TITLE PAGE

Re: Why stillbirth deserves a place on the medical school curriculum: the importance of culturally sensitive care

Running title: Stillbirth education for UK medical students

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MAIN TEXT

Sir,

We welcome the recent BJOG Perspectives article from Ravi and colleagues advocating for universal inclusion of stillbirth in UK medical school curricula and their thoughtful discussion about opportunities for medical students to contribute to perinatal bereavement care[1]. We support their conclusions and provide additional emphasis on two particular aspects of care after stillbirth: firstly, ensuring that care is culturally appropriate; and secondly, acknowledging the specific needs of fathers.

Stillbirth is a stigmatised and neglected problem that has been overlooked by the local and global health agenda until very recently. The Lancet's Ending Preventable Stillbirths series (2016) highlighted the medical, economic and psychological implications of the 2.6 million stillbirths that occur annually and demonstrated the immense potential for high-quality bereavement care to minimise associated trauma to affected families[2].

The survey conducted by Ravi et al. confirms that the Lancet's renewed call to action is yet to filter through to UK medical schools, where only 57% of respondents reported that stillbirth featured somewhere in their curriculum. This is particularly striking when considered in numerical terms: in 2017 there were 2,873 stillbirths in the UK, a figure that significantly exceeds the 428 deaths from HIV; but omitting HIV from a medical school curriculum seems inconceivable.

Ethnic diversity in the UK is high: 28% of births are to mothers who were born outside the UK[3]. It is therefore vital that any educational programme designed to teach medical students about stillbirth emphasises the importance of culturally sensitive care. The literature on perinatal bereavement care comes predominantly from authors in high-income settings, but the vast majority (98%) of the international burden of stillbirth is concentrated in low- and middle-income countries (LMIC)[2]. Although the perception of stillbirth as a devastating, life-changing event is universal, certain coping strategies that are highly valued by parents and actively endorsed by staff from high-income settings may not be appealing or culturally appropriate in women from different ethnic, religious and socio-economic backgrounds. For example, seeing and holding the baby after birth, which is an important consideration for bereaved parents in high-income countries, may not be the norm for bereaved parents from LMIC[4]. Even within countries and within religions there are often differences in attitudes to bereavement. Staff should avoid assumptions about parental attitudes according to ethnicity or faith, provide information in different languages, offer culturally appropriate psychological support, and consider referral to hospital chaplaincy services according to individual circumstances.

It is also important to acknowledge that mothers and fathers often respond divergently to the death of their baby; fathers have specific needs frequently overlooked[5]. While anxiety and depression are more prevalent in mothers, fathers are more likely to suppress their grief, which may increase the risk of post-traumatic stress disorder.

We thank the authors for bringing culturally sensitive care to the attention of the readership and stress the need to incorporateem stillbirth into UK medical school curricula.

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