

not uniformly held by the anaesthetists on the one hand and the surgeons on the other.

6. Page 3; "Perceptions; 4": While there may have been a view among many of the anaesthetists that ITU stays seemed long, it would be better not to extrapolate this into the statement that they were unanimous that morbidity was excessive. As stated, there were no hard data either for this unit or for others. Length of stay in ITU depends among other things on the skills of the staff in other areas and is not a valid index of the overall quality of the care given.

7.1 Data analysis. This exercise is extremely difficult and we are grateful to the Visitors for grappling with the complexities. There are several difficult areas in this section which are highlighted in their next section (Weaknesses and deficiencies., 1-4). We accept the final conclusions and most of the recommendations that follow, but we have two major concerns: firstly that page 4 should not be taken out of context, and secondly that the percentage figures given on this page should be read in the light of the total figures.

7.2. The unit lost confidence in their performance of one operation (neonatal switch) referred to one surgeon. He took steps to refer these elsewhere pending the appointment of a new colleague with particular experience in this area. This is quite standard practice in all surgical units undertaking high risk operations. Nevertheless paragraph 3, page 4 describes nine deaths in a group of patients **many of whom** must have been at an exceptionally high risk **because of the additional malformations**; not all of these would have been detected preoperatively.

7.3 Excluding these cases, the results of surgeon 2 were excellent. We are grateful to the visitors for their strong support for his continued involvement in paediatric care and their helpful comments regarding the relationship between the disciplines.

7.4 In the final section "Conclusions., 4" the visitors comment that Consultant 1 has decided to "concentrate his activities" on adult work when the new appointee arrives. It was decided that he would withdraw from paediatric surgery some time ago. We fear that the report could be read as an unjustified criticism of this surgeon, though we think this is an unintentional result of the fact that there appeared to be no need to comment on his future role in the unit.

7.5 We strongly disagree with the conclusion on the last line of page 4. No data are presented to show how this surgeon is ranked nationally. In the tables provided, there is no significant difference between the mortality figures of the two surgeons. The total number of deaths in 1992-5 was very similar; the team which **operated on the smaller number of children** had a non-significantly higher mortality. A total of only four fewer deaths would have yielded equal percentages. There were four excess deaths in the "miscellaneous" group among patients with very unusual diagnoses not all of whom had operations. AVSD repair, a procedure which had proved very successful in this

p = .2

*This para is
not easy to follow.*