Fetal medicine training for neonatal trainees: a national survey

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Integral to the role of a neonatal consultant is antenatal consultation of parents-to-be when there are fetal concerns or anomalies. With an increasingly full curriculum and with the majority of neonatal posts being busy and time pressured, we were concerned that exposure to fetal medicine counselling and training was insufficient for many trainees to feel prepared for this as a new neonatal consultant. We aimed to gain a snapshot insight into exposure to fetal medicine and readiness for this role among neonatal subspecialty trainees in the UK.

In September 2018 an electronic survey was circulated by email to trainees on the subspecialty mailing list. The survey was anonymous and comprised 10 questions to collect quantitative and free-text qualitative information about exposure to fetal medicine and confidence with counselling.

There were 34 responses and 60% were from senior trainees (ST7/ST8) (**FIGURE 1**). All of the respondents had greater than four months' tertiary neonatal experience. The main findings of the survey were:

- 64% rated their exposure to fetal medicine training so far as 'average' or 'poor' (**FIGURE 2**)
- often experience had been arranged by individuals and/or undertaken in their own time
- everyone expressed interest in attending fetal medicine clinics
- many were also keen to attend fetal medicine/neonatal multidisciplinary meetings, as well as educational sessions such as local lectures or external courses focusing on counselling
- observing senior colleagues undertaking counselling was considered the most valuable educational opportunity
- lack of structured opportunity and difficulty with release from the busy clinical environment were cited as common hurdles to learning.

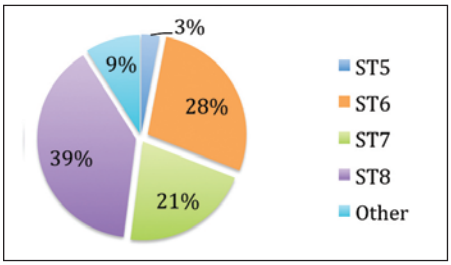

FIGURE 1 The training level of respondents.

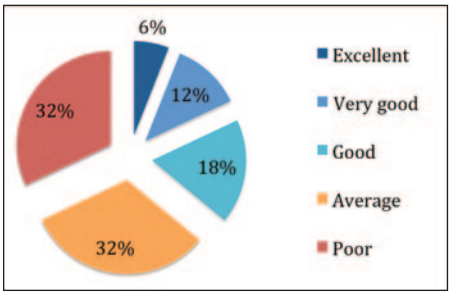

FIGURE 2 How neonatal trainees rated their exposure to fetal medicine.

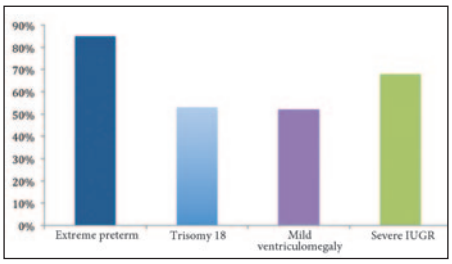

FIGURE 3 Neonatal trainee confidence in counselling parents about various fetal conditions (average score).

Confidence with counselling

We asked how confident the neonatal trainees felt at their present stage of training to counsel families regarding a variety of fetal conditions (**FIGURE 3**). Predictably, trainees were far more confident counselling families with a baby with severe intrauterine growth restriction (IUGR) or threatened preterm labour – conditions more commonly seen and for which counselling is often delegated to trainees. This was compared to the less common conditions of trisomy 18 or mild ventriculomegaly, which would usually require antenatal consults with a neonatal consultant.

Some comments made in the survey can be seen in **FIGURE 4**.

It has been challenging to attend fetal medicine clinics

Only as a medical student

We need more exposure. My experience is that it is not prioritised as a topic

The training could be improved, as at present each trainee's experience of exposure to cases is likely to vary significantly

I have worked in big centres and had great exposure – as much as the rota permits

We need some please – ASAP!

No clear pathway. It takes time to build up relationships with obstetricians in each new trust and there is no time dedicated to this in our rota so it is quite difficult to organise yourself

The fetal medicine units are busy and the NICU is also extremely busy so there is limited time to spend on fetal medicine

MRI meetings only. No attendance at clinics

I arranged to attend a few fetal medicine clinics over the last six months…otherwise I would have had none

Simulation is great

Very limited, none formally organised, all self initiated

There should be some protected time or allocated slots to attend and observe consultants during fetal medicine clinics. Observe, learn and practice

Little or no clinic experience

I have made a lot of my own arrangements

Get involved and seek out opportunities. There's heaps of opportunity even at times when you are not based at the specialist fetal medicine centre

I have made a concerted effort to get training. It is not built in and I have done a fair bit in my own time

FIGURE 4 Comments from neonatal trainees about their fetal medicine training.

Conclusion

In summary, the results of our small survey suggest that among neonatal subspecialty trainees, the level of experience in fetal medicine and antenatal counselling is inconsistent and confidence is generally lacking. This seems to be as a result of variable opportunity to learn about fetal medicine and develop counselling skills. More emphasis on the importance of developing this knowledge and these skills during subspecialty training is required to highlight the issue among trainees as well as neonatal and fetal medicine consultants.

Greater support is needed to facilitate protected time for attendance at fetal medicine clinics, multidisciplinary team meetings and to accompany senior colleagues to observe counselling sessions. Ideally, there should be structures in place to support trainees to seek out and maximise local opportunities to learn while more formal teaching sessions are established and embedded into both local and national training.

It is in the interest of patients, current neonatologists and fetal medicine consultants that the neonatologists of the future should feel equipped to confidently support obstetric colleagues and families. This will be of growing importance in this era of earlier antenatal detection of anomaly and the ongoing evolution of neonatal intensive care.

PATIENT SAFETY

Oral sucrose vials and the risk of choking

infant PATIENT SAFETY *Working together*

NHS England and NHS Improvement Patient Safety have passed on information about the risk of twist off caps from oral sucrose vials inadvertently falling into the mouths of infants and causing a choking hazard.

In the trigger incident, a baby admitted with bronchiolitis was being treated for the condition but was showing a gradual deterioration. A decision was made to transfer the baby for intubation. As the procedure commenced, inspection of the oropharynx revealed a plastic object. This was removed prior to intubation and it was noted that it appeared to be the cap off a sucrose vial.

Oral sucrose is a mild analgesic that is effective in decreasing short-term pain and distress during minor procedures. Small amounts of oral sucrose are placed on an infant's tongue to reduce procedural pain.

Points for consideration:

- Are these products used in your organisation?
- Are staff aware of this risk and if so how is it managed?
- The individual ampoule lids are transparent so potentially easy to lose and miss in a patient's mouth, particularly in a high-stress situation.
- A sucrose cup might appear to present no risk from ingestion, however the solution will require drawing up in a suitable receptacle such as an oral syringe. This could be left unlabelled at the patient's cotside, which may lead to further risk of wrong route error or infection control issues if used multiple times.

Join us to help improve patient safety

British Association of Perinatal Medicine

In collaboration with BAPM, *Infant* journal is keen to help improve patient safety and raise awareness of issues affecting neonatal patients, their families and staff by devoting a specific section to patient safety in each edition of the journal. Anyone can submit an article so if you have ideas for highlighting safety aspects to improve care, please do let us know.

- Have you implemented an initiative locally which has demonstrable benefits for improving safety?
- Are you developing a new initiative which might benefit from a wider application?
- Do you have experience in any human factors-related improvement that you'd be able to share?

If you would like to submit a patient safety article to *Infant*, please email lisa@infantjournal.co.uk

If you have any incidents for national learning, please contact BAPM by emailing bapm@rcpch.ac.uk