The reproductive politics of second trimester pregnancy loss in England.

Submitted by Aimee Middlemiss to the University of Exeter as a thesis for the degree of Doctor of Philosophy in Sociology, March 2021.

I certify that all material in this thesis which is not my own work has been identified and that any material that has previously been submitted and approved for the award of a degree by this or any other University has been acknowledged.

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Abstract

This thesis is a feminist examination of women's experiences of second trimester pregnancy loss involving labour and birth in South West England. Drawing on ethnographic interviews with 31 women, it analyses second trimester pregnancy loss as a distinct phenomenon produced by the interaction of biomedical and governance discourses, and enacted on the bodies of pregnant women. Extending Franklin's concept of foetal teleology (1991), it argues that prioritised discourses about second trimester pregnancy loss in England are underpinned by a teleological ontology of pregnancy, in which the reality of pregnancy is defined by its outcome of a separately living person. In the second trimester, a pregnancy ending because of foetal death, premature labour, or termination for foetal anomaly will almost never result in this outcome. This means that at an ontological level the foetal beings which emerge in the second trimester are conceptualised as a non-persons, the pregnancies which produced them are not ontologically 'real' pregnancies, the labours and births which resulted are insignificant, and the pregnant women who undergo those labours are not 'real' mothers.

The thesis is a novel ethnographic account of the events and impact of second trimester pregnancy loss, and the consequences for reproductive politics of the teleological ontology of pregnancy it makes visible. In relation to biomedicine, it shows how diagnostic classification of the foetal body as being in the second trimester restricts women's care options in the English NHS. In terms of governance, it shows how in second trimester loss parental choices and resource entitlements are determined by the ontological status of the foetal being. It shows how these prioritised discourses, and their ontological underpinnings, disrupt women's ontological security (Giddens, 1991) by conflicting with embodied experience. And it shows how an alternative English kinship ontology of pregnancy which centres embodied personhood is agentially used by some women as resistance to the erasure of their gestational kin and person-making work.

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Key to quotes from participant interviews:

The names of participants in the text of the thesis are pseudonyms unless the interviewees requested otherwise.[1]

The real names of those participants who wished to be acknowledged by name are listed on page 7. Where participants wished their babies' names to be acknowledged, these can also be found there.

Participants' choices about terminology used to refer to foetal beings and babies have been respected. This means that most are referred to in the text through their kinship relationship to the participant. The babies or foetal beings have not been given pseudonyms. Where the participant knew the sex of the baby, gendered kinship terms are used. Other kin are also referred to through their kinship relationship to the participant and have not been given pseudonyms.

Non-kin persons who are referred to by participants are described through job titles or their relationship with the participant.

Short quotes from participants are demarcated by single quotation marks. Longer quotes from interviews are indented, with questions from me in italics.

Verbal emphasis by participants is indicated by bold type, additional description such as emotional tone is explained in square brackets where I felt it was particularly relevant to the meaning of the words.

[…] indicates that I have internally edited a quote.

'…' indicates a pause or hesitation in the flow of speech.

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[1] The use of names in the thesis is further discussed in the Methods chapter.

Chapter 1: Introduction

I begin this thesis with the story of one of my research participants, Holly, a twenty-five year-old care assistant who lives in a small town in South West England. In 2019, after she had seen my request for participants through a chain of posts on Facebook, Holly sat with me at her kitchen table and described her experience of the pregnancy loss of her second daughter a year earlier. Holly's baby[2] had died at some point during her birth at 21 weeks' gestation in the second trimester of pregnancy. Her death was the result of a complex situation in which ultrasound imaging at 20 weeks had resulted in a diagnosis of serious developmental abnormalities. Holly and her partner had been asked to make a decision about whether they wanted to proceed with the pregnancy or to have a termination for foetal anomaly when Holly's waters broke spontaneously. Still feeling foetal movement, she went into hospital, where the labour did not progress.

Eventually Holly was given medication to induce labour, which is also the procedure for an induced termination of pregnancy in the second trimester. The baby girl was born dead late the next day, after a long and difficult labour in which, against the wishes of medical staff, Holly insisted on many members of her family being present, including her father, her brother, and her partner's mother and sister. Holly expressed with passion to me how much she felt her baby to have been part of her family – her family had been present at her elder daughter's birth, and she wanted everyone to participate in the birth and death of this second baby. For Holly, the baby was a person, situated in a kinship system, who before and after her birth and her death had parents, grandparents, and a sister. However, these relationships were not recognised in her experience in hospital:

> [Medical staff] don't address her as my daughter, or a baby. They say 'foetus', which really annoys me.
> I'm like, 'No, my **daughter**, you mean?'
> 'Yeah, your foetus.'

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[2] Terminology used in the thesis is discussed in section 1.4.5.

> No.
>
> *What makes a difference there, do you think it's the age that she was, or do you think it's that she didn't get born alive, or....? When would they not do that?*
>
> I think they just think she wasn't breathing, she wasn't...you know, she didn't take a breath. To them, it's just a foetus.

In common with many of the women I interviewed for this research, Holly's daughter, born dead before legal viability at 24 weeks' gestation, was not eligible for state birth registration, the process through which legal persons are recognised in England. Legally, as this thesis will describe, she was not a person but a foetus, because she showed no life outside her mother's body and was born before viability. Holly was deeply upset by this definition and her daughter's exclusion from birth registration:

> She was a person! You know. Why? I still don't understand why they can't? I know they can't do it from like...ok there has to be like a level in pregnancy of when they say like, we can't do it? But she was a fully formed baby! She had fingernails. She had everything. And I think: she was alive. Why? I don't understand why they can't...be registered? Like any other baby is.

For Holly, the baby was a recognisable human being, formed like a human body, born in the same way as her older daughter was born, and welcomed into the family, despite being born dead and before viability, and despite ambiguity about whether the birth was officially classified as spontaneous or a termination. A framed photo of the dead baby was kept in the house and regularly carried about by her older sister. She had been blessed by the hospital chaplain and then buried in the cemetery at the local church where, months later, Holly was married to her partner, the baby's father. But there was no recognition by the state of the kinship-based personhood which Holly attributed to her child. Holly lost her job because of time off during the pregnancy loss, but she was ineligible for the financial support through Maternity Allowance or Child Benefit to which she would have been entitled if a registered baby had died. And in the community beyond her supportive family, Holly felt marginalised and excluded by virtue of the fact that her daughter was not an officially recognised person:

> Even if your dog dies, people come up to you: 'I'm so sorry, I heard about your dog, that's really sad.'
> 'Oh, thank you.'
> But your baby dies.
> Everyone's like: 'oh god, just don't look at her, you don't have to speak to her then.'

This thesis is based on interviews with 30 other women besides Holly, all living in South West England, who experienced pregnancy loss in the second trimester. It also draws on fieldwork at pregnancy memorial events and sites, and on analysis of documents relating to the governance of pregnancy to produce a feminist ethnographic examination of the reproductive politics of second trimester pregnancy loss in England. It explains how discursive positions on foetal personhood, pregnancy, and pregnancy loss are produced by the entangling of biomedicine and the law in England, and the effects of these on women experiencing second trimester pregnancy loss. It shows how some women agentially resist these definitions of their pregnancies using an alternative ontology of kinship and embodied personhood, based in the English kinship model (Edwards, 2000; Strathern, 1992) and expressed through everyday kinship practices, sometimes directed towards a prenatal or posthumous person.

It also describes a teleological ontology of pregnancy as it becomes visible through the site of second trimester pregnancy loss in England. This ontology underpins the biomedical and legal discourses. It understands a ‘real’ baby or person to be one which is born alive, or after legal viability. Foetal beings born dead or which die before 24 week viability in this model are not understood to be ‘real’ persons, and the pregnant women in whose bodies they gestated are not understood to be ‘real’ mothers. This is because pregnancy in England is ontologically understood in relation to its outcome of a living, viable, healthy baby rather than the gestational experience of the pregnant woman.

1.1 Pregnancy loss in the second trimester: the site of inquiry

A human pregnancy usually lasts approximately 40 weeks and in many cases ends with the spontaneous vaginal birth of a living baby or babies. However, gestation may also end earlier than this (see Appendix 1 for a table of possible outcomes). Endings before full gestation is completed can be because of the death of the foetus *in utero*, either spontaneously, or because of feticide or surgical termination. The foetus may be expelled as a miscarriage, or, if a spontaneous death is discovered by ultrasound, its removal from the pregnant woman's body may be initiated using medication to induce the emptying of the uterus. The same process can be followed in the termination of early pregnancy. In other pregnancies, the pregnant woman may spontaneously go into premature labour with a living foetus and that being may be born alive or dead. Premature birth may take place because of medical intervention such as medical induction of labour. Or, as Holly experienced, birth might be as a result of an ambiguous situation somewhere between the two. Processes of birth may involve Caesarian section rather than vaginal birth, though this is very rare before viability, and all of the women in this research experienced vaginal birth in the second trimester of pregnancy.

In biomedicine, the continuum of pregnancy is often divided into gestational time categories, called trimesters (NHS, ND), each of which has different possible outcomes in terms of the survival of the foetal body and the social definitions of what has happened in that pregnancy (Appendix 1). In both biomedical and English legal frameworks, a key time threshold within the continuum of pregnancy is that of foetal viability. This is set in England at 24 completed weeks of pregnancy, as determined by medical diagnosis and defined in law by the 1967 Abortion Act and the 1990 Human Fertilisation and Embryology Act. Before viability, there is no legal personhood in cases of foetal death before birth, and an event of pregnancy loss is understood to be a miscarriage or termination. After viability, a pregnancy which ends in foetal death is categorised as a stillbirth, and a set of different legal statuses apply to the foetal being and its kin. Furthermore, after viability the termination of pregnancy on any grounds other than foetal anomaly or a serious threat to the life and health of the pregnant woman is not permitted[3]. This time-based threshold intersects with another legal and biomedically determined category, which is that of live birth. A biomedically confirmed live birth at any point in pregnancy also results in a specific legal outcome, that of legal personhood and state recognition of kinship. Live birth is possible before viability, and was experienced by some women in my research, although long term survival before viability is rare (RCOG, 2014).

This thesis is concerned with the second trimester of pregnancy, understood in the UK to be between 13 completed weeks and 24 completed weeks of pregnancy (NHS, ND; NICE, 2012; RCOG, 2011b), and therefore delimited by viability at its furthest reach. The production of knowledge about second trimester pregnancy loss in England is limited because of its particular position in relation to biomedical and legal categories of viability, live birth, and abortion. It is a historically contingent category which is both determinative of outcomes, and also partly rendered invisible by its own legal and medical parameters. Some pregnancy loss in the second trimester is visible to the state and the state National Health Service (NHS) in England. Statistics are produced on all abortion, through the requirements of the 1967 Abortion Act. Whilst termination for foetal anomaly can potentially take place at any point in pregnancy since the 2008 Human Fertilisation and Embryology Act, it is particularly relevant to the second trimester because NHS routine ultrasound and genetic screening for anomalies takes place before 24 weeks and most termination for foetal anomaly takes place in the second trimester (Speedie, Lyus, & Robson, 2014). Statistics on live births and subsequent neonatal deaths are generally collated through the requirements of the 1953 Births and Deaths Registration Act, though which of these occur in the second trimester is not recorded through birth registration systems. Some statistics from the second trimester have been collated since 2013 through a national system which reports live births and neonatal deaths from 20 weeks' gestation or foetal deaths from 22 weeks' gestation (MBRRACE-UK, 2020). However, there is a paucity of quantitative and medical

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[3] The relevant legislation here is the criminalisation of abortion by the 1861 Offences Against the Person Act and the 1929 Infant Life (Preservation) Act, to which exemptions are only granted in specific circumstances by the 1967 Abortion Act and the 1990 Human Fertilisation and Embryology Act.

knowledge about the end of pregnancies in the second trimester in general (Peel & Cain, 2012). This means that second trimester pregnancy loss is not produced as an object which can be acted upon by the state health service. Furthermore, specific experiences of second trimester loss which this thesis considers, such as the mandating of labour and birth, or encounters with a formed foetal body, are relatively invisible in wider society because all pre-viability spontaneous losses are categorised as miscarriages. Miscarriage is commonly conceptualised as a relatively minor, commonplace, and inconsequential reproductive event, although this may not be the experience of women to whom it happens.

In the thesis, I explain the consequences for pregnant women of a wanted or accepted pregnancy ending in the second trimester, as diagnosed by medical surveillance technologies. The first consequence is that in the English NHS, events of foetal death, termination for foetal anomaly, and premature labour will routinely be managed through labour and vaginal birth rather than surgical removal of the foetal body, which is usually only available for the termination of unwanted pregnancy under Ground C of the 1967 Abortion Act. These medical options for women are detailed in Chapter 4, and the consequences for their medical treatment are explained in Chapter 5. The second consequence of second trimester pregnancy loss is that unless there is a live birth, there will be no birth registration in the UK of a pre-24 week being, explained in Chapter 6. This means there is no legal personhood for most second trimester losses. The thesis provides a novel ethnographic account of second trimester pregnancy loss as experienced by women in England, showing both the range of their experiences and the common factors implicated in their treatment by biomedicine, the law, and wider society. I draw on this empirical base to present a series of theoretical contributions which are sketched in this introduction and which will be detailed over the course of the thesis as a whole.

1.1.1 Siting the research in England

The research presented here is explicitly located in England. This is because the United Kingdom of Great Britain and Northern Ireland does not have a unitary set of laws or practices related to pregnancy and pregnancy loss because of the devolved nature of many aspects of governance and healthcare. For example, health services are devolved to the separate nations, and the NHS also has regional commissioning of health services within England. Not all medical treatment is the same everywhere in the UK, and different health authorities and hospitals have different protocols and funding. Some hospitals may adopt national standards of care, such as the National Bereavement Care Pathway[4] for pregnancy loss, promoted by charities and professional organisations, but decisions to adopt the standards are made at NHS Trust level.

Furthermore, access to different medical treatment is subject to the different jurisdictions of the nations which make up the UK. For example, after decades of being completely unavailable, abortion was decriminalised in Northern Ireland in 2019, though access still remains restricted on a practical level. In the remainder of the UK, abortion remains illegal except in specific circumstances when doctors who provide it become exempt from prosecution under the 1967 Abortion Act. Disposal of foetal tissue comes under different rules in England compared to Scotland, and birth registration is managed differently in Scotland. As a consequence of these differences, I sometimes refer generally to the ‘UK’ in discussion of medical and legal discourses where this definition includes England and English law, but at other times I use ‘England’ or ‘English’ to demonstrate where there is divergence from other systems within the UK. The pregnancies and foetal beings described in this thesis are located in a specific legal and biomedical framework of governance.

I also ground the knowledge produced by this research in a specific time and place, on the understanding that reproductive loss should be clearly located and contextualised (Earle, Foley, Komaromy, & Lloyd, 2008; Letherby, 1993; Oakley, McPherson, & Roberts, 1984). I wish to draw attention to the contingency of concepts such as ‘the foetus’ or ‘a person’, and to break down models of ‘Euro-American’ or ‘Western’ personhood or kinship into more ethnographically located particularities (Edwards, 2009; L. M. Morgan, 1996). This follows long established calls for local sites of research in the investigation

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[4] See Glossary.

of body politics (Lock & Kaufert, 1998). One of the foundational readings in this research was the comparison made by Conklin and Morgan between the relational and processual personhood of the Wari and the relatively individualistic personhood of the USA (Conklin & Morgan, 1996). Conklin and Morgan also point out that constructions of personhood can be contested within one cultural milieu. This reading prompted me to consider the differences between prenatal personhood constructions apparent in England. As I demonstrate in this thesis, and elsewhere (Middlemiss, 2020a), relatively processual and relational personhoods do exist in England in relation to prenatal and posthumous personhood, though they are not the prioritised and dominant ontology. Possibilities of prenatal social life or personhood have also been found in other settings which might be thought of as ‘Western’ (Han, 2009; Lupton, 2013) and in other contexts in relation to globalised biomedicine (Howes-Mischel, 2016).

These approaches to personhood run counter to a more readily recognised Euro-American ontology of personhood which states that personhood is an innate attribute of a human being, particularly an autonomous living human being whose existence is delineated by the inscription of birth and death dates in official records and is characterised by rights. Ouroussoff (1993) has argued that the person as a bounded and separate individual is in fact a construct of European liberal philosophy uncritically adopted by anthropologists in their analysis of ‘Western’ culture and not necessary derived from ethnography. Others have also commented on the existence of UK constructions of personhood which do not fit the individualist model, particularly in relation to reproduction and the existence of a ‘popularly understood relational identity’ (Carsten, 2004, p. 101). In this thesis, I argue that whilst a biomedical-legal ontology of personhood based on live birth and separate individualism is the dominant and culturally promoted idea of personhood in England, embedded in English institutions such as the NHS and civil registration systems, it is not the only understanding of personhood in English society. Ethnographic investigation of pregnancy reveals that there is a widely recognised lay counter-ontology which constructs foetal personhoods as non-binary, processual, relational, and contingent. It is therefore important to break down ‘Euro-American’ models and concepts into more specific ethnographic locations.

1.2 The methodological value of investigating pregnancy loss

Investigating second trimester pregnancy loss, then, is a site of research which is ethnographically particular and also which has not yet been a discrete object of social science research in England[5]. The marginalisation of this type of experience for pregnant women, and its ambiguous status as a medical object, described above, also makes it a productive area for research. Marcus urges multi-sited ethnographers to 'follow the conflict' (Marcus, 1995, p. 110) in searching for social meaning. Moments of rupture and contestation in lifecourse events, such as when Holly's pregnancy loss was not acknowledged by her medical caregivers or her community, can be significant moments of reorientation for the woman experiencing them (van der Sijpt, 2020). They also offer potential for the researcher. Conflict between naturalised categories and individual biography, such as when Holly questioned her daughter's classification as a foetus, can produce sociological insight (G. C. Bowker & Star, 2000). Abu-Lughod (1990) talks of investigating resistance as a method of understanding power, as when Holly contested her daughter's exclusion from state person-making birth registration. Furthermore, social science studies of disruption in relation to reproduction can produce insight about 'taken-for-granted cultural constructs' (G. Becker, 1994, p. 404; 1999), also noted in other cases involving reproduction disrupted by death (Simpson, 2001).

Investigating pregnancy loss can therefore generate knowledge about concepts related to normative reproduction and pregnancy in general, such as ontologies of foetal beings and their social status, personhood, and kinship, which are central to this thesis. I argue in this thesis that the teleological ontology of pregnancy which underpins biomedical and legal discourse concerning the making of recognised persons is made visible by foetal and neonatal death in the second trimester. This is a different way of approaching knowledge production than the cross-cultural comparative method used in anthropology to critically examine English or Euro-American kinship (Carsten, 2000; Franklin &

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[5] See Chapter 2 for a literature review.

McKinnon, 2001; Strathern, 1992), pregnancy (Ivry, 2010), foetal personhood (Conklin & Morgan, 1996), or miscarriage (Kilshaw, 2020a; van der Sijpt, 2020). Instead, it uses the site of pregnancy loss to examine tensions within what is assumed to be one bounded and fairly uniform ‘culture’.

The thesis is broadly connected to the large body of work in sociology, anthropology, and science and technology studies which has investigated social contexts and impacts of assisted reproductive technologies since the 1980s (for example, in the UK context: Baldwin, 2019; Dow, 2016; Edwards, 2000; Edwards, Franklin, Hirsch, Price, & Strathern, 1999; Edwards & Salazar, 2009; Franklin, 2014; Nordqvist, 2019; Strathern, 1992). These works have focused scholarly attention on new forms of reproduction enabled by biomedicine, and how these produce new knowledge in social science. Analysis of new reproductive technologies has also emphasised their potential for disruption and resistance (Sawicki, 1991b). However, it is not only classic technologies of assisted reproduction such as IVF or surrogacy, aimed at producing living babies, which are capable of denaturalising reproduction and offering critical distance for the analyst. Other biomedical technologies represented in this research, such as prenatal diagnosis and termination for foetal anomaly, ‘assist’ a particular type of normalised reproductive outcome when they offer the possibility of screening out certain foetuses, categorised as impaired in a system predicated on normalisation, and preventing their live birth (Tremain, 2006; Wahlberg & Gammeltoft, 2018). Still other reproductive technologies, such as ultrasound visualisation and foetal Doppler heartbeat listening, can produce the foetal being as dead or unviable and thus play a role in reproduction which does not ‘assist’ this particular pregnancy to the outcome of a living baby, but may indirectly ‘assist’ the live birth of some future child. And diagnostic technologies such as ultrasound measurements which establish the foetal being as being in the second trimester of gestation categorise the foetal being in legal and biomedical categories. In this thesis, I approach both biomedicine and the law as technologies of reproduction which are underpinned by, produce, and perform ontologies of pregnancy, personhood and kinship which can be critically examined through consideration of their effects in the world. I argue that second trimester pregnancy loss in England is a site where conflict between, and contestation of, these ontologies is particularly visible.

In this introduction I lay out the broad theoretical and conceptual frameworks employed in the thesis, ahead of a literature review of pregnancy loss literature in Chapter 2.

1.3 Problematising personhood, the foetal being, and kinship through pregnancy loss

As Holly's thoughts about her daughter's death illustrated at the beginning of this introduction, experiences of second trimester pregnancy loss in England can problematise the relationship between the category of 'person' and that of the foetal being. The problem for women like Holly is one of wishing to claim prenatal and posthumous personhood for a dead foetal being, of understanding it as a 'baby' or 'person', in the face of the formal discourse of biomedicine insisting on its status as 'foetus' and a legal insistence on its status as 'non-person'. Furthermore, for women who understand foetal beings to be forms of person already situated in relation to themselves as mothers, and to other relatives as kin, second trimester pregnancy loss and its official exclusion from the recognition of such relationships is problematic at an ontological level, as I will show.

In the thesis as a whole, I contribute to literature which critically investigates ontologies of foetal beings in different ethnographic settings (see for example: Conklin & Morgan, 1996; Han, Betsinger, & Scott, 2017; Hockey & Draper, 2005; James, 2000; Kaufman & Morgan, 2005; Lupton, 2013; L. M. Morgan & Michaels, 1999b; Sasson & Law, 2009; C. Williams, Alderson, & Farsides, 2001). Concepts of foetal beings can be theorised in relation to technologies of reproduction, bodily surveillance, and abortion (Petchesky, 1987; Rapp, 1999; Sandelowski, 1994) and in relation to the limitations of pregnant women's control over their own pregnancies (Kukla, 2005). Here I situate the thesis in relation to conceptual framing in the social sciences. This does, however, overlap with reproductive politics, which are considered later in the chapter. In doing this, I draw on my undergraduate training in anthropology and then in STS and sociology in approaching ideas of personhood in relation to the foetal being. I define personhood as who or what is recognised as a being which is part of human society, with an understanding that this can be radically different in different social contexts (Carrithers, Bracken, & Emery, 2011; Conklin & Morgan, 1996; Degnen, 2018). Furthermore, membership of society through personhood is connected to a ‘supercharged moral value’ of that being, which sets it apart from other elements of the world (Carrithers et al., 2011, p. 663). Anthropological and sociological inquiry in this area has a long history of connecting ideas of human bodies, law, recognition, status, role, naming and concepts of the self (Mauss, 1938/1985). It also recognises the contingency of personhoods and the breadth of variation which is possible.

For example, personhood may be understood as intrinsic to the individual, and related to capacity, potentiality and agency, perhaps linked to biological markers and corporeal autonomy, as has been argued in relation to Euro-American cultures (Conklin & Morgan, 1996; Littlewood, 1999). Or it may be more relational, whereby it can be constituted, granted, maintained or withheld by social relations, especially kinship relations, which may endure after death (Carsten, 2004; Conklin & Morgan, 1996; Despret, 2019). Persons may be recognised by some but not others in the same cultural setting (James, 2000; C. Williams et al., 2001), or personhood may be conditional (Christoffersen-Deb, 2012), limited, or withheld (Scheper-Hughes, 1993). Personhoods may be politically important, especially when recognised or withheld by the state. Personhood can be partial or cumulative over time (James, 2000; Lancy, 2014; L. M. Morgan, 1998) or may contain ambiguities (L. M. Morgan, 1997). Time is also implicated in processual forms of personhood (Conklin & Morgan, 1996), and thresholds of birth and death may be of less relevance in different cultural contexts where persons can and do exist posthumously and before birth (L. M. Morgan, 1996). Such possibilities are also recognised in more sociological work, though the concepts used here may be those of a ‘self’ (Hockey & Draper, 2005) or a being with ‘social existence’ (Mulkay, 1992).

Posthumous personhood possibilities are also noted in interdisciplinary death studies, through the concept of continuing bonds after death (Irwin, 2015; Klass, 1997; Walter, 1996), drawn upon in relation to negotiations about the place and role of the dead (Mathijssen, 2018) and in the context of stillbirth (Hayman, Chamberlain, & Hopner, 2018; S. Murphy & Thomas, 2013). This thesis therefore also contributes to literature in the field of death studies in which more than one idea of posthumous relationality exists in the UK (Howarth, 2010; Valentine, 2007; Walter, 2019). As Strathern (1992) has shown, whilst persons in the English system are understood to be embodied individuals, the boundaries of life and death are not continuous with the definition of a person, and personhood can continue after death. In my research site, not only does pregnancy loss involve disruption to the production of persons, where personhood has been attributed to foetal beings, it also involves the end of personhood through death. Studies of death produce knowledge about the living, personhood and embodiment (Mellor & Shilling, 1993; Shilling, 2012) and problematise the relationship between physical death and social death (Glaser & Strauss, 1965; Mulkay, 1992; Valentine, 2007). They concern how social relationships between persons are built, maintained and divested (Miller & Parrott, 2009).

This social, and primarily anthropological, concept of personhood and its possibilities is an approach which is distinct from, and yet contains overlaps with, legal approaches to personhood which are also relevant in this thesis. Naffine (2003) argues that there are divisions in legal thinking about what a legal person can be, which can be summarised in three distinct approaches to the concept. These include the legal person as a fully abstract legal artifice, which could include any beings or entities which might be granted status in law (such as foetuses, or animals). Alternatively, the legal person is sometimes understood as coterminous with living humans only, bracketed by birth and death and defined by an ontological position which understands persons to be naturally given beings with innate properties. This type of person is defined by live birth as the necessary condition for their recognition by the state in relation to civil registration and citizenship. Finally, the legal person is sometimes understood as a subject who has moral agency, a position which potentially excludes some living humans from legal personhood. These types of person resonate with those used in arguments about abortion, for example whether foetuses have no personhood because of lack of consciousness and separate life (M. A. Warren, 1973), or whether they do have personhood because they have a ‘natural’ human potential which is curtailed by abortion (Marquis, 1989)[6].

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[6] Abortion is further discussed in relation to the research in this project later in the chapter.

Recently, legal theorists have also used relationality in talking about the legal person (C. Foster & Herring, 2017; Herring, 2011). In the course of this thesis, I argue that the legal person is relevant to the possibilities of personhood which are available to women who seek to define their own foetal beings. The law lays out some options for them, and curtails other options. It also intersects with biomedicine in the field of pregnancy, as others have noted, for example, in relation to the status of embryonic beings and abortion rights (Franklin, 1999b; Sheldon, 1997). Furthermore, since legal personhood is so widely understood and performed, both in biomedicine and in other social contexts, it dominates ontological understandings of personhood and crowds out alternative formulations of what a person is, and what beings can be classified as persons.

As all these possibilities of prenatal or posthumous personhoods imply, kinship and family are intimately connected to ontological positions on personhood. Pregnancy loss also involves disruption to those who are primarily responsible for making the new person, particularly the categories of pregnant woman, mother, and parent. In pregnancy loss, there is also 'motherhood lost', as Layne's eponymous book (2003a) has shown in the US context. Just as the clear distinction between the two material bodies in pregnancy has been complicated by recent research in social science (Kelly, 2012; A. Martin, 2010; E. Ross, 2018), I seek to show that the social beings of pregnancy are less clear cut than presented by English biomedical-legal models of personhood. In fact, multiple forms of social relations including biomedical diagnoses, governance arrangements, and kinship practices can produce foetal personhood and matrescence (Raphael, 1975) before birth and after death, as Holly's story illustrates. The relationship between pregnant woman and foetus may fluctuate or develop over the course of a pregnancy (Han, 2013; Schmied & Lupton, 2001) or may be uncertain and ambiguous (E. Ross, 2016). This challenges the supposed binary model of foetal beings as either persons or non-persons (Casper, 1994) and also of pregnant women as either mothers or non-mothers. This ambiguity also exists in biomedical practice, where the personhood of the foetal being may not be constructed as a binary, but may exist on a 'human/non-human continuum' (C. Williams, 2006, p. 13).

In discussing social relationships in pregnancy related to personhood and kinship, I also situate this research within studies of kinship, in which reproduction makes new humans and also kinship relationships (Edwards, 1999). In particular I focus on the overlaps between English kinship and personhood, gender, bodies and materiality (Carsten, 2000, 2004, 2007; Edwards & Salazar, 2009; Franklin & McKinnon, 2001; Strathern, 1992). I use the term kinship because it is potentially more critical and challenging of normative Euro-American ideas which have been associated with ‘the family’ (D. H. G. Morgan, 2011) and it is used in sociology and anthropology with reference to the UK (Edwards, 2000; Finch, 1989, 2008; Finch & Mason, 2000; Holmes, 2019; Strathern, 1992). The openness of ‘kinship’ to human creativity, and its connection to equally diverse and creative concepts of personhood and gender (Carsten, 2004) is particularly useful in this thesis. It is, however, less meaningful to my participants, who would themselves use the term ‘family’.

1.4 Siting the research in the politics of reproduction

As described above, second trimester pregnancy loss is a particular category of pregnancy loss, which comes into being through biomedical diagnosis but is then rendered invisible by legal structures including British abortion law and the viability threshold. It is thus marginalised as an experience, as are many other forms of pregnancy loss (see for example, Earle et al., 2008; Earle, Komaromy, & Layne, 2012; Hey, 1989; Kilshaw, 2020b; Layne, 2003a; Lovell, 1983). Like these earlier studies, this thesis seeks to contribute to the de-marginalisation of pregnancy loss experiences, as a political and feminist act of scholarship. Producing a feminist ethnographic account of a marginalised experience linked to the sexed and gendered body is part of its contribution to reproductive politics. However, the contribution is more broad than this.

1.4.1 A feminist contribution to reproductive scholarship

In this thesis I heed calls for social scientists to pay attention to ‘ordinary’ pregnancy (Han, 2013; Ivry, 2010) alongside the assisted reproductive technologies which have dominated the field for many years. In this framework, pregnancy itself is considered as a biosocial phenomenon and meaningful cultural category, challenging Euro-American assumptions that the meaning of pregnancy is determined by the birth of a baby (Ivry, 2010) or that the prebirth period is ‘passively transitional’ (James, 2000, p. 184). A challenge is also posed to the assumption, noted by many feminist scholars, that pregnancy or reproduction is a form of production, which normatively should end in the birth of a ‘healthy’ living baby (E. Martin, 1987/2001; Rothman, 1986/1993; Taylor, 2000). The thesis builds on Franklin’s concept of foetal teleology, whereby what the foetus is going to become, and its developmental potential, determines its ontological reality (Franklin, 1991). It also draws on the concept of ontological choreography described by Thompson in IVF clinics, in which *ex vivo* embryos, as potential future persons, were treated differently in the clinic to gametes, which did not contain the same ontological potential (2005). I argue that English ontologies of pregnancy itself are also teleological, and that they offer principles which underpin discourses in biomedicine and governance in which reproductive outcome is determinative of the reality of pregnancy. This can be seen when the normative outcome is disrupted in pregnancy loss in the second trimester. I understand this focus on outcome in the teleological ontology of pregnancy to be a technology of power which is both patriarchal and biopolitical. It is the ontological underpinning of biomedical and legal discourses which act together to valorise and reify certain reproductive endeavours, centred around the production of healthy living citizens in an example of biopolitics (Foucault, 1976 /1998, 1997/2003; Rabinow & Rose, 2006) which is further explored below. In the English context, this is particularly visible because of the involvement of the state in healthcare and medical governance through the National Health Service (NHS). The governance of pregnancy is focused on the optimisation of outcomes in terms of the born baby at the end of pregnancy because it is based on the teleological ontology of pregnancy.

The thesis also draws on feminist concepts of reproductive governance and reproductive justice. When official, legal personhood and motherhood recognition require the separation of a living foetal body from the pregnant body as diagnosed by state medical practitioners, as this thesis describes, pregnant women in England are excluded from the possibility of prenatally or posthumously defining their own kin. This is an example of reproductive governance, whereby a multiplicity of actors ‘produce, monitor, and control reproductive behaviours and population practices' (L. M. Morgan & Roberts, 2012, p. 241). It intersects with ideas about the stratification of kin-making (Clarke, 2018) and reproductive justice which concerns the ability to have or claim a child as well as the right *not* to have one (ACRJ, 2005; Luna & Luker, 2013; L. M. Morgan, 2015; L. Ross & Solinger, 2017). In the thesis, I show that when the 'production' of a living born baby is disrupted in wanted or accepted pregnancies, and this outcome does not occur, the processes of pregnancy, labour, and birth can still have meaning to those who experience them. Pregnancy loss events thus contain possibilities of agency and resistance. In the context of the types of second trimester loss described in this thesis, in which labour and birth are mandated, I also draw on studies which consider the materiality of childbirth as a bodily event and the political and theoretical implications of this (Akrich & Pasveer, 2016; Chadwick, 2018; Lupton & Schmied, 2013; Walsh, 2010). The research is therefore a contribution to feminist reproductive politics drawing on empirical knowledge from women's lives in a specific setting (Ginsburg & Rapp, 1991; Inhorn, 2009a).

1.4.2 Foucauldian approaches to reproduction and power

Over the course of the thesis, I bring together this feminist approach with the analytic tools of Foucault, following in the footsteps of many feminists before me in the fields of politics (Hekman, 2009) and reproduction (see for example, Bordo, 2003a; Lupton, 1995, 1999; L. M. Morgan & Roberts, 2012; Sawicki, 1991a; Tremain, 2006). I start from the position that human reproduction is a site of the production of power which connects the individual, disciplined human body at the level of anatomo-politics with population level biopolitics (Foucault, 1976 /1998, 1997/2003; Rabinow & Rose, 2006). Discipline is a process by which individual bodies are made into docile, conforming bodies through the use of space, time, examination and normalisation (Foucault, 1977/1991). It has long been recognised as a technique of power in obstetric practice (Arney, 1982) and I show how disciplinary techniques are used in the healthcare system to reinforce normative categories of personhood and kinship, as part of an 'apparatus of truth' (Rose, 1999, p. 4).

Biopolitics involves strategies and contestations in relation to human life and death at individual and collective level. Such strategies are focussed on removing that perceived as degenerate and abnormal in processes of purification aiming towards the optimisation of life and survival at a population level, which may be enacted at an individual level (Foucault, 1976 /1998, 1997/2003). Biopower itself may dovetail with, and use, disciplinary power. According to Rose and Rabinow (2006), reproduction is the ultimate biopolitical space. In their explanation, the elements present in biopower involve truth discourses and authorities who can speak this truth, strategies for intervention in relation to life and health, and modes of subjectification in which individuals work on themselves to conform to truth discourses. All these elements apply in pregnancy and pregnancy loss in England. I argue in this thesis that the dominant teleological ontology of pregnancy in England is an example of biopower. It involves the discursive construction of pregnancy through governance and state biomedical apparatuses which actively exclude pregnant women from the definition of their experiences and kin when their reproduction does not result in a healthy, living baby. Cases of termination for foetal anomaly and pre-viability live birth in the second trimester are particularly clear examples of the creation of truth discourses around health and life. These are then implemented by strategies of intervention (or lack of intervention) at the level of life and death, when pregnancies are terminated or previable infants are not offered medical treatment to prolong life.

Where I depart from Rabinow and Rose, is in their emphasis on the all-encompassing reach of biopower (Rabinow & Rose, 2006). I argue that biopolitical discourses from multiple sources of governance are not always wholly effective in working together to support a particular truth, in this case of the pre-viability foetal being as non-person and the pregnant woman as non-mother. I show how the biomedical-legal ontology of pregnancy is inconsistent and confused when viewed from the second trimester, and this leaves space for women whose experience does not accord with the biomedical-legal ontology to find points of critical distance which they can use in their resistance. Furthermore, biopower as conceived by Rose (1999) is particularly focused on subjectification, whereby citizens work on themselves to conform, rather than oppression. In this thesis, those women whose second trimester pregnancy losses lead them to experience conflict with the biomedical and legal discourses are shown in Chapters 8 and 9 to resist the dominant or prioritised ontology rather than work on themselves to conform to it. In the process of doing this, they use the foetal body as evidence of foetal personhood, in a reverse discourse (Foucault, 1976 /1998) drawing on biomedicine itself to produce foetal personhood at this point in pregnancy in the face of biomedical discourse which claims the opposite.

1.4.3 Materiality, discourse, and ontology in relation to pregnancy and pregnancy loss

In this thesis I am using both ‘discourse’ and ‘ontology’ in my descriptions of the systems of thought around pregnancy, pregnancy loss, the foetal being and kinship which become visible through second trimester pregnancy loss. This is because sometimes the dominant mode of thinking is discursive, such as in the biomedical-legal understandings of what pregnancy is, as represented in legal, regulatory, governance and biomedical texts, or the language used around pregnancy loss. However, at other times there are elements present which go beyond the discursive, incorporate materiality and practice, and seek to describe, delimit, and produce reality itself. Whilst there is a biomedical-legal *discursive* position on pregnancy, which says an unborn, pre-viable, or dead foetal being is not a person, this is enacted through practices in biomedical and governance settings which take it beyond a form of simply linguistic categorisation. Furthermore, the content of discourse and practice is concerned with fundamental understandings of the nature of social reality itself: what a person is, what pregnancy does, and who or what is kin. In the context of second trimester pregnancy loss, the life and death of persons is also brought into question. These are ontological positions and systems of thought which underpin and produce discourse, and can be traced in it.

I therefore take a position in sociology related to that of Shilling and others, which says that the body can generate social meaning as well as be constituted by social discourse (Jutel, 2011b; Lupton, 1995; Shilling, 2005, 2012; S. Warren & Brewis, 2004) and which acknowledges the complexity of the relationship between a person and a material body (Conklin & Morgan, 1996; Hockey & Draper, 2005; Valentine, 2007). Such an approach is compatible with a feminist approach which discusses power and knowledge in relation to the body, particularly the female reproductive body (Bordo, 2003c; Duden, 1993; Ivry, 2010; Kukla, 2005; Longhurst, 1999) but also the foetal body (Mitchell, 2001, 2016; Tremain, 2006). It is also compatible with Foucauldian analysis, despite Foucault being commonly understood as a post-modern or post-structuralist theorist. Following Hekman (2009), I take a Foucauldian approach to power to be one which is not purely discursive, but which in fact successfully integrates the discursive and the material or non-discursive, particularly through practice in relation to events. Foucault's writings are saturated with materiality in relation to the body, in particular through his concept of discipline and the production of docile bodies. Through disciplinary techniques, discourses and their material outputs, such as hospitals, interact with individual bodies to produce new realities and materialisations of power (Foucault, 1977/1991). Foucauldian approaches analyse materiality and practice as well as discourse in the production and connections of knowledge and power. Furthermore, as (Hekman, 2009) argues, Foucault used ideas of ontology as well as discourse This is particularly useful for this research, in which I argue that there can be a productive and resistant interaction between women's material and embodied experiences of events and practices in pregnancy, labour, birth, and encounter with the foetal body, and those prioritised truth discourses in which constructions of foetal personhood and kinship with the foetal being are denied. There is a connection here with ontological politics, in relation to who has the agency to describe and define ontologies (Mol, 1999), the enaction of which through materiality and practice has been described in other biomedical settings (Mol, 2002; Thompson, 2005). Ontological politics extends beyond the discursive into the realms of material and embodied knowledge and practices, through which social reality is made.

1.4.4 Situating the thesis in relation to abortion

Bodies, foetuses, persons, ontological realities: this thesis at first sight appears to hover on the edge of a thorny area for feminist reproductive research, which is the connection between the status of the foetal being and the existence of grounds for the non-prosecution of abortion. British women's experiences of pregnancy loss such as miscarriage have been partly defined by debates on abortion (Elliot, 2020). Tensions between mourning a pregnancy loss and possible attributions of foetal personhood have been understood as potentially threatening to abortion rights (Keane, 2009; Layne, 2003a). Anxieties about the possibility of undermining a pro-choice feminist position on abortion have been noted by other academics in reproduction (Andaya & Campo-Engelstein, 2021; L. A. Martin, Hassinger, Debbink, & Harris, 2017). This is particularly pertinent in my research because the second trimester is itself defined by legal viability, which also defines the parameters of abortion law in England. Discussing my research in academic contexts, I have been asked whether undertaking it at all threatens the pro-choice position. Unease about this possibility permeated some of my friendships at the beginning of the project and was raised by some participants in the research.

However, I refute this on several grounds. Firstly, the fact that something may be controversial is not a reason to leave it unexamined. Having carried out this research and a previous project with pregnant women in England (Middlemiss, 2020a), I know that some women in England do construct forms of foetal personhood before birth. In terms of social science, the careful examination of this is both important and necessary. As previous scholars have proposed, it is also a feminist endeavour to engage with discussion of the foetus, what it might be and mean, and not cede this ground to the anti-abortion movement (L. M. Morgan, 1996; L. M. Morgan & Michaels, 1999a), accept the Euro-American framing of women's abortion rights *versus* foetal personhood (Bordo, 2003a), or avoid engaging with pregnancy loss experiences grounded in the loss of a person (Layne, 2003a; Rothman, 1986/1993).

Furthermore, the invisibility of pregnancy loss and specifically of loss in the second trimester means that there is an element of reproductive justice in focusing on this area of research at all. Reproductive choice is not just about conflict between the rights of a foetus against the rights of a woman (Bordo, 2003a) and reproductive rights can include the right to bear children as well as terminate a pregnancy (Thompson, 2005), particularly when the framework of reproductive justice is used (Luna & Luker, 2013; L. M. Morgan, 2015; L. Ross & Solinger, 2017). In this vein, I propose that denying women the right to define their foetus/baby as a person where they wish to do so is also a restriction on women’s reproductive freedoms and a form of reproductive injustice, and that pointing this out should be a focus of feminist endeavour. Indeed, acknowledging nuance, complexity, and ambiguity in reproduction is an important way forward for feminist research.

In addition, a rights-based discourse is inappropriate in this specific context. There is no legal ‘right’ to abortion in England, but simply legal grounds on which prosecution of doctors will not occur in relation to what is still a criminal act under the 1861 Offences Against the Person Act. The law on abortion is highly restrictive and medicalised, rather than an absolute freedom, or ‘reproductive right’ for women (Sheldon, 1997). This positions this thesis in a particular juridical space, which is significantly different, for example, from that of the USA. And as others have described, abortion is not necessarily a ‘choice’ for women in any case but may be the outcome of circumstances beyond their control (Hey, Itzin, Saunders, & Speakman, 1989; Rothman, 1986/1993), including for some women in my research.

In the thesis, I consider who has the power to define a pregnancy or foetal being, including as a person in a kinship relation, or as process which can be terminated through abortion, or both at once. In this sense, it seeks to destabilise concepts of personhood often used as the basis for rights-based arguments about abortion which are reductive and overly focused on supposed absolute truths, frequently based in scientific discourse. Without reworking these well-worn arguments in detail, many involve binary disputes about whether the foetal being has intrinsic, individual properties which afford it ‘rights’ whilst still unborn, such as sentience, the capacity for pain, agency, subjectivity, consciousness, survival outside the womb, or the potential of a future life (see for example, Marquis, 1989; Singer, 1993; Tooley, 1972; M. A. Warren, 1973). They also often frame abortion as a conflict between the rights of the foetal being and the pregnant woman (Thomson, 1971), and claim universality whilst being based in a culturally specific philosophy and morality (see for example, Hursthouse, 1991 and most of the literature cited in this paragraph). By contrast, I take the position that pregnancy loss can be acknowledged alongside abortion if foetal personhood is understood as relational, socially and agentially constructed, and therefore as containing different content in different pregnancies and at different times (Cacciatore & Bushfield, 2008; Jutel, 2006; Layne, 1997, 2003a; Mullin, 2015; Oaks, 2000; Parsons, 2010). As others have argued, it is possible for pregnant women to consider the same foetal being as a form of person as well as the object of an abortion (Ludlow, 2008; Mullin, 2015), and abortions can be and are grieved (Rothman, 1986/1993). I have tried to bring this nuance and relationality into the methodology of the thesis through the inclusion of termination for foetal anomaly as a form of pregnancy loss in the second trimester, which will be further discussed below.

1.4.5 A feminist approach to terminology

The use of language is important in this thesis, because language contributes to the construction of gender through reproductive discourse (E. Martin, 1991) and in literature dealing with many types of reproductive loss (Jensen, 2016; Jutel, 2006; Letherby, 1993; Lovell, 1983; Moscrop, 2013; Peel & Cain, 2012). Medical terminology, such as diagnoses of 'incompetent cervix', as applied to four women in my research, moves into everyday language use and carries with it gendered content about the responsibility of female partners in unsuccessful sexual reproduction (L. Bowker, 2001). Observations about the judgement and responsibility implied by the term 'miscarriage' have been made elsewhere (Jutel, 2011b; Kilshaw, 2020b; Layne, 2003a) and were echoed by women in my research, such as Helen, whose second child died *in utero* and was born at 16 weeks' gestation in a traumatic incident at home:

> I don't like the word 'miscarriage' anyway. It's just clunky and awful and...[…] It feels like there's blame there. It's quite a clinical term, of a woman's body just **mis**-firing, you know, it's **missed** something, it's a kind of **mis**-take. You know? It is a horrible word.

Language can and has been used to exclude or denigrate women and their bodies in their reproductive endeavours, and therefore the choice of language in this work is a feminist issue. In this section, I explain my choice of vocabulary and its relationship to existing literature in the field, and the experiences of my participants. By necessity, as will be explained below, there have had to be some compromises made, because shared understanding of language is important in the communication of research. For this reason, I will sometimes need to use some of the medical terminology to which women in my research objected. Where possible, however, I will avoid this unless quoting directly. I try to select the most neutral terms or the terms women used themselves. For example, I use ‘premature labour’ to encompass events such as preterm premature rupture of the membranes (PPROM) and also ‘incompetent cervix’, since both result in preterm labour and birth. I use ‘termination for foetal anomaly’, however, rather than the more lay term ‘TFMR’ (‘termination for medical reasons’) often used in online discussions, because in this research terminations occurred specifically for foetal anomaly rather than because of any health complication of the pregnant woman. The medical term used is usually ‘TOPFA’ (‘termination of pregnancy for foetal anomaly’), but this acronym is cumbersome to use in the text and was not used by women themselves.

1.4.5.1 *‘To them, it’s just a foetus’: an exploration of the terms ‘foetus’[7] and ‘baby’:*

There is no neutral term in English to refer to the human conceptus (Lupton, 2013). The medical and scientific term ‘foetus’ applies to all mammals and therefore does not contain meaning related to specifically human social life, which limits its usefulness in this study related to human personhood. In England, ‘foetus’ also excludes foetal personhood claims because it refers to the live birth understanding of legal personhood acquisition in which there is no person until the foetus fully emerges from the pregnant woman’s body and ceases to be a foetus (Herring, 2011). Foetus and person are thus legally distinct categories, and so ‘foetus’ sits uneasily in a study partly about personhood claims denied by the law. In addition, ‘foetus’ is not used in ordinary English speech about accepted pregnancy, (Duden, 1993; Rothman, 1986/1993), and it has been argued that the use of the term with regard to loss is a deliberate depersonalisation of the experience which is an exercise in medical power (Hey, 1989). As Holly’s story above shows, women in my research often strongly objected to the term ‘foetus’. Natalie, whose second son

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[7] I spell ‘foetus’ in the English tradition rather than the American or biomedical ‘fetus’ to emphasize the geographic, jurisdictional, and social positioning of this entity.

died *in utero* and was later discovered to have Patau's syndrome[8], explained her vocabulary choices:

> 'Foetus' is what's normally used as well when, you know, you don't want the baby. Someone's, you know, intending to not go through with the pregnancy. To sort of disassociate the fact that, with that baby...But yeah, as soon as you find out you're pregnant you tell everyone, don't you, 'I'm having a baby!' Not, you know, 'I have a foetus in my uterus!' [laughs]

The main alternative to 'foetus', and the term used in lay contexts in England is 'baby', observed in other studies of women in mid-pregnancy in the UK (Lie, Graham, Robson, & Griffiths, 2019). This term was preferred by my participants. At the same time, the term 'baby' has its own difficulties, in that the language contains a form of personhood recognition, and this can be seen as threatening to the pro-choice position on abortion. Furthermore, even within medical discourse in England there is inconsistency in terminology. For example, the official NHS online guidance for parents to be uses *only* the term 'baby' from conception (NHS, 2019b). The Royal College of Obstetricians and Gynaecologists uses 'baby' alongside 'fetus' when referring to late foetal death in professional guidelines (RCOG, 2010a). Categorisation of the second being in a pregnancy, the one which is not the pregnant woman, can be inconsistent or mutable, even in medical contexts (C. Williams et al., 2001).

Other scholars, particularly feminist ones, have noted similar terminological difficulties (Jutel, 2006) and have tried to resolve them with a variety of terms including 'unborn' (Duden, 1999; Lupton, 2013), 'prenatal being' (Giraud, 2015), 'born-still' (Hayman et al., 2018), 'fetus/baby' (Markens, Browner, & Mabel Preloran, 2010; Markens, Browner, & Press, 1999), 'gestateling' (Romanis, 2019a), 'foetal entity' (E. Ross, 2016). I prefer to use 'foetal being', which I feel gives a sense of contested and contestable meanings and fluid boundaries, including the possibility of prenatal death or posthumous personhood. However, in this text I will use the term 'baby' when this is used by

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[8] A glossary of medical vocabulary can be found at the end of the thesis.

participants in the research, or when talking about relational and personhood aspects of the human conceptus, as other UK studies have done (Death Before Birth Project, ND). One of my participants, Paula, who had experienced termination for foetal anomaly, chose before the interview to use the term 'foetus', although during the interview she actually repeatedly also used 'baby'. In referring to Paula's story, I use 'foetus'. However, the other women who experienced termination chose the term 'baby', and in line with other work (Ludlow, 2008; Mullin, 2015), this study will show that there is not necessarily an incompatibility between claiming foetal personhood and kinship with the foetal being, and taking a decision to terminate a pregnancy.

1.4.5.2 'Still attached to pain': using the vocabulary of 'pregnancy loss'

The term 'reproductive loss' has been used by other scholars in this field to include all forms of pregnancy loss including termination, maternal death, and other losses relating to reproduction such as the absence of a 'normal' experience in high risk births (Earle et al., 2012). I do not adopt it here because my field of inquiry is specifically defined and does not include, for example, maternal death. Furthermore, this was not the vocabulary used by my participants. Some used the term 'baby loss', which is the term used by many charities in relation to the UK memorialisation and recognition movement, connected to participation in the international 'Babyloss Awareness Week' (Sands, 2019a). However, not all participants saw themselves as having lost a 'baby'. An alternative widely used in the UK is 'pregnancy loss'. Although in the USA this term has been critiqued on feminist grounds as being uncritically close to anti-abortion campaigners (Reagan, 2003), I believe that in the UK it has a different meaning. The term is widely used in lay discourse, particularly online, and is generally understood to include any woman who defines herself as having a loss, whether the loss was spontaneous or induced by termination. It has connections to the 'baby loss' movement, which in the UK can also include terminations, but does not fully adopt it. It is understood in medical discourse in the UK (Moscrop, 2013). It also has a history of use in social science and related literature (see for example Cecil, 1996; Layne, 2003a; McNiven, 2016).

The phrase ‘pregnancy loss’ includes a wider definition of what a pregnancy is than alternatives such as ‘foetal demise’ or ‘miscarriage’, which focus on the foetal body alone, or impute blame to the woman’s body, because ‘pregnancy loss’ includes the changes to the woman’s body and the relational aspects of pregnancy (Parsons, 2010). Whilst Parsons claims that the term ‘loss’ is not always sad, this is not the case in my study, where I use the phrase ‘pregnancy loss’ because the women in this research were talking about wanted, planned, or accepted pregnancies and therefore there was loss, of varying character and content, involving sadness, also of varying character and content. Amber had struggled to find ways to publicly speak about the death of her daughter due to termination for foetal anomaly after diagnosis of Smith-Lemli-Opitz syndrome, a genetic disorder resulting in multiple health complications (Pierre, 2018). Five years after the loss, she had found a form of words to use if people asked about her reproductive history:

> ‘I'd a little girl that I lost.’ I could say that, now. I felt really, like, when it first happened I really struggled with how to explain it. Whereas now I can. I know. I know the reality. But 'lost'. I feel like that's...[pause] acceptable. Palatable. For me.
> *For you, or for other people?*
> Both. Yeah.
> *Has that word got enough content in it for people to understand...?*
> Yeah, it's general enough. And still attached to pain.

‘Pregnancy loss’ can act as an umbrella term to include spontaneous *and* induced foetal and neonatal deaths which are mourned, which might in other contexts be called ‘miscarriage’, ‘stillbirth’, ‘premature birth’, ‘termination for medical reasons’ or ‘abortion’, and this is the way I use the term here. The phrase contains within it the sense of unwished for outcomes. In this sense it connects to wider definitions of relational loss which extend beyond bereavement (Miller & Parrott, 2009) and does not exclude pregnancies which are terminated, since these may also be forms of loss even if a bereavement is not claimed (Hey et al., 1989; McNiven, 2016; Sheach Leith, 2009).

1.5 Positionality, and personal experiences of pregnancy loss

Finally, in concluding this introduction, I briefly situate myself in relation to second trimester pregnancy loss. I do this for feminist reasons related the production of knowledge from situated researcher positions which need to be identified for ethical and epistemological reasons (Haraway, 1988; Harding, 1987, 1992; Hartsock, 1987; D. E. Smith, 1974). I also understand knowledges, including of pregnancy, labour, childbirth and relations with the foetal being, to be located in bodies, which are themselves located, and gendered (Bordo, 2003b; Shilling, 2012; D. E. Smith, 1974). My production of the knowledge presented in this thesis therefore draws on my life experiences, my own embodiment, and my personal reflection on these. Some of this positionality is structural, and the research was able to happen at all because of my privileged position as a middle-aged, white, British woman with an elite education who was able to obtain ESRC funding. I am also influenced by having completed my undergraduate degree in social anthropology in my early twenties, in a department led by Professor Marilyn Strathern, which permanently orientated me towards feminist and critical approaches to social knowledge. Other influences are more intimate, and based in my own kinship biography, including my experiences of pregnancy and mothering in my heterosexual marriage, and experiences of non-normative kinship relations through a wider family history which includes parental divorce and remarriage, lesbian marriage, stepfamilies, and adoption. Yet other biography, such as direct experience of pregnancy and birth in South West England, gave me contextual knowledge of the English antenatal and obstetric healthcare system, medical terminology, local hospital layouts, and the ability to more easily ‘appreciate the connotative’ in ethnographic work as a result of conducting research in my own social world (Rapport, 2002, p. 7).

However, the direct impetus for this research came from the second trimester foetal deaths of my babies Summer and Oliver in 2010 and 2011 whilst I was teaching the now defunct A-level Anthropology in Cornwall. Teaching about kinship, personhood, and gender whilst going through my own reproductive losses and raising my three living children, Ida, Miranda and Felix, was an intellectual journey as well as a personal and emotional one. Discussing my experiences with other women on a British online forum for second trimester loss prompted me to put together the research proposal. As Sheach Leith (2009) has commented in relation to her own reproductive losses, in such situations research can become about linking personal experience to wider social processes. It became clear to me that what seemed at first like a personal, private, medical event had resonances and connections to broader ideas about the meaning and politics of pregnancy, mothering, personhood, and kinship. As such, this thesis follows in the footsteps of other women who have thought and written about social, philosophical, and historical aspects of fertility, pregnancy and pregnancy loss during which they have drawn on their personal lifecourse experiences, in different social contexts (see for example, G. Becker, 1999; Elliot, 2020; Ivry, 2010; Kilshaw, 2020a; Layne, 2003a; Letherby, 1993; Letherby, 2015; Lovell, 1983; S. Murphy & Thomas, 2013; Peel & Cain, 2012; Reagan, 2003; Sheach Leith, 2009; Thompson, 2005). Reflection on the researcher's subjectivity and lifecourse experiences can give epistemological insight in research (Letherby, 2015), and openness about shared experience can minimise and disrupt extractive power relations in research (Oakley, 1981). At the same time, there is a need to not assume similarity between experiences, or to downplay power-related differences between researcher and researched (Doucet & Mauthner, 2007). I therefore follow Strathern in claiming that the adoption of a feminist approach must entail a radicalism of approach in both politics and research (Strathern, 1988), in which a critical approach to categories of thought on which identity is constructed is central to the research process. As a consequence, I acknowledge the significant role that my personal experience and knowledge has played throughout the research, including in my conversations with participants, my analysis, and my writing of this account. However, I wish to make it clear that the stories I tell, and which form the ultimate knowledge basis of the thesis, are not my own but those of my participants, as they thought fit to share with me.

1.6 Overview of the thesis chapters

The biomedical and legal governance discourses and the teleological ontology of pregnancy are intertwined and co-constitutive. However, in order to present my argument it is necessarily to disentangle them and present them in a sequential way. I have chosen to do this a way which simultaneously tells the story of second trimester pregnancy loss in a linear fashion, telling women's stories from diagnosis of a problem with the pregnancy, through the experience of labour and birth, to the consequences afterwards of birth registration, disposal of the body of the foetal being, and for some women social disruption and resistance through memorialisation of the foetal being as a baby, a person, and kin.

I follow this introduction with a review of pregnancy loss literature, paying particular attention to scholarship which investigates UK pregnancy loss, and then an explanation of the methods by which the knowledge in the thesis was produced. The body of the thesis which reports the ethnographic findings is then divided into two parts. Ethnography Part 1 is an account of the practical consequences of biomedical-legal ontologies of pregnancy for women experiencing second trimester pregnancy loss in England. These findings can potentially apply to any women experiencing second trimester pregnancy loss, whatever her position on foetal personhood or the nature of her loss, because they limit action and agency in multiple directions. In Chapter 4, I show how biomedical diagnosis of the foetal body being the second trimester of pregnancy limits and structures the healthcare options available to women. In Chapter 5, I describe the use of disciplinary techniques in healthcare which sometimes amount to obstetric violence to perform boundary work around ontologies of the second trimester foetal being, pregnancy, and the status of the pregnant and post-pregnant woman. I then turn to governance to explain the consequences of legal aspects of the dominant English ontology of pregnancy in second trimester loss. Chapter 6 explains the consequences of birth registration law as it applies in the second trimester, and how this can limit post-pregnant women's access to resources in the second trimester if they do not produce a living baby. Chapter 7 discusses the governance of the dead foetal body and its consequences for parental choices around disposal and post-mortem[9].

In the second part of the thesis, Ethnography Part 2, I provide an account of the ontological consequences of second trimester pregnancy loss for those women

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[9] A version of this chapter has been published in *Mortality* (Middlemiss, 2020b).

who experience conflict with the dominant teleological or biomedical-legal ontology. This part of the thesis is relevant to women who contest the ontological position that their experience did not produce a baby or person, or make them mothers. In Chapter 8, I describe how conflict between embodied experience and the dominant biomedical-legal discourse and practice produces ontological disruption for some women. In Chapter 9, I offer an explanation of how ontological disruption can be resolved, and the biomedical-legal ontology of pregnancy can be resisted, through the agential use of English kinship ontology and practices related to it.

The thesis concludes in Chapter 10 with the contributions it has attempted to make to the field of reproductive politics, and to ethnographic knowledge about foetal personhood and kinship in England.

Chapter 2: A review of pregnancy loss literature

Having situated the thesis in relation to broader theory and concepts of personhood, reproductive politics, and ontology in the introduction, in this chapter I give an overview of relevant existing social science literature on pregnancy loss. I draw from literature in sociology, anthropology, and socio-legal studies, with some forays into studies in other fields where they concern themes which are central to social science, such as psychology and loss literature (Peel, 2010; Peel & Cain, 2012), or nursing literature which uses anthropological methods and concepts (F. Murphy & Philpin, 2010). I broadly define social science as that conducted by academics situated in social science fields, rather than where they publish. This section also includes social science literature with an international scope which includes UK data (for example, S. Murphy & Cacciatore, 2017). However, in general I am critical of the lack of specific geographic and cultural context of some of these studies, for reasons which I laid out in Chapter 1. My survey is not exhaustive in that I do not include work which is located in applied health studies and which does not make a theoretical contribution to the literature. I also exclude review articles which do not add novel empirical knowledge.

In the chapter, I first show how pregnancy loss has been investigated in social science in the UK context, with consideration of absences or tensions in the literature in relation to my specific field of interest of second trimester pregnancy loss. I then consider how studies from other settings add to knowledge about what might be happening in pregnancy loss, in particular theoretically. In the course of this review, I draw out themes which are relevant to the work presented here and which were set out in Chapter 1. These include the cultural specificity of experiences of pregnancy loss, the importance of a critical attention to contingent categories of loss and their consequences, links between institutions and structures in society such as biomedicine and the law, the role of pregnant women's agency and reproductive politics, and the construction of types of foetal personhood and connections with abortion politics. I argue that whilst several of these themes are often present across the different studies presented here, there has not been an explicit examination of all of them in the UK context. Critical analysis of the UK category of second trimester loss and its consequences for pregnant women has not been carried out prior to this thesis, and it is a lens through which many of the concerns of the general literature on pregnancy loss can be scrutinised.

2.1 Pregnancy loss in the UK as the object of social science

In 1983, a short article in the journal *Social Science and Medicine* brought women's experiences of some types of pregnancy loss to the attention of sociology (Lovell, 1983). Based on interviews with medical professionals and women in England who had experienced stillbirth (at that time defined as after 28 weeks' gestation), perinatal death, or late miscarriage (then 20-28 weeks' gestation), it covered an enormous amount of ground which is still relevant to pregnancy loss analysis decades later. Lovell approached pregnancy loss as a classificatory issue connected to fundamental ontologies of personhood, kinship, and motherhood when she asked the questions ''What is a baby? and 'What is a mother?'' (Lovell, 1983, p. 755). In the article, she described the withholding of foetal personhood by medical staff (Lovell, 1983, p. 756) and the medical 'de-mothering' of pregnant women whose baby has died (Lovell, 1983, p. 757). Lovell also touched on some of the consequences of pregnancy loss governance, in her recognition that state certification acts as a proof of existence, and also that classificatory practices can limit state support for women. So long after this study, it is significant to note how many of the themes Lovell identified in the liminal pregnancy loss of her time (post 20 week losses) are still present in the liminal pregnancy loss of the second trimester (13 to 24 weeks) which is the focus of this thesis. However, although Lovell's analysis touched on power relations in pregnancy, especially with regard to medicalisation, her work did not draw broader conclusions based in reproductive politics or feminist analysis. Nor does the short article address women's agency in their pregnancy losses, for example in relation to memorialisation. Her conclusion focused on practical recommendations around giving women choices in healthcare, and did not provide answers to the questions she raised about *what* a baby or a mother *is* at an ontological level.

