This article was originally published in Midwifery 2008;24(3):335-43 doi:10.1016/j.midw.2006.03.010 and is available at

http://www.sciencedirect.com/science/journal/02666138

REPRESENTATIONS OF RITUALS AND CARE IN PERINATAL DEATH IN BRITISH MIDWIFERY TEXTBOOKS 1937 – 2004

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Keywords: Midwifery education; perinatal loss; ritual

SUMMARY

Objective: to assess the evolution of attitudes and practices relating to perinatal loss through an analysis of British midwifery textbooks.

Design: a literature review of midwifery textbooks, written or edited by midwives, published in the United Kingdom after 1902. Critical analysis of textbooks to determine the ideological and professional standpoints presented to readers.

Findings: The rhetoric and ritual relating to perinatal loss as portrayed in British midwifery textbooks has changed, with the most dramatic changes taking place in the past 30 years. Evidence to support the changes is largely anecdotal and little reference is made to research relating to perinatal death. The 'dirty' elements of perinatal death relating to the decay that takes place in the infant body after death are not addressed. The critique of psychological theory relating to loss is absent as are alternatives to the model proposed by Kübler Ross . Cultural aspects of loss and bereavement are rarely addressed.

Key conclusions: The review of midwifery textbooks suggest that an ideological shift has taken place in relation to perinatal loss. The changing demographic trends and the move of birth and death from home to hospital have altered both the expectations and experiences of parents and professionals. Midwifery textbooks provide readers with a prescribed and formulaic approach to perinatal loss.

Implications for Practice: The absence of information relating to the appearance

of the dead baby, together with the lack of clinical exposure may mean that midwives are unable to provide parents with appropriate information. The lack of reference to an evidence base that may conflict with the ideology presented in the midwifery textbooks leaves readers with an incomplete understanding of the professional issues relating to perinatal loss.

Introduction

In the United Kingdom, parents embark on pregnancy in the knowledge that there has never been a safer time for a baby to be born. Babies born at early gestational ages or with significant medical problems have an increased chance of survival because of the advances in neonatal care. For this reason, it is suggested that perinatal loss has certain unique features that differentiate it from other types of loss: the close proximity to the birth; the parents are likely to be young and this may be their first experience of death; the death is likely to be unexpected (Mander, 1994).

Some commentators suggest that perinatal grief is exacerbated by the inability of caregivers to reconcile the essentially ‘happy’ nature of birth with the loss of life (Kohner & Henley, 1991; Mander, 1994). Midwives are the predominant professional group involved with the care of bereaved parents around the time of birth, in the immediate postnatal period and in the community. Since midwifery practice appears to be influential in the way that parents perceive perinatal loss (Kohner & Henley, 1991), an analysis of the way that midwifery practice has developed over time could illuminate helpful indicators for practice.

The construction of midwifery textbooks can be represented as a compromise between the competing professional, cultural and political ideologies prevailing at the time of writing. Textbooks can be seen as instruments of socialisation for the intending midwife and a means of promoting cultural homogeneity (Apple, 1991).

Analysis of midwifery textbooks may demonstrate how attitudes and practices relating to perinatal loss have evolved and inform an understanding of the relationship between ideologies of loss and changes in clinical practice.

Until the middle of the 20th century, midwifery textbooks were written by doctors. However, the emergence of textbooks for midwives written by midwives can be seen as a means of sustaining the coherence of the profession through the dissemination of shared professional knowledge and values. Because the focus of this critical analysis is on midwifery practice, it was decided to concentrate on textbooks predominantly written or edited by midwives. The way each society or culture deals with death and childbirth is very different. In order to ascertain the influence of the cultural context of care following perinatal loss, only textbooks aimed at British pre registration midwifery students were included.

METHODS

The literature search focused on material written after 1902, since this was the date of the introduction of the first Midwives Act in any of the United Kingdom countries, when midwifery was formally regulated.

A search was carried out using electronic and on-line databases:
BIDS, CINAHL, MIDIRS, FirstSearch and Medline using the following search terms:

- Midwifery

- Midwives
- Textbook
- Handbook.

In addition, a search was carried out of the on-line catalogues of the National Library of Scotland and the British Library. A hand search was made of the library of the Royal College of Midwives.

