

How to make a “Heart Team” a “real” Team to ensure optimal patient care

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Introduction

Due to the ongoing ageing of the population with increased related co-morbidities, transcatheter interventions are spreading around the first world countries like an unstoppable firewall. Some (the tip of the iceberg) have already established in “normal clinical life” and became very safe procedures for the “modern high-risk patient” with acceptable outcomes over the last decade but many more are just evolving currently being under investigation with first in-man clinical trials.

In the initial phase of the clinical adoption of transcatheter valve therapies (2007/2008), different specialists with different professional backgrounds, skill-sets and personalities were “forced” to work together

out of necessity. As a result, interventional cardiologists and cardiac surgeons started to work as a “Heart Valve Team” in order to overcome the respective lack of knowledge (ie. wire skills for surgeons and valvular anatomy and well-established surgical valve therapies for interventionalists) and to merge in a complementary way to offer the best possible treatment. The establishment of a “Heart Team” was a need, which was desired and perceived by the physicians themselves. But with the progressive fast establishment of a complementary “hybrid” culture, the need for such a “Heart Team” became soon less stringent, and many individual conflicts emerged, mainly due to not shared targets and willingness to be the predominant leader of the team.

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Therefore, the ESC/EACTS have recommended in the 2012 guidelines as a mandatory prerequisite for a Valve Centre performing transcatheter therapies to establish a “Heart Team” consisting of multiple specialists in order to be capable to discuss the cases interdisciplinary and to decide the optimal individual treatment option. The presence of the “Heart Team” became a “condition sine qua non” (in the interest of the patients) for every centre to be allowed to be part of the game (modern transcatheter therapies). In the last 2017 Guidelines the presence of a multidisciplinary “Valve Team” has reached a Class IC level of evidence recommendation, and today in many countries formal “Heart Team” discussions are even mandatory for reimbursement.

How to build a functional and functioning “Heart Team”?

While trying to establish this suggested “Heart Team”, the following questions arise: who is the leader in an interdisciplinary team and how are decisions made in the presence of hierarchy, unbalanced information sharing and hidden agendas? Or is the “Heart Team” doomed to fail before it could be established in clinical practice? At present, there is no defined “standard” for the performance of a “Heart Team Meeting” which can result in biased decision making in a “Team of Experts” who do not share common goals.

Therefore, before answering the questions above, we first have to become aware of the definition of “Team”: in a team, all members have shared goals, there is interdependency and reflexivity. If these criteria are not met, quality of decision-making suffers.⁽²⁻⁵⁾ Are there shared goals in a “Heart Team” besides the well-being of the patient? Is there interdependency and reflexivity within a “Team of Experts” who ultimately aim to support their own specialty? Without standards, the final decision of a “Heart Team” may depend on status, individual points of view and decision-making habits rather than on integration of interdisciplinary expertise, which might result in less optimal treatment decisions.

In order to create a functioning unbiased “Heart Team”, the following should be considered:

First of all, a shared “basis” or “goal” has to be created for the different specialties involved within an institution. A team of experts of different specialties has to be rewarded as “one team”: the establishment of an official “Heart Centre” is advisable.

Secondly, the performance of a “Heart Team Meeting” has to be standardised with defined timeframe, leadership, role of team members, discussion culture and decision making process.

Thirdly, while conducting the “Heart Team Meeting”, the members have to be aware of various team interaction phenomena, types of leadership with their respective consequences and discussion culture, which have a tremendous influence on the outcomes of decision-making.

Typical pitfalls of biased decision-making and evidence-based suggestions how to overcome them are the following:

- Lack of “speaking up”: important information or concerns are not automatically integrated into decisions because team members do not necessarily dare to voice them.⁽⁶⁾ This results in impaired quality and safety of patient care.^(7,8) Team leaders can avoid this pitfall by inviting and encouraging to speak up by establishing process rules to make sure that team members can share their unique expertise without negative consequences.⁽⁹⁾
- “Groupthink” is a common “silent consensus phenomenon” within a team that does not reflect the individual team members’ true beliefs but has been found to result in catastrophic decisions (i.e. Bay of Pigs invasion in Cuba.⁽¹⁰⁾) This phenomenon can be controlled when team leaders are open for new information and exclusively invite team members to dissent.^(11,12)

- “Anchoring and confirmation bias”: preferred opinions are usually “anchored” in one’s mind, its advantages are overemphasized, weaknesses are not mentioned and evidence is sought to confirm them.⁽¹³⁾ Team leaders can avoid this pitfall by inviting and allowing dissent, sharing information instead of opinions, and inquire instead of argue.^(4,11,12,14)
- “Majority rule”: makes decisions less time consuming but focuses rather on compromise instead of discussing important differing viewpoints. Decision-making is improved when team members discuss instead of vote.⁽¹⁵⁾
- “Leadership style”: has a crucial impact on the decision-making process and decision quality (outcome can be biased by the leaders opinion):⁽¹⁶⁾ leaders can be the main reason for the lack of speaking up by demonstrating hierarchy.⁽¹⁷⁾ To avoid this they should ask instead of instruct, create a safe atmosphere that allows open discussion, take responsibility for the decision-making process by inviting team members to share their unique expertise and initiate reflections on the team’s decision-making.^(13,14,18-20)

Conclusion

In a “real” team all members have shared goals,

there is interdependency and reflexivity which is not easily achievable when multiple specialties are involved. For that reason a “Heart Team” can only perform its purpose properly if it is deliberately forced to become a “real” Team whose decisions are not biased by hierarchy, unbalanced information sharing and hidden agendas. On the basis of the establishment of a “Heart Centre”, we suggest the implementation of a standardized “Heart Team Meeting” protocol with defined timeframe, leadership, role of team members, discussion culture and process of decision making. If these evidence-based recommendations can be adopted, optimal decision-making and patient care can be achieved for the modern ageing high-risk population.

In order to achieve the education needed for the establishment and running of a functioning “Heart Team”, the University of Zurich has initiated the world-wide very first “Certificate of Advanced Study (CAS) in Structural Heart Intervention” courses.

The education not only includes clinical and innovational elements, but most importantly communication, financial and leadership skills, along with elements of conflict solving in different scenarios. We believe that in the future, all members (especially leaders) of a “Heart Team” must undergo such an officially certified education in order to guarantee optimal patient care.

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