and acute heart failure. In the 1960s, cardiac surgeons were as famous as astronauts and were celebrated figures in public life. Drs. Christiaan Barnard, Michael DeBakey, Norman Shumway, and Denton Cooley were celebrities and well known to many members of the public. In the days of the first cardiac transplants and rapid promulgation of cardiopulmonary bypass, cardiac surgery as a discipline was well funded, was revered by the public, and became increasingly clinically effective at phenomenal rates. Over time, cardiac surgery has somewhat become a victim of its own profound success. Very few people today are astounded that someone can undergo an emergent coronary artery bypass grafting (CABG) and go home in well under a week. Cardiac surgeons are still valued members of society, but they are not looked upon as the giants they used to be—they have rejoined the ranks of the mortals. And perhaps most importantly, cardiac surgeons have now taken a place as a valued, but not necessarily dominant, member of a more varied and complex team of professionals.

One of the great lessons that we can learn from cardiac surgery is that if one wants to improve outcomes, one must design valid questions and metrics, then measure them correctly, and share that information in a way that it can be used effectively (non-punitively). The early work of the Northern New England Cardiovascular Study Group has served as a model for outcomes analysis and collaborative effort. Without doubt,

CABG procedures are more straightforward in measurable variables than some other procedures, but the principle still holds.

Cardiac surgery also teaches us that the future of surgery ain't what it used to be (apologies to Yogi Berra). The advent of statins and stents, combined with the exceptional success of cardiac surgeons themselves, have created circumstances where the focus of cardiac surgery has shifted somewhat away from the care of the acutely ill patient to the care of the patient with chronic disease. This is likely to happen in many disciplines. The impact of these observations as regards work force projections, health care cost per patient-year, and shift from predominantly inpatient expense to chronic outpatient expense (especially pharmaceutical) is something we will all face at some point.

Cardiac surgeons have had to develop effective service line models to remain competitive in the market place. Globally priced procedures for cardiac-related services are common. Cardiac surgery in some respects is highly compartmentalized and therefore easier to offer in either boutique settings or "medical tourism" models, thus increasing the pressure on established programs. Add in highly developed clinical pathways and narrow variation in costs for many patients, and one has a "medical product" that lends itself well to bargaining pressure from government or third party payers.

The development of these service line products does create new, or newer, versions of problems for us also. Although turf battles have been around for as long as there has been turf, once a group is sharing the same limited (and getting more so) pie, the turf battles intensify. With developments in cardiac imaging, interventional cardiology, and interventional radiology causing significant overlap in what one discipline can offer that used to be the sole province of another discipline, these matters have become increasingly problematic on an administrative and reimbursement level. Cardiac surgeons may find it difficult to remain free of these entanglements also.

If all of the developmental issues, historical interests, political considerations, and scientific examples were to suddenly resolve, we general surgeons should still have great interest in the knowledge of cardiac surgery and surgery of the great vessels. The concordance of symptoms between acute cardiac and great vessel problems and problems requiring the services of a general surgeon are substantial. The need for knowledge of evaluation of cardiac performance before noncardiac operation is essential for every general surgeon. And lastly, the ability to recognize and manage the patient who has perioperative cardiac problems is absolutely necessary for every general surgeon.

We are indebted to Drs Kron and Kern and their collaborators for this excellent issue of the *Surgical Clinics of North America*. They are consummate professionals in every sense of the word. We will all be well served to learn from the successes and challenges that our brethren in cardiac surgery face as we develop through these interesting times. For several decades they have been at the front line of innovation—and that alone might earn them the revered position they once had.

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