you will not be given drugs to dry up your milk. You will stop producing milk quite quickly, but do not express the milk even if you feel uncomfortable, as expressing will stop the milk drying up. Your midwife or health visitor will be able to advise you how to relieve discomfort at this time.

Registering the baby's death

A stillbirth has to be registered with the registrar of births and deaths and the hospital will tell you what you have to do. It will help you to talk about your baby if you give him or her a name.

Funeral and burial arrangements

If you so wish the hospital can arrange for your baby's burial without charge. Parents often find a funeral service and marking the grave or the place of cremation helpful to them in their loss.

Parents' grief

Whenever someone we love dies we go through a period of grief and mourning. This also happens after a stillbirth, although parents may feel they are grieving for a child they have never known, especially if they have never seen the baby, because a stillbirth leaves the parents with an emptiness and a bewildering sense of a non-event. People grieve in different ways. After the first shock some people want to talk about the tragedy repeatedly while others want to withdraw into themselves. Some feel angry; others reproach themselves, and many women after a stillbirth feel inadequate and a failure as a woman. Many are excessively concerned over their other children, while some find themselves unable to cope with them. These are normal reactions which generally lessen in time. Most important is to recognise that it is better to let yourself grieve and express your sorrow. When parents feel depressed, talking to another parent who has suffered a stillbirth can help and so can talking to others whom they feel are understanding, such as a doctor, chaplain, social worker, or health visitor. It can help to make a marriage deeper and stronger if parents share their grief.

Children's reactions to stillbirth

Children are sensitive and share the family's loss. They may not understand or talk about death in the same way as an adult. Stillbirths are especially difficult for them because the baby they expected has disappeared. They may not be able to talk about their fears and the younger ones cannot understand explanations. They need to be reassured of their parents' love and affection, however difficult it may be for parents at the time. It helps to explain the facts to them and allow them to express their feelings of sadness, anger, or bewilderment. Children are often less afraid of death than adults and are more upset by disappearance. It is less frightening for children to be told the truth than to leave them in ignorance at the mercy of their imagination. Children in the family are sometimes bewildered that the brother or sister they were expecting is not coming after all and they may need to be reassured they were not the cause of the baby's death. Some children become difficult instead of showing their grief, while others may only allow their distress to come out later. Help is available from your family doctor, who may refer you to a paediatrician, a medical social worker at the hospital, or to a child guidance clinic.

What about another pregnancy? When to have another baby? Where to have your next baby?

Your obstetrician or family doctor will advise you about this, but it is advisable to wait a few weeks or even longer before starting another baby. Don't let yourself be pushed into having another baby but wait until you are ready. People are often unaware of how deeply and for how long some parents can mourn a stillborn child. Neighbours, friends, and relatives may not understand your grief and are often embarrassed to talk to you about the baby. The deep feelings that are brought to the surface by a stillbirth often lead to family disagreements that you should not take too seriously.

You should discuss with your family doctor where to have your next baby. You may be happier to return to the obstetrician you already know, but do not feel guilty if you find you prefer to go elsewhere if you have unpleasant memories of the events surrounding your loss.

Anxieties during your next pregnancy

You are bound to be anxious about your next baby. Make sure that your family doctor knows what has happened and see him as frequently as you need to. Explain to friends and relatives that you may need them any time you feel worried. The right company or even a chat on the telephone can calm fears. If you have other children they may become anxious during your next pregnancy, and, although they may not show it, they may need the opportunity to talk about it. There is a great sense of joy and relief when the next baby is born safely, alive, and well, but there can be unexpected and bewildering reactions. Some react either by being totally absorbed in the baby or feeling unreal and unable to care for him. Some parents over-protect the new baby. It is not uncommon and quite normal for parents to find themselves crying for the baby that died and grieving anew while loving and cuddling their newborn baby.

Reactions of others to the next baby's birth

Most people are delighted when you have your next baby and often assume that you will then forget that you ever had a stillbirth. Don't let these reactions interfere with your enjoying your new baby.

