MEDICAL PRACTICE

*Contemporary Themes***Bereavement counselling after sudden infant death**

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Abstract

Of 14 families who suffered a sudden infant death, eight were followed up intensively over several months and offered individual counselling, parents' group meetings, and interviews with doctors as a way of helping them come to terms with their feelings of loss. Five couples accepted short term support from their health visitor, and one refused help.

Many families experienced considerable stress including marital conflict, difficulties with surviving children, and anxiety about future children becoming victims of the sudden infant death syndrome. It was concluded that medical social workers, health visitors, hospital paediatricians, general practitioners, and parent self help groups are in key positions to help. The success of such help is likely to depend on the confidence that each helper has that his or her contribution will be valued by the bereaved family.

Introduction

Sudden unexplained death is the third largest component of infant mortality after perinatal conditions and congenital anomalies. The sudden infant death syndrome claims the lives of one in 500 infants between the ages of 8 days and 2 years. There is a clear peak prevalence around three to four months.¹ Much research work is being done in Britain and America to unravel the causes of this baffling syndrome. A steady flow of publications report the acute distress caused by these deaths and the longlasting damage

inflicted on families.^{2,3} Watson commented on the value of skilled counselling being available to families at the immediate time of crisis.⁴

Before December 1982 this hospital did not offer specific counselling to bereaved families. As social workers in a large children's hospital serving Liverpool and the surrounding areas we had become aware of a need for this service for families in contact with our accident and emergency department. We therefore agreed with the medical and nursing staff to offer support to all newly bereaved families and to review our work after 12 months. In this paper we discuss the aims of our bereavement counselling service and the methods used and recommend ways of meeting the various needs of bereaved families.

BEREAVEMENT COUNSELLING

Although grief is an intensely personal emotion, overall patterns in the process of grieving have been identified.⁵ A key element in coping with death is finding an appropriate person with whom to share the grief in order that it may eventually lessen. Bereavement counselling in its barest elements consists of a readiness to listen, often at length, while bereaved people impart often overwhelming feelings so that they can resume the threads of their lives. Help may often be needed with practical tasks until the person can regain control for himself. In many cases, of course, this help is provided by families or close friends, and counselling by professionals is needed only when this fails.⁶

Families whose children have died of the sudden infant death syndrome may need particular help. The unexpectedness of the death leaves parents unprepared and exposed to endless feelings of guilt as they search for an explanation. Neighbours and relatives are similarly bewildered, and if the coroner's officer (a police officer) is called in this can lead to hostile comments from neighbours. The parents are often young with no experience of death. In a society where infant mortality is low they are unlikely to be able to draw on the experience of family or friends and may need outside support. So intense were the emotional and physical

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reactions of several young mothers that they confessed to us that they believed that they were going insane. The death of a baby bereaves many people; the mother and father are most severely affected, but the grandparents and surviving siblings also suffer. When everyone in a family circle is devastated they are likely to find it particularly difficult to help one another. Fathers and mothers often have different ways of expressing their grief, which can cause marital stress.⁶

Methods

From December 1982 to November 1983 all families whose babies were brought to the accident and emergency department of this hospital with a presumptive diagnosis of the sudden infant death syndrome were included in our study. We saw parents for an initial assessment as soon as possible after the death, when particular attention was paid to practical issues such as funeral arrangements. The family's general practitioner was informed of the death, and contact was made with the family health visitor to discuss what help the parents might need and decide who could best help the family. We offered regular counselling facilities to the families when appropriate as well as an interview with a hospital paediatrician or the family doctor after the results of necropsy were available. If parents wished it we put them in contact with the local parents' self help group so that they could meet other bereaved couples in a group setting. The self help group was run by representatives of the Foundation for the Study of Infant Deaths.

Results

Fourteen babies who were victims of the sudden infant death syndrome were brought to this hospital during the study. (This does not represent the total prevalence of the sudden infant death syndrome in the Merseyside area.) Our sample showed the expected cluster of deaths in the winter months and the expected preponderance of boys over girls (table). One

Seasonal occurrence of the sudden infant death syndrome

	Dec	Jan	Feb	Mar	Apr	May	Aug	Sep	Oct
Boys	2			2	1			2	2
Girls		1	2			1	1		

child was the first child in the family, nine the second, three the third, and one the sixth. Two babies were aged 1 month, one 2 months, one 3 months, seven 4 months, one 5 months, and two 6 months.

