

Multidisciplinary approach to heart disease. The patient as a priority in medical decision

Walter J. GOMES¹, Rui M. S. ALMEIDA², Domingo M. BRAILE³

The new publication of the guidelines for artery bypass grafting of ESC/EACTS (European Society of Cardiology / European Association for Cardio-Thoracic Surgery), incorporating the most recent and updated scientific evidence for decision making in patients with coronary artery disease and specifically recommends the adoption of multidisciplinary approach in clinical decision making, emphasizing the concept of *Heart Team*. This concept provides a multidisciplinary collaboration among the specialties to provide the best patient-oriented care. The process of decision making and medical information of the patient must be guided by following the “four principles” of health ethics: autonomy, beneficence, nonmaleficence and justice [1].

The establishment of a multidisciplinary team is intended to allow balanced medical decision, using evidence-based protocols designed by collaboration between clinical cardiologists, cardiac surgeons and interventionalists. All cases of stable patients with coronary artery disease must from now on be discussed by a multidisciplinary team before making a decision regarding the type of revascularization procedure to be implemented, either surgery or angioplasty, or simply the maintenance of the drug treatment.

We recommend the use of institutional protocols following standards consistent with current guidelines in order to avoid the need for systematic review on a case of all diagnostic angiograms. Hospitals and facilities must be encouraged to create multidisciplinary teams to promote the concept that the patient must be at the center of attention of the entire cardiology team. This account has been neglected in the past, but must once again be emphasized and reinforced. Institutions and physicians must take a clear stand to ensure that the patient will be most benefited by the decisions taken.

The patient must also have active participation in the treatment decisions. The information towards the patient must be objective, impartial and based on current scientific evidence, and also understandable, accessible and consistent. The informed consent requires transparency,

especially when there is controversy about the indication of a specific treatment involving percutaneous intervention, surgical revascularization or medical treatment. However, most patients have a limited understanding of their illness and the prognosis associated with it, at times with unrealistic expectations regarding the proposed intervention, its complications or the need for new procedures.

The patient deserves to understand the risks, benefits and uncertainties associated with their disease and their processing. It must be avoided the use of incomprehensible technical language and it is compulsory to use simple and consistent terminology that the patient can understand. The information concerning the medical decision must clearly state the benefits related to the procedure and risks in the short term as well as what it is expected in the long term. Risks and benefits in terms of survival, relief of angina, quality of life and the potential need for late reintervention must be clearly informed. It is also very important that any other interest in decision making by professionals involved in the different treatment options is made known to the patient.

It is recommended that the patient must be given enough time, even several days if necessary, between diagnostic catheterization and intervention so that he can reflect on the indicated treatment, seek a second opinion when desirable, or discuss the results and consequences with the his cardiologist or regular doctor.

The growing public demand for transparency in relation to the results of the surgeon and the hospital requires that the anonymous treatment must be avoided. It is the patient's right to know who is about to treat him and have access to information about the qualification of the surgeon and the volume of procedures from the center to be chosen. In addition, the patient must be informed if all treatment options are available on site and if necessary, surgical intervention is available at the institution.

With patients increasingly presenting with complex diseases, there is often need to involve other specialists for treatment. Depending on the co-morbidities related there

must be involved diabetologists, general practitioners, assistant physicians or anesthesiologists, where the conjunction of ideas and efforts of the specialties combined will contribute to improving patient care and result in a favorable outcome.

Expanding the concept to new upcoming technologies, the PARTNER study also introduced the multi-disciplinary approach in the selection of patients to be treated with transcatheter aortic prosthesis whose study protocol requires that two independent surgeons need to agree and sign that a patient was not eligible for conventional surgery and therefore could be included in this study [2]. In Europe, there is already consensus that at least one surgeon, an interventionist and a cardiologist must review the patients on a case and make joint decisions in order to prevent the expansion of indications for cases that are not appropriate and that currently do not have evidence of benefit to the patient.

Therefore, the establishment of a consensus of a multidisciplinary approach to heart disease represents an achievement which must necessarily be implemented with the support of doctors, hospitals and specialty societies, making once again the patient the primary goal of care and medical treatment and being the most benefited by joint clinical decisions.

REFERENCES

1. Task Force on Myocardial Revascularization of the European Society of Cardiology (ESC) and the European Association for Cardio-Thoracic Surgery (EACTS); European Association for Percutaneous Cardiovascular Interventions. Guidelines on myocardial revascularization. *Eur J Cardiothorac Surg.* 2010;38 Suppl:S1-S52.
2. Leon MB, Smith CR, Mack M, Miller DC, Moses JW, Svensson LG, ET al. Transcatheter aortic-valve implantation for aortic stenosis in patients who cannot undergo surgery. *N Engl J Med.* 2010;363(17):1597-607.
1. Scientific Director and Elected President of the Brazilian Society of Cardiovascular Surgery (SBCCV). President of the Latin American Society for Thoracic and Cardiovascular Surgery. Associate Professor of Cardiovascular Surgery. Escola Paulista de Medicina - Universidade Federal de São Paulo.
2. President of the Department of Endovascular and Minimally Invasive Surgery of the SBCCV. Associate Professor and Head of the Cardiology and Cardiovascular Surgery Discipline at Universidade Estadual do Oeste do Paraná (UNIOESTE).
3. Chief Editor of the Brazilian Journal of Cardiovascular Surgery (*Revista Brasileira de Cirurgia Cardiovascular*). Professor Emeritus and Vice-President of the Postgraduate School of Medicine of Sao Jose do Rio Preto (Famerp). Lecturer Professor at Unicamp.