

the diagnosis and evaluation of patients to be anesthetized, the prescription of treatment for such patients, and the direction or administration of the treatment. These primary responsibilities could not be delegated to others, the group concluded, unless nurse anesthetists, anesthesiology assistants, and others who receive training in anesthesiology would assist the physician with the diagnosis and evaluation of the patient and administer the treatment prescribed by the physician (but not prescribe the form of the treatment).

The question who should train the nonphysician practicing anesthesia was discussed by the fourth group, which pointed out that we, as anesthesiologists, should guide the training of nonphysicians in our specialty, since it affects the welfare of the patients throughout the United States. The on-the-job training

found in hospitals today varies from poor to superb. An extensive discussion attempted to delineate the varieties of available training programs, including colleges of allied health professions, junior colleges, and bachelor's degree programs. The question was raised and not settled whether the nurse anesthetist or equivalent personnel should work for a bachelor's degree.

After a general discussion many participants felt that further examination of the complex issue is needed and that more time should be devoted to this important subject, which affects everyone in our specialty.

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APNEA IN PREMATURES The respiratory patterns of 22 premature infants were monitored continuously using an impedance plethysmograph which activated an alarm system for apnea. Apnea which lasted longer than 30 seconds occurred in about 25 per cent of the infants studied in the first ten days of life. Bradycardia of less than 100 beats/min occurred within 30 seconds or less of the onset of apnea. The decrease in the heart rate was more rapid during those apneic episodes most difficult to terminate. All apneic episodes began in expiration during periodic breathing. In most instances, cutaneous stimulation resulted in resumption of breathing. However, 8 per cent of the episodes required resuscitation with oxygen by bag and mask. Apneic episodes of 45 seconds or more resulted in mottling, cyanosis, hypotaxia and unresponsiveness to stimulation, suggesting that early intervention is required to prevent significant hypoxia and central depression from apnea. In each of six additional infants, apnea was associated with a high environmental temperature. (*Daily, W. J. R., Klaus, M., and Meyer, H. B. P.: Apnea in Premature Infants: Monitoring, Incidence, Heart Rate Changes, and an Effect of Environmental Temperature, Pediatrics 43: 510 (April) 1969.*) **ABSTRACTER'S COMMENT:** This paper demonstrates that continuous monitoring of respiration in small infants is now clinically feasible.

DIAZEPAM IN LABOR A controlled, double-blind study of the effects of diazepam on the course of labor was made in 188 patients. The treated group required less supplementary analgesia than the control group. Uncorrected labor-progression data showed generally longer labors among control patients. Data obtained from pairs of patients matched appropriately for analgesia as well as for other pertinent factors revealed no significant differences in progression of labor, although the first stage was consistently more rapid with diazepam. Labors conducted with diazepam are relatively unimpaired by inhibitory effects of sedation. (*Friedman, E. A., Niswander, K. R., and Sachtleben, M. R.: Effect of Diazepam on Labor, Obstet. Gynec. 34: 82 (July) 1969.*)