Scaling the ascent to mastery

Robert J. Cerfolio

Division Clinical Thoracic Surgery, Lung Cancer Center, NYU Langone Health, New York, NY, USA
Correspondence to: Robert J. Cerfolio, MD, MBA. Chief of Thoracic Surgery at NYU Langone, Division Clinical Thoracic Surgery, Lung Cancer Center, NYU Langone Health, New York, NY, USA. Email: robertjcerfolio77@gmail.com.
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We congratulate the authors on providing actual data concerning conversions for video-assisted thoracoscopic surgery (VATS) and robotic assisted lobectomy (RAL) (1). Many of the author's findings are not surprising: conversions are associated with increased blood loss, increased morbidity and are more common on left-sided pulmonary resection (probably upper lobes compared to lower lobes). This is not new data. The truth is a conversion should not increase mortality but unfortunately in this study it did.

Perhaps the most important finding and import of this report is that they found that "lower volume centers had increased rates of conversion (P<0.001)." The author's study queried The Society Thoracic Surgical database from January 2015 to December 2018. It examined about 28,000 patients who underwent minimally invasive lobectomy in 269 centers and found a conversion rate of 11% for VATS and 6% for RAL.

The main import of our editorial and hence its title is simple. The outcomes are disappointing to many of us who perform robotic pulmonary surgery daily. Why are outcomes so discordant across centers or even in centers and across surgeons? Why can some have little to no morbidity and few if any conversions and one-day length of stays and yet others have numbers like those reported in this study?

We believe the answer is leadership, accurate data and a bit of ego. Ego leads to a defensiveness and resistance to change. Leadership allows us to scale our expertise over time and share our experience with our partners and with one another. It invites open and honest and transparent conversation that are tough to have, but when properly sheparded, soft to listen to. We believe that every thoracic surgeon in the world is our partner. In addition, their patients deserve our collective experience as well as my patients that deserves theirs. If we could all mitigate our egos and then lean on and learn from our colleagues, our patients would all get better outcomes.

At our institution, seven diverse thoracic surgeons have now all improved their outcomes and posted collective metrics of: conversions rates under 1%, a 30-day mortality of less than 0.3%, a median operative time of 2 hours, median blood loss of 30 cc, a median lymph node count of 20 lymph nodes from a median of 5 N2 and 2 N1 lymph nodes stations, median length of stay now of 1 day (down from 2 days a year ago). In addition, together we perform 98% of all of our pulmonary resections robotically. Even the complex double sleeves and post induction cases are performed robotically.

How did we achieve these collective executive outcomes? Leadership. Leadership and honest self-awareness and reflection inspired by accurate meaningful data. Data derived by the "The Efficiency Quality Index (EQI)" (2). The EQI changes a culture and improves patient outcomes.

No one changes their practice unless they believe that change is warranted. We have to believe that someone actually does it better than they do. Few if any administrators present data to surgeon that inspires them to change. Most data from hospital leadership leads the surgeon to say, "The data you have for me is wrong", "Your data fails to reflect my complicated patients and practice" and "You measure and report metrics that do not clinical matter." And "You are comparing apples to oranges."

And most times they are right. Once you as a leader or boss present this type of data to a practicing physician or any hard-working successful person for that matter, you have lost their hearts and their respect for the next several years. The EQI by definition eliminates all of these problems and criticisms. Here is how.

The EQI only measures data that physician's sign off on as accurate and correct. The EQI only measures metrics of quality of a very specific operation or period of care. Thus, it only makes fair comparisons. We have an EQI for segmentectomy and for lobectomy and esophagectomy. An EQI is generated for any intervention. The physicians decide which metrics best reflect quality of care. If you wrap EQI data around a positive open and fun environment, everyone's performance improves. We do not use punitive measures for poor performers; rather we celebrate the best performers and share their process. This inspires changes to elevate everyone's performance. In this manner, we all get better together. We all win, as do our patients and our healthcare system. Currently we do not tie pecuniary incentives to the EQI.

The EQI shortens the climb towards mastery. It allows us to scale that ascent towards mastery across a large network and/or healthcare system comprised of a large number of diverse individuals. Mastery is a non-achievable destination in our opinion. Any true professionally loves the challenge of the life-long climb. The struggles endures and forges character. In medicine, it means that patient gets better care with less cost at higher value. It also improves patient experience. And what is better than offering our patients better care and higher satisfaction.

Acknowledgments

Footnote

References

1. Servais EL, Miller DL, Thibault D, et al. Conversion to Thoracotomy During Thoracoscopic vs Robotic Lobectomy: Predictors and Outcomes. Ann Thorac Surg 2022;114:409-17.
2. Cerfolio RJ, Chang SH. Efficiency Quality Index (EQI)-Implementing a Novel Metric That Delivers Overall Institutional Excellence and Value for Patients. Front Surg 2021;7:604916.