£500 000 of taxpayers' money "defending the indefensible," to use the words of my defending Queen's Counsel, Mr John Hendy. While it claimed to have dismissed me for "breach of confidentiality" (no patient was ever named), Mr Hendy saw through this. "It is plain," he stated, "that the real reason Mr Pink was sacked was because he complained publicly about lack of nurses. Criticism is something the health authority was not prepared to tolerate. Throughout, Stockport's behaviour has been patently and crudely unfair."

After the industrial tribunal I sent additional detailed evidence to the UKCC regarding my allegation of misconduct of the nurse managers. The council claims that one of its principal aims is to serve the public interest by safeguarding "standards and quality of care available for members of the public at times of great dependence and vulnerability." My experience, and that of so many nurses who have contacted me, suggests that this is simple hogwash.

The council found that the Stockport nurse managers had no case to answer, in effect approving their conduct and seeing their behaviour correct in every particular. Any council members who believed that there was not even a case to answer is in my view a disgrace to themselves, the council, and the profession.

Speaking in the House of Commons on 17 June 1993 of the health authority's capitulation at the industrial tribunal, the prime minister implied that justice had been done. I fail to see by what perversion of language the outcome could be described as "justice." In view of management's rampant cynicism throughout, fully supported by central government, Oscar Wilde's aphorism, "A cynic is a man who knows the price of everything and the value of nothing," seems particularly apt. While so many people in Britain believe that the values of health service managers and their political masters must be questioned, I can certainly tell you the price of truth.

A passage through grief—the Western Australian Rural Pregnancy Loss Team

Simon Knowles

It's a dark wet chilly winter morning on the runway at Perth domestic airport. The Western Australian Rural Pregnancy Loss Team clambers into one of those small planes with odd rows of seats, two on the right and one on the left of the aisle. Makes you wonder why they don't fly lopsided; right wing down a bit. I don't really have that much attention to devote to aerodynamic theory because I've got a complete set of fingernails digging into my upper arm: Helen, a founder member of the roadshow, past president of the Western Australia chapter of SANDS—Stillbirth and Neonatal Death Support; a speech pathologist by trade. She has a serious fear of flying and the plane will soon echo to the combined sounds of turboprops and Helen, screaming in concert. The others in the team are Robert, Sue, and Elena. We are taking the roadshow to a country town in Western Australia. The plane speeds, relatively, down the runway. Helen, some speechie, utters inarticulate but irreverent comments at the top of her voice and tonal range. Robert, a hospital chaplain in civvies, indicates through sign language that she's certainly not with him. Not for the first time, I wonder what on earth we are doing.

According to our application to Healthways, the Western Australian Health Promotion Foundation, what we are doing is "diminishing the morbidity associated with miscarriage, stillbirth, and perinatal loss in rural Western Australia by promoting local support groups and transferring appropriate skills, attitudes, and knowledge to local caregivers." According to Helen, what we are doing is exposing ourselves to serious physical danger in the air and to the risk of cirrhosis, or worse, on the ground.

The situation

Anyone who has experienced it knows that the death of a baby before, during, or shortly after birth is a personal crisis of major proportions. Margaret Nicol, a clinical psychologist who has worked extensively in this field, found that more than half of the Western Australian women she surveyed after pregnancy loss had a moderate or severe deterioration in their health following the loss. After comparing the results of her research with studies on the effects of bereavement on

women after the death of their husbands, she concluded that the loss of a baby can have as severe an effect on the mental and physical health of a woman as the loss of a husband. In many cases a woman sees her miscarriage, stillbirth, or preterm labour as the first time that her body has let her down, providing a further reason for grief, guilt, and anger. The consequences transcend the loss of the infant and have a significant impact upon the parents, other siblings, extended family, and wider community. Morbidity is substantial. Perhaps as important, it is largely unrecognised.

