The role of the resident consultant in neonatology

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Medical care of neonates has traditionally been delivered largely by doctors at different stages in their training, with widely varying degrees of competence and experience.

One of the themes of the NHS plan published in 2000 was the move to a consultant-delivered service[1]. The important role of the consultant in providing effective and high quality services within the NHS was highlighted in the Darzi report[2]. This emphasis for quality in healthcare delivery has also contributed to the recommendation by Royal Colleges and the British Medical Association for a consultant-based service with more 'hands-on' care being provided by trained doctors[3,4]. There are many arguments that have been put forward to support this model of delivery of care. These include improved level of care and patient safety, better supervision and training of junior doctors, and smoother running of the service outside the working week hours[5]. However, there has also been considerable debate regarding how this model of healthcare delivery could actually work in practice[6].

I am one of five recently appointed resident consultants in neonatology at St Mary's Hospital Manchester. I have been in post for ten months and would like to share my experience of the role. The day-time clinical responsibilities of resident and non-resident consultants are similar. These include ward rounds, 'hot week' in intensive care and out-patient follow-up of babies admitted under the respective consultant. In addition, other responsibilities include appraisal, involvement in governance, teaching and training, continuing professional development, research, management and service development. Out-of-hours and night cover of the neonatal unit is delivered by the resident consultant along with a team of junior doctors including one registrar (ST4-8) and three ST1-3 grade doctors.

Being a busy tertiary referral centre, we have some of the sickest, smallest and most vulnerable babies admitted to our unit. There is a high throughput and at times, the unit is extremely busy. When an unwell or very preterm baby is admitted to the unit, in most instances, the overall care and management is taken over by nurses and junior doctors. The role of the consultant is generally that of support, guidance and troubleshooting. It has been suggested that a 24-hour consultant-delivered service would have a positive impact on patient care and safety. An article describing the experiences of a 24-hour resident consultant service in obstetrics in New Zealand reported a subjective improvement in care with better organisation, planning and critical assessment of emergency cases[5]. Having this level of senior support at all times of the day can be extremely reassuring to both medical and nursing staff as well as parents. Finally, the presence of a consultant available to update parents shortly after their baby has been admitted to the unit or when there has been a deterioration, has a positive impact on parental experience.

Many junior doctors including senior registrars have commented on the advantages of having a consultant physically available throughout the day, particularly during an emergency or complex situation. Having someone senior around, makes it easier to discuss various aspects of management, at any time. Some registrars report hesitating before phoning a consultant at home in the middle of a night for something which they consider 'trivial' but nevertheless would appreciate an opinion on. Sometimes, more than the advice we offer, it is the opportunity to discuss aspects of management which is considered easier face-to-face or by the bedside, rather than over the telephone.

We have to, however, balance this with the relative loss of autonomy that some registrars feel by the constant presence of a consultant. Historically, many doctors in training have valued the independence provided by night shifts when they were 'the most senior doctor on the floor' using the input of non-resident consultants mainly in the form of advice. The value of independent decision-making and management in the training of junior doctors cannot be understated. It is very important therefore that a balanced approach is taken whereby registrars continue to be able to make independent decisions while feeling well-supported and supervised.

Being present on the unit, particularly after hours, does provide resident consultants with increased contact time with juniors. I have found that with the shift system junior doctors work in, there are more opportunities outside the normal working hours for direct observation of practical procedures, appraisals, supervision and providing feedback. In addition to the traditional ward-round based teaching and formal teaching sessions, evenings and nights provide opportunities to undertake teaching in various forms – case-based discussions, small group teaching sessions and membership practice sessions.

The nursing staff in our centre report feeling better supported, by consultant presence out-of-hours in the event of an emergency. They have also commented on the benefit of having face-to-face discussions and negotiations on bed management and admitting issues particularly at night.

From a personal perspective, many of us are attracted to the practical skills involved in neonatology. Being physically present on the unit makes it easier for junior staff struggling with certain procedures to seek help earlier. This in turn helps to keep our practical skills fresh. Some senior consultants have felt that when resident, they were performing jobs more appropriate to the skills of a registrar, particularly when the latter were busy[5]. Many hospitals have ongoing difficulties with junior doctor recruitment and particularly if the middle grade tier is made up of less experienced doctors, this issue may be a deterrent for many consultants or trainees interested in this role.

Being resident gives us a lot more free time during the week. Our current work pattern ensures a healthy balance of work and time off. Adjustment to daytime sleeping, particularly for those with young families, can prove difficult but the rota accommodates sufficient breaks following night shifts.

In summary, improvement in aspects of patient care, better support of medical and nursing staff, maintaining personal practical skills, and having more time off work during the week, are some of the advantages of providing a resident consultant service. Personally, having done the job for close to a year, I continue to enjoy the role and the opportunities it provides. However, consideration should be given to whether resident shift working will still be appropriate for neonatologists as they progress through their career, particularly when the duties are regularly intense. The financial, organisational and logistical implications of developing and maintaining this service have to be carefully evaluated if it is to be viable and realistic and at the same time provide job satisfaction in both the short and longer term.

Four consultant neonatologists at St Mary's Hospital, Manchester, who work a modern job plan. From left Dr Minju Kuruvilla, Dr Michelle Parr, Dr Mo Sarwar and Dr Karthik Ganesan.

References

1. **The NHS Plan.** A Plan for Investment. A Plan for Reform. London: Stationary Office. 2000.
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3. **Royal College of Paediatricians and Child Health.** RCPCH guidance on the role of the consultant paediatrician in providing acute care in the hospital. May 2009.
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5. **Edmonds S., Allenby K.** Experiences of a 24-hour resident consultant service. *The Obstetrician and Gynaecologist*. 2008; **10**: 107-11.
6. **Dixon J., Dewar S.** The NHS Plan. As good as it gets – Make the most of it. *BMJ* 2000; **321**(7257): 315-16.

Letter to the Editor

Re: Awareness of preterm infant's behavioural cues

Dear Editor

Linda Hannah in her paper in the May 2010 issue of *Infant* about behavioural cues[1], raises an important point about the gap between knowledge and practice. During our workshops on behavioural observation we ask doctors, nurses and therapists to watch infants at the bedside for periods of 10 to 15 minutes and to think about the impact that the environment (bedding, light, noise etc) has on them. Invariably participants tell us they have never actually stood and just observed a baby before and that what they see is a revelation. Knowing what behavioural cues are on paper is not the same as recognising them in real life, being able to make an appropriate response, and to pass that skill on to others. To become skilled at observing the complex behavioural patterns that occur during caregiving, and recognising their significance, takes many hours of practice and coaching over months or even years as anyone who has undergone NIDCAP training will confirm. It is not easy, and observing can raise painful emotions. Some people are intuitively better at it than others, which in part could explain the negative peer pressure that the author refers to. Parents can become expertly attuned to their baby's behavioural repertoire but may need staff to affirm their observations; when they notice that some staff are more sensitive to their infant's cues than others this can cause tension.

We would agree that without opportunities for proper training it is not surprising that staff lack the confidence to implement cue-based care, and also to manage changes in attitudes and aspirations in the team so that this can become a normal part of care.

Reference

1. **Hannah L.H**. Awareness of preterm infant's behavioural cues: a survey of neonatal nurses in three Scottish hospitals. *Infant* 2010; **6**(3): 78-82.

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