Whilst I also do not give definitive answers to these questions in my own work, I do seek to locate the answers given by others, such as biomedicine, or different pregnant women, in the context of feminist reproductive politics.

2.2 Political approaches in pregnancy loss literature from the UK: feminism and medicalisation

Lovell's groundbreaking work was followed by explicitly feminist accounts of miscarriage and ectopic pregnancy in the UK which aimed to produce empirical knowledge of women's lives, and to make their experiences more visible within society and medical institutions (Hey et al., 1989; Oakley et al., 1984). This reflected increased attention to women's experiences of pregnancy loss in the charity sector. Sociological work followed the lead of lay publications on pregnancy loss which were focussed either on improving medical care or on recognising loss (Elliot, 2020). Early sociological accounts of pregnancy loss in the UK are located alongside developing theories of medicalisation (Conrad, 1992), and specifically the medicalisation of pregnancy (Arney, 1982; Oakley, 1980, 1984; Zola, 1972). In this vein, Hey argued that the medical management of pregnancy loss in the NHS in the 1980s was an exercise in power in which women's experiences were marginalised and downplayed by the NHS's mostly male doctors (Hey, 1989). She argued that where medical practitioners were unable to effect a different outcome in pregnancy loss, they downplayed the event to make it less problematic and significant, for example using a model of menstruation to describe the pain of miscarriage.

Such 1980s studies of pregnancy loss were attempting to redress a power differential between women, understood as patients, and the medical establishment, understood as a repressive apparatus of power with varying connections to patriarchy. Since this period, it has been argued that the general theories of medicalisation are an oversimplification of the expansion of medical dominance in society which does not pay enough attention to lay agency (see for example, Ballard & Elston, 2005). The early studies of pregnancy loss do support this critique, since whilst they describe agential action by women in the face of pregnancy loss, they do not explicitly theorise about this. Letherby (1993) was the first to explicitly point out the potential agency of some women when she focussed on the meaning of the miscarriage to her interlocutors, who grieved for the loss of a baby or person in the face of medical lack of acknowledgement of this. She emphasized that despite medical denials of women's motherhood, for example through treatment on gynaecology wards and lack of pain relief, some women were able to assert their grief at miscarriage as a form of resistance to the medicalised management of the event.

However, all the early pregnancy loss studies in the UK understand medicalisation to involve the medical control of processes related to pregnancy (such as childbirth or miscarriage) and how they are managed in a hospital setting. There is no connection to broader ideas about medicalisation as the location of control of deviance (Conrad & Schneider, 1992), through which, for example, the medical management of pregnancy loss could be understood as the management of deviant reproduction, or deviant female reproduction. Early social science investigation of pregnancy loss in the UK was often descriptive, focused on building empirical evidence of poor treatment of women in the NHS in order to effect change in medical protocols and systems based on underlying psychological models of grief and bereavement, rather than theorising about a broader politics of reproduction in the way this thesis does.

2.3 Contextualising pregnancy loss beyond biomedicine

The site of pregnancy loss experience within NHS medical care, understood and critiqued as a purely medical event, is also a limitation to twentieth century pregnancy loss studies in the UK. There was little room for wider contextualisation or connections between other social structures, institutions, norms and discourses, except a broad feminist idea that women's experiences are marginalised. Some exceptions in early literature came from outside sociology: Cecil's small anthropological study on rural women's pregnancy losses in Northern Ireland addressed the lack of ritual response to the losses in a highly religious society, which she concluded was a statement about lack of acknowledgement of the event compared to the death of an adult (Cecil, 1996). Published in the same edited volume, the institutions of law and medicine were linked in a historical account of eighteenth-century English court cases involving prosecution of women for infanticide in which women accused of murder claimed to have experienced pregnancy loss (M. Jackson, 1996). Jackson's work is notable for its connections of the law, medical diagnosis of the gestational stage of a woman's pregnancy, a foetus' potential viability or personhood based in its own developmental stage, and wider social attitudes to deviant reproduction in women. Although the research is historical and legal, this approach pays attention to political relations, agency, gender, and deviant reproduction in a way which I would hope to reflect in this thesis and which align with theoretical linking of the medical domain to that of the law (Conrad & Schneider, 1992).

Since Cecil's book, other anthropologists have sought to contextualise pregnancy loss in the UK setting and to understand it in relation to other social structures. Shaw has considered young British Pakistani Muslim women's experiences of pregnancy loss as potential contestations and renegotiations of foetal personhoods in the context of customary Islamic practices around personhood recognition and funerals (Shaw, 2014). Kilshaw has analysed experiences of miscarriage in England in relation to neoliberal attitudes to the control of risk and the construction of planned pregnancy as a form of good motherhood (Kilshaw, 2020a). These approaches, which pay attention to the context of pregnancy loss beyond the biomedical setting in which it may take place, inform my own approach in this thesis. Their location of pregnancy loss in wider discourses, such as religion or motherhood, are able to capture pregnant women's agency and locate experiences of loss in broader ontological positions.

2.4 Attention to categories of pregnancy loss

Until the Stillbirth (Definition) Act 1992, spontaneous pregnancy losses up to 28 weeks' gestation were all legally classified as miscarriages. As a result, the feminist sociologists in the 1980s and early 1990s conceptualised pregnancy loss pre-28 weeks as miscarriage and ectopic loss, and they also did not include terminations as pregnancy losses. Pre-28 week loss was therefore understood as one type of experience, defined by a specific gestational timeframe and the spontaneous occurrence of the event (Hey et al., 1989;

Letherby, 1993; Oakley et al., 1984). Although Lovell had connected different types of pregnancy loss in one study based on how they were dealt with in the hospital (Lovell, 1983), she did not include induced termination, perhaps because of its relative rarity at this time when prenatal diagnosis was still in its infancy (Carlson & Vora, 2017).

Pregnancy loss social science in the UK context since the early studies has also often uncritically accepted the medical and legal diagnostic criteria which divide types of loss into exclusive categories based on gestational time and parental intention, such as miscarriage, stillbirth or abortion, or has not clearly defined categories such as 'miscarriage' (see for example, Simmons, Singh, Maconochie, Doyle, & Green, 2006). There are three broad approaches to categorisation in UK pregnancy loss literature. One is to accept legal and medical categorisations at face value and use them to investigate particular types of distinct event. A second is to draw categories together as 'reproductive loss' or 'pregnancy loss' and to have this as a singular experience. The third approach, which I believe is the most analytically rigorous, is to pay attention to specific biomedical categories, but to locate these within a broader experience of pregnancy loss in order to critically examine them by comparison. This third approach is that which I seek to employ in this thesis when I investigate the second trimester and the experience of labour and birth in the separation of foetal and pregnant bodies as the common experience for participants, but maintain interest in differences too, such as whether there was a live birth or whether feticide was used. It critically approaches biomedical categorisation as a technology of power which has effects in the world beyond biomedicine.

2.4.1 Employing the biomedical and legal definitions of loss

Uncritically accepting biomedical and legal definitions of loss, by contrast, can distort the literature around pregnancy loss in several ways. Firstly, there is a tendency to select one biomedical or legal category as a paradigmatic loss and therefore to represent what happens in that type of loss as unique, without critical examination. For example, until recently women's experiences of abortion and spontaneous pregnancy loss have usually been treated as different research objects in social science in the UK. Social science investigating abortion has tended to focus on women’s choices and their medical care, often not distinguishing between gestational stages of abortion and motivations for abortion, using the grounds for abortion defined in the 1967 Abortion Act as categories for investigation (see for example, Ingham, Lee, Clements, & Stone, 2008; Lee & Ingham, 2010; Purcell, Brown, Melville, & McDaid, 2017; Statham, Solomou, & Green, 2006). The law, defining as it does the parameters of abortion in the UK, has played a central role, with social scientists and social policy stepping into socio-legal territory and vice versa (see for example, Lee, 2004; Sheldon, 1997), and making useful analytic connections between the interaction of law and medicine (Statham et al., 2006). However, such connections have not been broadened to include types of pregnancy loss which are spontaneous, or do not come under the 1967 Abortion Act.

Geographic specificity is a strength in abortion research, because the nations of the UK have differential access to abortion (Beynon-Jones, 2012; Purcell et al., 2017; Purcell et al., 2014). The particular case of Northern Ireland, where the 1967 Abortion Act does not apply but abortion has very recently been decriminalised has been the subject of geographically and nationally specific study of women’s experiences and options in the context of abortion rights and restrictions (see for example, Best, 2005; F. Bloomer & O’Dowd, 2014; F. K. Bloomer, O’Dowd, & Macleod, 2017). But in these studies, connections between women’s experiences of abortion and other forms of pregnancy loss which are not regulated by the abortion law have been limited. Some comparisons have been made across abortion and spontaneous pregnancy loss, for example the necessity of travelling to England from Scotland in cases of late abortion under Ground C of the Abortion Act when late miscarriage could be treated in Scotland (Purcell et al., 2014). However, overall the literature on abortion and that on spontaneous pregnancy loss in the UK has been distinct and divided by national geographic boundaries. Intentionality has been assumed to be the key factor in pregnancy loss, rather than other factors which this thesis investigates, such as the timeframe of gestational development of the foetal body.

Other types of pregnancy loss have been investigated sociologically without making critical assessments of the biomedical and legal definitional terms, or whether there are connections to other forms of loss. For example, stillbirth studies have described gendered stigma around the pregnant woman's failure to produce a living baby (S. Murphy, 2012c), the effects of stillbirth on parental identity (S. Murphy, 2012a, 2012b) and the effects on grandparents (S. Murphy & Jones, 2014) which could all apply to many other types of pregnancy loss, including termination for foetal anomaly. Such effects were found in my own research on second trimester loss, showing they are not unique to stillbirth. Murphy's work drawing on the concept of continuing bonds with the dead (Walter, 1999) in its description of ongoing relationships between parents and stillborn babies (S. Murphy & Thomas, 2013) also applies in other forms of pregnancy loss. Therefore, although these studies represent important additions of knowledge about stillbirth, they are not necessarily unique to stillbirth as a category of loss. Similarly, investigation of non-heterosexual women's experiences of 'missed' miscarriage in the UK focussed on the need to avoid heterosexism in healthcare (Peel & Cain, 2012). However, this conclusion about heteronormativity in pregnancy care is likely to be applicable to other forms of pregnancy loss, including stillbirth or termination. The contribution of such studies in terms of empirical detail and theory could be broader if they were explicitly situated in broader categories of pregnancy loss, or could be more theoretically strong if they explained why the experience is particular or unique to the form of loss they describe. This thesis attempts to do that in its attention to the experiences of labour and birth which are mandated in second trimester pregnancy loss.

Sometimes when one category of loss is used in research there can be a lack of attention to cultural and geographic specificity. Murphy and Cacciatore (2017) are critical of stillbirth, perinatal death, miscarriage and abortion being conflated into one category of 'pregnancy loss', which they consider problematic in terms of reviewing research in the field. Their critique, however, is undermined by their own form of conflation, when they analyse experiences of stillbirth in North America, the UK, and other parts of the world as the same type of experience, despite different legal and medical definitions of stillbirth in each location. This is an example of another type of distortion in the literature, in which experiences of pregnancy loss are insufficiently particularised and contextualised because the theoretical objectives behind the study are assumed to take precedence over other considerations, especially locality. Further examples include work which assumes that non-heterosexual women have similar experiences whatever their type of pregnancy loss in settings as diverse as the UK, Australia, the USA or Italy (Craven & Peel, 2017; Peel, 2010). There is a minimisation of the cultural, legal and healthcare contexts of loss in research which assumes that all non-heterosexual or non-cis women will have similar experiences of all types of 'pregnancy loss' in any context. The assumption is that non-heterosexuality is *more* determining of experience than other factors, such as local practices. It is surprising that geographic and cultural difference is not more acknowledged in these studies, particularly when other types of cultural difference is sometimes key to the argument. For example, Peel acknowledges that the prevalence of 'missed' or silent miscarriage in the USA is greater than in the UK because of earlier access to ultrasound scans (Peel & Cain, 2012), meaning that there are substantial cultural differences in this type of pregnancy loss. These difficulties in the literature contribute to my determination in this thesis to locate my research in a specific geographic, jurisdictional and cultural space.

Some social science literature from the UK has avoided generalisation in terms of locality and culture. Cecil's work in Northern Ireland paid anthropological attention to the particularity of Northern Ireland within the UK, for example in discussing differences in abortion law, healthcare provision, family sizes and sectarianism (Cecil, 1994a, 1994b). The research focused on women's attitudes to their medical care and the availability of support for the pregnant woman from her kin. However, as with other work looking specifically at one category of pregnancy loss Cecil did not explain whether the experience of first trimester miscarriage was significantly different to other types of pregnancy loss in respect to her theoretical interests in the support offered to miscarrying women. In fact, her discussion of the results stated that most of the women themselves described their early loss as the loss of a 'baby' and did not see the miscarriage as categorically different to a later loss (Cecil, 1994b). In this thesis, I seek to avoid this issue and to represent the specificity of loss in the second trimester of pregnancy as a distinct experience.

Where investigating pregnancy loss through the different categories prescribed by biomedicine is particularly fruitful is in those studies where the materiality of the category itself is investigated. Frost et al.'s (2007; 2006) interview study of women from South West England experiencing first trimester miscarriage found that the frequent absence of a discernible foetal body in early loss resulted in ambiguity about the nature of what was that was lost. Similar findings in relation to the lack of foetal corpse in early loss were found in a study of pre-16 week miscarriage in Wales, which also found liminality and ambiguity in gynaecology nurses' treatment of miscarriage came from classificatory connections between early miscarriage and menstruation (F. Murphy & Philpin, 2010). In these studies, attention to the materiality inherent in the particular gestational time-based category of loss provided insight into women's experiences and their medical treatment. In this thesis, I seek to maintain such attention to materiality in the specific category of second trimester pregnancy loss, especially in relation to the size of the second trimester foetal body and the mandated experience of labour and birth for the pregnant woman.

2.4.2 'Pregnancy loss' as a singular experience

Besides investigating discrete types of pregnancy loss based on biomedical definitions, such as 'stillbirth' or 'miscarriage', recently some studies have turned to the broader category of 'pregnancy loss'. This has productively emphasized how alignments between types of bereavement are produced by similarities in practices, such as the disposal of infant and 'nearly viable foetuses' in special 'baby' areas of cemeteries in the UK (Woodthorpe, 2012, p. 143). However, there can be assumptions behind the categories of loss employed in the studies. McCreight (2007) examined the role of self-help parental groups for all types of 'pregnancy loss' in Northern Ireland and stressed the importance of mutuality and shared experience across different types of pregnancy loss, from miscarriage to stillbirth. She does not describe any conflict related to hierarchies of these losses but in her writing she explicitly labels experience with loss categories. This suggests that there was a significant distinction made between categories of pregnancy loss, either by McCreight or the parents themselves, but this was not explicitly addressed in the study. Furthermore, since this study took place when abortion was illegal in Northern Ireland, presumably the support group was not open to parents who had had a termination. The apparently inclusive term ‘pregnancy loss’ may contain some hidden exclusions. In another study of fathers’ grief in relation to pregnancy loss aimed at improving the acknowledgement of this, McCreight (2004) mentions the different types of pregnancy loss in terms of registration and disposal arrangements but does not systematically analyse the causes or effects of the categorical distinctions on fathers’ grief. In this thesis, I seek to focus on one biomedical category of loss, in the second trimester, but also not to lose sight of the political work that the categorisation itself is doing in including and excluding experiences and agency in relation to other categories of loss.

2.4.3 Critical examination of pregnancy loss categories

Taking ‘pregnancy loss’ as the object of social science can avoid the difficulties described above if it is combined with a careful analysis of the categories used by different groups of people in different circumstances, and the political effects of these categories. Lovell’s early consideration of commonalities of response to neonatal death, stillbirth, and late miscarriage may have omitted some of forms of pregnancy loss which would now be recognised, such as termination, but her attention to difference and similarity within and across categories is central to this type of approach. Moulder, investigating the medical care of women experiencing miscarriage, stillbirth and termination in 1990s England was critical of differential access to medical care based on gestational time and the voluntary or involuntary nature of the loss, which she argued did not reflect women’s experiences, which were better envisaged as a continuum (Moulder, 1998). She deliberately took ‘pregnancy loss’ as an object of research defined by women’s multiple and diverse experiences, whilst still paying careful attention to the categories of loss imposed by medical definitions of the event and their impact on specific experiences. Moulder was the first to include termination in all its forms within accounts of pregnancy loss, following the lead of UK charities such as Sands with whom she collaborated, and she also retained a critical perspective on whether involuntary loss necessarily produced grief. She also acknowledged the blurring of categories between miscarriage and termination in some specific cases of induction of labour, which is relevant to much pregnancy loss in the second trimester. This work also was the first to specifically address second trimester loss as a category, describing the medical management available to women and linking it to third trimester loss. It was not, however, an investigation of the wider social setting of pregnancy loss, nor a contribution to the politics of reproduction but as with much sociology of health and illness research in the UK was aimed at assisting health professionals to improve their practice, giving specific evidence-based recommendations for care. The research presented in this thesis has a different aim in terms of understanding the reproductive politics of second trimester pregnancy loss.

Navigating this tension between specific and general forms of loss through attention to classificatory categories is very relevant to this thesis and has been pursued by several researchers since the 1990s. Earle et al. (2008) broadened the concept of ‘reproductive loss’ to include all spontaneous loss of the baby or foetal being, as well as maternal death and infertility. By 2012, two of these authors working in a UK context had joined with Linda Layne, eminent anthropologist of pregnancy loss in the US context whose work is further discussed below, to also include abortion in their definition of ‘reproductive loss’ (Earle et al., 2012), removing intentionality as the determining factor in categories of loss. Similar work was done in Canada (Lind, 2017) and in philosophy in the US in which Parsons (2010) used the term ‘pregnancy loss’ but did not distinguish between ‘chosen’ loss (termination) and ‘involuntary’ loss (miscarriage, stillbirth etc). Around the same period, sociologist Sheach Leith (2009) published an autoethnography about her own multiple pregnancy losses in the 80s and 90s in Scotland and noted how classifications of her losses produced different trajectories for each baby. For example, she and her husband did not name the first, who died through termination, until much later, and the second trimester losses were disposed by incineration, but the stillborn boy merited a gravestone and parental involvement in post-mortem choices. She discussed these losses in the context of evolving debates about the construction of prenatal personhood and the social legitimacy of grief for prenatal beings, especially in relation to intentionality and the ‘illusion of choice’ in termination for foetal anomaly (Sheach Leith, 2009, p. 208). Such work pays attention to the effects of biomedical and legal classification of types of pregnancy loss, and also to the assumptions these classifications carry with them, such as emphasis on individual choice and responsibility in abortion. By comparing categories of loss in a critical approach, analysis is possible which investigates the reproductive politics of those loss categories.

Most recently, the interdisciplinary Death Before Birth project between 2016 and 2018 brought together termination for foetal anomaly, some gestational stages of miscarriage, and stillbirth as the object of its investigation of parental decisions about what happens to a baby after death (Death Before Birth Project, ND; Kuberska, Fuller, Littlemore, McGuinness, & Turner, 2020). Contributions to social science literature so far include consideration of ambiguities around the legal and medical procedures regarding disposal of pre-24 week pregnancy remains in England and Wales (Austin & McGuinness, 2019). In this paper, it is clear that comparison between stillbirth and miscarriage, and also between miscarriage and termination, were instrumental in producing knowledge which would not have been visible if the medico-legal categories of pregnancy loss had not been brought alongside one another. From the same project, Kuberska's work on funeral services for pre-24 week losses critically examines categories of loss and the consequences of these for disposal rituals and procedures (Kuberska, 2020).

Bringing categories of pregnancy loss, including termination, alongside one another therefore produces insight into the commonalities of the experience for women. It can also highlight specific characteristics of particular categories by contrast with others, as in the research into early loss and the absence of a foetal body. For example, recent research on termination for foetal anomaly in England and France clearly laid out the differences between this type of loss and miscarriage in terms of the element of parental decision making and the moral component of the decision, and the similarities in terms of losing a wanted baby before birth (Lafarge, Rosman, & Ville, 2019). This also forms part of a move in the literature to set pregnancy losses alongside one another. This is not without its own analytic and political complexities, in the sense that 'pregnancy loss' or 'loss' may not always be the most appropriate term in spontaneous events or in terminations. On the other hand, uncritically accepting the biomedical and legal definitions of categories of pregnancy loss does not fit with some women’s experiences. This thesis, with its focus on bringing together second trimester experiences which share the same medical management, hopes to fill a gap in the literature in relation to study of the second trimester as a biomedical and legal category. It will offer insight into loss, and also into pregnancy in general, by critically engaging with what the category of the second trimester means in UK pregnancy loss. It will do this whilst paying attention to geographic specificity in relation to the cultural, legal and healthcare setting of the UK. It will seek to represent the effects of classification of a pregnancy as ending in the second trimester, and to consider the political implications of this classification.

2.5 Pregnancy loss literature beyond the UK setting

Having considered social science literature related to pregnancy loss in a UK context, I now turn to selected international work in the field, drawn from medical sociology and medical anthropology. The importance of understanding pregnancy loss in its specific cultural context has been emphasized in anthropological studies which have noted the cultural specificity of the knowledge produced in their research (Kilshaw et al., 2017; Omar et al., 2019) or have warned against inappropriately importing biomedical concepts of the body into different settings (Sobo, 1996). Comparative studies have described different cultural contexts of pregnancy and the consequent contingent meanings of what has occurred, in particular in relation to gender politics (Jeffrey & Jeffrey, 1996; Winkvist, 1996) and the agential use of beliefs about the body (Sobo, 1996). Furthermore, the salient factors in categories of pregnancy loss in one culture may not be recognised in another – for example, where distinctions are not made on the basis of intentionality between ‘abortion’ or ‘miscarriage’ (van der Sijpt, 2020). However, there are empirical and theoretical connections to be made across cultural settings, whilst retaining an emphasis on locally situated knowledge. For example, empirically there are similarities between pregnancy loss in the UK and in other contexts in the medical management of induced terminations on gynaecology wards in Canada (Chiappetta-Swanson, 2005), or the representation of foetal beings as dead children in cemetery and online memorialisation in Denmark (Flohr Sørensen, 2011), and there are often similar, though not identical, practices of pregnancy loss mourning and bereavement in different international settings. Empirical similarities or differences described in one site can prompt critical distance from, and reflection on, empirical data gained from another site.

2.5.1 Pregnancy loss, motherhood, and foetal personhood

Other work in an international context goes beyond empirical description of experiences of pregnancy loss or practical recommendations for improvements to medical care, and approaches pregnancy loss theoretically and politically. The most influential international work on pregnancy loss is Layne's feminist anthropological investigation of pregnancy loss support groups in the USA in the late 1980s and 1990s (Layne, 1997, 2000, 2003b). The book which resulted from this work, *Motherhood Lost*, drew on and echoed Lovell's early questions asking *what is* a mother and a baby, and gave a relational answer in the particular historical and cultural context of the USA (Layne, 2003a). This work firmly established pregnancy loss as an object of social science, and despite its clearly located ethnographic context it continues to influence pregnancy loss research around the world.

Layne argued that the increasingly public construction of the human foetus through medicine and new reproductive technologies such as ultrasound, alongside American anti-abortion activism, had resulted in earlier social construction of the personhood of the future child in individual pregnancies. Combined with lower infant mortality and a decreased knowledge of negative pregnancy outcomes, she argued that unrealistic expectations of pregnancy had been produced which made invisible those pregnancies which were 'unsuccessful' through a cultural taboo which limited social acknowledgement and support for those who experienced this type of loss. Layne then focussed on the effects of this on women's experiences, and how the consequent cultural denial of the 'realness' of their baby, themselves as mother, and their grief as valid became a problem for them (Layne, 2003a, p. 17). In her explanation, Layne drew on processual-relational ideas about personhood (Conklin & Morgan, 1996) to describe 'person-making practices' in American pregnancies (Layne, 2003a, p. 28) situated alongside biological scientific understandings of the foetus, and anti-abortion rhetoric about rights based in foetal bodies, and the social liminality of foetuses and their corpses. She described in detail the ways in which American parents used material culture, including biomedical technology and consumer objects related to babies to construct the personhood of the dead baby in the face of this ‘realness’ problem of pregnancy loss. For parents, acts of remembrance resisted the cultural denial of the event as a loss. This attention to relationality and parental agency in the face of exclusion from mainstream discourses is central to my own thesis, as is Layne’s anthropological understanding of the possibility of posthumous personhood recognition.

My research is different from Layne’s approach in methods and in analytic emphasis, as well as being located in a different cultural context. Layne’s use of pregnancy loss support group newsletters as the source of her information drew her attention to bereavement and its practices, especially at group level. By contrast, the emphasis of this study on ethnographic interviews with women (see Chapter 3) has resulted in its focus on corporeal experience and the medical management of pregnancy loss. Layne conducted analysis of the reproductive politics of pregnancy loss, especially in relation to its marginalisation by pro-choice feminism and natural birth advocates. She also highlighted the problems caused by ‘a culture that often understands pregnancy in terms of capitalist production’ (Layne, 2003a, p. 145), which connects to the concept of teleological pregnancy in this thesis. However, her focus was also an anthropological analysis in which the primary cause of the marginalisation of pregnancy loss was a liminality intrinsic to the dead foetal body, rather than a wider disciplining of pregnancy itself, which I argue over the course of this thesis.

2.5.2 Pregnancy loss, social structure, and agency

Layne’s theoretical connections between the experience of pregnancy loss for women and the wider social and cultural contexts and structures in which it occurs have been developed in studies around the world, often in the field of anthropology. This type of pregnancy loss research centres the experiences, perspectives, and agency of pregnant women. It also often focusses on forms of agential resistance to normative understandings of pregnancy loss. For example, subsequent to her 2003 book, Layne wrote on the agential use of naming by parents as an assertion of the personhood of a baby in pregnancy loss, a practice described in pregnancy loss in other settings (Peelen, 2009; van der Sijpt, 2017). Research has been carried out on grassroots activist campaigns in the US for state certification of birth in pregnancy loss cases as a form of recognition of existence (Cacciatore & Bushfield, 2008). Layne has also discussed the concept of the ‘Angel Baby’, now prevalent in multiple online discourses, as a new form of family formation which deliberately emphasizes the uncanny nature of pregnancy loss in an agential assertion of kinship and loss (Layne, 2006, 2012). A similar concept has been noted Romania where ‘Angel Mothers’ can be mothers to beings who died in pregnancy (van der Sijpt, 2017). In these works, pregnancy loss is situated in relation to local social structures, and understood as the site of agential action, an approach which I seek to emulate here.

The importance of local, contingent and culturally specific contexts of pregnancy loss is emphasized in research which considers relationships between social structures and agency. Work on pregnancy loss in Cameroon challenged the universality of biomedical models of pregnancy disruption by considering local models of pregnancy in relation to local social structures (van der Sijpt & Notermans, 2010). Instead of seeing pregnancy as a biomedical event in one biological body, this research analysed the pregnant body as a relational body, situated in a fluid and contested context of gender, marriage and kinship which gives meaning to pregnancy loss disruption. In such circumstances, pregnancy loss can be sometimes be interpreted as spontaneous, or sometimes as abortion. Furthermore, a local focus on the degree of formation of the foetal body rather than a time-based linear gestational process produced elements of ambiguity which could be agentially used by pregnant women to assert their own interpretations of different reproductive disruptions (van der Sijpt, 2012). Van der Sijpt’s later work in Romania (2017) described the agential contestation of norms around pregnancy loss by parent groups in a specific post-communist state with a history of pronatalist policy making and an Orthodox Christian church which does not fully recognise infant loss.

In the Netherlands, research has described how connections between religious and medical institutions affected twentieth century responses to pregnancy loss, for example through Catholic edicts about the liminal status of unbaptised children (Faro, 2014; Peelen, 2009). Changes over time have led to the construction of memorial monuments in the Netherlands through which stillborn children are agentially socially integrated and the legal classification of the status of earlier losses can be challenged (Peelen, 2009). The law, religion, and biomedicine are entwined in this work, which illustrates how resistance to institutional definitions has come from families but has gradually moved back into the institutions themselves to form new norms. In Israel, medical and religious institutions are connected by rabbis advising couples about the religious acceptability of termination for foetal anomaly in order to spread the moral burden regarding reproductive decision making into the community (Ivry & Teman, 2019). These entanglements of religion, medicine, and parental agency in pregnancy loss connect to Layne's analysis of pregnancy and loss in Christian families in America as ordained by God, in which each event can be agentially used by individuals as markers of moral worth or pathways for spiritual growth (Layne, 2003a). Such research pays careful attention to specific local cultural and institutional norms and values and how these interact with the agency of individuals and families. In this thesis, I attempt a similar approach when I consider interactions between biomedical and legal categories of second trimester loss and local ideas about personhood and kinship.

2.5.3 Pregnancy loss, medicine, and the law

These theoretical and yet empirically situated connections between the medical management of pregnancy loss and other social institutions and structures can produce insight in diverse fieldwork settings. In New Zealand, sociologist of diagnosis Jutel (2011b) has described the interplay between medical diagnosis of foetal death and legal entitlements to the economic resources of maternity leave and pay However, most relevant to this thesis is the work of Memmi, who analysed how types of foetal being in France are produced through interactions between medical practices around allowing parental viewing[10] of the dead foetal

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[10] Memmi uses the verb 'regarder' which also has connotations of 'to observe' and 'to look at'. In English, in the context of pregnancy loss, I would argue this is perhaps closer to ideas of witnessing or

body in pregnancy loss, the practices of disposal by funeral professionals, and the law in France about forms of registration and disposal of the foetal body (Memmi, 2011). Changes in French law culminated in 2008 with a position where, at the parents' request, foetuses at any gestation can be given a first name, registered as a death in the official family record, and given a funeral. Memmi understood these beings as different from *juridical* persons, because they do not themselves have rights and cannot enter into contracts, but argued they are nevertheless produced as human beings, in a compromise which allows legal abortion and forms of foetal personhood to coexist. This categorisation of the foetal body as a human being is constructed by the physical body, its gestation and size but also by the social production of the foetus as a human life in the womb, through the viewing of ultrasound images of the living foetus and its prenatal construction as a separate psychological entity.

Memmi argued this shift to a form of personhood recognition is also derived from the valorisation of the child and the project of having a child in modern France in the context of low birth rates and infant mortality. There is therefore a historically and culturally situated social recognition of the psychological suffering engendered by pregnancy loss in women whose 'project of a child'[11] does not materialise. This recognition is enacted by medical professionals caring for women, and by the administration of corpses in the hospital. Memmi used the case of pregnancy loss to argue that biopolitics in France has been delegated to individuals, usually the caregiver in hospital in collaboration with the parents, who decide on the outcome of pregnancy loss situations such as termination for foetal anomaly on a case by case basis and in the context of the parents' commitment to the 'project of a child'. The ambivalence produced by the numerous possible outcomes in the pregnancy are stabilised by the professionals' use of the corpses to represent what has happened, for example presented as a dead baby where the 'project of a child' is accepted by the parents. In other cases, such as pre-14 weeks' gestation where abortion on demand is still legal, the foetal body will not be shown or seen.

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encountering, but still with a visual element, so I am using the term 'view' as the translation. There are connections here to Foucault's ideas of producing a subject through observation (Bartky, 1990; Foucault, 1977/1991, 1976 /1998).

[11] 'Le projet d'enfant' in French (Memmi, 2011, p. 125).

Memmi’s interest in the possibility of different types of personhood and their construction through complex social structures and the materiality of the human body is being developed by other authors in France, for example in work on social personhood recognition through the burial of foetal bodies (Charrier & Clavandier, 2019). In this thesis, I seek to bring this approach to personhood into the English context. Memmi’s use of theories of biopolitics in relation to pregnancy loss is also an important extension of reproductive politics beyond feminist analysis. Her analysis of the interplay between different local and contingent discourses and institutions such as biomedicine, the law, and cultural values around kinship and parenting is very close to the approach I take in this thesis. At the same time, there are significant differences in approach, perhaps because of my specific focus on women’s experiences as the empirical basis of this thesis. Memmi focused on psychological suffering rather than physical pain and suffering in the event of pregnancy loss. She often interchanged the terms ‘parents’ and ‘mothers’ in a way which I believe elides the gendered disappearance of the reproductive labour of the pregnant woman who has no child to show. There is also little space in her work for empirical detail regarding the agency of the pregnant woman and her kin – for example, when she wrote of post-mortem photos being used to produce persons, it was the medical professionals who were doing this, not kin. In my research, the agency of the pregnant woman is specifically considered in Chapter 10, and is central to an investigation of the reproductive politics of second trimester pregnancy loss.

2.6 Conclusion: the aims of the thesis in relation to the literature on pregnancy loss

This review of pregnancy loss literature from the UK and further afield has demonstrated that the research object of this thesis, women’s experiences of second trimester loss in England, is one which fits into existing literature and yet is a novel approach to pregnancy loss. There has been no previous study which takes women’s experiences of biomedically and legally defined second trimester pregnancy loss as its object of inquiry. There is also limited inclusion of termination in pregnancy loss literature from the UK, with the exceptions described above, particularly the Death Before Birth project (Fuller & Kuberska, 2020). Furthermore, not only is there is a limited amount of work on pregnancy loss from England, sometimes this is conflated with the UK as a whole. Much of the specific social science work from England is not theoretically motivated, does not address reproductive politics, and is more empirical and focused on improving medical practice.

There are therefore several empirical gaps in the literature which this thesis fills: knowledge of women's experiences of loss in the second trimester category from a critical perspective, ethnographic knowledge about pregnancy loss in England, and feminist knowledge which includes termination for foetal anomaly as reproductive loss. Furthermore, the thesis makes a contribution to theory in the field of reproductive politics. As part of this endeavour, it draws on concepts from a wide range of social science theories, many of which have arisen in the literature described above and which include ideas around the construction of personhood, kinship between persons, posthumous personhood, and the role of the foetal body in biomedicine. It considers the role of biomedical discourse, including diagnostic categorisations of loss, alongside analysis of medical practices which pays attention to issues of power and agency in the context of medicalisation. It investigates interactions between biomedicine and other social structures and institutions related to the governance of the foetal body and the pregnant body in England. And it considers the agency of women and their kin in their responses to second trimester pregnancy loss in England.

Chapter 3: Methodology and methods

In this chapter, I explain the methodological approaches and the practical techniques which were used to create the knowledge presented in the thesis (Ellen, 2010). The overall approach is a feminist multi-sited ethnography drawing on the disciplines of sociology, anthropology, and science and technology studies. In laying out the terrain of my research in Chapter 1, I described my own situated position within the project. This is because I understand research to be the production of constructed knowledges from situated positions which need to be identified (Doucet & Mauthner, 2007; Haraway, 1988; Harding, 1992; D. E. Smith, 1974). I also understand knowledges to be located in bodies, which are themselves located and gendered (Bordo, 2003b; D. E. Smith, 1974). This includes knowledges of pregnancy, labour, childbirth and maternal-foetal relations which are specific to those sexed and gendered female bodies which experience pregnancy. Feminism is therefore my philosophical starting point for knowledge production, and it is also central to the theoretical underpinnings of this research investigating pregnant and foetal bodies and power. For me, feminism is a critical, radical, and ethical position in relation to power, which should inform all aspects of the research process, from encounters with participants through analysis and the presentation of knowledge.

The research also has an element of interdisciplinarity, as is common in research on reproduction (see for example, Franklin, 1999b; Inhorn & Birenbaum-Carmeli, 2008; Layne, 2003a; Lupton, 2013; Thompson, 2005), in research on kinship and the family in the English context (for example, Finch, 2008; Finch & Mason, 2000; Strathern, 1992), and in the sociology and anthropology of Britain, an ethnographic locale in which there is flexibility and permeability of disciplinary boundaries (Degnen & Tyler, 2017; Dow, 2016; Lawler, 2017). Interdisciplinarity is also embedded in my training in anthropology, then STS, then sociology. Whilst interdisciplinarity can risk resulting in work which is not clearly situated in one academic discipline or another (as discussed by, for example, Hockey, 2002; Hockey & Forsey, 2013; Ingold, 2014; Miller, 2017), I believe it can also be a strength in its potential to create new knowledge and provide grounds for the critical interrogation of received ideas in social science which is foundational in feminist research (Reinharz, 1992).

3.1 Feminist ethnography

There is considerable debate about the definition of terms such as ethnography, participant observation, fieldwork, and so on (Hockey, 2002; Hockey & Forsey, 2013; Ingold, 2014; Miller, 2017), sometimes concerned with shoring up disciplinary boundaries (see, for example, Ingold, 2014). In this study, I use ‘ethnography’ to describe the method as well as the written analytic account of the research, in direct contradiction of arguments that ‘ethnography’ happens *after* the field encounter (Ingold, 2014). In fact, ethnographic elements occur all the time during the process of research, in a deliberate and productive iterative cycle, before, during, and after encounters in the field (Buch & Staller, 2007; Hammersley & Atkinson, 2007). In my research, analytic ideas and thoughts were explored *during* any given interview, and also in subsequent interviews with other participants, as well as during the rereading of transcripts and notes, and in the writing. Theory is also embedded in and constitutive of the ethnographic research process and its results, the finished writing (Nader, 2011). For example, selection of the persons with whom the ethnography is conducted affects the theory which can be produced. Ethnography does not necessitate a completely open engagement with all comers in the ethnographic process, and in my research I have selected women who have experienced second trimester pregnancy loss including labour and birth, rather than everyone who might have some connection with the event, such as other family members or medical staff. This affects the knowledge which is produced. This selection of participants is also feminist in approach, since second trimester loss takes place in and through the bodies of women, and I seek to centre their experiences, as well as bring feminist theory into the methods and writing which pays attention to issues of power (Buch & Staller, 2007). I attempt to integrate this into different parts of the research process. For example, my decisions about offering options around the naming of research participants (see 3.2.2) were connected to the theoretical role of names in claiming personhood for foetal beings, and also to theoretical feminist concerns about fairness in acknowledging roles in knowledge creation, as I discuss below. For the purposes of this chapter, I have broken down the research process into discrete parts in order to explore each in more detail. However, I would like this to be read in the knowledge that the stages were less clearly defined, and the connections between them more interdependent, than the writing of this chapter might suggest.

I therefore describe my overall work as feminist ethnographic research, and my specific methodological techniques within this as fieldwork involving ethnographic interviewing, participant observation, analysis of documents and the analysis of material culture. I describe the research as ethnographic rather than simply qualitative because of this breadth and openness of possible sources of knowledge. Ethnography also depends on an openness to what is found in the field, rather than a reliance on answering pre-established narrow research questions (Pelkmans, 2013). Ethnography includes within it an openness to change and challenge, to a less prescriptive and more flexible approach to research, and to an iterative approach across the life of the research project (Buch & Staller, 2007). It pays attention to relational aspects of research. Ethnographic fieldwork, to me, is a broad immersion in the field of inquiry in whatever way is possible, in a process involving my own learning and adaptation as I enter into relationships with others in the field, whilst still retaining a theoretical focus.

Ethnographic research has close links to some feminist approaches to research (Buch & Staller, 2007), and both have interests in individual experience situated within uneven power systems (D.-A. Davis & Craven, 2011). Attention to human agency and experience, the role of the researcher as the primary medium for the production of knowledge in intersubjective relationship with participants (Stacey, 1988) and a focus on power from different standpoints (Naples & Sachs, 2000) make links between feminism and ethnography. Reflexivity in research practice is relevant to both approaches, which centre the situated feminist researcher or the ethnographer in the production of knowledge (Ortner, 1995). Ethnography pays attention to accounts of relationships between the researchers and the researched (Skeggs, 2001) which are so important to feminist researchers interested in understanding power and its inclusions and exclusions (see, for example, Harding, 1987; Oakley, 1981). The feminist emphasis on the relational positionality of the researcher and researched has a parallel lineage in ethnography, for example in multi-sited ethnography where the politicisation and situatedness of the ethnographer can become a form of activism (Marcus, 1995). Feminist ethnographers have also emphasized the potential for political action through critical engagement in the context of reproduction research (D.-A. Davis & Craven, 2011; Layne, 2003a). Multi-sited ethnography therefore fits well with the feminist principles of this project, and also with the dispersed geography of sites of second trimester pregnancy loss in England described in section 3.1.1 below.

3.1.1 Ethnographic engagement in a dispersed field site

Fieldwork for this thesis was conducted across multiple sites in South West England, in the administrative and historic counties of Cornwall, Devon and Somerset, and the suburbs of the city of Bristol, in 2018 and 2019. The region spreads out into the Atlantic into a long peninsula (see map and location list in Appendix 2). Much of its population is dispersed over areas of rural landscape, separated by the semi-wildernesses of the moorlands of Dartmoor, Exmoor, and Bodmin. As a consequence, it has some of the lowest population densities in England (ONS, 2012). Some of my fieldwork trips were to small cities such as Bristol, Plymouth, Exeter, and Truro, others were to rural houses and villages, or small and medium towns. Participant observation at memorial events and charity events, and site visits of cemeteries and memorial gardens were spread across the three counties. The 31 interviews took place in a family home or in a café or pub nearby. There were also informal conversations in other locations, for example whilst dog walking on the beach.

The cascading, root-like distribution of population spreading into the remote South West was reflected in the spatial experience of second trimester pregnancy loss, where actual events of loss were often centred in the towns and cities where healthcare is located. These urban hubs are also often the site of communal memorialisation of pregnancy loss and the location of funerals and cremations. Communal disposal sites such as designated areas of cemeteries and crematoria for ashes scattering or burial, known as ‘baby gardens’, are similarly located in hub sites. Charity, hospital, or church-led events held in remembrance of babies who have died, for example during the national BabyLoss Awareness Week in October, or at Christmas, also take place in urban hubs. Women's homes, however, were physically isolated and separated from one another, in some cases lone family houses down deep cut lanes, a car ride from the nearest shop. Fieldwork in Britain is by its nature fragmented, as much social life takes place in indoor private spaces (Hockey, 2002). This is even more the case for the atomised, individual and private experience of pregnancy loss in South West England. Women outside the cities were usually unaware of anyone else in their communities who might have had a second trimester loss. For example, three participants in Cornwall were women of my broad acquaintance whom I did not know had had a second trimester loss similar to my own until they reacted to my online call for participants. This is partly a feature of the invisibility of this type of loss in English society, but also a feature of geographic distance from population hubs in this fieldwork setting. For example, until 2019 the Sands charity peer support group in Cornwall was held in the main city of Truro, a 45 minute drive from Penzance, or 75 minutes from Bude. In the more rural areas, this meant women who wished to make connections could not identify other women who had similar experiences of pregnancy losses through support groups and were reliant on internet networks to connect them to others.

This dispersed field site necessitated a multi-sited approach to ethnography, as there is no bounded community of persons interacting face-to-face with one another. However, I argue, following Hockey, that it is still possible to take an ethnographic approach. I define this as immersion in a social world, rather than simply analysing discrete interview events as in an interview study. During the course of the research I engaged widely with as many aspects of the field as I could. I spent time attending the All Party Parliamentary Group on Baby Loss in London, where I met employees of pregnancy loss charities, and Plymouth funeral director and activist LeighAnne Wright[12], who became one of my participants. I followed online Facebook and Instagram accounts related to pregnancy loss in the South West, including some set up by my participants. I attended pregnancy loss memorial events run by charities and religious groups

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[12] LeighAnne Wright has asked for her full name to be used in this research. See 3.2.2 for discussion of naming participants.

in the South West and paid attention to national events such as October's Babyloss Awareness Week, and I visited memorial sites, crematoria, and cemeteries. I made fieldnotes on these occasions, retained literature, and occasionally, where appropriate, took photos which I used as reminders. Prior to beginning fieldwork, I had thought I might meet participants at memorial events. However, it became apparent that it would be inappropriate to bring up requests for research participation at these events, which were emotionally charged and at which individuals or family groups did not interact much with one another. I therefore recruited interviews participants online, as described in section 3.3 below. During interviewing it emerged that I had actually attended some of the same memorial events as my interviewees. I also engaged in follow up correspondence and meetings with some interviewees, and in 2019 I became a committee member of the local Sands charity in Cornwall, along with one of my participants. All of these activities added to my knowledge of the field and broadened the study beyond one based solely on qualitative interviewing.

3.1.2 Interviewing as ethnographic practice

The bulk of the detailed knowledge of the effects of second trimester pregnancy loss in specific women's lives on which this thesis is based was gained through ethnographic interviewing of 31 women. There is a long history of interview studies of parents and professionals in UK pregnancy loss social science, (see for example Frost et al., 2007; Letherby, 1993; Lovell, 1983; McCreight, 2004; S. Murphy, 2012b; S. Murphy, 2012c). On a practical level, the dispersal and fragmentation of the sites of pregnancy loss means that interviewing afterwards is the sole means of gaining social knowledge of the event itself, through the words of those who were there at that time. Interviewing is also the most effective way of accessing emotional responses and the internal life of a participant (Hockey & Forsey, 2013; Lamont & Swidler, 2014; Pugh, 2013) and seeks to access the knowledge and perspective of participants (Kelly, 2010). I take the position that knowledge about society is created by the understandings of people within that society (C. A. B. Warren & Karner, 2005), and the practices in which they engage (Miller, 2005), and that people may reflexively engage with the discourses in which they are situated (Foucault, 1976 /1998). This means that the statements of social actors about their lives are both valid and important as the basis for social analysis (Giddens, 1984), and ordinary everyday experience is valuable to social science (D. H. G. Morgan, 2011; D. E. Smith, 1987). As well as being practical and having validity in creating knowledge, interviewing is potentially an ethically and politically engaged method (E. Murphy & Dingwall, 2001), because it recognises that both parties in an interview create meaning and knowledge together (Kelly, 2010; Kvale & Brinkmann, 2009). This is compatible with a feminist approach which seeks to pay attention to and minimise the power relationships within social research interviews (Hesse-Biber, 2007) and which acknowledges the need for the researcher to invest themselves in the interview encounter (Oakley, 1981). Furthermore, the use of participants' own words in interview studies about women's experiences can contribute to feminist attempts to move beyond androcentrism in social science (Reinharz, 1992; Reinharz & Chase, 2001).

Researchers working in a British context have pointed out the connections between interviewing and ethnographic fieldwork (Hampshire, Iqbal, Blell, & Simpson, 2012; Hockey, 2002; Hockey & Forsey, 2013). Ethnographic fieldwork usually involves interviews, at varying degrees of formality, and interviewing has elements of participant-observation, with sensory, embodied factors in the encounter playing a part in the production of knowledge (Hockey, 2002). Hockey also describes interviewing as a form of fieldwork which both pragmatically solves problems of the heterogeneity and dispersed nature of research sites, and also reflects the nature of social life in Britain: 'the research interview is a culturally appropriate form of participation in Britain' (Hockey, 2002, p. 210). I describe the interviews I conducted as ethnographic (Hockey, 2002; Hockey & Forsey, 2013; Rapport, 2013; Skeggs, 2001), consisting of an open approach which allowed women's experiences to unfold in different ways, for example through the sharing of artefacts, the inclusion of other family members in the interview, or post-interview contact.

3.1.2.1 Investing oneself in interviewing practice

Since Oakley's foundational work on interviewing women (Oakley, 1981) it has been important in feminist research to consider one's own identity and role during interviewing. Decisions about disclosure of my own position came up constantly during fieldwork and interviewing. I understood the interviews which form the basis of this research to be collaborative endeavours in which my own experiences of second trimester pregnancy loss, motherhood, birth and so on were potentially relevant, and sometimes discussed if participants asked me about them, or it was odd not to mention them. I had mentioned my own losses in the recruitment materials (Appendix 4), which many participants brought up during our encounter. Some women described how this made them more comfortable participating in the research, and this was a factor in including this in my call for participants. Whilst it is not enough to assume that having the same gender identification, or life experiences in common, will automatically lead to a non-hierarchical relationship in research (Doucet & Mauthner, 2007; Riessman, 1987; Tang, 2002), it was helpful to me and many of my participants to have grounds on which we could meet. I felt that the knowledge of my own pregnancy losses sometimes bridged more noticeable differences in age or class between me and participants, and they would draw on what they felt to be a common experience. Often, I was asked to acknowledge shared experience by participants when they used phrases such as '*you* know what I mean', as other interviews of women have noted (Devault, 1990). This disclosure was not intended to be a self-serving attempt to increase rapport and gain participants, a potential problem in feminist research which relies on intimacy and friendliness (Kirsch, 2005; Stacey, 1988), though it may also have resulted in this outcome. I intended it as a consideration about the impact of the intimate, personal, and emotional aspects of the research process on participants. It was an effort to provide a form of care through offering some of myself in the creation of a safe space for them to speak. In each interview I had to make decisions about disclosure of my own history and whether it would be useful to participants, or artificial to withhold, with a consciousness that I might be misinterpreting the situation. Abell et al. have described how researchers who perceive themselves as 'doing similarity' during research may be perceived very differently by some participants who focus on difference rather than commonality (Abell, Locke, Condor, Gibson, & Stevenson, 2016, p. 241). For example, I have had three pregnancies which did not end prematurely, and so I have living children, which might be difficult for some of those whose reproductive endeavours ended differently. In those cases, I tended to avoid speaking of my own position unless directly asked. Therefore my own position as researcher both inside and outside the subject matter (Gair, 2012; Griffith, 1998; Hampshire et al., 2012; Oakley, 1981) was a constant issue in the interview interaction, connected to ethical decisions discussed in section 3.2 below.

3.1.2.2 Ethnographic interviewing practices during the research

For some women, the content of what they shared with me was explicitly affected by their knowledge of my experiences. Angela had shown me photos and scan pictures of her dead son, and during our encounter I was sitting in her living room beside an urn containing his ashes and a display of objects related to his memorialisation, which will be discussed in Chapter 9. As Angela explained:

> It makes a difference knowing you've had some losses. A couple of times I've referred to, you've known what I mean. You've had that experience, or…I don't know what choices you had to make, and things like that.
> *You don't have to manage my introduction to [baby]'s picture, or anything?*
> No. I know you're not going to feel uncomfortable or embarrassed talking about him, or saying that his ashes are there [on the dresser].

As she talked to me, she was also holding her sleeping second son, born just under a year after the death of her first in the second trimester of pregnancy. My encounters with women in the research, taking place mostly in their homes, often involved the presentation of relevant material objects, as noted by other researchers in the field of death (Mathijssen, 2018). They also sometimes included other people, such as children and partners, as well as pets. This located the study in a domestic and kinship sphere and sometimes structured what was discussed (for example, if I noticed or was shown family photographs in the room). It broadened the sources of knowledge beyond the words of the interview itself and moved the encounters into a more ethnographic type of interviewing embedded in the wider lives of participants. The use of artefacts also drew me into the narratives, which could be moving for me and for the participants, who sometimes expressed anxiety about whether I would be overwhelmed by their sadness or the stories I was hearing. At other times they thanked me for giving them space to speak of their experiences, as I was thanking them for sharing them with me. Many of the quotes I have selected in the thesis also include my words, to try to represent the relational aspects of the interview encounters and the conversational style they took. On the other hand, it is also true that I retain the power to select which parts of the interviews are reproduced here, in a way which the interviewees do not and which I also discuss below in relation to publication of the research.

The interviews themselves were therefore conversational in practice, and followed the lead of the participants whilst also repeatedly coming back to their experiences of loss through my questions. Although I had started the interview phase of research anticipating carrying out semi-structured interviews using a prepared interview guide (see Appendix 6), the guide very quickly became irrelevant to the process of each interview and I only referred to it at the end of each interview to check I had not missed a topic of interest. A more appropriate approach was more open and flexible: interviews began with a question about the beginning of the pregnancy which was lost and then followed the participant's storytelling to produce an account of the events around the loss and its aftermath. This usually loosely resulted in a narrative structure telling the story of the loss from beginning of pregnancy to the present day, a pattern noted by other pregnancy loss researchers (Layne, 1997; McCreight, 2004). Several of the participants mentioned that they had never had an opportunity to tell the whole story to anyone prior to their interview with me. Hayley's daughter had died in 2004:

> You're probably the only one I've spoken to in depth about this. Don't get me wrong, me fella [sic], and all that yeah, I sort of told him what happened. But I only answered the questions that he's asked me. I only ever answer questions rather than having to…this is the first time in a long time that I've sat and thought right back through it all. How it all come about [sic], and where I am now.

I did not curtail interviews, but attempted to judge when interviewees were finished by where they were in the narrative, whether they had moved onto general conversation, their body language, and factors such as repetition. Whilst my questions related to the pregnancy loss, I did not seek to close down other topic areas which women brought up. This did sometimes lead to digressions, but at other times it was productive, such as when Phoebe described the death of her beloved grandmother just before the death of her baby in the second trimester and it became clear how much she was connecting the two deaths in her life as the death of persons. Over time, the analysis I was simultaneously carrying out alongside fieldwork also found its way into the interview process, and I asked participants questions related to what I was thinking about more abstract and theoretical aspects of the research, such as what difference the formation of the foetal body made, or who defines personhood. Participants also brought up related issues, such as the Irish referendum on the legality of abortion which was taking place during much of my fieldwork. These departures from more sociological traditions of semi-structured interviewing were important in allowing the iterative analysis which took place during the research to be incorporated into the interviewing. Sometimes the loose structure meant repeatedly returning to themes. For example, interviewing Heather about her two second trimester losses, she told each story separately, treating each loss as distinct and meaningful. Circling around themes and returning to them rather than assuming that topic was exhausted is partly how the richness and depth of the ethnography was created. This approach, and the emotional content of the conversations meant interviews averaged about two hours, with the longest lasting 3 hours 38 minutes.

All interviews were transcribed verbatim, with the exclusion of the detail of some digressions and interruptions for reasons of transcription time. Notes were made of distinct other sounds where I considered these to be relevant, such as crying or sighing, but I did not transcribe all verbal sounds (C. A. B. Warren & Karner, 2005). Pauses were indicated once they become prolonged to the extent that conversational flow was altered, because I considered they indicated nuance, such as thinking time, the emotional impact of the narrative, and sometimes uncertainty. After each interview, I also made field notes on my impressions and on salient facts which might not be on the recording. The transcriptions and notes became my reference point for analysis and were repeatedly revisited during the course of the research.

3.2 Ethics

Engaged, reflexive and critical approaches to ethics are crucial in feminist research with its interest in issues of power, normativity, and the potential for change. All stages of the research process have ethical dimensions which need reflexive consideration throughout the duration of the project (ASA, 2011; Farrimond, 2013; Kvale & Brinkmann, 2009), and this is another example of the difficulty of trying to divide methods into different processes or phases. For example, the concept of relational ethics is one which comes into play when a researcher tries to avoid a model of an extractive encounter with anonymous research subjects and acknowledge ‘mutual respect, dignity, and connectedness between researcher and researched’ (Ellis, 2007, p. 4). As such, it has connections with feminist ethics and also with ethics of ethnographic fieldwork as described above. Relational ethics is ongoing in the research I am conducting, and in the writing of this ethnography, and will continue into publication as I strive to fairly represent my participants and their concerns.

This also involves ‘ethics in practice’ (Guillemin & Gillam, 2004, p. 262) which acknowledges that research is not neutral and takes positions which need justification (Madison, 2005). The very subject choice of a stigmatised and marginalised reproductive event has an impact on the potential benefits of the project, and therefore its claims to an ethical instrumentalism connected to social justice, or the radical politics within which Strathern (1988) places feminist research. Many of the decisions already described in relation to this research, about methods and vocabulary choices have ethical dimensions, particularly relational ethics and ethics in practice. However, there are some particular ethical points which need to be made in relation to methods. In this section, I explain the procedural aspects of gaining formal ethical approval from my institution’s ethics board, the certificate of approval for which can be found in Appendix 3. I then detail one important set of decisions relation to methods, the practices I adopted around anonymity and naming.

3.2.1 Procedural ethics

Ethical quandaries which may arise during research cannot be fully predicted in advance (Kvale & Brinkmann, 2009; Roulston, deMarrais, & Lewis, 2003), but plans can be put in place to try to mitigate anticipated harm in encounter with human subjects (ASA, 2011; BSA, 2017). At the formal level of ‘procedural ethics’ (Guillemin & Gillam, 2004, p. 263), this project was approved by the University of Exeter Ethics Committee in 2018. It was based on best practice around informed consent and participation in qualitative research. This involved disclosure of the broad aims of the project and my own role as researcher to participants in interviews via an information sheet detailing the arrangements for the confidentiality of the data and its storage, and the options for anonymity of participants (see Appendix 6). Participants in interviews were asked to give written consent, including to audio recording and data storage, by signing a consent form at the beginning of the interview after verbal discussion of its contents (see Appendix 5). They were also informed in discussions during first contact, and at the beginning of the interview that they could stop the interview at any time. There are complex issues around individual consent in ethnographic fieldwork involving large groups of people (Hammersley & Atkinson, 2007), but I have only attended either public events or events where I have gained permission to be present from the gatekeepers of the event, such as a member of the organising committee. I have also not described individuals from whom I have no written consent in a way which could identify them (ASA, 2011).

3.2.2 Ethical practices regarding anonymity and naming

Although the default practice in social sciences is to offer anonymity to human research participants (Farrimond, 2013), this is not always the most ethical choice in research which claims to listen to people who are not usually heard (Kvale & Brinkmann, 2009). At the outset of the study, I decided to offer alternatives to full participant anonymity for three reasons: potentially challenging the stigmatised and marginalised topic of pregnancy loss, acknowledgement of the role of participants in the creation of knowledge, and the role of naming in the production of foetal personhood, which is so central to the research topic. I decided that automatically conferring anonymity on research participants in the case of already marginalised women simply because this is the research convention risked further compounding their exclusion. In other social research on pregnancy loss, decisions have also been made against automatic anonymity, with partial naming of participants (Healthtalk.org, 2019; Oakley et al., 1984; Peelen, 2009), and naming of research participants has been used in feminist anthropology of pregnancy (Browner & Root, 2001). Furthermore, sociological ethnographic research in London has argued that the naming of participants, with their consent, is an ethical choice which acknowledges participant contributions to knowledge creation (Sinha & Back, 2013).

Beside the potential naming of study participants, the naming of the beings who have died in pregnancy loss is a political act which asserts personhood, the child’s place in the family, and one’s role as a parent (Layne, 2006). In British culture, individual and family names are conferred on children by parents, and it is parents who carry the primary responsibility for reporting a birth and registering a name with the state. These issues are further discussed over the course of the rest of the thesis, in relation to inclusion and exclusion from birth registration, and the kinship practices used by women in this research, especially in Chapter 9. Additionally, the naming of individuals in memorial events can be used to establish political or moral accountability (Bodenhorn & vom Bruck, 2006). This has been seen in the UK in responses to the 1998 Omagh bombing, when unborn twins were included in a memorial representation, and in relation to the 2017 Grenfell Tower disaster, when stillborn Logan Gomes is included in casualty lists. Naming and including the post-viable unborn as persons in certain contexts is already part of UK culture. Women who name their children who die before 24 weeks are therefore making claims about the validity and importance of those beings. Excluding from written research the names of pre-24 week foetuses who have died could be construed as an act of silencing of the women who gave those names to their dead babies and who use the names when referring to them. The complication here is that having a name is designated a child’s ‘right’ under the UN *Convention on the Rights of the Child* (Bodenhorn & vom Bruck, 2006) and therefore it could be argued that recognition of the naming of any foetus to some degree carries with it a recognition of a form of foetal rights. As discussed in Chapter 1, arguments around abortion law in England are a constant presence in this thesis.

In my research, I offered three choices to women who participated in interviews, as allowable in the University of Exeter Research Ethics Framework (University of Exeter, 2017). The first level, chosen by three women, was complete anonymity, as traditionally offered to human research participants. At the other end of the scale, complete non-anonymity was offered, using participants' real names throughout the project, with their consent. I explained to participants that this could mean their stories might be accessible in the future, for example through internet searches, and that this could potentially compromise their or their family's privacy, depending on whether they had unusual names or characteristics. Professional funeral director LeighAnne Wright chose this option, as did participant Helen Woolley.

In between these choices, I offered anonymity in relation to direct quotes and descriptions in the body of the research, in which the participants are pseudonymised in the body of the text. This level of anonymity conserves the privacy of the participants, so that quotes or behaviour are not attributable to any specific person, and protects the privacy of non-participants in the research, such as family members. This level of anonymity, however, included an offer to publish participants' names in a general list acknowledging their contribution to the research, and/or to include any names of their dead babies if they so wish in a memorial page, which both acknowledges the contribution of women to the research and allows them, if they wish, to link their participation to named babies. This page can be found at the beginning of the thesis. Most of the women who took part chose options meaning either their own names, their babies' names, or both, are listed on these pages whilst they are anonymised in the text.

The choice of anonymising in the body of the text threw up some practical complications over the course of the research. I had initially planned to offer a choice of pseudonym to participants for themselves and their babies, on the basis that me renaming babies was politically unacceptable when their names act as claims to personhood. This proved to be impractical on two levels. Firstly, women started selecting one another's names to be pseudonyms, potentially causing privacy issues over the whole thesis. Secondly, it was completely inappropriate at the beginning of the interview process to ask women to think on the spot of a new, additional name for their dead baby to act as a pseudonym. I abandoned this idea after five interviews, initially replacing it with a plan where I would use false initials for participants in the body of the text, so I could avoid renaming them. On beginning writing, however, this also proved inadequate because it was hard to track women's stories through the thesis using just initials, and because initials seemed very impersonal and abstract compared to the personal stories they were attached to. In the end, I compromised and used in-text pseudonyms for all the women who chose the second level of anonymity. I explained this to subsequent participants during the consent process and adapted the consent form with them to note that I would choose a pseudonym. Fortunately, the earlier participants' choices were able to be reflected in this decision. I also decided not to rename the babies at all, because of undermining the significance of the names which were chosen for them by their parents. I therefore refer to them in the text in relation to the relationship claimed by the pregnant woman, often an expression of their kin relationship, such as [daughter]. This preserves privacy whilst honouring the naming decisions of participants. I extended this approach to other people referred to by participants, using relational terms referent to the woman I was interviewing, such as [husband], [partner], [boyfriend].

I also had to conceal some other identifying features of participants. Because I had agreed to list participants' and babies' names in publications, if I too closely described the circumstances of some participants' private lives, they could potentially be traced to real people. For example, one participant had a family history which had been very public in her local area – the listing of her name in the acknowledgement page, linked with any other identifying features in the text such as the number of her children or the local area could allow quotes to be attributed to her. Even though the family history was interesting and had some significance in relation to her pregnancy loss, I took the decision to keep it out of the body of the text. This also applied to another participant who had an unusual occupation. I have also brushed over in the text the exact locality of many participants for identification reasons, particularly in Cornwall where the communities can be very small. This meant that the decision to offer participants acknowledgement in my text did to some degree affect the richness and thickness of the resulting text. However, since so many women responded so enthusiastically to my offer to acknowledge their contribution and/or the lives of their babies, I feel this drawback was compensated for by the ethical gains.

3.3 Recruitment and sampling

Relational ethics were also implicated in the recruitment of participants. My decision to limit my fieldwork to South West England was taken for practical reasons based on where I live and study, and also feminist ethical ones, because I consider this to be my community, in which I can be a named and visible researcher, in an acknowledgement of feminist ethics around research locations (Okely, 1996; Strathern, 1987). This definition of the fieldwork location led me to refuse some offers of participation from women in other parts of the UK. I also had interest from women with post-viability losses, who were therefore in the third trimester. Refusing such offers of participation was awkward in research about marginalised experiences, and methodologically difficult because of my awareness of the artificiality of my boundaries around my fieldsite. However, I believe the fieldsite itself is as distinct as any community may be, and the knowledge I acquired of practices in South West England, and the particular hospitals and locations, could not be replicated in the same depth on a national scale, and therefore it was useful to limit the geographic spread of the research.