A total of 29 textbooks was identified. Two textbooks were excluded because their primary focus was registered midwives. A series of two textbooks was identified as meeting the criteria for inclusion: Mayes' Handbook for Midwives and Myles' Textbook for Midwives. Mayes' Midwifery was first published in 1937 and has gone through 13 editions. Myles' Midwifery was first published in 1953 and has gone through 14 editions, making a total of 27 books.

Analysis

The texts were analysed thematically using a coding framework to enable comparisons to be made within each series and between the series. As well as including data relating to perinatal death, information was elicited relating to the political and organisational aspects of the maternity services to enable the data to be contextualised. A concept map was developed to reduce the content and organise it in a linear manner.

To analyse the language, rhetorical analysis was used to consider the development of plausible arguments relating to care in perinatal loss. Leach (2000) proposes an approach that includes exploration of the situation thus allowing underlying assumptions about the context within which the rhetoric is constructed to be explored. Evidence relating to perinatal loss was analysed using the critical appraisal tools produced by the Critical Awareness Skills Programme (Public Health Research Unit, 2005). The content analysis and coding was undertaken by the first author and verified by the co-authors to ensure reliability of data analysis.

Comparisons were made between different editions of the same textbook and between the two textbooks. While analysing the data three themes emerged: ideology, rhetoric and ritual. Ideology refers to the system of values and beliefs shared by a community or culture. The construction of the values and beliefs is such that they appear 'natural' or logical – how things really are. Rhetoric concerns the use of language and the way that it shapes and reveals thought, knowledge and beliefs. Ritual gives meaning to actions, although the meanings may not be evident or understood by the participants. In this paper, ritual also refers to midwifery practice in relation to perinatal loss.

In addition to the themes of ideology, rhetoric and ritual, four distinct time periods emerged. The time periods were defined by the prevailing professional, social and

political movements. The matrix in Table 1 shows how the themes and time periods link.

Table 1

FINDINGS

Period 1 1937 – 1949

Ideology

During this period, the Second World War took place and the National Health Service was introduced. The majority of births took place at home. The perinatal mortality rate in England and Wales was very high - almost 60 per thousand births (Macfarlane, 1984). However, this was overshadowed by the very high maternal mortality rate. In 1937, the maternal mortality rate in England and Wales was 4 maternal deaths per thousand births (Macfarlane, 1984).

In the first three editions of Mayes' Midwifery published between 1937 and 1941, no mention is made of the impact of perinatal loss on the parents. Reference to perinatal death relates to the statutory responsibilities of the midwife around the registration of the death (Mayes, 1937; Mayes, 1938; Mayes and Gannon, 1941). The ideology of the inevitability of death reflects a society where high maternal mortality rates overshadowed the loss of babies. There seems to be a degree of immunity to loss, perhaps brought on by the high perinatal mortality rates, together with the loss of life experienced during the war years. It is likely that in a society

where death is common, there is no need to elaborate on the needs of parents for support in a textbook, as family, friends and neighbours would be likely to have expertise and experience on which they could draw.

Rhetoric

The rhetoric in the textbooks reflects the inevitability of death. The learner is instructed in the art of baptism for babies ‘in extremis’ and taught that ‘an early recognition of the need for the administration of this sacrament will be appreciated by the parents’ (Mayes, 1937).

Rituals

There is no explanation of any rituals related to the loss of the baby – the preparation of the body, for example. It seems to be taken for granted that the midwife would learn this by example. The only ritual mentioned is that relating to registration of the death of the baby (Mayes, 1937; Mayes, 1938; Mayes and Gannon, 1941).

Period 2 1950 – 1969

Ideology

Post-war there was a marked reduction in maternal deaths. This was due in part to the introduction of antibiotics, as well as the improving health of women as social conditions improved. By 1950, the maternal mortality rate in England and Wales was 0.79 per thousand births (Macfarlane, 1984). In England and Wales in 1950,

the perinatal mortality rate had fallen to 38.7 per thousand births, as the health of women improved and basic neonatal intensive care was introduced (Macfarlane, 1984).

The marked reduction in perinatal mortality rates is associated with the concept of 'medical heroism' and feelings of optimism – technology is presented as having the wherewithal to reduce further perinatal deaths. In the 7th edition of Mayes' Midwifery published in 1967, it is explained to the reader that the woman is asked about previous pregnancies:

> If she lost her baby, she is asked if she knows why. Though it will distress her to have to recall this unhappy confinement, she will readily co-operate, realising that this pregnancy and labour will be conducted with her previous misfortune in mind; and that every effort will be made to achieve a happier outcome (Da Cruz, 1967; p123).

