Re: Why stillbirth deserves a place on the medical school curriculum: implications for patients both in the UK and overseas

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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 offer further justification in the form of the potential to benefit patients both in the UK and overseas.

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) emphasised 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.

As the authors acknowledge, the incidence of stillbirth in the UK pales in comparison to rates in low- and middle-income countries, where the vast majority (98%) of the international burden of stillbirth is concentrated[2]. However, educating UK medical students about stillbirth and the principles of perinatal bereavement care has potential to translate into global benefit. Data from the latest F2 Career Destination Report demonstrate a persistent year-on-year reduction in the proportion of F2 doctors planning to proceed directly into specialist training in the UK (37.7% in 2018, compared to 50.4% in 2016 and 71.3% in 2011)[3]. Over 15% of the 6,407 respondents stated their intention to transition from completion of F2 training to a destination outside the UK: given that the majority will not have undertaken a Foundation Obstetrics & Gynaecology rotation and as such are unlikely to have had specific training on stillbirth, their medical school curriculum may represent the only opportunity to equip them for encounters with this uniquely challenging scenario.

Finally, it is vital that any structured training programme designed to teach medical students about stillbirth emphasises the important of culturally sensitive care. Parents' decision-making can be strongly influenced by religious and social factors, and certain coping strategies that are highly valued by parents and actively endorsed by staff in high-income countries may not be desirable or culturally appropriate in low- and middle-income countries. Staff should provide information in different languages and avoid making assumptions about parental attitudes according to their faith or ethnicity. It is also important to acknowledge that mothers and fathers often respond divergently to the death of their baby and fathers have specific needs that are frequently overlooked[4].

We thank the authors for bringing this issue to the attention of the readership and hope that our additional perspectives reinforce the case for incorporating stillbirth into UK medical school curricula.

References

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