

paediatric cardiac centre, either the cardiologist or cardiac surgeon would undertake to make the referral. A sample list of patients referred to other centres from 1992 to 1994 is attached as Appendix E 1. When surgery at BCH or BRI was recommended, the cardiologist or cardiac surgeon would normally dictate a note reflecting the decision of the meeting, and might add a comment regarding the surgical approach.

E 5 *Who bore the ultimate responsibility of deciding whether and what surgery was appropriate for a child, who should perform it, and when it should take place.*

The decision-making regarding whether and what surgery was appropriate for a child is covered in E 4.

For most operations, the surgeons would agree as to which one would take on a particular patient. If only one surgeon was able to be present at a meeting, he would accept the patient. This applied to all conditions, except for the deliberate decision that Mr Dhasmana would undertake all arterial switch operations, for neonates and non-neonates, from 1990.

There were rarely problems with regard to the timing of an operation for patients requiring an *emergency* procedure. These emergencies were often in newborn babies or young infants who required immediate palliative shunt operations at BCH (eg. pulmonary or tricuspid atresia), or corrective procedures at BRI (eg. total anomalous pulmonary venous connection). A theatre slot could always be arranged at BRI for these patients, even if it meant cancelling a previously booked adult case. Quite often, these operations would be fitted in over the

weekends.

The *non-urgent* cases would often be delayed beyond the anticipated date for surgery because of competition with the long, adult waiting list. On the other hand, the long term outcome for these patients would usually not be any different, even after delays of several months. The main repercussion was on the families who, quite understandably, became very frustrated after waiting anxiously for a date for surgery, which was then deferred.

The major difficulties occurred in the *urgent* group of patients, for whom surgery was not so critical as to need an operation within about 24 hours, but who could deteriorate in the course of weeks or months. This group included patients who became increasingly cyanosed; and infants with large communicating defects and left to right shunts, causing high pulmonary blood flows and severe heart failure. Despite intensive treatment with appropriate medication, these babies remained breathless, could not feed adequately, and failed to thrive: they were often hospitalised at BCH for many weeks while awaiting surgery. Also in this group were infants with pulmonary hypertension, as occurs particularly with complete atrio-ventricular septal defects, typically in babies with Down's syndrome.

E 6 *The organisation and management of theatre lists.*

This was entirely in the hands of the paediatric cardiac surgeons, since they knew the length of the adult list and the order of priority.