SAE needs to be done. Prevention is key to getting patients home.

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Commentary: Ptolemy versus Copernicus: The times they are a-changin'

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In this issue of the *Journal*, Lala and colleagues¹ report a secondary analysis of 552 patients discharged alive after surgery for moderate or severe mitral insufficiency. Patients were followed at least a year and analyzed for risk factors for non-home discharge (NHD) and associated outcomes including death, serious adverse events (SAEs), and quality of life (QOL). The risk factors for NHD included older age (odds ratio [OR], 1.52), history of diabetes (OR, 1.94), and previous heart failure (OR, 1.64). Postoperative SAEs almost doubled the risk of NHD. Comparing patients discharged to home versus NHD, at 1 year the hazard ratio for death among the NHD was an impressive 4.29. Curiously, there was no difference in QOL.

Putting patients' concerns at the center of data reporting requires a shift in practice.

CENTRAL MESSAGE

As we move to patient-centered medicine, outcomes we track must be those meaningful to patients and their families. To do this, we must transition from proceduralists to practicing disease management.

For many practitioners, the 1-year outcomes of NHD are unknown. However, similar results have been demonstrated with other cardiac surgical procedures,^{2,3} and our own pre-publication data demonstrate the same after transcatheter aortic valve replacement. We have further shown that for revascularization patients followed 8 years, NHD conferred an OR for mortality of 62.2 in the first 120 days and 1.62 thereafter compared with home discharge (data pending publication).

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These data by Lala and colleagues have important implications for surgeons, our patients, and our professional societies. Too long we have reported easy-to-measure “surgeon-centric” data. But in the words of Nobel laureate Bob Dylan, “The Times They Are A-Changin’.” We must be prepared to lead the change. Our patients seek relief of symptoms with an expectation of return to a high-quality life, usually implying independent living. Among patients discharged to skilled nursing facilities, 1 year after cardiac surgery, 42.3% were alive and only 30.6% were alive and at home.³ Many patients, especially elderly patients, are more interested in the quality than the quantity of life.³ The data of Lala and others should be an important component of shared decision making and fully informed consent. However, the implications for surgeons do not stop there. As surgeons, we must transition from proceduralists to participants in a disease-management approach. This involves following patients at least 1 year and recording patient-centric data including not only mortality, but also subsequent SAEs, QOL, and days out of facility. Our societies should not only endorse this approach but facilitate it by creating databases conducive to recording and warehousing longer-term data.

More work is needed. Patient-centric outcomes need to be reported for the common acquired and congenital

cardiac procedures. More specifically, and in reference to the report by Lala and colleagues, efforts to document/report QOL issues need to be prioritized. The lack of a decrement in QOL associated with NHD is counterintuitive and may have to do with the metrics used or cognitive dissonance⁴ in reporting among patients who committed to the procedure and now must accept the outcome.

Surgeons have always been leaders. However, the practice changes needed are considerable and disruptive. The question before us is: will we cling to our old paradigms like the world did when Copernicus challenged the Ptolemaic theory of geocentrism, or will we lead the change?

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