The magnitude of the problem is considerable. In Australia, early pregnancy loss occurs in at least one of every 10 first pregnancies, and over one in 10-15 pregnancies subsequently. Western Australia has about 25 000 live births a year. Additionally, of all registered births in Western Australia 4.6/1000 are still-born and 4.2/1000 die in the perinatal period, representing over 200 babies a year across the state, of whom at least 60% are from country communities. The emotional impact of a pregnancy loss exerts an influence over years; the cumulative effect on our community is huge.

The situation is not made any easier in country areas. The state covers over two and a half million square kilometres, which makes it 10 times the size of the United Kingdom. Although most of our 1.6 million residents live within easy shout of the centre of Perth there are around 250 000 people strung around the state from Albany in the south up to Derby and Broome in the far north. Owing to an excellent but intensely centralised tertiary obstetric service, many losses to rural families actually occur in the metropolitan area. We have a low threshold for intrauterine transfer via the Royal Flying Doctor Service. This has been a most successful strategy and serves rural areas very well. But a significant number of preterm infants are born, live, and die within the walls of a teaching hospital. Their families return to communities who have not shared the events surrounding the loss. Especially in the mining towns, personal isolation is intensified by the transient nature of the population; this often means transient health professionals and thus there may not be local expertise to deal with the social and emotional consequences of fetal death.

King Edward Memorial Hospital, Subiaco, Western Australia 6008, Australia

Simon Knowles, perinatal pathologist and head of laboratory services

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So a couple of years ago we put a proposal to Healthways. We suggested that a team of seven professionals working in this field should visit country centres to expose local workers in health, pastoral, and community care to the issues involved in pregnancy loss. We would also hold a public meeting and do our best to attract local media coverage in order to get the point across to as wide an audience as possible. The foundation agreed but cut our numbers to four. By scrimping on the budget we compromised on five—Helen, Robert, Elena, Sue, and me. On this visit we will do a one day seminar for professionals, an evening public meeting, a radio interview, and something for the local paper.

The sessions

Sue, our midwife, starts the sessions by talking about breaking the news—in antenatal clinics; in ultrasound; in the labour ward; on the nursery. The news that is sometimes inevitable but often completely unexpected—like at an 18 weeks' ultrasound examination or when there have been diminished fetal movements for a day or there is an abruption. News that almost always comes from a relative stranger because you can't really hide the body language when the ultrasound shows fetal death in utero. Sue, and all the rest of us talk about trying to slow down the roller coaster of events that then come into play. How to give parents as long as possible to say hello to their baby whilst preparing to say farewell when there are so many distractions: the forms; the arrangements; telling the rest of the family; sorting out things at work. There is hardly any time to get to grips with what has happened and then—all of a sudden—the family is back at home and there is little to show for the pregnancy and all that pain, apart from a death notice in the local paper and an empty nursery.

Robert Anderson, the chaplain, is an Anglican and calls himself a creative liturgist (we are not sure what his archbishop calls him). This means that he performs magic in the chapel without recourse to much help from the prayerbook. And, let's face it, when you look

there's not much to use. Nothing much for infants, and certainly nothing specific to those who have died before they were born. So Robert tailors the service to the needs and beliefs of each family. The body will often start off in a cot and be picked up and passed from person to person until the mother places the child into an open coffin. Children will put gifts, letters, favourite toys into the coffin. If they haven't seen the body before, Robert will often have taken them down to Parent Education to show them the Adam Rouilly models so that they won't be surprised at the size and colour of a 20 week infant.

The grief

This is a good time to dispel one very entrenched myth about the grief associated with pregnancy loss. This is not a phenomenon of wimpish modern woman. Our hardy mothers and stalwart grandmothers did not just get on with life and "have another one" with the fortitude of a true Australian settler. What they did, mostly, was to grieve. Silently, privately, and alone. and in many cases they have failed utterly to come to terms with the events fate had meted out.

