



## “The Heart Team: Can It Become a Reality? Should It?”

The “heart team” concept—a group of physicians who bring different views to decision making in cardiovascular medicine—has received a lot of attention recently. It is not a new concept, as consultation among cardiologists, surgeons, primary care physicians, and others about the optimal recommendations to be made in the treatment of a patient with complex problems has been advocated from medical school onward. Some disciplines, such as oncology and transplantation, have a very well-developed concept of a team approach.

The recent interest in use of the heart team approach for ischemic heart disease decision making was stimulated by the clinical trial SYNTAX. In that study of advanced coronary artery disease, all eligible patients were screened and a mandated consultation between cardiologists and surgeons was built into the protocol. Consensus as to whether PCI or CABG was the only reasonable option, or if both were possible options, had to be reached in order to offer randomization or the preferred, mutually agreed-upon treatment. That concept of the heart team approach was picked up by the European Society of Cardiology’s revascularization guidelines and subsequently has become the first recommendation in the ACC/AHA guidelines for PCI and CABG.

The European guidelines suggest input from a surgeon, an interventional cardiologist, and a general cardiologist. On this side of the pond, a cardiologist and surgeon were suggested as a minimum for patients with advanced multivessel disease. Of course, there are many decisions to be made in patients who have less severe coronary artery disease and in whom consideration of quality-of-life issues are of more import than any survival considerations. So, if the patient is to benefit from the expertise and judgment of multiple disciplines in making the decision, how can this be accomplished practically?

One significant barrier to optimal collaboration is the current fee-for-service reimbursement system. Who gets credit for the RVUs? Consultation is often not reimbursed, so how is the effort

to be rewarded? Case conferences are frequently built into hospital practice as part of quality improvement initiatives, and physician participation is required, or just appreciated, but not often reimbursed. It is unlikely that a quality improvement conference could meet the need to discuss all patients, and certainly not in a timely manner. Payment systems other than fee-for-service probably have an easier path to enabling the heart team approach. However, if it is of value, efforts should be made to find ways to make it function.

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The other major barrier is the practice of ad hoc PCI. The coronary arteriogram was once considered a diagnostic test. In the SYNTAX trial (and, by the way, in the COURAGE and BARI 2D trials), the coronary angiogram was always available before the decisions were taken. In practice, however, the angiogram is often thought of as a part of an interventional procedure. Arguments can be made that much of risk stratification can be accomplished with noninvasive measures, but the information needed by the heart team in making recommendations regarding revascularization is only available after the angiogram is examined. Performing PCI in the same setting as the angiogram is appropriate in many situations—i.e., STEMI and many other acute coronary syndromes, in suspected restenosis, and in many patients with documented regional ischemia and high-grade obstructive lesions in that territory. In situations in which the heart team approach will add greatest benefit, the angiogram must be treated as a diagnostic test and the patient taken off

the catheterization table. True informed consent about revascularization choices cannot be made without knowing the anatomy and functional significance of the disease.

Should we be concerned about this “heart team” concept? We are increasingly being asked, and often being required, to make sure the care delivered is appropriate. The consequences of performing inappropriate procedures are now well known. I think the creation of appropriateness documents is a worthwhile exercise and, like the guidelines, helps us reflect on the evidence that is available about groups of patients. However, to get more granular in decision making, it is necessary to personalize the process. This is where the heart team concept is of value. I have often participated in pro and con discussions about the value of PCI, medical therapy, or CABG for patients with coronary artery disease. However, when specific cases are presented, consensus among all participants is usually reached when the patient-specific data are considered. The heart team approach, although not novel, is now timely and efforts to operationalize it in our institutions should be made. Current obstacles of time, logistics, and finances are significant, but if we believe that this approach is optimal for our patients, our challenges may become opportunities. Some have suggested that in 10 to 15 years fee-for-service reimbursement may represent less than 25% of healthcare financing. How optimal care decisions are made must be part of a rational health system, and the heart team can be a model. We would do well to find ways to make it work.

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