On My Mind

Partnership Over Permission: Redefining Anesthesiology-Cardiology Collaboration

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This phone call happens dozens of times daily in hospitals across the country: "Can you clear this patient for surgery?" It's become so routine that we rarely stop to consider how profoundly problematic this question actually is.

By asking for "clearance," we anesthesiologists are abdicating our fundamental responsibility as perioperative physicians and perpetuating a dangerous fiction – that someone can grant permission that makes surgery safe.

Consider this sobering statistic: Even in completely healthy patients with a revised cardiac risk index score of zero, the pooled risk estimate for major adverse cardiac events is 3.9% (*Can J Cardiol* 2017;33:17-32).

There is no such thing as risk-free surgery. Yet, when we ask cardiology to "clear" a patient, we're implicitly seeking reassurance that doesn't exist and can't be given (asamonitor.pub/4stMlSj). We're asking our colleagues to bless a journey they won't be taking with us.

Even more troubling is what this language reveals about our professional identity. When we defer risk assessment and perioperative optimization to other specialties, we're surrendering the very expertise that defines us.

No other specialty understands the physiologic stress of surgery and anesthesia as we do. No other specialty has our granular knowledge of what happens in the OR – the hemodynamic swings, the ventilatory challenges, the fluid shifts, the potential for massive hemorrhage. This is our unique advantage, our irreplaceable perspective in caring for surgical patients.

What we should actually be asking

Anesthesia malpractice claims data from The Doctors Company reveal that clinical judgment issues are the second-highest contributing factors to claims (behind technical performance issues). Thirty-seven percent of anesthesia claims had clinical judgment contributing factors, including improper selection and management of therapy, inadequate patient assessment, and insufficient patient monitoring (asamonitor.pub/4s8RJL4).*

When anesthesia practitioners consult cardiology or any other subspecialty, we should achieve three specific goals to maximize our clinical judgment:

First, data and history. What cardiac diagnoses does this patient carry? When was their most recent echocardiogram, and what did it show? What did their previous cardiac catheterization reveal? What medications are they taking? This information gathering is essential and straightforward.

Second, optimization through a subspecialty lens. Can this patient safely stop anticoagulation, and if so, what's the appropriate bridging strategy? Would initiation of beta-blockade reduce their perioperative risk? Are there long-term cardiac issues that could be better managed before we add the stress of surgery? For severe aortic stenosis, what is the optimal timing for transcatheter aortic valve replacement? This is where the cardiologist's deep expertise in managing chronic cardiovascular disease becomes invaluable.

Third, subspecialty perspective on risk modifiers. Given their intimate knowledge of this patient's cardiac pathology, what specific cardiologist concerns should shape our perioperative approach? It's a collaborative approach and an information exchange, which is essentially asking, "What should we know?" Notably absent from this list: asking permission to proceed. The goal is consultation, not seeking absolution.

2024 guidelines give us the tools

The recently updated Guideline for Perioperative Cardiovascular Management for Noncardiac Surgery provides anesthesiologists with robust frameworks for risk assessment and optimization (*Circulation* 2024;150:e351-e442). These compiled guidelines help us determine a) when additional testing is warranted, b) which patients benefit from preoperative medical optimization, and c) how to stratify cardiac risk using validated calculators. In many cases, these tools allow us to answer our own questions about optimization and risk without requiring medical subspecialty input.

This doesn't diminish the value of our cardiology colleagues – quite the opposite. By handling straightforward risk assessment ourselves, we preserve their expertise for cases where it truly matters: 1) the patient with unclear functional capacity and multiple risk factors, 2) the patient with recently decompensated heart failure, and 3) the patient whose complex medication regimen requires specialized knowledge to adjust safely.

Taking ownership of the perioperative space

Here's an uncomfortable truth: 100% of airliners that have crashed were "cleared for takeoff." Clearance doesn't prevent disaster – preparation, risk mitigation, and appropriate resource allocation do.

As anesthesiologists, we need to lead in these areas. When we identify a high-risk patient undergoing major vascular surgery who's stopping anticoagulation near the deadline for coronary artery stents, our job isn't to get someone to approve the case – it's to ensure that the case doesn't happen in an ambulatory surgery center. It needs to be performed at a facility with interventional cardiology capabilities and a catheterization lab.

