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The Role of the Cardiac Anaesthetist in Core Interdisciplinary Heart Teams

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Interdisciplinary heart teams (IDHTs) have evolved over the last decade and now play a central role in managing complex cardiovascular diseases while adapting to each patient's specific needs.¹ Their primary aim is to establish tailored, patient-centric treatment plans, and they play a central role in treatment decision-making in well-established transatlantic clinical practice guidelines for patients with various conditions, including ischaemic and valvular heart disease.^{2–8} In heart valve centres, IDHTs are considered particularly helpful where uncertainty exists or when patients have clinical characteristics that differ from those included in clinical trials.⁴ ACC/AHA and ESC/EACTS guidelines include the IDHT (or heart valve team) as a class I recommendation when considering transcatheter and surgical intervention in severe heart valve disease.^{2,4} Similarly, IDHTs have become an important paradigm in everyday clinical practice for patients with acute and chronic coronary syndromes.^{5–7}

THE ROLE OF ANAESTHETISTS IN HEART TEAMS

There is widespread expert consensus on the composition of heart teams. Decisions made by IDHTs are based on patient-centred care and shared decision-making, with the patient positioned at the centre of the process.¹ Leonardi and colleagues have clearly outlined the role of the cardiac anaesthetist within the core IDHT for patients with complex coronary artery disease requiring myocardial revascularization, highlighting the unique contribution of anaesthetists to perioperative and periprocedural management, where advanced physiological knowledge and haemodynamic expertise are essential.¹ Also, a recent EACTS Expert Consensus document on “protected

cardiac surgery” underscores the critical role of cardiac anaesthetists in IDHTs.⁸

We propose that anaesthetists must be core members of the IDHT caring for patients with complex valvular heart disease. This position is supported by previous European guidelines on the management of valvular heart disease, which explicitly identify anaesthetists as core members of the IDHT.³ In contrast, other specialists (such as geriatricians, heart failure specialists, or critical care physicians) are included as additional members of the wider heart team, according to the patient's preoperative comorbidities and clinical needs.³

Against this backdrop, the recently published *ESC/EACTS* valvular heart disease guidelines on the composition of the IDHT represent a concerning step backwards in the evolution of multidisciplinary cardiovascular care.⁴ The new document removes the cardiac anaesthetist from the core IDHT, and, importantly, this change was made without formally involving cardiac anaesthetists either in the task force or among the designated reviewers.

Advances in structural heart interventions over the past decade, including major developments in valve technology, have made many catheter-based procedures less invasive and more standardized. In transcatheter aortic valve implantation (TAVI), as the most utilized procedure, smaller delivery systems, improved valve platforms, and the widespread use of the transfemoral approach have shortened procedures and increased the use of conscious sedation in appropriately selected patients. This evolution may create the impression that specialist anaesthetic involvement is less necessary. However, anaesthetic presence and expertise remain essential during TAVI procedures, irrespective of the type or invasiveness of anaesthesia used.⁹ Based on individual patient risk factors, anaesthetists make key decisions regarding

preoperative optimization of comorbidities (eg, optimization of chronic obstructive pulmonary disease), selection of the most appropriate and safest anaesthetic technique (eg, awake sedation versus deep sedation versus general anaesthesia), the level of invasiveness of perioperative monitoring (eg, Minimally invasive monitoring versus additional arterial, central venous, and urinary catheterization), and the planning of postoperative care (eg, recovery unit and ward care versus intermediate or critical care unit admission).¹⁰ These decisions are fundamental to safe perioperative planning and appropriate postoperative bed allocation, thereby facilitating optimal care for this high-risk patient population and contributing to the best possible clinical outcomes. They enhance patient safety, optimize procedural outcomes, and strengthen the collective decision-making process by providing a unique perspective on patient risk, comorbidity optimization, and intraoperative strategy. A decision therefore to remove the cardiac anaesthetist from the core heart team may overlook the complexity of modern cardiovascular practice, it disregards previously established scientific consensus and potentially conflicts with fundamental principles of patient safety.

Cardiac anaesthetists are specialists whose broad and integrative training positions them at the intersection of physiology, perioperative medicine, and critical care. Anaesthetists play a central role in maintaining intraoperative cardiovascular stability, providing continuous haemodynamic and cerebral monitoring, and adapting anaesthetic strategies to support recovery and ensure safe transitions across perioperative phases. They contribute meaningfully to discussions of complex cardiovascular cases and play an essential role in periprocedural risk assessment, especially as patients increasingly present with multiple coexisting comorbidities alongside moderate-to-severe cardiovascular illness. Excluding anaesthetists from the core IDHT undermines this holistic, patient-centred approach that established the IDHT model in the first place.

CONCLUSION

In an era characterized by increasingly complex, multimodal cardiovascular therapies, collaboration—rather than restriction—must guide the structure and function of multidisciplinary care. We therefore invite the authors and relevant European societies to reconsider the composition of the core IDHT for the management of patients with valvular heart disease.

