

# Foreword

## Breast Cancer



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Life is cyclical. The examples are endless: tides, planetary motion, seasons, birth and death, and so on. Lifelong learning is also cyclical—or at least it should be. Most learning models are predominantly linear in that we build a foundational base and then add on to it in some vertical manner. Perhaps at some point in development the foundation is expanded horizontally, or we join two existing structures. Some efforts lead to a coherent architecture, and sometimes we create bizarre patterns of foot traffic and hallways that lead to nowhere. As occasionally happens with buildings, people frequently forget to go back and look at the structures that underpin our further learning that we are building upon.

If one works in health care as someone who provides direct care to patients, there is rarely cause to think about the physical space one practices in unless something specific isn't working. If one works in health care at a system level (whether in a clinical capacity or not), one must be very concerned about the physical space—and its maintenance. If the assumed behind-the-scenes and taken-for-granted items malfunction, one will rapidly realize that a failing heater/chiller system, problematic air handlers, failing medical gas lines, unreliable water supplies, and so forth, can be far more detrimental to a health care platform than provider performance, personnel-related problems, or even pandemic-level patient stresses we face.

In medical education, and in particular continuing medical education, I am not so sure we fully grasp the idea and necessity of knowledge foundation maintenance at the system level. We are very interested in shiny objects and new and different (which is fine). We do not appear to share the same enthusiasm for keeping the base of knowledge secure and well maintained.

I have spent most of my medical career in some manner of formal medical education. A significant part of my job was to moderate the morbidity and mortality conference and our conferences on indications. During that time, more of the marginal clinical outcomes, or questionable decisions in general, I saw could be traced back to a

suboptimal understanding of basic foundational knowledge or failure to apply that knowledge appropriately rather than lack of knowledge of the cutting-edge topics. We tend to assume all of us who reach a certain level of career development have that solid base of knowledge and it has been well maintained. The reality is, for some of us, time has made our foundation less stable, while for others, perhaps their foundation was a little wobbly at the outset. In either case, focused concentration on improving the knowledge base would be good for both groups.

At the *Surgical Clinics*, our fundamental model is to return to most topics on about a 5- to 7-year interval. We pick that timeframe because it about matches the length of training of most surgeons who start off in general surgery. We choose to come back to broad topics—often from a slightly altered perspective—because we feel that the foundations of our knowledge perpetually need examination and improvement; not just for some of but for all of us. Of course, we also try to combine this with updating our platforms on what is new (shiny or not) and what is on the cusp.

In the previous issue of the *Surgical Clinics*, we focused on the benign disorders of the breast. In this issue, we flip the coin to the malignant breast disorders. If ever there were a field of surgical thought that needed great attention to its foundational basis, breast surgery may well be the poster child. It does not take too close a look to realize the breast cancer models of the Halsted era bear little to no resemblance to our current understanding today, and today's model probably won't look much like those in the not-too-distant future.

Drs Seydel and Wilke, along with their collaborators, have compiled an excellent collection of articles that range from the absolutely fundamental to the edge of where we are heading. I am grateful to all of them for their efforts. The interested reader who devours these articles should be able to significantly improve or reinforce her/his understanding of this topic.

In an idealized world, all surgeons and other physicians would be allowed to, if not required to, take some time to go back to “medical school” on some regular interval with the intent of rebuilding the foundations of our knowledge as we did originally. I can hear the cries of incredulity as I type this. It's too expensive, it's too disruptive, it's logistically challenging, “we already do this by other means,” “I don't need/want to,” and so forth. All these claims are valid to some extent. Yet still we must find ways to not just add on knowledge but also truly reinvent and reinforce the base of our knowledge. I am not convinced we do that as well as we could.

In the meanwhile, we at the *Surgical Clinics* shall continue our efforts to examine the entire spectrum of surgical knowledge as best we can. We remain grateful to all those who have collaborated in making these issues possible. We remain even more grateful to those who use these materials as part of their toolset to improve the care of their patients and their communities.

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