When we're caring for a patient with severe pulmonary hypertension undergoing a high-risk procedure, our responsibility isn't to document that cardiology "cleared" them. Our responsibility is to ensure we're operating at a center with inhaled pulmonary vasodilators readily available, transesophageal echocardiogram capabilities for intraoperative monitoring, and extracorporeal membrane oxygenation backup if things go catastrophically wrong. If those resources aren't available, we need to advocate for

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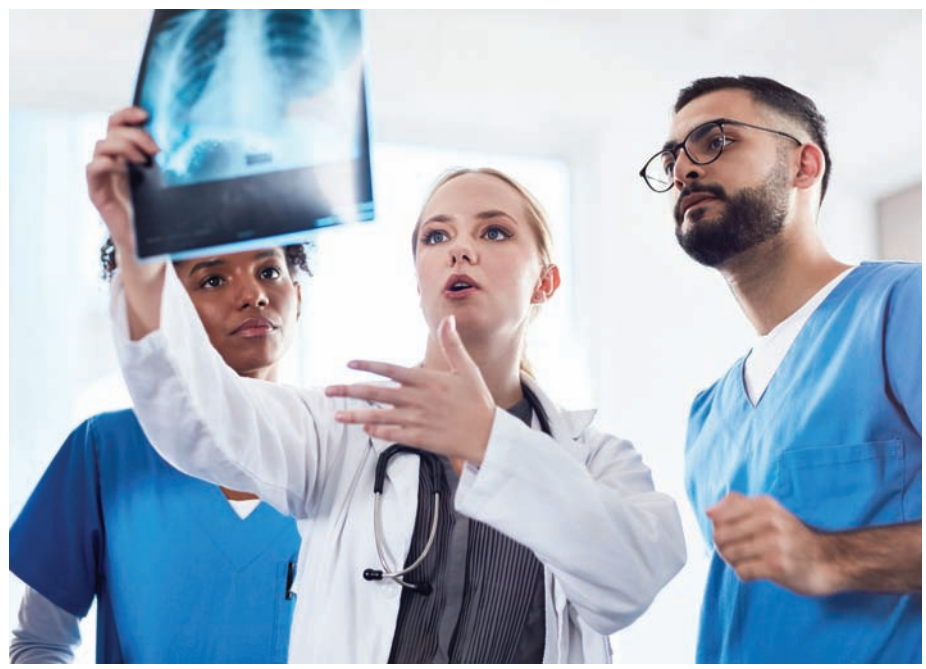

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transferring the patient or delaying the case.

This is risk mitigation in action. It's using our knowledge of what can go wrong in the OR to make proactive decisions about where cases should be performed, what monitoring is required, and what level of postoperative care is needed. These are fundamentally anesthesiology decisions, grounded in our distinctive understanding of perioperative physiology.

Our unique perspective

We see things other specialties do not:

- We know that a patient who looks stable in the preoperative area may become profoundly hypotensive with induction.
- We understand that positive pressure ventilation can unmask right ventricular dysfunction that was compensated at baseline.
- We recognize that a patient who appears "fine" may not tolerate even modest blood loss due to their limited cardiac reserve.

This knowledge should drive our decision-making about intraoperative monitoring, medication choices, fluid management strategies, and postoperative disposition. We ask:

- Should this patient have an arterial line?
- Do we need central access and goal-directed fluid therapy?
- Should we plan for postoperative ICU admission, or can they safely recover on the floor?

These aren't questions for cardiology – these are questions for us.

Moving forward

The shift away from "clearance" language isn't just semantic – it represents a fundamental reorientation of our professional role.

We are not seeking permission; we are gathering information, optimizing patient care within our scope, consulting specialists for their unique expertise when needed, and then making informed decisions to safeguard our patients throughout the perioperative period.

This is harder than asking someone else to approve our cases. It requires staying current with perioperative guidelines, becoming comfortable with risk stratification tools, and taking ownership of difficult conversations with surgeons and patients about what is and isn't feasible. But this is precisely what our specialty trains and expects us to do.

Every patient deserves an anesthesiologist who understands their risk, has worked to mitigate it, and has a clear plan for managing complications if they arise. No consultant's note can provide that. No "clearance" can substitute for it.

It's time we stop asking for permission and start leading. ■