Archives of Disease in Childhood, 1988, **63,** 103–109

Correspondence

Doctors and nurses in neonatal intensive care

Sir,

Drs Chiswick and Roberton seem to propose a new deal for neonatal nurses, but are they not really hoping to maintain doctors in the hospital service in the lifestyle to which they have been accustomed?[1] The fact is that all acute hospital services, not only neonatal ones, demand 24 hour care by trained, and that means permanent, staff. The idea that the primary function of our hospitals is the training of doctors is out of date and should be put to rest. What other service or industry in this country discards many of its workers at the moment when they have been trained and could be of the greatest value? It is not unreasonable to suggest that the staffing structure of the great Victorian voluntary hospitals is not applicable to hospitals in the twenty first century.

Reference

[1] Chiswick ML, Roberton NC. Doctors and nurses in neonatal intensive care: towards integration. *Arch Dis Child* 1987;**62:** 653–5.

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Sir,

The case for allowing nurses to assume some of the duties of medical staff in the intensive care baby unit could be put in a less circumspect way than by Chiswick and Roberton though perhaps less tactfully.[1] The problem of requiring more junior staff in a medical specialty than there are consultant posts eventually available for them is not new. Indeed it could be said to be an old tradition of United Kingdom postgraduate medical training. If this, for whatever reason, is no longer acceptable, the work of junior medical staff will either have to be taken over by additional consultants or by appropriately trained nurses.

Increasing the numbers of consultants is an expensive solution, condemning medical staff to a lifetime of working unsocial hours, and is a recipe for intractable personal rivalries within any one unit. On the other hand the sheer joy of employing nurses to do the work of junior medical staff would be boundless. A dedicated career nurse in such a position would avoid all the hassle of retraining medical novices every six months. She would work all hours, have no ambitions to replace the consultant, and by definition of work roles, she could not do so anyway. And on top of all that it would actually cost less money. To argue in this situation that the nurses' job would be more interesting is the kind of thing that gives male chauvinism a bad name.

Neonatal nurses could do worse than chat to their midwifery colleagues. Without the considerable practical skills and professional experience of midwives more obstetricians would have to be employed to spend their lives delivering babies at night, and daytime gynaecological practice would be under threat. Midwives have attained the level of practical indispensability that paediatricians would wish on their own senior nurses. Why then is there so much unrest among hospital midwives? And why so much talk of the days when they worked alone in people's homes?

Reference

[1] Chiswick ML, Roberton NC. Doctors and nurses in neonatal intensive care: towards integration. *Arch Dis Child* 1987;**62:** 653–5.

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Hospital medical staffing: achieving a balance

Sir,

Our fears about the future of women doctors in paediatrics were confirmed on reading the British Paediatric Association's response to the consultative document, *Hospital medical staffing: achieving a balance.* Despite the intake of female medical students having been around 50% for the last decade, there is still a disproportionately small number of women reaching senior posts in a specialty recognised as popular with female doctors. While welcoming an attempt to redress the now serious problem of hospital staffing and career structure, the proposed new non-training intermediate grade seems to offer indefinite routine and emergency work to help distribute the amount of time spent on call. Experience has shown that such posts lead to frustration and loss of commitment with a deterioration in standards. We recognise that such posts would be desirable for a few female doctors but as members of the Medical Women's Federation we thoroughly agree with their policy, which is to advise any doctor strongly against taking one of these positions, though it may appear attractive in the short term at a time of heavy domestic commitments. Adequate part time training opportunities in posts equal in quality to those filled by full time doctors would serve the needs of these women better and lead to a higher standard of care in hospitals. Later they would be able to make a

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