Foreword

Critical Care

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One of the issues that has been plaguing me of late is, how do we best distribute and apportion limited medical resources. As I type this foreword, we are approaching the 2-year mark into the global SARS-CoV-2 COVID-19 pandemic. I vividly remember when this pandemic began that I felt like it would take us a good long while to sort ourselves out and get back to something resembling normal living—but I did not imagine that 2 years in we would be struggling this hard with no clear path to normalcy in sight.

I rack my brain trying to understand how the United States of America—with all its resources and capabilities—can be one of the most affected nations by this disease. On some levels, it makes sense. The United States is a country with unfettered travel within its borders and historically high volumes of people traversing its borders for myriad reasons. This country has had historical insulation from many world problems given its bicoastal geography, which may have lulled us into a false sense of security. We are used to solving problems and getting the results (more or less) that we want. On the other hand, globalization is real, and oceans aren’t as protective as they used to be. Our domestic investment in infrastructure and reserves has dwindled in service to short-term economic indicators favored by many “leaders.” While all those shortcomings have played their parts, perhaps the reason that concerns me most is that we have simply crossed over to a society that shuns collectivism in favor of a notion of individualism—which more accurately would be described as tribalism, in my opinion. In fact, if it were only individualists that failed to be part of the solution to our larger problems, this discussion would not be necessary. It takes a group or a tribe to successfully thwart a collective effort.

Tribalism exists across all sectors of the economy, all socioeconomic classes, and among and between all political ideologies—and always has. While most groups are quick to point out that the “other” should change their ways, I don’t see a lot of introspection for groups to look inward at how they could change. The unfortunate net
result of large sections of the population pulling in a diametrically opposed fashion is a compromised ability to plan for and deal with the consequences of our choices.

As of the writing of this foreword, the COVID-19 infection has been listed as the cause of death for over 5 million people worldwide and over 750,000 persons in the United States alone. I repeat, 750,000 persons dead—well over 200 iterations of the 9/11 attacks. And still, we can’t come to uniformity of purpose on how to respond. And while the mortality has been horrible, the resource utilization required to treat the sick has not only taxed or exceeded the capacity to treat those ill from COVID but has reduced our capacity to treat and manage other diseases as well. It may be decades before we can accurately assess the excess mortality related to this pandemic.

Of course, not all these deaths were preventable, though some fraction was. Furthermore, thanks to the dedication and brilliance of countless people and organizations, many people survived infection and many more were prevented from becoming ill thanks to a previously inconceivable vaccine development and implementation program. We all owe these people an enormous debt of gratitude.

On the treatment side of the equation, those in the intensive care unit (ICU) setting truly standout. I mean no disrespect to our colleagues in the emergency departments, or general medical care teams, or our first responders—they have all done so much and received so little recognition for their efforts. Yet, the ICU world has had to learn to fix the airplane while still in flight. So much had to be learned so quickly, and much of what was learned was somewhat counterintuitive.

In the past, I have written that in the ICU one must always remember these principles: air goes in and out; blood goes around and around; and oxygen is good. For the most part, all that is still true. What has changed is the complex bits of how we view each of those simple aphorisms have expanded to new levels.

This issue of the Surgical Clinics on critical care as put together by Dr Brett Waibel and his colleagues is designed to help us revisit and reimagine what we need to know about critical care and how we can use its principles to benefit not just patients with COVID-19 but also patients with any severe physiologic derangement. We have asked much of them for this issue, and they have delivered. The reader of this issue will benefit from facts and analysis that will help to make a huge difference for someone in perhaps their most perilous moments. We are deeply indebted for their efforts and for their sharing of their wisdom.

This pandemic has taught us (hopefully) many things: we can do what we can to prevent people from becoming ill; we can do what we can to mitigate illness once it occurs; and we can try to improve the survival of those most greatly afflicted with disease. It has also taught us that our resources are limited. We cannot simply absorb an unlimited quantity of ill persons and provide all of them with the care they need at all times. Our system of health care in the United States is not designed to effectively transfer patients all over the country when bed shortages occur. At that level of population health, collective engagement of the communities, the states, the regions, and the nation is required to mitigate the burdens. Decisions made at the collective level have real impacts on individuals. Conversely, individual decisions can have significant impact on the collective society. In order for civilization to function, we must find a mechanism to balance these competing desires and needs.

The current wave of this pandemic is slightly on the downturn at this instant. I would be hesitant to assume another wave is not in the offing at some time. Even if we were to significantly turn the corner on this disease, I would hold off on declaring victory just yet. The fractious state of our health care apparatus, the lack of strategic and operational reserve we hold, and the lack of ability we have shown to unify have all been
undeniably demonstrated. At present, we are not as prepared as we need to be for the next challenge, COVID related or otherwise. We must be thinking about the future events as we continue to manage this crisis.

In my opinion, the best way to prepare is to become educated. This issue of the Surgical Clinics should greatly help in that regard. Once we have become educated, we must find a way to educate others. Perhaps most importantly, we, as subject matter experts, need to find a way to instill trust in our communities and regain our ability to be helpful as an institution. As difficult as this may be, the alternatives are likely to be far worse.

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