INITIAL ASSESSMENT

Of the 13 families who accepted contact with a social worker, five received short term help (one month) and eight had longer term contact (up to 12 months). The five who received short term help were well known to the health visitor, who felt able to cope with the counselling needs of the parents. The extended family was also supportive. The work with families in the group needing more help is discussed below. One family, who were members of a strict religious group, refused any contact.

For all families initial assessment focused on practical problems and parents' emotional needs. Parents were offered help with funeral arrangements; six couples accepted this offer, which entailed negotiating with the Department of Health and Social Security and the funeral director over the cost of a baby's funeral (£100-350). In all cases a coroner examined the child after death, and this procedure had to be explained to the bewildered parents, who felt that they were the centre of suspicion. At this early stage parents were told that they could return to the hospital when they wished to discuss their baby's death with a paediatrician. They were given appropriate advice and guidance on expected and normal grief reactions for they were often frightened by the strength of their reactions and their physical manifestations. We found it necessary to make visits by appointment because couples tended to stay away from home or spend little time at home after the death of their child. Seven families either moved home or tried to do so during the study period.

LONGER TERM COUNSELLING

The eight families who accepted longer term help had several features in common. The members of the wider family were often either too distressed themselves to be supportive or misguidedly tried to turn the young couples' minds away from the topic. Husbands and wives generally found it difficult to help each other because their styles of grief were so different. The husbands tended to find relief in rage and anger early on and then to brood alone, while the wives needed to talk endlessly about the dead child. In our society women can weep more readily than men, and this imposed great strain on the young fathers.⁷ With one exception, church membership did not seem to provide great help.

All eight families were visited at intervals of two to three weeks for at least three months, and in one case for 12 months owing to continued stress. Common problems were feelings of guilt, anger, violent outbursts, nightmares, disturbed sleep, loss of appetite, general depression, and spiritual doubt.

All but one family had surviving children, and for this too the parents needed help. Williams described the various reactions of surviving siblings of different ages to the loss of a baby by cot death and commented that "the majority of children were disturbed not so much by the death of the baby as by their parents' emotional state and their family's turmoil."³ We noticed that, though all the children showed some anxiety and insecurity (clinging to the mother, resumption of bed wetting, etc), the worst affected were those whose parents were not coping well. Helping parents to understand why their children reacted as they did was valuable. Mothers often became overanxious about a surviving child, though one showed the opposite reaction of temporary withdrawal from and even hostility towards the survivor.³ For two fathers one of the most difficult problems was that their children blamed them for killing the babies after witnessing their desperate efforts to revive the dead infant. Offers of hospital appointments with a paediatrician were accepted by all eight families. Four couples attended parents' group meetings.

INTERVIEWS WITH PAEDIATRICIANS

All parents were offered the opportunity to discuss the circumstances surrounding their baby's death and the results of necropsy with a paediatrician at the hospital. Nine couples took up this offer, one saw their general practitioner, and three declined the offer.

During initial interviews with the parents the social worker went through specific queries and anxieties, writing them down so that parents would be able to benefit fully from the later discussion with the doctor. A copy of the list of questions was given to the paediatrician before the interview. The most common questions were:

- What were the findings of the postmortem examination?
 - Did the baby suffer pain?
 - Did the baby suffocate, choke, or overheat?
 - Did the baby die quickly or over a period of time?
 - Would the baby have had brain damage had he survived?
 - At what point did the baby slip into unconsciousness?
 - Need we be frightened that this will happen to any further children or surviving brothers and sisters?
 - Why did it happen if he was well cared for?
 - Would breast feeding have prevented it?
 - How long was the baby dead?
 - Is there any special check for future babies we may have?
- All the parents found it difficult to return to the hospital where their baby was brought in dead. Those who did return, however, said how much they had gained and thought that it marked a turning point in adjusting to the loss of their babies.

These interviews are not easy for the parents or the paediatrician because some questions do not have a straightforward answer. The most helpful approach was for the social worker to accompany the parents and for the interview to take place in a comfortable room in the hospital in as relaxed a manner as possible. The interview lasted for from one to one and a half hours. One interview took place in the family home.

PARENTS' SELF HELP GROUPS

Parents were put into contact with the local cot death society, which is organised by mothers who have experienced a sudden infant death. Families also met one another in groups that we run to complement the work of the cot death society. A particular feature of these sessions was the overwhelming need of the parents to talk about their dead children and their loss. Guilt and self blame featured strongly early on, as did problems in communicating with husbands, who tended to resist talking about the dead child. Many were frightened by the intensity of their pain and told us

that they were relieved that they were not alone in experiencing such feelings. Attempts were made to get the fathers to take part in the discussions and to help the couple share their grief, though this was often difficult.