Similar ambiguities apply to the boundaries around the selection of women who took part in the research. I am reluctant to describe the women who took part in this research as a ‘sample’ because of the connections to quantitative research and its assumptions about generalisability (Maxwell, 2013), which are at odds with my interest in the specificity of local, situated, experience. Qualitative research aims to discover representations of an issue rather than counting people or opinions (Gaskell, 2000, p. 41), or finding some subsection of population which could be scaled up to represent a larger whole. I am not producing knowledge which claims to be definitive or to represent all women, since I believe all social representation is situated, partial and not generalisable (Bryman, 2016; C. A. B. Warren & Karner, 2005), and that all experiences of pregnancy loss produce important knowledge. I am also wary of claiming that I have produced a 'sample' because of that term's connection to selecting participants on the basis of demographic categories. Ethically, refusing participation to women who wished to take part on the basis of them not fitting demographic criteria would have been problematic. Second trimester pregnancy loss is also a relatively low incidence occurrence and therefore representation across demographic groups is not likely to be evenly spread in the 31 interviews I have carried out.

However, whilst I have not produced 'a sample', I have carried out 'sampling', in the sense of seeking out certain people for participation in this research through purposive, or purposeful selection (Bryman, 2016; Maxwell, 2013). As described above, I limited those who could take part at a point prior to their own decision to participate. My call for participants (see Appendix 4) was focussed on a specific gestational period used by the NHS and English law and I set out to find women who went through second trimester pregnancy loss in South West England between 13 and 24 completed weeks of pregnancy, who went through labour and birth, and whose baby did not survive. Maxwell (2013) states that selection of participants through purposive sampling such as case studies can protect the researcher against accusations of over generalisation and help them recognise diversity within a setting or amongst individuals. This concurs with my intentions in terms of representing the knowledge here as derived from the thoughts and stories of specific women in specific locations, shared with me on specific occasions and building together towards meaning.

It is also illusory to claim I have had full control over who has decided to participate in my research. Participants were self-selecting, mostly in response to online social media sharing of requests for participation which themselves will have structured who was likely to respond. Initially I spoke to friends and acquaintances in my local community about what I was doing, and some participants heard about the project through word of mouth, and a few through snowballing from interviewees. This was effective because I have lived and raised my children in the area for fourteen years and I have a strong local network. My first call for participants was initially posted on my personal Facebook page (see Appendix 4), which I have used for many years in my life as a mother in Cornwall, and which I also used for recruitment for a previous project on foetal Dopplers (Middlemiss, 2017, 2020a). This visibility of myself as a researcher is part of my feminist accountability as a named person in my community and I believe it increased trust for participants that they could make connections to me through others, or see aspects of my personal life as I was asking them to share their own with me. However, only women who felt able to talk about what happened to them with a relative or complete stranger have taken part – this may have excluded many people, including those for whom reproduction attempts have been particularly fraught. For example, Charlie, who had a complex reproductive history of IVF and multiple losses told me that before her living children were born she would have been too upset to agree to talk to me about her reproductive history. Furthermore, my personal visibility as a mother on Facebook and my framing of myself in later recruitment as a local mother (see Appendix 4) may have put off as many people as it attracted.

In the context of Facebook and where I was posting, it was more appropriate to use the term 'baby' than 'foetus'[13], but this is likely to have limited who responded. Only one of my participants, Paula, used the term 'foetus' rather than 'baby' most of the time. This is a limitation in the study, in that only some experiences are represented. It is also, however, a strength, in that the call for participants has attracted many women who have some degree of conflict with the biomedical-legal ontology of pregnancy and their own experiences, and this produced some of the findings, in relation to resistance and agency. These women are some of those whose experiences have not yet been heard in academic literature (see Chapter 2) and whilst they do not represent all women experiencing second trimester pregnancy loss, they still have a particular experience worthy of investigation by social science.

I broadened the scope of the call by asking permission from moderators to post directly on local parenting and pregnancy loss Facebook pages (see Appendix 4). Many participants were recruited online, and all had smartphones, consistent

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[13] See Chapter 1, section 1.4.5 for a discussion of the terminology used in the thesis.

with norms in the UK (ONS, 2018). Many of the participants in this study followed local and national charities and support organisations (listed in Appendix 2) through Facebook pages or websites, and some were active in seeking out other women with second trimester losses on Facebook, Twitter, Instagram or on specialist forums such as Babycentre. The internet can be used for making contact with others if one lives in a low population area (Davidsson Bremborg, 2012) and can be a space for articulating difficult to express narratives around pregnancy loss (Hardy & Kukla, 2015). I was able to use local online pregnancy loss groups to focus my recruitment in the South West. These methods of recruitment did mean that only women who came into contact with the calls for participants were able to express an interest in taking part.

The charity Sands agreed to send out a call for participants to supporters in the South West (see Appendix 4) which had to be discussed with the head office[14]. The same call was shared by LeighAnne Wright and her Plymouth charity Little Things and Co. I agreed to write a more detailed call for participants for these organisations and also used it for other postings which extended beyond my networks in Cornwall. It was tricky to get the tone of this right, between the casual tone of Facebook parenting pages, the potential of inserting a distressing topic into people's feeds (I added a warning at the top of the Facebook posts), and the need to represent the research as serious and having some degree of formality. This resulted in a call for participants which started with a statement of my position as a local mother who had experience of pregnancy loss, establishing my credentials in reaching out to other women but also potentially only appealing to women who felt a connection with me. I tried to counter this by flagging up that I wanted to include many different experiences. I was concerned that the detail required by these charities for their own ethical and governance reasons combined with my practical details might overly structure the type of participants who got in touch. I was also reluctant to rely solely on the charities to recruit, in case this method produced a set of participants with a particularly uniform attitude to pregnancy loss. I therefore also actively recruited from general parenting sites and snowballing as well. I believe this to have been ultimately successful because 15 of the participants in

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[14] Sands also provided a letter for support for my research proposal funding application and bereavement training for me in advance of my fieldwork, for which I am very grateful.

the study had no involvement with charities. Of the other 16, involvement ranged from active membership of, or fundraising for, a local or national charity through to some use of their outreach materials.

I posted on Twitter, too, but this did not result in any interviews, probably because my networks there are professional rather than personal. Whilst I argue that my visibility as a named researcher in the community I live in and on Facebook was an ethical and feminist strength in recruitment and research, it is true that the research was invisible to other women who did not have any connection back to me. In addition, those women who contacted me sometimes did not choose to go ahead with interviews – 19 women made some contact with me which never resulted in an interview, even after following up. Some of these interviews did not happen because of time constraints on the women concerned. Others I believe fell by the wayside as they became pregnant again – I gained knowledge of some new pregnancies on Facebook or through my local networks. Still others never got in touch again after I detailed the parameters of the project, or proposed visiting their homes – they may have realised they did not fit the parameters, have disliked the idea of me coming to visit them, or have disliked something about the tone of my messages. And others still may have just changed their minds over time – one possible factor here, gleaned from women I did interview and who explained their motivations for speaking to me, may be the time of year the request was received or the interview was proposed in relation to key dates, such as anniversaries and due dates.

3.3.1 Heterogeneity and homogeneity amongst participants

Having claimed above not to be producing a representative sample, I have considered aspects of the demographics of my participants as a group in order to judge heterogeneity within the research. I believe there are advantages to including a broad range of women in the research, both for ethical and political reasons of not excluding certain people, and for the knowledge produced to be deeper and perhaps more nuanced. I therefore deliberately tried to recruit women from different areas in the geography of the South West in order to capture a general diversity in the population by seeking out local Facebook groups and asking permission to post my request for interviewees. I also logged demographic details for each participant, most of which were elicited from the interviews (such as age, occupation), but some of which required specific questions (such as ethnic origin) which were quite intrusive during interviews because they disrupted the interpersonal flow of conversation. These details and a discussion of the limitations of demographic categories as they relate to South West England can be found in Appendix 7 because they are contextual rather than contributing to the overall argument of the thesis. Overall, all but one participant in interviews identified as White British, and all the women were aged between their 20s and 40s, with a range of social classes represented in the group. This means that the demographics of participants are consistent with South West England, but not with more racially, ethnically, or religiously diverse parts of England.

3.4 Analysis

In this work, analysis was an iterative process, taking place during and after the collection of data (Buch & Staller, 2007; Hammersley & Atkinson, 2007). It also drew in my experiential knowledge from my participant observation at memorial and other events, from site visits, from online and media reading, and from visits to participants' homes where material artefacts and other household members were encountered. I conducted some discrete analytic activities in relation to textual analysis where documents relevant to biomedical-legal aspects of pregnancy were selected on the basis that they related to issues raised during interviews. These included the official, legal, and institutional documents which will be referred to in the following chapters, such as Acts of Parliament, regulations, guidelines from professional organisations such as the Royal College of Obstetricians and Gynaecologists, or the Human Fertilisation and Embryology Authority, medical texts, and charity publications. These were read in detail, with salient points noted, and analysed during the writing of the relevant chapters.

Texts were made by transcribing interviews, which was long and laborious, but also productive in its requirement of detailed attention to the interview audio. These records of the interviews were inductively thematically analysed, with a view to understanding women's experiences of this specific category of pregnancy loss. This was initially done through repeat reading of the transcripts (Gaskell, 2000) in an inductive approach to identifying patterns used by other feminist researchers (Malacrida, 2007; Wall, 2010). I then started coding in the computer assisted qualitative data analysis software NVivo for Mac 11, at the same time as creating tables of interviewee demographics with a view to comparative analysis possibilities across different women's experiences (Baszanger, 1997). I anticipated that NVivo would be helpful in terms of data management rather than analysis, since analysis cannot be done by a computer programme (Ingold, 2014). My approach to coding in NVivo was open, adding new codes as new themes and ideas emerged, and resulted in the generation of over 80 codes from the first 5 interviews.

At this point, reviewing my analysis, I felt that it had become overwhelming and that the approach was not helping. Coding in NVivo was cumbersome and limiting because the programme would only accept relatively small chunks of text under one code, whereas I wanted to include whole passages, including my own questions and contextual information, for both feminist and ethnographic reasons. I rethought my approach and started manually organising the material thematically by systematically reading through each interview adding material to Word files which I had divided into folders collecting information on medical, legal and bureaucratic, and agential aspects of the experience. These divided into:

- women's narratives of their experiences during the medical response to their pregnancy loss (including during diagnosis, during management of the loss, after the loss, during post loss investigations, during subsequent pregnancies)
- women's narratives of their experiences in relation to the governance of their pregnancy loss (including any birth registration issues, the disposal of the dead foetal body, any entitlements based on maternity)
- women's narratives of their own actions and agency in response to their pregnancy loss

Once these documents were completed, I was able to use them to pull together the argument of this thesis. I was also able to use this system to make comparative analyses, because each theme contained different experiences. This was important in maintaining an attention to diversity within the analysis. Though I had technically abandoned line-by-line ‘coding’, I believe that first phase was useful in pushing me to differentiate my ideas and their origins in the interviews and allowed me to come up with the next level of analysis.

The analysis in the end was a form of iterative thematic analysis drawing on ethnographic analysis and also on feminist voice-centred relational analysis (Mauthner & Doucet, 1998; E. Ross, 2016). What I took from Mauthner and Doucet’s reworking for sociology of voice-centred relational analysis from social psychology (L. M. Brown & Gilligan, 1993) was the feminist approach paying attention to relationships and power in research, the use of the voices of participants in building theory, and the relational ontology of social life which underpins the analysis. In this analysis, there is a move away from abstracted themes, as in Grounded Theory analysis (Mauthner & Doucet, 1998), where data would be sought to fill theoretical absences (Hood, 2013). Instead, themes come from the words of the participants themselves, which are considered to be sufficient for the generation of theory. The substantial differences between my work and voice-centred relational analysis included when analysis took place and what was analysed. Voice-centred analysts describe a distinct analysis phase in their research, whilst still acknowledging that this is not the only point at which analysis occurs (Mauthner & Doucet, 1998; E. Ross, 2016). I wish to place more emphasis on the ongoing and iterative nature of analysis, over the whole course of my research. Furthermore, voice-centred relational analysis focuses on the analysis of transcripts, whilst acknowledging the role of field notes. By contrast, my analysis draws on a wider range of sources, including the documents mentioned above and the material artefacts shared with me during fieldwork.

3.5 Conclusion: methodological choices

This chapter has described the methods I employed in planning and carrying out this research. Strengths include the fit of ethnography with a feminist attention to power and situated knowledge, the fit of multi-sited ethnography with the dispersed fieldsite, the breadth of ethnographic engagement with sources of knowledge such as material culture, and the iterative nature of knowledge production. The suitability of interviewing as a method in a UK setting was also a strength. Attention to feminist ethics in researcher accountability and acknowledgement of the labour of others was woven into the research and writing processes.

Methodological choices necessarily produce research which is partial. There are many absences in the account described in the rest of this thesis. I have focussed on the experiences of pregnant and post-pregnant women, rather than men, siblings, other kin, or medical staff. I have not accessed any participants who do not use the internet to communicate. I have not accessed many participants from non-white communities, and I have not accessed any participants from white ethnic minorities, nor participants from organised religions other than Christianity. I have not accessed any women who are not in heterosexual relationships or who define themselves as non-binary, nor anyone disabled. Though some of this lack of diversity was specific to the location in South West England, such as the lack of racial, cultural, or religious diversity, the self-selection of participants was a more determining factor. They were a specific set of women who had experienced some degree of conflict, or torque (G. C. Bowker & Star, 2000), in relation to the classification of their pregnancy loss experiences in the biomedical-legal discourse around pregnancy, and who experienced the end of their pregnancy in the second trimester as some form of loss. Any women who experienced their second trimester pregnancy losses as unproblematic, insignificant, or fully resolved and in the past, would not have been motivated to contact me to take part in the study.

Furthermore, my interest in women who had experienced labour and birth as a defining part of my recruitment strategy meant that I did not recruit women who had surgical terminations under Ground E of the 1967 Abortion Act (for foetal anomaly). The very low numbers of these types of terminations in England and Wales (DHSC, 2018a) mean I was unlikely to find many women in the South West with this experience. Similarly, I have not accessed any women who had second trimester terminations on grounds other than Ground E but who conceptualised those terminations as a pregnancy loss. This would include the so called ‘social’ abortions usually under Ground C or D, and also those few carried out because of threats to the health of the pregnant woman, Grounds A, B, F or G (DHSC, 2018b). This is probably because non-Ground E terminations in the second trimester are usually surgical and I had asked for women who went through labour and birth. I do not mean to suggest by this omission that an abortion for other reasons than foetal anomaly are not pregnancy losses if the woman concerned understands them as such. But this does mean that this research has produced knowledge of a particular type of second trimester pregnancy loss, a particular reaction to it, and a particular set of parameters around positions on foetal personhoods. I argue, however, that the content of the thesis in terms of the limitations around women’s agency I will lay out in Ethnography Part 1 applies to most women in England experiencing second trimester pregnancy loss because I describe the structural classifications of what has happened and the consequences of these, which no one can escape. Part 2 of the ethnography, which describes ontological disruption and resistance, does only apply to some women in England with second trimester losses. Furthermore, the conclusions I draw about teleological pregnancy actually apply to all pregnant women, not just those experiencing loss.

In conclusion, my methodological choices, in particular around ethics and feminism are central to the research. I will now move on to the knowledge that was produced from these methods about the experience and consequences of second trimester pregnancy loss for women in South West England.

ETHNOGRAPHY PART 1: THE CONSEQUENCES OF SECOND TRIMESTER PREGNANCY LOSS

Having reviewed the social science literature on pregnancy loss in the UK and England, and described the feminist ethnographic methods used to create the knowledge in this thesis, I now explain the research findings. This is divided into two parts. Ethnography Part 1 considers the consequences in women's lives of the biomedical-legal ontologies of pregnancy and loss in relation to second trimester reproductive disruption involving foetal death, premature labour, or termination for foetal anomaly. The findings in Ethnography Part 1 are relevant to all women facing these types of second trimester pregnancy loss, whatever their position on foetal personhood or their own kinship relation to the foetal being. Ethnography Part 1 shows how pregnant women's choices and options in healthcare, official personhood recognition, and disposal of the body of the foetal being are determined by biomedical and legal ontologies related to the foetal body. This takes precedence over assessments of the pregnant woman's body or her agential choices in healthcare. Biomedical and legal or governance discourses and practices in relation to reproduction are intertwined in England, as others have noted (Franklin, 1991, 1999b, 2014; Sheldon, 1997), but for the purposes of clarity I attempt in this section to disentangle them. I do this by simultaneously telling the story of second trimester pregnancy loss as experienced by women, from diagnosis of a problem through management of the healthcare crisis, to the post birth legal, governance, and bureaucratic aspects which limit and structure women's choices and options.

In Chapter 4, I explain how medical diagnosis of the foetal body being the second trimester delimits the medical care options offered to pregnant women facing loss in the second trimester. In Chapter 5, I then show how ontological positions from biomedical discourse about the foetal being as 'not a real baby' and the pregnant woman as 'not a real mother' result in the disciplining of pregnant women during the practical management of their labour and birth in English medical care. This disciplining shores up ontological boundaries in ways which amount to obstetric violence on the body of the pregnant woman.

In Chapter 6, I move on to legal, bureaucratic, and governance practices related to second trimester pregnancy loss. I consider the consequences of state birth registration law in the production of persons and non-persons and their kin. I explain the consequences for the pregnant woman’s claim to motherhood through state bureaucratic systems such as maternity rights. Chapter 7 explains how regulation of the dead foetal body can produce it as person, non-person, or something between the two. Both chapters emphasize how far practices of personhood and kinship recognition are outside the control of pregnant women.

Later in the thesis, Ethnography Part 2 considers the ontological impact of positions on pregnancy and pregnancy loss which are established by biomedicine and the law. It describes the possibilities of ontological disruption through second trimester pregnancy loss, and the agential resistance of some women to the biomedical-legal ontologies of pregnancy described in Part 1.

Chapter 4: 'You don't have a choice, you have to do it': How diagnosis of the foetus as second trimester limits pregnant women's healthcare options.

One of my early encounters in this research was with Paula, a business owner in her 40s, and mother of four living children. Paula had extensive experience and knowledge of pregnancy and birth, from six pregnancies over a twelve-year period. Her first two pregnancies were straightforward, and ended in uncomplicated vaginal births. The third pregnancy ended in a miscarriage late in the first trimester, which was resolved surgically. After the fourth pregnancy, which had resulted in the birth of a third child, she and her husband started worrying about the middle child being left out, and decided to try for a fourth child to even out the family. Nineteen weeks into this pregnancy, after diagnostic blood tests had come back normal, an ultrasound scan detected abnormalities in the foetus and eventually Spina Bifida was diagnosed. Paula and her husband were asked to decide whether they wanted to continue the pregnancy. After consultation with friends and their parents, they eventually decided to end the pregnancy and returned to the hospital to discuss this with medical staff:

> Initially I said to them, 'Are you just going to take it away?'. Because I'd had a D&C[15] before. I said to them, 'are you just going to take it away?' and they were like, 'Oh, no, no, you've got to have a…you've got to come in and give birth.'
>
> *Was that a shock to you?*
>
> Yeah. […] I'd probably say that that was the biggest shock. The realisation that I would have to go through childbirth. I'd have to deliver. And it just hadn't crossed my mind. I just thought that they would put me to sleep, deal with it, and then I would wake up and it would be all...gone, sort of thing.

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[15] See Glossary.

Instead, Paula endured a slow and painful induction of labour, involving an epidural and then manual removal of the placenta. This removal of the placenta was incomplete, and a week later she woke in the night haemorrhaging and had to return to hospital for surgical removal of retained placenta under general anaesthetic. Despite Paula’s previous pregnancies, she had no idea that a termination for foetal anomaly in the second trimester normally involves a labour and vaginal delivery. This lack of awareness of the mandating of labour and birth in second trimester pregnancy loss in the English NHS was common to almost all the participants in my research, even medical professionals. In talking about my research in both lay and academic settings, very few people know that foetal death or termination for foetal anomaly is usually managed through induced labour and birth, and that this or spontaneous premature labour at this point in pregnancy can be a protracted and painful experience and may involve serious complications.

This chapter explains how the diagnosis of the foetal body as being in the second trimester of pregnancy delimits the medical care and procedures available to pregnant women facing second trimester pregnancy loss in the English NHS, producing a specific ‘trajectory of care’ (Allen, 2019; Corbin & Strauss, 1988). The significance of this diagnostic classification is that it then permeates all aspects of women’s experiences of healthcare in circumstances of second trimester loss. Later in the thesis, further consequences of the diagnosis of ‘second trimester’ will be spelt out in relation to healthcare practice, and the governance of pregnancy.

4.1 Classification and categorisation

Mechanisms of classification and categorisation are ways that social worlds create structure and meaning (G. C. Bowker & Star, 2000; Douglas, 1966, 1972; Durkheim & Mauss, 1903/2010; Leach, 1989; Okely, 1983). Classification sets boundaries between things which might otherwise be understood as on a spectrum (such as trimesters in pregnancy). It then puts those things alongside others in order to convey complex meaning, to produce knowledge, or to make things happen (G. C. Bowker & Star, 2000). As I will show below, the temporal classification of pregnancies as in the second trimester, through diagnosis of the foetal body, does bureaucratic work within healthcare in terms of setting pregnant women onto different trajectories of care within the English NHS. However, classifications are contingent and value-laden, rather than absolute and neutral. Referring to earlier work on boundary objects (Star & Griesemer, 1989), Bowker and Star think of classifications as abstract boundary objects: things with enough of a constant identity to be used by different communities of practice but which are plastic enough to adapt to different local meanings. Classifications are thus part of the production of ontologies, as understandings of what is there, in reality, and of epistemologies, relating to how that reality can be accessed or described. Classificatory systems, as with any boundary objects, are embedded in systems of meaning, knowledge, and power, and are not politically neutral (Foucault, 1976 /1998; Huvila, 2011).

4.1.1 Classification and power in science and medicine

In England, the power to designate a foetus as being in the second trimester, and to then divert the pregnant woman in whose body it has developed into a particular path of medical care, lies with the medical profession within the institution of the National Health Service. This is consistent with classic sociological work on the balance of power between medicine and lay society or patients (Conrad, 1992; Foucault, 1963 /2003; Zola, 1972), and specifically the medicalisation and medical control of pregnancy, childbirth, and abortion (Arney, 1982; Oakley, 1984; Sheldon, 1997). Jutel (2011a) points out that diagnostic classification is rooted in the 18th century scientific drive to create a taxonomy of the world, and the drive of medicine to prove itself distinct from lay knowledge and claim authority and power from that distinction. The power of diagnosis can then change lives, as it designates a person as subject to this or that disease or condition, and then determines the resources available or not available to them. Diagnosis, or classification in medicine, therefore exists as a 'site of contest and compromise' (Jutel, 2011a, p. 5) through which power relations can be perceived and produced. The identification of diagnostic categories is not an objective, scientific exercise defining some external reality, but a social one into which different facets of life can be drawn. In New Zealand, Jutel has shown how medical classification of foetuses as viable and non-viable[16] is rooted in ‘the values and concerns of the society in which the diagnosticians practice’ (Jutel, 2011b, p. 51) in conjunction with available resources, such as neonatal care for very early neonates. Furthermore, she explains, there are consequences in New Zealand to a diagnosis of fetal death as miscarriage rather than stillbirth which extend beyond the medical, such as access to welfare benefits. I will explore similar consequences in England later in this thesis.

It is therefore possible to consider the biomedical classification of pregnancy by looking inwards, to what other cultural or classificatory content is drawn into the classification, because that classification does not exist in a vacuum. And it is possible to look outwards, towards what effect the classification has in the world, for example in the work that it does (G. C. Bowker & Star, 2000). In both forms of analysis, it is imperative in a feminist analysis to consider power relations and political consequences, in relation to whose classification is prioritised, and what the impact of that prioritisation of classification on individual bodies might be. Looking inward, classifying pregnancies and foetuses as being in the second trimester draws in content from other classificatory systems, such as the legal definitions of what is a person, or who is kin to whom. When medical diagnoses are made about a pregnancy being in the second trimester, doctors are not producing a disease classification, but an ontological category of person / non-person who is in a system of kinship relations, or not. When a pregnancy ends without the production of a person, dead or alive, that classificatory decision is linked to other decisions about what a pregnancy ontologically *is*, for example that is necessarily productive, that the end result (a live baby) teleologically determines the nature of the process. The end result also determines the actors in the process, and the component parts, such as a pregnancy, a labour, a birth, an abortion, a foetus, an embryo, some parents (Beynon-Jones, 2012; Franklin, 1991; Pfeffer, 2009; Thompson, 2005). Furthermore, because classification is connected to knowledge production (G. C. Bowker & Star, 2000; Foucault, 1976 /1998), and a classificatory decision in one area has links to other ontological decisions, the consequences of

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[16] In New Zealand, this distinction is made at 20 weeks’ gestation rather than 24 as in England (Jutel, 2011b).

diagnosis may have effects in the social worlds of the persons to whom the diagnosis pertains.

4.2 Diagnosis and the delimiting of care options in the second trimester

Medical classification of the foetal body as gestationally between 14 and 24 weeks of pregnancy, i.e. in the English second trimester, takes place in the context of medicalised pregnancy (Duden, 1993; Rothman, 1986/1993). This is an understanding of pregnancy in which the foetal body has become the subject of medical scrutiny and observation (Casper, 1998; Lee & Jackson, 2002; Petchesky, 1987; Weir, 2006; C. Williams, 2005; C. Williams et al., 2001), often using standardised time in the obstetric management of pregnancy and birth (Simonds, 2002). The proven existence of an embryonic or foetal body within her own body defines the pregnant woman in the dominant model of pregnancy in England today. Legally, for example, in the context of assisted reproduction the 1990 Human Fertilisation and Embryology Act defined a woman as ‘carrying a child’ from the point of implantation of the embryo. This is a biomedical model of pregnancy (Clarke, Shim, Mamo, Fosket, & Fishman, 2003) in which it is necessary to have proof or evidence, derived from biomedical surveillance technology, of the existence of a foetal body. In the NHS, this evidence of the foetal body is determined through routine ultrasound, offered at roughly 12 and 20 weeks of pregnancy (NHS, 2016). At these appointments, besides being assessed for possible abnormality, the foetal body is measured to estimate the gestational duration of a pregnancy (Loughna, Chitty, Evans, & Chudleigh, 2009), within a margin of error (Beynon-Jones, 2012). Gestational time is therefore determined by the foetal body as observed by medical technology, rather than the pregnant woman’s account of her menstrual cycle or sexual activity, or medical assessment of the pregnant body, such as pelvic examination of women, which is no longer recommended because it does not ‘accurately assess gestational age’ (NICE, 2008).

Biomedical examinations in pregnancy are disciplinary apparatuses which are acting on the body of the foetus in the defined, enclosed space of a woman’s body. They are forms of hierarchical observation of the foetus which ‘see without being seen’ (Foucault, 1977/1991, p. 171) and which judge and value the foetal body in relation to norms of measurement and norms of morphology, in relation to a temporal elaboration of standardised foetal development. This measurement and normalisation results in medical judgements or diagnoses being made about the gestational age of the foetal body which have profound consequences for the medical management and care of the pregnant woman's body in the second trimester, as noted in late abortion provision in Scotland (Beynon-Jones, 2012). This is because as the gestational age of the foetus increases during pregnancy, so does the likelihood of women having to labour and give birth to the body of the foetus, whether it is already dead because of spontaneous foetal death or feticide in a termination, or will die during or after premature labour. The examined and normalised foetal body thus determines the existence of pregnancy as an ontological category, and the possibilities of medical care available to the pregnant woman's body.

4.2.1 Invisible labour in the second trimester

When women in a wanted or accepted pregnancy receive a diagnosis of foetal death, irreversible premature labour, or serious foetal anomaly for which they have decided to terminate the pregnancy, there are two levels of shock, as Paula's story illustrated. One is that their anticipated baby has died or will die. The other shock is that they will be required to labour and give birth to remove the foetal body from their own. This shock is recognised in the medical literature, for example on termination for foetal anomaly (RCOG, 2010b). In my research, the only participant who was aware of the requirement to give birth in advance of being told it in relation to her own pregnancy worked in a clinical capacity with pregnant women. All of the other women received the news with incredulity, whether they had had previous pregnancies or not. They had knowledge of the process of early miscarriage (eleven women had experienced first trimester miscarriage), and they were aware of the spectre of late term stillbirth, but they had not given any thought to the possibility of second trimester loss and how it could occur. It is a feature of the invisibility of second trimester loss in society that experienced women have no knowledge of it until it happens to them. Eva, already a mother of two, was told at an ultrasound scan 18 weeks into the pregnancy that her son had died in the womb. Like Paula, she was not expecting the news:

> *Did you know what that would mean for you, what you would have to do?* No, not at all. I hadn't considered it at all. I hadn't really realised that you'd have to go through sort of full labour. I just assumed that's what happened when you were, you know, 30 weeks pregnant or whatever. I just thought they could do a quick operation.

Even with medical and experiential knowledge, most women could not opt for surgical resolution of the pregnancy loss. Kerry was a nurse with a substantial experience of pregnancy, including two full term births, several early miscarriages followed by D&C, and two surgical abortions under Ground C of the Abortion Act, one of which was somewhere between 14 and 16 weeks. In her last, wanted pregnancy, she started bleeding at 18 weeks. An attempt to stop her going into premature labour with a cervical stitch[17] failed, and the amniotic fluid started leaking, exposing the foetus and her to infection. Labour was therefore induced at 20 weeks and her son was born alive, living for 45 minutes before he died. I asked her if she was given a surgical option when it became clear the baby would not survive:

> They just said, ‘we've **got** to take the stitches out and you've **got** to give birth’, that's what they said.

Kerry had experienced surgical removal of previous foetuses which she does not mourn. She deeply mourns the son who died in the second trimester, who was anticipated as the only child of a new relationship, who lived for a short time, and who looked in the posthumous photos she shared with me like a small, skinny baby. I will discuss the relational aspects of labour, birth, and encounters with the foetal body in later chapters. Here I consider the mandating of labour and birth in the medical management of second trimester pregnancy loss in the English NHS.

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[17] See Glossary.

4.2.2 The foetus as too big: Labour and birth because of foetal size

The most salient factor in the mandating of non-surgical removal of the foetal body from the pregnant one is foetal gestation. A pregnancy which has reached the second trimester will usually be one with a substantially sized foetus (Kiserud et al., 2017). In the English NHS, those women experiencing loss in the second trimester who do not go into spontaneous labour are not offered surgical removal of the foetal body. This includes women who have had foetal death confirmed by ultrasound, or who are undergoing termination for foetal anomaly, or those in spontaneous labour where the labour has not progressed. In the first trimester, smaller foetal bodies can be surgically removed via the cervix and vagina[18], and in the third trimester sometimes Caesarian section may be possible. However, in the second trimester whilst surgical removal is possible, there are very few surgeons capable of, or willing to, undertake surgical removal of the foetal body. For example, Tamsin, carrying twins who were discovered at 17 weeks to have no heartbeats, was told that they were too big for her to have surgical removal at her local hospital[19] because of a lack of a surgeon capable of carrying out the procedure. This is similar to findings in Scotland where surgical management of abortion is not available after 18-20 weeks (Purcell et al., 2017; Purcell et al., 2014). The alternative offered to women whose foetuses exceed the required size for surgical management is induced labour and birth.

In my research, foetal size was a factor for those women who were on the lower threshold of the second trimester, and gestational time affected their access to surgical management for this reason. In her third pregnancy, after a miscarriage and an older child from a previous relationship, Joelle was told at the routine 12-week ultrasound scan that there was the possibility of a chromosome disorder. This was then confirmed as Edwards' Syndrome[20] by a CVS test[21], the results of which came through about a week later:

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[18] See Glossary.

[19] The twins were smaller than would have been expected of a singleton foetus at this gestation, where this would be unlikely to be considered at all.

[20] See Glossary.

[21] See Glossary.

> They basically phoned me back the next day, and by that point I was almost 14 weeks. They said, 'if you, if you want the surgical termination, you need to do it this Friday.' …and she was like, 'you need to let me know this afternoon because I need to get you booked in.' [crying]
> So. They didn't give me much time to decide. I said, 'I'm not, not really ready to make that decision.' So by that point I had to go for the induction.

This lack of availability of surgical removal of the foetus in the second trimester is supported by literature on second trimester abortion provision which states that surgical removal using D&E is not widely available in the NHS because there are few gynaecologists with the necessary skills (RCOG, 2010b; Rowlands, 2019; Speedie et al., 2014). The method of surgical removal of the foetus used in the first trimester, vacuum aspiration through a cannula inserted through the cervix, is not thought suitable for after 16 weeks, again because of the size of the foetal body (Lohr & Lyus, 2014), though it can take place between 14-16 weeks (RCOG, 2015).

This means that in the second trimester an induced labour and vaginal delivery, known as medical management or medical termination of pregnancy is the usual means of management in the NHS of terminations for foetal anomaly (RCOG, 2010b; Speedie et al., 2014) and for foetal death or irreversible premature labour which is not progressing. Medical induction of labour in these circumstances is through the use of a dose of oral mifepristone and then after 36–48 hours up to 4 doses of misoprostol given vaginally every 3 hours (RCOG, 2010a; Speedie et al., 2014). This was the treatment experienced by the women in my study who did not spontaneously go into labour, such as Eva, and also those women whose spontaneous labour stopped after membrane rupture and partial opening of the cervix, such as Kerry. This management occurs despite there being an increased risk of complications for pregnant women, including retained placenta, in medical management compared to surgical management (Comendant, Hodorogea, Sagaidac, & Rowlands, 2014; Grimes, 2008; Grossman, Blanchard, & Blumenthal, 2008; Lohr, Hayes, & Gemzell-Danielsson, 2008; Whitley, Trinchere, Prutsman, Quinones, & Rochon, 2011), and also as gestational time increases (RCOG, 2010b)[22]. These studies have been done with reference to cases of medical termination, but it is reasonable to assume the same consequences apply for induction for foetal death carried out using the same medication, and may also apply in cases of spontaneous labour in the second trimester. This suggestion is supported by a recent workshop hosted by the Royal College of Gynaecologists and Obstetricians which grouped together all forms of second trimester pregnancy loss to claim that surgical management is the safest method of uterine evacuation (RCOG World Congress 2019, 2019). In other medical systems, such as in the USA, suction evacuation methods are used in second trimester termination (Ludlow, 2008). And in cases of termination in England in the second trimester which are not for reasons of foetal anomaly (for example under Ground C of the 1967 Abortion Act), surgical management may be available through outsourcing to the British Pregnancy Advisory Service or Marie Stopes (personal communication with anonymous NHS abortion provision staff, 23 September 2019). However, this option is not available to women in the English NHS experiencing termination for foetal anomaly or any other foetal loss in the second trimester.

Joelle's daughter, the baby with Edwards' Syndrome mentioned above, was eventually born at 16 weeks after medical induction of labour. I asked Joelle if she thought it would have been easier if she had had surgical management of the termination:

> Um...I don't know. I...I do appreciate the time that we got to spend with her. And originally we didn't even plan to see her or anything. And then, when it all happened, I had really bad haemorrhaging and really traumatic...I don't think they really tell you all the risks of things that can go wrong? Because I had a lot of retained placenta, I was really unwell for about 6 weeks afterwards.

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[22] It might be assumed that a known potential for increased complications, such as retained placenta, would lead to increased postnatal care for women with second trimester losses. However, as Chapter 5 explains, this is not the case.

The substantial physical consequences of medical management of second trimester loss which were faced by Joelle and are mentioned in the literature related to medical termination were common in my research. Many of the women endured long and painful labours. Eva for example, who had hoped for a quick operation to remove the foetal body, spent five days in hospital waiting for labour to progress. Although a few women reported that they had not felt much pain, most experienced painful contractions and were sometimes given oral morphine and gas and air to combat pain[23]. Women with other children were able to compare the second trimester loss with full term birth experiences. I asked Lucy how the birth of her second child at 21 weeks during a termination for foetal anomaly compared to the vaginal births of her two other children:

> The pain was as bad. The only thing that wasn't as uncomfortable was the actual crowning[24], because obviously the size is completely different. You know, he came out literally with no…I didn't really feel…sounds awful doesn't it, but he almost fell out. Whereas with my other two that actual crowning feeling was like [strained] oh god! Painful! But the rest of it was exactly the same, it was just as painful contraction wise.

Not only was the actual physical experience exhausting and painful for women, the postnatal consequences could be serious too. For example, at least 10 other women besides Paula and Joelle had retained placentas, requiring surgery to remove the remains of the pregnancy. Several developed infections and others lost large amounts of blood, with one needing an iron infusion and three needing blood transfusions as a consequence.

Assessments of the gestational age of the foetal body, as determined by normalised measurements on ultrasound scans, therefore have consequences for the medical treatment of the pregnant woman facing second trimester loss in relation to NHS resources and capacity. However, this is either not explained to women, or other reasons are given to them for mandating labour and birth. Fiona's first baby died in utero, and the discovery was made in a private

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[23] The availability of pain relief in second trimester loss is inconsistent and is discussed in Chapter 5.

[24] See Glossary.

ultrasound scan at 16 weeks at which she had hoped to discover the baby’s sex. She was then told by NHS doctors that they needed to induce delivery:

> I remember speaking to my sister, and her saying to me 'I think you should have a - is it called D&C? - I think you should have that. I think you shouldn't be doing this.' And I was like, ‘why?’ and she said 'I think it will be awful, it will be too traumatic, you need to find a private doctor and have a D&C. […]'
> And I remember thinking, maybe I should, maybe that's better? I rang a private doctor and he said - I spoke to his secretary - long story short, eventually they phoned me back and said not at 16 weeks when I'd never had another baby, I needed to follow [NHS hospital]'s advice. Which then I thought, ok, I accept that. I understood the reasons why. Because your cervix has never opened.

The cervix not having previously opened would not be reason to prevent a woman having a surgical procedure for abortion on grounds other than for foetal anomaly in the second trimester, but it was used as a reason to persuade Fiona in a case of foetal death to accept medical management. Generally, women were not told about the possibility of any other forms of management of the situation besides labour and birth, nor given any comparison of the potential risks of medical management in relation to surgical management. They did sign consent forms for any medication they were given, and also if they had surgical removal of retained placentas after delivery, but I do not know the details of these. And as I will describe in Chapter 5, the potential medical seriousness of labour and birth in the second trimester was routinely minimised in their healthcare experiences.

It is clear, therefore, that medical assessments and classification of the foetal body have consequences for the medical treatment of the pregnant woman in the second trimester of pregnancy in the English NHS, resulting in medical management of the removal of the foetal body in cases of foetal death and termination for foetal anomaly. Furthermore, this provision of treatment is at least partly based on lack of NHS resources rather than selection of the treatment option with fewest complications for the pregnant woman.

4.2.3 The foetus as too young: Labour and birth because of non-viability

The other factor in deciding on the medical management of the situation is the stage of development of the foetal body in terms of its viability as a separate physical being outside the body of the pregnant woman. The foetal body which has gestated for less than 24 completed weeks is considered non-viable, as defined by English law (see Chapter 1). This classification as non-viable before 24 weeks means that in many hospitals, excluding those with advanced neonatal care mostly located in hub cities, there will be no attempt to preserve the life of the foetus after premature labour if it is born before 24 weeks. Similar viability threshold related decisions about treatment have been described in medical settings in the USA (Christoffersen-Deb, 2012). Furthermore, in cases of foetal death, or termination for medical reasons, there is no need to factor in the consequences of birth for the foetal body - it either is already dead or is intended to be dead. This means that there is no clinical reason to carry out a Caesarian section to save the life of the baby, with its attendant risk to the pregnant woman. Amber, facing the termination of her pregnancy after a diagnosis of Smith-Lemli-Opitz syndrome, had only experienced birth by caesarian section previously:

> With [older daughter], I got to 7 cm [dilation of the cervix] before my emergency C section, but I never pushed, I'd never given birth to a baby. So I didn't know. What it would be like. And not that you can…you don't have a choice, you *have* to do it, they don't offer you a C section. Cos [husband] said, 'you can't do it any other way?'

Caesarian was not an option open to Amber in this birth process. Induced labour and vaginal birth is how foetal deaths or terminations for foetal anomaly are managed if the pregnant woman is considered physically able to go through labour.

Assessment of the gestational age and developmental stage of the foetus, this time as not having reached sufficient maturity to survive, has consequences for the treatment of the pregnant woman in circumstances where the foetus may be understood to be healthy. This is well illustrated by the story of one woman who had the misfortune of being able to compare her experiences of two spontaneous premature labours, either side of the 24 week foetal viability categorisation. Charlie, aged 30 when I spoke to her, had become unexpectedly pregnant at the age of 22 and went into spontaneous premature labour at 23 weeks and 5 days’ gestation. She described how being two days short of viability affected her and her unborn daughter’s care in the non-specialist local hospital as she faced the possibility of lack of intervention if the baby was born alive:

> They tried to play with my dates, as far as they could, and they were like, 'there's no way we can get this pregnancy, like, above 24 weeks. You **are** 23 and 5.' Like, 'it is what it is, we can't get this pregnancy above, however we try, like growth scans, dates, she **is** just 23 and 5.'
> *In terms of intervening when she was born, was that?*
> Yeah. So they said - so this is when they said, and I remember this conversation like, like...it's probably the most graphic in my head. More than anything else. [crying]
> She said: 'when this baby is born, you're going to have to hold her until she...sorry…until she passes.' [pause]
> And I remember my mum just looked at her and was like, 'you're not intervening? If this baby's born and this baby's like, breathing and crying, you won't intervene?' And they said 'no, cos she's not 24 weeks. We don't have the care here to care for her.'

After hours of painful labour, Charlie requested a Caesarian and was fobbed off:

> At this point I was like 'give me a section, like, I don't even care!' But they don't like doing it for babies that have passed because they don't want the scar to remind you, [midwife] was saying they don't want the scar to remind you?

Like with Fiona, staff appear to have come up with an excuse to stop Charlie requesting a different form of treatment. Eventually after a long and difficult labour the baby girl was delivered with forceps but had died during the labour:

> They took me down to theatre, gave me an epidural […] And then they delivered her with forceps, and they were like 'oh, she's here...' But then the whole room goes quiet. And in my naivety, I was thinking I was going to hear a baby cry. But obviously, I didn't. And then they came over and said that she'd already passed.

That ominous silence was to return in a different manner when Charlie became pregnant with her second daughter two years later, this time after IVF with her new husband. Again, after vaginal bleeding in the second trimester, it became clear the pregnancy was under threat, and a cervical stitch to try to preserve it was carried out. Days later Charlie was discovered to have an infection and it was decided that the baby would need to be born, but this time at 24 weeks and 3 days, beyond the second trimester and the viability boundary. This time she insisted on being treated at a specialist hospital, where the consultant gave her steroids to attempt to mature the baby’s lungs, magnesium sulphate to attempt to reduce any brain damage, and then decided to deliver the baby by Caesarian section with a paediatric team ready in the room for resuscitation. On Charlie’s sitting room wall there is a photo of this little baby daughter being lifted alive from her body in the operating theatre, her thin arms and legs stretched in the startle reflex.

> Did the section, [baby girl] was born. She cried. So we were like 'she's crying, everything's going to be ok, she's crying!' And then they'd explained that I wouldn't get to hold her because she's so tiny, she straight away needed, like, warming up and stuff. And that was fine, like, she'd cried, so I felt... They were like 'congratulations, it's a beautiful baby girl, what do you want to call her?' And like, all the people were coming over and congratulating you, and like 'aww.' And it was just so nice. And then...like, she stopped crying. The cries stopped. […] And then all of a sudden the whole room went silent. Like, eerily silent.

Charlie's second daughter had lived for 45 minutes before dying from infection. This short life meant she was registered on the Births and Deaths register, in contrast to Charlie's first daughter, who was officially categorised as a miscarriage. For Charlie, the few days separating her daughters' gestations had enormous consequences for the medical treatment offered to her and to them. Such decisions about medical care of the foetus or born baby, made on the basis of assessments of the foetal body in relation to viability and resources available in medical contexts, are similar to those noted elsewhere (Christoffersen-Deb, 2012). However, in this research, the impact is felt not only in relation to intervention on the foetal body, but also on the choice of treatment and birth process available to the pregnant woman.

4.2.4 The foetus dead or alive: limiting choice around feticide in the second trimester

The position on live birth personhood in United Kingdom law, further discussed in Chapter 6**,** means that the biomedical judgements on the state of the foetal body are also instrumental in determining the use of another medical procedure, that of feticide. This is also a procedure carried out on two bodies, that of a pregnant woman facing a second trimester loss in the case of termination for foetal anomaly towards the end of the trimester, and the foetal body. Feticide is carried out by the injection of potassium chloride into the foetal circulation through the pregnant woman's abdomen (Oloto, 2014; RCOG, 2010b), whilst she lies still, using an ultrasound image to guide the needle into the foetal heart. This was the experience of the four women in my research who had experienced feticide in any of their pregnancies, who therefore witnessed the timing of the death of the foetus.

Since the 1990 Human Fertilisation and Embryology Act extended the possibility of termination of pregnancy for severe foetal abnormality beyond the 24 week viability cut off, and since ever-evolving prenatal diagnosis techniques have increased the possibilities of prenatal surveillance and assessment, the possibility of later terminations for foetal anomaly has increased, as have the survival rates of pre-24 week babies in neonatal units (Graham, Robson, & Rankin, 2008). This has led to anxiety about the possibility of live birth where one is not desired, and therefore to the development of feticide in late terminations for medical reasons (Graham et al., 2008). This is therefore a procedure sometimes faced by women who are seeking to terminate the pregnancy of a foetus in the second trimester which would not be offered to women in the first trimester, and which would be likely to be mandated in a third trimester termination. Guidance from the Royal College of Obstetricians and Gynaecologists states:

> The RCOG currently recommends feticide for terminations over 21+6 weeks. The only exception to this rule is when the fetal abnormality itself is so severe as to make early neonatal death inevitable irrespective of the gestation at delivery. (RCOG, 2010b, p. 29)

As Graham et al. (2008) have noted, medical guidelines do not place feticide in any social context and present it as a neutral term[25]. They show that the use of feticide, and the term itself, both conceals and reveals the political positioning of the procedure in different settings. The ambiguity of the vocabulary in the RCOG guidance notes is interesting in this context, in terms of whether the guideline is a 'recommendation', or a 'rule'. And if it is a 'recommendation', who is deciding whether it is to be carried out? Graham et al. discuss the role of 'professional discretion' (Graham et al., 2008, p. 298), and Speedie et al., note that statistics show that feticide is sometimes not carried out at this gestation, which they suggest may be due to women declining it (2014).

In my research, there was variation in both who was offered feticide, and who was given no option to either choose or reject it. Out of 10 women who had terminations for foetal anomaly, three underwent the procedure, with a fourth having undergone it without being given a choice for a previous post-viability termination. Of the three who had a feticide in the second trimester, one woman at 21 weeks' gestation was presented with it as a choice which she accepted, and the other two, at 23 weeks' foetal gestation were not given the option to refuse, with both finding the procedure traumatic. Gemma's middle daughter was diagnosed in pregnancy with a serious heart condition and she and her husband decided to terminate the pregnancy:

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[25] The repercussions of a feticide in terms of lack of access to birth registration and maternity and paternity benefits are considered in Chapter 6.

> *Did they give you an option about the injection [to stop the foetal heart]?*
> No. They just said that that's what they did once the baby got to that gestation, because otherwise there was a chance she could be born and still alive initially. And then that…kind of…whether then there would be a decision as to whether they would try to keep her alive or not, or…so. Yeah, it was just kind of, that's what they did really. I was probably in shock at the time and I just kind of went with what they said.
> *That must have been distressing?*
> That was almost the hardest bit really. Obviously the labour and stuff was horrible, but you're kind of…in a lot of pain and everything as well, and there was things going on at that point. Whereas the injection you just lie there while they do it. Which I found really, really difficult. And then…yeah you sit in a little room […] because they have to check you after half an hour and make sure the heartbeat has definitely stopped. You have to kind of sit in this little room drinking tea. And trying to – I don't know what we were talking about – trying to have a normal conversation, almost? Because you don't know what else to do. And then…go back and have another scan. So. That was, yeah, I found that day really hard.

In other termination cases, the RCOG guidelines appear to have been flexibly interpreted. One woman was not offered feticide at all at 23 weeks in a termination after diagnosis of Edwards' Syndrome, perhaps because the diagnosis was so serious (RCOG, 2010b). In other cases, women were offered feticide around 20 and 21 weeks but declined. And in the case of Lucy, whose son was diagnosed prenatally with a serious heart defect, doctors offered feticide at 21 weeks but suggested she might prefer a live birth:

> I was really concerned about him feeling any discomfort or pain. And I had a conversation, once we'd made the decision that we weren't going to carry on, and that we were going to deliver him early, um, I remember having a conversation with one of the consultants about whether to have the injection.

> And they said, ‘well we wouldn’t normally offer it at your gestation, because he probably wouldn’t survive, but if you wanted us to, we could do it.’ And then the other consultant said, ‘just think about it, because I know some mums in the past have really valued that time that they’ve had with their baby whilst they’ve been alive? So…just have a think about it. You can have it if you want to, but just think about it, especially with the likelihood being that he’s not going to be alive very long, if at all.’ So we didn’t have - they call it feticide - we didn’t have the feticide, and I’m so glad that that consultant gave us that advice, to think about, because [baby boy] actually ended up living for 4 hours. So you can see [showing his birth and death dates on his memorial box] he crossed a day, he was born at 11 and he died at 2 the next morning. And, you know, those 4 hours…

Feticide in the second trimester is both a recommendation in some cases, and a rule in others. Previous research has described some of the reasons for performing feticide, which include avoiding a resuscitation dilemma for the pregnant woman and medical staff, avoiding the consequences of an unintended live birth that survives, and avoiding the possibility of a coronial inquiry into the death of a neonate (Oloto, 2014; Statham et al., 2006). However, none of the ten women in my study who went into *spontaneous* premature labour, rather than terminations for foetal anomaly, were offered feticide to prevent a live birth. In fact, four of those women did experience live birth in the second trimester, in different hospitals. Furthermore, of those women with pre-viability potential live births, only one, Rachel, was offered resuscitation of her 23 week gestation daughter after her placental abruption. When the baby was born, resuscitation was initiated but then Rachel quickly gave permission to stop to prevent her daughter from suffering and allow her to die, and in fact live birth was never medically diagnosed. There is an inconsistency here which points the way towards the purpose of feticide. It cannot be mainly carried out to prevent the distress of live birth to the parents, or the resuscitation dilemma, or the possibility of an early term survival, since it does not always apply in terminations for foetal anomaly, nor does it apply in other second trimester cases where a live birth could occur. Furthermore, in my research the distress of the feticide itself was enduring for some women who underwent it, whereas the distress of a live birth and subsequent death was balanced by some acceptance or even satisfaction at having witnessed the living baby in all the other cases in my research. This contrasts with other research which emphasized the acceptability of feticide to some parents, but which seems to have taken place in a context where they were given options to select or refuse it (Graham, Mason, Rankin, & Robson, 2009), which was not always the case for my participants.

I argue, therefore, that feticide may often be routinely carried out because it is understood to be a procedural requirement, something in the guidelines, in a field in which bureaucracy can exempt doctors from prosecution for illegal abortion. Oloto (2014), in giving reasons for feticide, does not mention the bureaucratic consequences for doctors of a termination which has not been successful, such as being required to inform the Care Quality Commission of the death of a person during the provision of a regulated activity such as termination. Nor does he mention the legal requirement to register a live-born baby and to produce a death certificate when it dies. Nor does he mention the potential expense to the state or private sector in terms of the costs of maternity leave and so on which can be claimed after a live birth in the second trimester. The burden is on doctors to carry out these state governance requirements in an environment where abortion is a criminal act from which they are merely exempted from prosecution under certain circumstances by the 1967 Abortion Act. It is certainly more straightforward for caregivers to conduct a termination for foetal anomaly which does not end in live birth. And feticide also exists in the context of the illegality of euthanasia in the United Kingdom, where the distinction of birth between a foetus and a baby prevents the active taking of a born child’s life – as Costeloe (2007) says, the procedure of feticide carried out moments after birth would be murder. The distinction between euthanasia and the withdrawal of life support is one of immense legal uncertainty for doctors in relation to withholding treatment from a born child, who has a right to care under the NHS. In cases where parents do not consent to the withdrawal of treatment for living children, the situation could become even more complicated for doctors, as has occurred in recent legal cases involving babies Charlie Gard (Wyatt & Siddique, 2017) and Alfie Evans (Collins, 2018), where lengthy court cases pitted parents against doctors.

It is much simpler for doctors to perform feticide and avoid these issues. However, the consequences of this legal framework are that the women in whose bodies the foetuses live often have little choice over whether to undergo the process during terminations for foetal anomaly towards the end of the second trimester. It is significant that Lucy, who was advised by doctors to consider no feticide and a live birth at 21 weeks, was employed in the maternity department in a clinical capacity and was personally known to the doctors involved. She may have therefore been less of a risky parent for doctors, who knew she would not insist on intervention to try to prolong her baby's life. In other cases, women facing a possible live birth after going into premature labour were not offered the procedure. The decision about feticide or live birth is thus not usually made by the pregnant woman, but by clinical staff. In this research, there was little or no choice for the women about feticide, a medical procedure aimed at the foetal body, but also taking place on their own pregnant body.

4.3 Conclusion: the foetal body and the production of stratified trajectories of care for pregnant women

When facing pregnancy loss through foetal death, termination for foetal anomaly, and premature labour, the biomedical assessment of the foetal body in relation to gestational time, and its diagnostic classification as being in the second trimester, defines the type of healthcare procedures available to the pregnant woman. Access to surgical removal of the foetal body, available in the first trimester of pregnancy through the cervix and vagina, and sometimes in the third trimester through Caesarian section, is usually not available to women in the second trimester, who must labour and give birth. A lack of resources in the NHS to offer surgical removal of the foetus via D&E, because of a lack of doctors with the relevant skills, means women cannot select this treatment even though it is medically less consequential for their bodies. Gestational time classifications also affect whether women must undergo feticide in terminations for foetal anomaly. However, in spontaneous premature labour feticide is not offered, and the focus is more on what neonatal treatment will or will not be offered to the resulting baby if it is born alive. This means that women may have no choice but to witness their newborn baby's death.

These restrictions on women's care, combined with a lack of clear information for women about alternative procedures and the comparative risks of different ways of managing second trimester loss mean that pregnant women have their healthcare options restricted within obstetric and gynaecological care in the NHS in England. Furthermore, resource availability means the NHS is possibly not offering the safest care to women. These choices, or non-choices, are being made because of classifications of the foetal body, when that body is not alive or will not live. However, they are played out on the body of the pregnant woman, who is frequently required to suffer pain, postnatal complications, and emotional distress without being able to weigh up the benefits and disadvantages of labour, birth, and feticide for herself. I argue therefore that stratified trajectories of care are produced in the English NHS in relation to pregnancy, in which different levels of agency are being accorded to pregnant women. Furthermore, access to these different trajectories of care is determined by biomedical classification of the foetal body rather than the agential choice of the pregnant woman, depending on the possible outcome of the pregnancy in terms of producing a living baby. This raises issues of consent, bodily autonomy, power and agency which have been a priority for feminist scholars of reproduction for several decades, in a field of reproductive politics to which this research contributes (See for example, Bordo, 2003a; Colen, 1995; Duden, 1993; Oakley, 1984; Rothman, 1986/1993; Sheldon, 1997).

The next chapter will further illustrate the impact of biomedical classification of the foetal body on the care of the pregnant woman experiencing second trimester pregnancy loss by showing how women's experiences are minimised and marginalised in their day-to-day healthcare experiences.

Chapter 5: ‘They’re not supposed to deal with this kind of thing’: Ontological boundary work, discipline, and obstetric violence in the medical management of second trimester pregnancy loss

In 2018, happily expecting her first baby at the age of 24, nursery nurse Bethany woke in the night to feel a gush of liquid in the bed. Her husband was working nights, so she rang her mother to take her to hospital, where it was discovered that at 17 weeks of pregnancy her membranes had ruptured, she was going into premature labour, and the baby would be born. Bethany described how once her husband arrived, she and her family were left to get on with the process in a side room of the hospital:

> I think 22 weeks is when you go on to the maternity ward. So I was in the gynaecology ward in a side room. And I had no midwife, I had no-one. I had [husband] and my mum. And I had no idea what I was doing. I'd never had a baby before. I just had…I was just completely clueless. […] And then, you know, my mum was like, 'this doesn't feel right, I think someone should be here making sure you're ok.'
> And the nurse basically just said 'when it's happened, come and get me and I'll sort it out.’

The hospital at which Bethany was treated did not classify her experience at this point in pregnancy as a labour and delivery, which would be treated on the maternity ward. Bethany was put on to the gynaecology ward, which is the routine process at some hospitals in South West England for pregnancy loss which is pre-viability. Bethany had had no birth training, because she was still early in her first pregnancy:

> Just being left in a room…I just felt like I didn't know what to do and I was just basically relying on my mum and [husband] to know that if something wasn't right, or if I needed to move, or, I don't know…

She was left to labour without medical support for several hours in a lot of pain and with poor access to pain relief:

> They started me off with paracetamol. And I very quickly said, ‘this is not…paracetamol…I can't actually cope.’ So they gave me gas and air[26] but even that was...[husband] had to go out and ask for it […] I was literally writhing in pain, I couldn't.[…]
> [Husband] went out to get it, and they literally wheeled it in and went 'there you go.'
> *Didn't show you how to use it?*
> No. And then at one point, they came in and I was constantly breathing it, and they said 'you need to go steady on that thing, because it will freeze the lines.' And I was like, 'I've never done this before! I'm just sucking on it because it's helping!'

Bethany was not examined for progression of labour, with nurses saying that they didn’t know how dilated her cervix needed to be for birth to happen, because they didn’t know how big the baby would be. Her mother’s attempts to monitor contraction frequency were described as ‘pointless’ for the same reason. Bethany and her family were therefore left alone to get on with the labour with no sense of how long it might last. When delivery happened, there was no medical support in the room. So Bethany’s husband had to look under the sheet to see that the tiny, premature baby had been born, and then go and call for a nurse, exactly as they had been told at the beginning of labour: ‘when it’s happened come and get me’.

Bethany’s first experience of labour, and her birthing of her dead son, included difficulty accessing pain relief because it was not routinely available in the space in which she was cared for. Diagnosis of the foetus as being in the second trimester took precedence over her clinical symptoms of pain in relation to the availability of pain relief. Her medical care involved no midwife support, being alone at the point of delivery, and judgmental comments by staff on her

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[26] See Glossary.

coping abilities. She also experienced a lack of information and informed consent about the processes she was going through. For example, she was not warned about the pain of manual placenta removal on just gas and air, nor that it could be ineffective and might still necessitate surgery, as it did a fortnight later. Yet despite describing her experiences as traumatic, Bethany was cautious in her criticisms of her care:

> I mean they're obviously busy, aren't they? They've got other people to see, and they're stretched as it is, so I don't blame them. I think it's the system? It's...they're understaffed, or...they're not supposed to deal with this kind of thing.

In trying to comprehend the failings in her care, Bethany ended up emphasizing the deviant nature of her pregnancy loss compared to normative pregnancy. The systematic failures of the care of her pregnant self were caused by the sheer *wrongness* of ‘this kind of thing’: the pregnancy which could not produce a living baby.

The previous chapter showed how classification of a pregnancy as being in the second trimester structures the healthcare possibilities available to women facing pregnancy loss, defining whether a woman is expected to labour and deliver vaginally, and which medical procedures are available to her. This chapter draws on the stories of women such as Bethany to explain how the nature and quality of the birth experience for women, its attendant medical care, and subsequent postnatal care is also structured by the second trimester classification. I trace how the experience of second trimester pregnancy loss in English healthcare is systematically minimised and marginalised, through disciplinary techniques and events of obstetric mistreatment and violence, in order to protect ontological classifications of second trimester foetus as ‘not a baby’, and the pregnant woman as ‘not a mother’ which are produced by biomedicine and English law. I argue that this boundary work around classification is enacted through a form of Foucauldian discipline which produces docile pregnant bodies through the classification of deviant foetal bodies and the disciplining of the pregnant bodies which contain them. This occurs in the context of a teleological biomedical-legal ontology of pregnancy focussed on the outcome of a living baby.

5.1 Mistreatment of women and obstetric violence in healthcare

Bethany's experiences in relation to the birth and death of her son are consistent with the marginalisation and deprioritisation of pregnancy loss in healthcare practice in the UK which has been evidenced over many years (see Chapter 2). Her experiences also fit into a recent typology of forms of direct abuse directed against women in all forms of childbirth in multiple global settings (Bohren et al., 2015). Many of the forms of mistreatment these authors identify were also described to me by other women in my research. These include verbal abuse such as blaming; stigma and discrimination based on medical condition; failure to meet professional standards of care (such as an attendant being present at delivery or refusal to provide pain relief); loss of autonomy; lack of consent; and health system conditions and constraints. These themes recur throughout this chapter in relation to women's experiences in the healthcare system.

Bohren et al. prefer the term 'mistreatment of women', but they explicitly situate their research alongside frameworks of 'obstetric violence', a concept developed in South America to describe the disrespect and abuse of women in pregnancy and childbirth (Perez D'Gregorio, 2010; Sadler et al., 2016; C. R. Williams et al., 2018). Obstetric violence draws on the concept of structural violence (Farmer, 2003) and consists of both an individual act of power by a caregiver, and a structural response to the devaluing of women's reproduction in patriarchal society. As a framework for understanding some types of pregnancy care, it is useful because it draws attention to the many specific ways in which women's bodies and subjectivities may be the object of aggression and violence during pregnancy and childbirth in a type of gendered violence (Borges, 2017; Chadwick, 2018; Cohen Shabot, 2015; Cohen Shabot & Korem, 2018; Shabot, 2020). It links the lived experiences of women to the medical exercise of power, but also beyond that to the wider valuing of women and their reproduction in patriarchy (Zacher Dixon, 2015).

However, the obstetric violence concept relies for explanation of the abuse on a causal link between the devaluation of women and their activities in wider society, and what then happens to them in obstetric care. This is an insufficiently complex explanation in the case of second trimester loss, because it misses out the role of ontologies of pregnancy and the foetus. Understanding obstetric violence as gender based discrimination against the pregnant body in favour of the foetal body (Borges, 2017) is not sufficient as an explanation in second trimester loss, when the foetus will not survive. It is not solely because women's reproduction is generally devalued that medical care in second trimester pregnancy loss is so problematic for many women. A further factor is the complex relationship between classificatory technologies of biomedicine and the law, drawn upon in healthcare practice, which results in the marginalisation and disciplining of certain pregnancies. These classificatory practices centre the deviant foetal body, and are enacted on the deviant pregnant body during second trimester pregnancy loss. They are based on ontological positions about the status of both bodies. Obstetric violence does not just happen, it is used and performed for particular purposes within the medical management of pregnancy, labour, and birth, in the context of ontological politics.