Robert quite often finds that when elderly relatives are nursing an infant in the chapel they are calling it by a different name, that of a long dead and unmourned infant of their own. We get calls from mothers of 20 years ago or more asking for details of their infants: method of disposal, any photographs, identity bracelets, and so on. Even a copy of microfiche patient's notes can lend some reality to events that may have come to have the vagueness of a dream.

The necropsy

Because these days parents often see, dress, nurse, and cuddle their infants before and during the service, we assume that all babies on whom we perform postmortem examinations will be extensively handled by relatives, including siblings. This means exquisite reconstitution by Elena, perinatal technologist and all round good person and radio quiz addict. It has also, over the years, meant a progressive modification of my necropsy technique to accommodate ever changing expectations from relatives.

But why bother? The necropsy has fallen seriously into disuse in the realm of adult medicine. Interestingly, and against the trend for adults, the perinatal necropsy rate has increased over the past few years. There are several reasons for this. Foremost is almost certainly the fact that the examination is being performed for the benefit of the next of kin. They need to know what happened, whether they were to blame, what the implications are for the next pregnancy. Perhaps as important is a tendency for senior paediatricians or obstetricians to talk to the parents about the necropsy themselves rather than delegating the task to a junior. Whatever the reasons, it is crucial that nothing be done to deter parents from consenting to necropsy. Factors that act as a negative influence include issues such as the retention of body parts, fear of "mutilation" of the body, and an inappropriate perception of pathologists and pathology.

In the knowledge that parents are likely to see and hold a baby after a necropsy, I have made several changes to my originally conventional technique. My incisions are smaller. I never take down the tongue with the mediastinal structures: surely no one other than a pathologist would believe that the tongue is part of the chest. We specifically contract not to harm the face, hands, or feet as part of the necropsy consent. We have scrounged a neonatal laryngoscope from the nursery and I find this quite satisfactory for examining the vast majority of larynges in fetuses down to around

"In the KEMH chapel" by Krystyna Petryk, artist in residence at King Edward Memorial Hospital, 1992

20 weeks' gestation. We do not perform some of the more drastic procedures commonly used in perinatal pathology. I will not, for instance, remove the bony cranium, and vertebral column in continuity, a technique which produces admirable material for neuropathological examination but which, in my (minority) opinion, demeans both the infant and the pathologist, particularly as it is referred to by its aficionados as the "toffee-apple" technique. Nor do we retain the brain, or any other large organ, in its entirety. The greater part of every organ goes back into the body after the examination and, as far as possible, goes back where it belongs. This is particularly important in the case of the brain. Watch the way people pick up infants. They usually put a hand under the head. It is very disconcerting to find that the head is as light as a feather because it's full of cotton wool. The brain goes back. In the head. In cases where it is absolutely crucial that we retain the whole brain for a few days to allow for perfect fixation (not often now that most laboratories have bought themselves microwave ovens) we discuss alternatives and enter into a specified and explicit contract with the parents.

Contracts and reports

Contracts with the family seem to help enormously, and it seems to me that this is precisely what the necropsy consent should be all about: a contract, negotiated to suit several parties. To that end, we have modified our consent form to include a brief explanation as to the importance of the examination. This is followed by a variety of options open to the parents, including talking to the pathologist (me) before consent, before or after the autopsy, and at any time later. Perhaps surprisingly, parents seem to cope well with talking to the person who actually did the examination. Perhaps, as in the case of most fears, real pathologists are less alarming than imagined ones. We also discuss the option of a limited necropsy, depending on the circumstances.

Our best received innovation is to offer a plain language report for the relatives on the consent form. This makes the point that the examination is done for and on behalf of the parents. Plain language reports also prevent clinicians from dishing out the full technical report. I just hate that—next of kin may have a legal right to the full report but I do not write it for them. Reports containing expressions like "fetal distress" do not assist in the process of understanding why your baby died. Nor do explicit and graphic details of the postmortem findings. But it is important that parents be given the option of something to keep, relating to the events surrounding their baby's death. When you grieve, you go into repeated action replay. The events are rehearsed and relived time and time again. It is very useful to be able to read and reread a report detailing the clinical history, necropsy findings, and implications for the future. I find, though, that these reports are difficult to write. Plain language reports generally take me twice as long as the full detailed medical report.

