M Didi

Endocrinology Department, Royal Liverpool Children's Hospital Alder Hey

Correspondence to: Dr S M Ng, Endocrinology Department, Royal Liverpool Children's Hospital, Alder Hey, Eaton Road, Liverpool L12 2AP, UK; ngszemay@yahoo.com

doi: 10.1136/adc.2005.091264

Competing interests: None declared.

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Neonatal resuscitation in Italy: an ethical perspective

The attitudes of doctors and nurses toward neonatal resuscitation have been described previously.¹ However, the studies were conducted before the publication of the last versions of the official international guidelines for neonatal resuscitation, in which, for the first time, some practical indications related to the ethical aspects were reported.^{2,3}

We aimed to survey the practice and the approach to neonatal resuscitation in Italian tertiary centres from an ethical perspective.

A structured 73-item questionnaire and an accompanying introductory letter was sent by email to the heads of the 86 tertiary centres provided with on-site delivery.³ The questions included multiple-choice, fill-in and yes/no questions.

Information was obtained from 76 (88.3%) centres. In all, 38 (50%) units had a written protocol for deciding the management of the ELBWI in the delivery setting and 45 (59.2%) centres declared referring to a specific gestational age (mean ≥ 23 , range 22–24 weeks) or birth weight (mean ≥ 400 , range 350–500 g) for initiating full intensive care. In 2002 at the surveyed centres, the lowest mean gestational age and birth weight at which an ELBWI received full resuscitation were 23 (range 20–27) weeks and 480 (300–750) g, respectively.

Figures 1 and 2 show the choices of the head doctors (and their colleagues) when faced with the birth of an extremely premature infant. In these situations, the final therapeutic decision is routinely taken by the attending doctor (47.9%) or by the obstetric-neonatal team (52.1%). The head doctors of the Italian III level centres consider that in their centre, the feeling among the doctors facing the birth of an extremely premature infant is considered: low (11.1%), sufficient (32%), good (54.1%) and very good (2.8%). Hospital ethics committees at 21 (27.6%) centres play a part in decision making for individual cases.

When confronted with a full-term infant with cardiorespiratory arrest (Apgar score 0),

Figure 1 Decision-making in the delivery room. A woman starts labour at 23 complete weeks of pregnancy. No fetal distress is detected and the baby's weight is estimated as 500 g. At birth, Apgar score at 1 minute is 1. Would you: (a) resuscitate the baby and start intensive care even if you knew that, once started, intensive care would not be withdrawn whatever the prognosis; (b) resuscitate the baby and start intensive care, provided that intensive care can later be withdrawn if the baby's prognosis appears poor; or (c) withhold resuscitation.

Figure 2 Decision-making in the delivery room (see fig 1). In this case, the parents' wishes would influence the therapeutic choice

discontinuation of resuscitative efforts is made after 10, 15 and 20 min at 16 (21.0%), 18 (23.6%) and 18 (23.6%) centres, respectively. A specific time for discontinuation of resuscitative efforts in case of severe asphyxia is not codified at 24 (31.8%) centres.

When confronted with the birth of a neonate with confirmed trisomy 13, 30 (39.4%) centres would start resuscitation and intensive care and 46 (60.5%) would give palliative care.

Although international guidelines were designed to standardise and optimise resuscitation in newborns,^{2,3} previous studies showed that deviations are frequent.⁴ From an ethical perspective, our data show that the adherence to neonatal resuscitation guidelines is low across Italian tertiary centres. When evaluating the approach to neonatal resuscitation, other factors, along with professional guidelines, have to be considered.

D Trevisanuto, N Doglioni

Paediatric Department, School of Medicine, University of Padova, Padova, Italy

M Micaglio

Department of Pharmacology and Anaesthesiology, School of Medicine, University of Padova

R Bortolus

International Centre on Birth Defects, Rome, Italy

V Zanardo

Paediatric Department, School of Medicine, University of Padova, Padova

Correspondence to: D Trevisanuto, Paediatric Department, University of Padova, Via Giustiniani 3, 35128 Padova, Italy; trevo@pediatria.unipd.it

doi: 10.1136/adc.2005.092627

Competing interests: None.

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Presence of parents during ward rounds: experience from a Greek NICU

We read with interest the paper by Bramwell *et al*¹ and we would like to add our experience on this issue. An unrestricted visiting policy has been practised at our neonatal intensive care unit (NICU) since the early 1980s. Even now, this is the only unit practising unrestricted visiting among the 15 NICUs in Greece. Initially, parents were present during ward rounds. However, several things became apparent:

1. During ward rounds, parents present were trying to overhear what was discussed about their baby. It was also evident that they could neither understand the medical jargon that was used nor fully appreciate what had been discussed. This had often led to misunderstandings regarding their baby's true condition. These erroneous perceptions had to be corrected and explanations given by the medical staff. Also, parents seemed to fixate on numbers of laboratory results mentioned during the ward round, which again had led to erroneous perceptions regarding their baby's true condition.

2. Parents who had overheard medical discussions regarding other babies had sometimes contacted and informed the parents of the relevant baby. This on some occasions had created problems, with the particular parents receiving information in such a manner, and further explanations had to be given by the medical staff. Also, some parents complained that they did not wish other parents to overhear information regarding their baby.

3. Medical and nursing staff believed that the presence of parents had a restrictive effect on how the baby's condition could or should be discussed.