Rhetoric

During this period increasing numbers of birth took place in hospital. Birth as a social event changes into a medical event and family members are excluded from participation. The health of the baby is seen as a national concern. Sutherland, an epidemiologist, writes in 1950 about the continuing high stillbirth rate, saying 'we can no longer afford to lose so many potential citizens' (Sutherland, 1950). This is echoed by Myles in 1953, when she says 'although the birth of a baby is a very personal matter to the mother, the ultimate health and well being of the nation

depends on an efficient obstetric service.' She goes further and places the responsibility for the national well-being with the mother:

> The high perinatal mortality rate in Great Britain is giving rise to grave concern and expectant mothers should be advised (…) regarding causes under their control that are known to be avoidable (Myles, 1964; p93).

The meaning inherent in these statements is that perinatal death represents a loss of potential to the nation, rather than a personal loss. Furthermore, the individual loss is potentially preventable and the mother can be seen as being culpable in bringing about the loss of her own baby.

This period sees the introduction of photographic plates in textbooks. Both Mayes' Midwifery and Myles' Midwifery show pictures of stillborn babies with signs of maceration – the changes that take place in a baby who dies in utero. The wording beneath the photographs draws the reader's attention to the changes and they are left in no doubt that they are looking at a dead body.

The language used in relation to perinatal loss is still very matter of fact and depersonalised. The words used to describe maternal feelings about perinatal loss in the textbooks include 'disappointed', 'unhappy' and 'frustrated'.

Ritual

Ritual or practice in this period relates to the care of the mother. Because of the move of birth into hospital, together with the increased possibility of a happy outcome, bereaved and disappointed mothers are out of place. Myles (1968) stresses the need for staff to keep the disappointed women out of sight and sound of other women with their babies. It is not clear if she believes it would be better for the bereaved women or because it would distress women who had given birth to healthy babies. It is also possible that removing bereaved women from the normal maternity environment would protect staff from the emotions produced by the loss. She also goes on to say that early discharge from hospital should be arranged – highlighting this in her text for additional emphasis.

Period 3 1970 – 1989

Ideology

In 1970, the Peel report recommended 100% hospital delivery (Department of Health and Social Security, 1970) and birth moved out of the home into the hospital. The maternal mortality rate continued to fall and this was mirrored by a fall in the perinatal mortality rate (Macfarlane, 1984).

At the beginning of the period, a hierarchy of loss was evident. Bailey, editing the 8th edition of Mayes' Midwifery states:

> The extreme lability of mood (in the first trimester) does have one advantage, if an abortion (miscarriage) occurs in these first twelve weeks it

> has a much less profound effect than one occurring later (Bailey, 1972: pp128 – 129).

The nature of perinatal loss begins to be personalised during this period. Self-help groups such as the Stillbirth and Neonatal Death Society (SANDS) and the Miscarriage Association emerge. However, the perinatal loss of the eighties is different to the personal loss of the 1930s and 1940s. This is the loss of a baby – a real person, as well as the loss of parenthood.

The construction of the dead baby as a real person is demonstrated through the use of rhetoric and ritual. However, there are differences between the textbooks that could probably be attributed to the personal perspectives of the authors and almost certainly this mirrored the debate among professionals and the public.

Rhetoric

Myles (1981) says:

> If the pregnant woman is not aware that her fetus is dead, some authorities consider that she should be told. Whether to tell her before labour is a debatable point and the husband's advice should be obtained. The pain and distress of labour will be more unbearable when added to the anguish of being deprived of her child. Whether the mother should see a seriously

> malformed infant is controversial and should be left to the discretion of the father (p 687).

In 1989, two new editors took over from Myles. The language and tone relating to perinatal loss changes. The loss, readers are informed, is ‘devastating’. Parents need support. The concept of healthy grieving is raised and the process outlined by Kübler Ross (1970) is identified (Tickner, 1989).

Sweet, editing Mayes’ Midwifery in 1982 discusses the need for women to see and hold their baby. The need for the baby to be called by their name is stressed. This is part of building up a picture of reality. Sweet states that this is important so that ‘parents would have no fantasy about how their child would develop’.

Ritual

In both Mayes’ Midwifery and Myles’ Midwifery towards the end of the 1980s, rituals relating to perinatal loss become more and more elaborate. The rituals include taking photographs and gathering mementoes such as a lock of hair. The need for parents to talk and have their loss acknowledged by staff is emphasised. The role of groups such as SANDS is acknowledged and the need to refer parents to them is stressed (Sweet, 1988; Bennett and Brown, 1989).