5.2 Ontological boundary work in English healthcare

I argue in the thesis as a whole that the ontological underpinnings of biomedical discourse define a pre-viable or dead foetus as a non-person. Since pregnancy is understood teleologically, as the successful production of persons, a pregnancy which will not produce a living child, as in the second trimester, is deviant at an ontological level. In this biomedical ontology, a foetus which is dead or will die cannot fulfil its teleological destiny, and therefore is not a 'real' baby. Ontological positions about pregnancy loss not involving 'real' babies are embedded in longstanding conventions and practices of healthcare. For example, work on gynaecological nursing has shown how nurses explicitly make contrasts between ontologies of foetal bodies delivered on labour wards by midwives, who deal with the 'nice chubby baby' (Bolton, 2005, p. 177) and gynaecology wards which often handle late miscarriage and termination and 'ugly dead babies' (Bolton, 2005, p. 178). Similar classifications are made by hospitals in research in Canada on termination for foetal anomaly carried out on gynaecology wards (Chiappetta-Swanson, 2005).

However, second trimester pregnancy loss involving labour and birth and the formed body of a foetal being poses a potential ontological threat to these classificatory decisions. Second trimester loss is not the live birth of a healthy infant which is the normative end of a pregnancy and which clearly produces a person in the English legal system. And yet it bears a resemblance to some endings of a pregnancy, such as stillbirth in the third trimester, which do produce a form of legally recognised person[27]. Furthermore, within healthcare itself confused ontological positions on the foetal being co-exist. This chapter lays out the myriad ways in which a foetal being defined as a non-person produces particular trajectories of care and experiences of second trimester loss for the pregnant woman. Holly's story which opened this thesis showed how healthcare staff sometimes continued to use the term 'foetus' when a woman clearly preferred 'baby'. Chapter 7 will describe how definitions of the dead foetal body as forms of medical waste rather than corpses were imposed on other women, such as Eva and Tess. But at the same time, in NHS antenatal care pregnant women are encouraged to perceive their foetus as a 'baby' from conception through NHS educational materials (NHS, 2019b). In this guidance, the section for parents on miscarriage and stillbirth also refers to the foetal being as a 'baby'. Official guidelines for approaching parents about consent for post-mortem use the term 'baby' for the dead body of a born foetus (HTA, ND-a). The born and formed dead foetal body is also often represented by medical staff as the corpse of a baby, in line with best practice recommended by the pregnancy loss National Bereavement Care Pathway[28] (NBCP, 2019a, 2019b). Sometimes the ontological classification of the foetal being is embedded in institutional discourse. At other times, ontological shifts from 'non-baby' to 'baby' in second trimester loss take place *after* birth in the hospital setting. In my research, ontological shifts to 'baby' occurred in relation to a discernible foetal corpse, separate to the body of the pregnant woman, onto which practices of personhood could be enacted by medical staff, as directed by bureaucratic protocols. The dead foetal body could potentially be produced as the docile

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[27] This is discussed in Chapter 6.
[28] See Glossary.

body of a dead baby once its material separation from the woman's pregnant body had been completed.

At the same time, in the second trimester pregnancy losses examined here, there were situations in which the foetal being was produced as non-baby, or deviant in relation to a teleological ontology of pregnancy. For example, a foetal being born alive in the second trimester has breached spatial and temporal boundaries because it is inappropriately outside the pregnant body at the time when it cannot survive in the outside world. It has become deviant (Foucault, 1977/1991). As Charlie's story in Chapter 4 showed, this deviance alters the care trajectory for a pre-viability baby, who will not be offered medical treatment. A foetal being which has been judged to have abnormalities consistent with the possibility of termination for foetal anomaly is also deviant in relation to being judged, through hierarchical forms of observation, in relation to normalised bodies, producing deviance through discipline (Foucault, 1977/1991). And a dead foetal body which has not yet been born is also deviant, existing as it does within a pregnancy which will not have a normative outcome of separate life. These deviant foetal beings breach the teleological biomedical ontology of pregnancy, because they will not result in a living baby. Second trimester pregnancy loss is therefore an event which must be pulled back into classificatory conformity through practice activity in a boundary infrastructure (G. C. Bowker & Star, 2000, p. 299). I argue in this chapter that in order to achieve this, medical institutions perform boundary work during the care trajectory to produce the foetal being in second trimester loss as 'not a real baby' and the pregnant woman as 'not a mother'.

This ontological boundary work is enacted on the bodies of pregnant women, foetuses, and babies using Foucauldian disciplinary techniques (Foucault, 1977/1991, 1976 /1998). Deviant and docile pregnant and foetal bodies are produced using temporal and spatial decomposition, hierarchical examination, and normalisation. Some of this normalisation of the foetal body is based on gestational time and normative development and formation, as observed through biomedical surveillance such as ultrasonography or prenatal genetic testing. However, at its most fundamental level normalisation is against the teleological biomedical ontology of pregnancy, in which a pregnancy should produce a living person, and a second trimester foetus cannot become a living person. Furthermore, foetal deviance is also enacted on the other body in pregnancy, that of the pregnant woman. She too is disciplined, because her foetus does not fit the normalised teleological ontology of pregnancy. For women such as Bethany, the consequences are a trajectory of healthcare which does not understand this process as the loss of a baby, nor as a labour and birth requiring the same level of pregnancy care as a normative birth. As in Mol's ontological politics (Mol, 1999), the performance of one ontological object, in this case the foetal body as 'not a baby', impacts on the performance of other objects, in this case the labouring and birthing pregnant body. This chapter traces these processes in healthcare practices.

5.3 Differential trajectories of healthcare as disciplinary penalties and obstetric violence

Once the foetal body in the second trimester has been classified as deviant by disciplinary techniques, the pregnant woman is also deviant, because she will not produce a living baby. As a result, within healthcare, a penal mechanism is enacted on the pregnant subject, who must be subject to disciplinary penalties because she has departed from the normalised rule (Foucault, 1977/1991). An alternative trajectory of care is put in place which clarifies to both healthcare practitioners and the pregnant woman herself that this is a deviant pregnancy, as Bethany described. As a consequence of this, at each point in the sequence of events which make up a second trimester pregnancy loss the gravity of the event for the pregnant woman's body is minimised, and women's experiences are marginalised, by a healthcare system which seeks to constantly affirm its classifications of second trimester loss as medically inconsequential and different to other forms of birth. Gestational time, medical space and differential healthcare were used as forms of discipline to produce the pregnant women in my research as deviant, sometimes alongside forms of more direct obstetric violence.

5.3.1 ‘Not pregnant enough’: gestational time, medical space, and differential healthcare access in the second trimester

Women in my research consistently had difficulties accessing medical care in second trimester pregnancies. Being accepted into different medical spaces was conditional on gestational time, at every stage of the event, in an example of the management of pregnancy and birth through the institutionalisation of time (Simonds, 2002). Antenatal monitoring is sparse in the NHS in the first two trimesters of a pregnancy believed to be uncomplicated (NHS, 2016), and it was clear to women in my research that the fact that medical staff were relatively powerless to intervene to assist the pre-viable foetus explained their lack of attention to the pregnancy at this stage. The potential teleological destination of a foetal being determined access to medical resources for the pregnant woman. Concerns women had about the pregnancy in the second trimester were routinely minimised in the period running up to the loss. Access to medical examination, itself disciplinary, was restricted, and non-examination of the second trimester pregnant body acted as a form of exclusion. Phoebe had a typical experience during a placental abruption at 17 weeks in 2017 in her mid-twenties. She struggled to get her concerns about persistent vaginal bleeding taken seriously by medical staff, being told on the phone that the local hospital Early Pregnancy Unit would not see her before 20 weeks’ gestation. Eventually her waters broke at home, and she started bleeding very heavily. She expressed her bemusement to me about the way her fears had not been responded to:

> I’d had my midwife appointment, I had these scans and things in the run up, and you hear about it all the time, all these charity campaigns, ‘anything wrong, phone your midwife!’ All these leaflets saying, ‘anything wrong, worried, concerned? Phone us!’ I phoned them, and they weren’t concerned. […] I felt like I was bothering them because I wasn’t pregnant **enough**. Not important enough.

Being able to access medical care at anxious points in the second trimester was difficult for women because of the gestation of the foetus. Even in labour, women’s need for and entitlement to medical care was in doubt. Heather was given medication to induce labour after foetal death was diagnosed, and then sent home. With her experience of two previous vaginal labours, she then realised labour had started and went to hospital, but staff refused to admit her because they did not believe she was in labour. They sent her home again, where her waters broke and she had to rush back to hospital for birth. This lack of access to care and the dismissive attitudes of staff in relation to pregnant woman's concerns are forms of mistreatment of women in obstetric care (Bohren et al., 2015), related to obstetric violence.

It is also significant that women themselves were hesitant about their claims to medical care. A factor in second trimester loss is that women doubt the validity of their experience in a form of self-discipline, the defining factor in a successfully operating disciplinary system (Foucault, 1977/1991). For example Helen, who had the intrauterine death of her daughter diagnosed at 15 weeks in her second pregnancy, was given a date to come back for delivery, and then sent home, where the baby was born in the bedroom with a massive loss of blood. Instead of calling an ambulance, she called a midwife friend:

> I couldn't get up off the floor, absolutely out of it, and the blood was still coming, and [midwife friend] said, 'you need to call an ambulance, you're losing too much, I can estimate the amount of blood you're losing.' And I really didn't want to, but I just didn't know how to get down the stairs and into the car.
> *Why didn't you want to?*
> Because it isn't a medical emergency. I wasn't dying.
> *But it's quite serious though? Did you feel unentitled again?*
> Yeah, but all you hear is people calling ambulances for ridiculous reasons.
> *But you were bleeding all over the floor?*
> [laughs] I don't know. I don't know the logic in it. I just felt like I was wasting time. Again, maybe it was this...everything is so normalised, to the point where you feel 'just get on with it, can't you just cope with a miscarriage?' So you kind of feel like you're the idiot who calls the ambulance, you know. If...I really wish in some ways they'd prepared us

> for how big it was. I wish they'd said, 'if you need an ambulance, you call it'.

Access to medical space and care was limited by classificatory decisions relating to the unborn foetal body and its gestational stage, rather than by the clinical symptoms which women were experiencing in their own bodies. Often a sense of lack of entitlement to medical care was expressed by the comments of medical staff, such as those made to several patients about needing to free up their beds. Women in England are expected to be compliant and restrained in pregnancy care, particularly in relation to using NHS resources, the unnecessary use of which is often perceived as unethical by patients themselves (McDonald et al., 2007). There is a perception that to criticise NHS care is in itself wrong, as Bethany hinted at the beginning of the chapter, and which Angela expressed as a horrified ‘I’m faulting the service!’ when she caught herself being critical of her medical care. Women had often internalised the classifications of their pregnancies as less important because of the gestational stage of the foetus, with the attendant sense that the event they were experiencing was ‘not medically serious’ and not a ‘real’ birth or labour, to the extent that they limited their own attempts to access care in medical spaces for fear of being judged unworthy or demanding.

5.3.2 ‘We went out the back door of the labour ward’: medical space as a disciplinary technique in second trimester loss

Once it has been accessed, the arrangement of medical space itself illustrates to women experiencing pregnancy loss that they are deviant. This is a development of the way space is used as an obstetric technology demanding compliance (D. Davis & Walker, 2010). Where there is a specialist maternity bereavement suite in a hospital, this is sometimes concealed even on the hospital site by being unmarked on site maps. When I visited one hospital the staff on the general information desk did not know about the bereavement suite or the hospital’s pregnancy memorial garden. Pregnancy loss is thus produced as in need of hiding, as shameful and deviant. Contact between normatively pregnant women and women experiencing second trimester loss was sometimes avoided through the use of non-standard routes: several women pointed out the use of ‘back doors’ in their care, through which they were ushered into or out of different trajectories of care. Amanda found out at a satellite clinic at a routine 20-week scan that her unborn son had ventriculomegaly[29]. The sonographer arranged for her to meet a specialist next day at the main hospital:

> She gave us some photos and showed us out the back door. [small laugh]
> *Back door is weird?*
> Well, she didn't want us having to walk past all the other people, because obviously we were upset, being told there was a problem with the baby.
> *For them, or for you?*
> I don't know. I don't know. That's a really interesting question. Possibly for us? But also I suppose, it stops panic in the corridor, doesn't it?
> *But also immediately you're put on a different route?*
> Yeah, completely. It carried on when we got down to [main hospital maternity unit], because we then sat waiting with the scans with the normal mums […] So there's the window that the receptionists are in, and you sit there and she's got one pile there...and we watched her put a pile of notes down, and then go, 'oh, that's the special case' and with that somebody walked out and picked them up and then called us.
> *So you were already being different?*
> Yeah, so we were sat with everyone but our notes...and we heard it, so I'm sure everyone else did.

This combination of the space and bureaucratic procedures, such as maternity notes, being used to separate and individualise women as cases in the Foucauldian sense (Foucault, 1977/1991) was also experienced by Simone. A week after the delivery of her daughter, she had to return to hospital to have retained placenta removed. Because she had delivered her baby, her green maternity notes, the NHS symbol of pregnancy carried around by all pregnant women, had been taken off her, but she occupied the same space as women who were still pregnant, which she found very difficult:

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[29] See Glossary.

> It's those green folders. [small laugh] Those green folders stand out when you don't want to see them. And I know they've got it separate, the [bereavement suite where she had laboured], but it is...
> *You've got to walk through it?*
> You've got to walk through, and, you know, where the people were waiting to be induced, they were there and they were all walking round because that's what you do. Yeah, and you just saw everyone with their bumps. And you had to walk through them. And then walk back again. It was horrible.

Joelle, who had a termination for foetal anomaly, and who felt ill prepared for the trauma of the subsequent birth, was also affected by the bureaucratic use of green maternity notes. When she had left hospital after her daughter’s death, her green notes had been removed from her. But she then experienced severe abdominal pain for six weeks after the birth. She struggled to get healthcare professionals to react to this until eventually she was scanned and found to have retained placenta which had to be surgically removed. During this process she constantly had her right to be in the maternity space questioned because of the absence of her green notes:

> As soon as you book in for the termination they take all your green notes off you, so I'd go in [to the maternity unit for postnatal care] and they'd say 'well, where are your green notes?' And you just have to keep going through the same thing, over and over again.

The use of green maternity notes as a signifier of normative pregnancy and a passport to maternity spaces meant that their removal and absence was a label of deviance.

Deviance can also be emphasized through the public exposure that the spaces of normative pregnancy impose on a woman whose pregnancy is not going well. There were many tales of routine antenatal scans at which diagnosis of foetal death or anomaly occured where the architecture of the hospital required distressed women to leave through a public waiting room of other pregnant women. Simone had attended a routine ultrasound scan without her husband, who was working, and with her youngest son, for whom she had no childcare, when she was told that her unborn daughter had died. Staff told her to phone her husband on her mobile phone. However, there was no mobile signal, and so she had to walk, crying and dragging her son’s pushchair, through the crowded waiting room to leave the hospital and find a signal in order tell her husband that their expected baby had died. Fiona, waiting in a corridor for the induction of her dead son was handed a pregnancy loss memory box by a midwife and had to sit publicly holding it outside the gynaecology unit where her baby would be born. Megan, diagnosed with no foetal heartbeat at the 20-week ultrasound scan, found there was no separate space for a private conversation with midwives about the need to induce birth. With her thoughts on the lack of heartbeat of her own baby, she was exposed to the heartbeat sounds of normative pregnancies by the use of space in the hospital:

> There wasn't a room where we could go in. So [midwife] was like, 'we're desperately going to get you a room, we're just going to find you a room, blah, blah, blah.' And she, like, you could tell the midwife was like, who was trying to deal with us, was panicked a little bit. Because in, like, the 2 rooms that were like opposite where we were sat, there's both pregnant women in there with the [foetal heartbeat] monitors on? You know, with the [foetal] heartbeat going, ‘duh, duh, duh’? I was like, ‘oh god! I feel sick.’

This leakage and porosity between normative pregnancy spaces into those of pregnancy loss was very common. If there was a bereavement suite or separate maternity room available for pregnancy loss in the second trimester, it was usually physically situated very close to the labour ward, presumably for the convenience of medical staff. This increased the chances of women being forced into comparisons between their births and normative ones because of the sight or sound of other pregnant women during their labour experience. Charlie explained a typical layout:

> So you go into labour ward, you turn right and you've got the 10 main rooms down the right hand side, and if you turn left you've got this suite,

> which has like a specialist bathtub and that in it. But it's classed as the bereavement suite because it's got the two double doors and the lift in between it, you're not meant to hear everything from the main ward? But obviously you still can. But you're not meant to. So it is classed as like, putting you out the way a bit?

Such arrangements often served to reinforce deviance from normative pregnancy. Rachel went into premature labour with what eventually was diagnosed as placental abruption. The bereavement suite in the hospital was unavailable, possibly because it was already in use, and after the birth and death of her daughter, she was moved into another room:

> They put us onto a quieter room, I remember walking in and there was a lady giving birth, and she was giving it what for, 'ah this really hurts, get this out of me.' […]
> We weren't in the bereavement suite. Unbeknown to us, we just didn't know, but we were…I don't know where we were. But it wasn't the bereavement suite.
> *So you had this sort of image of, like, normal birth right next to what just happened to you?*
> Yeah, you could hear this woman giving it some and then the scream of the baby when the baby was born, and we were like, ‘well, at least you get to go home, you know, you went through all that and you get to go home with your baby.’ So yeah, it was just quite surreal.

Having been placed alongside other women at the beginning of the process of termination for foetal anomaly, at the end of her labour Lucy was given an alternative route out of the ward, one which would not be used by women who had delivered living babies:

> That was the hardest thing, walking out. Just walking away and sort of saying…We went out the back door of the labour ward, so that we weren’t going through where everybody else was going through with live babies.

These experiences of being placed at one time alongside women with normative pregnancies, and at another time being separated from them was very common in my research, as if movement within medical space represented the confusion over women's status and treatment in the second trimester. Women sometimes had to move in and out of the main labour ward – Kerry, whose son was born alive after spontaneous premature labour, had a cervical stitch put in, and then taken out again when it became clear that the pregnancy could not be saved:

> And again, you had to go back onto delivery suite, past all the bloody crying babies and stuff, back to the room at the end. And again, they had to put you in the bloody stirrups and stuff, and pull the bloody [stitch] out. […] And then you just have to wait. [for labour to progress and her son to die]

Eva also experienced being moved in and out of spaces in a way which emphasized the deviant nature of her pregnancy. She was admitted for induction after the death of her son was diagnosed by ultrasound, but initially there was no space in the specialist bereavement suite. She was given a private room, but for several days had to keep emerging onto the antenatal ward because staff had not offered to bring food to the room:

> For mealtimes I had to queue up with pregnant people in the ward […]
> And...I was just like, again, 'got to get through this, got to get through this showing no emotion. Right. Got to eat. Got to queue up with these people.'
> *Did they not try and talk to you and stuff?*
> Yeah, they were. And I was trying to - it's hard, because you spend so much time trying to make other people feel ok, don't you? They are asking questions, but 'don't worry! I'm going through this, my baby's dead...don't worry!'

Movement through space in these cases is reminiscent of ontological choreography (Thompson, 2005), in which the teleological destination of a particular body in a medical space defines it ontologically. Women moved back and forth between bereavement suite, labour ward, and antenatal ward, depending on the expected outcome of their pregnancy for the foetus.

5.3.3 Obstetric violence and discipline within the maternity unit

During labour and delivery in the maternity unit, most women in this research experienced standards of care which would not be typical of labour and birth in the third trimester. The standards of care were often congruent with typologies of mistreatment of women in childbirth (Bohren et al., 2015), which themselves are aligned with obstetric violence. Particularly strong examples were the lack of informed consent and adequate pain relief, poor support in labour from medical staff, and giving birth alone. These were direct forms of mistreatment of women, and also disciplinary in the way they produced deviance from normative pregnancy in the cases of second trimester pregnancy loss.

5.3.3.1 Lack of informed consent

Women in my research were under prepared by medical staff for the experience of labour and birth, in relation to the duration of the experience, the possibility of pain, and the risks to them. A handful of women were warned in advance that the experience might be painful, either directly by staff or by literature they were given. Access to a bereavement suite and midwife contact in advance of labour, particularly at later gestations, sometimes resulted in careful explanation by staff of pain relief options, including one woman being told she could have an epidural if she wanted. Epidurals are highly effective in controlling pain during induced terminations for foetal anomaly, though they are not routinely available (Speedie et al., 2014). However, for most women in this research epidurals were not an option for labour, though they were sometimes used for placenta removal. Clear information about possible pain levels in induction was not given. Instead, the physical consequences of labour and birth were usually minimised in advance by healthcare staff. This was particularly significant for the 11 women whose first labour this was, who had had no birth training. NHS antenatal classes typically take place in the third trimester (NHS, 2018a) and availability of and access to antenatal classes even in late pregnancy is known to be poor in the South West peninsula (NHS Northern Eastern & Western

Clinical Commissioning Group, South Devon & Torbay Clinical Commissioning Group, & Kernow Clinical Commissioning Group, 2014), with only 10-15% of pregnant women in Cornwall attending classes (Private communication with NHS staff member, 2019). This means women were being induced, or going into labour, with very little information about what this involved. In emergency spontaneous premature labour cases, women were assumed to realise what was happening rather than it being explained to them, even in their first pregnancy. Georgia went into premature labour at 21 weeks and was never told what was happening to her, despite a throwaway comment which she did not understand about her cervical dilation[30] being 4 centimetres. She and her husband had no idea what was happening, to the extent that her husband, not realising the emergency, was fiddling on his phone when the baby was suddenly born.

Women who had already experienced labour with previous children were surprised at the duration of the labour in their second trimester loss. Eva's induction to deliver her dead son's body lasted five days and was very painful, but she had been told in advance it would be over in a few hours. Lucy worked in maternity, personally knew the clinical team caring for her, and was generally given a lot of autonomy in her healthcare experience compared with other women in this research. However, she still didn't expect the experience to be as long as it was:

> So I've got a friend who's a midwife and she said to me afterwards, 'oh yeah, we expect people of your gestation to have a really long induction.' I was kind of like, 'oh, that would have been helpful to know?' Just so you kind of know what you're roughly dealing with.

Pain was also downplayed by staff. Some labours on maternity were managed with paracetamol for long periods, even though research and guidelines say this is ineffective (RCOG, 2011a; Speedie et al., 2014). Amber had laboured for some time in a previous pregnancy before an emergency caesarean, but she

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[30] See Glossary.

was underprepared for the pain of her subsequent second trimester termination for foetal anomaly:

> I thought it was gonna be like what the lady said, be a couple of hours, a few period pains. God knows I didn't know what to expect.
> *Why did they say that, I wonder?*
> I don't know, cos it wasn't true. So why not tell me the truth? What difference would it make? I don't know, but yeah, I heard that a few times, so it was quite a shock. It was a shock when I went into what I classed as full on labour. It felt like full on labour. Cos I asked for more pain relief, I think they had to go and get permission, and they were like 'because of what's happening you can have as much as you want. It's not going to affect the baby.'

The advance minimisation of the gravity of labour and birth for the pregnant woman in the second trimester, combined with the medical knowledge of its actual increased risks described in Chapter 4, raises serious questions around informed consent in second trimester loss. In the last chapter, I described how Joelle felt she was kept in the dark about the risks of second trimester termination for foetal anomaly and was persuaded to accept labour and birth over surgical management. She then had a very traumatic birth experience involving a retained placenta:

> The doctors came in, they all came rushing in because I was - I literally felt like I was going to die. I said to [fiancé], 'I think I'm going to die.' I just felt...I couldn't feel my body, and I was just bleeding so heavily, and the doctors came in and they just start pressing on your belly, like, with their hand inside you, and like the pain was just...crazy. The worst pain ever. And they said, 'oh, yeah, it's because of your gestation, and your body's gone into shock, it doesn't know what's going on.' And so obviously they do know that there's a risk at that point, but they seem to tell you 'oh this is the most natural way, this is, everything's going to be fine.' But it…yeah, it was horrific.

This stressful birth and its aftermath, when Joelle could not access care for an infected retained placenta, was very different from what she had been led to expect when she made choices about how to manage the termination of her pregnancy.

Lack of informed consent has been conceptualised as obstetric violence in births where foetal wellbeing is prioritised over the pregnant woman's autonomy (Borges, 2017). In second trimester pregnancy loss, however, the justification the marginalisation of consent processes is not the wellbeing of the foetus, which will die in all circumstances. Therefore, there is another reason motivating caregivers' inattention to informed consent. I argue that this occurs because caregivers have made decisions about the ontological status of the event, in relation to it not involving a 'real' baby because the foetus is under 24 weeks and viability and will not survive. What follows from this diagnosis and classification is that this is not a 'real' labour which would deliver a 'real' baby, and therefore the experience for the pregnant woman is also in some way lesser. The consequent minimisation of pain and duration of labour, the risk of home birth, and the lack of attention to informed consent around induction of labour is therefore classificatory boundary work, separating second trimester labours from 'real' third trimester ones. Such boundary work results in obstetric violence for many women.

5.3.3.2 Lack of support during labour

A lack of medical support during second trimester labour can also be classified as 'neglect, abandonment or long delays' which are forms of mistreatment of women in labour because of the failure to meet professional standards of care (Bohren et al., 2015, p. 6). Although women are sometimes left alone to labour during full term births in English healthcare (CQC, 2019), it was routine in second trimester loss. Angela, talking to me about the death of her firstborn, expressed her surprise at the difference in the care she got in her subsequent labour, when the baby was expected to live, on the same maternity unit:

> I had a midwife with me constantly! I remember thinking, this is amazing! How can there be a midwife with me the whole time? And yet there [during the second trimester loss], I had nobody.

Two women described to me that there was a technical fault with the call bell from their room which meant no one came when they rang it. It seems rather coincidental that in a study of 31 women this should be the case, and in informal conversations with two midwives I have been told that midwives do actively prioritise those which have a live birth outcomes over pregnancy losses. This lack of support available to anxious women was a feature of second trimester loss, particularly when the foetus was already known to be dead and the situation was considered to be under control as an induced labour. The examination of women's bodies for progression of labour was also limited in cases of second trimester loss, in another example of divergence from the usual trajectory of care in a vaginal birth. Women who expected to be told how dilated they were because of previous vaginal birth experiences were frustrated by staff explicitly refusing to do internal examinations as they would in normal births[31]. For the women involved, this meant they felt they had no idea how long their labours needed to be endured, and this added to their distress.

5.3.3.3 Giving birth alone

In bereavement suites and maternity wards, despite the presence of midwives on the unit, it was very common for women to be alone when the baby was born. Having no skilled attendant present at the time of delivery is another form of mistreatment of women in childbirth (Bohren et al., 2015) and has also been found in Canada in relation to termination for foetal anomaly (Mitchell, 2016). In my research, it was most likely in cases where the foetal being was known to be already dead, in cases of induction after spontaneous foetal death or feticide. Of the thirteen women I interviewed who went through this, only three had an attendant with her for the moment of birth, and another called the midwife in when her baby was partly out. The others all gave birth alone, and had to

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[31] I have been unable to find out in conversations with practitioners why internal examinations would be refused if women specifically request it. I believe there may be a possibility, if the foetus is alive, that it is to avoid any potential prosecution under the Infant Life (Preservation) Act 1929.

decide whether to look at or touch the body of their baby without anyone experienced to assist them. Other women who were alone at the point of birth were experiencing termination for foetal anomaly where there was little chance of foetal survival because of the foetal medical condition or the gestation, and the pregnancy was being deliberately terminated. Those who almost always had medical attendance at the point of birth (9 out of 10 women, with Bethany as the exception) were the women who were in spontaneous premature labour with a living and healthy foetus, and these were the cases in which whilst there would not be long term survival, there was the possibility of a diagnosis of live birth and consequent legal personhood (see Chapter 6). Where the foetus was potentially going to inhabit the category of ‘person’ or live baby, then medical staff were present to facilitate this diagnostic ontological shift. Where the foetus needed to stay in the ontological category of ‘non-person’, staff were not present or turned away. Joelle had accepted medical induction of birth for the termination of her pregnancy at 16 weeks’ gestation after diagnosis of Edwards’ Syndome. She described the moment of birth:

> And then my waters broke, and I rang the bell, and they said 'oh, we're just in the middle of changing shifts at the moment.' And they came in and they put another pessary in, and they said, ‘just to sort of help it along a bit.’ And then...I had to sit on the bed for half an hour while that was in. And I remember just the feeling, and I was like, 'that's it.'
> Rang the bell, and the midwife came, and she's like, 'I'm your new midwife.'
> And I'm like, 'I think the baby's just come.'
> And I didn't want to look, and [partner] didn't want to look, and so they just got a - I was under the sheets anyway -...and she'd literally just got in the room, and she's like, 'I'm so unprepared!'
> *But you had given them warning, you'd just told them that your waters had gone?*
> Yeah, but they were changing the staff. And yeah, the, like, student midwife just held the sheet there for what seemed like ages, while the other girl went to get her gloves, and everything that she needed. And I was just looking at [partner], like, 'what am I supposed to do?' They're just stood there, like, in silence.

> *And the student midwife didn't know what to say to you?*
>
> Yeah.
>
> *Because they could have done a lot there, they could have told you what she looked like, for example?*
>
> Yeah. And then like, looking back now, I think, what if she was still alive at that point? And, I...like, didn't pick her up or anything…[crying as she spoke]

The delay in anyone examining the baby meant no signs of life were noted by medical staff, with the result that Joelle’s anxiety about whether her daughter died before birth or lying on the bed instead of in her arms will never be resolved. It also means, because no signs of life were diagnosed, that the ontological classification of the event as the termination of a non-baby remained unchallenged because of the absence from the room of the midwife for the minutes after the baby’s birth. There is no statutory legal definition of ‘life’ in a born baby in England (Herring, 2011), and this has an impact in the pre-viable second trimester when signs of life as determined by a medical practitioner are based on subtle clinical judgements (Macfarlane, Wood, & Bennett, 2003; L. Smith, Draper, Manktelow, Pritchard, & Field, 2013). The production of a ‘live’ baby (and therefore a legal person) in the second trimester is under the control of medical staff, in a further example of biomedicine producing the ontological status of beings produced in pregnancy.

5.3.4 Exclusion from the maternity unit: gynaecology wards as disciplinary mechanisms in second trimester loss

Like Bethany, whose story began the chapter, not all women were even able to access the semi-private spaces of bereavement suites or delivery wards on the maternity unit. Foetal gestational time determined women’s access to different spaces for labour and delivery. In multiple examples in at least two hospitals in this research, second trimester labours did not warrant access to either a specialist pregnancy bereavement suite or the labour ward[32]. Women in my

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[32] 15 women were treated in a specialist bereavement suite or another part of the labour ward, 8 were on gynaecology or a general ward, 3 births were at home, 1 was in A and E, and the remaining 4 did not know the classification of the ward they were on.

research understood the differences in the meaning of the space, and how not accessing maternity space labelled them as non-mothers and their experiences as non-births. Whilst this classification will suit some women's understanding of second trimester pregnancy loss, other women's ontological positions are denied in this space. Angela was admitted to the bereavement suite on a maternity ward at 21 weeks when she went into premature labour. She was able to compare this experience to a previous miscarriage in the first trimester which had taken place on the gynaecology ward in the same hospital:

> So I'm glad I was on the maternity ward [for the second trimester loss]. It felt…it felt like I was pregnant, and I was having a baby. Regardless of what my outcome was, I was getting the same treatment? And that was important, I guess. If I look back in hindsight, I was treated like I was pregnant and I was having a baby. […]
> *Being included in that category?*
> Being included in that community, yeah. I think if I'd been on the gynae ward where I'd been before when I had a miscarriage…you're just a person in a room. And actually it was…you had your own room, but it was mixed, there was a man next door and you weren't special enough, if that makes sense?
> *And it doesn't have the family element that….That's very much as if you'd gone in for your kidneys?*
> Yeah. Absolutely.
> *Like, a ward that is 'we deal with this part of your body'?*
> Yeah.
> *There is no 'this is a baby, you are becoming a mother and a family…'?*
> Yeah. I guess that's key. The people who looked after me were midwives. So they were – trained, or not trained, I don't know – in bereavement, or a special kind of care? But they were all midwives, they were all about helping people become families, looking after babies, looking after mothers. So that did make a difference I would say. […] Because when I had the miscarriage before, the one where I had the retained placenta, it was just like a ward. Literally, I was sat with just a curtain between a man having an ingrown toenail taken out and them asking me all these questions…

The implications of being admitted to non-maternity wards for second trimester loss were could be disciplinary or could involve direct obstetric violence. Many of the standards of care on non-maternity wards were similar to those for second trimester labours and births on maternity wards described above, in terms of pain relief and midwife support. Women on gynaecology wards in my research were uniformly offered paracetamol for labour, and they then struggled to get access to more effective forms of pain relief, sometimes going through the entire labour with only liquid paracetamol. Fiona, also facing labour for the first time after her son had been diagnosed by ultrasound as having died, was very anxious about the possibility of pain:

> *Did they not offer you morphine?*
> No. I said, ‘it's going to be more painful than that.’ And they said, 'well, no, we start with paracetamol and see how you go.' And I was like, oh god! I remember just feeling terrified.
> And I said this to [private doctor she already knew, whom she happened to bump into at the hospital].
> And he said 'that's ridiculous, you can have any pain relief you want. You're here for a very bad reason, so the least we can do it make you comfortable. I'll speak to them.'
> And I said, 'ok, brilliant, thanks very much.' Felt really relieved. And then I was starting to have just like, light cramping. And one of the nurses came back, and I said 'oh, that doctor said I can have strong pain relief, and I can have that thing where you press it, is that morphine? You press it when you need it.'
> And she said, 'oh no, we won't be doing that yet.'
> I said, 'maybe not yet but can we line it up for when I am in pain?'
> And she said, 'no, we'll just start you off on paracetamol, we'd have to get someone to sign that off.'

Like Bethany at the beginning of this chapter, there was a delay and a fuss about fetching gas and air from the maternity ward. In both hospitals, gas and air was apparently not even stored on the gynaecology ward, though it is available in portable formats, for example for home births. Other consequences of being cared for on a gynaecological ward were lack of attention to progression of labour, and being left alone for long periods, both forms of mistreatment of women in labour. Care on gynaecological wards was structured by the space and its possibilities, rather than by the clinical needs of the pregnant and labouring woman.

Labour on a gynaecological ward typically involved no midwife support, despite Royal College of Obstetricians and Gynaecologists' guidelines which say intra-uterine foetal death should be delivered under the care of an experienced midwife (RCOG, 2010a). Instead, support was from nurses, who sometimes appeared to have no experience of pregnancy loss, or who actively avoided dealing with foetal bodies. This chimes with Bolton's study of gynaecology as 'dirty work' (Bolton, 2005). When Heather had given birth, the staff appeared not to have experience of dealing with foetal bodies despite being on the ward on which these events were routinely handled, in a city with a large population:

> Well, she was born, and then we pressed the button, and the woman came in and...she was obviously quite upset, the woman who came in, because she hadn't, she wasn't expecting this, so she was just a...a nurse who was on the ward. So she wasn't even a midwife. And...so she did an amazing job, she was fantastic, you know, to say that she wasn't, you know, she wasn't prepared for it. […] So she went through the whole process of cutting the cord, and clamping, so she obviously knew what to do. But it was quite...she obviously wasn't expecting it to happen.

Phoebe, who I described above as struggling to get her vaginal bleeding taken seriously at 17 weeks, lost her son to placental abruption on an Accident and Emergency ward in 2017. She was then moved to another ward and asked whether she wanted to see the baby:

> I was like,'I don't know. I don't know what to expect, you know? Is he scary, does he look scary?'
> [The nurse] said 'no, to be fair, I've seen a lot of babies in this situation and he's one of the better looking ones!' [Phoebe gave a small laugh]
> I was like, 'Ok…' […]

> Because they just took him away. So I had assumed – I didn't know what a baby looked like at that age. I maybe assumed at that point that that was it?
> But no, she said 'he's intact, you know, he's all in one piece and he doesn't look **that** scary.' She said 'if you want to see him you can. It's better to do it now,' she said, 'because I'm more comfortable doing all the preparation to bring him, whereas some of the nurses aren't 100% comfortable.'

It was made very clear to Phoebe that she was about to witness something abnormal and deviant, something that even medical staff were not comfortable with, and that the nurse was doing her a great favour in providing this service. Not only did this encounter produce second trimester loss as deviant, but poor staff attitudes and judgemental comments are types of mistreatment of women in childbirth (Bohren et al., 2015).

For Alice, even the gynaecology ward was unavailable for her second trimester loss. She was in a position to make a clear comparison between the treatment of a post-viability loss and a pre-viability loss. In 2018, she underwent a termination for foetal anomaly at 24 weeks because of the effects of a foetal congenital diaphragmatic hernia[33] which were incompatible with life. She was treated on the maternity ward by midwives and despite the sadness of the event felt well cared for. Less than a year later, in her next pregnancy, the new foetus was diagnosed with Down's Syndrome[34] and she decided on another termination. She asked specifically whether she could be cared for in the same way as her previous loss, and was told that, no, she could not go on to the maternity ward at 17 weeks' gestation:

> They said, 'the baby will die when you miscarry. It will be an induced miscarriage. So you will go to the [general] ward.' It's a regular ward. There were old boys walking around with their pyjamas on. There were nurses, there were no midwives. […] You go in through the main entrance to the hospital, as you would do if you were going in for…I don't

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[33] See Glossary.

[34] See Glossary.

> know, anything else. I don’t know, I’ve never been to hospital for anything else. Whatever. We went and sat in a little waiting area on the ward with a little suitcase, and the nurse came over and said ‘What are you here for?’ And I was like, ‘Errr…’ I said ‘I’m due to have a miscarriage today.’ I didn’t know what to say. I said, ‘I’m due to have a miscarriage today.’ She went, ‘Ok!’ I was like, oh god, I don’t even know how to phrase it! ‘I’ve booked in for a termination?’

This second termination was an even more upsetting experience than the first:

> I think going into the hospital, I felt like this is ok, I’ve done it before, I can do it again. But it was so different that that really shook me up. I wasn’t prepared for it. And [husband], he was quite shaken up by the whole thing as well, because it was all very quick, and very sudden, and actually very medical, you know? ‘Here’s a bedpan. Sit on the loo.’ […] It felt like the nurses didn’t have any concept of…[pause]…parenthood, or motherhood, or what it’s like to have been…or sort of empathy with the mother, the parental side of it.

As Alice put it:

> Same hospital, same person, two completely different experiences.

Subsequent to my interview with her, she made a complaint to the hospital about this treatment and was invited to a meeting with a view to making changes in future. She wrote to me afterwards:

> One of my very specific questions to them at the start of the meeting was: is there any administrative or clinical reason why women in 2nd trimester are not treated in the labour ward? Their answer was no, administratively there is no reason for it, it's just a handful of cases every year, clinically no reason either, it's just that this has always been the status quo and nobody had thought to make changes until recently.

The use of gynaecology or general wards for second trimester losses are disciplinary technologies which act on the pregnant woman's body but derived from diagnostic and ontological classification of the foetal body based on gestation and ontological destination. The results for the pregnant women are typically decreased access to pain relief, decreased access to skilled attendants, increased stigmatisation, loss of autonomy in defining their own births, decreased privacy, dismissal of women's concerns, poor communication, and judgement by medical staff, all of which are forms of mistreatment of women in childbirth (Bohren et al., 2015) and which I argue are forms of obstetric violence.

5.3.5 Minimal post-partum care: Minimising the consequences of birth for women

Immediately after delivery, women who had experienced second trimester loss on bereavement suites or maternity wards were often well attended in relation to facilitating time with the body of the baby, if they wished it. To varying degrees, the born body of the baby could be presented *as* a baby by medical staff. The body of the pregnant woman, however, continued to be subject to disciplinary penalties which produced it as a body which had not 'really' given birth. Healthcare practices did not mirror the ontological shift of 'second trimester foetus' to 'dead baby' with a transition from 'pregnant woman' to 'post-partum woman'. The absence of a living baby seemed to disappear pregnant women from healthcare, as noted elsewhere (Hardy & Kukla, 2015). Joelle, cared for in the bereavement suite for a termination for foetal anomaly, described her experience after her daughter was born:

> I think it was so bad, the aftercare. I mean at the time, when I had the induction and the delivery, we had a dedicated bereavement midwife? She was amazing. So sensitive. And they're obviously trained for that job. But when they left, the care that we had afterwards, was just awful. No-one knew where the baby would be taken afterwards. She filled out all the paperwork with the wrong names. No-one came to change, like, my morphine drips, I had to keep phoning them and they like, make you feel like you're an inconvenience.

Joelle felt even more like an inconvenience next day when she was told that someone else needed the room so she had to leave, despite her pain (from retained placenta) being unresolved. Those on general postnatal wards or gynaecological wards also struggled to get their needs attended to – Heather’s two second trimester losses were very serious, involving a blood transfusion, but she was not monitored after delivery and no one emptied the bag of urine from her catheter.

It is possible that where women received poor postnatal care this was part of the generally substandard postnatal care in the NHS (Bick, Rose, Weavers, Wray, & Beake, 2011; Cumberledge, 2016). However, when read in the context of the other consequences of a second trimester pregnancy loss there is at least the possibility that second trimester loss compounds the experience of poor care, because of the ontological decisions which have been made that these are not ‘real’ births because they are before viability. Furthermore, some aspects of poor postnatal care in hospital were distinctly related to ontological decisions about the pregnant woman’s experience of birth. For example, very few women were given information about the possibility of lactation, and only one was offered medication to suppress this. Charlie explained the impact of this omission on her:

> They didn't tell me my milk was going to come in. And then, I think [daughter who died at 23 weeks] was like a week old, or five days old, and I was in getting my tattoo done for her, that's just what I do, like, getting a memorial tattoo. […] And then suddenly my boobs started leaking, with a male tattooist! Nobody told me my milk was going to come in. So that really upset me.

Lactation after loss is a known phenomenon and best practice guidelines say it should be explained to women and ways of managing it should be proposed (NBCP, 2019a, 2019b), but the sense that women had not delivered a ‘real’ baby in a pre-24 week loss seems to be the reason that this consequence of birth is marginalised in second trimester loss.

For most women, access to medical follow up after discharge from hospital was distinctly poor. Lack of adequate postnatal care after termination for foetal anomaly is already known (RCOG, 2010b; Speedie et al., 2014), but in my research all losses in the second trimester had restricted access to postnatal care in the community, despite a known increased risk of retained placenta (Whitley et al., 2011). More than a third of the women in my research experienced complications with retained placenta, with several developing infections and needing readmission for surgery. Best practice suggests women in the second trimester should be under community midwife care on discharge, but it was clear to women such as Megan that this was not actually available to them:

> The midwife at the hospital was like 'right, we're now going to discharge you. Your midwife needs to come and see you in the next 24 hours, so she will ring you and come and see you at home.'
> But she said, 'but I also know that community midwives are rubbish', she said. 'So if she doesn't ring you, or doesn't come and see you, please ring us back on this number.'
> And my midwife rang up and said 'oh, how are you feeling?' I said, 'Oh, ok.' She said, 'I don't feel like I need to come out.'
> She literally had a 2 minute phone call with me and went 'I don't feel like I need to come and see you, so you know, as long as you're ok.' Then hung up. But I didn't ever ring [the hospital] and say that.

Women did not experience the postnatal care the NHS offers to women who have had post-viability births, which include midwife care for at least the first 10 days, and, since 2020, a 6 week check at the GP alongside their baby’s 6 week check. Some women had no contact at all with healthcare providers. A few women were visited postnatally by a bereavement midwife and some, like Megan above, had a phone call from the midwife. Alice, who had terminations either side of the viability threshold, had a postnatal midwife visit after the birth of her third trimester baby and not after her second trimester loss. In general, women in my research did not get a GP six week check after a second trimester loss. The only person who did have one was Esther, whose son was born alive. The postnatal 6 week GP check until 2020 was funded by the NHS for living babies, not for post-partum women (Stokes-Lampard, Regan, Seneviratne, Walton, & Wilkie, 2019). It now takes place for women alongside their baby's check-up. Women without a living baby are therefore not entitled to a routine GP check post-partum, in a further example of how the foetal or baby's body structures and limits women's entitlement to care for their own bodies in the English NHS.

5.4 Conclusion: ontological politics in the medical management of second trimester pregnancy

In the previous chapter, I explained how medical classification produces stratified trajectories of care in pregnancy, to which access is granted by the diagnosed status of the foetal body rather than the pregnant body. In this chapter I have shown how the content of a diagnosis of non-viable foetal body is an ontological classification of it not 'really' being a baby. Once this ontological fact has been accepted, the consequences are that pregnant woman cannot be experiencing a real labour and birth, because the performance of one reality on one object entails the performance of that same reality on other objects (Mol, 1999). Clinical assessment of women's needs takes second place to the classificatory judgements which have been made based on ontological positions. The consequences of this are that the biomedical diagnosis and classification of one body (the foetal body) can actually be a barrier to good healthcare for another body (that of the pregnant woman). Some of the consequences are forms of direct mistreatment and obstetric violence, such as lack of midwife support, lack of pain relief, lack of an attendant present at birth, lack of postnatal care, lack of choice about the place and manner of birth, and stigma and discrimination. Other consequences are disciplinary, in which the foetal and pregnant bodies are produced as deviant in relation to the norm of teleological pregnancy. The biomedical classification of the second trimester foetal being as 'not a real baby' is being defended by healthcare staff in a form of ontological boundary work enacted through obstetric violence and through disciplinary techniques, particularly the use of space, time, normalisation, and disciplinary penalties.

Part of the ontological politics in this case is the contestation of biomedical-legal ontologies of second trimester pregnancy loss. The women in my research wanted care for their symptoms, rather than care defined by the classificatory category to which they had been allocated by biomedicine. Contestation in medical diagnosis has been defined as taking place where there are generally accepted conditions recognised by lay people which are either not allocated a biomedical definition, or where a definition has not been agreed (P. Brown, 1995; P. Brown & Zavestoski, 2004). However, in the case of second trimester pregnancy loss it is not usually the biomedical definition or classification in itself, as a second trimester pregnancy defined by gestational weeks, which is contested but the ontological content it carries with it, which defines this foetus as ‘not a baby’ and this woman as ‘not a mother’, and this event of loss as ‘not a real labour and birth’. The consequences of these ontological aspects of diagnosis and classification means access to care and treatment is inferior in quality to that afforded to women in the third trimester of pregnancy. This politicises the diagnostic and ontological knowledge produced by biomedicine and the law in relation to second trimester pregnancy loss.

Chapter 6: What counts as a baby and who counts as a mother? Civil registration and bureaucratic entitlements in second trimester pregnancy loss

Having examined the healthcare consequences for pregnant women of a pregnancy loss in the second trimester in the English NHS, I now move on to address the legal, regulatory and bureaucratic frameworks related to second trimester pregnancy loss in England. In the story of what happens in a second trimester pregnancy loss, the following chapters address the period after the medical crisis is over. At this point, different legal and bureaucratic ontological positions on what was lost in relation to whom come to the fore, as do the consequences of these definitions. Drawing on fieldwork interviews and analysis of legal, regulatory and policy documents, I consider processes of governance (Bevir, 2011), and reproductive governance (L. M. Morgan & Roberts, 2012) through which persons and kin are produced or not produced by different agencies, more or less loosely related to the state. I use the concept of governance rather than governmentality because the latter has been specifically defined as not having the state as a point of reference (Rabinow & Rose, 2006), whereas the state is a very active agent in the politics of pregnancy and pregnancy loss, as the following chapters will show.

This chapter therefore explains civil registration in England, how it produces legally recognised forms of person, and how this is experienced by women whose second trimester foetuses and babies are included in, or excluded from, those categories. It also explains the bureaucratic consequences of civil registration entitlement, and how these affect resource allocation such as maternity benefits in the second trimester. The subsequent chapter moves onto the governance of the dead foetal body and its consequences for the production of foetal personhood and kin, and for choices around disposal and post-mortem.

6.1 The reproductive governance of pregnancy and pregnancy loss in England

Biomedicine and bureaucracy, law, and regulation are closely intertwined in second trimester pregnancy loss. The actors involved in governance processes affecting second trimester pregnancy loss include the state, the state healthcare system of the NHS, and non-state actors, such as charities, religious groups, and professional bodies. Statutory legislation in the UK emerges from parliamentary debate in a representative democracy in which lobby groups with particular ontological positions can influence outcomes, as has been demonstrated in relation to legislation on abortion (Sheldon, 1997) and the human embryo (Franklin, 1999a, 1999b). Also implicated as actors in reproductive governance are legal and regulatory texts which now apply to situations of pregnancy loss, but which may have been produced in different circumstances and been adapted to suit new purposes. For example, stillbirth registration was set up as an attempt to control infanticide, but has subsequently been adapted to the recognition of stillborn babies and their parents. Combinations of all these actors result in reproductive governance, in which multiple actors 'produce, monitor and control reproductive behaviours and practices' (L. M. Morgan & Roberts, 2012, p. 243).

If multiple actors produce reproductive governance in England, the mechanism by which they do this is the same: the application of classificatory categories in relation to the foetal being. Knowledge systems use classification to produce power (Foucault, 1977/1991, 1976 /1998) and large scale bureaucracies naturalise classificatory divisions by embedding them into routinised practices (G. C. Bowker & Star, 2000). The role of the law and regulation is well recognised in the production of foetal beings as contingent concepts which have developed over time in specific historical circumstances and have then been naturalised. Multiple scholars have connected governance arrangements to the discursive production of classificatory categories of regulated foetal subjects in the UK context. Herring (2011) reads the Offences against the Person Act 1861 as a form of protection of the foetus as a separate entity. Franklin's work on the Human Fertilisation and Embryology Bill (now Act) shows how the human embryo was produced as a 'civil subject' (1999b, p. 163), and she links the production of these embryonic beings to new forms of kinship.

Whilst Sheldon (1997) argues that the regulated subject in the 1967 Abortion Act is the woman seeking abortion, she also interprets the emphasis on viability in the 1990 Human Fertilisation and Embryology Act as the production of the foetus as a separate individual. Tremain (2006) proposes an analysis of the legal possibility of termination for foetal anomaly as the production of a prenatal impaired human body which is a form of foetal subject. Pfeffer and Kent (2007) describe the discursive production of embryos and foetuses as biological entities in UK regulatory policy in relation to their use as sources of stem cells. Pfeffer (2009) describes how the transformation of aborted foetuses into sources of stem cells for research takes place in part through their decoupling from identifiable social origins.

Thus governance of the embryonic or foetal body produces the beings it regulates through classification. In the governance of second trimester pregnancy loss, the basic differentiating classification is the status of a foetal being relative to personhood. The consequences of reproductive governance in the second trimester, however, fall on the pregnant or post-pregnant woman, whose options and agency are limited by the classificatory judgements made in relation to the foetal being, as I will show below.

Governance processes related to pregnancy and pregnancy loss are therefore discursive and based on classification. However, they are also ontological in relation to the underlying principles of what is being classified: the reality of persons and their bodies, the reality of what a pregnancy is. I argue that the disruption of pregnancy loss gives an insight into the ontologies of pregnancy which are produced by the interactions of biomedicine and the law in the context of reproductive governance. In particular, the centrality of telos in ontologies of pregnancy is made clear. As noted by Franklin (Franklin, 1991, 1999b) in relation to English legislation around the human embryo, the teleological outcome of the foetal or embryonic entity defines its ontological essence. Similarly, reproductive governance in the US regarding pre-pregnancy preparation of the female body for child bearing refers to a ‘future fetus’ as an entity which needs protecting (Waggoner, 2017, p. 25). Franklin’s analysis of telos connects to commentary by legal scholars who have pointed out that a child’s body considered to be a ‘body with potential’, in other words a future body, will be given priority in legal decision making (Bridgeman, 2002, p. 100). In termination for foetal anomaly, medical judgements are made regarding the 'best interests' of the putative child and their future life (Wicks, Wyldes, & Kilby, 2004). And the regulation of fertility treatment in the UK requires consideration of a legal entity referred to as the 'future child', even though it does not yet exist (Lee, Macvarish, & Sheldon, 2014; Sheldon, Lee, & Macvarish, 2015)[35]. I argue here that ideas of telos are not just present in ontologies of the foetal being or future child, but that they define the whole of pregnancy as a teleological process, defined by its outcome of the production of a living person. This future oriented ontology of pregnancy is highlighted when pregnancy is disrupted by death, such as in second trimester pregnancy loss. Using second trimester loss as a case study, it is also possible to see different consequences of pregnancy governance, such as its incoherence, exclusions, and conflicts, and the way it can steer people down paths which are not of their choosing. It has been argued that there is a lack of coherence in UK death-related policy (L. Foster, Woodthorpe, & Walker, 2017). In the following chapters I take a similar position in claiming that in the governance of pregnancy, when seen from the second trimester, there is incoherence about the legal status of the dead foetal being in relation to what counts as a baby, and incoherence about the status of the post-pregnant woman in relation to what counts as a mother.

6.2 The civil registration of persons and kin in the UK

Two legal positions structure civil registration in the United Kingdom in relation to pregnancy outcome. Firstly, all live births must be legally registered with the state, as must the death of a registered person. Secondly, stillborn babies born in the third trimester, after 24 completed weeks' gestation must be separately registered with the state. Some foetal beings are thus defined as babies and persons, who have legally recognised parents and other kin, and others are defined as foetuses, who do not. Later in this chapter, I will show how these legal classifications of the foetal being affect post-pregnant women's options and entitlements when they experience pregnancy loss in the second trimester.

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[35] Not only does the Human Fertilisation and Embryology Act thus create a being in need of legal protection before it materially exists, it also creates potential kin to that potential person in the form of acceptable or unacceptable putative parents.

Legal personhood, which defines a living being as a human baby, is conferred by having a human body which is alive at the point of separation from the body of the genetrix (House of Lords, 1997). This is a 'threshold' concept of personhood (C. Foster & Herring, 2017) which means that technically a foetus in the UK has no separate personhood or claim to individuality in law, because by definition it is still within the body of the pregnant woman, although it may be offered some protections as a form of marginal person. Herring (2011) argues that the birth of a living baby is a distinct moment of transition from a blurred dual identity of pregnant woman and foetus to separate identities of mother and baby, in which the latter's legal rights can be assessed separately because it is no longer dependent on the body of the mother for existence. Birth is therefore convenient for lawyers seeking to ascribe legal personhood (Herring, 2011) in a way that pregnancy is not. The legal difference between a baby and a foetus, the point of ontological shift, is produced by 'the bright line of birth' (Burin, 2014).

However, Herring also spells out the difficulties of defining exactly when a live birth has taken place, with case law, rather than statute, having come to define it as *full* emergence from the pregnant woman, and when the baby lives and breathes separately from her, with a separate circulation. He concludes that the assessment of the presence of 'life' in a born baby is conveniently left to doctors rather than lawyers (Herring, 2011), in what I argue is another example of the enmeshing of biomedicine and the law. Where there is ambiguity in the UK about whether a being is alive or not, judgements are biomedically determined (Wicks, 2017), and clinical staff determine signs of life in the second trimester. In the second trimester, if there is no diagnosed separate life, then there is no access to birth registration. On the other hand, if there is diagnosed life, such as in the cases of premature live birth in this research, then birth and death registration is *required*. In both cases, the status of the foetal body determines what the post-pregnant woman cannot or must do.

In addition, this apparently simple model of personhood based on live birth recorded by civil registration is complicated by some other legal arrangements in the UK, which I argue establish a form of personhood based on the foetal body which is born dead. Romanis (2019b) proposes that the ‘bright line’ of the assignment of legal personhood at live birth is on the verge of being breached by artificial womb technology, but I contend that this has already happened through stillbirth registration, in which personhood is recognised in beings born dead after viability. There is mandatory separate state registration at the General Register Office of stillbirths, defined in the United Kingdom since 1992 as those who are born dead after 24 completed weeks’ gestation[36], including after late term abortion, under the Births and Deaths Registration Act 1953, as amended by the Stillbirth (Definition) Act 1992 (House of Commons, 2019). Since 1983, there has been the possibility of registering a name for a dead baby on the stillbirth register, a political act connected to foetal personhood claims and the decoupling of physical and social birth (Layne, 2006). The registration of stillbirth alongside live birth and death in the annals of the state produces some legal record of the existence of a being which never lived independently, a being defined by particular stages of foetal bodily development over gestational time, which have themselves changed historically (General Register Office, 2013). If, as historians have argued, stillbirth was initially neglected in official records because those records were designed to record legal rather than biological persons (G. Davis, 2009; Higgs, 2004), the more recent development of stillbirth registration since the 1926 Births and Deaths Registration Act demonstrates the opposite – a form of legal birth through civil registration. The bureaucratic recording of such an event, including the name of the baby and the names of its parents, confers official existence alongside a form of legal parenthood. It acknowledges the significance of the event of stillbirth and situates it in the immediate family and in the wider community, whilst also emphasising a unique identity for the dead baby. Conversely, not being included in stillbirth registration, because the baby was born dead during the second trimester, before viability, produces a foetal being and its parents who are deemed insignificant and irrelevant to the state and wider society, as argued by Tim Loughton MP’s Private Member’s Bill, now the Civil Partnerships, Marriages and Deaths (Registration Etc.) Act 2019, which called for a report into the possibility of pre-24 week birth registration (House of Commons, 2019).

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[36] Stillbirth is defined differently in different countries and contexts, with the World Health Organisation using foetal death at or after 28 weeks’ gestation (WHO, 2019), but, for example, parts of the USA defining a stillbirth as occurring from 20 weeks’ gestation (Sanger, 2012).

6.2.1 Live birth registration: producing citizens in relation to the state

The birth of a living baby in the UK, at any stage in pregnancy including the second trimester, results in mandatory official recording of the birth at the General Register Office (GRO), which is responsible for civil registration in the UK. This civil registration system has been developed since 1836 out of multiple bureaucratic systems (Higgs, 1996) and in a ‘piecemeal’ fashion (Crawshaw, Blyth, & Feast, 2017, p. 1), with its original intentions and purposes being overlaid by new meanings. At present, registration of a live birth in the UK generally entitles a baby to citizenship, establishing a relationship between a living individual and the state (Breckenridge & Szreter, 2012). In the UK, this status includes rights such as individual access to the National Health Service (Frith & Jackson-Baker, 2002). Registration also situates the individual in relation to the state when it contributes demographic information to macro level planning and service provision (Bainham, 2008; McCandless, 2011). However, even when there is a live birth in the second trimester, survival rates are very low (RCOG, 2014), and none of the women in my research had a surviving baby from the second trimester, partly because I had specifically asked to interview those who had experienced second trimester loss. Therefore, the modern citizenship aspects of birth registration for the baby itself are not relevant in this thesis.

However, civil registration is not just about a relationship between the individual and the state. Historically it concerned kinship in relation to legitimacy and the establishment of lines of descent for property purposes (Higgs, 1996, 2004, 2018; Probert, 2011). The identification of individuals in civil registration is through the names of persons and also their relationships to one another, which must be recorded in order to administer them (Scott, Tehranian, & Mathias, 2002). In birth registration, two parental identities can be recorded on birth certificates (Bainham, 2008; Probert, 2011; Sanger, 2012). Names are understood in social science to invoke, create, and display connections between individuals and their family or kin (Bodenhorn & vom Bruck, 2006; Finch, 2008; Layne, 2006; Pilcher, 2015; Pilcher, Hooley, & Coffey, 2020) situated in understandings of personhood and relations between the living and dead (Benson, 2006)[37]. As I will show below, for women in this research access to, or exclusion from, birth registration of the foetal being affected their own relationship to the state, with regard to entitlements such as maternity rights. Civil registration has thus shifted from being about defining individuals through relational kinship, to defining relational kin through the existence of individual persons.

6.2.2 The baby certified as real: civil registration's ontological work

In second trimester pregnancy loss, civil registration also does ontological work. For women in my research, civil registration was understood as an official, formal acknowledgement of the ontological reality and existence of the baby, under conditions of this potentially being in doubt after the baby's death in the second trimester. Fuller et al (2018) also describe the meaning of civil registration for women being an acknowledgement of the child's existence, and parental grief. Most women in my research were happy to have had civil registration or would have liked it (16/31). Eight did not engage on this issue. A minority (7) did not want, were neutral about, or were unsure about registration for their baby. For those women who had live births which were registered, the act of registration as an acknowledgement of their baby was very important, as Esther told me when reflecting on the fact that her first child was born alive at 22 weeks' gestation:

> I suppose the result of that as well, which makes it a bit easier for me than for a lot of people, is that I therefore did get birth and death certificates, which made it a little bit more like he'd existed, whereas obviously before 24 weeks otherwise it would have been as if he'd never been there.

By contrast, Amber's daughter died during termination for foetal anomaly in the second trimester, and therefore was not eligible for civil registration. She had found it impossible to talk to people about what had happened, and very few

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[37] The giving and use of names in an intimate kinship context is considered in Chapter 9.

people knew about it. For Amber, registration of her baby would have been welcome:

> I would have preferred it that she could be registered. […] And it would have made it official. In my head she exists, she was a person, she was born, she was buried. You know. But. It would have been nice to have an official, you know, the rest of the world... Not that it matters that much. But yeah, it would have been nice, I think.
> *Kind of an acknowledgement?*
> Yeah, to say that she existed as a person. Cos she did. So yeah, yeah.
> *And do you think that would have...made the knowledge that you have, that she existed as a person, like, allowed you to sort of communicate that to other people?*
> Possibly. But she'd have been on the record, she would be on a...You know, if someone came back in years to come and went, 'oh what, you know, the family history, oh look, Amber, she had 2, she had 3 children'. You know what I mean? It's just that. She existed.

Birth registration could potentially ontologically situate babies who had died alongside living babies and children as recognised and recorded persons. At the time of her son's live birth after termination for foetal anomaly, Lucy had felt indifferent about the registration of his birth and death. During her conversation with me, however, she decided that the way her son had been registered made him a person like her living daughter, and it was the setting alongside one another of the state recognition of both existences, which she had enacted by her active registration of both her children, which was important to her:

> I mean, you know, just sort of thinking about it now, it's another validation of him, as a person. Something else that we've got as a memory of him, you know, we've got 2 certificates [of birth and death] that are his because he was in the world. And…that act of going and registering him, because it was so soon after we'd registered [older daughter]'s birth, because you know, he was…born in the [summer] and she was born in the [previous winter], so you know, months later we're doing exactly the

> same thing that we'd done for her. It kind of seemed **right**? Because it was echoing what we'd done with her?

Besides the validation of the baby's existence, birth and death registration was a validation of the parent-child relationship and situated the baby in a wider, officially noted, kinship group, as Amber described above. This echoes the original purpose of registration as the establishing of legitimate (fathered) children in a kinship group, originally for inheritance purposes (Higgs, 1996; Probert, 2011). Angela's first son lived briefly when he was born at 21 weeks after she went into premature labour:

> *What does that mean to you now then, that he was registered?*
> Oh, huge! Physically, I've got a certificate. And it says 'mother' and 'father' and things like that on it. Again, a silly thing, not that I share all this crap with my husband, but if you do family tree research in 20, 40 years' time, his name will be on there? So he **did** exist?

Birth and death registration provided validated proof of existence, acknowledgement of personhood and recognition of loss, and the endurance over time of the official record of existence for the family tree. It also involved naming, which will be further discussed in Chapter 9.

