of children and I feel that I should pay more attention to details of heat losses in theatre, acidosis and inotrope requirement in small children to improve my clinical service.

The adult mortality is acceptable but should be addressed, and the current audit of clinical practice in cardiac anaesthesia and surgery may well establish the underlying severity of disease in the population operated on in this region. For both paediatric and adult work, the surgeons and anaesthetists must establish mandatory convenient morbidity and mortality meetings to fulfil both training and audit requirements, and I look forward to the speedy introduction of such meetings.

The gross neurological damage rate in the adult cases is 3.8% but many small postop deficits may be missed on the ITU in the first 24 hours. I see this as an area in which closer collaboration between the anaesthetists and perfusionists is vital and I intend to make my patients the subject of intensive neurological audit when the Cerebral Function Analysing Monitor is available here.

Anaesthesia for Ophthalmic Surgery

Mr. Grey's lists have provided a welcome respite from the cardiac service and an enjoyable clinical challenge. There has been a 43% paediatric workload and of the adults 25% are aged 65 years and over. Open discussion of difficult patients prior to surgery has made the initiation of medical treatment and planning of elective anaesthesia and surgery much simpler and has led to few cancellations for anaesthetic reasons alone. Preoperative investigation of such patients has usually been good. Communication remains the best avenue to a smooth clinical service in this specialty.