

consultant. During the day these consultants were always anaesthetising in theatre. I found it difficult and very stressful to look after sick patients on CICU when I was at the same time anaesthetising for cardiac operations. Often I would have to leave my patient in theatre with a trainee anaesthetist while I went to CICU to assess patients. If I was the on call anaesthetist on a Monday, I would wait until my patient in theatre was safely established on cardiopulmonary bypass before visiting CICU for a complete ward round. This round, usually at 10 to 10.30am was fraught with problems, partly due to time pressure, and partly as a result of conflicts with medical management initiated by the surgical registrar round at 8am. (See comments B12 for similar problems with the intensivist's ward rounds). At night the anaesthetic consultants were on call from home. I believe that I was always contactable, when on call, as I carry a radiopager and more recently, in addition, a mobile phone. Consultant cardiac surgical cover was provided by Mr Wisheart and Mr Dhasmana who did not attend the morning ward rounds but usually saw their patients at other more variable times during the day. They were not always available during the day due to theatre, clinic and, for Mr Wisheart, management commitments.

G5: The development and organisation of immediate post-operative care.

3. The consultant anaesthetist who had anaesthetised the child would take the patient back to the intensive care unit, liaise with the on call medical and nursing staff and would be on call that night. Prior to leaving the hospital the anaesthetic consultants would lead a further CICU ward round together with the on call specialist registrars in surgery and anaesthesia, and the resident cardiac surgical SHO. If there were difficult paediatric cases from that day there would invariably be a discussion of the immediate management plan with Mr