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Re: Palliation bias is being overlooked in neonatal hypothermia trials

We thank Ziinu for the comments on our review. We agree that there is a risk of bias when the intervention is unmasked and this may also influence the decision to withdraw intensive care. Indeed, this is one reason why studies have chosen a composite outcome measure that includes rates of disability, but we agree that this does not completely remove the possibility of bias. It is one reason why we advise caution in the interpretation of the reported results and why a meta-analysis of the current studies can only be speculative. The additional data from approximately 600 infants that are being recruited in ongoing studies will help determine the efficacy of therapeutic hypothermia more precisely. We need to await those results before therapeutic hypothermia is considered standard treatment for perinatal asphyxia.

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Falling rates of perinatal postmortem examination: are we to blame?

Information from a high-quality postmortem examination is the right of every parent after the death of their child.¹ Postmortem examination rates worldwide, however, continue to fall. Much of this decline has been attributed to changing societal views on postmortem examination, recent issues of organ retention, and evidence to suggest that parents or carers are less likely to give consent.²

Having reviewed our own practice, we hypothesised that rather than a decline in parental consent, clinicians were less likely to offer a postmortem examination. In November 2004, we carried out a semi-structured telephone interview of 60 consultants from 46 level 2 and level 3 neonatal units in England and Wales. There were three interviewers, and the interview took between 5 and 10 min to complete. Given the several clinical scenarios, ranging from an infant born at 23 weeks' gestation who could not be resuscitated at birth to a term infant with seizures and evidence of grade-III hypoxic-ischaemic encephalopathy, we asked

Table 1 Reasons for not offering a postmortem examination to all bereaved parents

Reason	Respondents (%)
Concern that the result might question your clinical judgement	2
Being uncomfortable with the postmortem examination process yourself	4
Recent cases of organ retention	9
The new consent form for postmortem examination	15
Concern that it might upset parents further	20
Availability of a perinatal pathologist	35

consultants in what circumstances they would offer parents a postmortem examination. We found that 60% of consultant neonatologists interviewed would routinely offer a postmortem examination in the event of every neonatal death.

Of the 40% who did not routinely offer a postmortem examination, more than half had a clear reason for why they did not (table 1). In all, 35% of consultants were not offering bereaved parents a postmortem examination owing to lack of availability of a perinatal pathologist; 37% of respondents thought that the perinatal postmortem examination seldom provided useful new information about a case (ie, in <25% of cases); 66% of consultants believed that with the new consent process, their discussions with parents were now more difficult because of the explicit nature of information shared from a postmortem examination; and 80% of consultants had received no formal training in obtaining consent for a postmortem examination.

Offering a postmortem examination and asking parents for consent after the death of their child is one of the most emotive and challenging areas in which neonatologists work. McHaffie *et al*⁴ in their study on parents, 3 and 13 months after the death of their child, showed that the biggest parental reasons for refusing consent to postmortem examination were the dread of the child being mutilated and a feeling that there were no unanswered questions. The perinatal postmortem examination, however, remains the gold standard for investigating perinatal death. With new information available in as many as 40% of perinatal postmortem examination,³ we owe it to the parents of babies who have died and to future infants in our care to be sure that we have the best explanation of why a child died. Our study suggests that 40% of consultants are not offering parents this opportunity. The lack of availability of a perinatal pathologist remains the biggest single reason why clinicians are not offering postmortem examination to all bereaved parents.

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Delay in screening premature infants for congenital hypothyroidism

Optimal management of congenital hypothyroidism (CHT) includes early diagnosis and prompt treatment.^{1–3} We conducted an audit over a 12-week period in 2002 to determine whether time of screening for CHT was in adherence to standards published by the UK Newborn Screening Programme. The minimum standards recommended for time of screening for CHT is 5–8 days of life.⁴

Screening for CHT was carried out at the Regional Screening Laboratory, Royal Liverpool Children's Hospital, Alder Hey, Liverpool, UK. During the study period, 6425 infants with complete data were included for analysis. In premature infants ($n = 591$), median age of CHT screening was 10 days compared with 7.6 days in term infants ($n = 5834$). In all, 25% of premature infants were screened at age ≥ 10 days compared with 8% of term infants ($p < 0.001$). Age of screening was significantly delayed in premature infants and the more premature infants seemed to have a greater time delay for screening ($r = -0.3$, $p < 0.001$).

The audit showed that premature infants are at risk of delayed screening for thyroid-stimulating hormone, which may have a marked effect on the neurodevelopmental outcome.^{2,3} This may be due to interhospital transfers, lack of prioritisation of the Guthrie test during management of sick premature infants or an intentional delay in obtaining blood spots to simultaneously obtain phenylalanine levels, which requires the infants to be fully enteral fed. Medical staff need to be educated on the importance of obtaining routine screening blood samples for CHT between day 5 and 8 of life in premature infants in accordance with standards recommended, regardless of clinical condition.

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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.

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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.