revascularization covers such a breadth and depth of techniques that it is becoming a subspecialty within cardiac surgery, and consider establishing CABG fellowships. Those performing MAG need to impart the philosophy to trainees and practice partners not already facile with MAG.

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See Article page 1548.

Commentary: All we like iSheep: Reflections of an early adopter

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In this manuscript, Gaudino, Kurlansky, and Fremes¹ have presented a convincing claim that the use of the radial artery as a second arterial conduit in coronary artery bypass grafting has failed to penetrate daily practice despite overpowering evidence of its clinical value on long-term outcomes. There are few investigators better positioned to collate these data, as they have contributed the most important articles on this topic. However, the reader is left with the nagging reservation that they have answered the “what,” but they have not addressed the “why.” We are no further ahead on

What are the factors that inhibit uptake of low-risk modifications to CABG?

CENTRAL MESSAGE

Penetration of radial artery use in CABG remains low. This is probably already indisputable. The time has come to figure out why we cannot change this practice pattern.

understanding why there is such a resistance to use the radial artery in the United States (this is not an issue for the rest of the world), despite the overwhelming strength of supportive data.

The essay touches base on the potential rationale of fear of increased complications; however, these arguments relate to the use of a second internal thoracic artery. Catastrophic vascular compromise of the hand after radial artery

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harvest is unheard of when appropriate screening has been done. There may be mild early sensory-motor changes, but these are not statistically significant,² and there is no difference in grip strength or manual dexterity at 3 and 12 months.³ In this surgeon's experience, an arm incision is much easier to manage than a leg incision in terms of pain and mobilization and in the majority of a patients the quality of the radial is vastly superior to the saphenous vein even in the elderly.

One wonders if this resistance is related to market forces in the American health care system. Survival is dependent on projected confidence and once a practice pattern has succeeded to garner referrals, there is a sense that intellectual conservatism works. "If I have been doing this a certain way for a long time and my patients have done OK, do I really need to change?"

Convincing surgeons to apply high-quality, evidence-based medicine is not just a trait of cardiac specialists, as others have been shown to be slow to adapt.⁴ We need strategies that can be woven into practice that make multiple arterial grafting an everyday occurrence. We need to focus on behavior to encourage practice improvements; peer comparison programs using the Hawthorne effect (making people aware of their own performance relative to their peers to improve the quality of

their work), advocating for publicly reported data on multiple arterial grafting, working with our cardiology colleagues to create a permissive environment to facilitate optimized radial artery use, and linking reimbursement to longer-term outcomes.

Samsung successfully challenged the cult of Mac as "iSheep," criticizing the loyal following of Apple products despite equal or better innovations in competitive products. Perhaps the same dynamics explain polarized politics that seem to defy logic and facts. There remain many surgeons who have a blind loyalty to use a single arterial conduit despite convincing data that we can do better. The question of benefit has been answered, we need to ask the why that will promote effective change.

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