The certificates themselves could be used by women in an assertion of their loss and their right to grieve. Georgia's first child died after he was born alive at 21 weeks. She celebrates him as her son on social media and in her community, and felt his live birth and subsequent registration helped her claim him as a person in relation to doubters in her wider family:

> *And is that important to you, that he had that recognition?*
> Yeah. Especially the...the birth certificate more. Because I had a cousin, I remember my mum fell out with my cousin, because she'd read in a magazine once that babies born at that gestation don't get a birth certificate.
> And my mum was like [triumphant tone] 'well, he was born **alive**, so he **does**!'

For those women whose babies were not born alive, hospitals usually offered unofficial certificates, based on templates from pregnancy loss charities. These were important keepsakes to some of my participants, but others referred to them as ‘token’, ‘fake’, or ‘made up’: having a different version of official acknowledgement was secondary to inclusion in the national register of real persons. Charlie’s first daughter was not eligible for civil registration, and she was in a position to compare this to her next daughter, born alive after viability:

> [First daughter] didn't get a birth certificate. But [hospital] did make one, a pretend one.
> *Is that what it feels like then?*
> Yeah. [scathing tone] I know it's pretend ‘cos they specifically **told** me it wasn't a real one. They were like 'this isn't a **real** birth certificate, because she wasn't 24 weeks, so you can't have a birth certificate.' And then with [second daughter who died after birth], it was like, really official, 'you **have** to come and register her birth and her death.'

Another substitute for some women was inclusion in books of remembrance held at the hospital, sometimes by the chaplaincy, and used during memorial events. This was not quite the same as civil registration, but the public nature of the books and the open record went some way to compensating for lack of birth and death registration, because they did some of the same ontological work as the birth and death register in recognition of a form of personhood. For the last decade, Amanda has made a point every year of attending her hospital’s communal pregnancy loss event to commemorate her son who died through termination for foetal anomaly, in order to see his name in the book of remembrance. Similarly, Bethany felt that her son’s inclusion in the hospital memorial book after he was ineligible for birth and death registration was a confirmation of his reality:

> I don't know what it is about having his name written somewhere that makes him any more real, but...it does. Like, the first time I went in and saw his name, I was like, 'oh! He was real! His name is somewhere.'

However, despite these attempts at alternative inclusion, overall exclusion from full birth and death registration was an issue for a large number of women in my research. It was their lack of control over the definition of their baby as a ‘real’ person with officially recorded parents because of lack of biomedically confirmed separate life which was the key distress.

Significantly, several of the women who actively did not want birth registration or who were neutral about their baby not being registered were those who felt the process did not add to the reality of their experience and their baby. They tended to see registration as a purely bureaucratic exercise which did not affect the meaning of their loss. For these women it was themselves, the baby’s father, and wider kin rather than the state who could determine the reality of a pregnancy or a person. Gemma had had a particularly supportive reaction from her family to her daughter’s death through feticide and termination of pregnancy for a severe heart condition at 23 weeks’ gestation. Her husband and mother were present at the baby’s birth, and then her sister and her father came to visit and witness the baby’s body. Gemma described how she felt about not registering her daughter:

> It didn’t really bother me particularly. I kind of was…at the time I think I was just pleased that I didn’t want to have to go through anything else, almost. […] And it hasn’t really bothered me since. To be honest. I still feel like she was **there**, and the fact that she hasn’t got proper bits of paper doesn’t really bother me particularly. I can see why it would some people.
> *Also the significant people in your life actually met her?*
> Yeah. I think that seemed more important than anything formal like that. And at the time I just didn’t want to have to do anything extra.

For Gemma, exclusion from civil registration did not affect the ontological status of her daughter, which was derived from a more intimate, kinship-based ontology which is further explored in Chapter 9.

6.2.3 Birth registration and the making of persons

Besides ontological work, birth registration was understood by women in my research as having the potential to produce persons through bureaucratic processes. Paula, the only person in my research who did not claim her termination for foetal anomaly as the loss of a baby or person, expressed this as we talked about the possibility of an optional form of birth registration[38]:

> Like, with ourselves we didn't see it as 'the baby', we saw it as tissues that had gone wrong. But suddenly if someone's saying you **can** register it, then you start questioning… Sometimes I feel as though we were a little bit harsh, because actually we did look at it as tissues, and...I just think it would be another pressure, and do you start questioning your own...not **beliefs**, or…

Paula felt that civil registration would potentially have made her foetus into a baby – if the legal and bureaucratic process had been possible in her case, this would have disrupted her own ontology of the foetus as non-baby. For women in my study, civil registration was a formal ritual of recognition of personhood, whether this was something they wanted or did not want. Civil registration also tied the foetal being down in terms of its ontological status. Charlie would have liked registration for her first daughter who died during her premature birth in the second trimester, but she also felt her exclusion from registration allowed the family some flexibility in terms of redefining her later on. The baby was posthumously adopted by Charlie's husband, who was not her biological father, and buried with her younger half-sister, who was his biological child, under the same surname. Charlie described how she felt this was made easier by the lack of birth and death registration of her daughter:

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[38] At the time of this interview in 2018, the government had commissioned a Pregnancy Loss Review to look at the possibility of a form of birth registration for pre-24 week losses ahead of a legal requirement established by the Civil Partnerships, Marriages and Deaths (Registration etc) Act 2019. I was invited to present to the Pregnancy Loss Review in June 2018 about birth registration before viability. After political changes to the government and cabinet, and the dominance of Brexit and Covid-19 over government time, this report has not yet been published and as far as I am aware in early 2021 there is no plan to do so imminently.

> She has got [husband's] name now, because the dad doesn't want...I don't know, he doesn't go to the grave, he doesn't...And after we lost [second daughter who was their joint biological child], we decided - well, I knew I would put them in [a grave] together. And then that was when I was like, '[first daughter] is a [husband's surname]!' But [first daughter] hasn't got a birth certificate anyway because she was only 23 and 5 [weeks gestation]. So regardless, it's not like I'd legally have to change anything.

Registration would have tied Charlie's baby to a specific classification, as a person officially related to certain other kin, and in her particular case would have restricted her own posthumous redefinition of her baby and her kinship. The compulsory nature of birth and death registration was therefore potentially an issue for women who wished to define their own pregnancies. Similarly, a few women in the research expressed doubts about potential extensions of birth registration to the second trimester because of possibility of causing difficulties for women seeking abortion. Mandatory official bureaucracy was understood both as a potential restriction on women's choices and as a potential validation of women's experiences. This echoes Higgs' (2018) comments about the details on state registration documents such as gender, or third party parents being fundamental to people's understandings of their own identity. In second trimester pregnancy loss, the bureaucratic requirements cut both ways: exclusion or inclusion could be counter to the intentions of the pregnant woman.

6.2.4 Stillbirth registration and the exclusion of second trimester losses

Women in this research were by definition all excluded from stillbirth registration for their second trimester births because stillbirths happen in the third trimester. Stillbirth is defined by biomedicine. It is not enough for most diagnoses of stillbirth for the woman to have thought herself pregnant for 24 weeks, but scientific, standardised ultrasound foetal measurements are used to establish the 24 week timeframe, which is defined in law and connected to 'viability' as the point in pregnancy at which foetal life separate from the mother's body is thought possible (Infant Life (Preservation) Act 1929, Abortion Act 1967, Human Fertilisation and Embryology Act 1990). I described in Chapter 4 how this happened to Charlie when her first daughter was two days short of the viability threshold and how staff said they could not ‘play with her dates’ to get the pregnancy above 24 weeks’ gestation. Biomedical technological surveillance of the foetal body determines its definition as miscarriage or stillbirth dependent on normalised measurement by biomedical instruments of surveillance. By contrast, in the case of requests for abortion on grounds other than Ground E before 24 weeks there is no routine ultrasound foetal measurement and dating of the foetal body unless there are ‘clinical’ reasons to suspect ‘wrong dates’ (RCOG, 2011a, p. 52). Instead, access to abortion is based on the dating of the pregnancy through estimates based on menstrual periods and the timeframe for conception and implantation of the embryo (E. Jackson, 2001), giving some leeway in the application of abortion timeframes. Only where there could be a claim to stillbirth registration (including post-viability termination for foetal anomaly) is there a perceived need for biomedical assessment of the foetal body, as either defective (at ‘substantial risk’ of ‘handicap’[39] according to Ground E of the Abortion Act 1967) and therefore abortable or as having passed the criterion for viability of 24 weeks’ gestation. The governance of access to civil registration and the resources which follow, such as maternity benefits, is performed by a combination of the law and biomedicine interpreted and applied by medical professionals.

The intentions of the pregnant woman in recognising any parental or kinship relationship are not taken into account in defining a dead foetus as a type of person. A dead foetus will be registered as a stillbirth if it was intentionally aborted after 24 weeks (RCOG, 2011a), whether the pregnant woman wishes it or not, but will not be registered as a stillbirth if it died before 24 weeks, whether she wishes it or not, despite repeated legislative challenges to this such as the Civil Partnerships, Marriages and Deaths (Registration Etc.) Bill 2019. This was the situation faced by Alice in her third and fourth pregnancies which she terminated at different gestational stages. Alice could not register her son’s death at 17 weeks, but was legally obliged to register her daughter’s death at 24 weeks, even though both babies were wanted and planned and the decision

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[39] The term ‘handicap’ is the term used in the Abortion Act 1967 and in Department of Health reporting on abortion, but is offensive, so I have used it here in quotation marks to express my distance from it.

to terminate each pregnancy was taken in relation to their future quality of life. Alice and her husband did not particularly value registration as a form of state recognition, but they did want both babies treated the same. However, this ontology of equal value and status for the two foetal beings was one which the state explicitly refused to acknowledge because of birth registration law. Furthermore, the two different categorisations had consequences for the family's state benefits related to the state's recognition of her and her husband as parents which I will explain below. This was a similar situation to Charlie, whose spontaneous pregnancy losses either side of viability also prevented her from treating both babies the same in terms of personhood. Family positions on which persons are included as family members were completely overridden by state definitions of the legal status of foetuses or babies[40].

Many of the participants in this research who did not personally experience the starkness of this contrast in different pregnancies because they did not have third trimester losses were nevertheless aware of the possibility of stillbirth registration after 24 weeks. They knew that the magical threshold of legally defined viability was one at which a form of foetal personhood was recognised, and that this was one which their own non-living foetuses had not reached. For the majority of women in my research who did not experience live birth, the viability threshold served as a second barrier of exclusion for their babies, and a denial of their experience as pregnant women. Hayley, whose daughter died *in utero,* found out about the distinction after her baby was born at 22 weeks:

> I asked [the nurse] about a birth certificate, I was like, 'where do we go?' She said, 'you don't get one because it's classed as this that and the other.'
> And I felt…I didn't like that. These babies aren't acknowledged. In the medical world. It's just on our records that we had a miscarriage, really. When people think of miscarriage, they think of, you know, your body does it itself and there's nothing there. As you well know, I'm sure, it's not like that.

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[40] Ontologies of persons and kinship are discussed in Chapter 9.

The classification of an experience as ‘miscarriage’ produces it as an event which has happened to the pregnant woman, rather than the birth or stillbirth of a person. This limits the potential social recognition of that event and its impact on the persons involved, including a pregnant woman who wishes to define it as the death of a baby.

6.2.4.1 Stillbirth registration as the production of a different type of baby

However, despite their general knowledge of the possibility of stillbirth registration, and their interest in whether it could, or should, apply to them, most women I talked to were unaware of the detail of the difference between the two forms of registration. It is not commonly known that the Stillbirth Register in England is a closed register – it is not open to searching, for example for the making of family trees in future, in the way that the full Birth and Death registers are. This is because it was developed for the purpose of protecting women who experienced stillbirth from being prosecuted for infanticide under the Infant Life (Preservation) Act 1929. It was understood as a safeguard for newborn babies and a national record of postnatal and antenatal mortality, rather than a form of civil registration or public record (G. Davis, 2009). The General Register Office today says the closed nature of the register is ‘due to the sensitive nature of stillbirth registrations’ (GRO, Personal communication). This makes the register different to the general registers of births and deaths, and the General Register Office’s statement contains an assumption that there is something particular or different about the distress caused by stillbirth, which must be private rather than public compared to other deaths.

This register therefore does not fulfil all the roles that many women in my research would have wanted from civil registration. There are similarities with live birth registration, in that amendments to stillbirth registration have over time made space for the dead baby’s name and for both parents to sign (UK Government, ND-d) which bring the format nearer to birth registration and recognise an incipient or partial foetal personhood. Similarly, the benefits to which stillbirth registration entitles a family (examined below) also align it with birth registration. The adaptations of stillbirth registration over the last 40 years, hard fought by activists such as Bel Mooney and Hazelanne Lewis (Sands, 2019b), produce the post-24 week stillborn child as a form of person, registered somewhat like others, with a name and recognition of kin. This does result in certification of the event of pregnancy loss as ontologically ‘real’, and it does grant recognition of parenting and also sibling relationships in relation to the dead baby. This is because the General Register Office will provide access to stillbirth certificates for the registered mother or father, or, if they are deceased, the siblings (General Register Office, 2013), so those relationships are officially recognised and prioritised in relation to access to state bureaucratic information. However, stillbirth registration does not place the dead baby in the official open record of wider family life, nor does it provide publicly accessible recognition of the baby’s existence. When I explained this to the women in my research, they felt that as a consequence stillbirth registration was a second-rate form of registration compared to full birth and death registration. Most women in this research conceptualised their pregnancy loss as closer to a third trimester stillbirth than a live birth, but for many of them the stillbirth registration process, if it were extended to pre-24 weeks, would not solve the exclusion of their dead baby from official registers.

6.3 The bureaucratic and resource consequences for kin of the legal classifications of foetal beings

Registration in the UK of live birth and of death, or of stillbirth, recognises the individual involved as a person, but also brings state recognition of the social relationships in which that person exists or existed, especially in relation to kinship and property relations (Higgs, 1996). Registering a birth and sometimes stillbirth can give entitlement to state resources paid to parents, such as Child Benefit (UK Government, ND-a). Where a living person has died, there are also financial consequences for kin, for example in inheritance law, or through access to bereavement benefits such as Bereavement Allowance, Bereavement Support Payment, or Widowed Parents Allowance (UK Government, 2019). Entitlements to financial resources through relationships to kin who have died can be a source of meaning and value to the bereaved (Corden & Hirst, 2013). By contrast, it has been argued that the recognition that financial entitlements brings in the context of death can be undermined by inequity stemming from an incoherent set of systems for the administration of state support around death

(L. Foster et al., 2017). In other contexts, principles of entitlement though relations with kin have been applied to pregnancy loss. Sanger (2012) has argued in the US that stillborn birth certificates produce a posthumous change in legal status similar to that of noncitizen soldiers who were killed in combat and acquired posthumous US citizenship entitling their families to naturalisation. By contrast, a non-person, who is not registered as a birth, death, or stillbirth is excluded from state recognition and any financial entitlements, and their kin share in their exclusion. Legal classifications of a person or non-person as enacted by civil registration as a form of reproductive governance therefore have a relational effect on other kin, as when the same ontologies are performed on different objects (Mol, 1999). I now describe how this played out in the lives of women and their families in my research, in terms of the legal classification of their baby as foetus or person, and themselves as parent or non-parent.

6.3.1 'Have I got to go to work tomorrow?': maternity entitlements and live birth

In the crisis of the event of pregnancy loss, the first impact on women was in relation to employment: the right to take time off for the emergency, and to recover afterwards, in which they turned to maternity rights, or to sickness employment rights. In the UK, maternity rights accrue differently to those in employment and those in self-employment. Statutory Maternity Leave (SML) is up to 52 weeks for anyone in employment, and Statutory Maternity Pay (SMP) is an entitlement for employed women who earn above a threshold and have worked for their employer for over 26 weeks. This pay is up to 39 weeks at two different rates (UK Government, ND-c). Employers may choose to offer more generous benefits, but this is the legal minimum, developed and extended since maternity leave was introduced in the Employment Protection Act 1975. For the self-employed, those who have recently stopped paid employment, or some workers who do not qualify for SMP, there is the possibility of a lower benefit called Maternity Allowance (MA) which is payable for up to 39 weeks depending on circumstances. Women who are not in any form of paid employment cannot claim maternity benefits. Claiming all these benefits relies on the birth of a living baby, at any gestation, or the stillbirth of a third trimester baby, both of which will have forms of civil registration at the General Register Office, as described above.

In my research, some of the women who had medically confirmed live births were able to claim forms of maternity leave and pay, or other state support. Georgia’s first son was born alive at 21 weeks after she went into early labour. He died two hours after his birth. She is a self-employed nail technician, and therefore qualified for Maternity Allowance and she had seven months off work after her son’s death. She found this very useful because she finds her client facing job emotionally demanding and the long hours physically tiring. She felt she would have struggled with these aspects of work whilst grieving for her son. By contrast, Esther, whose first son was born alive after weeks of attempts to prevent her going into labour, did not qualify for Statutory Maternity Pay or Maternity Allowance, but the fact that her son was born alive entitled her to a limited amount of Child Benefit, a state benefit paid for registered children who have lived (UK Government, ND-d). The status of the foetal and born body determined the level of this financial entitlement, and her own work record determined her non-entitlement to state recognition of her pregnancy. Her own physical condition after having been pregnant and given birth was not part of the assessment of her entitlements.

Employed women should be able to access maternity leave and pay after live birth, but this was not always straightforward. Kerry nearly did not get maternity benefits after her third son was born alive at 20 weeks. Despite being employed at the hospital where her son was born and died, she struggled to access her entitlement:

> They don't really tell you anything. And I know it sounds stupid, and it's not something you really think about at that point, but you are sort of thinking, you're not pregnant any more, have I got to go to work tomorrow? […]
> My boss had rang up [sic] to see what had happened, and [HR] said, ‘no, she only gets a bit of sickness and then she has to come back to work.’
> […]

> I was like, ‘**what?**’ I said, ‘there's no way I'll be coming back in 2 weeks or whatever.’
> So she said, 'well, you can get signed off sick for however long, but you don't get maternity leave because it's before time.'
> […]
> I rang my boss back and said, ‘I think that's wrong.’ I said, 'can you please look into it again because I've looked through these documents? And it clearly states that if you've got a heartbeat at birth, and it wasn't a stillbirth, you can get maternity leave?' […]
> And the woman from HR did ring me in the end and say, 'I'm really sorry because this doesn't happen very often,' she said, which I suppose it doesn't, 'I wasn't entirely sure what it was, but it does actually say you can.'
> I said, ‘I **have** got a birth certificate, I **have** got a death certificate.’

Those women who did receive some maternity leave or pay were conscious that others did not. All the women in my research knew that live birth or third trimester birth were the thresholds for entitlement. Kerry, having had doubt from her employer about her entitlement, emphasized the particularity of the second trimester loss experience:

> I've miscarried before at different times, and a miscarriage at 8 weeks is completely different to a miscarriage, which they class this as, at 20 weeks. […] It shouldn't be **miscarriage**, because a miscarriage is not what that was. That was a **birth**. But it just didn't have an outcome.

This focus on teleological outcome is key to the biomedical-legal ontology of what pregnancy *is*, and it structures the governance of pregnancy in terms of entitlements and benefits for kin, especially pregnant women and mothers.

6.3.2 ‘Just from circumstance’: second trimester exclusion from maternity benefits

Most women in this study were not entitled to maternity leave or pay because their babies were born dead, having died before or during birth, including through feticide. Nor could they claim benefits associated with stillbirth because their loss occurred before viability. The status of the foetal body as a form of registered person or not, itself resting on biomedical assessments of gestation and independent life, was the gateway to maternal entitlements. State and private sector employment benefits thus accrue through kinship relationships. Alice, whose babies were born during terminations for foetal anomaly either side of the viability threshold could see how her second trimester loss limited the financial support available. In her third trimester loss she had received Maternity Allowance:

> I felt like after losing our baby at 24 weeks, you know, it was really helpful to have 2 or 3 months just to recover from that. I felt not able to work myself for a good few weeks, possibly even a couple of months. But I didn't feel like I needed a full nine months to stop work, that seemed crazy to me. And yet when we lost our [subsequent] baby at 17 weeks, there's nothing. It doesn't…so neither of them made sense to me.

Alice felt that her own definition of what had happened to her was the same in both terminations, but the viability threshold had made an enormous difference to the two medical experiences, described in the previous chapters, and to the entitlements to time off and financial support that she had after the non-live births of the babies.

Many other women in my research who had non-live births but experienced the increased postnatal complications known to be a factor in second trimester pregnancy loss (see Chapter 5) were signed off sick by their GP. This was for varying lengths of time up to six weeks, but usually for two weeks or more. The two week standard appears to relate to the compulsory period of maternity leave (2 or 4 weeks depending on employment conditions) and will be further discussed below. However, not everyone had access even to sickness leave. Danielle, a care worker, had just experienced her second loss in a few months when she spoke to me. She had no sick leave after the loss of her first – the hospital where she was treated did not mention sick leave, and it never occurred to her to go to her GP. Her employer gave her a week of unpaid compassionate leave and then she was back at work. When I spoke to her, she was planning 10 days of unpaid leave after the death of her second son, and was anxious about the consequences of losing more pay. Danielle had very little awareness of her rights as a worker – for example, she was accustomed to booking holiday time from her job to attend antenatal scans, even though employers should give time off for these. After her second loss, she was anticipating reduced earnings, but her solution was not to turn to the state for help but to her local network of colleagues who offered to do a collection to give her some income during her time off.

Similarly, Joelle took time off under holiday entitlement for the termination for foetal anomaly of her daughter. She works as a manager in the retail sector and has responsibility for rotas:

> I had to do all the rotas and things like that, and plan, plan around it basically […] So they tried to book me in [for the termination] around 14 weeks [gestation], and I said no. And they kept phoning to ask me what my decision was. And it finally got to the point where I had that week off [on leave]. And...they, they booked the slot. […] But I never really wanted to go ahead with it. [small laugh] It was more just...well this is when I'm off work, this is the convenient time to do it.

Several self-employed people also had to return to work very quickly after a pregnancy loss. Helen had just opened her own business when she discovered her second child had died *in utero*:

> I'd just opened my shop two or three weeks before, I had no staff. I'd just started and I had to close. […] [tearful] I went back to work on the Tuesday, four days later. I was bleeding for about 6 weeks, I had to go back into hospital for them to, just to check there was no extra debris, because bleeding never really stopped. […] I became very angry later that no-one stopped me doing that. Which...My husband was signed off work! Because he's employed by a big employer! He had free counselling! [laughs] Which he absolutely needed, not at all begrudging him it, but the difference between what I had and what he had, just from circumstance, is...you know…was telling.

A longer gestation of the foetus, beyond viability, would have entitled these women to Maternity Allowance or perhaps SML and SMP, but circumstances, the exclusions of benefit entitlements, and the lack of interest from GPs meant they faced different consequences. The consequences of lack of maternity entitlement were keenly felt. They had a material impact on the income of women, on their range of actions in the weeks and months after pregnancy loss, and on their sense that their experience was acknowledged or validated. Birth registration, including stillbirth registration, as the means of accessing maternity rights is therefore associated with recognition for the pregnant woman – her pregnancy work is validated by the state through the bureaucratic processes of registration when a live or certified stillborn baby results from the pregnancy. Where this does not occur, in the majority of second trimester pregnancy losses, the post-pregnant woman and her partner as the second parent are excluded from maternity and parental employment rights. In those cases, women's pregnancy work is invisible and her labour is classified as sickness, if it is recognised at all as a physical event, because it did not produce a living person in the biomedical-legal, teleological ontology of pregnancy as a process of production ending with a specific outcome.

6.3.3 'You tick the maternity, and they look like you're from Mars': Prescription and dental care entitlements

Pregnant women in the UK get free state-funded medical prescriptions and free dental treatment during pregnancy and in the first year after the birth of a child. The prescription entitlement is evidenced by a Maternity Exemption (MATEX) certificate, applied for when pregnancy is medically confirmed. At present, women who have experienced miscarriage, termination or stillbirth can continue to claim free NHS prescriptions until the certificate expires, once they already have one (NHSBSA, ND). However, this more generous entitlement is recent: previously women had to return the certificate after pregnancy loss. For those women who had experienced the previous system, it was a bureaucratic exercise in exclusion, which said that their own physical health after pregnancy loss was not a priority for the state, because they had no living baby through which they could claim their own bodily needs post-pregnancy. Effectively, the state denied the possible physical effects of pregnancy in cases of pregnancy loss. Even recently, lack of knowledge of the system meant women in my research had not been able to claim their entitlement to free medical prescriptions. Bethany, pregnant with her second baby when I spoke to her, described how the certificate has changed and now spells out the post-pregnancy loss entitlement:

> On the back of the one I've got now [pregnant in 2019], it says if you have a miscarriage or stillbirth you can still use until it's exempt. The other one [in 2018], I'm pretty sure didn't say that. I would have read it. So last time, when I had, I had to have antibiotics, I had to have those anti-inflammatories that I didn't need from my doctor, I had to pay for all my prescriptions. And I was like, obviously, if it's going to make me better I don't mind, but had I, I thought the whole idea was that because you're pregnant they should be looking after you? And this wasn't my choice to happen? So I haven't made myself ill, and I need these things.

Even with the current entitlement, there are social barriers to claiming the free prescriptions using the certificate after pregnancy loss, particularly in close knit communities, as Kerry explained, based around the lack of a baby to prove pregnancy:

> So you go in to the doctors' to get a prescription because your boobs are like rocks [with mastitis], with no baby in your hand: 'have you got an exemption certificate?'
> You tick the maternity, and they look like you're from Mars. Because first they're looking at the fact that, 'she's 40, why's she going to be needing that?' and two, I'm not dragging baby in a carrier or a pushchair. […]
> *So then you look like you're scamming them or something?*
> That's what I mean!

Similarly, entitlement to free dental treatment can be hard to claim. Free dental care is based on pregnancy rather than possession of the MATEX certificate. As the NHSBSA states:

> … being pregnant entitles you to free NHS dental treatment, not the fact that you hold a certificate. (NHSBSA, ND)

NHS dental treatment is only free during pregnancy, after live birth, or after stillbirth. After other forms of pregnancy loss, the entitlement to free care only applies if the course of treatment was started during the pregnancy, ie: before pregnancy loss. The consequences of this are difficult encounters for post-pregnant women in claiming care for their own bodies, despite their nominal entitlement to the care. For example, Joelle recounted how she had to explain to a dental receptionist why she was no longer pregnant to show that she was entitled to care booked before her termination. Entitlements to resources and their inclusions and exclusions thus bureaucratically produce pregnancy as a teleological process which should end in the birth of a living baby, through which claims on the state are made, rather than a process which is happening to the woman's body and through which she can make claims herself. Futhermore, women experiencing pregnancy loss may have difficulty in making these claims because the claims are so reliant on evidence of the body of a foetus or baby to prove pregnancy.

6.3.4 The incoherence of UK maternity entitlements when viewed from the second trimester

Not only do UK maternity and healthcare entitlements include and exclude certain women based on the outcome for the foetal being, they also contain classificatory incoherences which add to the liminality of the pregnancy experience of a woman who has a second trimester loss. One of these has been discussed above, when Esther was able claim Child Benefit for her son who died immediately after birth, but not any form of maternity leave or pay for herself. The entitlement to 'maternity' time away from paid employment and money during this period for the pregnant woman, is further confused by the inclusion of live birth before viability, and post-viability stillbirth in maternity leave entitlement. These inclusions raise questions about the purpose of maternity leave. Reading maternity leave entitlements from a perspective of second trimester pregnancy loss exposes inconsistencies at the heart of pregnancy governance. In pregnancies which end with the expected, normal outcome of live birth, these questions are black boxed. Second trimester exclusions, however, reveal that that maternity rights are confused and their purpose uncertain.

There is a compulsory element of maternity leave, which is 2 weeks for most forms of employment and 4 weeks for factory workers. This compulsory element must therefore relate to recovery time from labour for the pregnant woman. It would seem that the rest of the time away from work might be for nurturing the newborn, particularly since after the compulsory period the leave and pay can sometimes be shared with the non-pregnant partner under the Shared Parental Leave Regulations 2014 (UK Government, ND-e). These regulations also state that entitlement to leave is related to responsibility for the care of the child in relation to the mother and the other parent of the child, or the partner of the mother[41]. However, the inclusion in maternity leave and pay rights of mothers of stillborn babies, and those of pre-viability live births, where the baby will not survive, suggests that most maternity leave and pay is not for the nurture of the baby, since the baby has died in these cases. Furthermore, not all women who have living babies are entitled to any maternity pay: those who are not in paid employment will not get maternity related money, despite their nurturing. Therefore, the financial aspect of maternity entitlements beyond the compulsory period seems to be about compensating whichever parent for not being in paid employment, rather than to provide for a living child. This suggests that in these cases, the post-pregnant woman is being paid to grieve, or to recover from a serious trauma which will affect her employability, since she is not being paid to care. However, only those with a live birth or a post-viability stillbirth are included in this category of being paid to recover. Those women who experienced non-live births, of non-persons, have not had a loss which needs this attention.

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[41] In fact, notice must be given of an intention to share parental leave 8 weeks *before* the expected birth of the 'child' defined in the regulations. This establishes some form of parental responsibility for both mother and her partner through an anticipatory recognised kinship relationship with a person who does not yet legally exist. The inclusion of the second parent in this makes the difference – a woman who is pregnant is effectively giving notice of her own need for time off after birth, but the non-pregnant parent here is claiming anticipatory kinship with a future person. This is another example of the breaching of the legal live birth personhood principle in the UK, and the teleological ontology of pregnancy.

6.3.5 Shared parental rights and paternity rights in second trimester loss

Shared parental leave rules further complicate what is being enacted through maternity leave and pay, because the regulations are somewhat ambiguous about what happens if the baby is born dead or dies quickly, as in second trimester live births. My reading of the Shared Parental Leave Regulations 2014 accords with that of the charity Maternity Action (Maternity Action, 2019) in understanding that the death of the child during or after pregnancy disqualifies parents from any claim to sharing parental leave. By contrast, the charity Working Families which advises on employment rights argues that if the required notice has been given of the intention to share parental leave, this still applies even after the death of the relevant child, if the child was born alive (Working Families, 2017). Still other organisations have more inclusive policies which go beyond legal minimums. Angela, who has a senior managerial job for a national company, shared her maternity leave after the live birth and death of her second trimester son with her husband:

> So, my employer was brilliant. So me and my husband, because [son] was born alive, I got a birth certificate and I got maternity leave. Me and my husband shared my maternity leave. Again, working in HR I was fully aware of what our rights were. So we shared. And we had both 4 months off together. Which was brilliant. We had days when we just sat here and watched crap on TV. We had days we went to the beach. We just had that control, I guess?

Angela’s ‘rights’ in maternity leave were related to her company’s careful equal treatment of all bereavement and parents rather than a legal position. She had not provided 8 weeks’ notice to her employer of her intention to share parental leave, but she told me that ‘the company wanted to do everything they could to help’. In cases such as Angela’s, where shared parental leave is permitted, both parents’ loss is being acknowledged and their withdrawal from paid employment for a period of time is compensated. This means post-mortem shared parental leave is similar to bereavement or compassionate leave. However, for most deaths in the UK there is no statutory bereavement leave. The only exception is a very new form of bereavement leave introduced in 2020 for parents who lose a registered or stillborn child, giving them two weeks' paid leave from work (UK Government, ND-f). Stillbirth, the neonatal death of a live baby during the maternity period, and the death of a child are constructed through this benefit as unique bereavement events, but only apply to some people, those who meet criteria based on their specific kinship relationship with a foetal being which has been biomedically assessed to be in a particular legally certified relationship to them.

Where shared parental leave is not permitted in cases where the baby has died, the implication is that it is only the qualifying pregnant woman, or mother, of the baby who is suffering and needs time off paid employment. It excludes any other parents, and also women who do not qualify because of the legal status of their foetus or baby. There is an impact both on the recognition of their own experience, and on the consequent support available for the post-pregnant woman who may still be suffering the increased complications of second trimester labour and birth described in Chapter 5. There may also be financial consequences for the whole family. For example, Megan, a self-employed hairdresser mother of three, had no earnings while she was recovering from the intra-uterine death of her son discovered at 20 weeks, and her partner, also self-employed, lost a week of work. For the household of five people this was a significant problem, and it had an impact on the choices available to the couple about whether to have a separate funeral for their son. Financial constraints meant they chose the free hospital-provided group cremation, but Megan regrets that as a consequence of this she does not have her son's ashes. The bureaucratic and governance boundaries around pregnancy loss can thus affect women indirectly through their other kin. This again demonstrates that the underlying ontology of pregnancy in governance terms is the production of new, separate persons, rather than an event which happens to a woman and her kin in a relational network.

6.4 Conclusion: the foetal body as the basis for the reproductive governance of second trimester pregnancy loss

In this chapter, I have shown how biomedical assessments of the foetal body interact with legal personhood statuses of live birth or stillbirth to produce classifications of the foetal being in the second trimester. These classifications affect whether any foetal being born in the second trimester will be included in, or excluded from, forms of civil registration. In turn, the foetal being's inclusion in, or exclusion from, civil registration affects the legal status of the pregnant woman and her partner, and whether they will be recognised as parents to a person. Where they are recognised as parents, they may be entitled to resources such as time off or maternity or paternity pay. Where the foetal being is classified as a non-person, it does not have legally recognised kin and there will be no entitlement to state or private sector resources for the pregnant woman and her partner. At the same time, where the foetal being is live born or stillborn, the mandatory nature of birth and death and stillbirth registration means that it is bureaucratically produced as a person with legal, registered parents, even if those parents do not wish to recognise these statuses.

The ontological status of the foetal being as person or non-person, with kin or no kin, is produced through the interaction of biomedicine and the law, as has been noted in other examples of the governance of pregnancy in the UK (Franklin, 1999b; Sheldon, 1997). The way biomedicine, the law, and then regulation and bureaucracy work together gives the system strength as reproductive governance, because it is hard to challenge enmeshed discourses which share a tactical polyvalence (Foucault, 1976 /1998). The result is a form of reproductive governance through which pregnant women's options, choices, and entitlements are defined by biomedical and legal ontological positions on the status of the foetus as person or non-person. This biomedical-legal ontology regarding the foetal being itself rests on an ontology of pregnancy which is teleological and defined by the outcome of the production of a living person. This then affects the production of other kin such as mothers. Gestation does not count as a claim to motherhood unless it is completed with the birth of a person. In much of pregnancy loss in the second trimester, gestational work is made invisible by governance processes, and bureaucratic entitlements minimise the physical consequences of labour and birth for women as well as producing the event of loss as inconsequential and unimportant. This is repeatedly enacted in bureaucratic encounters which stem from second trimester loss, particularly around resources such as maternity leave and pay where live birth or third trimester stillbirth is a threshold for eligibility. In this chapter, I also argued that the category of stillbirth, its registration, and its resource entitlements aligned with live birth create an incoherence and inconsistency in policy classifications around pregnancy. Furthermore, the existence of stillbirth policy regarding resource allocation serves to emphasize the ambiguity and liminality of the experience of second trimester loss for women. It complicates an ontology of pregnancy which is teleological and in which pregnancy only has value when it produces a living baby to be a citizen and the object of biomedical attention. This ontology sidelines the intentions, desires, and needs of the pregnant woman, and her partner, in their experience of second trimester pregnancy loss as it relates to the events immediately after the loss. There is no space for women to define their own pregnancies and their pregnancy outcomes because of the bureaucratic control of ontologies of pregnancy. These ontologies are based around pregnancy outcome, in relation to the foetal being, rather than needs or experiences of the pregnant woman. The following chapter will explore similar limitations of pregnant women's agency in relation to the governance of the dead body of the foetal being.

Chapter 7: Pregnancy remains, infant remains, or the corpse of a child? The governance of the dead foetal body[42]

In the previous chapter, I showed how classifications of the foetal body established by civil registration law affect the governance of legally recognised personhood and parent-offspring relations through the biomedical assessment of gestational time and the living or dead status of the born foetal body. In this chapter, I address the governance of the material body of the dead, born foetus or baby through its classification as human corpse, infant remains, or pregnancy remains. I argue that this reproductive governance can produce forms of foetal personhood and parental kinship with the foetal being. Furthermore, I show how these legal and regulatory classifications, produced by multiple actors, structure women's choices about what happens to the body of the foetal being, including in post-mortem and disposal. I also show that the accumulation of governance in this area over time has produced incoherence in classificatory practices, whereby apparently clear-cut boundaries of personhood, kinship, and the status of human tissue are breached in circumstances where different forms of governance interact. The liminality of the second trimester foetal body makes visible some of these incoherences.

7.1 Disposal of the foetal body: human tissue or human corpse?

Once a foetal being has emerged from the pregnant woman in the second trimester, its substantial material body needs to be disposed of. Morgan (1999, 2002) has described how the classification of a dead foetal being affects attitudes to, and regulation of, the ways in which its material presence is dealt with in specific geographic and historical contexts, for example as anatomical specimen, medical waste, or as a human corpse. Classificatory judgements about the ontological status of different types of foetal body in the UK are also made in relation to medical utility value, such as the permitted use of aborted foetal bodies in medical research (Pfeffer & Kent, 2007). Confusion of classificatory categories can be very controversial: in England, investigations

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[42] A version of this chapter has been published in *Mortality* (Middlemiss, 2020b).

were held in the 1990s into the medical retention of human body parts, organs, and foetal bodies at Bristol Royal Infirmary and Alder Hey Children's Hospital in Liverpool after the practice caused public outrage (K. Mason & Laurie, 2001; Sque, Long, Payne, Roche, & Speck, 2008). These reports formed part of the move to the regulation of storage and disposal of human tissue by the 2004 Human Tissue Act, which itself forms the basis of many practices described in this chapter. Conversely, the social production of a foetal body as a person, in need of disposal as a human corpse, can lead to the ritual burial or cremation of foetal bodies alongside other human bodies. In France, Charrier and Clavandier (2019) describe a shift in French disposal regulation away from classifying the post-15 week foetal body as waste and towards its inclusion in cemeteries. Recent work on ceremonies of disposal for foetal tissue in England points out that guidance on pre-24 foetal disposal in England places these tissues alongside those of persons who have lived and died, with the ceremonies producing an 'invisible mourner who is a parent' (Kuberska, 2020, p. 212). In this chapter, I examine how laws and regulations on disposal of, and action on, the dead in England and Wales produce the material bodies of foetal beings as different classificatory entities. I also consider the consequences of these classifications for choices around disposal and post-mortem, and the recognition of personhood and kinship in the second trimester.

7.1.1 'Human corpse': classifying the live born or post viability foetal body

In the UK, being dead or alive at birth, combined with the biomedically determined gestational timeframe determines the legal classifications of the dead body of a foetus/baby. If a baby is born alive (and registered as a birth and death), or registered as a post-viability stillbirth, including after termination, then the body is classified as a human corpse. A human corpse in the UK does not belong to anyone, not even surviving kin, but there are common law obligations to dispose of it appropriately as established in the case of R. v. Stewart (1840) (Sperling, 2008). These obligations fall to various people including executors, close family, and sometimes local authorities which will be discussed below. A human corpse must be buried, or in England and Wales cremated (under the Cremation Act 1902), or it can sometimes be preserved

(Conway, 2016). Esther's son was born alive and midwives explained her options about his body once he had died:

> They said that I actually *had* to arrange something for him because he, you know, he'd sort of lived. They explained to me that it was a neonatal death even though it was also technically a miscarriage because it was before 24 weeks. *[…]*
> The hospital could do it, but I wanted to organise it myself. I didn't really fancy the idea of him…I wouldn't have minded the idea of, the concept of, being in with a load of other babies, but then the fact that it's not your baby's own grave, it's sort of shared, kind of thing.

Esther and her husband bore the legal responsibility of making sure their son's body was buried or cremated, as do all parents whose registered child dies (Conway, 2016; HTA, 2015). The outcome, of a separate grave site in a general cemetery, aligned their son's death with other deaths through the disposal of his corpse. Their involvement as parents in the burial aligned their bereavement with that of other parents who lose a child. The same requirement is in place for stillbirths after viability and there may be further changes to the law in future which also align stillborn corpses with those of fully registered infants and older persons through coronial law. The government is required by the Civil Partnerships, Marriages and Deaths (Registration etc) Act 2019 to consult on extending coronial powers to investigate the circumstances of a death to babies who are stillborn, a change which would establish them still further as persons to whom the state has a responsibility.

7.1.2 'Pregnancy remains': classifying the pre 24 week foetal body as human tissue

In other circumstances, such as non-live birth in the second trimester, the dead foetal body is legally classified as 'pregnancy remains'**.** This is a form of human tissue belonging to the pregnant woman (and not the genetic father), under the Human Tissue Act 2004, regulated by the Human Tissue Authority in England, Wales and Northern Ireland:

> The Human Tissue Act 2004 (HTAct) makes no distinction between the disposal of pregnancy remains and the disposal of other tissue from a living person; pregnancy remains are regarded as the tissue of the woman. (HTA, 2015, p. 2)

The consequences of such classifications are that the foetal body is not understood to be the body of a dead person. For those women who did not share this ontology, the resulting medical terminology could be distressing. Eva's son, who died *in utero* and was born after a long and difficult induction, was sent to the neighbouring county for post-mortem, in the hope of discovering a reason for the death. Visiting her consultant to be told the inconclusive results of that investigation, Eva described how she stole a look at her notes:

> …he went out of the room for some reason, and he left my files, like, open on the desk. And I looked. And I remember it said something really horrific about [son's] body, like, it refers to the body, as I don't know, medical waste? Something about 'the foetus has arrived and the leftover bits have been, like, sent back…'

For Eva, the thought that his body was classified as a form of waste still disturbed her when she spoke to me seven years after his death. She had been told that her son, who died before viability, would not be registered as a birth and death or as a stillbirth and was legally 'pregnancy remains'. He was not recognised as a person to whom she was a mother. Yet she and his father had been required as parents to officially consent to post-mortem and cremation, which will be further discussed below.

Similarly, Tess saw a reference to 'foetal remains' on her medical notes which she found dismissive and inattentive to her feelings about her daughter, who died after a termination for anencephaly:

> That language wasn't helpful. I think that's, that's a shame, because that wouldn't have been used had she been 3 weeks older. And that's like 'hmm'. The definition of a life. She's not really a life. She's not really considered worthy of a title of proper human. And that's...a bit hurtful. […]

> And it seems very disjointed, it seems very discordant with my experience than what they're describing it as [sic].

Besides potentially clashing with women's ontological position on what has happened to them, classification of the dead foetal body has legal consequences for disposal. Under the Human Tissue Act 2004, the pregnant woman's consent regarding how 'pregnancy remains' are disposed of is not legally required. This is similar to any other material from the human body, such as amputated body parts where consent for disposal is considered part of amputation consent (Hanna & Robert, 2019). However, the HTA says that the woman's wishes regarding 'pregnancy remains' should be given special attention because of 'the particularly sensitive nature of this tissue' (HTA, 2015) and guidance is built around choice for women (McGuinness & Kuberska, 2017). The fact that 'pregnancy remains' are considered different to other human body parts relates to the potential presence of the foetal body. Pregnancy remains can include the placenta, umbilical cord etc, but it is the foetal body rather than these which produces a special status. The HTA recommends three options for the disposal of 'pregnancy remains':

> Cremation and burial should always be available options for the disposal of pregnancy remains, *regardless of whether or not there is discernible fetal tissue.* Sensitive incineration, separate from clinical waste, may be used where the woman makes this choice or does not want to be involved in the decision and the establishment considers this the most appropriate method of disposal. (HTA, 2015, emphasis in original.)

In addition, because 'pregnancy remains' before 24 weeks are legally part of the woman's body, she can choose to take them away from hospital, as Tess did. The prevalence of each choice in practice is not known (Kent, 2008). The multiplicity of disposal options including incineration is an attempt to cover multiple ontological outcomes in pregnancy outcomes. For example, it attempts to manage circumstances where women do not want to choose the disposal outcome, or wish for disposal that aligns the foetal tissue with other human tissue, in which case they can delegate the decision about disposal to the hospital. This might be particularly relevant in some abortion circumstances – in my research, Paula delegated the disposal of her foetus to the hospital. The HTA regulations also try to govern situations where there is no identifiable foetal body but there *may* be one present amongst other tissue. The separation from other clinical waste is designed to allow for that possibility because, as the HTA explains, crematoria will not usually accept remains that do not include foetal tissue. The flexibility of the HTA guidelines reflects the liminality of the status of the foetal body, but it also emphasizes the 'sensitive' nature of the experience of termination or pregnancy loss (HTA, 2015, ND-b), producing it as a ambiguous and liminal experience for women through the treatment of the foetal body.

Research into the acceptability of these forms of disposal was undertaken for the Human Tissue Authority and found that choice in the disposal of pregnancy remains is still not widely available: most hospitals offer only shared cremation (McGuinness & Kuberska, 2017). Women in England are not routinely given information about all the legal disposal options for 'pregnancy remains' incineration (Austin & McGuinness, 2019; McGuinness & Kuberska, 2017). In my research, the clarity for women regarding what is actually happening in second trimester disposal is limited in practice, despite the HTA's insistence on women having choices about disposal. The HTA spells out in its guidance that 'pregnancy remains' from multiple pregnancies will be disposed of in one package (which should be made up of separately packaged units) unless women specifically object:

> The current practice of collecting several pregnancy remains in one receptacle separate from clinical waste can be the default position, providing there are safeguards in place that ensure women know they have choices, that they are given the opportunity to make their choice and that their wishes are carried out. (HTA, ND-b)

I found these distinctions are not widely spelt out to women, who were often told that if they chose group disposal their baby would be cremated 'with other babies' without any detail about how this form of disposal actually occurs. This echoes concerns that some hospitals are conflating cremation and 'sensitive incineration' practices and calling hospital based incineration 'cremation'

(McGuinness & Kuberska, 2017). In ‘shared’ cremations, multiple pregnancy remains are placed in separate boxes but put together in one coffin or larger box (Kuberska, 2020). Joelle inadvertently discovered that the standard ‘group cremation’ offered by her hospital included other pregnancy remains such as placental material:

> When you fill out the paperwork you have the option of having the group cremation, but they can't tell you when it is, or, you can't go to it. And that's it, you just leave the baby and they deal with it. And I found that when I had the surgery to have the placenta removed, I filled out the same paperwork. Because it's classed as, what is it, like, ‘foetal remains’? Even though it was just the placenta? And when I did that I was just so glad I'd chosen to have my own funeral [for her daughter]? Because it just made me think, like, what are they doing? Everything just goes into one...one thing?
>
> *And that wasn't what you wanted for her, or for you, or for…?*
>
> No, I think...At the time, when I picked the group cremation, they didn't tell me that it's literally like, everything. [Pause] So I'm glad we did it ourselves and we got the ashes and things.
>
> *And would that have seemed disrespectful, then, putting her in with things like...*
>
> Yeah, I think it does, because it's not...saying that there's any difference between a bit of someone's placenta, and the baby? [pause] And I guess it's the same, like, if people have abortions and things, it's not treated very respectfully, is it?

For Joelle, this classificatory alignment of her daughter’s body with placental material through disposal decisions would have been inappropriate, and it conflicted with her belief that that foetal remains should always be treated with the respect due to a dead body rather than as clinical waste. The HTA’s guidelines fudge is not without its casualties when it tries to produce categorical boundaries which meet everyone’s needs in its governance of pre-viability dead foetal bodies.

7.1.3 ‘Infant remains’: reclassifying all foetal bodies through cremation regulation

As with so many of the classificatory issues in second trimester loss, there exists a certain amount of incoherence in cremation regulations about the status of the foetal body. This was touched on above, where the HTA suggests that the presence of a foetal body is required by crematoria, but also that whether there is a discernable foetal body or not, cremation should be an option. Cremation has been heavily regulated in the UK since it was made legal by the Cremation Act 1902, and a set of regulations were established and came into force in 1903, which have since been repeatedly amended. The original regulations paid attention to pregnancy loss in that they included the first regulation of ‘stillborn’ corpses, even prior to their first state registration under the Births and Deaths Registration Act 1926[43]. In the 1903 cremation regulations, a ‘stillborn child’ could be cremated if a medical practitioner confirmed it was born dead, but there was no gestational timeframe related to the definition of ‘stillborn’ as a classificatory category. This was to be legally developed over the following century in relation to the increasing linkage of the concept of foetal ‘viability’ with that of ‘stillbirth’, though successive legal moves including the Infant Life (Preservation) Act 1929, the Abortion Act 1967 and the Human Fertilisation and Embryology Act 1990.

Very recently, however, there have been moves to partly decouple disposal from notions of viability, and to situate all cremated foetal beings alongside other human corpses in cremation regulation. Regulation in this area has recently begun to expand the category of ‘infant remains’ to include second trimester and other foetal bodies. One pressure to move regulation in this way involves acknowledgement of mourners’ desire to receive identifiable ashes from the cremation process. Two reports into the non-collection of individual ashes from infant cremations, the *Report of the Infant Cremation Commission* in Scotland in 2014 and the *Report into Infant Cremations at the Emstrey Crematorium Shrewsbury* in England in 2015, criticised practices in which parents were not given the ashes of registered children (House of Commons,

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[43] This act was the first to require the medical diagnosis of stillbirth before disposal through burial could take place, but this was not linked to a legally defined gestational timeframe until the 1953 Births and Deaths Registration Act drew on the Infant Life (Preservation) Act 1929 to establish stillbirth as after the 28th week of pregnancy, later amended to 24 weeks.

2018). The reports prompted both the Scottish government and the UK government to review practices at crematoria, with the intent of recovering more individual ashes to give to mourners. In the process they have extended the definition of ‘infant remains’ in crematorium regulation to unregistered foetal bodies. Justice minister Caroline Dinenage explained the plans in the House of Commons in 2016:

> Where parents choose a cremation following a pregnancy loss of a foetus of less than 24 weeks’ gestation, we will bring such cremations into the scope of our regulations, like all other cremations. I must stress that we have no plans to alter parents’ current choices following a pre-24 week pregnancy loss, so parents will continue to be able to choose between cremation, burial and sensitive incineration or they can ask the hospital to make all arrangements on their behalf. (Dinenage, 2016)

This change produces the foetal body as a human corpse, particularly in the second trimester where the body is substantial enough to be identified and to produce some ash residue after cremation. Furthermore, the Cremation (England and Wales) Regulations 2008 require that records of cremation of stillborn babies must be kept by crematoria, and stipulate that these records can be accessed on request. Substantial documentation is also already kept on the disposal of pre-24 week foetal remains at the recommendation of the professional body the Institute of Cemetery and Crematorium Management (ICCM, 2015). Research with funeral professionals has found that the record keeping aspects of pre-24 week loss are already being attended to by funeral directors because of emissions requirements, retaining a traceable link to the hospital records of the woman who had been pregnant (Kuberska, 2020). The government’s plans to dispose of pre-24 week foetal bodies on the same terms as post-24 week bodies, which are recorded under the Cremation (England and Wales) Regulations 2008, mean the record keeping of crematoria will be further extended to become another site of bureaucratic governance through which there is a form of personhood recognition for second-trimester deaths based around the status of the foetal body.

7.2 Defining parents through their obligations towards the corpse of a child

The final factor in the governance of the disposal of foetal bodies is the role of parents. I have described above how the classification of the foetal body as human corpse, pregnancy remains, or infant remains in the cremation context affects the choices available to relations about the disposal of the body. It also affects who has responsibility to pay for and arrange the disposal, conceptualised through normative UK cultural assumptions about family relations and obligations reflected in state financial support for funerals (Woodthorpe & Rumble, 2016). In relation to disposal responsibility, there is some flexibility in English law about who this falls upon, as I noted above, except in the case of parents. In common law, parents are responsible for the disposal of the body of a dead child (Conway, 2016), unless they do not have the means to carry out disposal, in which case the local authority may be responsible under the Public Health (Control of Disease) Act 1984. This applies to all registered children, including stillborn and post-viability foetal deaths caused by termination. This means that parental kinship relations are recognised through legal responsibilities in certain types of pregnancy deaths, including the live born and post-viability stillborn. In terms of legal rights acquired through these relationships, parents may be entitled to Funeral Expenses Payments if they have a low income (UK Government, ND-b). Some dead foetal bodies are classified as children, and some of their parents are given a parental responsibility for them. For some women in my research, this was a welcome confirmation of their ontological position on what had happened. In the last chapter, I described how Georgia’s cousin had questioned her son being entitled to a birth certificate. For Georgia, the requirement to treat her son’s body like a human corpse also validated her grief:

> And [cousin] had said something about 'babies that age don't have a funeral', and stuff like that.
> And because he was born alive we legally **have** to have a funeral.

At the same time, the classification produces exclusions, in the form of those second trimester deaths where there is no parental responsibility to provide for the disposal of the foetal body, although because of the pregnant woman’s disposal decision making required by the Human Tissue Act 2004, this distinction is usually concealed from parents. One case, however, where the distinction was brought into sharp relief was for Alice, who had terminations for foetal anomaly within a year of one another but either side of the viability threshold and who had already faced the need to register one baby and not the other:

> Afterwards they said ‘you can see the bereavement counsellor if you like, you don’t have to have a funeral because it’s not 24 weeks, but you obviously can if you want to, and we will pay for it and arrange it for you if you want.’
> And we said ‘yes, please. We want to do exactly the same as we did before, because that would be the right thing to do.’
> *Is that because you were treating them both the same?*
> Yeah, yes. Yes. We felt…that they were both equally valid as individuals and relevant to us in our lives. And it just would have been awful saying yes, for our little girl we had a lovely funeral and flowers and all this stuff, and no, for the little boy, ‘no, you can do what you like with **him**.’ It doesn’t make any sense. You know? Just because he was littler? But I just don’t know where that cut off point is as to…
> *And I think it’s part of your parenting again, isn’t it, that you are parenting a being that is your son?*
> Yes. It’s acknowledgement. Exactly. It’s acknowledging that he was there.

Alice was one of the few women in my research who was in a position to see that there was a difference between the *requirement* to have her post-viability daughter’s body disposed of officially, and the hospital’s *concession* that her pre-viability son’s body could be treated similarly. Her case highlighted the classificatory decisions behind the governance of pregnancy loss.

7.2.1 Producing liminal parental and foetal personhood status through funeral funding and organisation

Furthermore, the actual enactment of parenthood in relation to born foetal beings is partly defined by the way regulations around second trimester and other pregnancy loss disposal by hospital settings are applied in practice in different settings. In many cases, such as that of Alice above, payment of funeral costs and arrangement of the event was undertaken by the hospital. This could be a practical relief to parents, as well as an acknowledgement of the alignment of their loss with other child deaths, as in the case of Hayley:

> I turned round and said, ‘how much is all this going to cost?’ When they mentioned a funeral. I was like, ‘this sounds daft, it doesn’t matter, but what are we facing?’
> They said, ‘there’s no charge for any child under 2.’ They pay for it. Which that, I have to say, was the biggest relief.

On the one hand, the expectation that Hayley would not bear the costs of her baby’s funeral meant that she was classified as having a diminished parental responsibility compared to a parent whose older child had died, who would have legal responsibility and financial responsibility for disposal. On the other hand, the fact that the hospital paid for all costs for other under 2 year old deaths meant Hayley was classified as having experienced a similar parental loss to other infant deaths, aligning her experience with that of the parents of registered infants. Payment and arranging of funerals, on the terms which hospitals were prepared to offer under the HTA regulations, produced both a liminal type of dead foetal body and a liminal type of parent. Women in my research were usually excluded from the group disposal arrangements by hospitals, who either specifically told them they could not attend a group funeral, or never mentioned the possibility of attending, in line with findings from research with funeral directors (Kuberska, 2020). Stacey, whose daughter died during termination for foetal anomaly, explained how she had special dispensation to attend the cremation:

> We were told, 'you're not allowed to attend. You're not allowed to attend the mass cremation.’ But the [hospital] chaplain agreed that we could go. Apparently it's because I was so upset. He made a special decision to allow us to go. […] We were treated special, and apparently they did special compensation for us. They treated us differently, they went the extra mile.

Stacey felt her extreme grief as a bereaved parent had made the hospital recognise her parental status and change its ordinary rules to accommodate her suffering. The bending of the rules classified her as a less liminal parent than those of other second trimester babies, but she felt upset that other parents had not had this opportunity:

> I felt like I was there for **all** these babies [pause]. And that still gets me now, it still gets me now, that we were the only ones there. Why should you not be allowed to go?

Stacey was satisfied with the acknowledgement of her parenthood which took place during the ceremony, for example, when the funeral director told her he was sorry for her loss. However, whilst in this case she was acknowledged as a bereaved parent, her daughter was still a liminal being, in a casket with several others. Whilst the fact that there was a funeral was an acknowledgement of some form of personhood, the way the funeral was conducted produced the foetal beings as generic and non-individualised:

> The one thing that bothered me during the whole funeral was that he didn't read out names of the babies. It was just, 'we bless all these babies, dahdahdah.'

The hospital arranged funeral was in itself a sort of second-best arrangement, not quite a normal funeral, access to which Stacey thought was restricted because parents did not have to pay:

> I think it's because...[the crematorium] do it, I think it's for free. They do it before the day starts and because they're doing it out of the goodness of their hearts, they don't...I think it's the crematorium that don't allow it, rather than the hospital, but you're told when you're given the option, if you choose a hospital cremation you're not allowed to go. You know the date it's happening, you don't know anything else.

At other times, it was funeral services which offered funerals for free to the parents experiencing second trimester death. However, these funerals also often occupied a liminal space between a ‘normal’ funeral and the pregnancy loss version, producing different types of loss. Joelle arranged her own funeral through a funeral director near her home, but there was a particular set of arrangements in place for the free cremation of babies who died in pregnancy. Normally these took place early on a Wednesday morning, before other people were likely to want to use the crematorium. This was the same for the group cremation for her local hospital, which also took place early in the day at the same venue. However, there was heavy snow on the day scheduled for Joelle's daughter's cremation and the roads were impassible:

> So we got as far as [next village], and we couldn't get anywhere and we just phoned them and we said, 'we can't get there, we can't get to the funeral!' And so we had to cancel it.
> And then luckily they managed to reschedule it that afternoon, but they said 'just to let you know, there is a big funeral on at the same time.' So we went there […] and there was like 10 cars, and a massive coffin with lots of flowers, and all these people turning up to this other one, and then there was just us. [pause] [Fiancé] carried the coffin in, we had some songs and did some readings, and that was it.

Accepting the free funerals where the normal parental responsibility to pay for the disposal of a child's corpse was delegated to hospitals or funeral directors produced pregnancy losses as different to the loss of an older person, or older child, and removed some control over the event for parents. This liminality reflects findings in research into funeral directors' attitudes to pre-24 week loss, in which different language, such as 'products of conception' was used behind the scenes by professional funeral staff, compared to language such as 'son' or 'daughter' used when speaking to parents (Kuberska, 2020). It also reflects research into the use of separate areas known as 'baby gardens' in cemeteries in which infant and foetal remains may be buried or ashes scattered, and in which the use of separate space differentiates these deaths from other deaths (Woodthorpe, 2012).

In my research, parents were aware that professionals viewed the foetal body as not quite the body of a person, and the parents as not quite the same as other parents or mourners as a consequence. Amanda felt this keenly after her son died from feticide during a termination for foetal anomaly:

> And so [funeral directors] were like 'well, what do you want?'
> I said, 'I want a willow casket.'
> 'Well, no, they don't do them small enough.'
> And that was the message of everything that I asked for, 'no, he's too small.'
> They didn't do a hearse, because he was too small for a hearse: 'It's not worth getting the hearse out. He can go in the boot of the people carrier.'

Amanda found that a combination of the size of her son, his gestation, and his lack of registered personhood set parameters on the disposal of his body which was not considered to be so formal an event as the disposal of an older being, even when she was accepting the financial liability of his disposal and thereby acting as his parent. Her actions and choices as a parent regarding disposal were partly limited by the material condition and status of her son's body, as her actions and choices in her own medical treatment had been during the termination of her pregnancy.

7.2.2 Defining parents as kin through post-mortem consent

Apart from burial, cremation, or sensitive incineration, the material foetal body which has died in the second trimester may be subject to post-mortem[44]. Of the 31 women in my study, 14 consented to post-mortem at least once. Post-mortem consent and procedure is a sensitive subject in England because of the historic scandals at Bristol Royal Infirmary and Alder Hey, described above, and consent levels have been declining (Breeze, Statham, Hackett, Jessop, & Lees, 2012). Many of the bodies from which parts were retained without consent in the past were those of infants and foetuses (Sheach Leith, 2007). Several women in my research mentioned these scandals during the interviews. Perhaps as a result of anxieties around retention of body parts, the regulation of

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[44] Post-mortem consent also affects disposal options for any tissue which is removed from the body of the baby. If tissue has been removed and preserved, for example in slides for microscopes, these cannot be cremated and another form of disposal must be decided on for these body parts (Sands, 2013a; Sque et al., 2008). If burial has already taken place, it is unlikely that a grave could be reopened to bury any additional tissue later on. No-one in my research mentioned this having been explained to them in our conversations about post-mortem consent, although neither did I ask directly because I was unaware of this information at that point in my research.

consent to processes concerning the dead foetal body other than disposal, such as post-mortem or organ donation for research, is derived from multiple agencies working together in a classic example of governance (Bevir, 2011). Responsibility is thus both spread out across actors and also devolved to parents. In this respect, governance of post-mortem consent for perinatal beings is similar to governance of termination for foetal anomaly, in which a combination of legal and medical frameworks and institutions interact with the wishes and intentions of parents, an example of a tactical polyvalence of discourses, in which people and institutions may align their interests for a particular purpose (Foucault, 1976 /1998).

Post-mortem consent for adults and older children is regulated by the Human Tissue Authority (HTA), but the HTA has delegated the production of advice on perinatal and pregnancy loss post-mortem to the pregnancy loss charity Sands, funded by the Department of Health. Sands have produced a package of advice and consent forms in consultation with a number of other actors including medical professionals, mortuary managers, and parents and this is now the standard practice recommended by the HTA (HTA, 2019). This best practice on the consent and authorisation of a post-mortem applies to all foetal beings born alive or dead and at any gestation, which are referred to by the guidance as 'babies', and who, on the sample consent form, have separate spaces for name, surname and date of birth[45], producing them as a form of person recognised by state and NHS bureaucracy, individually accounted for as a 'case' through which power produces a form of reality (Foucault, 1977/1991).

The Sands/HTA guidance states that consent and authorisation for a post-mortem *must* be received, and this 'should always' be given by the pregnant woman (referred to as 'the mother' in the text) unless there are exceptional circumstances such as her being too ill to consent, and 'wherever possible' should be sought from 'the father' (Sands, 2013a, p. 13)[46]. Having noted the heteronormative nature of the guidelines, they are also potentially controversial in their undermining of the definition of 'pregnancy remains', which as discussed

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[45] This may be because Sands have used the post-24 week stillbirth scenario, historically the charity's main interest and site of action, as the standard for all pregnancy loss.

[46] The sample consent form itself allows 'father' to be replaced with 'partner with parental responsibility' (Sands, 2013b, p. 2).

above are legally considered part of the pregnant woman's body. The Sands guidelines applied in a second trimester pregnancy loss therefore effectively allow the other parent of the foetus (assumed by them to be male) to give permission for the medical examination of tissue which legally belongs to the pregnant woman. It is not clear what would happen if one party consented and the other did not.

