Harmony in the NICU

Neonatal intensive care units (NICUs) are stressful places for both parents of babies and health professionals. Most junior doctors in NICUs are competent and find their neonatal experience enjoyable and beneficial to their career. The name neonatal intensive care unit emphasizes that the focus is not only INTENSIVE, in terms of trying to cure the critically sick babies, but that our approach is one of saturating the electronic and print media, we read with interest the recent articles on the promotion of well being amongst doctors, and a Lancet editorial on bullying amongst health professionals.1 Workplace bullying is “the deliberate, repeated, harmful mistreatment of one person (the Target) by a perpetrator (the bully) whose destructive actions are fuelled by the bully’s need to control the target.” The incidence of bullying ranges from 5% amongst doctors and nurses in Finland1 to 80% for Australian nurses.2 These findings may be signals of widespread distress amongst doctors and nurses calling for remedial action.

We have noted with interest that there has been no escape during the long, exhausting night shifts either. The choice is then between accepting sarcasm or public humiliation depending on whether seniors have to come in or not and the reactions of the onlookers. In a faculty where 27% of the consultants and 32% of nurses have been reported to have psycho-emotional dysfunctions, it may be very difficult to sound the icebergs of workplace bullying in neonatology.3 The only ray of hope is a mentor who comes to the aid of the student and combines humanity with science during supervision of trainees.1

References


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POSTSCRIPT

LETTERS

Bullying in neonatal intensive care units: free for all

The increasing recognition of bullying (mobbing) at workplaces has resulted in the need for more evidence of this occupational hazard—immune to the professional status and difficult to define. Neonatal intensive care units probably represent the Antarcctic, if the commonly repeated phrase in relation to bullying at workplaces is “What happened to me is just the tip of the iceberg”. As places expected to function like a military base but run by civilians, such units probably provide the best training grounds for bullying under the disguise of legitimate management actions or “manifestation of work related stress”. Given the abundance of potential victims and the high prevalence of risk factors like technical-clinical inexperience, isolation, long shifts, and fatigue, it is not surprising that bullying of the new trainees is rampant in neonatal nurseries. Sadly, I have been a silent witness over 17 years to the devastating effects of bullying on the junior staff (especially the registrars) almost on a daily basis in neonatal nurseries. I have lost track of the number of trainees who resigned, lost self esteem, and developed a strong dislike towards neonatology due to constant bullying disguised as “constructive criticism” at work. Morning rounds provide the most common opportunity for professional humiliation of the registrars in neonatology. However, there is no escape during the long, exhausting night shifts either. The choice is then between accepting sarcasm or public humiliation depending on whether seniors have to come in or not and the reactions of the onlookers. In a faculty where 27% of the consultants and 32% of nurses have been reported to have psychological dysfunctions, it may be very difficult to sound the icebergs of workplace bullying in neonatology.3 The only ray of hope is a mentor who combines humanity with science during supervision of trainees.1

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contrast radiograph of the femoral catheter showed extravascular spillage of dye, in this case in the extraperitoneal space. In retrospect, the infant showed no rise in haemoglobin after two packed cell transfusions. Extravascular migration of the catheter tip was diagnosed and the catheter was promptly removed.

Case 2. A 24 week preterm female infant was admitted to the neonatal intensive care unit where she was ventilated and treated with surfactant. Severe respiratory distress of the infant showed no rise in haemoglobin after two packed cell transfusions. Extravascular migration of the catheter tip was diagnosed and the catheter was promptly removed.

Case 3. A 28 week preterm infant with a PICC in the leg developed a skin abscess at the site of the catheter. The infant showed no rise in haemoglobin after two packed cell transfusions. Extravascular migration of the catheter tip was diagnosed and the catheter was promptly removed.

In each of these case reports, femoral catheter tip migration was detected after extravascular extravasation of blood or parenteral nutrition fluid. Haemoperitoneum has been reported in the past as a complication of central catheters but may not be widely recognised. In comparison with PICCs, these catheters are shorter and more rigid, hence more likely to perforate the vessel wall. Femoral venous access is readily obtained in infants and is commonly used in intensive care units for parenteral nutrition, maintenance fluids, blood transfusions, and other parenteral treatment. Although malpositioning of a femoral catheter is readily detected in most instances during placements, spontaneous extravascular migration of a previously well placed catheter tip is possible in some cases. As opposed to frank rupture of the blood vessel and haemorrhage into the retroperitoneum, slow extravascular infusion of blood in the low resistance extraperitoneal space may not be promptly detected in the absence of a high index of suspicion. In preterm newborns and malfonnoured infants, the integrity of the vessel wall may be compromised, and migration of a previously normally positioned catheter tip may be more likely. Femoral venous catheter tip positions must be reviewed in all cases of unexplained ascites and abdominal distension. Contrast radiography, digitalised image inversion, and ultrasonography have a role in determining catheter tip position and diagnosing malpositioned intravascular catheters.

We agree with the DoH recommendation that there should be a prospective national audit of such cases.

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References
from displacement of a portion of a water phase of the plasma by lipid. This problem (which may be observed with flame emission spectrometry) can be avoided by using a sodium selective electrode without dilution. The problem may be observed with flame emission spectrometry and can be avoided by using a sodium selective electrode without dilution.

Hyperglycaemia and hypertriglyceridaemia are common in extremely low birth weight (ELBW) neonates—the group at highest risk for chronic lung disease (CLD) and symptomatic PDA. The incidence of hyperglycaemia in very premature neonates ranges from 20% to 86% and is at least 18 times greater in ELBW neonates. The consequences of chasing such spurious hyponatraemia in neonates at risk for CLD and PDA cannot be overemphasised.

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References

BOOK REVIEW

Monographs in Clinical Paediatrics: Neonatal Jaundice.

This monograph is a useful summary of the problem of significant hyperbilirubinaemia in the neonate with full description of the biochemical and pathophysiological aspects of the condition. Each of the subjects is also dealt with from a historical perspective, which provides considerable interest. I was particularly interested to note that the first ever exchange transfusion performed on a jaundiced child (five previous children had died of bilirubin toxicity) is described as “transfusion and exanguination” via the saphenous vein and sagittal sinus respectively; this was carried out as a continuous exanguination/transfusion. Since that time, many techniques have been used, although the approach to the sagittal sinus via the anterior fontanel is no longer practiced. Interestingly, although other continuous techniques have been developed they are now rarely used; there is a common preference for a “in/out” technique.

In the chapter on The Clinical Approach to the Jaundiced Newborn, the algorithm of the American Academy of Paediatrics is reproduced. I was particularly interested to look at the approach to persistent jaundiced and was disappointed to find that the only advice given for jaundice persisting more than three weeks was to “perform appropriate physical and laboratory assessment of infant including possibility of cholestatic jaundice” when it had already been established that the infant did not have abnormal physical exam results, dark urine, or light stools. In my view, the demonstration of normal levels of conjugated bilirubin at this age is sufficient to rule out significant liver disease, which requires further management.

There is an interesting discussion of whether total or unconjugated bilirubin should be measured in assessing risk for kernicterus. The surprising conclusion (supported by anecdotal case reports) is that conjugated bilirubin should not be subtracted from the total unless it exceeds 50% of the total, when there is some evidence that even conjugated hyperbilirubinaemia may contribute towards kernicterus in the presence of a high total bilirubin.

I conclude that this is a useful reference text and an excellent source of definitive information, but it is unlikely to find its way to the benchbook section of the neonatal library.

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