Mementos and memories

Elena does far more than the technical stuff. She takes photographs of all her babies in clothes provided by parents or by our lovely Ladies' Auxiliary. Elena takes hand and foot prints. She archives all this material indefinitely so that parents who don't want these mementos at the time of death can access them subsequently. She also acts as the crucial point of contact for funeral directors, parents, pastors, social workers, and clinicians. She is often the one member of the team who is best known, on the end of the phone or

Paul and Jayne-Anne with baby Alastair

fax, by the nurses and funeral directors in the country. A worthwhile investment who can also find her way around a computerised database.

Mothers

Helen is ex-president of SANDS (WA). Like all members of SANDS she is a bereaved parent herself, having lost a baby boy on the neonatal nursery. She talks directly and frankly about Curtis and the events surrounding his death, both good and bad. It is so important to have someone who can say with confidence and experience that you are not going mad when everyone in the supermarket seems to have a baby in a pram and they all want to chase you down the aisle to the babyfood section. That you are not going mad if you still feel bad months later when your friends really don't want to see your baby photographs for the umpteenth time. That you are not going mad when your husband has apparently put it all behind him and wants to look to the future. And, most particularly, that you are not going mad when you deliver a perfectly healthy baby next time round and promptly burst into tears because all you can think is that this should have happened last time.

Helen and other SANDS members have taught us all hugely about the little things that make all the difference. Such as taking your baby for a walk round Kings Park after he has been taken off the ventilator because you had always promised him and yourself that that is what you'd do first thing after he was discharged. Or being able to take a stillborn infant home for the night to give her brothers and sisters a real memory of the sister they had looked forward to. Helen also talks about how to manage birthdays and other anniversaries and, especially, Christmas—that ultimate celebration of birth and hope.

Fathers

One problem we've not been able to come to grips with fully is the dads. Just look what our hospitals do to them. As soon as there is trouble we encourage them to take on the protector/organiser role: would they arrange the funeral directors; sort out the death certificate; arrange for someone to look after the other kids; let the relatives know what's happened; answer all the concerned inquiries; be tough; be strong; be a man. Then back to work within a day or two. How's the wife? she's a bit upset. How's the wife? she's doing well. How's the wife? she's OK. How are you? the wife's OK. No chance to share the sadness. And difficult to get support groups going for the blokes. All a bit too public; and often at inconvenient hours.

Men and women grieve differently. So, to add to the tension, there comes a time when a partner may not be the best person to turn to for understanding. Support perhaps; understanding perhaps not. This is very frightening in a society which force feeds an emotional diet of all encompassing interdependence: you should be there for your partner at all times and in all ways. Says who? The roadshow hasn't made a huge impact in this area, but there is merit in just bringing the subject up and this is an area where support groups can be of enormous help by giving couples "permission" to take divergent paths towards the resolution of their grief.

Another problem is the thorny question of who cares for the carers. The members of the roadshow cope because, give or take a really bad headache, we are there for each other. We are also lucky that Western Australia produces some really good wines. It's a bit more difficult for the worker in a country community where there's a good chance of bumping into a client at the local shops and there may be few colleagues who understand the pressure or can share the burden. Although we can help a little at a distance the problem remains just that—a problem. SANDS train their support personnel to deal with this sort of danger, and extending training sessions to country groups will be an important development, subject to funding.

On the air and back to earth

The plane lands—more entertainment for the rest of the passengers as Helen lets forth another blood curdling scream—and we taxi to the terminal. We'll be met by the local organisers, who have put in heaps of

work organising venues, publicising the meetings, and setting up interviews with the media.