The appearance of a 'partner with parental responsibility' on the consent form suggests that permission is not given on the basis of biological link with the foetus, as the male genetic parent, nor as next of kin of the pregnant woman, as her partner, but on the basis of a social parenting role in relation to the foetal being. The effect, therefore, of this confused position, is to produce a second parent or a father to the dead baby through the consent to post-mortem. This aligns post-mortem consent for all pre-viability foetuses, including those who were born dead and who do not have legal personhood status, with the HTA post-mortem consent processes which apply when a dead legal person has not themselves given permission for a post-mortem, and a series of qualifying kinship relations can give consent in their place (HTA, 2017a, 2017b). These qualifying persons are defined in the 2004 Human Tissue Act and include parent-child relationships second only to spouses and partners. The governance of post-mortem consent therefore produces parents as kin to foetal beings which are not otherwise considered persons and whose kinship with parents is in doubt in other areas of the governance of pregnancy, such as civil registration or maternity entitlements, discussed in the last chapter.

The post-mortem therefore constructs a foetal personhood through the individualisation of the foetal being, and a parent-child relationship through consent procedures. It is also implicated in the production of a foetal person because of its judgement on the sex of the foetal being which has died. In the second trimester, the formation of foetal sex organs may not yet clearly indicate biological sex, or the foetal body which has died in utero may have deteriorated so that sex is hard to determine visually at birth. A perinatal post-mortem involves chromosome analysis which fixes the sex of the foetal being. For many women in my research, the pronouncement of sex after post-mortem chromosomal diagnosis was an important moment which sometimes conflicted with their own idea of the sex of the baby, or at other times confirmed it. For some women, such as Natalie, the unexpected disclosure of sex in the post-mortem results was distressing. Natalie's previously unnamed and unsexed baby born dead before viability was not legally classified as a person, but the post-mortem gave him a sex, and for her this made him a more tangible form of person:

> [The consultant] wrote to me, and I just opened the letter, and, and it said, you know, 'I can confirm that your baby was a boy.' And I was here on my own, and I hadn't actually asked to know the sex. They hadn't given me the option, 'Would you like to know the sex?' If I had, I would have preferred to have been told verbally, rather than in a black and white letter. I was here on my own, and I opened it, and suddenly it changed things, you know.
>
> *What did it change?*
>
> It just changed to having another son. You know. From just losing a baby, to losing a son.

The governance of perinatal post-mortem through the HTA guidance and medical practice produces a foetal being in the second trimester which has a definite sex, which is individualised in bureaucratic records linked to the state using a personal and family name, and which is situated in relation to parental kinship. This being, although dead, has many of the prerequisites of personhood which apply to other beings, such as the post-viability stillborn person.

7.3 Conclusion: the incoherent reproductive governance of the dead foetal body

I have shown above that the death of the foetal being in the second trimester of pregnancy brings together a set of governance arrangements in relation to the dead material foetal body which are confused and contradictory, and which can limit the agency of the pregnant woman. Disposal laws and regulations, and those around post-mortem, situate the second trimester pre-birth death (which was most of the babies in this research) as a liminal being. On the one hand, the death is categorised as similar to the neonatal death of a recognised person, in the sense that special attention is paid to the material foetal body and it can be subject to post-mortem and buried or cremated. New cremation regulations individualise the pre-viability foetal body, and produce it as a corpse with identifiable ashes belonging to next of kin, which includes both parents. This aligns it with the stillborn corpse, which has a long history of being treated legally like the corpse of a recognised human. This produces the foetal being as a form of person. On the other hand, under the Human Tissue Act, the body is not legally classified as a ‘real’ human corpse but as part of the pregnant woman’s body. In this guise, it may be incinerated as a form of clinical waste, if the pregnant woman chooses this. Kinship with the father or other parent is not recognised in these cases, and such foetal beings exist only in relation to the pregnant woman who can decide their disposal. Sometimes this relationship is understood as a form of mother, if burial and cremation are selected, and other times this is a form of clone relationship, with the foetal being simply understood as a separated part of the gestational mother. Whilst the pregnant woman can make some choices in this situation, these are limited – the foetal body cannot be treated as medical waste, nor can it be registered as a person.

At the same time, there is a clear distinction between the legal status of the second trimester foetal being born dead and the live born gestationally similar baby. A live born baby in the second trimester is always a person, and must be buried or cremated, and this responsibility must be executed through parental agency, although the hospital can assist. In these cases, personhood status of the foetal being, and related parental status has been fully established through the civil registration of live born babies, and this cannot be disavowed by parents, whatever their own desires might be. In all cases, therefore, the pregnant woman’s choices and options about what happens to the foetal body are constrained by governance, despite an apparent focus on choice in the HTA regulations. This governance is reproductive governance, through which dead foetal bodies and their parents are at times recognised as persons who are kin to one another, with responsibilities and rights, and at other times these statuses are withheld from them. Sometimes pregnancy governance produces dead babies and grieving mothers and other parents who can make choices for one another’s bodies. At other times there is just foetal tissue belonging to one individual rather than forming two. However, in each case the determining factors are not the choice of the pregnant woman, nor the other parent, but the biomedically assessed status of the dead foetal being in relation to gestational time and live birth personhood.

ETHNOGRAPHY PART 2: DISRUPTION AND RESISTANCE IN SECOND TRIMESTER PREGNANCY LOSS

In Part 1 of the ethnography, I described how pregnant women experience events of second trimester pregnancy loss within a teleological biomedical-legal ontology of pregnancy which understands a loss before viability, especially one without a live birth, to be largely inconsequential. Pregnancy loss in the second trimester is broadly not conceptualised as the birth and death of a person, who should properly only emerge alive (and likely to survive) at the end of a full-term pregnancy, at which point their life begins and is registered by the state. In the English NHS, this ontology means that labour and birth in the second trimester which will not have this long-term outcome is often not understood to be a 'real' labour and birth, with outcomes of a 'real' baby and mother, and this has consequences for healthcare practices. In relation to the governance of the being which is born, civil registration law means that a non-live birth in the second trimester cannot produce a 'real' person, with parents who may have a claim through kinship to recognition, resources, and benefits. However, other governance of the dead foetal body, including stillbirth registration, complicates the biomedical-legal ontology of pregnancy by producing incoherent forms of semi-personhood, sometimes through kinship relations, even in beings which are dead or will not live. Alongside the explanation of practices in healthcare and governance, I told the story of how the events of second trimester pregnancy loss play out in women's lives in South West England in ways which are beyond their control because of these ontological positions.

I now step back from the intricacy of how the biomedical-legal ontology of pregnancy is enacted through healthcare and governance practices to consider in Part 2 the effects of the wider ontological claims on women experiencing second trimester pregnancy loss. In Chapter 8, I describe how ontological disruption can be produced by conflict between the biomedical-legal ontology of non-personhood in the second trimester, and women's reflections on their embodied experiences of labour, birth and encounters with the foetal body. In Chapter 9, I show how some women counter this disruption with an agential and resistant alternative ontology, that of English kinship, which does allow the foetal being to be conceptualised as a real person, with real kin. In this context, I describe some of the practices which women use to assert the ontological reality of their babies and their pregnancies in intimate and domestic settings.

Chapter 8: 'It wasn't all a figment of my imagination': Ontological disruption in second trimester pregnancy loss

In this chapter, I argue that for many women in England, second trimester pregnancy loss can be such a deeply disorientating event that it amounts to ontological disruption, a disruption in their understanding of reality itself. All the women in my research felt their pregnancy losses as fundamentally and enduringly disruptive. This was often part of the reason for them taking part in the research at all, sometimes years after the event. The event is a serious disruption to the expected lifecourse (G. Becker, 1999). Epistemic shock in relation to trust in biomedicine has been described in the context of unexpected outcomes of reproduction (Kelly, 2009). However, I argue that in second trimester pregnancy loss there can also be a more profound disruption of knowledge of reality itself which amounts to ontological shock and disruption. This, I argue, is based on confrontation between the biomedical-legal discourses drawing on teleological ontologies of pregnancy enacted in healthcare and bureaucracy, and the embodied experiences of second trimester loss which form the basis of a different knowledge of reality.

The dominant biomedical-legal ontology of pregnancy and pregnancy loss broadly says that a second trimester loss has not produced a real person, did not involve the death of a real person, and did not produce a real mother, with some partial exceptions for live births. This can fundamentally conflict with the understanding of reality which is held by pregnant women themselves, in cases where they understand themselves to have given birth to a baby, to whom they are a mother. This alternative ontology is one derived from embodied experience in pregnancy, labour, birth, and encounters with the body of the foetal being. It is knowledge partly based on foetal materiality and one's own corporeal relation to that being. Yet this ontological position is deprioritised and marginalised in experiences of healthcare and bureaucracy which directly contradict and undermine it, as previous chapters demonstrated. In explaining this ontological disruption, I bring together Giddens' concept of ontological security (Giddens, 1991), from sociology, with that of reproductive disruption, from medical anthropology, in which expectations of a normative reproductive lifecourse may be altered by fertility events and their biomedical management (G. Becker, 1994) in the context of wider political relations (Inhorn, 2009b).

8.1 Ontological (in)security and ontological disruption

Giddens proposes a model of society in which there is a universal need for humans to have security on a philosophical and existential level as well as a practical one, defined as ontological security (Giddens, 1991). Ontological security is provided by having a framework of reality which can offer some consistency to experiences of the world, including existential questions about the nature of existence, the nature of human life, the nature of other persons, and self-identity. It allows society to operate on trust, which is particularly important in high modernity where reflexivity and connectivity between people means there are greater levels of doubt. The competent routine control of one's body is implicated in ontological security because it is essential to the individual agential self in terms of their narrative of self-existence, and because it is connected to their acceptance by others. Failure in upholding acceptable narratives of self, including bodily competence and control, can result in shame. Because of its scope, lack of ontological security is potentially disruptive to the individual to the extent that the reality of things and persons can come into question (Giddens, 1991).

All death has been interpreted as a threat to ontological security (Giddens, 1991; Mellor & Shilling, 1993) because it cannot be controlled by, or delegated to, institutions or abstract systems. In these circumstances ontological security comes under strain. For Giddens, 'fateful moments' such as death confront individuals with existential questions which are normally smoothed over by 'reflexively ordered abstract systems' and which may challenge their ontological security (Giddens, 1991, p. 203). In the case of second trimester pregnancy loss, the death of the anticipated baby can therefore be a challenge to ontological security. However, there are also further levels of disruption beyond the challenge of apprehending death for women experiencing second trimester pregnancy loss. I have argued already that the 'reflexively ordered abstract systems' which are implicated in pregnancy loss in England, such as the biomedical-legal discourses of pregnancy produced by biomedicine, NHS healthcare, and governance of the foetal body, its personhood and kinship, are unable to accommodate second trimester pregnancy loss. They produce violence towards women, exclusions, and marginalisations, and they contain incoherences in classificatory categories. This is disruptive knowledge and experience which is only accessible to those experiencing second trimester losses, because in stillbirth and full-term pregnancy it will never come into view.

Women encountering this knowledge and these systems, therefore, had their ontological security challenged by death itself, and by the particular isolating and marginalising experiences of second trimester loss in English healthcare and bureaucratic institutions. However, their ontological security could be even more shaken by the confrontation between the teleological and biomedical-legal ontologies which classified their foetal beings as non-babies and non-persons, and their own ontological understandings of what had happened. In most cases of second trimester loss, the biomedical-legal discourse did not even consider that a ‘real’ death, of a ‘real’ person, had actually occurred. Those women who understood themselves to have been pregnant with a person, and perhaps to have been a mother to that person even if only during pregnancy, suddenly found themselves in a world not of their making, in which their entire experience and understanding of pregnancy was abruptly shown to be radically different to the framework of reality held by other people. Who or what is a person, and who can be a mother or a bereaved person was fundamentally challenged by the ontological disruption of second trimester pregnancy loss, in the context of a teleological ontology of pregnancy. This is an example of torque, in which biography is twisted in the framework of a dichotomous classification system (G. C. Bowker & Star, 2000). In this case, the dichotomies are that a foetal being is either a baby/person, or not a baby/person, and therefore the post-pregnant woman herself is either a mother or not a mother, entitled to grieve or not to grieve. In the context of pregnancy loss, it also intersects with ideas of liminality, whereby incomplete rites of passage produce liminal persons whose social status is ambiguous and uncertain (Turner, 1976; van Gennep, 1908/1960). This was intensely isolating for women in my research, as I describe in this chapter. It was also more fundamentally shocking than the concept of reproductive disruption as a rupture in the normative life course (G. Becker, 1994, 1999), because alongside a personal lifecourse disruption, it could produce a rupture with social reality itself.

8.2 ‘Boof, up against the wall of reality’: disrupting the teleological ontology of pregnancy

Shock, disorientation, and disruption can be produced by all forms of reproductive loss (See Chapter 2, and also G. Becker, 1994; Inhorn, 2009b; Memmi, 2011) and has been interpreted as a form of Post-Traumatic Stress Disorder (Farren et al., 2016). However, there are aspects of second trimester loss which produce specific forms of disruption. The lack of visibility of second trimester loss compared with other types of pregnancy loss meant several women in my research were unaware that a pregnancy could be lost at all at this stage, because they had only heard of early miscarriage and stillbirth. The personal shock of the baby’s death was therefore magnified by its apparent rarity and strangeness. Silence subsequent to the loss, in close social circles and in the wider world, also threatened women’s ontological security in terms of the reality of what had happened. Eva’s son was discovered at 17 weeks to have died *in utero* and she welcomed the hospital’s written acknowledgement of his birth:

> It recognised that it wasn't just a figment of my imagination, I had a baby. Because after all people don't talk...Well, they find it hard to talk to you anyway about it, don't they? But they even talk about it less, like, months and years on. And you kind of feel like maybe a lot of it was in your imagination.

For Eva, the realness of the death of her son could be called into question in her own mind by the silence around her loss. The same phrase, ‘it wasn’t all a figment of my imagination’ was used by Kerry in relation to countering the absence of recognition of her son’s personhood by his father and many of her friends after the baby’s live birth and death at 20 weeks’ gestation. Many of the women used the term ‘surreal’ when describing what happened to them. Lack of social knowledge and recognition of the events of birth and death, and of the foetal being as a real person, destabilised many women to the point that they sometimes doubted their own reality and felt the need for external verification. For example, Bethany was relieved that her mother and friend saw her labour, because she felt in need of other people's witness to prove that this event was significant and based in reality rather than a non-event.

As well as being capable of prompting this questioning of reality, the experience of disruption was one which reached into all areas of the self, including the physical, intellectual, and emotional. The unexpectedness of the news of a problem with the pregnancy and the shock of this was often described as a physical sensation of numbness, falling, or violence which expressed the scale of disruption, echoing Becker's findings about metaphor in infertility (G. Becker, 1994). Chloe's daughter was discovered at 18 weeks to have died in utero. Hearing this news was a physical sensation for her:

> It was just like being hit by a bus, and winded, and stabbed, and run over…

Tess, given news of her daughter's serious foetal abnormality at an ultrasound scan, also described the experience in terms of physical violence, a disruption to reality, and a distortion of the life course:

> We weren't expecting anything and just suddenly, […] consultant came in, and, and said, you know, 'I'm really sorry but the baby's got anencephaly.' And having like that brick wall moment of, like, **boof**, up against the wall of, of reality.
> What? **What?** You know, you come in on one path and then suddenly life has batted you in the opposite direction.

The lack of awareness of second trimester loss and the possibilities of non-normative pregnancy outcomes contributed to the disruptive shock when problems with the pregnancy were first diagnosed. This formed the background to ontological disruption produced by the healthcare management of the events after diagnosis alongside the embodied experiences of pregnant women. However, such shock was only the beginning of the possible ontological disruption.

8.2.1 Conflict with experiences of embodied pregnancy

Biomedical technologies, such as foetal Doppler listening and ultrasound scans produced disruption to pregnancy in second trimester loss which conflicted with women’s somatic experience of pregnancy and their intellectual expectation of the outcome of pregnancy, and was thus ontologically disruptive. Modern biomedical surveillance of the foetus means that pregnancy loss can begin before the pregnant body begins to expel the foetus, if foetal anomaly or foetal death is discovered in advance of labour and birth. Women in my research were sometimes experiencing their bodies as being in established pregnancy, whilst being told the foetal being was dead. Sometimes they were feeling the movement of the foetal being inside them, whilst being told that this being was unviable, or that they were in premature labour, and therefore that it would die. Kerry felt her son moving as doctors removed the cervical stitch which had failed to stop her premature labour, which she knew would result in his birth and death. Amber had felt a lot of movement from her daughter diagnosed with Smith-Lemli-Opitz syndrome because of the lack of amniotic fluid caused by the condition. She described the dissonance caused by discussing termination during ultrasound appointments where she experienced her daughter as living through the biomedical technology:

> I remember seeing her, her heartbeat. So we're talking about her, and her heart's still beating.

Pregnancy loss can begin in the second trimester as an intellectual awareness rather than a physical process, and as an intellectual awareness in conflict with other parts of the experience, such Amber looking at images of her daughter’s still beating heart whilst discussing her future death. Though this is possible in earlier pregnancy loss, the fact that in the NHS the first ultrasound scan is usually at 12 weeks’ gestation means first trimester miscarriage, ectopic pregnancy, or medical abortion is usually first experienced somatically when bleeding starts, rather than experienced intellectually through the mediation of biomedical technologies which may themselves conflict with or heighten somatic experience.

Knowledge of foetal death through technological mediation in advance of labour and birth was very disruptive and echoed findings in Canada in which the experience of unexpected ultrasound findings caused a rupture with expected reality (Mitchell, 2004). For women who experienced this because of spontaneous foetal death, such as Helen, Chloe and Eva, there was disruption to the idea of their own bodily integrity, to the ‘normal’ experience of pregnancy, and to their own somatic experience of their bodies as still pregnant. For other women, the use of feticide in termination for foetal anomaly, routinely a few days before induction of delivery, also produced dissonance in terms of knowledge of foetal death whilst the pregnancy continued. The awareness of being pregnant with a dead foetus mediated through biomedical technologies and processes was similar to those women who had experienced foetal death *in utero*. However, for women who had consented to termination for foetal anomaly there was an additional layer of disruption connected to the necessity of consenting to abortion and the consequent sense of personal responsibility for the death of the wanted baby, which is further discussed below. For both groups of women, the experience of still being physically pregnant whilst knowing intellectually that the foetal being was dead conflicted with the whole idea of pregnancy and its purpose. Fiona, whose first son was discovered during a commercial ultrasound ‘gender’ scan to have no heartbeat, described the dissonance of knowing herself to be pregnant with a dead baby:

> Thinking he's *inside* me, and *what*...just, it's just surreal, isn't it? You think, this baby's still inside me, and he's died, he's inside me...and you're just thinking, I remember at first thinking, ‘I need him out, get him out!’ But then I was kind of calmer about it and thinking ‘he's going to come out, but for now it's ok.’ I dunno.

Simone, whose fourth child died in utero at 17 weeks, felt alienated from her pregnant body once the death had been discovered:

> I just wanted to kind of put my bump over there and just be like, carrying on. It felt horrible. Yeah. Because I still had the sickness, I had the sore

> boobs, I still felt like I was pregnant. So it wasn't easy just to kind of go around with this bump and think, it's not ok any more.

Biomedical normalised judgement of the foetal body through technology in termination for foetal anomaly produced some similar disruptions in terms of alienation from the pregnancy. Paula, whose foetus was diagnosed with a foetal anomaly at the 20-week ultrasound scan, found the process of termination alienating in relation to her own body and the body of the foetus to which she does not attribute personhood. She was very concerned about the possibility of the foetal being having a monstrous appearance after warnings from a family friend and declined offers to see it. For Paula, what had emerged from her body during induction was a highly disruptive being. She did not consider it a person, but she also resented staff calling it a ‘failure’, and eleven years after the event she still cried when she talked about the moment of death. During the interview, she veered between referring to ‘it’ and also ‘she’ and ‘he’, and she described an awareness of a missing child in her family of four, imagining the relationships the dead foetus would have had with her other children. Paula was the person in my research who most interpreted her loss in biomedical terms as the loss of a non-viable foetus, but she also struggled to consistently apply this categorisation and her emotional distress about this conflict was difficult to witness for me. I felt responsible for prompting ontological insecurity with my questions. The interview process brought to the fore the inability of the biomedical ontology of the event to completely settle what had happened in Paula’s pregnancy loss.

8.2.2 ‘The real, little, fleshy person’: the experience of foetal materiality

For the many women in my research who did have an experience of witnessing the foetal body after birth, often because they were alone at delivery as described in Chapter 5, there was an ontological conflict between discursive accounts of what they saw that categorised it as ‘not a baby’ and their own experience of the material foetal being. All of them emphasized the material reality of what they had seen and held, and many spontaneously described the foetal being as a ‘person’ as a consequence of this materiality. The need to emphasise the reality of the baby in accounts of pregnancy loss has been noted in the US context, particularly in early miscarriage where there might be some doubt about whether there is a foetal body present or the woman is 'really' pregnant (Layne, 2000, 2003a). This echoes work with pregnant women which found uncertainty and ambiguity about the reality of the foetal being before birth (Lupton & Schmied, 2013; E. Ross, 2016). Biomedical technology such as ultrasound has been found to produce such foetal beings as 'more' real (Mitchell, 2001; Rothman, 1986/1993; Schmied & Lupton, 2001). Viewing of material pregnancy remains is also linked to confirmation of the reality of what has been aborted in abortion care in the USA (A. Becker & Hann, 2021) and in second trimester induced abortion in Sweden (Andersson, Christensson, & Gemzell-Danielsson, 2014).

For women in my study in the second trimester, the material existence of the foetal being during pregnancy was particularly tangible. Many had felt foetal movement, and had witnessed more technologically mediated representations of the foetal being, such as ultrasound or Doppler representations, so they had some sense of an 'other' body in the pregnancy. An encounter with the emerged foetal body was understood as *proof* of the reality of that body as another, separate being made in the pregnancy, as Phoebe explained in relation to her son who died at 17 weeks' gestation:

> He was part of us, you know. So. I thought, I need to see him, I need to see what he looks like. To know he was real as well, because up to that point, although I was pregnant, until you see the baby you don't think…To just have some validation he was there as well.
> *So even though you'd had some scans as well, and you'd had the private scan, that wasn't the same as this witnessing?*
> Yeah, it's not the same. The real, little, fleshy person. You know?

Women who witnessed the dead or dying foetal body emphasized how much its morphology was that of a human being, with limbs and facial features. Often the sex could be determined, meaning the baby would become a 'she' or a 'he'. Hayley described her daughter's body:

> Obviously she had no hair, but you could just see where the eyebrows would have been. They have like the crease in the lip there, that we've got there. She had tiny little fingernails. You could just see like the downy sort of stuff on her as well. She just looked perfect. A bit pinker, you know, the skin was quite, it's a bit transparent, isn't it? But she was **perfect**, you just could not see that there was anything wrong.

The term 'perfect' was repeatedly used to refer to the formation of the foetal body where there was no visible abnormality, even though in the second trimester it looked different to a full-term baby, being much smaller, thinner and often with skin which was a different colour. The staging of the foetal body as a 'baby' by medical staff using clothing and blankets has been described in other contexts as part of the production of a foetal person (Mitchell, 2016). In my research, clothing was often removed during an investigation of whole or parts of the naked foetal body. Charlie's second daughter was born prematurely and died during birth. She described how she stripped the baby's blankets off to examine her, and showed me photos of the baby in which she had placed a Coke can to remind her future self of the scale. Women often visually inspected the dead foetal body in this way, for its morphological orthodoxy in relation to a prototype human body. This, I argue, was partly a check on material reality in the context of ontological disruption, a way of anchoring their experiences in a material reality evidenced by their own sensory reaction to the foetal body, rather than, as has been argued in other contexts, simply a naturalised version of the maternal gaze (Mitchell, 2016). There is a connection with research into narrations of the foetal body in foetal imaging, where the normative formation of foetal bodies can personify the foetal being (Lie et al., 2019; Nishizaka, 2014).

The morphology of the foetal body in the second trimester was repeatedly contrasted to women's other experiences of earlier pregnancy loss. Sixteen women had experienced first trimester losses as well as second trimester ones. Although these caused sadness, they were clearly defined as a different type of loss because the foetal body was less formed. For everyone in my research, this meant personhood was less developed. Charlie had been through a stillbirth and IVF and aligned her second trimester loss with the stillbirth rather than the embryos which did not survive thawing during the process which led to the birth of a living daughter. Personhood for her was not intrinsic to conception but was connected to the developed body of the foetal being. Stacey, whose daughter died as a consequence of termination for foetal anomaly, had a subsequent early miscarriage:

> I was out at [local festival], I had stomach pains, felt like I needed to go to the loo, went to the toilet, miscarried, kind of fished it out, looked at it and went 'ok'. Wrapped it up. And put it in the dustbin. I didn't think what I was doing. And then after that, I went back out again, and went 'I've just had a miscarriage.' I was at work two hours later.
> *So that one didn't have the same impact at all?*
> No. No. […] I don't know why the two are so different, I don't know. I don't even...I don't even consider the other one. As bad as that sounds, I don't even consider that one. I don't remember the date I miscarried, or...anything. I don't know why that is.
> *Is it because you saw [daughter who died in the second trimester]?*
> I think it's because she was more...she was *there*. But this one wasn't a baby. It wasn't formed. It wasn't...I think that's got something to do with it. The fact that I felt her, I saw her, I held her. She was further gone. This one - I was probably 7 weeks when I miscarried? Something like that? There was no distinguishing features, if you like, you couldn't make anything out really. I think might have something to do with it, as horrible as that sounds.

Women’s experiences of earlier loss involving undifferentiated foetal bodies were not felt to be such strong experiences of foetal personhood. In research in Catalonia, similar contrasts between personhood in later and earlier foetal losses have been understood as based in kinship resemblance (Marre & Bestard, 2009), and this will be discussed in Chapter 9.

For those women whose babies were born alive, the witness of a ‘person’ in the encounter with the living body was more straightforward, despite differences in appearance and size compared to a full-term birth. Lucy was induced in a termination for foetal anomaly and her son was born alive. She experienced his emerged presence as that of a separate person:

> He was kicking his legs. And I even heard him take a breath in. And I kept saying to [boyfriend], I was like, ‘he’s moving, he’s moving.’ […]
> *Did you have a sense of him?*
> Yeah. He had a presence. Yeah, he was definitely a person, a being in the room.

A separately living being had a strong claim to personhood through its own material body, and it produced less conflict with biomedical and legal ontologies which also defined it as a ‘person’.

For other women, particularly those who had terminations for foetal anomaly where there were obvious differences in morphology, the physical foetal body was sometimes more difficult to witness if there was visual evidence of abnormality or damage. As described above, the prospect of non-normative morphology was instrumental in Paula’s decision not to look at her foetus. However, for other women physical difference did not mean there could be no attribution of personhood. This attribution could be partial or complete. Tess’s daughter died during termination for anencephaly:

> I'd prepared myself. To, to see something that wasn't particularly pretty. […] I think they'd made that clear as well, in terms of, you know, ‘don't be shocked by what you see. Or, you, you may be shocked by what you see.’ Because, you know, especially with not having the top of her head. And so, she was like a little old man really, with just very shiny red skin, as well. Obviously very, very tiny. So didn't look like a baby, really at all.
> *Did that shock you then?*
> Well…not really. Because it's kind of like, well, she, she's who she is. And...she was who she was. And that's who she was at that time. And...yeah, it didn't mean any less that she didn't look like a baby.

Tess very clearly defined her daughter as a baby and person despite abnormalities in her appearance which made her look different to a full term and fully developed baby, and which made other people more doubtful of the baby’s status. When other people made judgements like this, that the foetal being did not have the appearance of a ‘real’ baby, these conflicted with the reality experienced by women. Natalie’s mum asked to see photos of her son who died *in utero* at some time before 20 weeks’ gestation:

> I think she wanted to say the right thing, but really she said the wrong thing. She said, 'aw,' she said, 'at least you know it didn't look like a real baby.' [laughs] Bless her. She's so amazing, my mum, but sometimes she just says the wrong thing. But she thought she was saying the right thing. She was trying to sort of like, you know, make it **less**. Less...emotional for me. But I said, 'but mum, it does! It does look a real baby!' You know, 'and I **want** it to look like a real baby.' She was like 'oh, oh, well yeah...'. You know, because he didn't have proper eyes and a face...and I knew what she meant, but I was like...[rueful laugh]

Ontological conflict was produced in several such cases where women felt that the foetal being having a broadly human form was part of it being both ‘real’ and a form of person or baby, but other people actively tried to persuade them otherwise by comparison with the bodies of full-term babies. This is reminiscent of the distinctions made between ‘real’ relatives and stepfamilies in English kinship (Edwards, 1999). In both cases, someone claiming full kinship may make assertive claims against the norms of relatedness or personhood, in this case about being mothers to persons, which others do not recognise. In my research, ontological conflict was produced by biomedical-legal discursive categorisation of the born being as a non-person. These conflicts were the consequences of different ontological positions on the status of the foetal body. They caused disruption to the women in my study because they clearly illustrated different ontological positions on the personhood of babies. They can also be understood as destabilising in the context of Strathern’s findings on English kinship (1992), further discussed in Chapter 9, in which the visibility of individual persons, for example through prenatal ultrasound, forms the basis of relatedness, and notions of the individual are based in the body. When the individual foetal body had been encountered by my participants it therefore formed the basis of personhood and then of kinship, as I will consider further in Chapter 9, yet all around them other people were dismissive of this reality.

8.2.3 Birthing a person and a mother

Phoebe, whose witnessing of the ‘little fleshy person’ was so important, also emphasized how her own experience of labouring and giving birth to his body was involved in making her son a person:

> People say ‘you didn’t have a baby’, but I **did**. You know, it’s not the normal birth story, it’s not the normal labour story, but I can tell you: **I had a baby**. Whereas people who have never been through it or know about it, don’t associate the fact that I did actually give birth to a person. Yes, he’s not here. It’s no different to if I did it at 40 weeks. He is a person, I saw him, he’s got fingernails, you know? And I don’t think…it’s really hard for other people to comprehend that he was a person and it did actually happen?

There is a form of relational materiality here derived from the interaction between the pregnant woman’s body and the second trimester foetal body which is actively birthed. More than half the women in my research had experience of labours and vaginal births in previous pregnancies and were in a position to notice similarities between full term, live births, and those of second trimester babies. The emergence of these, even those who were not subsequently looked at or touched, was physically felt moving through the vaginal passage. Holly had a full-term vaginal birth, and then first trimester miscarriages, before her second daughter died in the second trimester:

> It's still sad having an early stage miscarriage, I don't take that away from any woman that have had them. I had a few before I lost [daughter who died in second trimester]. And you know, it was awful, it was dreadful. But. It doesn't come close to having given birth to your dead daughter.

For Holly, the physical experience of second trimester loss was closer to the process of birthing her living daughter than the experience of earlier miscarriage. Similarly, Kerry had had surgical terminations and first trimester miscarriages and she felt very strongly that these were different to the experience she had with her son who died in the second trimester, which she aligned with her full term births:

> He was a baby. Ok he wasn't a chunky big fat baby that, you know, like when they come out. But he was a baby, because every single part that needed to be there, was there. So to define that as something which...is not. Like when I had the 8 week [miscarriage], looks like, to be fair, lots of clots. They're not even in the same category, so why they are put together is not…I don't think it's fair.
> *So the things that you are saying are making a difference are the level of development of the body?*
> Yeah.
> *And also the experience you went through in giving birth? Because that was different?*
> Yeah. Obviously it's different to a normal birth, but roughly the same principle.

There is thus an embodied knowledge produced by the bodies of pregnant women in relation to foetal bodies and the physical processes of labour and birth which cause them to emerge (Walsh, 2010). Others have claimed that the birthing body does not have an essential nature despite its materiality (Chadwick, 2018), but in this research the material and embodied experience of birth instead produced knowledge about the essential nature of *reality* for the women involved. This knowledge claims that the beings which emerge from a labour and birth are forms of person. The process by which it is produced is a reflexive one which draws on previous experience of close relationships (Edwards, 1999) and also on embodied experience.

At the same time, the processes of labour and birth, and for some women, lactation, were understood by women in my research to have completed a transformation of themselves into mothers which had begun in pregnancy. This echoes findings in English kinship whereby children create parents as well as vice versa, and there is a particularly connected relationship between a pregnant woman and the baby she gestated (Edwards, 1999). Those women whose first labour ended in the second trimester saw the process of birth as a rite of passage which had made them mothers, even if the baby had died, and even though they had no other children. As Bethany explained shortly after the death of her first baby:

> Me and [husband]...to each other, would say that we are Mummy and Daddy. But...I wouldn't expect other people to see that. I don't think. Because...I think again because there's this whole like, 'miscarriage' thing. I suppose. I don't but I feel like because I did have this labour and experience, and we met him, and we named him, that, I feel that's why I feel like I'm a mum. But I don't expect other people to understand that because before I wouldn't have? Because I wouldn't have understood what they'd been through?

The experience of labour and birth was significant for both the labouring and foetal bodies involved, and in Bethany’s case also for her husband who witnessed her efforts and looked under the sheet to see the little baby boy. This echoes ideas in English kinship in which there is a special connection between pregnant woman and born child beyond any genetic or ‘blood’ connection (Edwards, 1999). In my research, labour and vaginal birth were experienced as producing both mothers and new persons through the ‘body-in-labour’ (Akrich & Pasveer, 2016) in relation to the ‘body-being-born’ (Lupton & Schmied, 2013), whether that body was alive or not on birth. However, it was clear to women in my study that this was not a widely shared ontology of pregnancy, personhood, or motherhood in relation to second trimester loss. In an example of socially withheld matrescence, motherhood would not be publicly recognised in the circumstance of second trimester loss, if the foetal being was born dead. Women were thus placed in an ambiguous position in relation to motherhood identity, particularly if they had no other living children to act as the threshold to motherhood, as Louise explained: ‘when you lose one child you're like, not a mother, you're a nothing?’.

Pregnancy loss in general has been interpreted as disruptive because the failure of the project of a child (Memmi, 2011), and because of the loss of potential motherhood (Layne, 2003a). However, in the second trimester the impact is different because the embodied experiences of labour and birth and the possible encounter with a foetal body mean women experience conflict between their own ontology of what has happened, based in material bodily experience, and that of dominant discourses which do not acknowledge these experiences. Women’s responses to this conflict will be discussed in Chapter 9.

8.3 ‘I just felt like a ghost’: the disappearance of the pregnant self

Women in my research, having experienced in disruptive and shocking circumstances what they understood to be labour, birth, and the encounter with the human-shaped body of another being, then found that their interpretations of these events were unrecognised by other people. This is the point at which ontological disruption became a reality for them. It was clear that they were experiencing the world very differently to other people. A key factor in the reality-disrupting experience of second trimester pregnancy loss was the sudden disappearance of the pregnant self, in terms of both the physical body and the social identity. Pregnancies in the second trimester have usually been publicly announced, and therefore have socially come into existence, often by the sharing of routine ultrasound scan images around 12 weeks. Pregnancies are also often visible to other people, including strangers, through the growing abdomen of the pregnant woman and her pregnant shape. Other people may, towards the end of the second trimester, have felt foetal movement through the pregnant woman’s abdomen, seen images of the foetal being, and heard Doppler mediated heartbeat sounds. When such a pregnancy ends, the woman is suddenly visibly not pregnant any longer, but there is no baby to show. Women are then repeatedly questioned about what has happened. Heather went back to work as a secondary school teacher after her first second trimester loss and stood in front of her students with her suddenly not pregnant body:

> They were aware [of the pregnancy]. And they did say, 'Miss, have you had your baby?' And I had to say, you know, 'unfortunately...'

Heather was later ticked off by other teachers for telling these students what had happened to her, with the implication that it would have been better to somehow conceal the loss because it was too shocking for her students to be exposed to.

The need to explain the disappeared pregnancy to relative strangers, and a wider range of people than an earlier loss, came up for many women, including all those with public-facing jobs. Joelle was a retail manager:

> I had...a customer at work that knew that I was pregnant. He'd not been in for a while, because he's like, on a yacht and he goes away for a few months. And he came back, and he was like 'oh, how did everything go with the baby?' And I was like, 'Oh, baby died.' And he was just like, 'oh, shit!' [small laugh] And then he just didn't know what to say. [pause]

Social ruptures were repeatedly caused by announcing news of the end of the pregnancy in a public context. The pregnancy had disappeared in a disruptive manner, leaving an important rite of passage incomplete. The soon not to be pregnant woman, or the post-pregnant woman with no baby, was marked as a liminal and disruptive being, who was socially and physically isolated from others, or felt herself to be marked out as transgressive. Fiona and her husband ran a small shop and had excitedly told all their customers about the coming baby. Fiona felt compelled to announce that her son had died while she was still waiting to be induced in order to forestall any difficult questions. However, reactions from other people, including people close to her, were often of horror or embarrassment and resulted in her social exclusion:

> I understand that people don’t know what to say. I understand that. But…it was quite difficult when I would go for days without hearing from people that you would expect to hear from. You know. A message to say ‘thinking of you.’ Anything. Sometimes I…I guess I’d have hoped for more. But then I, at the same time I understand why there wasn’t.

Like so many women in my research, Fiona disappeared from normal social life whilst being simultaneously very exposed to the possibility of awkward social encounters and public scrutiny and gossip – ‘like being an animal in a zoo’, as Georgia said. The incompleteness of their pregnancies in relation to the teleological ontology of what pregnancy *is* rendered them liminal and socially disruptive to the point where their own personhood could be called into question. Feelings of panic on encountering others during or after the pregnancy loss were common and were linked to a sense of responsibility for social disruption. Eva felt herself to be highly disruptive to others, to the point where she minimised her experience when she emerged into society suddenly not-pregnant:

> I remember I just felt like a ghost, going back to do the school run again, and then having to face everyone in the school playground. It was horrific. And then, yeah, I just remember people coming up to me and not knowing. […] Having to make them feel that it's fine that they've asked, because you're giving them some bad news, but it wasn't their fault. They didn't know.

Waiting for induction for termination for foetal anomaly, Lucy couldn't decide how to manage the public presentation of her still-pregnant body in a way which would minimise the disruption of what was happening to her when she encountered others:

> I just remember sitting on the end of my bed and looking at my wardrobe thinking, 'I've got no idea what to wear, because I don't want people to see that I'm pregnant. Because I can't have that conversation, I've got to wander around now for 2 days with my pregnant tummy and people might say 'oh, when's it due?' Like, just floods of tears thinking 'I don't know what to wear, I've got no idea what to wear, I don't know whether to wear maternity stuff.' Just not wanting to go outside, but having to.

This anxiety about exposure, about the right to claim the status of maternity, and the sense of having to hide the ambivalent pregnant self, extended for many women to the hiding of the whole self after second trimester loss. Natalie explained how this public stage of pregnancy affected her:

> Everybody knew. Everyone. So I'd go to Tesco in [town] and I'd see people and I'd literally hide. You know, I'd go into the next aisle. Because I didn't feel right in Tesco explaining to them what had happened. For a long time, actually, I kind of hid away a bit.

Kerry’s son was born alive and so she was able to take maternity leave. She described how she spent months in her pyjamas:

> I didn't got out, I didn't go anywhere. I didn't want to speak to anybody, I didn't want to see anybody. […] I used to pick a time to go in a supermarket and I would literally go in and keep my head down and pray nobody would speak to me. And tried not to make eye contact with anyone. I wouldn't look at anybody on the street. I had to keep me head down and walk. I didn't like going into town. Didn't even see my friends.

The contrast of their situations with still-pregnant women was also very difficult to manage for the women in my research. A few weeks after her daughter’s death, Joelle had to attend her a family funeral, and when her fiancé’s pregnant cousin arrived she ran upstairs to avoid her. When that baby was born, Joelle found the celebratory pictures on social media distressing and blocked the cousin’s posts. For a while, she took herself off Instagram and Facebook completely because of the contrast she perceived between her own life and that of the ‘perfect lives’ of others, effectively removing herself from part of the social world as a result of her second trimester pregnancy loss. Second trimester pregnancy loss produced conflict between embodied knowledge and discursive knowledge, in which the dominant discourses of biomedicine and the law could actually temporarily cause the material body of the pregnant woman to disappear from social worlds.

8.4 Disappearing the baby, disappearing the loss

As the pregnant self disappeared, so did the baby, and the disappearance of the baby meant the disappearance of bereavement for the post-pregnant woman. As described in previous chapters, the baby was structurally disappeared by the lack of official personhood and kinship recognition, and by those special arrangements made for the disposal of its body which produced it as a less important type of dead being. It was also disappeared in everyday interactions in which the ambiguity of the event of second trimester loss was emphasized. Holly came out of hospital after her daughter died to find that all the baby things she had prepared had been cleared out of her home by well-meaning friends:

> There wasn't a sign of her stuff. It was all in the loft. Even down to like, I'd bought big things of wet wipes. Everything. It was all gone. […]
> *Did you feel like that was stopping you talking about it?*
> Yeah. […] 'It's gone now, you have nothing to...' I know they were trying to be nice. But like I said to my partner, we, we should have been the ones to take the cot down.

Holly and her fiancé were well known in their small town, and many people knew about the death of their daughter, but social recognition of the event was patchy and fraught with anxiety. Everyone in my research struggled with disclosures of their loss. Amber explained how there was not even language to describe what had happened, because if she said her baby died ‘at five months’ people would assume this was five months post-birth rather than five months into the pregnancy. Pregnancy could not count as part of the existence of a foetal being, which only came into reality at birth in the prioritised teleological ontology. When, whether, and how to talk about what had happened was a constant anxiety. Public descriptions of family size, particularly in relation to the common question ‘how many children have you got?’, descriptions of birth order, or explanations of large gaps between children became fraught with difficulty because of the categorical ambivalence of second trimester loss. Esther, whose first son died after premature labour, expressed the problem for many women:

> It can like, stop a conversation or people can sort of freak out a bit. And not know what to say. And so sometimes it’s easier not to. And I found that particularly hard, especially when I was expecting [second son] because people would constantly say, ‘is he your first? Is he your first?’ And that would make a dilemma, like, do I say? And if I don’t say, then I’m kind of almost like denying [first son] ever existed, but it’s just easier not to.

There was deep discomfort about not declaring the existence of the baby who died, but there were also many occasions on which it was too socially disruptive or emotionally exposing to do so. This heightened a sense of having a private reality which conflicted with a public one.

When the loss was made public, sometimes because of the visibility of the pregnancy, experiences of pregnancy loss were routinely minimised by other people. Pressure was put on post-pregnant women to accept what had happened and put it down to fate. Georgia’s first son’s postnatal death was discounted by many of her acquaintances and she was encouraged to adopt a fatalism around her loss which she felt diminished it:

> 'Some things aren't meant to be!' […] Or 'everything happens for a reason.' That's the one, that is the worst one. Because...no one would say that about a grandparent that had died, or your auntie or uncle, or your parent that had died. But they can say it about a baby. And I just....I've had so many people say that to me. 'Some things aren't meant to be.' Or like, 'everything happens for a reason.'

Chloe’s encounter with a neighbour was illustrative of how foetal beings are understood to be replaceable and their deaths only minor events. She met her neighbour when she was walking her dog a few weeks after the *in utero* death of her first daughter:

> She knew that I was pregnant and she said 'oh how are you?' sort of thing, smiling, kind of looking at my belly kind of thing. And I just stuck my head down and I was kind of like, 'no, not good to be honest.' And I said, 'she died.' […] And she said, [dismissive tone] 'oh I'm so sorry, oh that's awful, oh, but you'll try again soon!'

The socially minimised disappearance of babies such as Chloe’s daughter, and the consequent minimisation of the event of bereavement led women themselves to minimise their own experience and place it as insignificant in a discursive hierarchy of loss. This hierarchy placed pre-24 week loss alongside earlier miscarriage as less distressing than stillbirth or neonatal death. Eva wondered, ‘am I making a fuss?’ when her son died *in utero*:

> All the time in my head I was like 'you shouldn't be grieving, you don't really have the right to grieve this baby, it was tiny...'

Women attempted to discipline themselves to accept the loss as insignificant, making comparisons to ‘worse’ situations such as stillbirth. However, some came to resent this pressure and its consequences. Bethany accepted a group cremation offered by the hospital because she felt excessive in claiming her son’s death as a bereavement, even though she would have preferred a separate funeral:

> I felt very...like...worried about what people would think.
> *That you were making too much of a fuss?*
> Yeah, because I was '**only**' 17 weeks. Which is what I said. That's what I said to everyone for the first month, 6 weeks, at least. It was 'I was only 17 weeks.'

Most of the women in my research felt at times that they should attempt to conform to social expectations based on a teleological ontology of pregnancy which said that a loss was unimportant before 24 weeks or if the foetal being died *in utero*, but then found that this was difficult to align with their own feelings and experiences. This contrasted with those women who experienced a spontaneous live birth and had the personhood of their baby validated by the biomedical-legal model, who did not report the same internal confusion, though they sometimes still had conflict with other people about the reality of the existence of their baby.

8.5 Transgression of the role of mother

The right to grieve for a person, and to claim a status as bereaved mother, was also undermined by a sense of failure in the role of pregnant woman, connected to the role of the ‘good mother’ who optimises the development of the foetal being (Longhurst, 1999; Lupton, 2011). Chloe, whose neighbour was so dismissive of her loss, felt a sense of personal failure:

> I keep thinking to myself, my body is supposed to protect her, grow her, you know, ultimately my body is supposed to be the safest place for her, it's where she's meant to be. And it let her down. That's my mindset.

Women who had spontaneous losses felt responsibility for the loss having occurred at all, and this ‘failure’ to mother meant they could not easily in themselves claim the status of bereaved mother. Other people were also sometimes quick to accuse the pregnant woman of an inability to nurture the baby that died. Simone phoned her mother-in-law when it was discovered that her fourth baby had died *in utero*:

> The first thing she said was, when I said 'I've lost the baby', she could barely hear me because of the signal, she said to me [contemptuous] 'oh you haven't lost that baby, have you?' [pause] And I don't get on with her the best anyway, but I was just like, 'oh...' Like, she basically blamed me, I suppose.

Women who had undergone termination for foetal anomaly in wanted pregnancies found it particularly difficult to make sense of what had happened, with consequences for their own ontological security and their place in the social order. Amber tried to explain:

> It was really hard to know how to describe it. Afterwards.
> *To other people?*
> Well, even in my head. Like, not that I told that many people. But. I didn't 'lose' a baby. I hadn't lost a baby. I'd, I'd killed my baby. But for the right reasons. [crying] What? There's no other word is there? […] So it's a hard one. Once it happened, I wanted everyone to know, and no-one to know. I couldn't look people in the eye. I felt really ashamed.

Women felt that the necessity of giving consent to termination framed it as a ‘choice’ which was a highly ambiguous one. It was understood as an attempt to avoid suffering, which itself was a form of care of the foetal being, but a form of care which also conflicted with social constructions of the good mother in its taking rather than giving of life. There was a constant anxiety around disclosure and the possibility of moral disapproval based in not knowing the other person's position on abortion. This could be seen during my fieldwork: when I was setting up interviews, or early during the interview women carefully sounded out whether I included termination as 'loss' and whether I was likely to be supportive of their decisions before they disclosed their story. All the women who had had terminations experienced a particular social difficulty in relation to claiming acknowledgement of a termination as a loss. Gemma explained:

> I found it quite hard to talk to people about it as well. Because, because you've…because there's that element of guilt because you've made the decision, as well. So there was that thing of, oh, people might just think that I've chosen to do it, so why? Rather than losing a baby naturally, I don't know. It seemed, it just had a different sort of thing. Because you'd had to decide as well.

This difficulty in relation to being entitled to grieve or claim support for bereavement through termination, was starkly illustrated by Alice's experience of terminations either side of viability. The first baby who died, the couple's third child, had been diagnosed with a condition incompatible with life and had died through termination in the third trimester. She was registered as a stillbirth. The second baby had Down's Syndrome, diagnosed earlier in the second trimester and Alice and her husband felt the decision to terminate was less clear cut and that people might condemn their decision this time. They deliberately minimised the death of the second baby to their wider social circles:

> When it came to it, we didn't tell anyone. We told my parents, and my [siblings] that we were going to have a termination. Everyone else we told that we had a miscarriage. We couldn't handle talking to anyone any more about any of it. And if you just say to someone 'oh, I just had a miscarriage', they're like 'oh, that's really sad, poor you.' And then they move on. That was the easiest. Because we couldn't handle being sent a million beautiful olive trees and rosebushes and [food] parcels and lovely

> letters [as they were sent with the first termination]. I don’t know if it’s just because we couldn’t cope with that? We didn’t want it this time. I don’t know why. […] It was like, everyone’s being so kind but they don’t need to do that again, they’ve done it. They’ve shown us how much they love us, and that’s fine. And also secondly I can’t bear everyone talking about our decision. I think probably cos I hadn’t figured it out, and I still haven’t figured it out in my head.

Similarly, Paula struggled to articulate the extent to which her termination and an earlier miscarriage threatened her identity as a successful mother and woman despite having four living children:

> I remember when I had my miscarriage, that's the feeling, there was a feeling of failure. Not failure? But...disappointment, and that you, as a woman, that 'oh I didn't, I didn't manage to have a baby, you know, I got pregnant but didn't manage to make it into a baby, or it didn't work...' That there's actually a bit of, not **shame**, I don't like to use the word shame, but do you know what I mean? There's that. That actually just to put your hand up and say... that you feel that you don't belong...not to **society**, but do you know what I mean? […] But even like going up to your parents, saying the baby's, I've lost the baby, or the baby's...you know. You feel like 'oh I've let everyone down.' All I had to do was have a baby.

The reproductive disruption of second trimester loss, spontaneous or induced, was highly threatening to understandings of the self, and of one’s ability to adequately fulfil the sexed and gendered roles of ‘pregnant woman’ and ‘mother’. Yet this disruption existed alongside the sense of accomplishment of part of those roles in having made the physical body of a person, having laboured and birthed it, as described above. Women in second trimester loss thus experienced themselves to have been both pregnant women and mothers to babies, and yet simultaneously not having achieved these adequately in the eyes of others. This reinforced the ontological disruption of second trimester pregnancy loss.

8.6 ‘Anything can happen’: the endurance of ontological disruption

Reproductive disruption endures beyond the immediate event and necessitates the reframing of expectations and relationships on a wide scale (Rapp & Ginsburg, 2009). After second trimester loss, women were often left with a level of insecurity about the world which leached into other areas of life and amounted to an enduring ontological disruption. Fiona felt her son’s sudden death *in utero* disrupted her ontological security even more than the sudden death of her father during her childhood:

> It’s left me with all this anxiety about what can happen in life. The thing is, I started worrying about [husband] dying, and me dying…And I still do, I’ve always had those fears, obviously, since my dad died, but something like losing a baby happens and you just realise **anything** can happen.

Fiona spoke to me after the birth of her second son, whom she held in her arms throughout the interview. His was a stressful pregnancy and she described herself as never feeling safe when pregnant with him. For many women, second trimester pregnancy loss destroyed their trust in pregnancy as a process which could have the outcome of a living baby, that a baby could survive at all. For many of the women, the pregnancies of others were experienced as disturbing and unsafe. Kerry explained:

> I feel bitter and twisted. When somebody goes 'I'm having a baby, and I'm so this, and my life's this...' I just think, ‘do you know what? I don't want to piss on your parade, but you don't actually know what's going to happen around that corner. You don't know what's going to happen.’

For Kerry, the pregnancy which ended in the death of her third son after premature labour had been her last. When I spoke to her she was about to have a hysterectomy and was facing having no biological children with the father of the son who died, who himself was ambivalent about that son’s personhood. She described to me how the disruption to her plans of a new relationship cemented by a child together, and the lack of acknowledgement of her third son by his father and others was so distressing that it had led her to contemplate suicide. Her difficulty with the pregnancies of others, however, was not unique to her, with many women describing distress at witnessing other pregnancies and a sense of doom around all pregnancy which was at odds with the usual cultural presentation of pregnancy as hopeful and positive.

Apart from Kerry, for whom the possibility of being pregnant again was removed, the other women in my research had either been pregnant subsequent to loss, were pregnant when I spoke to them, or hoped to be pregnant again in future. For all these women, the possibility of a positive pregnancy was permanently shifted by loss, as Rachel, whose first daughter died after premature labour, described:

> I remember when we were going through the pregnancy with [second daughter], it was like, oh, to be that ignorant again! And to not have all this knowledge as to what could go wrong. What can happen. Just to be in that naive bubble again. You would give anything to go back into that bubble.

The impact of the second trimester loss on subsequent pregnancies had different consequences for these women depending on the explanations given for the loss. A lack of biomedical explanation for the second trimester loss was disruptive because it suggested the possibility of unexplained reoccurrence. Eva was given no explanation for her son's death *in utero,* and she believed throughout her subsequent pregnancy that the new baby would die. This invaded her every waking moment and even her sleep, where she dreamt about dead babies. Simone, whose fourth pregnancy and first daughter had ended in foetal death, quickly became pregnant with another girl and had a very stressful pregnancy constantly checking for signs of foetal life:

> I was just absolutely an emotional wreck with her. I had to wait for the kicks before I got up, wait for the kicks when I'd have breakfast, it was just always 'wait for the kicks, wait for the movement.'

Spontaneous second trimester loss meant there was never a safe point in pregnancy where women could relax. The similarity to stillbirth in terms of the experience of labour and birth meant that even after 24 weeks many women felt there was no security in pregnancy. Tamsin's twins died *in utero* and she described how much she wanted another child to be a sister to her older daughter, and a living child for her new husband. But she felt could no longer rely on there being any safe point in pregnancy after an early miscarriage and then the death of the twins and now was worried about stillbirth and neonatal death as well as pregnancy loss.

Women who did have a biomedical explanation faced a different type of disruption. For those women who underwent termination for foetal anomaly, there was the fear of repetition of the condition. Where the condition was genetic, such as Smith-Lemli-Opitz Syndrome in Amber's family, subsequent pregnancies were stressful as genetic testing was carried out to rule out a repetition, with the knowledge that termination might have to be faced once again. Sometimes a genetic link was not found but there was still a threat to subsequent pregnancies. Gemma's second daughter had a fatal heart condition and she underwent termination for foetal anomaly, but then her subsequent daughter was discovered in utero to have a different, milder, heart condition which she survived. For Gemma, the extreme stress of these two pregnancies meant she ended her reproduction once she had two living children. For other women, serious consideration had to be given to undertaking pregnancy again even when they wanted more children. Lucy's second child died as a result of termination for foetal anomaly, but this loss alongside trauma from her past contributed to serious postnatal depression after the birth of her subsequent child. Reality was so distorted by her experiences that she had postnatal psychosis and was sectioned. She would like another child, but she knows that this could jeopardise her life, so this will be a considerable risk if she does become pregnant again.

8.7 Conclusion: the particularity of ontological disruption in second trimester pregnancy loss

This chapter has shown that the experience of second trimester pregnancy loss managed in the English NHS by labour and birth is an experience which can produce enduring and serious ontological disruption for the women who go through it. Though all pregnancy loss is potentially disruptive to the life course, the experience of second trimester loss has particular characteristics which set it apart. Often knowledge of foetal death or likely death is mediated by biotechnology and conflicts with the embodied experience of established pregnancy, causing ontological confusion. Then the material and somatic experiences of labour and birth, and encounters with the born and formed foetal body mean that this is not just the loss of a *potential* child, but an actual *specific* human to whom most women in my study considered themselves to be a mother. Yet the biomedical-legal ontology of pregnancy described in previous chapters specifically states that most births in the second trimester are not those of babies or persons, and that the pregnant woman cannot be a mother to a non-person. Matrescence is thus socially withheld, threatening the public social life of the post-pregnant woman, who is made liminal and disruptive, even as her baby is actively physically and socially disappeared. She is no longer able to rely on ontological security in relation to her narrative of self, or the nature of existence, or the nature of other persons, when it turns out that what she believed to be a person is not accepted as such by others. The conflict between her reality, experienced through her own and the foetal body, and the biomedical-legal discourse built on a teleological ontology of pregnancy which discounts this is profoundly destabilising. This can produce a perceived need to withdraw from society, feeling shame and confusion. At the same time, the material reality of pregnancy, which in the second trimester is obvious to others, means that there is reoccurring need to explain the sudden disappearance of the pregnancy and the baby. For women who have been through termination for foetal anomaly, it is particularly disruptive to try to reconcile the biomedical discourse which frames this as their ‘choice’ with the discourse which says a good mother protects her foetus during pregnancy. These ontological disruptions take place in conditions of reproductive politics in which there is a lack of control for pregnant women over the definition of their pregnancies, their foetal beings as foetuses or babies, and themselves as non-mothers or mothers. The following chapter will show how in the face of this ontological disruption, women turn to an alternative ontology, that of kinship, to assert their own agency in second trimester pregnancy loss.

Chapter 9: Resistance and agency in second trimester pregnancy loss

In previous chapters, I have shown that women experiencing second trimester pregnancy loss are subject to obstetric violence which disciplines them as deviant bodies which will not produce a living child. They have encountered bureaucratic exclusion and incoherence about the status of the event they have experienced. Their motherhood may have been called into question, and any official personhood they may wish to claim in relation to their baby is likely to have been denied unless the baby was born alive. In Chapter 8, I showed that second trimester pregnancy loss in England can call into question ontological security, resulting in serious disturbance in the nature of reality for those women who understand themselves to have had a pregnancy which resulted in a baby, now dead, who was nonetheless some form of person. This chapter shows how some women exercise agency in responding to this disruption. I argue that finding themselves in conflict with the biomedical-legal teleological ontology of pregnancy, which broadly defines them as non-mothers and their babies as non-persons, some women engage in agential social thinking and action which takes the form of resistance.

Some of this resistance is built on their experiential knowledge of pregnancy and birth, which can be opposed to biomedical knowledge (Abel & Browner, 1998), a conflict described in the last chapter. However, it is given authority and weight through being explicitly and strategically connected to an alternative authoritative, and readily available ontological position: the English ontology of kinship, as understood and practiced by the participants in this study. Using this way of thinking as a strategy of resistance, women in my research were able to move themselves away from Giddens' (1991) state of ontological insecurity and to actively produce continuity in the face of reproductive disruption (G. Becker, 1994). Faced with the minimisation and marginalisation of their pregnancies and losses, to varying degrees, using different strategies, and through different practices, women claimed their babies as human persons, situated in a kinship system in which they themselves were mothers to that person. This is 'kinship thinking', already noted in English ethnography (Edwards, 2000; Strathern, 1992), whereby social ties are modelled on concepts of pre-existing biology, and where new and complex situations can be actively understood through links and comparisons to already existing modes of thought. It is also an illustration of the creative potential of human engagement with ideas about kinship (Carsten, 2004), the reflexive and recursive character of human agency in relation to social structure (Giddens, 1984), and the agential potential of women in navigating reproductive mishaps (van der Sijpt, 2020).

This resistance in second trimester pregnancy loss to the English biomedical-legal definitions of persons, mothers, and pregnancy does not only exist at a discursive level but also draws on embodiment and materiality as sources of reflexive and generative social action, knowledge, and power (Foucault, 1977/1991; Shilling, 2012). Women's knowledge of the foetal being and their own relation is partly derived from agential reflection on embodied experience, such as pregnancy, labour, birth and encounters with the foetal body, as described in Chapter 8. It also derives from practice, particularly kinship and motherhood practices, in which the basic ontological reality of the foetal being and its relationships are not just seen from a different perspective, but are actually made into a different ontological object by what is effectively a different belief system (Mol, 1999, 2002). I argue here that women in my research were approaching the second trimester foetal being through a kinship ontology rather than the biomedical-legal ontology with which they were presented at the time of the event, and that this became a source of, and strategy of, resistance as they came to terms with what had happened to them.

9.1 English kinship ontology

All my participants in the South West were actively using the English kinship model, described over the last few decades by anthropologists: Rachel, who had knowledge of her parents' Chinese kinship ontology, actively rejected this in favour of the English approach because her parents' did not agree with her attribution of personhood to her dead daughter, or with her continued memorialisation of her daughter's death. I therefore briefly sketch out the key relevant features of English kinship here, as found in the ethnographic work of Strathern and Edwards in particular.

From Strathern, the main premise is that the English think of family as based in primordial natural ties between persons which exist prior to culture (Strathern, 1992). Persons are thought of as separate individuals, located in bodies. This is highly relevant to second trimester loss, in which the foetal body is visible and often encountered by the pregnant woman. The body of the foetal being in the second trimester produces a strong claim to personhood in the English system. However, this is situated in an ontological position about personhood and kinship. As Strathern describes this thinking, there is a fundamental idea that people exist as entities outside their relationships, because they are pre-existing material beings. This means that the alternative, that relationships are the building blocks of kinship, is to some extent optional, and kin can be shed, ignored, or excluded, or, conversely, can be privileged and prioritised (Edwards & Strathern, 2000). Furthermore, this element of selection and choice can be naturalised (Strathern, 1992). In relation to the second trimester, this means that in the same way as some persons can be ignored at the fringes of the kinship system, so can others be brought into the centre of it, including foetal beings and the dead, as I will detail below. The key to this choice, as Strathern states, is the degree of emotion felt about particular kin. This, in second trimester loss, accounts for different responses and degrees of kinship claim for different pregnancies and losses, some of which is described below. This echoes Strathern's assertion that the second 'fact' of English kinship, after the individuality of persons, is diversity (Strathern, 1992).

The idea that one should have a choice about kin, and one can have the agency to define it, is particularly useful to women resisting alternative categorisations of their babies and themselves, such as that produced by the biomedical-legal teleological ontology of pregnancy. It echoes processes of 'kinning' described in the Norwegian context, where a being is brought into a permanent relationship expressed through kinship, perhaps where that relationship is not already a given (Howell, 2003). The processes by which the divesting and prioritising of particular kin relations can occur in the English system include some people having a particular role in mediating kinship links, especially in ambiguous situations such as stepfamilies (Edwards, 1999). Strathern says that in English kinship, identity is understood to flow from parent to child (Strathern, 1992), and I argue here that this ontological position presents pregnant women with the possibility of defining their own babies as persons. In addition, children are understood in English kinship as creating parents (Edwards, 1999). Relationality embedded in biology is therefore intrinsic to the understanding of what kinship and personhood *are* at an ontological level. In the second trimester, the pregnant woman, defining herself as mother, can seek to define her foetal being as person, often invoking the ‘natural’ body of the foetus and its ‘natural’ connection to her own body to justify this, as I showed in Chapter 8. This picks up on a theme in kinship and reproductive literature identified by Strathern and developed elsewhere: the role of procreative intent in the definition of parents, and how this is naturalised (Strathern, 1992; Thompson, 2001, 2005). It is highly relevant in situations where there is no living separately born child, as in much of second trimester pregnancy loss, but parenthood and kin relations are still claimed in relation to that being. It is also highly relevant to termination for foetal anomaly, in which foetal personhood can be attributed at the same time as the pregnancy is ended.

The characteristics of English persons, then, include that they exist in separate bodies. In second trimester loss, this is the first claim that must be made to resist the biomedical-legal ontology of pregnancy which says second trimester foetuses are *not* persons. I will argue below that besides their own experiential evidence of the foetal body described in the last chapter, women use evidence from biomedical technology in a reverse discourse (Foucault, 1976 /1998) to prove their babies *were* persons. However, on a secondary level, persons also exist in relation to others in the English system: they are embedded in and embody kinship (Edwards, 1999, 2000). In circumstances of second trimester pregnancy loss, I then show that in order to resist the definition of their babies as non-persons, women situate them within kinship networks, by aligning them with other babies and other persons within their family, including other dead persons. In English culture, death is not necessarily a barrier to continued personhood (Strathern, 1992) or social identity (Hockey & Draper, 2005), and I argue here that this applies in second trimester pregnancy loss. This echoes findings from death studies about continuing bonds between living and dead persons, including dead children (Klass, 1993; Klass, Silverman, & Nickman, 1996; Mathijssen, 2018; S. Murphy & Thomas, 2013; Walter, 1996) and from anthropology about how the dead may continue to be persons for the living (Despret, 2019; Lambek, 2019). In this way, I set out some of the kinship strategies which women in my research used to assert their resistance to the biomedical definition of their babies as non-persons and themselves as non-kin to them.