The inclusion of the cardiac anaesthetist as a core member of the IDHT is not a matter of professional prestige or hierarchical positioning, but one of patient safety, evidence-based practice, and a shared commitment to multidisciplinary excellence. This principle has already been clearly articulated in the joint European position paper on the management of patients with complex coronary artery disease requiring myocardial revascularization.¹

Only through genuine inclusivity, close clinical collaboration, and adherence to established evidence can IDHTs fully realize their mission: to deliver safe, high-quality,

and patient-centred care for individuals with cardiovascular disease.

AUTHOR CONTRIBUTIONS

Conceptualization: Gianluca Paternoster, Milan Milojevic, Chirojit Mukherjee, and Gudrun Kunst. Writing—original draft: Gianluca Paternoster and Gudrun Kunst. Writing—review & editing: Gianluca Paternoster, Milan Milojevic, Chirojit Mukherjee, and Gudrun Kunst.

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CONFLICTS OF INTEREST

G.P. is president-elect of the European Association of Cardiothoracic Anaesthesiology and Intensive Care (EACTAIC). M.M. is the medical director for clinical practice guidelines at the European Association for Cardio-Thoracic Surgery. C.M. is immediate past-president of EACTAIC. G.K. is Chair of the Scientific Committee of EACTAIC.

AI USE

No generative AI or AI-assisted technology was used.

REFERENCES

- [1] Leonardi S, Capodanno D, Sousa-Uva M, et al. Composition, structure, and function of heart teams: a joint position paper of the ACVC, EAPCI, EACTS, and EACTA focused on the management of patients with complex coronary artery disease requiring myocardial revascularization. *Eur J Cardiothorac Surg*. 2021; 59:522-531. <https://doi.org/10.1093/ejcts/ezaa402>
- [2] Otto CM, Nishimura RA, Bonow RO, et al. 2020 ACC/AHA guideline for the management of patients with valvular heart disease: a report of the American College of Cardiology/American Heart Association Joint Committee on clinical practice guidelines. *Circulation*. 2021;143:e72-e227. <https://doi.org/10.1161/CIR.0000000000000923> [published Online First: 20201217]
- [3] Vahanian A, Beyersdorf F, Praz F, et al.; ESC/EACTS Scientific Document Group. 2021 ESC/EACTS Guidelines for the management of valvular heart disease: developed by the task force for the management of valvular heart disease of the European Society of Cardiology (ESC) and the European Association for Cardio-Thoracic Surgery (EACTS). *Rev Esp Cardiol (Engl Ed)*. 2022; 75:524. <https://doi.org/10.1016/j.rec.2022.05.006>
- [4] Praz F, Borger MA, Lanz J, et al.; ESC/EACTS Scientific Document Group. 2025 ESC/EACTS guidelines for the management of valvular heart disease. *Eur J Cardiothorac Surg*. 2025;46:4635-4736. <https://doi.org/10.1093/ejcts/ezaf276>
- [5] Vrints C, Andreotti F, Koskinas KC, et al.; ESC Scientific Document Group. 2024 ESC guidelines for the management of chronic coronary syndromes. *Eur Heart J*. 2024;45:3415-3537. <https://doi.org/10.1093/eurheartj/ehae177>
- [6] Lawton JS, Tamis-Holland JE, Bangalore S, et al. 2021 ACC/AHA/SCAI guideline for coronary artery revascularization: a report of the American College of Cardiology/American Heart Association joint committee on clinical practice guidelines. *Circulation*. 2022; 145:e18-e114. <https://doi.org/10.1161/CIR.0000000000001038> [published Online First: 20211209]

- [7] Byrne RA, Rossello X, Coughlan JJ, et al.; ESC Scientific Document Group. 2023 ESC guidelines for the management of acute coronary syndromes. *Eur Heart J*. 2023;44:3720-3826. <https://doi.org/10.1093/eurheartj/ehad191>
- [8] Lorusso R, Salazar L, Nersesian G, et al. EACTS expert consensus document on protected cardiac surgery: pre-emptive use of temporary mechanical circulatory support in adult cardiac surgery patients at high risk for perioperative low cardiac output syndrome. *Eur J Cardiothorac Surg*. 2026; *in press*. <https://doi.org/10.1093/ejcts/ezaf296>
- [9] Feistritz HJ, Ender J, Lauten P, et al.; DOUBLE-CHOICE Investigators. Peri-Interventional anesthesia strategies for transcatheter aortic valve implantation: a multicenter, randomized, controlled, noninferiority trial. *Circulation*. 2025; 152:1526-1537. <https://doi.org/10.1161/CIRCULATIONAHA.125.076557>
- [10] Ajello V, Fresilli S, D'Amico F, et al. Management of anaesthesia transfemoral transcatheter aortic valve implantation: an italian interdisciplinary consensus statement. *Br J Anaesth*. 2026; *in press*. <https://doi.org/10.1016/j.bja.2025.10.052>