The media: nobody other than a complete extrovert or masochist, or politician, could possibly enjoy being ushered into a strange radio studio, plonked behind a microphone opposite a complete stranger, plugged into the local airwaves, and then be expected to relax and talk normally about the death of babies and all that sort of thing. It doesn't help, therefore, if—immediately before the red light goes on—someone tells you he didn't want to do the interview in the first place because "this is a family show" and then promptly goes on the air and introduces the subject to his audience as "morbid." What was interesting about that particular interview was how easy it seemed to be, from the comments afterwards, for the listeners to pick up on the overprotective hostility of the interviewer.

The media have been very interesting in their attitudes and, by and large, very accommodating. Women reporters have been universally excellent and have immediately understood where we are coming from. The men; well, there was the chap just described; on the other hand, a magical interview a year later was conducted by another man, who had experienced the loss of a child and who treated the subject with much gentle passion and respect. We have had good exposure from the print media, even better from radio, and distinctly less enthusiasm from television but this, again, may be a gender thing, with overprotective male producers unhappy about exposing "their" audience to the reality of stillbirth. A very visual news item about American troops in Somalia is, presumably, all right for a family show.

On the flight back to Perth, we will go through the usual soul searching. Will they set up a local SANDS group? Who will act as local co-ordinator? Have we got a list of participants? Whose professional territory did we trespass on? What were the results of the post-seminar questionnaire? How much work will have built up by the time we get home? Where are we going next time? And, most importantly, who paid for that last bottle of chardonnay?

The Western Australian Rural Pregnancy Loss Team won the Quarterly Commissioners Award for Innovation and Excellence in Health in 1992 and has recently received funding from Healthways to continue the project for a further two years.

Cover story: Meg Campbell's "Mother and Child"

Given its subject matter, Simon Knowles's description of the pregnancy loss roadshow (p 1705) seemed an obvious choice for Christmas. Its visual references—to photographs, hand and foot prints, and identity bracelets—suggested that it might also provide the basis for this year's cover.

I saw Meg Campbell's etchings at an exhibition called "Reclaiming the Madonna: Artists as Mothers." They came out of a joint residency at the Princess Anne Maternity Hospital, Southampton, with the poet Fiona Sampson.

In the catalogue Ms Campbell moved from a description of a caesarean section to her etchings, in which "mythology, history, and culture form layers, like the layers of flesh the surgeon had to cut through to reach the baby. Embedded in them like archaeological finds are images of medical instruments, Minoan fertility figures, moons, renaissance madonnas, surgical diagrams, a real baby's footprint, the DNA spiral, and drawings from the hospital wards and theatre."

The footprint clinched it, and we commissioned the cover from Ms Campbell. Several images that she created on the way to the final image appear on earlier pages of the journal.

"Artists make art out of what is very important to them," said Ms Campbell when I spoke to her about her art. "When I was at art school, we were taught like men. The aesthetic springs of those who were held up to us as models were a

long way from the emotional and sexual lives of women. So I started looking at women's experiences.

"A lot of my images of the mother and child reflect the sense that you and the infant are one. All that future has been so much part of you, consciously and unconsciously. If you lose the world it's like the death of part of yourself. For the outside world it's as if the baby had never existed.

"I lost two babies in hospital—one from a very late miscarriage and one from a ruptured uterus. Afterwards the attitude was 'brighten up—you'll be fine.' The staff viewed it all in a very physical way. They seemed to miss the emotional intensity of the experience, which was as strong as if the baby had been born alive.

"On the whole men cannot easily feel their way into these experiences, whereas most women can. My subject matter differs from that of mainstream art. Nevertheless it applies to 50% of the population—I'm trying to find a way of making art out of their lives."

Meg Campbell's recent work continues this quest. It is included in "My Grandmother—My Mother—Myself," an exhibition of artists' books curated by Ms Campbell. The inspiration for the theme came from her time, in 1992, as a Churchill Fellow for Figurative Artists, studying the lives of women and children in north eastern South Africa.—TONY DELAMOTHE, *BMJ*