Period 4 1991 – 2004

Ideology

This period is characterised by increasing emphasis on the need for holistic care; a move towards consumerism and the rise of evidence based practice. The Expert Maternity Group in England published 'Changing Childbirth' - a report that emphasises the need for woman centred care (Dept of Health, 1993). The Parliamentary Committee into the Maternity Services recognised that not only was childbirth safer now than it had ever been before, it also recognised the inevitability of perinatal death (House of Commons, 1991-92). No matter how much was spent on technology and staff, some babies would die. This is the first time that a public acknowledgement of the inevitability of perinatal loss has been made.

Midwifery education moved into universities. The rise of degrees, especially postgraduate degrees in midwifery, focuses attention on the need for critical debate and analysis, particularly in relation to taken – for - granted knowledge and ritualised practice.

As an indicator of the rarity of maternal death the maternal mortality rate for the United Kingdom was measured per 100,000 maternities and was 5.3 per 100,000 between 2000 and 2002 (Lewis and Drife, 2004) In 1999, the perinatal mortality rate was 7.9 in England, Wales and Northern Ireland (CESDI, 2001).

As in the first period (1937-1950), the inevitability of perinatal death is again part of the ideology presented to readers. The 'immunity' of society to death is different from the first period. Very few people will encounter parents whose baby has died.

A maternal death is now so rare that some midwives and obstetricians will work for a lifetime and never encounter one. Care is personalised and is delivered at the level of the individual and thus the loss of the baby is more personal than before (Dept of Health, 1993). Part of the ideology of health care is the rise of the consumer user who defines the nature of the experience and directs the care. This is reflected in the rhetoric surrounding perinatal death in this period.

Rhetoric

The importance and impact of all perinatal loss is emphasised in the 13th edition of Myles' Midwifery. Shiers (1999), writing about early pregnancy loss, states that 'The effect of the loss of a baby at this time is underestimated by professionals.' The need for healthy grieving and the need to 'relinquish' the loss and 'move on' is apparent in all 3 editions of Myles' Midwifery in this period (Bennett and Brown, 1993; Shiers, 1999; Mander, 2003).

Sweet, writing in the 12th edition of Mayes midwifery, talks about the important task the midwife has in reversing the denial of death and lists the rituals that can be undertaken to aid this task (Sweet, 1997).

The photographs used to portray the dead baby change over this period. Photographs are no longer directed at informing the reader about the decay of the dead body. Instead they are given as examples of how a 'good memory' could be constructed. Tickner in 1993 describes the photograph of a dead baby thus:

> ‘By making folds in the blanket and exposing a little arm and hand the picture looks as if there has been movement…’ (Tickner, 1993, page 767).

In the 14th edition of Myles midwifery some attempt at critical analysis of the ideology of perinatal death takes place. Mander writing in 2003 begins to touch on the effect of class and religion on mourning rituals and the effectiveness of self-help groups such as SANDS. However, the staged approach to healthy grieving is still presented as ‘fact’. The language and photographs in the midwifery textbooks are indistinguishable from those used by voluntary organisations and self-help groups.

Rituals

The list of rituals and practices associated with perinatal loss grows throughout the period. From the gathering of a lock of hair and taking photographs is added: footprints/handprints, cot cards, namebands, naming the baby, bathing and dressing the baby, taking the baby home and writing a letter or poem.

In the latest edition of Mayes’ Midwifery, the entire chapter on perinatal loss has been written by a representative of a user organisation (Thomas, 2004). As in earlier editions, psychological theories relating to stages of grief and tasks of mourning are presented uncritically. Parents are presented with ‘choice’ in relation

to the care of their dead baby, but no mention is made of the problems of presenting or making choices in this context.

DISCUSSION

The role of midwifery textbooks as sources of information for midwifery students and midwives has changed since the first editions of Mayes' Midwifery and Myles' Midwifery were produced. A single midwifery textbook is no longer likely to be used as a source of knowledge on which to base professional practice as midwifery has increased its research base and midwifery education has moved into Higher Education. Midwifery students and midwives now have access to extensive libraries and electronic information resources. Nevertheless, midwifery textbooks may be perceived by some audiences as sources of authoritative knowledge. The inclusion or omission of material can be used to reinforce cultural or professional norms and may reflect professional priorities.