9.2 Biomedical evidence of the foetal body as a reverse discourse of personhood

The first problem which women need to solve in order to claim the foetal being as a person using an English kinship ontology is that of the separately embodied nature of persons. In Chapter 8, I described the presence 'in the room' of the born body of the foetal being and how this challenged the biomedical-legal ontology of non-personhood. This was an example of how the body can be 'pressed into service' in competing status claims, which I argue is particularly relevant to second trimester pregnancy loss with its high levels of visibility of the foetal body (Hockey & Draper, 2005, p. 47). I now show that women also use evidence from biomedicine itself to claim foetal personhood through evidence of the foetal body in the second trimester of pregnancy. This contributes to literature which has demonstrated the lay use of biomedically produced representations of the body of the foetal being within kinship and personhood discourses and practices (Han, 2009; Keane, 2009; Kroløkke, 2011; Middlemiss, 2020a; Roberts, 2012; Taylor, 1998). In the US context it is already established that biomedical evidence is used to represent the personhood of foetal beings in pregnancy loss (Keane, 2009; Layne, 2000). However, I argue that in the English context and in the second trimester, biomedical evidence is not simply a neutral 'proof' of personhood, but is used strategically and politically as a reverse discourse to claim personhood *against* the biomedical-legal ontology of no personhood without separate life before viability.

Reverse discourse was conceptualised by Foucault, who showed how in the nineteenth century discourse on homosexuality as a pathological category both made social control in this area stronger, but also provided a way for homosexuality to claim its own legitimacy and natural origins, '…often in the same vocabulary, using the same categories by which it was medically disqualified' (Foucault, 1976 /1998, p. 101). Reverse discourse is a way in which power can be exercised in the form of resistance. I argue that the power of biomedicine to define some babies as persons and some women as mothers makes space for those who are *not* included to deploy the same terms to argue that they *should* be included. When women construct pre-viable foetal beings as babies using the evidence of biomedicine in lay contexts they are producing a reverse discourse which expresses an ontological position which resists that of biomedicine. This is an example of the reflexive capacities of social actors (Giddens, 1984) and the way in which technologies can be subverted and redefined by different users (Akrich, 1992; Pinch & Oudshoorn, 2003/2005). Whilst Layne has described how women use the authority of science to prove the existence of the 'baby' in pregnancy loss in the US (Layne, 1997, 2003a), this takes on the character of resistance in the case of second trimester loss in England because using the authority of science in this context is a reversal of what 'science', or biomedicine, is claiming about these particular pregnancies.

Experiences of the foetal being during pregnancy which are mediated through biomedical technology, particularly imaging, but also foetal Dopplers, have been shown by feminist researchers to socially construct foetal personhoods whilst being presented as objective and neutral representations of scientific 'fact' (Duden, 1993; Hartouni, 1997; Howes-Mischel, 2017; Mitchell, 2001; Petchesky, 1987; Taylor, 1998). More recently, research in England has shown, however, that pregnant women are not passive in their responses to technologies which represent the foetus, and that these responses are not singular. Women planning abortions may decouple medical objectification from fetal personification, or use objectification through ultrasound as a moral resource to confirm their decision (Beynon-Jones, 2015). This echoes work in other settings about the agency of pregnant women in relation to biomedical technologies (for example, Han, 2009; Lupton, 1999), women's pragmatic responses to medicalisation and technology (Lock & Kaufert, 1998), and the use of biological facts as resistance by patients (Dumit, 2006). Similarly, in second trimester pregnancy loss pregnant and post-pregnant women may actively respond to and employ biomedical technologies to support their own ontology of pregnancy. This occurs through a reverse discourse which resists the ontological position of biomedicine. In the case of the women in my research, the outcome of the resistance, claiming foetal personhood, often aligned with the classic feminist analysis of biomedical technology *constructing* personhood. However, I argue this is in fact a case of the ‘tactical polyvalence of discourses’ (Foucault, 1976 /1998, p. 100), in which the outcome of different discourses are the same but the assumptions behind them are different. Women in my research were not passively responding to technological representations of their foetus in their foetal personhood claims, but brought their own knowledge together with that produced by technology and actively responded to both, depending on the degree to which it provided evidence to support their exact ontological position, in a pragmatic approach to medicalisation (Lock & Kaufert, 1998).

In the pregnancies I describe in this research, all the women had had routine experiences of antenatal ultrasound as part of the English NHS antenatal care programme (NHS, 2016, 2018a). Some, such as Joelle and Gemma, had experienced extensive further ultrasound investigations as part of prenatal diagnosis of foetal anomaly. Others had additional ultrasound to confirm foetal death. Most had had experience of midwife foetal Doppler heartbeat listening, and a few, including Heather, had used Dopplers at home to hear the representations of the foetal heart. Others, such as Stacey and Simone, had paid for additional private ultrasound scans, especially the more detailed 4D scans which produce still and video footage of the foetal being. The material traces of these experiences, including positive pregnancy tests, were often preserved and sometimes incorporated into family display practices which will be discussed below. They also served the purpose of providing forms of proof and evidence for foetal personhood claims in those families where this was desired.

In particular, for those women in my research whose baby was not born alive, and was therefore not biomedically or legally classified as a person, their experiences of biomedical technology during pregnancy could be used as evidence that their particular baby did actually fit the classificatory requirements of human personhood, as they understood them. For many women ultrasound provided proof there had been a living foetal being present, and therefore that the pregnancy had been authentic. Simone's daughter was discovered to have died in utero at 17 weeks, but the week before she had paid for a private ultrasound to find out the foetal sex, at which her daughter had been alive. This had given her some certainty about the duration of foetal life and of the pregnancy. This was important in the context where much of her family did not acknowledge the loss or include the baby as part of the family, her husband chose not to see her when she was born, and Simone felt very isolated in her grief. For other women, different technologies, such as Dopplers, could also provide convincing biomedical evidence that there had been life in foetal beings who were subsequently born dead. In Chloe's first pregnancy, the use of foetal Dopplers to hear the foetal heartbeat sound was the ultimate proof of the reality of the foetal being living inside her own body:

> When they do the heartbeat, and you hear a heartbeat from down here [gestures low on her belly] and it was...that really was, it really was the most incredible, more special...that was the best thing. […] And I think that, for both of us, that's when it really did get real. Because you can't…there's no **trickery** about those things - well, you probably could argue there is - but do you know what I mean? There's no **denying**.

Chloe and her husband had experienced through biomedical technology the sound which to them represented a living being and which proved that their daughter had lived, located within Chloe's body. They were able to call on this experience in asserting the reality of their daughter's existence after her death and birth, when they only felt able to look at her feet and legs. Similarly, Heather could say of her fourth pregnancy that she had witnessed the foetal heartbeat in the second trimester using a Doppler at home. Technology could be used to prove the living status of the foetal being.

Biomedical technology could also provide proof of human morphology prior to birth or death, which was an important factor in producing the personhood of the baby as Chapter 8 explained. It provided an individualised, historical, documented record of life, visually examined and normalised in the way Foucault describes as key in producing an individual (Foucault, 1977/1991). A formed human body was thus recorded before it was perhaps seen and touched after birth, effectively fleshing out the later brief encounter with the born body and producing the baby as a human person with a history stretching back into pregnancy. Joelle underwent amniocentesis as part of the diagnostic process which ended in the termination of her second pregnancy after her daughter was diagnosed with Edwards' Syndrome. During the diagnostic procedures, she had access to a higher resolution ultrasound and described herself as seeking as much biomedically mediated information about her daughter as she could despite knowing that she would not continue with the pregnancy. Stacey also knew before the birth of her daughter, also through termination for foetal anomaly because of Edwards' Syndrome, that she had a recognisably human shape and showed signs of being alive. She had biomedically produced proof of the appearance of her daughter on a DVD of the scan. She also had a recording of the heartbeat sound, which she played sparingly for fear the battery might run out. These things were displayed in a special cabinet in her living room as evidence of the baby's life and personhood. Again, like Simone, much of Stacey's family had not been supportive of her attribution of personhood to her daughter, with her dad telling her not to keep photos because 'you don't want the memories'. In this context, the biomedical evidence was particularly powerful. This connects to Layne's observations of the use of sonograms to 'prove' the reality of the baby through the use of images as supporting evidence (Layne, 2003a) but also emphasizes the way it is the content of the image – a recognisably shaped body, or a recognisable heartbeat sound – which is important in acting as evidence of realness.

Biomedical evidence of the sex of the baby was often important in asserting its reality as a person. Chapter 5 described how the withholding of foetal sex information was a denial of personhood on behalf of medical staff – the converse, the evidenced stating of foetal sex, is therefore an assertion of a form of personhood and Foucauldian individualism through the production of a case (Foucault, 1977/1991). Layne found in an American context that knowing the sex of the child in pregnancy loss 'greatly increases the individuation and "realness" of the fetus as a person' for the parents (Layne, 2003a, p. 83).Sexing the coming baby often happens during ultrasound in the second trimester (Han, 2009), and this genders the foetal being and is part of its production as a person and as kin (Kroløkke, 2011; Rothman, 1986/1993). It can also come from chromosome analysis as part of post-mortem investigations. In my research, it was certainly the case that technology which sexed the foetus could produce *more* personhood where that had only partially been attributed. For example, this was the case for Natalie, when her previously unsexed baby was sexed by post-mortem chromosome analysis, as I described in Chapter 7.

For other women, having biomedical evidence of the sex could eliminate uncertainty in presenting the existence of the baby as a person to others. Megan's baby's sex was morphologically ambiguous and she decided to take the midwife's judgement that he was male before she had the genetic test results from the post-mortem. She was then relieved to have chromosomal confirmation, because she had presented the loss of the pregnancy to her friends and family as the loss of a boy. Several women talked about how evidence of the sex of the baby allowed them to authoritatively refer to them to others using the terms 'she' or 'he' rather than 'it'. Gemma, whose second baby was diagnosed with serious foetal anomalies in the second trimester, found out at the same ultrasound appointment that she was carrying a girl. She described how this knowledge changed her perception of the pregnancy she was now faced with terminating:

> I suppose it made her more…real. Like, even though I felt that anyway, I think maybe for my husband it made her a bit more real. Because obviously it's a bit different isn't it, when you're carrying them, I think. He didn't have quite the same bond, kind of thing, I suppose.
> *Could you describe how that bond was for you? By that point in pregnancy?*
> Yeah, I mean, I'd just started feeling her moving and stuff. Which is kind of – well, with all my pregnancies, has been when I've felt more of a bond then. When I feel them. So I, I felt really connected to her already.
> *But did something about knowing girl or boy made that even more concrete?*
> Yeah, a bit more…And I think maybe because we already had a girl, so I kind of could imagine then that she looked like how [older daughter]

> looked when she was born, all that kind of thing, linking her with that more. Rather than being a sort of abstract baby, if you like.
> *And did you then start calling her 'her'?*
> Yeah.

Similarly, ultrasound was used to construct the foetal being as an individual person through observation of behaviour. Tamsin felt her twins, who died *in utero* at 17 weeks, had different personalities which were perceptible through technology:

> Because we'd been having scans every 2 weeks, we'd had a lot of scans, and I'd seen them a lot. And they, as far as I was concerned, they had little characters. Because [first twin] was always dancing when the scan was on, doing a funny thing with her feet, and [second twin] was always hiding as far back as she could get. So I felt they had personality, real personalities.

When the twins were born, Tamsin interpreted the physical differences between them as expressions of these characters and personalities seen prenatally on the ultrasound screen.

Thus technologically mediated biomedical evidence of the foetal body can be used to claim its status as a 'real' person, alive, with human morphology, with a sex, with some level of individual agency and character, to whom the pregnant woman is in relation. It is produced as a being which exists with/in a human body, which in the English kinship system is the starting point for personhood and kinship. The means through which this happens is a redirecting of biomedical evidence towards another knowledge system, that of kinship. The conclusions that are drawn from this evidence are the direct opposite of those drawn by the biomedical-legal ontology of pregnancy in terms of foetal personhood. This is an example of the way in which biomedical knowledge and other knowledges are not necessarily opposed to one another but may interact (Kroløkke, 2011; Markens et al., 2010; E. Ross, 2016). Instead, they can crosscut, or reorient, one another, or be implicated in resistance practices through the agency of individuals. In the case of second trimester pregnancy loss, knowledge from biomedicine can be used to support personhood claims, which form the basis of kinship in English kinship ontologies.

9.3 Second trimester babies as persons who are kin

Most of the foetal beings in this research were claimed as forms of person, fulfilling the requirement of Strathern's first fact of English kinship, that is it built on pre-existing embodied persons (Strathern, 1992). Once personhood was attributed, the babies were embedded in kinship relations, as persons are in the English system. However, the variety of personhoods involved is important. There was a wide range of positions taken on the detail and extent of personhood. This is consistent with the second fact of English kinship, that of diversity and choice (Strathern, 1992), and with the diversity of attributions of personhood by the same women across different pregnancies which was described in Chapter 8. Paula was the only person who did not claim personhood for her second trimester loss - she strictly defined the foetal being as a 'foetus' rather than a 'baby', though she also still imagined, years later, a ghostly child who might have been a companion to her living children. For the other women in the research, there was a range of emphasis on the foetal being as a 'real' person, as previous chapters have demonstrated. The diversity of detail in the construction of personhood was also found in the positioning of the person within kinship structures, using a range of strategies expressed through practices. The strategies were to situate the foetal being as a baby within this particular family alongside the other children; to align it with the other dead persons within the family; and to claim oneself as a mother to it and to construct other kin as its kin. For example, many women pointed out to me the physical resemblance of the dead baby to other family members as proof that it belonged in their kinship group. Amber said her daughter 'looked like one of us', with the same shaped nose as her older daughter, Kerry said the midwives noticed her son had his father's big hands, and Esther's mother had remarked that Esther's son had full lips like one of her uncles. Resemblance, and resemblance talk, has been noted in other contexts as constitutive of kinship (Han, 2009; Marre & Bestard, 2009; J. Mason, 2008; Nordqvist, 2017; Roberts, Griffiths, & Verran, 2017).

Rituals which pertain to other kin were another practice through which the personhood of the dead baby was asserted in the context of kinship. Esther's first son was born alive after a premature labour and her husband acknowledged her Christianity by baptising their child as soon as he was born. Similarly, Holly accepted the posthumous blessing the hospital chaplain offered for her second daughter and then decided to get her older daughter christened in church so that both daughters would have been treated the same. For other women, refusal of ritual was also part of marking the baby as 'one of us'. Danielle lost two sons in the second trimester, and the second time was offered a naming ritual:

> [Chaplain] offered us a naming ceremony? Which we said we didn't want. We didn't have it with [first baby]. [Partner] wasn't christened, he said he wouldn't want his children christened anyway. […] I like keeping things the same as I can for them.

In other cases, including funerals, cremations, and memorial services, ritual served to place the dead baby alongside the family's other dead. Earlier chapter in the thesis have described some of these rituals and illustrated their meaning for bereaved parents and family. Georgia, whose son lived for a short while after being born prematurely, held a big funeral in the South West for him:

> We just thought yeah, he's a baby, and he was very wanted and very loved, so...a private funeral for us wasn't an option. People came even from Liverpool. Friends from Liverpool, and like, Leeds, and Sheffield. Yeah. People travelled a long way. It was really nice.

Treating babies born pre-viability as full persons deserving of a traditional funeral in this way uses established practices to 'confer authenticity upon death ritual' (Hockey, 2011, p. 31) in a pregnancy loss context in which this might be challenged. The historical context of excluding dead foetal beings from cemeteries and ritual in the past, along with criminals and persons who died from suicide, means that including them today has political resonances of personhood recognition. Holly expressed this when she explained why she was pleased her son was buried in the municipal graveyard:

> That's where you put **people**. So to say that he's there, is one of those kind of things in the validation as well. Because, yeah, he's buried at the **cemetery**. To have that burial, along with the whole validation thing, is that he had a funeral, he had a proper funeral.

As Layne has stated, acts of remembrance become acts of resistance in cases where there is social pressure not to remember or acknowledge (Layne, 2003a). Women in my research were able to agentially mobilise many such practices in order to support their ontological position, based in English kinship, that defined their babies as persons and themselves as mothers to them.

In the remainder of the chapter, I go into detail regarding two further practices through which the babies in this study were strategically situated as persons and kin in the English tradition. I focus on these because they were used by almost all my participants, and because they were particularly political strategies of inclusion and resistance, with resonances in other literature and settings. Furthermore, they illustrate the range and diversity of personhood and kinship positions adopted by my participants within an ontology of English kinship. These selected practices are naming, and the display of material culture in relation to images of the foetal body and cremation ashes.

9.3.1 Names and the naming of second trimester persons

Positioning the foetal being as a baby, and a baby in a family, was often initially expressed through the giving of personal and kin names. Names express and constitute social relations (Bodenhorn & vom Bruck, 2006), often in the context of legal requirements for state registration (Bodenhorn & vom Bruck, 2006; Finch, 2008; Pilcher, 2015). They are connected to personhood, in that the detachability of names from the individual person allows personhood to be recognised, withheld or removed, in political acts of validation or repression which can be enacted through speech or official records (Bodenhorn & vom Bruck, 2006). In pregnancy loss, naming acts are therefore political acts using 'the person-making power of naming' (Layne, 2006, p. 37). Legitimacy in conferring names rests on the socially recognised right of the namer to act in this way within wider institutions, and thus to define what they name (Bourdieu, 1991). The giving of a name can be a responsibility and a source of power, but the right to do so may be contested or denied (Bodenhorn & vom Bruck, 2006; Layne, 2006). As described in Chapter 6, babies born dead before viability in England cannot have their names legally registered with the state. Giving a name in such circumstances is an act of resistance to this exclusion. Consequences may befall both the namer, whose naming may not be recognised, and the named, who may therefore not be integrated into a social role.

In my research, the act of naming was usually carried out by women, often together with their partners, and occasionally with advice from their own mothers or other kin. For women who experience second trimester loss and do name, giving and using a name is a statement about their babies and their own motherhood. Though naming was sometimes suggested by hospital carers, especially in hospitals which focused on bereavement practices recommended by the National Bereavement Care Pathway, many women had decided to name before it was proposed to them. They explained this with reference to personhood of the foetal being in a relational context. Tamsin named her twins in order to assert their personhood to other people:

> It was important to me that they had a name.
> *Can you explain why?*
> Not really. I think it was just...it made them a real being. Because...I found it really hard with the first miscarriage [a separate loss in the first trimester], a lot of the comments that you get from people are 'well, at least it wasn't a real baby yet' or 'at least it wasn't further along.' And I felt as though with that pregnancy, that nobody really saw it as a baby. And it was really important to me that...they [twins] were seen as babies, almost on a similar level to my [living] daughter. I wanted people to know that they were my babies.

Tamsin’s comments are also notable for their acknowledgement of the diversity of English personhood, which reflects Strathern’s diversity in kinship. Her twins, whilst persons, were not quite the same level of person as her living daughter.

But naming helped express their proximity to that personhood to other people. Simone also explained that giving a name was giving a public identity which could be used when referring to the daughter who had died:

> It just felt like, because you're having the birth, you're going through that, the person's got to have some kind of identity. You've at least got to give them a name. I don't know. And it makes it easier to talk about. You say about the name, instead of, you know, 'that baby', or whatever.

Naming claimed the dead baby as a person, equated them with other children, and prised open a space for this to be talked about with other people in the face of exclusion or denial.

All but three of the women in my research named the foetal being with a personal name. Strathern (1992) argues that offspring are individualised in the English kinship system through the allocation of personal names to children by parents, and their asymmetrical use in addressing children by parents, whereas children use kin terms to address parents. When parents name their dead babies in pregnancy loss, they are emphasizing those babies' individual unique identity and thus equating them with individual living persons. Furthermore, in English, names often have genders and naming often genders a person, again emphasizing an individual identity. Chloe, whose first daughter died *in utero* and was born at 17 weeks' gestation was desperate to get official confirmation of sex because she wanted to move from the non-gendered playful 'bump name' she had used in pregnancy:

> It was annoying me that people were still using the bump name […] And at that point, she was no longer a bump, she was a person. Do you know what I mean?
> *So that name was no good any more?*
> No.
> *Because it wasn't a human name?*
> It wasn't a human name. It's not even a dog name! [laugh][…]
> *And then also it's quite hard to talk about somebody without a name?*

> Exactly. Well, that's why you have your bump name, isn't it? You have your bump name so you're not saying 'it', you know. And it was just like, I remember it was only a few days ago [husband] actually referred to [baby girl] as [bump name], and I was like, '**No**!' I think he did it automatically, kind of thing, because like, for me, as soon as I knew, as soon as the bereavement midwife said, 'you've got a little girl', I cried. But...she became who she is. If that makes sense.

Chloe linked knowledge of the developed baby's sex with personhood, and human personhood with a 'human' name. Though she referred to her much loved dog as her baby's 'fur brother', she distinguished between human and animal forms of personhood, signified to her by naming differences which she also preferred to be gendered. A person should not have the sort of joke name that she had given her unsexed 'bump' or her dog.

Gemma and her husband never had a 'bump name', and had always planned to think about names once they knew the baby's sex. This was discovered in the process of investigating the serious congenital abnormality which resulted in the termination of the pregnancy. For Gemma, knowing the sex required action to acknowledge her daughter's personhood through naming before her death:

> We didn't actually even decide her name until we actually went to have the injection – they do an injection, like to stop the heartbeat - so until we were actually going for that, and then I thought, I want to make sure she's got a name before we do this, kind of thing.

For Gemma, naming the baby was also connected to her imminent death, a significant moment in English culture in which personhood can be asserted and relationality expressed (Valentine, 2007). It was an act of parental acknowledgement before the traumatic experiences of feticide, labour, and the birth of the dead baby, and like Chloe, the naming was a moment in which personhood was activated and acknowledged.

The use of names to gender persons, however, was sometimes avoided. For Louise, a name which did not gender was appropriate for the degree of personhood which she attributed to her baby who had a serious congenital abnormality:

> The only reason we chose that name is we didn't find out the sex, whether it was male or female, and we just wanted a little name that was like a baby name? That would never have been used, if you like? So it wasn't an official name? […]
> Our whole point, our whole point was that [unisex name] was a baby or a foetus, whatever you like, that baby never had a chance of life, so it was never going to be a male or female. It was never going to have a gender. So that was our sort of reasoning above a name that could be either, just giving it a little baby name because it'll always be a baby. It was never going to be a human, it never was going to be a girl or boy and go somewhere.

For Louise, who knew her baby would never live outside the womb and who terminated her pregnancy, the baby's gender was not important, although it was definitely a human person who needed a name. This was connected to her Christian beliefs, in which she felt the gender of a human who has died and no longer inhabits a body is no longer relevant, because the sexed body on which gender is based is discarded at death in the Christian faith.

Beside potentially gendering persons, names may situate them within other social groups such as ethnicity, religion, geographic area, class, and kinship (Bodenhorn & vom Bruck, 2006). In English social life, naming actively makes connections between persons, including kinship connections (Edwards, 1999, 2000). This can take place in situations of ambiguous family membership such as adoption (Pilcher et al., 2020), or within new family making practices such as post-divorce name changes (Finch, 2008). Shared surnames may express family belonging and claims to place (Edwards & Strathern, 2000) – working the same idea in reverse, in my fieldwork, means that claiming a surname and potentially a place, such as a gravesite, can constitute a claim to personhood within a kinship relationship. It was common, for example, to give babies the surnames of their fathers where these were different to the mother's name, situating the baby as a person in a specific set of family relations. In Chapter 6 I described in the context of birth registration how Charlie had split from the father of her first baby who had died in the third trimester. She then lost another baby conceived with her husband in the second trimester and she buried both babies in a joint grave marked with their first names and her new married name. She used naming to express the unity of her kinship group, and to establish kinship with and between the dead babies and the first baby's posthumous adoptive father, and publicly declared this using the grave site and its inscription with the names of those buried there.

Those families who had been entitled to the official state registration of names and persons because of live birth felt that it validated the personhood of their baby and its position as their kin because of its endurance through time, as described in Chapter 6. On a more intimate level, the extension of the kinship system through time also comes from naming practices where children are given family names, or named after family members, perhaps those who have died (Finch, 2008), entangling an individual into a cross-generational family history (Bodenhorn & vom Bruck, 2006; Finch, 2008). Georgia and her husband named their son after two of their grandads and with a name connected to their honeymoon location. Kerry named hers after her partner's grandad and with his surname. Both babies were registered, and these generational name links were therefore recorded by the state. Bethany named her son after her cousin who had died young and to whom she had been very close. She was not entitled to register this name, but her choice tied her baby into the family history and legitimised her claim to his inclusion in the family in this way. It is interesting to note that the cousin had died through suicide, and her linking of him and her son who was not officially a person made a double statement about inclusion and family history. For other women, names were selected because they had meaning in the context of the couple's reproduction – 'Hope', for example, was a name given by several families and situated the dead baby in the context of family history and future children. 'Saiorse', meaning 'freedom' in Irish, was selected to reflect Irish family origins and a sense of the spiritual destination of the dead baby. These names reached into the past and the future, locating the persons who bore them within specific family relationships.

Naming babies in pregnancy loss therefore can claim them as persons and as family members. But naming can also express some ambiguity about the person, with different degrees of personhood being possible in the English system. Helen didn’t name her daughter at first, only deciding on a name after she became pregnant again and went for counselling:

> Well interestingly at the beginning we didn't name her. […] We very much bought into this rhetoric that we were - that we'd got from the world around us - that she wasn't a real thing, it was still a miscarriage, it was medical waste. You know. She wasn't a real thing. […]
> I fell pregnant again and I just found it incredibly difficult. And I said, 'I don't know how to cope. Particularly, what if it's another girl? I don't know how to kind of distinguish.' And [counsellor] said, 'do you think about, you know, giving her a name?' And now I can't believe we didn't! I can't believe we didn't! But like I say, we kind of...we felt the messages we were getting from all around us, because of the term 'miscarriage' was that after 24 weeks, you're allowed to be attached. You have a death certificate, you're allowed to. You hold them, you dress them, you get hand and foot prints, you have a funeral. And then they're allowed to have an identity, but before then...**meh**. You know. Yes, you might see the formings of a baby, but the message you feel is it still wasn't...real.

Even though Helen did subsequently name her daughter, she chose a second-best name, keeping her favourite girl’s name in reserve, and she does not consider the baby to have a surname:

> It’s not our girl's name, we never used our girl's name. Just because...we might have had a girl in the future, and we didn't want to lose the girl's name that we loved! […] I still don't really call her [by a personal name and surname] like a child. Like my children.

Several other women, including Kerry, said they would not have picked the name they did for a child who was going to live. Kerry said she was more ‘flippant’ about the name she chose because her son would not live. Eva’s young daughters picked the name for her son, which she asked them to do because she was worried that picking a name herself would be too upsetting at a time in her loss when she was trying to suppress her emotional reaction to what had happened. Personhood and kinship was claimed through naming in these cases, but this was sometimes a limited form of personhood, expressed through the form of naming decisions.

For others, not naming was a way of positioning dead babies as special and distinct within the family. For Alice, whose third and fourth babies both died during separate terminations for foetal anomaly, recognition of inclusion in the family was important whereas naming was not. She felt the babies were not ready for names:

> I know most people do name them. But in a way that felt quite symbolic in itself, the fact that they just are ‘our babies.’ They weren’t anyone else’s, they didn’t have an identity, they didn’t have a label, they were just our private little people, that had only ever been with us, because they never were out in the world with other people. Is that making sense? So, they didn’t need something for anyone else to refer them as, because they weren’t…The very fact that they didn’t have a label was symbolic. They didn’t have a chance to be living humans in the world. Like, I suppose what I am trying to say is we didn’t not name them because we couldn’t be bothered, we didn’t **want** to. It was like a real conscious decision. Partly because giving them a name would have felt odd because we didn’t have one, but also because the fact that they didn’t have a name kept them as ours, and private, and special to us. Because that’s all they were, they were just our little babies. They weren’t X or Y, or whoever. People out in the world.

Though a name can make a person, Alice’s experience, and that of Natalie who had a similar experience with not naming her son, show that forms of personhood and kinship relationships can also exist without naming in the context of pregnancy loss. Decisions about naming or not naming therefore express the diversity of possibility within the English systems of personhood and kinship.

9.3.2 Material culture and family display in the making of second trimester persons

Layne (2000) has enumerated the ways in which material culture can enact personhood claims for foetal beings in the US context. Many of the practices she describes are relevant in UK pregnancy loss and in the second trimester. Women in my research, for example, bought goods for the dead baby which extended their personhood posthumously. Georgia decorated a Christmas tree with baubles bought by friends and family for her son. Heather bought gifts for her daughters to lay on their sisters' graves at Halloween and Christmas. Amanda bought her son a birthday card each year to put in his box of possessions. In deaths which are not pregnancy losses, the use of material culture in memorialising the dead, as individual persons, is well documented in England (Hallam & Hockey, 2001/2020 (2001); Miller & Parrott, 2009) and other European countries (Mathijssen, 2018). It is also documented in the death of children in the UK (Riches & Dawson, 1998), neonatal death in Ireland (Garattini, 2007), and in pregnancy loss in the USA and UK (Godel, 2007; Layne, 2000, 2003a; S. Murphy & Thomas, 2013; Reed, Whitby, & Ellis, 2018). In the case of pregnancy or neonatal loss, the keeping and use of images such as photographs and ultrasound scan images also relate to personhood claims (Keane, 2009), as does the giving of posthumous gifts (Garattini, 2007; Layne, 2000).

In my research, material culture and consumption was often used to equate the baby who had died with other, still living, children in the family, as part of a personhood and kinship claim. The organisation of this, particularly by mothers, was sometimes conceptualised as treating the children equitably, a practice which both claimed the dead baby as a child and also the woman as a mother to that child. Kinship and personhood were thus linked and invoked by material culture. Rachel, for example, was involved in organizing annual pregnancy support group events which took a great deal of time and effort, baking cakes and preparing decorations and invitations. She described these as a form of birthday party for her first daughter who had died and who would not have birthday parties like her other children. Megan's living children with her ex-husband had Christmas tree baubles with their names on, so she bought one with the name of her dead son, conceived in a new relationship, to go on the tree alongside them. Much of the activity around material objects and their meaning, however, whilst making political claims about personhood and kinship in the context of death, was relatively private and intimate and also did not differ in the second trimester from practices in other types of pregnancy loss in other settings (see in particular Layne, 2000; Layne, 2003a). In line with my interest in the body politics of second trimester loss, I select two practices around material culture amongst my participants which are more public in character and which draw on the materiality of the second trimester body as a resource: the display of images of the foetal or baby's body, and bodily remains in the form of cremation ashes, in the home and on the body of mourners.

9.3.2.1 Claiming personhood and kinship through family display of images and ashes

Kin relations in England can be created and sustained through family display of material culture (Bouquet, 2001; Finch, 2007), observed in relation to photographs in particular in the case post-viability stillbirth (Godel, 2007; S. Murphy & Thomas, 2013). In English culture, photographs of family members, including babies and dead relatives are widely displayed in homes, and in the case of photographs of the dead, the body that once existed 'resources social identity' (Hockey & Draper, 2005, p. 50). In my research, photos of second trimester babies, many of which had been taken posthumously, were used both online on social media networks such as Facebook, and in family display in the home. It is significant that in present day English culture photographs of dead bodies are understood as shocking, but that taking and sharing photographs of new babies is expected and encouraged. Using posthumous photographs of second trimester babies to memorialise, such as on funeral orders of service, or on social media, or in the home, aligns the person represented more closely to other babies rather than other dead people, even if the photos may have been selected because that is all that was available (Layne, 2000). When I visited her home only three weeks after her daughter's death, Chloe had placed a photo and a copy of an ultrasound image next to the large framed photograph of herself and her husband at their wedding, on the side near the TV. She explained her plans about the space:

> We're gonna get a nicer frame, because the scan photo, that was just a cheap frame that we found at the time. And of course, we were expecting actual baby photos. […]
> *Are you going to get one so you can keep it with your wedding picture?*
> Yeah. And I've seen them online, you can get ones that are specifically for angel babies. They've got the wings and everything. So I'm going to get like a nice...
> *And then you can keep it out?*
> Yeah, and make like a little...shrine to her. Because she's...she doesn't, well she might do, but I don't think she knows how much she is loved. And she's missed.

Chloe's placing of the images of her daughter's body beside the wedding photograph was part of a claim to both her individual personhood and her kinship position in the family. She described the loss of her daughter as particularly poignant because it was her first pregnancy and so she and her husband were 'forming as a family'. Such display also happened in wider kinship groups. Heather's third and fourth pregnancies ended with foetal death in the second trimester. She was strongly committed to these babies being persons, siblings for her living daughters, and grandchildren for her mother. These relationships were expressed through her display of scan images alongside framed photos of her living children, a display in which her mother participated:

> My mum's got a scan picture. I've got their scan pictures up there [gestures to bookshelf]. [First baby who died]'s on the right and [second baby]'s on the left, but Mum's got a picture of [first baby] actually in her house, and she's got it displayed. And it's in a wooden frame. And I gave one to the in-laws as well, but they don't display it. I think they're a little bit more reserved about it.
> *Where does your mum put it?*
> It's in the living room with the picture of the grandchildren as well, so it's there. So that it's on display, which is lovely. It's acknowledging.

Framed photos in English homes are usually of kin, and when displayed they form a moral commitment to remember the relationship (Drazin & Frohlich, 2007). The placing of framed images of the second trimester baby, besides asserting equivalence with other children or highlighting the relational context of marriage, could also align the baby with family dead and in a family history. Chloe, whose wedding photo was displayed next to her daughter's photo, also displayed a framed photo of her grandmother. She had been very close to this woman, who had died a few years earlier, and who had had a stillborn son. Chloe felt herself to be copying her Nan's example when she planned to keep her daughter's memory alive, and her Christian beliefs meant that she thought of her grandmother and daughter as being together in the afterlife. The images of the dead in Chloe's living space were part of this connection across time and across the boundary of death.

Ultrasound scan images or footprints were sometimes used in the family display practices of my participants because they were felt to be less shocking for unwarned viewers or visitors than a photo. Charlie selected hand and footprints for the front of the order of service of her second trimester daughter's funeral, for this reason. However, the prints were still representations of a human body and were making a point about personhood and kinship. Human feet metaphorically represent personhood (Han, 2009; Keane, 2009; Layne, 2003a) and footprints carry a suggestion of both individual journeys and the leaving of a mark on the world which are associated with personhood (Layne, 2000). Similarly, albums or collections of photographs tell a biographical story about an individual (Drazin & Frohlich, 2007). Many families in my research kept albums or ordered groups of photographs narrating the pregnancy and birth of the baby who had died, producing them as a person with a history in the family. Amanda, for example, made an album of photographs of her son's funeral, at which all the extended family and friends were present, to keep beside the albums she made for his siblings as they grew up. In such cases, the narrative devices of family photographs were used for 'making sense of situations that might otherwise remain alien' (Bouquet, 2001, p. 95). Babies were also historically situated within kinship groups by the display of photos, scan images, or footprints on social media at important family times such as Christmas or anniversaries of birth or death. This was a practice common to many of the women in my research who were in their 20s and particularly active on Facebook and Instagram, such as Georgia and Charlie. The semi-public nature of such posts was a political statement demanding inclusion and recognition of personhood, kinship, and loss.

Besides images, ashes from cremation were enlisted in forms of family display. As discussed in earlier chapters, cremation and retrieval of ash is often possible in the second trimester because of the size of the foetal being. In Britain, cremation is not always the point of separation from the material remains of the dead because ashes can be reclaimed (Kellaher, Prendergast, & Hockey, 2005; Prendergast, Hockey, & Kellaher, 2006). They can then be used in novel ways to situate the deceased in identity and biography rather than traditional or communal memorialisation, perhaps continuing a relationship after death (Prendergast et al., 2006). Instead of the dead being located in a public place, they can be kept nearby, for example at home, in a potentially transgressive and also intimate act (Kellaher et al., 2005). Angela, whose first son died after premature labour, kept his ashes in her living room on a dresser, alongside photos of herself and her husband holding him, and some memorial items given by friends:

> People ask, and I say, ‘he’s on our Welsh dresser.’ And it’s kind of like a thing now! But he’s here with us, if it makes any sense. And he’ll always come with us now, whether we move house, or what have you. […] We don’t want to make a shrine, but it’s there. It’s present, it’s there, it’s not a big deal, you wouldn’t necessarily walk in and notice it. So it’s discreet. It’s not a shrine. We keep his scan pictures because that’s the only picture we’ve got of him other than the snaps we took when he’d died. […] It just feels like he’s with us. And then we will tell [newborn second son] about him, and he’ll ask, and we’ll say ‘he’s there on our Welsh dresser!’

Amanda, whose son died through termination for foetal anomaly, kept his ashes on the mantelpiece in a living room which contained many reminders of his existence, including photos and a box of items understood as belonging to the baby. She also kept the ashes of the family’s many pet Dobermanns, but had put these away in a cupboard because the size of the dogs' urns was greater than her son's and she wanted to avoid visitors making comparisons. Ashes are a 'tangible substance' which for many people *are* the bodies of the dead (Prendergast et al., 2006, p. 884), and in second trimester loss when the ontological status of the material substance of the foetal body is in question they take on a particular importance in family display. Post-cremation ritualisation is a form of resistance to modernist rationality (Prendergast et al., 2006) which in the context of second trimester pregnancy loss counters the biomedical-legal teleological ontology of pregnancy which says this foetal being was not a person and never really existed.

9.3.2.2 Foetal bodies and relational bodily display

Family display incorporating the foetal being into kinship groups was also practiced on the body, as well as in the domestic space of the home and the related space of social media. Material culture displayed on the body, such as jewellery or tattoos, can be a memorial act but is one which takes place in a space which is both public and private, mediating between the wearer and other people (Fuller & Kuberska, 2020; Layne, 2003a). In the UK, McNiven (2016) has described the intentional visibility of pregnancy loss memorial tattoos and memorial jewellery acting as agential narrations of loss and creating opportunities to talk to others about it. In my research, whilst women used symbolic representations of the foetal being in jewellery, such as Simone's butterfly necklace or Amber's charm bracelet with symbols for each of her children, they also used evidence of the particular foetal body of their own baby on their own bodies. There is a significant difference in terms of claiming personhood in drawing attention to the embodiment of the specific foetal being rather than a generic symbol. Phoebe had her son's tiny footprints replicated in a silver pendant which she wore on a necklace, and her husband had the same footprints tattooed on his chest. Charlie, who very strongly asserted the personhood of her pre-viability daughter alongside that of her post-viability stillborn girl and her living children had memorial tattoos for both babies. However, the tattoos for the daughter who died at 23 weeks were much bigger and included that baby's life-sized footprints to demonstrate her size, in an assertion of her personhood which was perhaps more necessary than that of the other, stillborn and registered, baby.

The material body of the baby was sometimes incorporated in the use of ashes in jewellery. Ashes jewellery is common in the UK, with portability being an important element (Prendergast et al., 2006). However, it takes on a new meaning when the jewellery is worn by the woman whose body contained the foetal being, and when that foetal being's personhood is generally called into question. For Alice, the display aspect of this to other people was less important than the presence on her body of the remains of her two unnamed babies who died through termination for foetal anomaly. Her ring was not obviously an ashes ring:

> I just felt that on a daily basis I wanted something that would be a constant reminder of their presence but that wouldn't be flashy so that everyone would be like, 'oo, what's that?' And I'd be like, 'oh these are ashes…' you know? They are in there – that star is our little baby girl, and that heart is the little baby boy, there is a tiny bit of them, I don't know what he's done to make the hole in it and put some in. So I've got them in there, and I know they're there. […]
> *I think it's really interesting that it's on you as well - because you can't set your motherhood aside…?*
> Yes! Yes, yes, yes, yes! It's present, all the time. It's part of my identity.
> *And you've chosen something durable…?*
> Yep. Yeah, exactly. I was sort of looking at different options and there are lots of things you can do that are sort of in the house or…I don't know. I just wanted something I could have with me all the time that would be a little part of them. […] This will always be on my finger, until I'm dead and gone. This is always going to be on my finger.

As described in Chapter 8, Alice had not told other people the circumstances of her second loss, and kept much of her mourning private. For her, the ashes ring acted as a record of emotion and relationship, and was transformed by its connection with her own embodiment into an expression of her self as mother. Objects can thus be 'repositories of memory' (Lupton, 1998, p. 148) which create the self. By contrast, Kerry had a ring made containing some of her son's ashes displayed under a clear stone, which she wore to work, and which became an opportunity to talk to others about her loss:

> One of my [customers] did say to me, she said 'oh, that's a really nice ring!'
> And I did say, 'that's my son's ashes in it.'
> And she went [gasp], 'I'm really sorry!'
> So that's why I was off - cos clearly [customers] didn't know. There's only a couple that knew that I was pregnant anyway.
> I said, 'that's the reason that I was off.'
> She went 'oh, I'm really sorry.'

Kerry was one of the women described in Chapter 8 as avoiding other people in supermarkets in the months after her loss. Her prominent ashes ring was an agential refusal of this alienation from society. Gemma, in the same chapter, talked about how she found it hard to talk to people about having apparently chosen to terminate the pregnancy with her daughter. However, Gemma also wore an ashes ring every day alongside her wedding ring, and used questions about it as opportunities to talk about her daughter:

> People have just said they like it, and then I've said – it's not obvious, it's like a flat ring, so it's not got a gem or anything, the ashes are just in the ring. So people have said 'I like your ring' and I've said what it is then.

Gemma sometimes also wore a pendant with her daughter's footprint on it, and her own mother, who felt strongly that she had lost a granddaughter, wore an ashes ring. In second trimester pregnancy loss, representations of foetal embodiment such as these act as forms of memorialisation, but can also be public and agential statements about inclusion in relation to personhood and kinship, especially where they can prompt a response from other interlocutors who see the images or the ashes. Displayed on the body, particularly the parental or mother's body, the representation of foetal embodiment expresses commitment to a kin relationship which is asserted against the norm, in a form of resistance. These elements of public display can be used agentially by women to counter the shame and hiding described in Chapter 8, when the bodies of the dead baby and its mother disappeared in the ontological disruption of pregnancy loss.

9.4 Conclusion: agency and resistance in ontological politics

I have sought to show in this chapter that the narrow biomedical and legal definitions of what a baby, person, or mother *is* or *is not* at the level of ontology were not duplicated in the reality of people's lives in circumstances of second trimester pregnancy loss in England. Instead, women in this research used a range of strategies and practices to assert their own ontological positions, drawing on English kinship as a framework, in which second trimester foetal beings could be understood as persons, in kinship relation to themselves as mothers, to other living persons such as fathers, siblings and grandparents, and to family dead. Often, in the second trimester, these practices are distinguished by their reference to the material body of the foetal being, a theme which permeates all claims to the 'reality' of the foetal being in the accounts of my participants. The material body of the foetal being, with human morphology including sex, with some biomedically confirmed life in the uterus or after birth, with a documented biography in pregnancy and after death, is central to the personhood claims which women may make, and is also part of the practices which express kinship. This is consistent with other findings in the area of English kinship which find personhood in embodied beings, and also with findings in the field of posthumous relationality in English social life.

The strategies I have explained in this chapter are forms of resistance. The use of biomedicine in a reverse discourse, a known strategy of resistance described by Foucault (Foucault, 1976 /1998), particularly clearly expresses this. Kinship practices, such as naming and display, become resistance because of the context in which they take place, that of the English biomedical-legal denial of personhood and kinship without separate life before viability. It is true to say that much of this resistance is very local and small-scale, and may only take place in a domestic context, such as Simone quietly asserting her daughter's personhood against the wishes of her family. The relatively low prevalence of second trimester pregnancy loss, and the isolation of the experience, particularly in South West England, as described in Chapter 3, contribute to the small scale of this resistance. This type of action may not be conceptualised as a political form of resistance by the women involved. For other women, the resistance is on a larger scale, though still domestically based. Rachel persistently used her daughter’s name to her Chinese parents despite their discomfort, and she understood this as a form of assertion of her own ontological position against theirs. She and her husband are active in the local pregnancy loss support group, organising events that celebrate personhood and kinship in the context of pregnancy loss, which they understand as necessary in the context of these losses being ignored by others. Other women, such as Charlie, are active on local social media making themselves available to support other women going through pregnancy loss. Georgia and her husband fundraise for pregnancy support charities using assertions of their son’s personhood on social media. And LeighAnne Wright has drawn on her experience of the second trimester loss of her son to build a career in funeral directing and set up a charity in Plymouth which supports local families experiencing any loss. LeighAnne’s activism and resistance is particularly public, and she asked me to use her real name in this research. In 2017 she stood outside the Houses of Parliament in London and read out the names of babies who she knew to have died in pregnancy or neonatally in the Plymouth area, asserting their personhood at the heart of the UK political system. Some of the names she read were those of babies whose mothers took part in this research, and they expressed to me their approval of this public naming as a symbolic act claiming the personhood of their babies. Yet even these public forms of resistance have not yet been able to challenge the legal and bureaucratic recognition of second trimester pregnancy loss described in Chapter 6 in terms of achieving change.

Furthermore, as this chapter has shown, resistance is neither uniform nor homogenous in content and meaning. Attributions of foetal personhood and of kinship in the English kinship system have substantial elements of diversity and choice, and these are replicated at the level of second trimester loss. Not all women attributed the same type or extent of personhood and kinship in the second trimester, and Paula, for example, did not attribute personhood at all, whilst having some sense of lost kinship. Nor were personhoods expressed in the same way or by the same practices by all the women. As previously discussed, there was also variety in attributions of foetal personhood in other pregnancies and other pregnancy losses amongst the participants in this study. Layne and others have pointed to the existence of person-making before birth (Han, 2009, 2017; Howes-Mischel, 2016; Layne, 2003a, 2006) but my research emphasizes the non-binary nature of foetal personhood and kinship in the English system. This is different to Layne's insight that personhood can be revoked in pregnancy loss (Layne, 2006). In the English ontological position, I argue that it is possible to have a partial person, or a partly built person, or a type of person, rather than simply two options of person / non-person. This person can also be situated in kinship relations which are diverse and agentially defined, and which continue to exist after death. This will be further discussed in Chapter 10, but such multiplicities of ontological positions on personhood and kinship can be traced in the diverse kinship practices through which they are produced and which have been described in this chapter.

Chapter 10: Conclusion

In this thesis, I have explained how the classification of a pregnancy loss in England as being in the second trimester structures and determines the experience for pregnant women. Women diagnosed as being in the second trimester and facing foetal death, premature labour, or termination for foetal anomaly will be required to labour and birth the body of the foetal being, whether this is their preference or not. Their healthcare experiences in the NHS will be primarily determined by the foetus' gestational stage rather than their own symptoms, often resulting in poor pain relief, lack of specialist support, and lack of postnatal care in a disciplining of their 'failed' pregnancy which amounts to obstetric violence. Unless they experience medically confirmed live birth of the foetal being, civil registration systems will not certify any personhood of their baby, nor themselves as kin to it, with consequences for allocation of resources such as time off for recovery from birth, or maternity pay. The range of options available to women in relation to post-mortem and the disposal of the foetal body is determined by regulations which define most dead second trimester foetal bodies as liminal entities. These cannot be persons, or medical waste, but occupy a separate category, the meaning of which is not under the control of the pregnant woman.

In the event of second trimester pregnancy loss, then, ontological positions on the status of the foetal being determine what happens to the pregnant woman. These ontological positions are derived from a teleological understanding of what pregnancy *is*, itself produced by and underpinning the interaction of biomedicine and the law in England. If a pregnancy results in live birth, it produced a person and a mother, whether the pregnant woman wishes that or not. By contrast, if a pregnancy cannot and will not result in a living baby, then it is not a 'real' pregnancy, and the pregnant woman is cannot be a 'real' mother, should she wish to claim that status. For many women who experience pregnancy, labour, and birth in the second trimester, and who encounter the body of the foetal being, this ontological position is incomprehensible and fundamentally destabilising when set alongside their experience. The ontological disruption caused by the clash between their embodied experience and the discursive classification of it by biomedicine and the law is significant in scale and in potential. It contains possibilities of change and resistance, because the women who experience it are reflective social actors. For some women, the ontological disruption of dominant discourses of second trimester pregnancy loss can be countered by the agential use of an alternative ontology which may better explain their experience. These women use an English kinship model to understand second trimester pregnancy loss, to resist the erasure of their gestational work and their relationship with the foetal being, and to claim the foetal being as their baby. In doing this, they rely on particular features of English kinship, such as the embodied nature of persons, alongside a reverse discourse which uses evidence of the foetal body to assert its personhood and its relational kinship to themselves.

In this chapter, drawing on this new knowledge generated in the empirical chapters, I explain the broader academic contributions which the thesis makes: to the reproductive politics of pregnancy and pregnancy loss; to different understandings of foetal personhoods; to knowledge about personhood and kinship in the English context. I end with some thoughts on possibilities for the future, in terms of visions of change for women experiencing second trimester pregnancy loss.

10.1 The reproductive politics of pregnancy seen through second trimester loss

A central argument throughout the thesis is that it is the foetal body, as produced by interactions between biomedicine and governance, which determines what happens in second trimester pregnancy loss in England. There is little opportunity for the pregnant woman to influence the events of second trimester loss, its consequences, or its widely accepted meaning. However, the discursively produced consequences of pregnancy loss in the second trimester are enacted on the pregnant body. They constrain the pregnant woman's status in relation to motherhood, they delimit her healthcare choices in relation to her own body and that of the foetal being, they limit her person-making and her kin-making, and they challenge her understanding of reality itself. This is therefore a form of reproductive governance, producing, controlling, and managing reproductive life in relation to the second trimester of pregnancy through a broad range of actors, including the NHS, civil registration, state bureaucracy and institutions of death and disposal. The consequences of this reproductive governance are to marginalise the pregnant woman, to restrict her agency in pregnancy, sometimes to enact violence on her body, often to render her reproductive labour invisible, and sometimes to deny her bereavement, as I have described in the preceding chapters. Describing these restrictions, exclusions and forms of violence means that this thesis contributes to literature in the field of reproductive politics. Addressing these issues and making them visible through research is a contribution to reproductive justice and feminist politics.

10.1.1 Enacting the teleological ontology of pregnancy

The way in which reproductive governance is enacted in second trimester pregnancy loss is through the application in many separate incidents and micro decisions of an ontology of pregnancy which is teleological and focused on the production of a living person as an outcome. This teleological ontology of pregnancy underpins the biomedical and governance discourses which determine events and outcomes in healthcare or in relation to the state and wider society. A teleological ontology of pregnancy means the examined and normalised foetal body defines the value of each pregnancy in relation to whether it will produce a living, healthy person. A woman whose pregnancy ends in the second trimester cannot normally produce such a person. Her experiences of pregnancy are therefore marginalisable when understood through an ontology which says a pregnancy is only meaningful, and indeed real, if it will end in the appropriate outcome of a living person. The foetal body and its future outcome defines pregnancy itself, which is why it is so centred in the biomedical-legal discourses described in this thesis. The extent to which teleology and the outcome of pregnancy define the process of gestation itself is particularly visible from the point of view of second trimester reproductive disruption. Reproductive governance in England is built around the foetal body and the prospect of a live birth, rather than the woman’s experience of pregnancy and birth, whatever their outcomes. The thesis therefore contributes to literature which addresses the devaluing of gestation (Ivry, 2010), to literature which describes the marginalisation of pregnancy loss experiences (see the literature review in Chapter 2), and also to literature which seeks to understand women’s experiences in pregnancy in relation to power in the context of bodies (for example, Annas, 1986; Bordo, 2003c; Cohen Shabot & Korem, 2018; Duden, 1993; Lupton, 2012; Oakley, 1984; Rothman, 1986/1993).

10.1.2 The biopolitics of teleological pregnancy

Whilst other feminists have argued that a focus on outcome in pregnancy is derived from the values of patriarchy (Rothman, 1986/1993), I argue that the case of the second trimester shows that there is also a biopolitical impetus behind the teleological ontology of pregnancy. This can be seen by the way the ontology is enacted through close entanglements of biomedicine, the NHS, civil registration and bureaucratic regulation and entitlements. The reproductive governance of pregnancy in England is all broadly enacting the teleological ontology of pregnancy as an event defined by its purpose, of producing a ‘healthy’ living being at the end. In England, the state is particularly embedded in biopolitical pregnancy governance because of the NHS overseeing most pregnancies in the UK, and because of the broad access to abortion in cases of termination for prenatally diagnosed foetal anomaly. The teleological ontology of pregnancy is more visible in second trimester pregnancy loss than in completed full term pregnancy because a completed pregnancy with the outcome of a baby is often the goal of both the pregnant woman, and the institutions of governance. When this is successfully accomplished, in full-term completed pregnancy, there is no incentive to investigate what assumptions were embedded in the process of pregnancy, which has now ended how it should, in a tactical polyvalence of discourses (Foucault, 1976 /1998). When a living person emerges at the end of pregnancy, such a living person can enter into relationship with the state through civil registration and become a citizen. It can be acted upon as a separate body by biomedicine through the state medical system of the National Health Service, thus optimising the health of the population. Biopolitical goals of the production of healthy life are achieved, to the satisfaction of all involved.

In second trimester pregnancy loss, this telos is disrupted. The potential person is perhaps already dead, in cases of foetal death. Or it may die because medical interventions will be ineffective or withheld, in cases of previable premature labour and live birth. Or it may have been diagnosed as likely to be so disabled as to have no potential as a ‘healthy’ person, and therefore be the object of termination for foetal anomaly. In each case, a second trimester foetal being cannot be the outcome which a ‘successful’ pregnancy produces: a healthy, living person. In Rose and Rabinow’s terms (2006), the biopolitical truth discourse about pregnancy, that it should produce healthy living persons, is disrupted. The authorities of biomedicine and the law which speak these truths, and which stage biopolitical interventions regarding life and health, are challenged by the second trimester failure to comply with the teleological ontology of pregnancy which underpins their truth discourse. As a result, the pregnant women whose pregnancies do not fit the biopolitical outcome which is normative for pregnancy are excluded from the truth discourse, or as I prefer to understand it, the ontology of pregnancy which underpins action in this field.

It is thus possible to understand the teleological ontology of pregnancy as a technology of power, providing ontological underpinning of certain truth discourses which are then prioritised and valorised. These truth discourses exclude other discourses, in the context of biopolitical goals of the production of healthy, non-disabled, living citizens as persons, or members of society. So pregnancies involving beings which are not included in the classifications of potential persons or living healthy citizens can be excluded from classifications of ‘real’ pregnancy because they cannot fulfil the teleological ontology of what pregnancy is.

At the same time, women experiencing second trimester loss are themselves excluded from the truth discourses which say they have made a person, or that they are kin to that person. If their own truths conflict with this, they are marginalised because they challenge the ontology which says reproduction is about biopolitics and the optimisation of life and health in the production of citizens. They are also marginalised because they might challenge the resource implications of definitions of pregnancy loss. There is an assumption in the governance of pregnancy that if women are allowed to define their own pregnancy losses they *will* claim them, and they *will* claim to be mothers who had babies, and that they then will make resource or political claims from which pre-viability losses are mostly currently excluded. They might also challenge the privatisation of the responsibility for abortion for foetal anomaly, and this type of abortion might become the basis of political claims for recognition and resources rather than the shameful, private ‘choice’ which it is currently understood to be. Or it might be that some women might choose not to participate in the reproductive technology of termination for foetal anomaly and their born babies might as a consequence be a cost to the state through healthcare and other needs. Pregnant women are assumed in the teleological model of pregnancy to be a potential drain on the state and its resources, unless they are likely to produce a healthy living baby to compensate for their use of resources. Their own health and resource needs are secondary to that of a potential new citizen. Second trimester pregnancy loss and its consequences make this visible in England in a way which is concealed by full term, live birth pregnancy. But the conclusions of this thesis, that pregnant women are marginalised in the definition of their own pregnancies and the persons they produce, and that they have limited control over the processes and meanings of reproduction, are no less true for those pregnancies which reach full term.

10.1.3 Resistance through ontology

My final conclusion about the reproductive politics of second trimester pregnancy loss is about political agency and how it can be exercised through resistance. In reproductive politics, resistance has been described in empirical settings in relation to lay opposition to direct oppression, violence, and control, such as in childbirth (E. Martin, 1987/2001). ‘Counter-conduct’ has been described in the lay self-administration of biomedical techniques related to reproduction (M. Murphy, 2012). Resistance has been implicit in the production of knowledge about biomedical control and violence in reproductive healthcare (Borges, 2017; Oakley, 1984; Sadler et al., 2016; Shabot, 2020) whereby the authoritative and expert description of exploitative power practices offers evidence which challenges practices within institutions. In this thesis, I have described in Chapter 9 how Foucauldian reverse discourse can be used in lay settings to agentially resist classificatory truth discourses, in an example of the interconnectedness of power and resistance described by Foucault (Foucault, 1976 /1998) and feminist Foucauldian theorists (Sawicki, 1991b).

However, I also seek to make a broader point about the agential use of ontologies as forms of resistance, and their potential relationship to truth discourse. I argue here that discourse is ontologically underpinned by coherent and internally logical sets of assumptions about the nature of reality, which is necessary for it to make sense to reflective social actors. So, for example, a biomedical discourse which says that a dead pre-viable foetal being is not a person is underpinned by the ontological principles of personhood being conferred by live birth. This discourse is then carried into practices in healthcare, bringing with it the ontological principles it contains and rests upon, which then have further consequences as the discourse is enacted. However, the same situation, of a dead second trimester foetal being, can be approached with a different set of ontological principles. For example, it can be approached through the English kinship principles which say that pregnancy produces a person and that a formed human body, even if dead, is a form of person. This kinship ontology, defining what is real, conflicts with the biomedical ontological principles and their resulting discourse and practice.

In some circumstances, such a conflict would be a case of kinship knowledge being subjugated knowledge, a form of illegitimate and disqualified knowledge (Foucault, 1980). However, ontologies of kinship are deeply legitimate and authoritative, widely penetrating into other discursive positions, even undermining those which are built on a different set of ontological principles. For example, the principle of live birth conferring personhood in the biomedical model in England is already ontologically breached by post-viability stillbirth being formally understood as a form of personhood and a kinship relationship which is registered by the state. Kinship as a system of thought about the reality of the world is a strong and authoritative alternative to the ontological positions of non-personhood and non-kinship supporting dominant biomedical and governance discourse about the foetal being and pregnancy. It is therefore readily available to be used as a form of resistance in creative and agential social thinking about the experience, in this case, of second trimester pregnancy loss. Furthermore, ontologies of personhood and kinship connect ideas of nature and law, or nature and culture, in adaptable ways (Strathern, 1992). This means they are especially amenable to agential use or to contestation (Edwards & Salazar, 2009). For example, the biomedical and legal definitions of a being as non-person or non-kin which are so dominant in the second trimester of pregnancy can be countered by an ontological position on kinship because kinship can conceptually incorporate and potentially supersede truth claims by both biology and law. Others have argued in relation to reproduction and the body that resistance is shaped by existing moral orders (Lock & Kaufert, 1998). I argue here that even more fundamentally than moral orders, ontological principles which underpin understandings of reality can produce and legitimise resistance where they align usefully with agential intention. In cases such as second trimester pregnancy loss where ontological conflict occurs and ontological alternatives have authority, the subjectification of individuals, who would usually work on themselves to conform to biopolitical aims (Rose, 1999) becomes less certain and more open to agency and forms of resistance. I therefore argue that this thesis and the case of second trimester pregnancy loss in England offers insight into the relationship between ontology, discourse, practice and resistance. It also shows that in practice there is space for forms of resistance within systems which appear to be all encompassing and repressive of alternative truth discourses. Such resistance is aided by alternative ontological underpinnings which have their own authority and power.

10.2 Beyond the binary: foetal personhood possibilities in England

The knowledge produced in this thesis itself resists the dominant biomedical-legal and teleological discourses of pregnancy and pregnancy loss in England in several ways. Firstly, it shows through empirical research that the binary legal threshold personhoods which are produced by live birth and viability are not the only personhoods which exist in England. In fact, prenatal and posthumous personhoods exist and are recognised by kin. Secondly, these forms of personhood are not an either/or status, but exist on a continuum or spectrum, containing different forms of meaning and built on different experiences of the world and the body. As such, foetal personhood attributions are not uniform across one woman's reproductive life, or even one pregnancy, but are dependent on multiple factors. And finally, attributions of foetal personhood are compatible with decisions about termination of pregnancy. The value and meaning of pregnancy for women is not necessarily entirely defined by the outcome of a living person at the end. As such, the dominant teleological construction of pregnancy as a means to an end, and pregnancy loss as insignificant, is challenged by this thesis.

10.2.1 Prenatal and posthumous personhoods as empirical facts in England

Whilst civil registration and the state only acknowledge two types of persons in England, the live born registered person, and the post-viability stillborn, my research shows that a more complex picture of personhood attribution exists in everyday life. Biologically separate life is not necessarily a prerequisite of lay personhood, or kinship relations. Forms and degrees of personhood can be, and are, attributed to foetal beings during pregnancy, as other research has found (Han, 2009; Howes-Mischel, 2016; Lupton, 2013; Middlemiss, 2020a; L. M. Morgan, 1996; Rothman, 1986/1993). Indeed, the NHS encourages pregnant women to think of their foetus as a baby from very early in pregnancy (NHS, 2019b). Furthermore, whilst others have noted that personhood may endure after the death of a living person (Carsten, 2004; Conklin & Morgan, 1996; Despret, 2019), my research, including the analysis of stillbirth as a form of personhood recognition, shows that posthumous personhood can exist even when there has been no independent life and the foetal being has died before birth. This confirms Ouroussoff's (1993) point that ideas of innate personhood based on individuality and capacity can be challenged by ethnographic knowledge.

However, personhood innately vested in the separately living individual is not simply replaced in my research by relational personhood. Relational personhood as an intentional, dialogic, two-way process of mutual recognition is not possible in second trimester pregnancy loss where the foetal being does not survive and can play no part in agentially producing relations. Relational personhood as a conferring of personhood by one agent onto another being, a one-way process, is closer to what can happen in a second trimester pregnancy loss where a pregnant woman or other person produces the foetal being as a person. Such forms of relational identity are popularly understood in the UK (Carsten, 2004). Yet in my research women did not ascribe personhood to all their foetal beings in different pregnancies, nor did they always ascribe the same personhood to a foetal being as to a living child, as I will discuss below.

The key factor in my research why stronger or weaker forms of personhood might be produced is the foetal body, in relation to the pregnant one.

