stillbirth may aggravate bewilderment and promote difficulties with mourning. Parents of stillborn infants (uncommon, one in 100 births) should be encouraged to salvage everything they can from the experience and possibly to use spiritual solace if that helps them. By contrast, people should not be pushed into magnifying miscarriage (common, one in three or four pregnancies) into a tragedy. Those who are "thrown" by it require skilled psychotherapeutic help. Formerly, professional staff needed to be made aware of the psychological danger of treating stillbirth as if nothing had happened, but now it needs courage to urge some sense of proportion in very early pregnancy—difficult with such an all or nothing business.

A recent paper discusses the value of counselling for a related problem: middle trimester terminations for fetal abnormality.[9] Elder and Laurence interviewed women who had received counselling, focusing their inquiries on the grief reactions present six months after the termination. Four fifths experienced acute grief reactions initially and about one in four had unresolved reactions six months later (compared with the findings in a previous series that almost one in two women who had not received counselling had unresolved reactions).

The great unanswered question in all such studies is whether it augurs better for the future if someone is still grieving six months after a loss. Is too much better than too little? The quality of grieving may be more important than the degree of distress. Professional staff need to know when mourning is going wrong and when to refer for psychological or psychiatric support. The superb text produced by the Stillbirth and Neonatal Death Society will help them.

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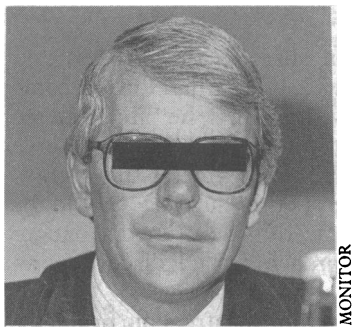
Keeping confidences in published papers

Do more to protect patients' rights to anonymity

A complaint by a patient to the Norwegian patients' ombudsman that she could be identified from a case report in a medical journal prompted Magne Nylenna and Povl Riis, two Scandinavian editors, to survey editors' attitudes to and practices in protecting patients' anonymity (p 1182).[1] In general they found that editors' good intentions were stronger than their explicit practices. Like many other journals, the *BMJ* has routinely taken some precautions—banishing patients' initials from case reports, masking their eyes in photographs, occasionally removing telling details—but these may not be enough to deter a determined journalist. Armed simply with the name of the hospital and information from the paper, a journalist may be able to trick further information on patients out of unsuspecting staff. New guidelines issued by the Vancouver Group are intended to offer patients some further protection (p 1194).[2]


MONITOR
Do you recognise this man?

Starting from the premise that patients described in clinical papers have a right to anonymity, the guidelines outline some mechanisms for preserving it. Omitting details—for example, occupation—to preserve anonymity may sometimes be acceptable but changing them is not. Omitting information has its risks: occupation or origin may later turn out to be relevant even though it is not thought so at the time (Haitians with AIDS, for example). But falsified data will be taken at face value and may mislead. For clinical photographs we have relied on the convention that masking the eyes in a photograph of a face preserves anonymity. But Slue showed recently what the guidelines point out—that a black bar masks nothing if readers already know the person; it only works if they don't (figure).[3] The answer in future is to emphasise anonymity but to get consent from the patient if there is still any risk that he or she might be identified, whether from a photograph or a clinical description.

For editors the guidelines suggest that their policies should match their intentions—and that they should publish their policies (we will incorporate the guidelines in our instructions to authors). For authors the guidelines mean that they need to think harder about the details essential to their case descriptions and whether they may inadvertently give away more than they mean to. A conventional description of occupation and geography gives away little for a civil servant in London but a lot for a housepainter in Spitsbergen. When the potentially identifying details might be important authors can protect themselves and their patients by being more ready to gain their patients' consent to describe them or use their photographs.

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Deputy editor, *BMJ*

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