Foreword
Head and Neck Surgery

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Readers of *Surgical Clinics* for any length of time are familiar that a great many of our issues cover topics that span clinical areas with specialty and subspecialty overlap. This issue, guest edited by our colleagues Drs Tubbs and Mitchell, on surgery of the Head and Neck is one of the best examples of that overlap. On one level, it makes perfect sense that specialist care for surgery of the Head and Neck has rapidly solidified its hold on the aspects of care while other disorders are cared for by a broader range of clinicians. Improvements in imaging and less-invasive clinical therapeutic options have helped to secure the need for significant consolidation of specialty and subspecialty care for many maladies of the head and neck. On another level, resource availability, provider distribution, and geographic disparities in resources yield an imperative that some of this care capability should remain in the hands of the more generalist clinician.

Historically, these opposing forces have been sources for internecine disputes that have played out in multiple fora. While some of that may still exist, tension along those lines may be reducing. There are many possible explanations for this. A moderate- to longer-term evaluation may suggest that specialization and hyperspecialization have gained greater acceptance among patients and physicians alike: reducing the basis for "turf war"–type concerns. Individual providers, even in rural or austere settings, have chosen to "pick their battles" (if you will) on just how much clinical ground to hold on to and how much to refer away. An analysis viewed through the prism of more recent events might also include that referral patterns are altered by the effects of the pandemic, in particular, with its impact on personnel, capacity, and equipment resources.

From the altitudinal viewpoint, the major forces that will shape how we best flow our patients and care from one environment to another are most likely to be business related. Consolidations of smaller health care entities into larger ones, better defined business agreements between systems that share geographic and regional interests, and the ever-increasing percentage of physicians who are employed by larger entities

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will reshape the resource availability, distribution, and incentives that ultimately decide where patients receive their care and from whom. Also, our continued ability to provide much care—even complex care—on an outpatient or near-outpatient basis will favor consolidation of care into entities that provide complex care without requiring acute care hospital level resources. These smaller, more focused enterprises will likely benefit from improved fiscal agility compared with larger competitors, who must factor in costly reserves in staffing and resources for a broader spectrum of concerns.

As with so many other topics, the view from altitude and the view from the ground are related but dissimilar. We, as stewards of care for our patients and our communities, must maintain broad knowledge and detailed knowledge to be effective in our roles. Administratively, we must be cognizant of the gains and losses to smaller and larger organizations as we siphon off care from one environment to another. Loss of situational awareness of the systemic fragility this can add imperils both the care-providing enterprises and the patient community as well in times of stress.

Our relationships between and among generalists and specialists have similar concerns. From a clinical standpoint, it benefits general surgeons (whether they work in larger or smaller enterprises) to have an excellent understanding of the knowledge and capabilities of our Head and Neck colleagues. Whether we are to care for a patient on a more local basis or whether referrals need to be made to those with more extensive specialty knowledge, a sound basis for understanding and communication can only help. We are indebted to Drs Tubbs and Mitchell, along with their colleagues, for providing us with the excellent collection of articles to help us have a better knowledge base.

On the macro level, we physicians need to have an excellent and deep understanding of resource capability and distribution. Even if an individual does not work in the administrative arena, clinician input is necessary and vital for our administrative partners to make decisions that truly improve the provision of care to our communities and not just address more restrictive financial concerns. At the *Surgical Clinics*, we strive to bring the readership content in context to help us all better serve our patients and improve our capabilities. We are grateful for those who contribute to the series and very grateful to the readership for their support and feedback. Stay safe and be well.

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