Results: 37 deaths were identified in this period (excluded 3 cases- brain death). The CPR was not performed in 50% of children. In 10 of 17 patients not reanimated, the plan for LSL was not recorded in the medical charts. In 80% patients of the “no CPR” group, the vasoactive drugs infusion and ventilator parameters were maintained/increased without differences when compared to “full CPR” ($p=1,0$ e $p=0,6$). The nurse’s practices evaluated using NAS score in the last 24 hours of life didn’t differ even when the patient wasn’t reanimated. When nurses were asked about participation on EOL decision, only 30% confirmed it.

Conclusion: Brazilian studies have demonstrated that EOL practice has been a process centralized on the medical perspectives. We observed that nurses and medical attitudes before death didn’t change even when the patients were considered terminal illness and the nurses rarely participated on the decision making process.

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BENEFITS OF STRUCTURED MULTI DISCIPLINARY MEDICAL ETHICAL DECISION MAKING

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Background/aim: Until 2008, medical ethical decision making (MEDM) in the NICU lacked structure. Moral deliberation and effecting ethical decisions were not up to standard. A guideline to improve MEDM was developed, and evaluated one year after implementation.

Method: The guideline consisted of multidisciplinary meetings presided by an independent chair, and uniform preparation and report. Meetings were structured following a five phase model: 1) exploration, 2) agreement on the ethical question, 3) analysis, 4) evaluating possible solutions, decision-making, 5) planning actions. Initially, health care workers (HCW) of the NICU were trained in ethical/legal aspects and practiced the method with a historical patient case. Before the training, HCW completed a 15-item questionnaire on ‘structure’, ‘role participants’, ‘parental representation’, ‘problems, solutions and deliberation’, and ‘decisions and documentation’. One year and 22 structured meetings after introduction, the same questionnaire was completed again.

Results: Response before and after introduction of the guideline was 91/114 (80%) and 85/123 (69%) respectively. Nurses and physicians were equally represented in the two samples ($N=63/63$, and $N=19/14$; $X^2=.601$; $p=.438$). Evaluation of the guideline showed improvement in ‘structure of MEDM’ ($p<.000$ for all 5 items), ‘role participants’ ($p<.000$ for all 3 items), ‘parental representation’ ($p<.000$, for 1 item), and ‘problems, solutions and deliberation’ ($p<.000$, for 2 items; the 3rd item treatment options did not improve, $p=.932$). ‘Decisions and documentation’ showed no improvement (3 items, $p=.215$, $p=.412$ and $p=.066$ respectively).

Conclusions: Ethical deliberation significantly improved after implementation of structured MEDM. Ongoing attention will be paid to ‘documentation of the decisions’.

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SEMI-STRUCTURED INTERVIEWS WITH GRIEVING PARENTS AFTER THE DEATH OF THEIR NEWBORN INFANT IN THE INTENSIVE CARE UNIT

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Background/aims: To obtain empiric data on parent’s experience of death of their newborn infant and to identify variables influencing the grief reaction.

Methods: Parents of all infants who died during a 5-year-period were asked to complete a standardized questionnaire and/or to participate in a semi-structured interview. Interviews were recorded and later transcribed. The questionnaire (242 questions, 21 pages) included the Perinatal Grief Scale (PGS).

Results: 31 mothers and 19 fathers of 48 children participated. The interviews lasted 2.6 hrs on average. PGS-Scores were higher (i) for mothers vs. fathers, (ii) if the couple had previous children, (iii) with increasing time after the infant’s death.

Grief intensity was not higher if there was parental involvement in the decision to withdraw life-sustaining therapy. 95% of parents involved in a decision to restrict intensive care felt their involvement was adequately handled by medical staff. 92% of these

parents did not regret the involvement. 85% said that they had no feelings of guilt. However, 45% felt overwhelmed by the decision.

No parent regretted the decision to be present during their child's death. All parents who had physical contact with their dying baby described this as a positive experience. The majority who had no physical contact later expressed regret for this missed opportunity. Most parents believed that their relationship became stronger after the death of their infant.

Conclusions: A study of grieving is feasible and acceptable to parents. Grief reactions vary considerably and individual differences should be taken into account through the counselling process.

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TOO LITTLE, TOO LATE: POLICY BENCHMARKING REPORT ON NEONATAL HEALTH AND SOCIAL POLICIES IN 13 EUROPEAN COUNTRIES

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The risk of dying is highest in the time around birth - a time when safe childbirth and effective

neonatal care are essential to the survival of the newborn baby. Four million neonatal deaths occur every year around the world - that is 450 every hour. Preterm birth is the major cause of infant mortality and morbidity in both developed and developing countries. In Europe, the prevalence rate of premature birth ranges from 5.5 to 11.4% - an average of 7.1% of all live births. In this report we compare the current health and social policies, as well as practices in 13 EU member states. Despite the growing prevalence and increasing costs, neonatal and preterm infant health rank low on the policy agendas of EU member states. Based on our findings we propose important issues to be considered for policies at EU and national levels.

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PARENTS PERCEPTION OF GIVING ANTENATAL CONSENT TO INCLUDE THEIR PRETERM INFANT INTO A RANDOMIZED CONTROLLED TRIAL (RCT)

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Background: RCT have shown that a slight delay in clamping the cord benefits preterm infants by reducing intraventricular hemorrhages and donor blood transfusion. One ethical problem with such study is obtaining informed consent from parents at a time when they are very vulnerable and stressed by expecting a preterm baby.

Aim: To evaluate parents' perception of including their unborn infant < 33 weeks' gestation into a RCT on a slight delay in clamping the cord or four times milking the cord.

Methods: Prospective, single centre study. Parents, whose infants had participated in the RCT, were offered to take part in a structured interview either performed at the hospital or at home. Recorded interviews were transcribed. The interview analysis was performed by a researcher, who was blinded to the infant's allocation, by using NVivo software. Analysis was then summarized by using systematic thematic analysis.

Results: 37 (31.9%) of 116 eligible parents agreed to take part in the interviews (22 female, mean age