Conclusion

Making Visible the Labours of the Second Trimester Pregnancy loss

Over the course of this book, drawing on the experiences of my participants, I have presented an empirical account of how the classification of a pregnancy loss in England as occurring in the second trimester structures and determines the event for pregnant women. This foregrounding of women's experiences deliberately counters the fact 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 legal, bureaucratic and resource consequences, or its widely accepted meaning. However, the discursively produced consequences of pregnancy loss in the second trimester are enacted on the pregnant body and person. They constrain the pregnant woman's identity 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 endeavours, or sometimes impose them on her, and they challenge her understanding of reality itself. Second trimester pregnancy loss is therefore embroiled in reproductive governance, though which reproductive life is produced, controlled and managed by 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 or her own definition of her pregnancy, as I have described in the preceding chapters. Describing these restrictions, exclusions and forms of

violence situates this book in the field of reproductive politics and in pregnancy loss literature. However, it also makes a contribution to wider theory in reproduction, which this chapter will draw out.

The Teleological Ontology of Pregnancy

The reproductive governance of second trimester pregnancy loss is enacted 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. Reproductive outcome is determinative of the fundamental reality of pregnancy. 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, her gestational and birth labour in this time, 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 define pregnancy itself, which is why it is so centred in the biomedical-legal discourses around the second trimester. 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 Biopolitics of Teleological Pregnancy

Whilst other feminists have argued that a focus on outcome in pregnancy is simply derived from the values of patriarchy (Rothman 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. Vitality and health outcomes as the basis of the teleological ontology of pregnancy are 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 1998). When a living person emerges at the end of pregnancy, they can enter into relationship with the state through civil registration and become a citizen. They can be acted upon as a separate body by biomedicine through the state medical system of the NHS, 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 pre-viable 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 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 portrayed as. 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 book, that pregnant women are marginalised in the definition of their own pregnancies and any 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.

Resistance and Ontological Politics

Despite the constraints on agency described above, in a true biopolitical manner, there is space for another politics in the teleological ontology of pregnancy. 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 (Martin 2001). 'Counter-conduct' has been described in the lay self-administration of biomedical techniques related to reproduction (Murphy 2012). Resistance has been implicit in the production of knowledge about biomedical control and violence in reproductive healthcare (Oakley 1984, Borges 2017, Sadler et al. 2016, Cohen Shabot 2020) whereby the authoritative and expert description of exploitative power practices offers evidence which challenges practices within institutions. I have described in the context of foetal personhood claims 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 1998) and feminist Foucauldian theorists (Sawicki 1991).

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 and 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 and 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. 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.

Beyond the Binary: Foetal Personhood Possibilities in England

The knowledge produced in this book 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, though not in every case. 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 itself challenged by this book, which 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), this book 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 and Strathern 2000).

My research shows that 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.

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 and as material entities. Kinship between persons has been conceptualised as partly based on the sharing of substances such as blood (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 principal 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 and 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 are 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. Second trimester pregnancy loss therefore shows English personhood at the margins of its recognition to be both invested in the individual body, and also relational and intercorporeal, based in particular ontologies of kinship.

For the Future: Challenges to the Status Quo, and Visions of Reproductive Justice

Feminist ethnographers have also emphasised the potential for radical politics in relation to radical scholarship (Strathern 1988) and, specifically in the context of reproduction research, for political action through critical engagement (Layne 2003, Davis and Craven 2011). Much of the knowledge presented here challenges the way in which 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 effective 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 judging 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 is really needed 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. We need to move away from a National Bereavement Care Pathway, with its normative presumption of grief and its exclusion of situations which do not fit its narrow parameters, towards a multiplicity of Pregnancy Ending Pathways.

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. There needs to be a challenge to the assumptions described in this book 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 some feminists baulk at acknowledging the possibility of personhood in foetal beings, or acknowledging the potential significance and weight of termination decision-making, 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, and there should be more options available to her. 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, rather than make the most informed choice they can in their own reproductive lives.

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. I tentatively welcome the recent Pregnancy Loss Review's proposal for pregnancy certification in England because of its potential flexibility and the way it will hopefully meet the needs of some women and families. However, it is also another quick, inexpensive fix to one element of the system, in one part of the UK: a useful compromise which does not sufficiently reimagine possibilities. In a more radical reimagining, 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 postnatal 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 all 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 is far away. The experiences of women in their second trimester pregnancy losses that I have described illustrate the gap between vision and reality. And yet reproductive justice in terms of women defining their own pregnancies and kinship 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 invisible for too long.