Neonatal practitioners—a view from pernicious Albion?

the US, NNPs are financially viable because they enable hospitals to accept more patients, and therefore more funds, than would be possible if there were no NNPs. In contrast in the UK health system there is no such financial incentive to the introduction of NNPs. Indeed, many hospitals would regard any potential increase in patient load to be a good reason for not introducing NNPs as this would impose a financial burden on the institution.

Funding limitations certainly constitute an important reason for the inertia and relative indifference with which the concept of NNPs has so far been greeted in the UK but there has also been a widespread scepticism among neonatal nurses themselves concerning the advantages to the patient of extending the role of the nurse. There has been, therefore, no formal development of the extended role of the neonatal nurse in the UK and the visiting team had no previous direct experience of NNPs. With these considerations in mind we hope that the following observations will be regarded, not as criticisms, but as areas that we would hope to develop after the introduction of our own NNP training programmes.

It was implicit, although not always overtly stated, in most of the conversations that we held with both nurses and doctors that the care delivered by NNPs was undoubtedly superior to that of most first and second year residents and, in some cases, at least equivalent to that of third year paediatric residents and even fellows. This is hardly surprising given the negligible previous neonatal experience of most newly qualified doctors and the parsimonious allocation of time for neonatal training given to new residents in neonatology. The surprise, perhaps, lies in the fact that, in those hospitals in which NNPs and paediatric residents coexist, there remains such a well demarcated separation in the training of NNPs and residents. Having witnessed the impressive benefits afforded by the introduction of NNPs we feel moved to ask: why are paediatric residents in both the UK and the US still not accorded the benefit of a period of training equivalent to that of NNPs before they are required to assume a degree of clinical responsibility, and to undertake intricate practical procedures, for which they are not adequately prepared? There are precedents for such periods of clinical training in the UK, notably in anaesthesia. Perhaps the answer lies in the financial implications involved in such a development.

In comparing the US with the UK there are important differences in medical staffing arrangements in neonatal units. First, the paediatric residents in the US—senior house officer equivalents—usually spend only one month at a time employed in the neonatal unit and, in accordance with recently revised guidelines, may receive a maximum of three to six months exposure to neonatology during their three year residency programmes. In contrast, paediatric senior house officers in training in this country are often employed continuously for six months and may spend longer at this level. Second, the clinical role of middle grade staff in the US—fellows—seemed to be less well defined in comparison to their UK registrar equivalents, particularly as there is now a requirement that fellowship programmes should emphasise training in research. Finally the ‘attending’ neonatologist in the US tends to be more actively involved in the day to day running of the unit than his UK consultant counterpart, at least in many non-regional centres. There are also important differences in the training and functioning of neonatal nurses: there is no equivalent to the English National Board postregistration 405 course in the US and the training of staff nurses is probably less comprehensive than that of nurses who have completed the 405 course in this country. Such differences may be relevant to the way in which NNPs are incorporated into the UK system and it is possible that a different type of NNP may evolve in this country.

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7 Cassady G. Through the looking glass—or, look before you leap. Pediatrics 1982;70:1001–3.

Commentary

The concept of the neonatal nurse practitioner (NNP) has been the focus of much informal debate within neonatal units, with a wide variety of opinion and support for the concept obvious. It is apparent from listening to these
discussions that a clear definition of an NNP does not exist. The major difficulty seems to be in confusing the extended role of the neonatal nurse with that of the NNP currently employed in neonatal units in the US and using the all embracing term of NNP to apply to both roles. The English National Board (ENB) describes the nurse practitioner as a nurse who has completed a course after basic training such as the ENB 405, and is encouraging development in curricula that includes extended practical skills traditionally associated with junior and middle grade medical staff, such as the siting of intravenous infusions, emergency resuscitation, and elective intubation. The emphasis is on practical competence rather than clinical diagnosis. This role would be more clearly defined as extended or expanded role. It appears within the grasp of current educational provision and established local management structures concerned with extended role nursing practices. The role of the NNP in the US describes the neonatal nurse functioning at a level similar to our middle grade medical staff, having a clinical caseload with responsibility for clinical diagnosis and management as well as extended practical competence.

Until these two clearly very different roles are recognised I feel there is a danger that local development will produce NNPs of varying levels of training and skill. This could compromise both medical and nursing staff as well as patients. The concept of an individual taking on a role of middle grade medical staff on a long term basis is an attractive one. The result would be an increase in depth of knowledge and practical skill and so would enhance the quality of neonatal nurse provision.

If this is the development neonatal nurses chose to pursue I feel it is imperative for a national body to be responsible for the standard of courses leading to this qualification. These courses should be at master’s degree level, which implies a minimum of one year duration. This level of education is essential to equip nurses to function in this role. If no national body has control over courses, nurses could be placed in a position that makes them unemployable in any other neonatal unit outside those linked with their training institution. This would represent a waste of financial resources and place a severe restriction on nurses’ career development and mobility. Consideration needs to be given to the increased nursing hours needed to make up the loss of nursing cover once provided by the new NNPs and that the workload of NNPs is not such that similar problems arise to those of the present junior doctors.

There does appear to be many highly motivated neonatal nurses keen to develop this role and the quality of neonatal provision would undoubtedly improve with the development of this role. Whichever professional group takes on this role a national initiative would seem the only way to ensure the strength of the concept surmounts this potential organisational weakness.

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