Authors' reply re: Why stillbirth deserves a place on the medical school curriculum. (Response to BJOG-20-0218.R1)

Movin Abeywickrema[1], Emily Tough[2], Krupa Ravi[3], Monica Davies[4], Shannon Gunawardana[3], and Krithi Ravi[5]

[1]University Hospitals Birmingham NHS Foundation Trust
[2]Oxford University Hospitals NHS Foundation Trust
[3]University of Oxford Medical Sciences Division
[4]King's College Hospital NHS Foundation Trust
[5]University Hospital Southampton NHS Foundation Trust

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Letter to the Editor, BJOG Exchange

Main title: Authors' reply re: Why stillbirth deserves a place on the medical school curriculum

Authors' title: The role of medical students in delivering culturally sensitive stillbirth teaching and care

Sir,

We thank Drs. Cornish and Siassakos for their encouraging response[1] to our article[2], and for highlighting that stillbirth care must account for the needs of fathers, and those from varied sociocultural backgrounds.

In addition to endorsing the importance of culturally sensitive stillbirth care[1], we advocate for solutions to tackle culturally specific stillbirth-related stigma. For instance, a qualitative study in rural Ethiopia[3] revealed that grandmothers, married women and mothers associated stillbirths with malevolent spirits: "Families lose their newborn because of an evil spirit." Whereas, younger girls believed poverty, lack of education, maternal ill health and improper care during birth to be contributory factors to stillbirth. Thus, it may be possible to harness the increased awareness and understanding of certain groups within communities to combat the stigma around stillbirth.

We agree that it is essential to avoid homogenising the experiences and needs of communities. For example, some Muslim Pakistani families have differences in burial practices and the assignment of personhood depending on readings of Islamic scholarship. Some believe that when babies are born alive, they have the opportunity for the *azān*(meaning the baby can be recognised in religion by name and have a Muslim funeral), but others feel stillborn babies are entitled to a Muslim funeral[4]. These differences within the same or similar cultures may lead to varied expressions of parental grief, and differences in the levels of openness about their grief.

Research and teaching on the range of attitudes towards and experiences of stillbirth, especially in low- and middle-income countries and minority communities in the UK, is therefore crucial. Moreover, in order to provide holistic care following a stillbirth, perspectives from fathers[1] and other involved family and community members (e.g. in-laws, community leaders) is required.

Medical students undertaking elective placements, collaborating with local clinicians, midwives and/or translators, are ideally positioned to fill this research void. Speaking with an 'outsider,' such as a medical student, may allow bereaved parents to speak more openly about their experiences. As the study would likely take

several months to years, including time required for recruitment and follow-up[5], we propose the establishment of long-term medical school–hospital partnerships, allowing batches of students to undertake a sustainable collaborative project. Research methodology can be adapted to better enable compassionate discussions around stillbirth. For example, in a study looking at rituals performed by Taiwanese women after a stillbirth, a 6-month period was allowed between the loss of the baby and conducting the in-depth research interviews[5].

Overall, we believe the best stillbirth-related teaching and care is achieved through flexibility, by adopting a "case-by-case" approach. Counselling, signposting to other services, holding the newborn and the use of photos may be helpful for some parents, but prolong grief in others[1]. Some parents may seek help from family networks and prefer to avoid institutional bereavement care altogether. Although we can be informed by overarching principles, care should be sensitive to individual needs and patient led.

Authors:

Movin Abeywickrema[1], Emily Tough[2], Krupa Ravi[3], Monica Davies[4], Shannon Gunawardana[3], Krithi Ravi[5]

1. University Hospitals Birmingham NHS Foundation Trust, Birmingham, UK
2. Oxford University Hospitals NHS Foundation Trust, Oxford, UK
3. University of Oxford Medical Sciences Division, Oxford, UK
4. King's College Hospital NHS Foundation Trust, London, UK
5. University Hospital Southampton NHS Foundation Trust, Southampton, UK

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