

INTRODUCTION

INVISIBLE LABOURS

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

Eventually Holly was given medication to end the pregnancy¹ by starting contractions. In common with most of the other participants in my research, Holly had not anticipated this process, and in particular had no prior knowledge of the requirement to deliver vaginally. The labours of pregnant women and the births of foetal beings in the second trimester are mostly invisible to those who do not have direct experience of these forms of pregnancy loss. The reactions of other people are typified by a conversation Holly described between her partner and a female friend, who asked how the body of the baby had been 'taken out':

[Partner] was like, 'you do realise she had to give birth?'

She was like, '*what?*'

'Yeah, it was full on, like, labour, everything's the same as like a full-term baby, it was no different.'

She was like, 'Oh!'

Yeah, it didn't just disappear. Which I just . . . some people, you just don't know, I guess.

Did you know, before it happened to you?

I didn't think . . . I did hope a little bit that they would maybe sort of . . . like a Caesarean sort of thing? When they said – cos I had to be induced – I was just like, 'this is going to be dreadful.' And they said, 'you know it'll be quite an easy birth; it won't be hard.' And when I was in labour, it was just as bad as it was with my full-term daughter.

After that long and difficult labour, Holly's daughter was born late the next day but she had died during the birth process. She emerged into the presence of many other members of her family. Against the wishes of hospital staff, Holly had insisted on having several members of her family present, including her father, her brother and her partner's mother and sister. Holly expressed with passion to me how much she felt her baby to have been part of her family – her family had been present at her elder daughter's birth, and she wanted everyone to participate in the birth and death of this second baby. For Holly, her baby was a person, situated in a kinship system, who before and after her birth and her death had parents, grandparents and a sister. However, these relationships were not recognised in her experience in hospital:

[Medical staff] don't address her as my daughter, or a baby. They say 'foetus', which really annoys me.

I'm like, 'No, my *daughter*, you mean?'

'Yeah, your foetus.'

No.

What makes a difference there, do you think it's the age that she was, or do you think it's that she didn't get born alive, or? When would they not do that?

I think they just think she wasn't breathing, she wasn't, you know, she didn't take a breath. To them, it's just a foetus.

In common with many of the women I interviewed for this research, Holly's daughter, born without signs of life before legal viability at 24 weeks' gestation, was not eligible for state birth registration, the process through which legal persons are recognised in England. Legally, as this book will describe, she was not a person but a foetus, because she showed no life outside her mother's body and was born before viability. Holly was deeply upset by this definition and her daughter's exclusion from civil registration:

She was a person! You know. Why? I still don't understand why they can't? I know they can't do it from like . . . ok there has to be like a

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

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

Even if your dog dies, people come up to you: 'I'm so sorry, I heard about your dog, that's really sad.'

'Oh, thank you.'

But your baby dies.

Everyone's like: 'oh god, just don't look at her, you don't have to speak to her then.'

The themes of Holly's experience of second trimester pregnancy loss include invisibility, exclusion, lack of agency in medical care, and conflict with wider social norms. They also include resistance, non-normative forms of personhood and the production of kinship outside that which is recognised by the state. Holly's story is one of those I draw on in this book to make visible the reproductive politics of second trimester pregnancy loss, in which all these themes reoccur. In the chapters which follow, I explain how discursive positions on foetal personhood, kinship, pregnancy and pregnancy loss are produced by the entangling of biomedicine and the law in England, and I detail the effects of these on women experiencing second trimester pregnancy loss. I show how some women agentially resist these definitions of their pregnancies using an alternative ontology

of kinship and embodied personhood, based in the English kinship model (Strathern 1992, Edwards 2000) and expressed through everyday kinship practices, sometimes directed towards a prenatal or posthumous person.

As well as providing an account of marginalised and invisible pregnancy loss experiences, the book is a contribution to understandings of pregnancy itself, in its specific setting and more widely. I describe a teleological ontology of pregnancy as it becomes visible through the site of second trimester pregnancy loss in England. This ontology underpins biomedical and legal discourses in which a 'real' baby is one which is born alive, or after legal viability. Building on Linda Layne's 'realness problem' noted in earlier miscarriage in the USA (2003, 2000), I show how foetal beings born dead, or which die before 24-week foetal viability, in this model are not understood to be ontologically 'real' persons, and the pregnant women in whose bodies they gestated are not understood to be 'real' mothers. The labours of those mothers, both in birthing the foetal being or baby, and in constructing the social personhood of coming babies during pregnancy and before and after loss, are invisible to society. This is because pregnancy in England is understood in relation to its teleological outcome of a living, viable, healthy baby rather than the gestational experience of the pregnant woman. Furthermore, in this context 'real' personhood and kinship are defined by the state through civil registration and the production of citizens, rather than by the intentions of the pregnant woman and other kin. The research is therefore framed by ideas of reproductive justice and autonomy and has implications beyond the specific site of pregnancy loss.

