paediatric SHO, of which 2 or 3 had duties with one of the cardiologists. We also used the consultants and senior registrars in paediatrics to help with any non-cardiological problems.

Sick infants were nursed on the paediatric ITU at BRHSC. This was established in 1985 and saw two expansions during my time (and another one since to accommodate cardiac surgery when this was eventually transferred from BRI). The funding for the original unit and the two expansions came almost entirely from money raised by various appeals, including the Guild of Friends and the Heart Circle. The unit was managed medically by a group consisting of the paediatric cardiologists, anaesthetists and Dr. Fleming from St. Michael's Hospital, acting as a paediatric intensivist. The paediatric senior registrars and SHOs also contributed. Latterly specific parts of paediatric SHO posts were devoted to the ITU but prior to that one of more SHOs at any one time combined work there with other duties. For the last few years I believe that Dr. Hughes, one of the anaesthetists, was in administrative charge.

The main amount of regular attendance was at two fixed rounds each day, 08.30 and 17.30 (including Saturdays, Sundays and Bank Holidays) at which we made every effort to see that at least one cardiologist was present. There was usually a consultant and SR anaesthetists and the paediatric SR on call for that day. Dr. Fleming also came regularly. In addition there were the SHOs with responsibility on the unit. The paediatric consultants did not usually come on these rounds but attended later, fitting in with their other duties, as did the paediatric surgeons. Obviously, if there was a cardiological problem at other times the cardiologist would be called and we were able almost always to ensure that the duty cardiologist was in the hospital or available from home.

Although they operated at the BRHSC on a regular basis (every Monday morning and some Wednesdays, all day) and saw their patients on return to the ITU from the theatre, the cardiac surgeons were less often available than the cardiologists. Initially some decisions such as when to remove chest drains were left to the surgeons, but increasingly were taken by cardiologists or other staff. (There were no cardiac surgical junior staff at BRHSC.)

When we required help from other specialities, such as the renal unit (based at Southmead), this was readily forthcoming. I do not have experience of paediatric ITUs elsewhere to allow comparison, but my impression was that the unit worked in a co-ordinated way and that there were sufficient staff and sufficient time was given, for problems to be fully discussed. We also, from an early stage, had echocardiography available and this was useful not only for diagnostic purposes but also to guide treatment, for example by assessing left ventricular performance or pulmonary hypertension. This of course also applied to non-cardiac patients nursed on the unit to whose management the cardiologists also made a contribution.

*E3 The reassessment of the clinical condition of children admitted for elective surgery, following admission.*

This was not always easy as far as the cardiologists were concerned as the children were admitted direct to Ward 5 at the BRI. Operation lists were produced the end of the previous month but were subject to change according to the need to deal with emergencies and the availability of postoperative ITU beds in the BRI ward 5. I tried to see admissions of all patients the day before operation, but since there was no formal arrangement for this I often got to ward 5 to find that the child had been sent off with his parents into town, having had his

routine tests done. I was not encouraged to write anything in the notes to say that I had seen the patient. Clearly, if there was anything which I noted which suggested that the decision to operate should be reviewed, I would make every effort to contact the surgeon concerned. In practice this was unusual, but did occur on a few occasions. It should also be noted that the pre-op catheters (35 mm cine film) and echo results (VHS tapes) would be at the Children's Hospital. It was possible for me or one of the radiologists (particularly Dr. Wilde) to carry out a further echocardiogram if this was indicated. This became easier once the Heart Circle had provided money for an echo machine to be kept on the ward.

Otherwise the clerking of patients was carried out by the cardiac surgical SHOs. The surgeons and anaesthetists did, of course, carry out their own pre-operative assessment and see parents to explain what was proposed. For part of the time we also had Helen Stratton as cardiac liaison sister to see parents.

We did set out originally to look at the next weeks operations in terms of reviewing the catheter and echo data at one of the combined (Monday or Wednesday) meetings with the surgeons, but since they did not manage to get to more than 50% of these at best, and there was often a backlog of recent investigations to discuss with them, this soon fell by the wayside.

There were a few occasions when I felt that there might be decision to be made at the time of operation to which I could contribute and I did try and get to the theatres when this occurred. Because of the split site, the surgeons did not very often attempt to contact a cardiologist if there was perceived to be a problem with the diagnosis when the chest was opened, although when they did, it did not usually take more than 5-10 minutes for me to get down the road and into theatre.

*E4 The manner in which decisions to recommend surgery for a child were discussed between paediatric cardiologists and paediatric cardiac surgeons, and other members in the cardiac surgery team; and the means by which such decisions were taken.*

Provided that time allowed, the decision was taken following review of investigations and discussion at one of the combined meetings, and was a joint decision by all cardiologists and surgeons present at that meeting. Dr. Masey was the only anaesthetist who I recall attended any such meetings from the BRI. The decision as to which of the two surgeons would be asked to carry out the operation (and of course to see the patient and parents for discussion) was largely a function of which surgeon happened to be present, although there were some procedures, particularly the arterial switch, where it had been decided that only one surgeon would carry out all operations.

*E5 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.*

Ultimately, this was the final decision of the surgeon, but it was very unusual for there to be any disagreement on the treatment. More commonly discussion centred on whether other investigations were necessary and the exact timing of the operation. While we could together agree on the optimum timing the surgeon was the only one who controlled the waiting lists.