

**F4** The theatre team comprised consultant and trainee surgeons, scrub nurse and runner, consultant and trainee anaesthetists, anaesthetic nurse (one of the pool of theatre nurses until about 1994) and then an ODA, and two perfusionists. I was allocated on a rota to attend the operating theatre on two days out of three (Monday, Tuesday, Thursday) each week and to be on call for nights and weekends on a rota basis (1 in 4 initially then 1 in 6 from 1994). I thus worked with all the consultant surgeons and theatre staff at some time.

**F6a** My experience, from my training period at Great Ormond Street, was of shorter operations and cardiopulmonary bypass times in paediatric cardiac surgery cases. I was particularly concerned when circulatory arrest times exceeded forty-five minutes and discussed these worries with colleagues, both anaesthetic and surgical on an informal basis.

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**G4** Anaesthetic cover for the cardiac intensive care unit (ITU), at the time of my arrival at the BRI in 1991, was provided during the day by one consultant and one trainee who were working in the cardiac operating theatre that day. A quick visit to the ITU before theatre (at 7.45am) to check that there were no urgent problems was followed by a complete round by the consultant of the patients, both adult and paediatric, when the first patient in theatre was on cardiopulmonary bypass. The trainee would remain in theatre to supervise the anaesthetic whilst the consultant attended to the ITU. Later in the day the on call trainee or consultant, depending on the relative needs of theatre and ITU, would visit ITU when feasible or if requested by the nursing staff. In 1993 when the first intensive care sessions began the intensivists (consultant anaesthetists) would take care of the Unit for initially two, and later (1995) four, mornings of the week. A trainee anaesthetist was also allocated to the ITU for the day.

After completion of the theatre lists and during the night, anaesthetic cover was provided by a non-resident registrar and consultant. The registrars could, and did, stay in the hospital overnight if any patients were particularly unstable or the registrar lived a long way from the hospital.

At weekends the registrar was on call for the Children's Hospital paediatric anaesthetic service and the BRI cardiac ITU and theatre. This meant that they were often working in the Children's Hospital, especially on Saturdays, leaving the consultant anaesthetist as sole cover for the BRI cardiac ITU.

In or about 1995 the anaesthetic registrar rota was split to enable separate cover for the BCH and BRI cardiac units.

**G5** Postoperative patients remain under the care of their consultant surgeon but much of their care is determined by the anaesthetist present on the ITU, particularly interventions in respiratory support, monitoring and sedation. The postoperative care of cardiac surgery patients has always been a team effort. Better co-ordination of the team and improvements in communication were enabled by the institution of intensive care sessions.

**G6** I found it relatively easy to liaise with those from other specialties involved in the care of the postoperative patients. Continuity of care was ensured by handovers between anaesthetists. These became more formal after the arrival of the intensivists.