Second Trimester Pregnancy Endings and the English Context

A human pregnancy usually lasts approximately 40 weeks, and in many cases ends around this time with the spontaneous or induced vaginal birth of a living baby or babies, or with a Caesarean birth. However, pregnancy may also end much earlier than this. Endings before full gestation is completed can be because the foetus dies *in utero*, or because the pregnant body expels it before full term. These events are further differentiated by the way in which they came about. For example, the foetus might die spontaneously inside the womb, or it might die before birth because of feticide or

surgical abortion. The pregnant body might expel the foetal body spontaneously during a miscarriage or preterm labour, or this process might be initiated intentionally using medication to induce the emptying of the uterus, which is also a technique of abortion. In cases of preterm labour or Caesarean with a living foetus, the foetal being might be born alive and might live, perhaps only briefly before thresholds of foetal viability, or with neonatal care at later gestations. These different pathways to early pregnancy ending are often subdivided into categories depending on whether they are spontaneous (such as miscarriage and stillbirth) or intentional (such as induced labour or types of abortion). However, as Holly experienced, there is not always a clear division between a spontaneous pregnancy ending and the intentional use of medication to end a pregnancy.

Cross cutting the way in which the pregnancy ended, the continuum of pregnancy is often divided by biomedicine into gestational time categories, called trimesters (NHS n.d.), each of which has different possible outcomes in terms of the survival of the foetal body and the social definitions of what has happened in that pregnancy – a miscarriage, an abortion or a stillbirth. In both biomedical and English legal frameworks, a key time threshold within the continuum of pregnancy is that of foetal viability, the point at which a born baby is considered able to survive outside the pregnant body with the assistance of medical technologies. This is set in England at 24 completed weeks of pregnancy, as determined by medical diagnosis and defined in law by the 1967 Abortion Act and the 1990 Human Fertilisation and Embryology Act. Before viability, there is no legal personhood in cases of foetal death before birth, and an event of pregnancy loss is understood to be a miscarriage or termination of pregnancy. After viability, a pregnancy which ends in foetal death is categorised as a stillbirth, and a set of different legal statuses apply to the foetal being and its kin. Furthermore, after viability the termination of pregnancy on any grounds other than foetal anomaly or a serious threat to the life and health of the pregnant woman is not permitted.² This time-based threshold intersects with another legal and biomedically determined category, which is that of live birth. A biomedically confirmed live birth at any point in pregnancy also results in a specific legal outcome, that of legal personhood and state recognition of kinship. Live birth is possible before viability, and was experienced by some women in my research, although long-term survival before viability is rare (Royal College of Obstetricians and Gynaecologists 2014).

My research is concerned with the second trimester of pregnancy, understood in the UK to be between 13 completed weeks and 24 completed weeks of pregnancy (National Institute for Health and Care Excellence 2019b, Royal College of Obstetricians and Gynaecologists 2011b, NHS n.d.), and therefore delimited by legal viability at its furthest reach. The production of knowledge about second trimester pregnancy loss in England is limited because of its particular position in relation to biomedical and legal categories of viability, live birth and abortion. It is a historically contingent category which is both determinative of outcomes, and also partly rendered invisible by its own legal and medical parameters. Some pregnancy loss in the second trimester is, in Scott's (1998) terms, legible to the state and the state National Health Service (NHS) in England. Statistics are produced on all abortions, through the requirements of the 1967 Abortion Act. Whilst termination for foetal anomaly can potentially take place at any point in pregnancy since the 2008 Human Fertilisation and Embryology Act, it is particularly relevant to the second trimester because NHS routine ultrasound and genetic screening for anomalies takes place before 24 weeks, and most termination for foetal anomaly takes place in the second trimester (Speedie, Lyus and Robson 2014). Statistics on live births and subsequent neonatal deaths are generally collated through the requirements of the 1953 Births and Deaths Registration Act, though which of these occur in the second trimester is not recorded through birth registration systems. Some statistics from the second trimester have been collated since 2013 through a national system which reports live births and neonatal deaths from 20 weeks' gestation or foetal deaths from 22 weeks' gestation (MBRRACE-UK 2020a). However, there is a paucity of quantitative and medical knowledge about the end of pregnancies in the second trimester in general (Peel and Cain 2012). This means that second trimester pregnancy loss is not produced as an object which can be acted upon by the state health service – it is illegible and invisible to the state. In the NHS in England, where many central decisions are made about healthcare by bodies such as the National Institute for Health and Care Excellence (NICE), this means that second trimester loss is also illegible and invisible to national level healthcare planners and providers. Furthermore, specific experiences of second trimester loss, such as the mandating of labour and birth, or encounters with a formed foetal body, have been invisible in wider society because all pre-viability spontaneous losses are categorised as miscarriages. Miscarriage is commonly conceptualised as a

