Chapter 2

'They're Not Supposed to Deal with This Kind of Thing'

Ontological Boundary Work, Discipline and Obstetric Violence

Expecting her first baby at the age of twenty-four, one winter's night nursery nurse Bethany woke to a gush of liquid in the bed. Her husband was at work, 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 pre-viability pregnancy loss.

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[1] 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 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 emphasising 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.

In the story of women's experiences of second trimester loss, this chapter describes how the 'wrongness' of second trimester pregnancy loss, breaching the teleological ontology of pregnancy which should not produce this outcome, structures the nature and quality of the birth experience for women. In the previous chapter, I described how diagnosis of the foetal body diverted the pregnant woman onto a specific trajectory of care, in the process of which her own possibilities of choice in healthcare disappeared. I now trace how the events of second trimester pregnancy loss in English healthcare are systematically minimised and marginalised, through disciplinary techniques and events of obstetric mistreatment and violence, with the consequence of disappearing the body of the pregnant woman as the object of healthcare. The practices of healthcare protect ontological classifications of the second trimester foetus as 'not a baby', and the pregnant woman as 'not a mother' in biomedicine and English law. Fundamental understandings of the reality of pregnancy are protected by these practices. They occur in the context of the teleological biomedical-legal ontology of pregnancy, in which a pregnancy which will not produce a living baby becomes invisible in the English healthcare system.

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 (Lovell 1983, Hey et al. 1989, Letherby 1993, Murphy and Philpin 2010, Moulder 1998). 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 English state healthcare system, and align with highly critical findings from three recent government-commissioned enquiries into failings in maternity care in England at Morecambe Bay, Shrewsbury and Telford, and East Kent (Ockenden 2022, Kirkup 2015, 2022).

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 (Sadler et al. 2016, Williams et al. 2018, Perez D'Gregorio 2010). 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, Cohen Shabot 2016, Cohen Shabot and Korem 2018, Cohen Shabot 2020, Chadwick 2018). 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.

Ontological Boundary Work in English State Healthcare

Ontological underpinnings of biomedical discourse define a previable or dead foetus as a non-person. Because 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: 177) and gynaecology wards which often handle late miscarriage and termination and 'ugly dead babies' (Bolton 2005: 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 does produce a form of legally recognised person (see Chapter 3). Furthermore, confused ontological positions on the foetal being

co-exist within healthcare itself. 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'. 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 1991). As Charlie's story in the previous chapter 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 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 within a boundary infrastructure which defines classifications through practices (Bowker and Star 2000: 299). 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 disciplinary techniques (Foucault 1991, 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. It is rendered invisible in the healthcare system.

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 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. My research found that gestational time, medical space and differential healthcare were used as forms of discipline to produce pregnant women as deviant, sometimes alongside forms of more direct obstetric violence, disappearing their experiences through the procedures of the healthcare system.

'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 2019a), 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 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 the birth. This lack of access to care and the dismissive attitudes of staff in relation to pregnant women'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 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?*
>
> [laughing] 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, which then disappeared in their attempt to access care. Often a sense of lack of entitlement to medical care was expressed in 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). In UK culture, the NHS is perceived through an emotional lens of gratitude and collective ownership which often puts it beyond critique (Arnold-Forster and Gainty 2021), 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.

'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 and are inappropriately taking up space when they should be invisible. This is a development of the way space is used as an obstetric technology demanding compliance (Davis and 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 existence of 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 congenital anomalies. 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. [laughing slightly]

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 [of notes] 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.

A combination of space and bureaucratic procedures, such as maternity notes, was used to separate and individualise women as cases (Foucault 1991), in a classic disciplinary technique. The Green Notes, the NHS symbol of pregnancy carried around by all pregnant women at the time of my research,[2] have been analysed as part of the NHS's work culture which puts pregnant women in a marginal position in relation to their own care, a Foucauldian surveillance technique in normative pregnancy which also symbolises the carrier's identity as a pregnant woman (Papen 2008). The use of the notes as disciplinary tools whose removal produced deviance was 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 had been taken off her, but she occupied the same space as women who were still pregnant, which she found very difficult:

It's those green folders. [Laughing slightly] 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? [I was aware of the hospital layout]

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 seen 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 emphasised through the public exposure that the spaces of normative pregnancy impose on a woman whose pregnancy is not going well. In these cases, visibility was heightened but with the effect of labelling the event as deviant. There were many tales of routine antenatal scans at which diagnosis of foetal death or anomaly occurred 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 to 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 two 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 ten 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 and suggest that the needs of the woman facing pregnancy loss are invisible in the planning of maternity services. 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 into 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. They were either inappropriately visible as women facing loss alongside normative pregnancies, or made invisible in the same contexts, where their needs were not factored into care practices. 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 Kerry, the wait was for labour to progress and her son to die.]

