Until recently, the routine use of high doses of intraoperative and postoperative opioids and benzodiazepines resulted in mandatory overnight mechanical ventilation for all patients undergoing cardiac operations. Justifications for this practice are to avoid the respiratory insufficiency that commonly occurs in the immediate postoperative period and to minimize the increased myocardial oxygen demands secondary to spontaneous ventilation or the stress response after cardiopulmonary bypass that may lead to myocardial ischemia. In the 1980s, the significant advances in the technology of extracorporeal circulation as well as in the pharmacology and delivery of myocardial protection were put into practice. Meanwhile, the introduction of propofol in Europe in the early 1980s prompted investigation of its use for anesthesia in cardiac surgery and postoperative sedation. Interest in early postoperative extubation in cardiac surgery was renewed by the impressive hemodynamic stability offered by the combination of opioid and propofol, the excellent sedating effect of propofol, and the short recovery time after discontinuation of the sedation. The concept of early extubation has been resurrected from the 1970s, when it did not gain wide acceptance. Cleverly, this rebirth in the 1990s has been dubbed “fast-tracking”. Fast-tracking protocols depend on a low dose opioid technique to expedite patient extubation and ambulation. It is fueled, in part; by market forces demanding more cost efficient quality care and to this end has achieved decreased hospital costs through reduced ICU and hospital stays. Increasing research becomes available to support the safety and efficiency of fast tracking for a variety of cardiac surgical patients.