relatively minor, commonplace and inconsequential reproductive event, although this may not be the experience of women and families to whom it happens.

The explicit location of the research in this book is therefore important. Whilst state provision of most healthcare in the United Kingdom of Great Britain and Northern Ireland structures some aspects of experiences of pregnancy loss and its visibility through centralised decision making, in other ways there is no unitary set of laws or practices related to pregnancy and pregnancy loss because of the devolved nature of many aspects of governance and healthcare. For example, health services are devolved to the separate nations, and the NHS also has regional commissioning of health services within England. Not all medical treatment is the same everywhere in the UK, despite the existence of NICE and professional bodies such as the Royal College of Obstetricians and Gynaecologists (RCOG), and different health authorities and hospitals have different protocols and funding. Some hospitals may adopt 'national' standards of care, such as the National Bereavement Care Pathway for pregnancy and baby loss (National Bereavement Care Pathway 2022), developed by charities and professional organisations. However, whilst the National Bereavement Care Pathway aspires to national status, it currently only applies to England, and decisions to adopt the standards are made at local Trust level, with 79% uptake in 2022.

Furthermore, access to different medical treatment is subject to the different legal jurisdictions of the nations which make up the UK. For example, after decades of being completely unavailable, abortion up to 12 weeks was decriminalised in Northern Ireland in 2019 (Campbell and Bloomer 2022), though access is still highly restricted on a practical level. In the remainder of the UK, abortion remains illegal except in specific circumstances when doctors who provide it become exempt from prosecution under the 1967 Abortion Act, and there is differential access to abortion in different nations (Beynon-Jones 2012, Purcell et al. 2017, Purcell et al. 2014). Disposal of foetal tissue comes under different rules in England compared to Scotland, and birth registration is managed differently in Scotland. As a consequence of these differences, I sometimes refer generally to the 'UK' in discussion of medical and legal discourses where this definition includes England and English law, but at other times I use 'England' or 'English' to demonstrate where there is divergence from other systems within the UK. The pregnancies and foetal beings described in the following chapters

are located in a specific legal and biomedical framework of governance. This means the body politics described here is culturally and historically grounded (Lock and Kaufert 1998), as with many other accounts of reproductive loss (Earle et al. 2008, Letherby 1993, Oakley, McPherson and Roberts 1984).

Pregnancy Loss in Relation to Abortion

At the same time as being located in a specific context, this research is also connected to debates about reproductive rights and abortion which travel across borders. During my fieldwork, several participants referred to the referendum on abortion access which was then taking place in the neighbouring Republic of Ireland. I wrote my thesis at the height of pandemic lockdowns, when discussions about early medical abortion access at home were playing out in British politics. Subsequently, the 2021 restriction of abortion access in Poland, the 2022 US Supreme Court overruling of *Roe versus Wade*, and, as I write this introduction, the tightening of abortion access in Hungary have threatened pregnant women's access to abortion in global contexts. Access to state funded abortion has existed in the UK since 1967, and the gestational time limits are more liberal than many other jurisdictions, including access to abortion on the grounds of foetal anomaly or threat to the life of the pregnant woman at any point in pregnancy. However, abortion is not fully decriminalised nor on demand (Lee, Sheldon and Macvarish 2018), there is limited availability of surgical abortion in later pregnancy (Speedie, Lyus and Robson 2014), and anti-abortion activism is increasing (Lowe and Hayes 2019). Campaigns to reduce access to termination for foetal anomaly have been mounted in the courts (Weaver 2022), though they have been unsuccessful to date.

