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# Correspondence

## The role of neonatal nurse practitioners: a viewpoint

Sir,

In October 1984 the British Paediatric Association produced a discussion document entitled, '*The Future in Paediatrics and Child Health*. This contained the sentence, 'We wonder if the newborn intensive care nursery could be the place to experiment with nurse technicians in order to reduce the dependence on junior doctors.' In August 1985 the matter was again raised in the editorial of the *Lancet*; the shortfall in senior house officers and registrars could perhaps be made up by neonatal nurses. Deferring to the North American experience, where nurse clinicians/specialists were undertaking procedures such as lumbar puncture, exchange transfusion, and arterial puncture, it was stated that neonatal nurses, 'might now be asked to consider a greater degree of responsibility in the neonatal intensive care unit, although ultimate responsibility for medical care will remain with the consultants. The British Paediatric Association has (albeit timidly) already suggested this and its members should now act boldly.'

A literature search into the role of the neonatal nurse practitioner showed that this post existed in some units in Canada and the United States and that appropriately trained nurses could replace house officers with no reduction in standards of care. It is not documented as being established in Great Britain, and we are uncertain to what extent practices exist, which fringe on the edge of this role in extended duties of the nurse in neonatal units. Two members of the executive committee of the Neonatal Nurses Association are currently undertaking a national survey of the practice and views of members on this development.

The introduction of this role raises many questions that require deep thought and careful assessment to ensure neonatal care is not compromised. If this role is integral to the future of neonatology, as our medical colleagues have suggested, we must consider the safety and effectiveness of such a role and the method by which it could be introduced. But we must first identify the current dilemmas, which pose grave difficulties for this speciality and are a matter of mutual concern in the United Kingdom.

During the past decade the face of neonatal care has changed dramatically. As medical and scientific understanding of the newborn has increased, the complexity and scope of newborn intensive care has demanded more versatile nursing practice and knowledge. Larger numbers of trained neonatal nurses are required to maintain the quality and continuity of care. Staffing neonatal units with discontinuous nursing resources is now the most persistent and critical area of concern to senior nurses. There is wide recognition of problems needing to be addressed as a matter of urgency. These include inadequate nurse establishments, failure to fill establishments, short tenure posts, and retention difficulties, and a lack of training places. Chronic understaffing has resulted in disproportionate nurse:baby ratios, and frustration in role satisfaction. Continuing education and the meeting of training needs is a major shortfall within the speciality. Many senior nurses lack time for nursing developments, research, and creativity in their chosen field.

The starting point must, therefore, be to provide quality care by trained neonatal nurses, albeit to the level recommended by British Association of Perinatal Paediatrics and the Neonatal Nurses Association. To introduce the neonatal nurse practitioner without the safeguard of adequate numbers of trained nurses may impose limitations in delivering sound nursing care. In preparation for a new role it would be important to determine and set our own professional standards and workloads and estimate our own staffing needs. This will entail reappraising use of trained neonatal nurse activity and using a greater proportion in direct patient care, teaching and training, and so forth. We need to consider the place of a consultant neonatal nurse to make nursing decisions regarding the care of the baby, in conjunction with medical decisions. Then, if we are in a position to welcome this role, we must ask questions of our medical colleagues and ourselves: Do we need it? Do we want it? What will be the depth of the role? Technician or Clinician? Will it entail exercising judgment and independent decision making? Who supervises? What place in unit structure, and what type of unit? How do we make up the deficit in trained neonatal nurses? Would it erode training of junior doctors? What update will be required?

A nurse technician who attains competence in technical skills in some invasive procedures is feasible in the current nursing framework. If, however, we are considering a medical change in the traditional delivery of neonatal care, with the introduction of nurse clinicians, we must identify their training functions and practice. We would need a national standard training curriculum at approved centres. The programme must consider the deficit in the basic educational background of nurses and establish a scientific foundation in pathology, physiology, biochemistry etc. To ensure clinical competence skills, and ability to make decisions, the nurse would need supervision and support by senior medical colleagues. Assuming he or she is proficient and the role is beneficial, it must be ensured that this proficiency is maintained.

Neonatal nursing is still in its infancy—in making changes we must be sure we do not lose the few nursing advances we have achieved and are endeavouring to achieve. In the words of John F Kennedy, 'When it is not necessary to change, it is necessary not to change.' If, however, change becomes inevitable, we must move forward with caution.

Presented to Neonatal Nurses Association, October 1986.

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## Assessment of child abuse

Sir,

Your recent correspondence includes debate on the case conference, the basic instrument of child abuse assessment recommended at Tunbridge Wells. A more pertinent topic might be the scenario after deregistration.

Unless one hears anachronistic 'go-it-alone' philosophy as in *The Swing of the Pendulum*[1] or the rejection of case conference by the Society of Clinical Psychiatrists, medical megalomania masquerading as purist ethic[2] may go unchallenged. Even if one takes the arguments of Drs Chapman and Woodmansey seriously, it is neither practical for child psychiatrists to take the central role regularly, nor acceptable that they decry all multidisciplinary conclusions—perhaps not even attend case conference!

It is apparent that much child abuse care remains parent orientated[3] and that the persistence of far from 'good enough' parenting rather than physical trauma, accounts for the sad sequelae of the acute syndrome for the child, and a legacy of child abuse for the next generation.[4] The preoccupation of social work protocol is still with non-accidental injury and expedience, avoiding having too many names on the 'at risk' register, deregistering, and closing the case as promptly as possible—not only for logistic reasons—seemingly without much awareness of, or intention to break, the cycle of underlying emotional deprivation. The truth of the latter suggestion is seen at case conference in the absence of any regular account of the abusers' childhood experience of parenting and the facility with which grandparents are proposed to foster abused grandchildren. Completing the protocol, deregistration, leaves the child in a dangerous vacuum and encourages parents to evade consultant surveillance, while the passage of years reduces the role of the primary health care team and often sees the end of non-accidental injury and failure to thrive, which may be more related to the child's age than to therapeutic intervention; the child enters school, and, hey presto, his problem is no longer medical but educational. The hard data of growth charts and physical injury give way to the subtleties of conduct disorder and intellectual delay—the hiatus in professional contact leaves the educational team unaware, or perhaps unkeen, to pursue the key aetiological factor, continuing emotional deprivation.

A handicapped child with rubella embryopathy or cerebral palsy from birth injury at once enters a defined system of assessment and care, formally supervised into the school years. By contrast, a child with social handicap, called child abuse, is subject to a flurry of attention after non-accidental injury but very soon drifts into oblivion despite his probable permanent handicap(s). Perhaps rather than struggling to prevent social services departments prematurely deregistering children—perhaps even with a new baby imminent—one should see the paraphernalia of case conference and registration simply as a rather brief management interlude to be followed by further formal consecutive process, thus recognising the time scale of child abuse and the limited resources of social services departments?

The title 'battered child syndrome' has subserved its purpose. Debate on balance at case conference and training of professionals is less important than filling the vacuum after deregistration: let the educationalists emerge from their statementing libraries and give us a declaration of intent on child abuse; let their role be formally guaranteed.

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## Medium chain triglyceride diet in epilepsy

Sir,

Sills *et al*[1] provide further important information about the use of a medium chain triglyceride diet in epileptic children, but the value of their study would increase with answers to the following questions:

1 How common were seizures before treatment?
2 After what period of time did the beneficial effect of the diet become apparent?
3 Over what periods were the post-treatment seizure rates assessed?
4 Was there a length of time following which improvement on continuing the diet was unlikely?

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