

ward round, which reviewed medical and pre- and post-operative surgical patients as a routine.

Children admitted to BRI for elective open-heart surgery would be under the care of Mr Wisheart and Mr Dhasmana, with day to day management by the cardiac anaesthetists and cardiac surgical junior staff. Because of their heavy work load with limited junior staff support [see Issue B: Background, paragraphs (iv) to (ix), pages 2 to 4] and the difficulties imposed by the split site [see Issue H], it was not possible for the consultant paediatric cardiologists to play much of a role in the immediate pre-operative assessment and post-operative care in the BRI.

The majority of patients admitted to BRI for non-urgent open-heart surgery,

- (a) would have been assessed fully, with echocardiography if necessary, either at BCH Outpatients Department or at a peripheral clinic, prior to the operation; and/or**
- (b) would not have required further assessment of the cardiac status following comprehensive diagnostic investigations even a year before surgery, if the condition was known not to deteriorate in the medium term, eg. secundum atrial septal defect.**

An exception would be those patients without symptoms but with potentially progressive pulmonary vascular obstructive disease, who comprised a small minority of all open-heart operations. However, repeat clinical, radiological, electrocardiographic and even echocardiographic examination in these cases would have been unlikely to establish whether a patient had changed from an operable to an inoperable state. I believe the only way to confirm the then current