10.2.2 Bodies and personhoods in the second trimester

Bringing the body back alongside a relational concept of foetal personhood is not a reversion to the model based on its living or dead status, capacity, potentiality, agency, or autonomy. It is distinct from the use of viability or autonomy as the basis for personhood attribution found in women in early pregnancy in Scotland (E. Ross, 2016). Instead, foetal personhood attribution is based on the foetal body in its formation as a broadly recognisable human body, possibly sexed in the second trimester or through post-mortem, sometimes perceived and apprehended through technology as well as through foetal movement within the pregnant body, which was birthed as human persons are birthed, and may have been encountered after birth as the ‘presence in the room’ that Lucy described in Chapter 8. This is a body in relation to the pregnant body and its experiential knowledges. It is connected to the pregnant woman’s experiences of her own body in pregnancy and in labour and childbirth. It is not dependent on the emergence of a living baby as an outcome, though such an outcome might increase that ‘presence in the room’ which Lucy experienced. The foetal body is also not fully determinative of personhood, in that women’s responses to it may vary. Yet personhood of the foetal being exists more, and is more likely to exist, as the foetal body is more: more developed, more human-formed, more substantial.

Furthermore, the role of the foetal body in relation to the pregnant body as an experiential source of personhood is connected to other cultural ideas about kinship and reproduction in England. The dominant mode of possession of a child, both legally and in lay understanding, is based on physical links which are based in the material bodies of children and parents. A child particularly ‘belongs’ to parents because of genetic or gestational material connections, often reflected in civil registration. Physical links in reproduction are understood through tracing origins to a particular body, or through genetic connection, for example in the ownership of frozen embryos of gametes. These material and bodily links may be carried forward into the production of persons, such as in some forms of surrogacy. It is therefore consistent with other cultural ideas about reproduction that having conceived an embryo or foetus, and gestated it, and given birth to it, these physical, embodied connections mean that one could potentially claim it as a child to whom one is mother.

10.2.3 Foetal personhood as a container: a metaphor for the English context

In my interviews, talking about the variation of personhood attribution with participants, I began to conceptualise foetal personhood in England as a pot or container, in an inversion of the discursive construction of the pregnant body as container critiqued by feminists and others (Annas, 1986; Bordo, 2003a; Hartouni, 1991; Purdy, 1990). In this container model of English foetal personhood, elements of personhood, such as the formed human body, biomedical and experiential evidence of prenatal and postnatal life, labour and birth, foetal sex, social practices such as naming, kinship relations, and so on are like items placed into a pot, which gradually and over time fill it to varying degrees. Pots of personhood, therefore, may be filled to different degrees with different content and may have different weight. What goes into the pot, how far it is filled, and what its final weight may mean lies in the agency of other persons - sometimes including medical professionals, sometimes other kin - but importantly the overall content of the pot is under the agential control of the pregnant woman herself. This is how some pregnancies, and some foetal beings, may produce more of a person than others. This thesis therefore sits within literature from other contexts which understands foetal personhood as partial, ambiguous, and changing over time (James, 2000; Lancy, 2014; L. M. Morgan, 1997, 1998; Rothman, 1986/1993), involving ‘different kinds, qualities, and degrees of fetal personhood’ (L. M. Morgan, 1996, p. 60).

This container model of personhood has connections to ideas of cultural variation in attachment depending on social circumstances (Scheper-Hughes, 1993) and delayed personhood in anthropology (Lancy, 2014). It steps away from an either/or binary in understandings of personhood and is more situational, processual, relational, and nuanced. The emphasis on partiality and time is reminiscent of Rothman’s ‘tentative pregnancy’ in the USA (1986/1993), also found in Scotland (E. Ross, 2016). However, the tentative pregnancy still sits within an understanding of pregnancy as teleological, or outcome-orientated, in which a reversal can take place and a pregnancy be disavowed if it is not going to produce a healthy living baby. Similarly, Layne argues that in pregnancy loss in the USA gradually acquired foetal personhood can be revoked if there is no live birth (Layne, 2006). This is not the case in my research. In the container model, once something is in the personhood pot, it cannot be easily be removed. Once the pot is filled to a certain level, a degree of personhood has been attained, and this cannot be reversed. This is likely to be particularly visible in my research, because all the pregnancies had been wanted, or accepted, by the second trimester. However, it is also a fit with English kinship, because as Strathern says, in the English model:

> Once a living creature has become a person, it always remains a person. (1992, p. 63)

This factor in the English ontology of persons means this foetal personhood is also different to incipient personhood, described by Morgan (1998) in Equador, in which coming into social being happened slowly and partially in pregnancy, but was not complete until after birth. In the English context, whilst foetal personhood also has processual elements and can be built up over time, it is not inherently ambiguous and in formation for the duration of pregnancy, as in Equador. By contrast, once the pot has enough elements in it to count as some form of person, the person-forming process is begun and is not undone, even by interruption of pregnancy or death of the foetal being. The personhood pot can, however, be filled up more after death, by kin-making practices such as naming or memorialisation.

This model also refutes the biomedical-legal assumption that a person just appears on emergence from the pregnant body after nine months of gestation. Instead it argues that a person is built slowly, through agency, and through social and material knowledge, over the course of pregnancy and birth, during separate life, and even after death. It makes visible person-making work which is done in gestation, including kinship relations which are prepared before birth. Pregnancy is not simply the project of ‘a’ child (Memmi, 2011), though wanting or accepting a future child is an element of continuing a pregnancy. It is also a project of ‘this’ child, a particular being which is formed slowly in multiple ways and which is contingent on many factors. For some women in my research, such as Megan, the pregnancy began with doubts about whether to continue it, and ended in the second trimester with a named and mourned baby. Others, such as Lucy, embarked on pregnancy with an idea of a future child to be a sibling to her daughter, but terminated the pregnancy in an attempt to prevent suffering after diagnosis of abnormality. For Paula, there was no embodied foetal personhood, though there was an imagined missing child in the middle of her family. For Natalie, inadvertently becoming aware of the sex of her unnamed baby made him into a dead son. For Louise, the body of her unsexed baby was less important than its soul, though she kept a photo of its tiny feet beside the pictures of her other children. Charlie posthumously gave her second trimester daughter her new husband’s name when they married and started a family together. Each woman filled the pot of foetal personhood to different degrees, and with different elements, and with differing results as to the degree of personhood which was produced. As such, my research shows that foetal personhoods in England are contingent, relational, diverse and non-binary, contributing to literature which challenges unitary ontologies of ‘the’ foetus (Casper, 1994; L. M. Morgan, 1996; E. Ross, 2016). I consider this to be a contribution to reproductive politics as well as a contribution to knowledge about foetal beings, because of its potential to challenge dominant ontological positions on the foetal being and the deprioritisation of pregnant women’s experience and knowledge.

10.3 Personhood and kinship in England: Bodies and relations

As well as contributing to ideas of foetal personhoods, this thesis adds to empirical knowledge of English personhood in general, and to the relations between persons which are understood as kinship. Building on the work of Strathern (1992), I argue that my research adds weight but also nuance to ideas that English personhood is built on concepts of a pre-existing material body. It also understands kinship relationships to be consequent to the physical body and that kinship can be agentially divested or prioritised (Edwards & Strathern, 2000).

My research shows personhood in the English context is connected to the materiality of the individual body, and in particular to broadly, though not absolutely, normative human morphology. The ‘perfect’ babies described by the participants in this research were human because they had recognisable physical features shared with other humans – feet, hands, faces, the shape of the family nose. This was why they were different to earlier pregnancy losses experienced by the same women which were physically experienced as unformed or simply blood. But the second trimester babies in my research could also deviate from physical and morphological norms of human persons – in size, in colour, in the development of their organs, in their inability to live independently – and still retain enough recognisable morphological normativity for them to be persons. Furthermore, whilst the presence of independent life is a factor in personhood attribution, it is not the determining one: personhood can exist prenatally and posthumously through corporeal presence rather than evidence of independent life.

My research shows there is also a material production of individual persons through the embodied experiences of pregnancy and birth for the pregnant woman, for example in the sensation of foetal movement in the pregnant body, sensations of emergence of the foetal being, and encountering the foetal body after birth. This means that personhood in the English context is in part produced by human bodies in relation to one another, as kin. Such kinship between persons has been conceptualised as partly based on the sharing of substances such as blood (L. H. Morgan, 1870), including in folk models of Euro-American kinship (Schneider, 1984). However, as with other findings in a European context, I find that the sharing of biogenetic substance is not the principle basis for kinship (Edwards, 2009), and was not prioritised by my participants. The important process in my research was not one of mutual sharing of physical substance, but instead was an interactive corporeal presence in pregnancy, labour, birth and during encounters between parental and born foetal bodies. In this ethnographic context, and contrary to ideas in other contexts about birth being unimportant in the formation of kinship (Sahlins, 2011), I argue that birth does produce persons and kin in the English system, as has been found elsewhere (Pande, 2009). However, the relevance of birth as a factor in the production of kinship is not based in the emergence of a living human being, as in the biomedical-legal teleological ontology of pregnancy. Experiences in the second trimester show that birth does not just produce persons through the emergence of a separate living biological individual who then initiates kinship, but through the intercorporeal processes of pregnancy, birth, and encounter between pregnant woman, foetal being, and other kin. Such intercorporeal processes can take place with a dead body as well as a living one. Such a being can still be a person in the English system. It has been produced by intercorporeal experience as a separate being, but not necessarily one with independent life.

Furthermore, as this processual and relational intercorporeality shows, the physical and embodied aspects of individual personhood do not exist independently of kinship relations. In the case of the second trimester, a relational personhood can be conferred by one or more living parties onto the dead foetal being. This is because kinship can be agentially produced or divested in the English system (Edwards & Strathern, 2000) and persons can act as kinship mediators (Edwards, 2000). Intention to make kin is also an intention to make persons who are kin to one another. This is particularly visible in the second trimester and is how Bethany and her husband understood themselves to be mummy and daddy to their son who died before birth. He was a person because of their intentional parent relation to him, and they were parents and kin because of his personhood in relation to them. It is also how foetal personhood can exist alongside termination, where intention to make a person and kinship co-exists with decisions to end the pregnancy. This relational personhood and kinship is therefore different to forms of kinship which are predicated on ongoing sharing of substance or care (Carsten, 2004) because the sharing has effectively ended, or was always a one-sided act of care conferred by one party on the other. I argue therefore that my research builds on the work of Strathern and Edwards to show how English personhood is both invested in the individual body, and also relational, based in particular ontologies of kinship.

10.4 Partiality and feminist politics

The representation of the experiences of second trimester pregnancy loss is necessarily partial and selective, and there are many aspects of my participants' experiences which have not found a place in this writing. These include further practices of kinship and mourning, the difficulties of reproduction after loss, and relations between other kin and the foetal being, as understood by the participants in the research. There are also many women in England whose experiences of second trimester pregnancy loss will not be reflected in the selected stories I relate here. In engaging in feminist research at all, and in writing this thesis as a contribution to reproductive politics, I am also inevitably imposing my values on others, possibly including some of my participants. In itself, this conflicts with my feminist principles in a circular argument which I am not able to resolve.

With some trepidation about the unknowable consequences, I make recommendations below for a vision of reproductive justice around second trimester loss and pregnancy in general which I believe to make space for many women whilst also challenging the status quo which is harming the women whose stories I tell here. However, I am aware that in promoting in my conclusions what Strathern refers to as 'the morality of choice' (Strathern, 1992, p. 153) around English models of kinship and personhood, I am also reproducing the normative values of English kinship in my investigation of it. As others have stated, studying kinship helps to constitute what it purports to describe (Franklin & McKinnon, 2001). I am unable at this point to see if this could ultimately be useful and liberating to women experiencing pregnancy loss in the second trimester, or if it is possible it will just constrain and determine their experiences in a different way. It is possible the resistance I describe in this thesis is simply the production of another subjectivity which may be equally restrictive or co-optable to restrictive ends (Abu-Lughod, 1990; Sawicki, 1991b). I would hope that the knowledge in this thesis could become a technology of power which allows more self-determination of the experiences of second trimester pregnancy loss. However, I am aware of the long history of power in relation to women's reproduction which suggests that any gains in terms of women defining their own pregnancies and reproductive choices and endeavours are small and fragile. I am not, at this point in my intellectual development, able to step outside the circularity of these conundrums. I offer my recognition of them as some mitigation for this.

10.5 For the future: challenges to the status quo, and visions of reproductive justice

Much of the knowledge produced in this thesis challenges the way that second trimester pregnancy loss is managed and approached in England. In particular, the management of the events of loss in the NHS needs to be changed. Lack of responsiveness to concerns about pregnancy, lack of access to care, lack of access to midwife support in labour, lack of access to decent pain relief, lack of choice about procedures, lack of management of the emergence of the foetal body, lack of management of lactation, lack of postnatal care, and lack of sensitive care in subsequent pregnancies are all shocking indictments of the supposedly woman-centred care in obstetrics and gynaecology. On the level of the physical experience of second trimester loss, there is much to be done in establishing a system which responds to women’s clinical and emotional needs rather than judges the gravity of their experience on the basis of the foetal body and its prospective outcomes. None of this is particularly difficult to do, but it does involve an ontological shift in terms of placing women’s needs alongside those of the foetal being in all pregnancy, not just pregnancy which will produce a living person.

Some hospitals already offer more responsive services to women. However, sometimes the focus is still on good bereavement care after birth, rather than also the physical needs of the pregnant or labouring woman during the loss. Whilst good bereavement care can make an enormous difference to women who consider themselves to have suffered a bereavement, I would be concerned if a presumption of non-personhood and non-motherhood in the second trimester was replaced with a presumption of personhood and motherhood. It is important that one restrictive system is not replaced with another, in which women like Paula are pushed into a response to pregnancy loss which is inappropriate for them. What I am really arguing for here is less prescription, and more informed and sensitive choice for women going through second trimester pregnancy loss, in a context of good healthcare responding to women's clinical needs.

Some of this involves a shift in thinking about pregnancy, rather than simply the second trimester, which are part of the broader contributions of this research. We need to challenge the assumptions described in this thesis that pregnancy is simply a means to an end, rather than a meaningful and important embodied experience for women whatever the outcome. Perhaps in accepted pregnancy we need to stop saying 'I'm having a baby' and revert to the old-fashioned 'expecting', with its possibilities of plans going awry. We need to challenge the associated assumptions that pregnancy loss is a failure: of control, of female bodies, of female behaviour. That somehow women are responsible, that it should be concealed, that women should just get on with it and try again, for a more successful outcome next time. Furthermore, we need to stop treating women as though they are making a fuss when they have needs in pregnancy. Instead, as a society we should try to meet those needs in an acknowledgement of the sheer work and effort involved in all pregnancy, whatever its outcome. We need to acknowledge those women who feel they are bereaved, whilst leaving the enacting of bereavement open and without prescription.

We need to bring termination into the open, to accept when women describe it as a loss, or when they do not. We need to make space for termination to potentially be an act of mothering and care, as well as a 'right' of sovereignty over one's body, or a medical procedure, or however else women might like to conceptualise it. When feminists balk at acknowledging the possibility of personhood in foetal beings, or acknowledging the potential significance of termination, they are doing many women a disservice. Ignoring what is there for some people is not going to sort this out. Instead we need to step back from dispute and the imposition of restrictive ontological positions, and acknowledge and respect diversity in ontologies of the person and kinship.

We also need to inform women about what a second trimester termination for foetal anomaly involves, in relation to the need for labour and birth, and to give them genuine choices about the benefits and risks of this process. Consent to antenatal surveillance and diagnosis should explicitly discuss what happens if there is bad news, and what termination involves, and space and time should be allowed to women attending antenatal screening to minimise their distress. It should not be a shock to every pregnant woman facing termination or other second trimester loss that she is expected to labour and deliver. She should be given every support in the process, whatever she decides. In subsequent pregnancies, there should be explicit attention paid to how the woman feels about any previous pregnancy disruption, and a plan put in place to help her manage her pregnancy emotionally as well as physically. It seems to me that the 3,000 or so women in England and Wales who face termination under Ground E of the Abortion Act every year are bearing the shock and disruption of the detail of termination in order to allow everyone else to carry on in blissful ignorance. This is unfair, and also patronising in its suggestion that most women are best kept in the dark about prenatal diagnosis and its potential consequences. It seems there is a fear that with full knowledge, women might stop conforming to the biopolitical and eugenic logics of termination for foetal anomaly. This is infantilising and undermines reproductive choice.

In terms of governance policy, the logical consequences of detailed knowledge of its effects on women experiencing second trimester pregnancy loss are deeply disruptive to the state’s systems. The cobbled-together and incoherent nature of civil registration, disposal regulations and maternity related entitlements would, in an ideal world, be completely rethought, putting women’s choices at the centre. The centrality of biomedically diagnosed viability and live birth thresholds controlling access to personhood acknowledgement would be removed and women and families would be able to define their own pregnancies and kin for registration purposes, which would be uncoupled from resource allocation. For example, the separate stillbirth register would be abandoned and replaced with a voluntary pregnancy loss register, with options for choosing public or private registration. Resource allocation (including the right to post-natal checkups) would no longer be based on the outcome of pregnancy, but on the woman’s physical experience, with a right to some paid time off work to recover from pregnancy and birth. ‘Maternity’ leave and pay rights would not accrue based on the gestational time the foetus was alive, but on the need to care for a living infant, decoupling them from assumptions about sexed and gendered care and allowing for sharing with non-gestating parents. They would then extend to all parents caring for a living child rather than just those women in qualifying employment.

This vision of reproductive justice, which seems to me at the completion of this research to be so obvious and fair, is far away. The experiences of women in their second trimester pregnancy losses that I have described in the thesis illustrate the gap between vision and reality. And yet reproductive justice in terms of women defining their own pregnancies and kin is the only solution which encompasses the positions and experiences of women in this research. It could accommodate Paula’s ontology of a foetus with no future alongside Rachel’s ontology of a named and mourned daughter. It could accommodate Holly’s desire for birth registration with Gemma’s relief that this was not required. It could accommodate Lucy’s rejection of feticide with Louise’s choice to accept the procedure. It could understand Alice’s decision not to name her babies whilst still mourning them, and Natalie’s desire not to sex her baby. It could accept Simone and Amber’s needs for bereavement support, and LeighAnne’s motivation to offer it. It could acknowledge Bethany’s understanding of herself as a mother despite having no living children. And it could recognise the multiple types of pain which all the women in this research experienced in their second trimester pregnancy losses, which have been too long overlooked.

Appendix 1: Table of possible outcomes of pregnancy in England

Table 1: The possible outcomes of pregnancy in different trimesters in England[47].

Gestational timeframe (completed weeks)	Possible spontaneous ending	Possible ending through medical intervention	Possible outcomes for the foetal body	Social definition of what happened	Civil registration
First trimester (1-13)	Miscarriage / labour		Foetal death	Miscarriage	No
	Intrauterine foetal death		Foetal death	Miscarriage	No
		Medically induced termination[48]	Foetal death	Abortion	No
		Surgical termination	Foetal death	Abortion	No

Continued on next page

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[47] For reasons of simplicity, I have not included molar or ectopic pregnancies here because they would never result in a living baby and their removal is necessary for the health of the pregnant woman. For ease of reference I have used medical terminology here.

[48] Under the amended 1967 Abortion Act and regulations set by the Secretary of State for Health in 2018 and 2020 allowing early medical abortion at home.

Table 2: (cont) The possible outcomes of pregnancy in different trimesters

Gestational timeframe (completed weeks)	Possible spontaneous ending	Possible medical intervention	Possible outcomes for the foetal body	Social definition of what happened	Civil registration
Second trimester (14-24)	Intrauterine foetal death		Foetal death	Miscarriage	No
	Spontaneous premature labour		Foetal death	Miscarriage	No
			Possible live birth but then likely death	Birth and death of person	Yes
			Some survival from 23 weeks+ with medical intervention[49]	Birth of person	Yes
		Medically induced termination	Foetal death	Abortion/ termination for foetal anomaly or medical reasons	No
			Possible live birth but then death (no medical intervention)	Abortion *and* birth and death of person	Yes
		Feticide and medically induced termination	Intrauterine foetal death	Abortion/ termination for foetal anomaly or medical reasons	No
		Surgical termination	Intrauterine foetal death	Abortion	No
		Caesarian section (rare)	Foetal death	Abortion/ termination for medical reasons	No
			Live birth but then likely neonatal death	Birth and death of person	Yes
			Possibility of survival from 23 weeks+	Birth of a person	Yes

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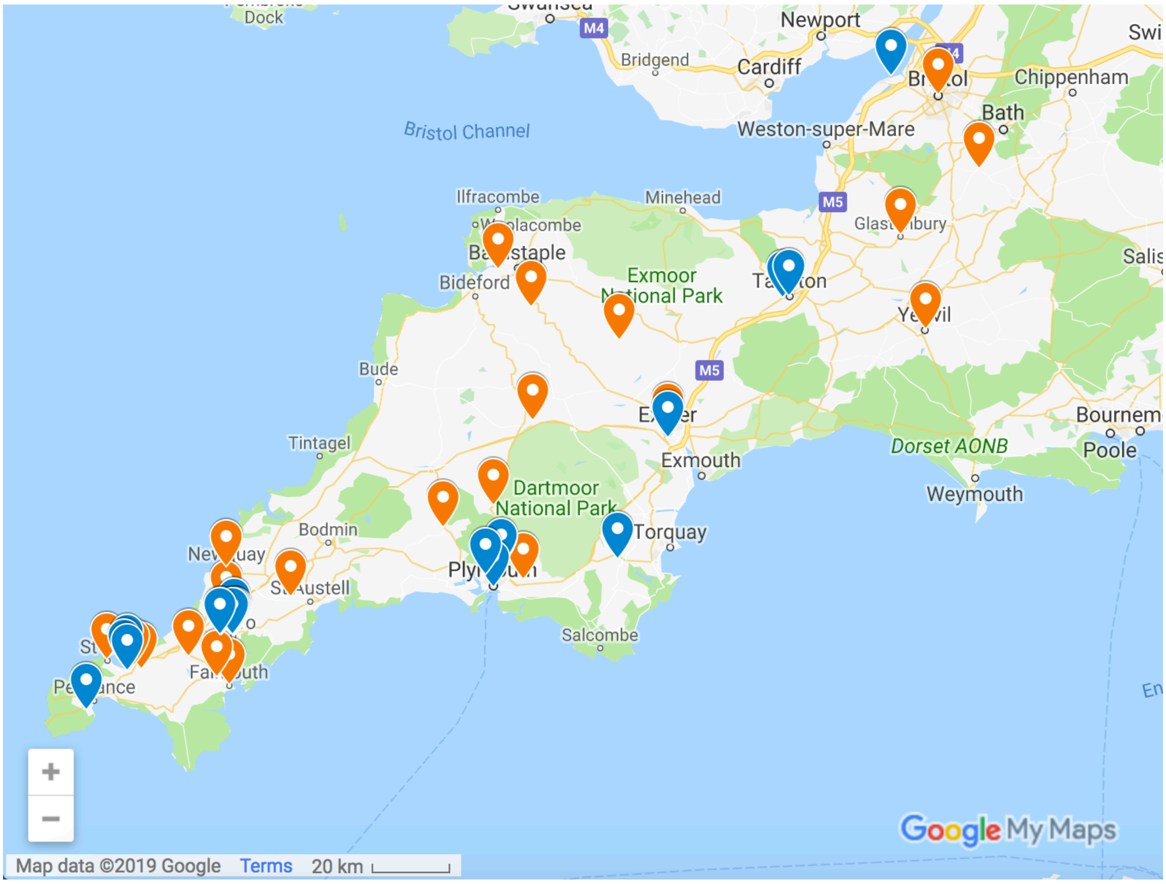
[49] See (RCOG, 2014)

Table 2: (cont) The possible outcomes of pregnancy in different trimesters

Gestational timeframe (completed weeks)	Possible spontaneous ending	Possible medical intervention	Possible outcomes for the foetal body	Social definition of what happened	Civil registration
Third Trimester (24-40, and 40+)	Intrauterine foetal death		Foetal death	Stillborn baby	Stillbirth
	Spontaneous labour		Live birth and survival	Birth of person	Yes
			Foetal death during labour	Stillborn baby	Stillbirth
			Live birth and neonatal death	Birth and death of person	Yes
		Induced labour	Live birth and survival	Birth of person	Yes
			Foetal death, or feticide if termination	Stillborn baby and/or Termination for foetal anomaly or medical reasons	Stillbirth
			Live birth and neonatal death	Birth and death of person	Yes
		Caesarian section	Live birth and survival	Birth of person	Yes
			Foetal death, or feticide if termination	Stillborn baby and/or Termination for foetal anomaly or medical reasons	Stillbirth
			Live birth and neonatal death	Birth and death of person	Yes

Appendix 2: Map of fieldwork locations and locations list



Map illustrating the geographic spread of the fieldwork. Orange markers denote interview locations (31), and blue markers denote fieldwork locations (21).

Locations relevant to the research

Hospitals where participants were treated

I name the hospitals at which women were treated to demonstrate the breadth of the fieldsite. I do not identify individual hospitals in relation to individual claims about care, and I have not sought responses to any of these claims from individual hospitals.

Royal Cornwall Hospital in Truro
University Hospital Plymouth (known as Derriford)

Royal Devon and Exeter Hospital
North Devon District Hospital in Barnstaple
Musgrove Park Hospital in Taunton
Yeovil District Hospital
Royal United Hospitals in Bath
Southmead Hospital in Bristol
University Hospitals in Bristol
King's College Hospital in London

Sites of communal memorialisation visited in the fieldwork

Baby Garden of Remembrance, Royal Cornwall Hospital, Truro
Penmount Crematorium and Baby Garden, Truro
Treswithian Downs Crematorium and Baby Garden, Camborne
Weston Mill Crematorium and Cemetery, Plymouth
Penwith Woodland Burial
Taunton Deane Crematorium and Baby Garden
Little Footprints Babyloss Memorial Garden, Follaton Arboretum, Devon

Minster Church of St Andrew in Plymouth (Anglican)
Our Lady of the Portal and St Piran in Truro (Roman Catholic)
Alphington Methodist Church
St Thomas Methodist Church in Exeter
Cleveden Pier on the Bristol Channel where Sands memorial events occur

Other

House of Commons, London

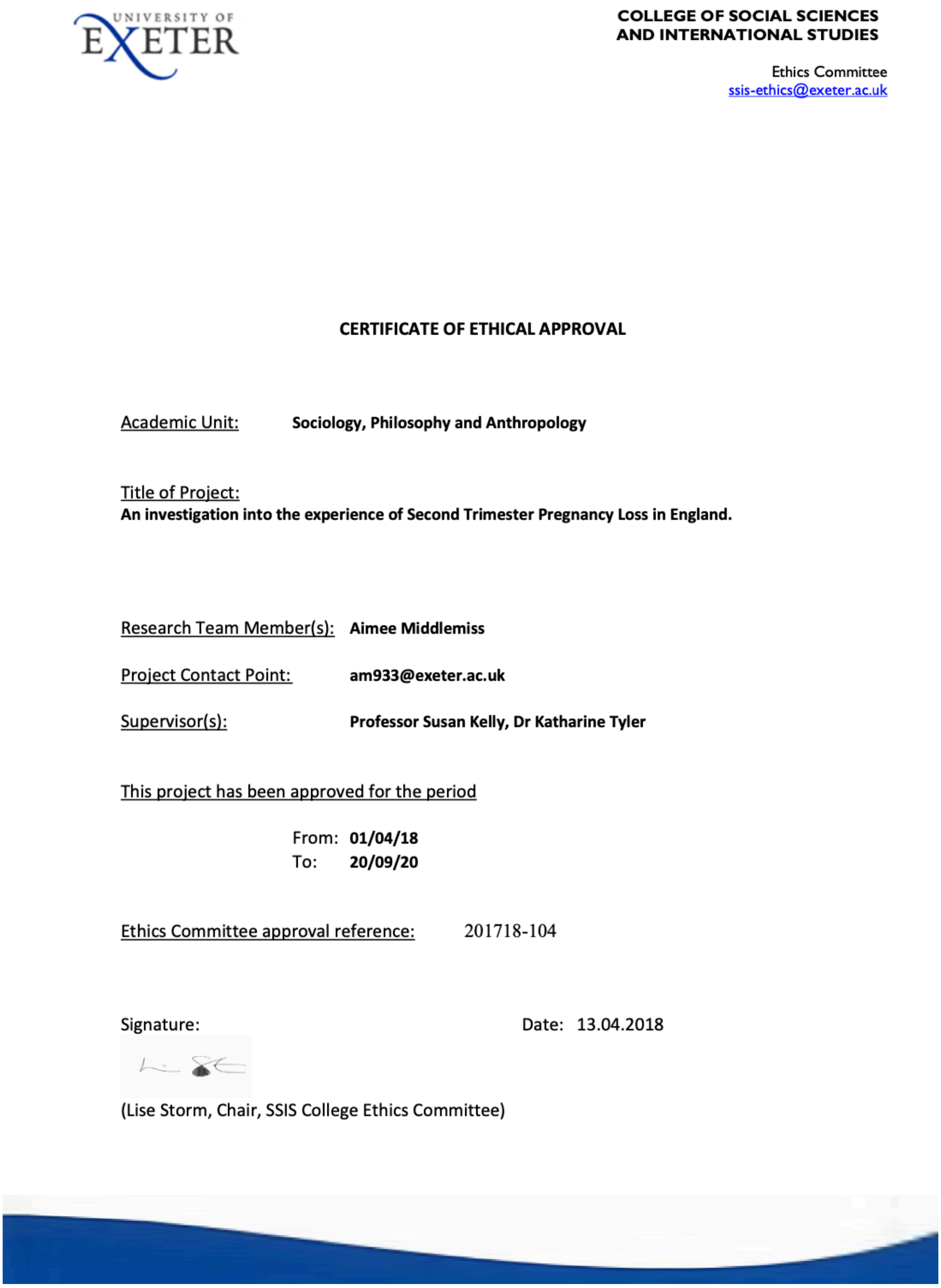
Online organisations relevant to the research

These websites and Facebook pages were accessed or followed by women in the research, and I used some of them for participant recruitment.

Sands national and local groups in Devon, Somerset and Cornwall

Miscarriage Association
ARC (Antenatal Results and Choices)
Babyloss Awareness Week
Ava’s Fund (Plymouth)
Choices Pregnancy Centre (Exeter)
Pregnancy Crisis Care (Plymouth)
Little Things and Co (Plymouth)
Ella’s Memory (Truro)
Cornwall Natural Parenting (Cornwall)
Stillborn and Babyloss Awareness (North Devon)
Towards Tomorrow Together (Somerset)
BabyCentre forums

Appendix 3: Ethics approval certificate



UNIVERSITY OF EXETER

COLLEGE OF SOCIAL SCIENCES
AND INTERNATIONAL STUDIES

Ethics Committee
ssis-ethics@exeter.ac.uk

CERTIFICATE OF ETHICAL APPROVAL

Academic Unit: **Sociology, Philosophy and Anthropology**

Title of Project:
An investigation into the experience of Second Trimester Pregnancy Loss in England.

Research Team Member(s): **Aimee Middlemiss**

Project Contact Point: **am933@exeter.ac.uk**

Supervisor(s): **Professor Susan Kelly, Dr Katharine Tyler**

This project has been approved for the period

From: **01/04/18**
To: **20/09/20**

Ethics Committee approval reference: 201718-104

Signature: Date: 13.04.2018

(Lise Storm, Chair, SSIS College Ethics Committee)

Appendix 4: Calls for participants

Facebook initial call for participants.

Aimee Middlemiss
June 12, 2018 ·

Sensitivity warning: Pregnancy Loss

Dear Facebook friends,

Many of you already know this, but I am currently doing a Sociology/Anthropology PhD at the University of Exeter about women's experiences of 2nd Trimester pregnancy loss.

I am now doing the research interviews for this project and would really appreciate help in finding women who would like to participate. I would like to interview women in the South West of England who lost a baby, for any reason, and went through labour and birth between 13 and 24 weeks of pregnancy, but whose baby did not survive.

I would be very grateful if anyone interested could contact me, either on Facebook (Aimee Middlemiss), or on email am933@exeter.ac.uk.

Please share, if appropriate.
Many thanks,
Aimee

Email call for participants, also used as post on Facebook pages other than my own.

Help please: Looking for women to take part in sociology research about Second Trimester Pregnancy Loss.

Hello,

I am a mum from Cornwall doing a PhD at the University of Exeter researching women's experiences of 2nd Trimester Pregnancy Loss in the South West of England. This research was prompted by my own experiences of losing my babies Summer and Oliver at this stage of pregnancy.

For my research, I would like to interview women in the South West who lost a baby, for any reason, and who went through labour and birth between 13 and 24 weeks of pregnancy but whose baby did not survive.

The reason I am looking at this particular stage of pregnancy is that it usually involves a labour and birth, which makes it different from early miscarriage. However, it is not legally or medically categorised as stillbirth, and for some people there can be a sense that the loss is unrecognised.

I am also focusing on women's experiences, rather than those of men affected by pregnancy loss, because of the experience of giving birth.

The research would involve talking about your experiences with me. I would like to talk about the labour and birth experience, what happened when your baby was born, and what happened afterwards, for example whether you had a post-mortem, or whether you had a funeral.

I would also like to talk about whether you have done or do anything to remember your baby since the loss. I would like to include a full variety of experiences and points of view and have no preconceptions about there being one type of experience which is more valid than any other.

I hope that the project will help inform attitudes to this type of loss in the future.

Participating would involve me coming to your home to interview you. I would anticipate that the interview would take up to 2 hours, and I would audio record it.

If you are interested in participating, I would be very grateful if you could contact me, either on email am933@exeter.ac.uk, or on Facebook Messenger (Aimee Middlemiss). You are very welcome to contact me for more information about my work before deciding whether to participate.

Please feel free to share this email with other people who may be interested, if appropriate.

Thank you.

Aimee

Aimee Middlemiss
Postgraduate Researcher
Department of Sociology, Philosophy and Anthropology
University of Exeter
http://www.eprofile.ex.ac.uk/aimeemiddlemiss

Appendix 5: Participant information sheet and consent form

INFORMATION SHEET AND CONSENT FORM FOR RESEARCH

An investigation into the experience of Second Trimester Pregnancy Loss in England.

This project aims to find out how Second Trimester pregnancy loss is experienced by women in England.

I will interview women who have gone through labour and birth after 13 weeks of pregnancy but before 24 weeks, and whose baby[1] did not survive.

Taking part in the project would involve at least one face to face interview with me, Aimee Middlemiss, which would last up to two hours. The interview could take place in your home, or in another private place of your choosing. I would make an audio recording of the interview to help me remember the content of the conversation. This interview might be followed by further interviews or other discussions and activities (fieldwork) if this was appropriate and acceptable to you. With your consent, I might photograph objects but not people.

I am aware of the emotional content of the topic, and I will do my best to be sensitive to this during my research. If at any point during interviews or discussions you did not want to answer a particular question, or you wanted to stop the interview, you could do so without needing to give me reasons. However, I also hope that the opportunity to openly discuss your experiences with me, and to contribute to knowledge about this type of pregnancy loss could be positive for you.

The research is for my PhD at the University of Exeter, in the department of Sociology, Anthropology and Philosophy. My studies are funded by a scholarship grant from the Economic and Social Research Council, part of the UK government. A synopsis of the final PhD thesis will be shared with Sands, the Stillbirth and Neonatal Death Society, who are providing training and other practical assistance.

If you would like a synopsis of the completed research, please provide your email address below.

Contact Details
For further information about the research please contact:
Aimee Middlemiss
Sociology, Philosophy and Anthropology
University of Exeter
Amory Building
Rennes Drive
Exeter
EX4 4RJ
am933@exeter.ac.uk

If you have concerns/questions about the research you would like to discuss with someone else at the University, please contact:
Professor Susan Kelly
S.E.Kelly@exeter.ac.uk

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[1] The project uses the word 'baby' rather than 'foetus' in interviews on the basis that this is the language most commonly used by pregnant women. However, I recognise that women will have many different experiences of pregnancy loss. For some it may be the loss of a baby, but for others it may not. If you would rather use the word 'foetus', or another word, please inform me.

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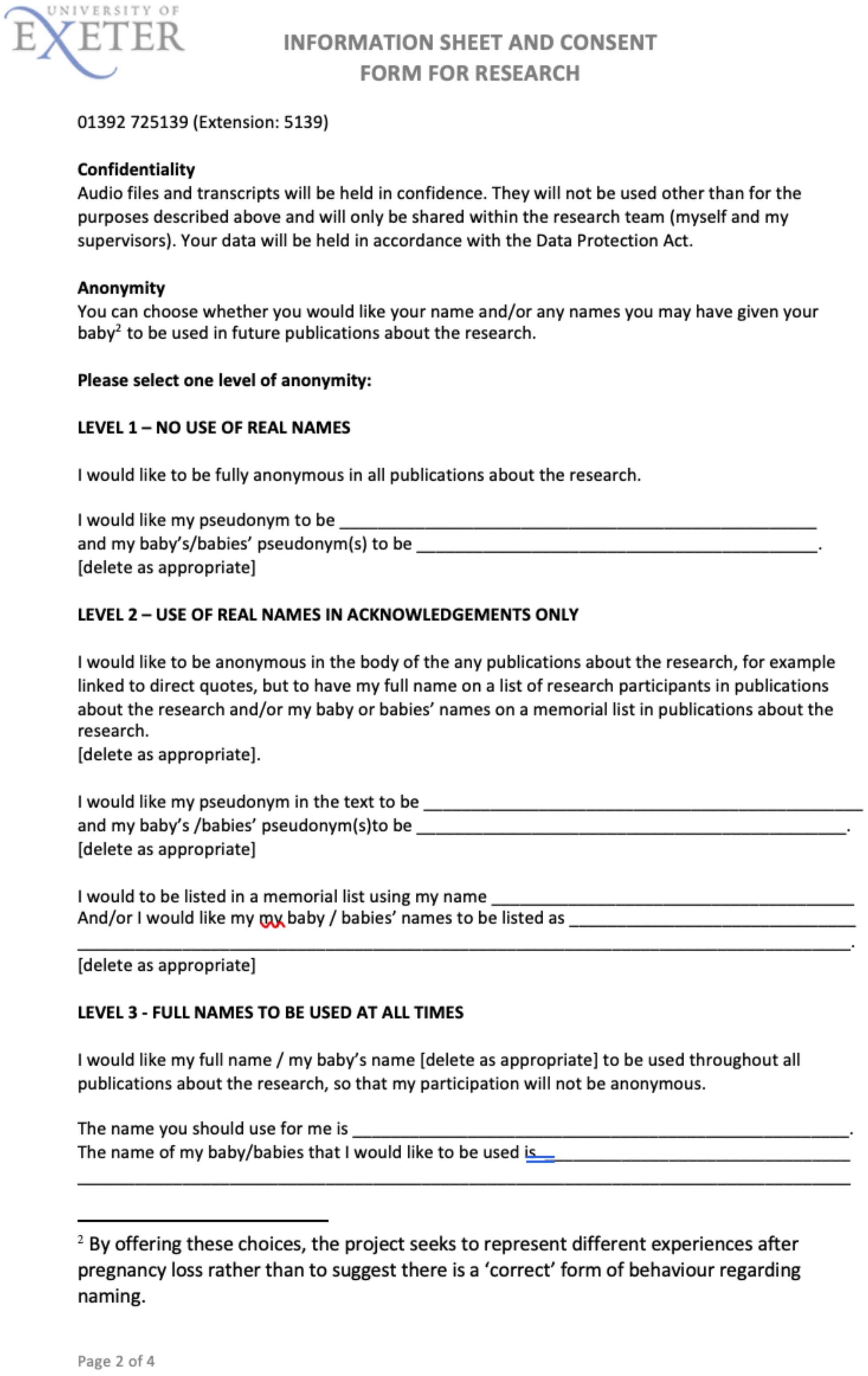

INFORMATION SHEET AND CONSENT FORM FOR RESEARCH

01392 725139 (Extension: 5139)

Confidentiality
Audio files and transcripts will be held in confidence. They will not be used other than for the purposes described above and will only be shared within the research team (myself and my supervisors). Your data will be held in accordance with the Data Protection Act.

Anonymity
You can choose whether you would like your name and/or any names you may have given your baby[2] to be used in future publications about the research.

Please select one level of anonymity:

LEVEL 1 – NO USE OF REAL NAMES

I would like to be fully anonymous in all publications about the research.

I would like my pseudonym to be ____
and my baby's/babies' pseudonym(s) to be _____________________________________.
[delete as appropriate]

LEVEL 2 – USE OF REAL NAMES IN ACKNOWLEDGEMENTS ONLY

I would like to be anonymous in the body of the any publications about the research, for example linked to direct quotes, but to have my full name on a list of research participants in publications about the research and/or my baby or babies' names on a memorial list in publications about the research.
[delete as appropriate].

I would like my pseudonym in the text to be ____
and my baby's /babies' pseudonym(s)to be ____.
[delete as appropriate]

I would to be listed in a memorial list using my name __________________________________
And/or I would like my my baby / babies' names to be listed as ___________________________
____.
[delete as appropriate]

LEVEL 3 - FULL NAMES TO BE USED AT ALL TIMES

I would like my full name / my baby's name [delete as appropriate] to be used throughout all publications about the research, so that my participation will not be anonymous.

The name you should use for me is ____.
The name of my baby/babies that I would like to be used is ____________________________
____

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[2] By offering these choices, the project seeks to represent different experiences after pregnancy loss rather than to suggest there is a 'correct' form of behaviour regarding naming.

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INFORMATION SHEET AND CONSENT FORM FOR RESEARCH

[delete as appropriate]

Data Protection Notice

The information you provide will be used for research purposes and your personal data will be processed in accordance with current data protection legislation and the University of Exeter's notification lodged at the Information Commissioner's Office. All data will be stored in encrypted form.

If you have chosen full anonymity (Level 1), the results of the research will be published in anonymised form, which means that your name and personal details will not be published. Your personal details will be stored separately to your interview transcripts and recordings and will be destroyed after 10 years. Anonymised data from the interview will be kept indefinitely.

If you have chosen to be anonymous in the body of the research (Level 2), anonymised data from the interview will be kept indefinitely. Your name as part of a separate list of participants will be stored separately from interview transcripts and recordings indefinitely. Your address and other contact details will be stored separately to your interview transcripts and destroyed after 10 years.

If you have chosen to be fully named in the research, your name will be stored indefinitely with your interview transcripts and recordings, but your address and other contact details will be stored separately and destroyed after 10 years.

Consent

I have been fully informed about the aims and purposes of the project. I understand that:

- there is no compulsion for me to participate in this research project and, if I do choose to participate, I may end participation at any stage;
- any information which I give will be used solely for the purposes of this research project, which may include publications or academic conference or seminar presentations;
- all information I give will be treated as confidential unless I have chosen not to be anonymous (Level 3);
- the researcher(s) will make every effort to preserve my anonymity if I have chosen to participate on an anonymous basis (eg Levels 1 and 2);
- Data, including sensitive personal information, will be stored in accordance with the Data Protection Act.

……………………………………………..	……………………………………………..
(Signature of participant)	(Date)
……………………………………………..	……………………………………………..
(Printed name of participant)	(Please provide an email address if you would like information about the outcomes of the project)
…………………………………………	…………………………………………
(Signature of researcher, Aimee Middlemiss)	(Date)

One copy of this form will be kept by the participant; a second copy will be kept by the researcher(s).

Appendix 6: Interview guide

The following questions were prepared in advance of fieldwork and referred to at least briefly during most interviews. See Chapter 3 for discussion.

- During consent form process: ask which terminology they prefer
- Could you tell me a bit about yourself, and your family?
- Could you tell me the story of your pregnancy loss?
- (Conception and family setting background)
- (Year of loss? In the NHS? Where?)
- (At what point in reproductive history did this happen?)

Discovery and management of pregnancy loss

- How did you find out things were going wrong?
- Labour (Spontaneous? Induced?)
- Birth
- Encountering the (baby's) body?
- Did you have your partner with you?
- Who helped you / who didn't help you?
- Going home / to hospital – what happened?

What happened in the days and weeks after

- How did you feel?
- What did you do?
- Who talked to you and what did they say or do?

(family, friends, GP, midwife)

- What happened to the (baby's) body? What did this mean to you?

(Hospital mortuary / bereavement service, post-mortem, cremation or burial)

- What happened to your body? What did this mean to you?
- Did you keep any objects?
- Telling people about the loss eg: work, family, had you announced the pregnancy?

- Medical explanations of what happened – 6 week check?
- Do you remember particular things causing you distress? Do you remember particular things giving you comfort?
- Was birth registration something which affected you?
- Was language used by doctors or others an issue for you?
- What choices did you have, or not have, in this whole process?

What happened later on?

- Did you do anything to remember the (baby)?
- How did you decide what to do?
- Did any objects play a part in your remembering of the (baby)?
- Are there significant times when you remember what happened to you? (of the year? Or events?)
- What did other people say eg family, friends? Did anyone particularly help you or make things worse?
- Do you tell new people about the pregnancy loss? What do you say? When?
- Did you seek any support?
- Have you done anything over a longer time frame related to this pregnancy loss? (eg charity involvement)

Other experiences of pregnancy and birth

- Before the loss?
- After the loss? (eg subsequent pregnancies)
- Can you describe how losing X made you feel about pregnancy and having children?

How do you feel other people react to what happened to you?

- Partner
- Close family, children, parents, siblings
- Wider family

- Friends
- Acquaintances / Work
- Public understanding and knowledge

- Would you like things to change about how people react to Second trimester pregnancy loss?
- What would you say to another woman going through this experience?
- (if some time later) When you reflect back on this experience in your life, how do you feel?

Demographic information

- Age
- Work
- Highest level of education
- Ethnic origin
- Religion

- **RECONTACT PERMISSION**

Appendix 7: Demographic details and diversity information related to the fieldsite and participants

The South West of England is an area of the UK which is predominantly White: Cornwall is 98% White British or Cornish (Cornwall Cornwall Council, 2013), Devon is 94.9% White British with the next ethnic minority group being White Other (Devon County Council, 2011), Somerset is 94.6% White British, with a non-white population of 2% (Somerset Intelligence, 2013).The foreign-born population is low compared to other parts of the UK (Krausova & Vargas-Silva, 2013), although there is substantial in-migration from other parts of the UK including retirees (see, for example, Cornwall Council, 2013). There is little diversity in terms of ethnic origin or religion. One of my participants described herself as Asian Chinese origin, born and educated in England, which was highly relevant in relation to the difficulties she and her white British husband had explaining their attitude to their daughter's death to her Chinese parents who had immigrated into the UK. All the other participants described themselves as White British, and so race and ethnicity became invisible in the research, as did the views of women from different communities who did not engage with my research. Similar lack of racial diversity in the South West was found by Frost et al. (2007)'s study on early miscarriage.

The area is mixed in terms of income, with Cornwall being one of the poorest areas of the UK (Cornwall Cornwall Council, 2017), and people in Devon and Somerset having lower incomes than the national average (Devon County Council, 2019; Somerset Intelligence, 2019), but with pockets of affluence around some cities. The area is also relatively stable in population. Most of the women in this study lived close by other kin, either their birth families or affinal relatives by marriage. The consequences of living near close kin included the fact that their presence or non-presence in the crisis of diagnosis or at the births of babies, and their attendance at funerals or grave visits could not be mitigated by distance and difficulty travelling. Those women in the study who lived in more urban or geographically well-connected parts of the South West were more likely to be involved with communities of other women and families who had experiences of pregnancy loss, though not specifically second trimester losses. Sands volunteer groups are active in Bristol and Exeter and include all types of pregnancy loss in memorial events. Plymouth has a particularly defined pregnancy loss community through the work of mother and funeral director LeighAnne Wright and her charity Little Things and Co. As a consequence, there is more integration of women experiencing pregnancy loss in Plymouth and the five women I interviewed knew LeighAnne, and some attended Little Things memorial events which I observed.

The age range of women at the time of the interviews was 25 to 48, and most were in their 30s. This is the age range at which many women reproduce in England and Wales (ONS, 2020), though the age of participants may also have been structured by the mostly online recruitment. The 31 women in this research had experienced a total of 34 second trimester pregnancy losses. Many of the women had also experienced live births, and losses at other times in pregnancy. Their second trimester losses occurred between 2003 and 2019[50], but most were in the last three years of the range:

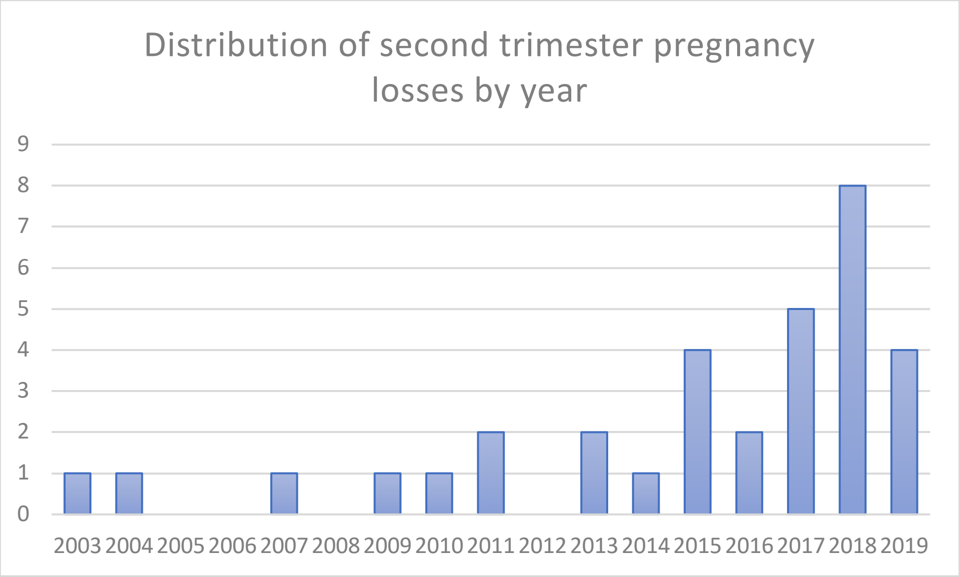

Figure 1: Chart illustrating the temporal distribution of the second trimester pregnancy losses of women in the study

This distribution shows that some interviews took place very soon after the event of pregnancy loss, for example those in 2018 and 2019 during which time

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[50] One second trimester loss in my study has no date because the woman in question did not reveal this.

period I was conducting fieldwork. The interview with Danielle took place less than a week after her second baby had died during premature labour, and the interview with Chloe took place before her daughter's body had returned from post-mortem. This did change the character of the interviews in those cases, which were more about recounting the facts of the events than reflecting on the meaning of the loss. Interviews about events which had occurred several years ago were more likely to be reflective about the nature of what had been lost and its place in a wider experience of reproduction.

There was a relatively even distribution of types of second trimester loss:

Type of second trimester pregnancy loss	**Number of babies who died**
Termination for foetal anomaly	10
Spontaneous foetal death	12
Spontaneous premature labour with no induction	9
Spontaneous premature labour plus some induction[51]	2
No official diagnosis	1
TOTAL	34

Figure 2: Chart illustrating the number and type of second trimester pregnancy losses experienced by women in this research

The balanced representation of the three types of loss I had identified as of interest to my research was a factor in deciding to end fieldwork, alongside practical factors such as time, and a sense of saturation in terms of the emergence of new themes or experiences (Francis et al., 2010; Guest, Bunce, & Johnson, 2006; Mauthner & Doucet, 1998). This distribution was not planned, because for ethical reasons I did not turn away anyone who wanted to tell me their story within the parameters of my calls for participants. My control over

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[51] This distinction between types of spontaneous loss is relevant as some which also involved induction may have been categorised as terminations and been legally recorded under abortion legislation reporting.

how many women were in each category was simply that I ended fieldwork at a point where each category was well represented numerically. However, the even spread of types of loss became useful for analytic purposes because I was able to make comparisons across the three types of loss. Furthermore, within these categories there were some examples of multiple losses: one participant had experienced two foetal deaths at different times, one had two spontaneous premature labours, and one participant lost twins. Analytic comparison was aided even more by women's other reproductive experiences because they could make comparisons across those experiences during interviews, as the diagram below illustrates.

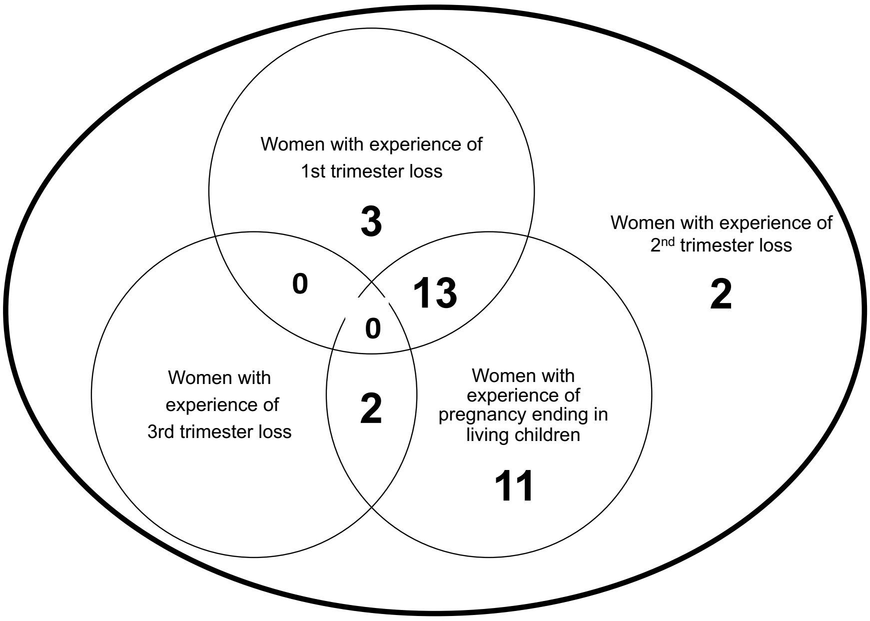

Figure 3: Diagram showing the number of women with different types of pregnancy experience

The comparisons that women themselves made between pregnancies were important. Most of the early miscarriages and abortions were not actively mourned although the dates and events were often noted and remembered. It was rare for names to be given, and early losses were repeatedly described as very different to second trimester losses. This is discussed in Chapter 8. Some of the knowledge produced in this research has come from the weight of evidence about commonalities in second trimester pregnancy loss experiences, but some has also come from the comparison of women's experiences in their other pregnancies, alongside comparisons between local medical management procedures in the event of pregnancy loss. The particularity of the second trimester pregnancy loss experience was well illustrated by these comparative possibilities.

The limitations of demographic categorisations in the specific fieldsite

Overall, my attempts at the logging of standard demographic categorical information such as class or relationship status revealed the limitations of these categories in producing meaningful knowledge in my specific research. For example, trying to categorise women into social class is fraught with issues, in relation to the researcher's imposition of a class on participants. Class is very nuanced and layered, and within one family experiencing pregnancy loss it may be a compromise between different parental classes. Furthermore, categorising people by education level or by job category does not necessarily explain their lived experience or their class. Due to the life stages, gendered work, and the geographic locations of the women I interviewed, several interviewees were doing paid work not associated with their class status, such as working in a surf shop despite being a graduate former consumer law advisor, because of the flexible hours it offered that fit with childcare. Taking one definition of class, such as 'shop assistant', does not reflect the social and economic position of that particular person. It is true to say that employment opportunities in the South West are limited, which might partly explain why the most represented occupation amongst my participants was care assistant. Furthermore, class doesn't necessarily come from occupation but from factors like precarity, such as Danielle's partner who couldn't attend hospital with her because he was only 3 days into a new job and could not jeopardise it. Defining class and class membership is therefore complex and subtle, and using demographic indicators is not useful. Instead, I relied on my own long-term tacit knowledge of society in the South West for my assessment that overall I have spoken to a broad range of women with different economic and social resources and have not just interviewed one 'class' of participant.

Another demographic indicator which was more complex than the numbers might suggest is that of religion. Although the census reports that 59% of people in England and Wales identify as Christian, 25% of people say they have no religion and this figure is both growing and concentrated in people under 49 (ONS, 2013). Amongst my participants, even fewer had a religion, with 20 describing themselves as having no religion or not being religious, and one more describing herself as having partly lost her faith. This is very different to literature on pregnancy loss in other settings, for example in the USA, where a more actively faith based response to loss has been described (Layne, 1997, 2003a). Four women were active Christians, and two described themselves as inactive Christians. However, the numbers conceal a more complex picture of engagement with post-loss memorialising. Many of the non-religious women, such as Joelle, deliberately did not engage with anything religious and avoided memorial services such as the one held by Royal Cornwall Hospital because it took place in a Catholic church in Truro. Other women encouraged a visit from the hospital chaplain but made it clear they wanted a secular conversation. However, of the women who stated they had no religion, some actively participated in some religious activities in relation to the death of their child, for example in the case of Holly and her fiancé, burying their daughter in the local church cemetery and subsequently getting married in the same church. Still others went along with being visited by religious hospital staff. Eva, who has no religious faith, had an experience structured both by living in a small community and by the NHS's chaplaincy programme which inserts religion into healthcare settings, when the chaplain who happened to be known to her personally turned up in the room shortly after her son was born. She did not feel able to challenge his presence. Having no religion therefore did not necessarily preclude participation in religious rites of passage for a variety of reasons.

Similarly, identifying as Christian could be a nuanced position: Louise had an active faith and felt strongly that the body of her baby was a vessel for its soul, but she had a termination for foetal anomaly including feticide when it transpired that the baby had a medical condition incompatible with life. In this she had the support of her church, who prayed for her. Simply reporting this as a demographic indicator of 'Christian' would not express the complexity of the position to readers better acquainted with Christian fundamentalism on abortion in the US setting. The Church of England, by contrast, hosts Anglican memorial services known as ‘Saying Goodbye’[52] for people who have lost ‘a child’ at which ‘all are welcome regardless of the type or circumstances of loss they have experienced’ (The Mariposa Trust, 2018). Local nuances affected the types of Christianity available, and also other types of spirituality which participants described. Some women considered themselves to have a spirituality which was not part of institutionalised religion but connected to their mourning, in an echo of findings on rituals around stillbirth in Sweden (Davidsson Bremborg, 2012). One woman was an active medium, several others expressed a belief in ‘the spiritual’ but said they had no formal religion, and one woman had been a Pagan but lost her faith after pregnancy loss. These belief systems affected their responses to pregnancy loss, but their would not be properly represented in broad demographic classifications. For example, there is a geographic and historical connection to nonconformity in religious or spiritual matters in South West England which includes acknowledgement of the pre-Christian landscape, Methodism (Brace, Bailey, & Harvey, 2006), paganism and a New Age sensibility (Heelas, 1993; Holloway, 2000) and which would not be represented in this research if the women who were non-conforming but still held spiritual beliefs were simply defined as having no official religion.

Relationship status and kinship details were also more complex than a simple demographic indicator would suggest. Twenty one women were married and two engaged, one was single, and the others were in partnerships with men at the point of interview. All the women in the research were in long term relationships with men when they became pregnant and when the baby died, although some women had subsequently separated from their baby’s father. I did not speak to anyone who was single when she became pregnant, in a non-heterosexual or non-binary relationship, or one involving multiple partners. Considering relationships numerically and categorically like this would suggest a certain conventionality in relation to sexual relationships, kinship, and parenting, or even monogamy. However, this is not necessarily the case when the ethnographic detail is added in. Some women had had the pregnancy loss with a previous male partner who was not the person now witnessing their

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[52] I attended these services in 2018 and 2019 in Exeter and Plymouth, and a different service at Truro Cathedral in memory of all children who have died.

grieving. Two interviewees were still married to their previous partners, who were not the fathers of the babies who died. One baby who died was conceived with a new partner in the middle of a divorce. Several interviewees had stepchildren through relationships with men who were already parents, or brought their own children to new relationships to be step-parented by new partners. Charlie's husband had informally posthumously adopted her dead daughter from a previous relationship, by giving the child his surname.

Numerical indicators of the number of children women had did not represent the complexity of their kinship relationships. Not all the children were with the same father, or the current partner, and sometimes this was highly relevant to the sense of loss when the pregnancy ended. For example, Kerry had two children from a previous relationship, but her current partner had no children other than the baby that died. Kerry had had a hysterectomy and now would never have children in this relationship, nor would her partner be able to have his own genetic children with her. Joelle had an older daughter, but this child lived with her father, who himself had a baby with his new partner at a similar time to Joelle's termination for foetal anomaly of her daughter with her new fiancé. Describing women simply by their partnership status or the number of children they had obscures the diversity and meaning in their kinship relationships which had an effect on their experience of pregnancy loss. The diversity of life experiences and values which are contained in the stories of women in this research cannot be adequately described by attempts to categorise them demographically. Ethnographic detail is required in order to adequately situate their pregnancy loss experiences in their lives.

Glossary of medical and technical terms

Cervical stitch, or cerclage	A procedure used to try to prevent the cervix from opening (NICE, 2015), usually carried out with the pregnant woman awake with her legs in stirrups after a spinal block. Two of the participants in this research underwent this procedure in the second trimester, and one in the third trimester but each time it was unsuccessful and had to be removed. One participant had the procedure in a subsequent pregnancy which ended in live birth at term.
Chorionic villus sampling (CVS)	A procedure which removes and tests cells from the placenta during pregnancy to check for genetic and chromosome disorders in the foetus (NHS, 2018b).
Cervical dilation or dilatation	The degree of opening of the cervix in labour. (Forrest, 2019)
Crowning	The point of passage of the foetal head through the woman's vagina in vaginal birth.
Dilatation and Curettage, or 'D&C'	An obsolete form of surgical abortion in which a curette is used to empty the uterus through the cervix (RCOG, 2015). 'D&C' has become a lay term referring to any surgical evacuation of the uterus.
Dilatation and Evacuation, or 'D&E'	The medical use of instruments and/or suction to remove the foetal

	body via the opened cervix and vagina (BPAS, 2015; RCOG, 2015)
Down’s Syndrome	Down's syndrome causes learning disability and health conditions affecting the heart, digestive system, hearing and vision. (NHS, 2018c)
Edward’s Syndrome	A serious chromosomal disorder also known as Trisomy 18 (NHS, 2017a).
Foetal congenital diaphragmatic hernia	A condition where the internal organs are displaced because of the absence of diaphragm and therefore the organs do not develop properly. (GOSH, 2016a)
Gas and Air	Entonox, a breathable analgesia used in labour and for other pain relief (NHS, 2017b).
National Bereavement Care Pathway	Partners in the National Bereavement Care Pathway include the charities Sands, ARC, Bliss, Lullaby Trust, Miscarriage Association, Teddy’s wish, and the Institute of Health Visiting, Neonatal Nurses Association, NHS England, Royal College of GPs, Royal College of Midwives, Royal College of Nursing, Royal College of Obstetricians and Gynaecologists. The group has been in place since 2017, initially funded by the Department of Health and Social Care and supported by the All Party Parliamentary Group on Baby Loss, and has produced guidelines which it asks English NHS Trusts to sign up to in order to improve bereavement care access at all

	gestations of pregnancy loss and neonatal death. Three of the hospital sites in this research had signed up to the NBCP since 2017 and before the end of my fieldwork. The pathway focuses on allowing parents to define their pregnancy losses as bereavement and much of the advice is about dealing with the body of the baby if there is one in a way which recognises it as a form of person, should the parents be open to that. There are repeated warnings in the documents to offer parents choice at all stages of the process. To some extent this focus on bereavement and the social experience *after* birth centred on the foetal body results in a de-emphasis on the physical experience of labour and birth for women, though the Pathway does discuss the need for consent and best practice in medical care, such as pain relief options.
Patau's Syndrome	A serious chromosomal disorder also known as Trisomy 13 (NHS, 2019a)
Spina Bifida	A congenital neural tube abnormality (NHS, 2020).
Ventriculomegaly	Enlargement of the ventricles of the brain, linked to hydrocephalus. (GOSH, 2016b)

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