

**Dr. S.C. Jordan****Statement to the Bristol Royal Infirmary Inquiry****Issue E**

came from two main streams: those whose initial training was in paediatrics and those starting their training in adult cardiology. My own position as a cardiologist trained in and carrying out both adult and paediatric cardiology would be very unusual now, but was common at the time of my appointment. I had had training in total at four units in the UK. A period abroad was generally considered an asset, but although I had two attempts (San Francisco and Toronto) this did not prove practical. Additionally most of what is now regarded as standard knowledge (for example echocardiographic diagnosis) developed after my appointment and had to be learnt after appointment.

As numbers increased and the complexity of the subject developed, paediatric cardiologists in many centres developed sub speciality roles. Some, for example, were proponents of echocardiography (sometimes limiting themselves to certain specific types of lesion) and did not carry out cardiac catheterisation as a routine. Others did not carry out their own echocardiograms but developed other interests, such as pathology.

It would thus be possible to look at any of the cardiologists in Bristol and find other cardiologists in other centres who had greater experience or reputation in individual branches of cardiology, but my view is that all three were proficient in the diagnosis of infants and children with all forms of congenital heart disease.

*E 11 The service provided by paediatric cardiologists in diagnosing or describing:*

- a. the structure and anatomy of the child's heart and lungs;*
- b. the clinical condition of the child;*
- c. the nature of the surgical procedure required, and any complications that might be encountered by the surgeon;*
- d. the speed or urgency with which any intervention was required.*

From 1987 onwards we had proper diagnostic equipment for angiography and echocardiography. All results were carefully and accurately described in the catheter reports and the angiograms were scrutinised firstly by the cardiologist carrying out the investigation, secondly by an experienced radiologist and thirdly by the clinicians generally at the combined meetings.

*E 12 The protocols or clinical guidelines, machinery, equipment or technical services (eg radiological interpretation) available to the cardiologists to assist them in this task.*

I do not think there were in general any protocols. We used the advice contained in the cardiological literature. In addition, although it was not intended as guidance for cardiologists, I had included a number of "guidelines" in *Heart Disease in Paediatrics* and none of these had been criticised either by reviewers or to me personally, so I had no reason to believe that we were doing things in any way different from other units.