Discussion

Although we approached this work with some trepidation and feelings of helplessness at the thought of trying to ameliorate such suffering, we were constantly encouraged by the parents' gratitude at our intervention. As our work progressed families were referred to us who had experienced a sudden infant death some years previously and were still having problems, sometimes caused by the birth of a subsequent child.

Our conclusion from this initial study is that positive support should be offered to all families with babies that have died suddenly. Social workers in hospitals are well placed to link parents with local support groups, health visitors, general practitioners, and a paediatrician in the hospital. We have little doubt that an interview with a sympathetic, informed doctor is an important step for many parents in coming to terms with their loss. The health visitor was often in an ideal position, but regular

support depended on whether a good relationship already existed. The work can be quite stressful, and, as Watson pointed out, not everyone is temperamentally suited to it.⁴ The sudden infant death syndrome is still fairly rare, so perhaps health visitors interested in working with bereaved couples should be identified and receive extra training and support. Bereavement counselling for trainee general practitioners could include specific guidance on the sudden infant death syndrome. For doctors, health visitors, and social workers the success of any help given is likely to depend on the helper's confidence that parents will value the support offered.

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Product liability in respect of drugs

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English law has for many years contained principles which enable persons injured by defective goods or products in certain circumstances to receive a money payment from another person. These principles apply to injuries caused by drugs as well as by any other product, though their application to drugs raises several special problems.

The law evolved in a pragmatic way and followed two separate lines of development. One concentrated on the immediate relationship between seller and buyer, there being a contract between them—which can be quite informal: there is a contract of sale of goods between a retail pharmacist and a customer who buys a bottle of aspirin. The other line concentrated on a duty to be careful owed by one person to another and does not depend on a direct contractual relationship.

Supply contracts

Not many cases arising from the sale of pharmaceutical products have come to court, but some important decisions have been made in cases concerning food or drink. Thus in one case (*Frost v Aylesbury Dairy Co* in 1905) milk supplied by a dairy caused the death of a Mrs Frost by typhoid. The dairy was sued for breach of the implied condition under the Sale of Goods Act 1893, then in force, that the milk would be reasonably fit for the purpose for which it was bought—namely, for human consumption. In its defence the dairy argued that it had taken every precaution possible in the then state of scientific knowledge to prevent infection, but the court said that this was irrelevant. Whether or not it was guilty of fault or negligence was

beside the point. Liability of this kind, where fault is irrelevant, is sometimes known as "strict liability."

There is an important limitation on these liabilities under the modern Sale of Goods Act 1979. Remedies under the Act are open only to the individual buyer who has entered into the contract of sale. Two cases where people were scalded by defective hot water bottles sold by pharmacists illustrate this. In one case the injury was suffered by the buyer who had gone into the shop to buy the hot water bottle. He was awarded damages under the Sale of Goods Act. In another case a father bought the hot water bottle but the injuries were suffered by his 7 year old daughter. She had no claim under the Act because she was not the buyer—and the father had no claim because he had not been injured. To obtain compensation the daughter had to look for a different legal principle.

Negligence

This brings us to the other line of legal development. After some hesitation the courts eventually held, as recently as 1932, that a manufacturer owes to the ultimate consumer a duty to take reasonable care in making and putting up the product. Failure to take reasonable care is negligence and the person injured can sue, contract or no contract.

Under this principle the 7 year old girl scalded by the defective hot water bottle succeeded when she sued the manufacturer. The manufacturer could not explain how the defect came about, and in the absence of any explanation the court concluded that an employee must have been negligent.

When the claim is based not on a contract but on an allegation of negligence it is a defence to show that reasonable care was taken. The dairy whose milk was infected with typhoid bacteria would, it seems, have escaped liability if it had been sued for negligence rather than breach of the Sale of Goods Act. So the standards imposed under this head of the law are lower than those imposed under the sale contract.

A private patient who buys a medicine on prescription from a pharmacist enters into a contract of sale of goods with the pharmacist. Thus the pharmacist is liable under the Sale of Goods Act if the medicine is not of merchantable quality (if, for example, there was a manufacturing defect and the medicine causes injury). But if the pharmacist dispenses the identical medicine under a National Health Service prescription the Sale of Goods Act does not apply. There is no sale by the pharmacist to the patient and no contract between them. If the patient is injured as a result of a manufacturing defect a claim for compensation must rest on the proof of negligence. Since

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