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INCOMPLETE DOCUMENTATION OF HIGH-RISK NEWBORN RESUSCITATION. Diana B. Doerr, Nan C. Sherman, August L. Jung. (Spon. by Lowell Glasgow). University of Utah Medical Center, Department of Pediatrics, Salt Lake City, Utah.

As part of an Outreach program to determine the need for continuing medical and nursing education, a chart review of high-risk newborns in community hospitals was undertaken. Part of the study evaluated recording of Apgar scores and initial resuscitation in the delivery room, assuming this critical period for any infant warrants compliance with accepted resuscitative standards followed by complete documentation in the record. 410 charts of high-risk infants born in 6 community hospitals (2 Level II, 4 Level I) have been reviewed. The high-risk population includes LBW infants, neonatal deaths, neonatal transfers and admissions to Level II ICU. Preliminary review indicates inadequate recording of initial assessment and resuscitative efforts following the birth of these high-risk infants. 92.7% of all charts had incomplete records of resuscitative measures. Absence of or incomplete recording of Apgar scores was observed in 16.1% of charts. Both 1 and 5 min Apgar scores were recorded in 83.9% of charts (344). Of these infants a total of 77.3% had an acceptable Apgar (> 6) by 5 min. This number seems to indicate that compliance with resuscitation standards may occur but, due to lack of documentation in patients' charts, it is difficult to evaluate. It is apparent there is need for continued outreach education, to increase nurses' and physicians' awareness of the importance of documentation of this critical period. Only when documentation of resuscitation is complete can true compliance of resuscitative measures with accepted standards be assessed.

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ACQUISITION OF KNOWLEDGE AND TRAINING NEEDS IN DEVELOPMENTAL PEDIATRICS. Paul H. Dworkin, Jack P. Shonkoff, Alan Leviton, Melvin D. Levine (Spon. by T. Berry Brazelton). Harvard Medical School, and Children's Hospital Medical Center, Division of Ambulatory Pediatrics, Boston.

Ninety-seven randomly selected, Board-certified, primary care pediatricians in 5 New England states were interviewed by 2 physicians to explore attitudes toward previous training and current sources of knowledge in developmental pediatrics. Formal training in development was rated as inadequate by 79% (statistically independent of year of medical school graduation); residency was viewed as highly valuable by only 30%, and 47% rated medical school as having no value. Although clinical experience was reported as a valuable source of knowledge by 99%, 63% did not regard it an adequate substitute for formal training.

Professional contacts were described as a highly valuable ongoing source of knowledge by 48%. Thirty percent reported weekly contact with a psychologist. At least monthly communication was reported with a neurologist (75%), learning disability specialist (60%), audiologist (51%), guidance counselor (45%), classroom teacher (44%), and speech pathologist (39%). Social class and size of practice did not correlate with differences in consultation patterns. Those practicing more than 30 miles from a medical center were more likely to have monthly contact with a physical therapist ($P < .001$) and guidance counselor ($P < .01$).

A part-time longitudinal clinical experience for further education was preferred by 97%. Improved training with greater interdisciplinary content is needed.

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MEDICAL STUDENTS AND THE DECISION MAKING PROCESS. Murray Feingold, Dept. of Pediatrics, New England Medical Center Hospital, Boston, MA

From 1974 to 1976 first year medical students were asked the following question: Should parents, parents and physicians, or parents' physicians, and the courts have the right to decide if the parents' profoundly retarded child with severe hydrocephalus and meningomyelocele, who has never talked, requires tube feeding, and is cared for in a nursing home, live or die as a result of their decision that treatment be given or withheld when an infection occurs? They were requested to answer yes, no or uncertain. After they made their initial decision, faculty members from Boston College Law School and physicians from the Genetic Service of the New England Medical Center Hospital discussed the pros and cons of the question. Following a discussion period the students revoted on the issue.

In 1974, 21 percent, and in 1975 and 1976, 23 percent of the students changed their original opinions. In all three years the most consistent change was from allowing parents to make the decision alone to sharing the decision making process with either the physician or the courts.

These findings are of interest because it emphasizes the uncertainty students have regarding such an ethical question. It also shows that a student's opinion is subject to change within an hour's lecture after receiving more information. Medical school faculty should always be aware of the significant role they play in formulating their students' opinions and should make a determined effort to present all sides of such an issue.

