Foreword
Pediatric Surgery

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Consulting Editor

Right patient, right clinical team, right facility, and right time: the Holy Grail of medical care and particularly true of surgery. I might throw in "right diagnosis" as well, as that should not always be considered a given. This basic premise of having patients cared for in the most optimal environment would be the backbone as well as the measuring stick of any worthwhile health care system that anyone might want to construct in an ideal world. Yet, it is not how we function here in the United States, and we are not alone in this dilemma.

If we take away malice and greed as the reasons for failing to achieve an "idealized" system (and let us only do that in theory for the moment), then what is it that prevents us from having an idealized system? Is it too few doctors? Too few nurses? Too few dollars? Too few devices? Too little imagination? In many cases, some or all the above are deeply ingrained in the problem. For resources-poor areas—whether locally poor or poor on a country-wide basis—lacking resources is probably the prime driver of system weakness. In areas where net resource availability is not the prime driver of system weakness, the remaining significant contributors to suboptimal systems are resource distribution, network (formal or informal) malalignment, and lack of agreement between the providers of health care and the consumers of health care as to what is needed. One may note that all the factors that are not associated with "too little stuff" are fundamentally sociopolitical issues. To which we must then reenter into our analysis the potential for malice and greed.

I would submit that the two populations of patients who best exemplify our need for strong systems arrangements and keen attention to resource distribution are the pediatric population and those who require organ transplantation services. For the latter, we have a very well-developed regional/national clinical system in place and a very well-described method of handling the financial requirements of it. The former group, our children, are not quite so organized, especially the fiscal pieces.

Surg Clin N Am 102 (2022) xiii–xv
https://doi.org/10.1016/j.suc.2022.08.010
0039-6109/22/

The genesis of the variance between the pediatric group and the transplant group is easy to understand on some levels. Children are largely healthy on a day-to-day basis until they aren't. Someone on an organ transplant list knows she/he is sick all the time and is waiting for a literal lifeline. There is usually time to establish clinical relationships over large distances and prepare for what may be required. For the more general pediatric population, children mostly live wherever their parents/guardians live—which is pretty much everywhere. Unless something comes up, most children don't need to develop a relationship with providers of complex or even inpatient health care. However, things come up with great routine that alter that need.

This conundrum of services that are required sometimes in some places but not at all times in all places brings us back to the main concern that drives our work at the *Surgical Clinics*—how do we divide work and responsibility between the generalist and specialist? Spoiler alert: in the grand scheme, there is no right answer. To make matters more challenging, I would submit that the dilemma is much more complicated for pediatric care. Even within the range of "pediatric care," there are further subdivisions that may alter our analysis. Subgroups could be constructed by factors such as children with single system disease, children who weigh more than our average health care provider, children who can receive care and go directly home with capable support. Of course, all these factors are routinely considered at some level.

There are many facets of the surgical care of children that can be offered in many kinds of environments with excellent results and patient/family satisfaction. There are some other types of care that it matters greatly which environment is being utilized, bringing us back to right patient, team, facility, time, and diagnosis.

The "right diagnosis" part of the equation becomes much more challenging in the pediatric population, especially in facilities that are not pediatric centered. Being a good clinical diagnostician is essential to providing good patient care. That said, being a good clinical diagnostician in this era means having a good working relationship with our diagnostic imaging colleagues as well. Having people who are good at both skill sets for the care of children in facilities that do not specialize in pediatric care is rare.

A friend of mine who was a US Marine officer once told me that he always had two plans so that if one didn't work, he had another. That made me think that Marines are geniuses because, in my time in the Army, I needed many more backup plans than that whenever possible. The concept of fallback plans also formidably has affected my thinking on patient care: whether it has been overseas in hostile, austere environments or here in the United States with a full complement of subspecialty help or little to no help from any other specialist, or even generalist, depending on time of day. Add to that the resource availability outside of the operating room from nursing care, family support, pharmacy, and so forth, and the pediatric patient group can become quite a logistical and dispositional challenge. When one who does not usually provide surgical care for children does engage in this care, she/he had best be prepared for what to do should the situation that is encountered be markedly different from that which was expected.

As with so many other aspects of life, self-education about solid fundamentals will go a long way to securing the tools required to avoid rushing in where angels fear to tread. Our Guest Editor for this issue, Dr John Horton, is an excellent pediatric surgeon who not only serves our children but also serves our country in the US Army. I had the privilege of working with him directly during my time working for the Department of Defense after I had retired from military service. He is an excellent clinician, an excellent teacher of surgery, and a tremendous colleague. He and his fellow contributors have generated an excellent collection of articles that will inform all of us well. They

have taken great care to not only focus on the issues that children face but also help address how those issues track to the adult phase of these patients' lives.

Still, no matter how well informed you may be, the main consideration in the surgical care of children is whether one has the totality of resources required to address all the likely issues and perhaps many of the unlikely ones as well. All families want to stay as close to home as possible, but very few want to stay close to home if that would adversely affect their child—and those that would consciously do so give us one more thing to consider.

I realize that we surgeons alone cannot solve all the problems, stagnations, inertia, and other woes that affect our health care system easily or maybe not at all. Yet, I would like to think that if there were some areas that a divided people might gather around, it would be the care of our children. Most children are not possessed of the tools to fend for themselves, and they must rely on adults until they can. Being well versed in what one can do to help in the moment and how we can educate others to do the right things to build a better overall system is an essential for all of us who wish to be leaders in the betterment of our society.

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