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Does a patient really care if he or she goes home on postoperative day 2 versus day 3? It depends on who is at home for that patient, and how good the service is in the hospital being left.

Does a patient truly care if he or she gets out of bed on the day of a minimally invasive lobectomy and walks, versus the next morning? No, not unless that walk the night before provides some value and somehow enhances the ability to recover fully from the operation. Do we have any data that it does? No. Patients with lung cancer who undergo surgery have simple desires. They want to have no pain, to have their cancer all out, to be cured with no further therapy, and to return to full activities without any problems as soon as possible. Do the metrics that we are currently measuring, tracking, and giving 3-star ratings really measure these values? Do early recovery programs and fast-tracking pathways help patients, or do they provide more value to the hospital, the payers, and the doctors?

I, like others, have been an advocate of enhanced recovery programs, care flow programs, and lean initiatives for more than 2 decades. The current ERAS colorectal programs are not new to thoracic surgeons who have been doing preoperative exercise, smoking cessation, intraoperative lean initiatives, and postoperative protocols to reduce cost, speed recovery, decrease pain, and get tubes out sooner for more than 30 years. Yet, we must recognize that some of these initiatives may provide greater value to stakeholders other than the patient. We need to refine the metrics that we measure and target. Most importantly, we must ensure that the targets are patient focused.

Our goals as surgeons and physicians should be centered solely on our customer, who sometimes gets lost in the complex process of health-care delivery. Once all the stakeholders in health care are aligned, and we remember whom we serve and why we serve them, then the factors that we target, the metrics that we measure, and the outcomes that we deliver will help the only people in the process who matter—our patients.

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ENHANCED RECOVERY PATHWAYS IN THORACIC SURGERY: TIME FOR A VERSION 2.0

Reply to the Editor:

I thank Drs Mehran and Martin¹ for their interest in and comments on my group's article regarding enhanced recovery pathways (ERPs) for patients undergoing video-assisted thoracoscopic lobectomy.² I totally agree with their statements. Our study, however, should not be interpreted as a negative message against ERPs. We strongly believe that the application of standardized pathways of care in our specialty can contribute to improving quality of care, patient safety, and team efficiency—and ultimately could save money. On a patient level, it seems clear that the use of traditional end points, such as early outcomes and length of stay, is not able to capture entirely the benefits of ERPs. The most probable explanation, as mentioned in our study,² is that most of the elements composing what is defined as an ERP have individually already been in use for many years in most thoracic surgery centers. In addition, our study was restricted to patients undergoing video-assisted thoracoscopic surgical lobectomy. Minimally invasive surgery is arguably the most important element of an ERP, likely blurring the effects of other elements. Unfortunately, as discussed in the limitations section of our study,² important subjective end points were not available to measure the effect of an ERP on patient-reported outcomes such as pain score, satisfaction with care, and quality of life.

Probably one of the most important messages of our study² is the need to progress from the current myopic performance evaluation that looks only at short-term outcomes to a more patient-centric appraisal of efficiency and value. Value can be translated into the ratio of quality to cost,³ where quality for our patients is represented by cancer-specific survival and quality of life. Ideally, future care map updates should be implemented that target value as the main metric.

Thoracic surgeons have been using elements of ERPs for decades, and it is likely that what is commonly defined as an ERP is now already “standard care” in most thoracic centers.⁴ We therefore need to evolve further by introducing additional standardized patient-centric elements of care that will represent a more efficient version 2.0 of ERPs.

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