We invite your readers' comments and criticisms, which we will try to incorporate in the final leaflet so that parents may have a combined professional approach to their problem.

R W BEARD
JANET BECKLEY
DORA BLACK
COLIN BREWER
YVONNE CRAIG
AVRIL M HILL
HUGH JOLLY

EMMANUEL LEWIS
HAZLANNE LEWIS
SYLVIA LIMERICK
JUDY LISTON
DAVID MORRIS
DAN SCRIVEN
RICHARD WILSON

Prolonged malaria prophylaxis

SIR,—In his recent letter (12 November, p 1287), Professor L J Bruce-Chwatt stated that there is no evidence that chloroquine taken at the dose of 300 mg base once a week causes any visual impairment, let alone blindness, and that chloroquine being the most reliable antimalaria prophylactic in Africa he would not hesitate to recommend it for prolonged prophylaxis in airline pilots. I write to support your expert's view that caution is needed here. In a recent article on ocular chloroquine toxicity in Ghana, I reported on nine out of the 32 cases of chloroquine retinopathy I had seen in Accra in a period of 20 months. In all, I have seen 46 cases of chloroquine retinopathy during the last three years in Accra. Most of these cases had been the result of chloroquine abuse, witness a patient who took 20 tablets of chloroquine sulphate every month for 12 years (432 g base) for what he called "frequent malaria" or another who took 64 tablets a month for two years. Several of them, however, took fairly low doses for long periods, such as 10 tablets every month for 10 years (180 g base). Two of the cases reported had ingested a cumulative dosage of only 72 g base of chloroquine. It is conceivable that if 10 tablets a month can lead to retinopathy in 10 years or less, then eight tablets a month (300 mg weekly) may well cause retinopathy after some years as your expert suggests. It is therefore reasonable to take a cautious attitude toward

the use of chloroquine as a long-term prophylactic especially in airline pilots, whose visual failure may result in a disaster. I am also studying a group of sickle-cell patients who have been on 300 mg base of chloroquine for many years to see how early they may develop retinopathy.

K O BENTSI-ENCHILL

Department of Surgery,
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¹ Bentsi-Enchill, K O, *Ghana Medical Journal*, 1977, 16, 119.

Role of the hospital in primary paediatric care

SIR,—In their letter about the Sheffield paediatric casualty department (26 November, p 1415) Drs Ann L Jay and J R Oakley state that over half the children with medical conditions came "because of their parents' inability to contact the family doctor or because of dissatisfaction with his care."

I think it reasonable to ask whether any effort was made to validate the parents' comments about the availability of their general practitioners. I would expect many to say they tried to contact their GP when they had made no attempt—this has been the case on a number of occasions when, as a casualty officer, I have checked patients' statements.

It is a serious criticism that the Sheffield study is making of family doctors; it is therefore paramount that some attempt should be made to validate the findings.

CLIVE STUBBINGS

Exeter, Devon

*.*We sent a copy of this letter to Drs Jay and Oakley, whose reply is printed below.—
Ed, *BMJ*.

SIR,—We made no attempt to validate the parents' comments in our study, as we were concerned with the parents' perception of the relative availability of the general practitioner, as it is this rather than the factual availability which determines whether the parent seeks help or not.

The parents who claimed that they had attempted to contact the GP and failed were in the minority, but it would be difficult to validate their claims, as the GP would usually be unaware of the attempt. By far the larger group were those self-referred parents who expressed either a belief that it would be difficult to contact the GP at that particular time or a dissatisfaction with previous treatment.

We believe that it is these parents who perceive medical care to be relatively unavailable who delay in seeking medical help for their sick children, resulting in avoidable infant deaths at home and increased morbidity. The paediatric casualty department provides one form of escape for these parents (who overall are probably few in number), although the real answer is to ensure that primary care is not only available but also seen to be available by the parents.

We are aware that some patients misinform their doctors, and as the parents in our study were interviewed by doctors in the casualty department we were concerned that some parents may have felt unable to express