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RULES REGARDING ADMISSION TO HOSPITAL IN PEDIATRIC TRAINING PROGRAMS. Jane H. Ferguson, Joel J. Alpert, Boston U. Sch. Med., Boston City Hospital, Dept. Ped. Boston

The decision to admit a patient to hospital in pediatric training programs is often made by housestaff. Many institutions have developed rules to help housestaff avoid missing an indicated admission. To determine how common rules are, a survey was carried out by mailed questionnaire of the 434 hospitals that make up the 284 US Pediatric Training Programs. 48 hospitals were eliminated from the sample largely because of duplication. 82%(318) of the 386 surveyed replied and reported 910 rules or an average of 6.1/hospital with a range of 1-78. 47%(151) of the hospitals had rules. Rules were reported as verbal(55%), verbal or written (26%), or exclusively written(19%). Rules were more common when the hospital was urban(55%) as opposed to rural(30%); when the Chief Resident completed the questionnaire(73%) as opposed to the Program Director(42%); when the hospital had > 30 housestaff(62%) or when the daily average census exceeded 100(77%). Rules were grouped as administrative(6%), psychosocial(21%), specific diseases(50%), and specific symptoms(34%). Most common symptoms, often associated with age, were fever(14%), neurological(18%), and respiratory(17%). Rules appear to be an important part of the decision to admit especially in larger programs but at least half of those surveyed reported no rules. How rules actually contribute to the decision to admit either in training or later in practice requires further study.

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PSYCHOLOGICAL, SOCIAL, AND MORAL PROBLEMS IN PROVIDING PEDIATRIC INTENSIVE CARE, Joel E. Frader, (Spon. by Charles August), Univ. of Pennsylvania Sch. of Med. and Children's Hosp. of Philadelphia.

A pilot observational and interview study was undertaken to determine if the medical staff of a pediatric intensive care unit experiences difficulty working in an area noted for psychosocial and ethical ambiguity. It was determined that physicians focus their attention on data about patients rather than on patients directly. The team has little difficulty discussing or acting on technical matters. However, they have minimal patience for or skill with ethical dilemmas.

In interviews, 14 of 15 pediatric house officers praised the education in the unit. All 15 felt the unit was an especially difficult place to work compared to other areas of the hospital. Nine reported feelings of depression. Eight reported signs or symptoms of that disorder, including problems in relationships with spouses or friends, irritability, poor performance, as well as sleep and appetite disturbances. Twelve residents sought emotional support from peers or attending physicians to a greater extent than usual. The residents were especially bothered by frequent deaths, interactions with patients' distressed families, ethical problem solving, unfamiliarity with the unit's technology and drugs, and the work load.

The staffs of intensive care units are ill prepared for the variety of biomedical, emotional, and moral problems they encounter. More attention to psychosocial and ethical issues is likely to improve patient care and staff adaptation.

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WHO SHOULD MAKE THE ETHICAL DECISIONS IN MEDICINE? - A COMPARATIVE STUDY. Lanny Freshman, Bruce Dearing and Frank A. Oski. Dept. of Pediatrics, SUNY, Upstate Medical Center, Syracuse, New York.

Technical progress in the maintenance of life has forced the physician into making complex ethical decisions. One technique that has been proposed to assist the physician in making such decisions is the use of an advisory panel containing some individuals without medical training. Such a panel would offer advice prior to instituting a course of action. Inherent in this system is the belief that diversity of background provides greater objectivity. In order to test this hypothesis and to examine the effects of medical education on development of ethical attitudes, 6 panels were presented the same 5 ethical problems. The panels were: 4th year medical students, senior pediatric residents, pediatric faculty, pediatric nurses, and 2 lay groups. Ethical problems dealt with: active euthanasia, the rights of adolescents, quality of life, rights of the retarded, and parental involvement in critical care decisions. Results revealed a high concurrence of final recommendations among all panels although factors involved in the decision-making process varied. Medical panels made prompter decisions. Lay groups were more concerned with economic issues and had a greater acceptance of euthanasia. These findings suggest that personal beliefs and not medical training are more important factors in reaching a decision. The use of lay individuals may offer no advantage or alter recommendations.