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POSITION STATEMENT

Portuguese Society of Cardiothoracic and Vascular Surgery/Portuguese Society of Cardiology recommendations for waiting times for cardiac surgery☆

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Consensus

Abstract Appointed jointly by the Portuguese Society of Cardiothoracic and Vascular Surgery (SPCCTV) and the Portuguese Society of Cardiology (SPC), the Working Group on Waiting Times for Cardiac Surgery was established with the aim of developing practical recommendations for clinically acceptable waiting times for the three critical phases of the care of adults with heart disease who require surgery or other cardiological intervention: cardiology appointments; the diagnostic process; and invasive treatment.

Cardiac surgery has specific characteristics that are not comparable to other surgical specialties. It is important to reduce maximum waiting times and to increase the efficacy of systems for patient monitoring and tracking.

The information in this document is mainly based on available clinical information. The methodology used to establish the criteria was based on studies on the natural history of heart disease, clinical studies comparing medical treatment with intervention, retrospective and prospective analyses of patients on waiting lists, and the opinions of experts and working groups.

Following the first step, represented by publication of this document, the SPCCTV and SPC, as the bodies best suited to oversee this process, are committed to working together to define operational strategies that will reconcile the clinical evidence with the actual situation and with available resources.
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PALAVRAS-CHAVE
Cirurgia cardíaca;
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Sistemas de saúde *beveridgianos*;
Recomendações;
Grupo de trabalho;
Peritos;
Consenso

Recomendações da Sociedade Portuguesa de Cirurgia Cardio-Torácica e Vascular e da Sociedade Portuguesa de Cardiologia sobre tempos de espera para cirurgia cardíaca

Resumo Nomeado em conjunto pela Sociedade Portuguesa de Cirurgia Cardio-Torácica e Vascular (SPCCTV) e pela Sociedade Portuguesa de Cardiologia (SPC), o Grupo de Trabalho sobre Tempos de Espera para Cirurgia Cardíaca constituiu-se com a missão de elaborar recomendações práticas acerca dos tempos de espera clinicamente aceitáveis para o largo espetro de patologias cardíacas do adulto que necessitam de cirurgia, ou de intervenção nas três fases críticas do seu tratamento: consulta de especialidade, ato de diagnóstico e terapêutica invasiva.

A cirurgia cardíaca detém uma especificidade própria, não comparável às outras especialidades cirúrgicas e, como tal, assume-se de especial importância a redução significativa dos seus tempos de espera máximos, assim como uma maior eficácia nos sistemas de monitorização e rastreabilidade do doente.

A informação presente neste manuscrito baseou-se, predominantemente, na informação clínica existente. A metodologia usada para estabelecer os critérios baseou-se em estudos de história natural da doença, em estudos clínicos que compararam o tratamento médico com a intervenção, em análises retrospetivas ou prospetivas de doentes em lista de espera e na opinião de peritos ou de grupos de trabalho.

Após esta primeira etapa, assinalada por esta publicação, a SPCCTV e a SPC devem ser consideradas como as interlocutoras naturais da tutela sobre esta matéria e comprometem-se a colaborar de forma decisiva para a definição de estratégias de atuação, através da adequação da evidência clínica com a realidade e com os recursos disponíveis.
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List of abbreviations

CCS	Canadian Cardiovascular Society
NHS	national health service
NYHA	New York Heart Association
OECD	Organisation for Economic Co-operation and Development
SIGLIC	Integrated System for Management of Waiting Lists for Surgery
SPC	Portuguese Society of Cardiology
SPCCTV	Portuguese Society of Cardiothoracic and Vascular Surgery

Preamble

The question of criteria for waiting times for cardiac surgery arises principally in Beveridge-type health systems, in which the State is mainly responsible for funding and providing health care. It is less of an issue in countries such as France, Germany, Switzerland, Belgium and the USA, where health systems are based on the Bismarckian model, in which health care (including surgical interventions) is managed directly between hospitals (and surgeons) and patients and insurers, with or without State support. In this model, there are no problems with the supply of treatment, and access to health care is governed by the patient's resources and/or the coverage and prices set by funding bodies. By contrast, as in the Scandinavian countries and the UK, the Portuguese national health service (NHS) is based on the Beveridge model. In Portugal, resources are limited, and it is thus essential to use them as efficiently as possible to ensure that the support structures of the NHS meet the health care needs of the population, including management of waiting lists.

Waiting times for cardiac surgery in Portugal are longer than those for other types of cardiological intervention, which may indicate inadequacies in the supply of treatment or in patient referral. Waiting times, while covered by the legislation governing the NHS, are also longer than recommended in international guidelines. It has not so far been deemed necessary to differentiate maximum acceptable waiting times for cardiac surgery (such as for aortic stenosis or coronary disease) from those for other types of surgery, such as orthopedic or ophthalmological, in which the consequences of delay are less serious. However, the effects of long waiting times for cardiac surgery are harmful not only in terms of patients' health and quality of life (worsening of symptoms and more adverse events such as deterioration of ventricular function, myocardial infarction, heart failure or death), but also in economic terms, incurring direct and indirect costs from morbidity, repeated or lengthy hospitalizations, and significant reductions in ability to work for both patients and their families.

A wide range of criteria are used to determine surgical priorities, but specific information is lacking on waiting times for cardiac surgery in both national and international guidelines. Determining priority levels is a complex task for physicians, based on objective and subjective criteria, including the patient's clinical status, the disease, results of diagnostic exams and medical judgment. From the patient's

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