The major limitation in relation to this study is that clinical practice may not always be represented accurately in textbooks and this needs to be taken into account when considering the findings. The accuracy of the findings in relation to clinical practice could be verified by extending the study to explore clinical guidelines and interview parents and professionals about their experiences. However, there is consistency between the textbooks and with user literature, suggesting that the intentions of professional practice in relation to perinatal loss are closely aligned. With this limitation in mind, the study raises important questions about the

construction of rituals in relation to perinatal loss and role of textbooks in reinforcing specific ideologies of loss.

From the dismissive ‘leave the mother to grieve quietly at home’ philosophy of the 30s and 40s, it would seem that the midwifery profession has now adopted an approach that involves increasingly complex rituals and the use of rhetoric to underpin the rituals. Professionals have adopted enthusiastically the ideology promoted by groups such as the Stillbirth and Neonatal Death Society. This group has changed the culture of perinatal death in the United Kingdom over the past 30 years but the mechanism of the change in culture is largely unexplored. Although professional groups such as the Royal College of Midwives and politicians have called for the user perspective to inform professional practice, the voices of users are remarkably absent from other areas of clinical practice such as care in labour (Thomas, 2002).

Snow et al (1986) describe how social actors such as self-help groups ‘frame’ their arguments to construct meaning systems and ideologies to persuade audiences of the validity of their claims. Kolker (2004) suggests that framing results in the redefinition an issue from being a private matter to being a public issue. Lofland (1978) described how an ideology of dying could be constructed. The private nature of grief is presented as ‘the structure of silence’. Self-help groups translate this lack of public discourse as evidence of the ‘taboo’ of death (Aries, 1981).

Lofland describes how the emergent movements construct an ‘ideal’ of the perfect death experience and then go on to demonstrate how reality differs from the ideal. The language used to differentiate between reality and the ideal draws on language that emphasises the dehumanising process and is endlessly repeated so that it becomes accepted as ‘fact’. Reform is driven by the need to meet the ideal.

Repeatedly, readers of midwifery textbooks are presented with the testimony and experience of bereaved parents as a basis for care. The authenticity of the experience of bereaved parents is stressed. In comparison, the voices of women are absent from the chapters focusing on care in pregnancy, labour and the postnatal period where a live birth is anticipated. This anomaly is not addressed by the writers in the textbooks.

The self-help groups and bereaved individuals prescribe care that is rooted in the ideology of perinatal loss that has been constructed. This has become more elaborate over time. The presentation of perinatal loss in the media has reinforced many of the rituals, including photographing and holding the baby. This ‘public death’ may enable a previously hidden subject to be discussed but it does leave us with a style of dying that is perceived as ‘normal’. Individuals who feel uncomfortable with this may not feel able to voice their discomfort with these rituals and this can lead to distress (Robinson, 2003). Although all the guidelines stress the voluntary nature of the suggested perinatal bereavement rituals, there is evidence that some parents comply against their wishes, although this is not

acknowledged in the texts. McHaffie (2001) carried out a study into the feelings of bereaved parents in Scotland and found that some parents were unhappy at bathing and dressing their dead baby but did it anyway, because they felt that it was expected of them.

Challenging the ideological positions of groups such as SANDS is difficult. The very publication of research relating to perinatal care brings strong responses. Hughes et al (2002) published their findings of a research study into the psychosocial care of parents following perinatal loss. This suggested that behaviours that were designed to promote contact with the dead infant were associated with worse psychological outcomes for women. There was considerable debate about their methodology (Matthews and Kohner, 2002) but the most emotive response was from women who had experienced stillbirth and who refuted the findings of the study based on their personal experiences (McCabe, 2002; Ambuehl, 2002; Brooks, 2002). The very existence of a debate is not reflected in the textbooks.

Perinatal loss is more likely to affect parents from social classes IV and V, as well as those from minority communities. However, they tend to be underrepresented in user groups (Nayar et al, 2004). There is little evaluation of the effectiveness of user groups in representing minority interests within health care and this is equally true of groups relating to perinatal loss. Despite these concerns, self-help groups are promoted uncritically within midwifery textbooks.