This means the context for this research on pre-viability pregnancy loss including termination for foetal anomaly is politically fraught. Tensions between mourning a pregnancy loss and possible attributions of foetal personhood have been understood as potentially threatening to abortion rights (Keane 2009, Layne 2003) and others have expressed anxiety about the possibility of undermining a pro-choice feminist position on abortion (Martin et al. 2017, Andaya and Campo-Engelstein 2021). This is particularly pertinent in my research because the second trimester is itself defined by legal viability, which plays a part in restricting abortion access in the UK for some categories of abortion and is a strategic camouflaging tool

used by those who wish to further limit abortion (Franklin 2014). Discussing my research in academic contexts, I have been asked whether undertaking it at all threatens the pro-choice position, and have faced challenges from abortion activists. Unease about the possibility of undermining abortion access permeated some of my friendships at the beginning of the project and was raised by some participants in the research. I acknowledge these anxieties and have felt them myself.

However, I believe it is also a feminist endeavour to engage with discussion of the human foetus, what it might be and mean, and not cede this ground to the anti-abortion movement (Morgan and Michaels 1999b, Morgan 1996). It is possible to challenge the Euro-American framing of women's abortion rights *versus* foetal personhood (Bordo 2003). It is also important not to avoid engaging with pregnancy loss experiences grounded in the loss of a person (Layne 2003, Rothman 1993). In my work, abortion is directly addressed through the inclusion of termination of pregnancy for foetal anomaly (TOPFA) in the range of experiences which make up second trimester pregnancy loss. This is a deliberate move away from the tendency in UK social science research to consider pregnancy endings as different research objects based on the legal and biomedical discourses which classify them according to spontaneity or intention to complete an abortion. Generally, pregnancy endings have been addressed separately, as miscarriage (Kilshaw 2020a, Letherby 1993, Murphy and Philpin 2010, Oakley, McPherson and Roberts 1984, Peel and Cain 2012, Frost et al. 2007), or still-birth (Murphy 2019, Murphy and Cacciatore 2017), or abortion (Beynon-Jones 2012, 2017, Lee and Ingham 2010, Purcell et al. 2020, Statham, Solomou and Green 2006). Whilst research on discrete categories of pregnancy endings is needed to understand the specificity of different experiences, bringing together abortion and spontaneous pregnancy endings can offer a critical perspective, centre the experiences of women, and remove intentionality as the determining factor in categories of loss (in the UK context, see for example Moulder 1998, Earle, Komaromy and Layne 2012, Sheach Leith 2009, Austin et al. 2021, Austin and McGuinness 2019, Kuberska et al. 2020). I believe the depoliticisation of miscarriage (Browne 2023) and the over-politicisation of abortion are both challenged by the research presented in this book.

The invisibility of pregnancy losses, and specifically of losses in the second trimester, also means that focusing on this area of research at all is an issue of reproductive justice. Reproductive choice is not

just about conflict between the rights of a foetus against the rights of a woman (Bordo 2003), and reproductive rights can include the right to bear children as well as terminate a pregnancy (Thompson 2005), particularly when the framework of reproductive justice is used (Morgan 2015, Luna and Luker 2013, Ross and Solinger 2017). In this vein, I propose that denying women the right to define their foetus/baby as a person where they wish to do so is also a restriction on women's reproductive freedoms and a form of reproductive injustice, and that pointing this out should be a focus of feminist endeavour. Indeed, acknowledging nuance, complexity and ambiguity in reproduction is an important way forward for feminist research.

In addition, a rights-based discourse is inappropriate in this specific context. There is no legal 'right' to abortion in England, but simply legal grounds on which prosecution of doctors will not occur, in relation to what is still a criminal act under the 1861 Offences Against the Person Act. The law on abortion is highly restrictive and medicalised, rather than an absolute freedom, or 'reproductive right' for women (Sheldon 1997). This positions this research in a particular juridical and cultural space. This space also does not recognise the same degree of rights for children as for adults in the UK, demonstrating that foetal rights are an inappropriate principle to pit against adult women's rights. And as others have described, abortion is not necessarily a 'choice' in which women assert rights in any case but may be the outcome of circumstances beyond their control (Hey et al. 1989, Rothman 1993), as was the case for some women in my research.

