What is best for my patient

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Innovation and new technologies are essential players in reducing the burden of cardiovascular disease. The great technical progress achieved in the field of interventional cardiology has enable the community to address very complex anatomies, and as such, the spectrum of cases considered as technically "feasible" by using percutaneous interventions overlap with candidates for open surgery. However, the "feasibility" of percutaneous intervention by using new technology is not an indication by itself. We should consider that our objective (the excellence in healthcare) is to propose "What is best for my patient".

This requires knowledge, power of judgement and intellectual honesty.

Knowledge is based on the critical, but positive, analysis of a huge amount of published or reported trials, registries and studies. The majority of interventional cardiologists have difficulties reviewing, synthesising and understanding all the data reported. It is the role of key opinions leaders, to synthesise data and present "state of the art" lectures on new technologies.

However, we have to analyse the past with intellectual honesty. At each stage of innovation or each presentation of late breaking trials, new dramatic claims are made (positive or negative), that are often prone to exaggeration. Often, after further larger trials or longer follow-up of patients, the same innovation or treatment strategy is followed by a more modest benefit and a then a 'regression' to the truth.

Translating data derived from trials, studies or registries to daily practice requires a common comprehensive information on "what data matters". I invite you, before adopting new technologies or strategy options derived from studies, to better understand the pre-established scale of value, and hierarchically rank the huge amounts of data available.

It seems today, that we have reached the limits of "evidence-based medicine" in the field of revascularisation of patients with stable coronary artery disease. To demonstrate a non-inferiority or superiority of percutaneous revascularisation over by-pass surgery or medical treatment in decreasing the risk of cardiovascular death or non-fatal myocardial infarction in these patients, mega-trials – impossible to conduct or financially support, with more than 10,000 patients in each arm, or very long-term follow-up – would be required.

Future advances in care of patients treated in daily practice will not come from controversial analysis of data derived from randomised trials data, but probably from an education stimulating the superiority of the "power of judgement" over the "state of the evidence".

Power of judgement may be defined as consistently selecting the right option, based on the interpretation of the global appraisal of each individual patient, from a set of possible options – and rejecting any eventual conflicts of interest.

Power of judgement remains an important predictor of outcomes even when evidence based medicine is considered the gold standard of our practice.

We must not assume that the application of the latest technologies always represents the best option, even if this option is "feasible". We should take the time to discuss the different treatment options in a team environment in order to identify the most appropriate strategy for each individual patient.

The number of options we are faced which makes the decision-making process a difficult one if we do it alone. With humility, we have the freedom to doubt – and to admit "I don't know" or "I'm not sure".

When done by a team, the sharing of experience, knowledge and different viewpoints, in a climate of mutual confidence enables us to identify – with open-mindedness – the options we have, and establish the best treatment option for each individual patient (together we achieve more).

Harmful long-term outcomes after percutaneous or transcatheter procedures in sub-groups of patients considered as excellent candidates for surgical procedures justify criticism of these techniques by the surgical community.

Only a strong collaboration between the different members of the cardiovascular community, with the full integration of surgeons will help us to achieve our common goal – to propose "What is best for each individual patient".

An ideal "team concept" approach is difficult to implement due to multiple forms of conflict of interest. It may be based on the concept of "collective intelligence", defined as "the capacity of human communities to evolve towards higher order complexity and harmony, through such innovative mechanisms

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as differentiation and integration, competition and collaboration".

With different opinions being expressed, discussed and debated – diverging opinions – are, as we move forward, eliminated, leaving us with the "best" options, converging into a consensual shared opinion.

In our daily practice, a converging consensus could be defined as a position reached by a group when everyone in the group can say, "I can live with it." That means that not all participants will necessarily find the outcome as their ideal.

The team implementing this consensus process will have the opportunity to adhere to a common concept of ethics of information, with both cardiologists and cardiac surgeons providing balanced information to each individual patient for his/her best interest, focusing not only on "the potential procedural risk" but also on "long-term potential benefit".

One of the key objectives of EuroPCR, official annual meeting of European Association of Percutaneous Cardiovascular Interventions (EAPCI), is to provide a platform of expression, an open forum for exchange, allowing all members of the cardiovascular community to express controversial opinions with the sole objective of reaching a consensus on "what is the best for each individual patient".