IMPLICATIONS FOR PRACTICE

This review of midwifery textbooks has highlighted several issues that have implications for practice. The question of what novice midwives need to know about perinatal loss is largely unexplored. Begley (2003) found that student midwives in Ireland were often excluded from the care of bereaved women to 'protect' them from potentially difficult situations. However, student midwives inevitably came into contact with perinatal loss and the lack of exposure meant that they felt vulnerable and acutely aware of their lack of knowledge and expertise. Midwifery textbooks currently used in the UK do not include information relevant to professional practice in relation to the pathology of perinatal loss, so it is likely that this lack of knowledge and experience may continue to have a negative influence midwifery practice and on the experiences of bereaved parents.

The recent editions of Mayes' Midwifery and Myles' Midwifery provide readers with information about the presentation of dead babies to parents (Mander, 2003: Thomas, 2004). This takes the form of presenting the babies in a 'natural' way that creates memories of the body as a baby, rather than the traditional photography that was used to emphasise the pathology of the body. Information is lacking about the process of decay that takes place in dead bodies, such as maceration, and how this can affect the bathing and dressing of babies. Since increasing numbers of midwives will not be nurses and may not have encountered death before, specific information focusing on this element of practice is required.

The use of psychological theories to underpin the care given to parents is problematical. The theory developed by Kübler Ross is used in both series of textbooks. Her research was conducted with the dying and she suggested that there were five stages in the dying process: denial, anger, bargaining, depression and acceptance (Kübler Ross, 1970). Progression through the stages in this model depends on the individual. Progress can become arrested at any stage and individuals may move back and forwards through the stages.

Kastenbaum (1995) points out that the existence of the stages has never been proved and there is no evidence that people move through stages. The methods used by Kübler Ross to collect and analyse the data are fundamentally flawed. Although her work did stimulate interest in the experience of death and dying, the methodological flaws inherent in the theory mean that it can not be accepted in the uncritical manner in which it is presented in midwifery textbooks. At the very least, the critique of Kübler Ross's work should be offered alongside the theory. Alternative theories such as Klass with his theory of continuing bonds are available but they are not discussed in midwifery textbooks (Klass, Silverman and Nickman, 1996). Instead, readers are presented with the concept of 'moving on' from grief as a universally agreed 'truth'.

The concept of healthy grieving pervades both textbooks now. But the reader is not encouraged to ask where the concept of healthy grieving comes from; who defines

it; or why it matters? Manders, in the latest edition of Myles' Midwifery begins to look at studies evaluating effectiveness of care relating to perinatal loss (Manders, 2003). There is no perfect study and she highlights some of the deficiencies in the current research. However, since a central tenet of midwifery practice is about providing individualised, woman centred care, it must be questioned if it is right that textbooks should suppress the range of debate in relation to perinatal loss.

CONCLUSION

This analysis of midwifery textbooks has highlighted the ideological shifts that have taken place in relation to perinatal loss over the past 50 years. The changing demographic trends and the move of birth and death from home to institution have altered both the expectations and experiences of professionals and parents. Midwifery textbooks have presented what is perceived to be a legitimate ideology of perinatal loss but fail to present readers with the tools to undertake a critical analysis of how this ideology is constructed. Lofland (1978) points out that what may seem to an acceptable solution to one problem may reduce the availability of alternative solutions. The rituals and the rhetoric related to perinatal loss have become increasingly prescribed and formulaic. It could be argued that in trying to change practice relating to perinatal loss, rather than increasing choice, we have replaced one dogma with another.

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Table One: Relationship between Themes and Time Periods

Period	Ideology	Rhetoric	Ritual	Social and Political Context
Period 1 1937 – 1949	• Individual • Inevitable	• Pragmatic	• Registration of the death • Baptism	• Second World War 1939 – 1945 • NHS Act (1946) England and Wales NHS Act (1947) Scotland

Period 2 1950 – 1969	• Medical heroism • Collective loss	• 'Matter of fact'	• Registration of the death • Baptism	• Cranbrook report (1959) • Association for Improvements in Maternity Services (AIMS) formed
Period 3 1970 – 1989	• Personal	• Self-help • 'Healthy' grieving	• Gathering mementoes	• Peel report (1970) • Maternity Care in Action reports (1984) • Stillbirth and Neonatal Death Society

				• Miscarriage Association formed

Period 4 1991 – 2004	• Individual • Inevitable	• Merging of professional and lay perspectives • Limited critical analysis	• Care giving • Gathering mementoes	• Changing Childbirth: Report of the Expert Maternity Group 1993. • Move of midwifery pre registration education in Great Britain into Higher Education • Framework for the Maternity