Eva also experienced being moved in and out of spaces in a way which emphasised the deviant nature of her pregnancy and the ambiguity of her visibility. 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. In the process, they themselves faded in and out of visibility in the practices of healthcare provision.

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 standards of care in labour and birth in the third trimester, though similar experiences have been noted in the reports on failed maternity care at Morecambe Bay, Shrewsbury and Telford, and East Kent (Kirkup 2015, 2022, Ockenden 2022). The standards of care were often congruent with typologies of mistreatment of women in childbirth (Bohren et al. 2015), 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.

Lack of Informed Consent

Women in my research were underprepared 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, Lyus and Robson 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 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, like Bethany at the beginning of the chapter, who had had no birth training. NHS antenatal classes typically take place in the third trimester (NHS 2018) 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, and 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 having their pregnancies ended, or going into labour, with very little information about what this involved. In emergency spontaneous premature labour cases, it was assumed that women would 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[3] 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-adjacent care, professionally 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 last as long as it did:

> 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 (Royal College of Obstetricians and Gynaecologists 2011a, Speedie, Lyus and Robson 2014). Amber had laboured for some time in a previous pregnancy before an emergency Caesarean, but she 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 [for morphine], 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 the chapter, 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. Explanations of such lack of advance information may lie with the management of relatively rare events of second trimester loss by inexperienced staff. They may also be connected to the general failings in the maternity care of women which has been evidenced in Morecambe Bay, Shrewsbury and Telford, and East Kent. However, the result in the experiences of the women in my research was that the potential gravity of the events of second trimester loss and the potential pain involved in labour and birth were consistently underplayed.

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 of 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: decisions have already been about its ontological status 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 and making the second trimester labours disappear. Such boundary work results in obstetric violence for many women.

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: 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 her earlier 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 amongst 31 women this should be the case twice. In informal conversations with two midwives I have been told that midwives do actively prioritise those which have 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.[4] 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.

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 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. 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, and the birth event became invisible to them. It is not clear whether this was deliberate policy, or the result of the lack of experience and training of staff as well as institutional deprioritisation, which consistently emerged in accounts from my participants and reflected findings in the Ockenden and Kirkup maternity care reports about poor management, communication with families, and training of staff. Joelle had accepted medical induction of birth for the termination of her pregnancy at 16 weeks' gestation after diagnosis of a serious genetic condition. 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? [This made Joelle cry.] And, I, like, didn't pick her up or anything.

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 (Smith et al. 2013, Macfarlane, Wood and Bennett 2003, MBRRACE-UK 2020b). Recent guidance, for example, states that signs of life which occur only for a minute after birth should be understood as posthumous reflexes rather than certifiable independent 'life' (MBRRACE-UK 2020b). 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 controlling the ontological (and civic) status of beings produced in pregnancy.

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. Fifteen women were treated in a specialist bereavement suite or another part of the labour ward. Eight were on a gynaecology or a general ward. Three births were at home, one was in Accident and Emergency, and the remaining four did not know the classification of the ward they were on. Women in my 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, and made them invisible to maternity. 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 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 (Royal College of Obstetricians and Gynaecologists 2010a). In line with findings in failed maternity units investigated by Ockenden and Kirkup, best practice in the care of women is not followed on the ground in NHS Trusts. Instead of experienced midwives, support for women in second trimester loss on gynaecology wards was from nursing

staff. These nurses sometimes appeared to have no experience of pregnancy loss, to be untrained, or to actively avoid dealing with foetal bodies, chiming with Bolton's (2005) study of gynaecology as 'dirty work'. 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, allowing her baby to be visible to her when it would normally be concealed. 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 congenital anomaly which was 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 a chromosomal anomaly, 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 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 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 second 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 are 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 forms of obstetric violence.

Conclusion: Ontological Politics in the Medical Management of Second Trimester Pregnancy Loss

Earlier in this book, I explained how medical diagnosis 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 and as a consequence of which women's choices are constrained. In this chapter, tracing the next events in a second trimester pregnancy loss, 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, in which the visibility of the labouring woman is at stake.

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 takes 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 (Brown 1995, Brown and 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', 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 mean that access to care and treatment is inferior in quality to that afforded to women in the third trimester of pregnancy where there is the potential for a normative pregnancy outcome. Combined with the practices of invisibility in second trimester healthcare, this politicises the diagnostic and ontological knowledge produced by biomedicine and the law in relation to second trimester pregnancy loss.

Notes

1. 'Gas and air' is Entonox, a breathable analgesia used in labour and for other pain relief (NHS 2023).
2. Green notes are now being replaced with electronic maternity notes in England and Wales.

3. Dilation is the degree of opening of the cervix in labour (Forrest 2019).
4. I have been unable to find out in conversations with practitioners why internal vaginal examination 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.