In this book, I consider who has the power to define a pregnancy or foetal being, including as a person in a kinship relation, or as a process which can be terminated through abortion, or both at once. In this sense, it seeks to destabilise concepts of personhood often used as the basis for rights-based arguments about abortion which are reductive and overly focused on supposed absolute truths, frequently based in scientific discourse. Without reworking these well-worn arguments in detail, many involve binary disputes about whether the foetal being has intrinsic, individual properties which afford it 'rights' whilst still unborn, such as sentience, the capacity for pain, agency, subjectivity, consciousness, survival outside the womb or the potential of a future life (see, for example, Warren 1973, Tooley 1972, Marquis 1989). They also often frame abortion as a conflict between the rights of the foetal being and the pregnant woman (Thomson 1971), and claim universality whilst being based

in a culturally specific philosophy and morality (see, for example, Hursthouse 1991 and most of the literature cited in this paragraph). By contrast, I take the position that pregnancy loss can be acknowledged alongside abortion if foetal personhood is understood as relational, socially and agentially constructed, and therefore as containing different content in different pregnancies and at different times (Layne 2003, Cacciatore and Bushfield 2008, Parsons 2010, Oaks 2000, Layne 1997, Jutel 2006). As others have argued, and as this research shows, it is possible for pregnant women to consider the same foetal being as a form of person as well as the object of an abortion (Ludlow 2008, Mullin 2015), and, whilst they are not necessarily the object of grief, abortions can be and are grieved (Rothman 1993).

Problematizing the Foetal Being, Personhood and Kinship through Pregnancy Loss

What this book attempts to do, therefore, is to introduce nuance, contestation and diversity into constructions of personhood in the English context, taking the position that personhood is not necessarily homogenous within one apparently bounded culture (Conklin and Morgan 1996). As Holly's thoughts about her daughter's death illustrated at the beginning of this introduction, experiences of second trimester pregnancy loss in England can problematise the relationship between the category of 'person' and that of the foetal being. The problem for women like Holly is one of wishing to claim prenatal and posthumous personhood for a now dead foetal being, of understanding it as a 'baby' or 'person', in the face of the formal discourse of biomedicine insisting on its status as 'foetus' and a legal insistence on its status as 'non-person'. Furthermore, for women who understand foetal beings to be forms of person already situated in relation to themselves as mothers and to other relatives as kin, second trimester pregnancy loss and its official exclusion from the recognition of such relationships is problematic at an ontological level. The research which I relay here is therefore a contribution to literature which critically investigates ontologies of foetal beings in different ethnographic settings (see for example: Lupton 2013, Han, Betsinger and Scott 2017, Kaufman and Morgan 2005, Morgan and Michaels 1999a, Sasson and Law 2009, James 2000, Williams, Alderson and Farsides 2001, Memmi 2011). Drawing on the experiences of women such as Holly, I show that pregnancy loss makes

visible the existence of diverse and multiple forms of personhood in English society which run counter to the prioritised legal definition of a person as a living, born human being.

Personhood concerns who, or what, is recognised as a being which is part of human society, and this can be radically different in different social contexts (Carrithers, Bracken and Emery 2011, Degnen 2018, Conklin and Morgan 1996). Membership of human society through personhood is connected to a 'supercharged moral value' of that being, which sets it apart from other elements of the world (Carrithers, Bracken and Emery 2011: 663). Anthropological and sociological inquiry in this area has a long history of connecting ideas of human bodies, law, recognition, status, role, naming and concepts of the self (Mauss 1985). It also recognises the contingency of personhoods and the breadth of variation which is possible. For example, personhood may be understood as intrinsic to the individual, and related to capacity, potentiality and agency, perhaps linked to biological markers and corporeal autonomy, as has been argued in relation to Euro-American cultures (Littlewood 1999, Conklin and Morgan 1996). Or it may be more relational, whereby it can be constituted, granted, maintained or withheld by social relations, especially kinship relations, which may endure after death (Carsten 2004, Despret 2019, Conklin and Morgan 1996). Persons may be recognised by some but not others in the same cultural setting (James 2000, Williams, Alderson and Farsides 2001), or personhood may be conditional (Christoffersen-Deb 2012), limited or withheld (Scheper-Hughes 1993). Personhoods may be politically important, especially when recognised or withheld by the state. Personhood can be partial or cumulative over time (Lancy 2014, James 2000, Morgan 1998) or may contain ambiguities (Morgan 1997). Time is also implicated in processual forms of personhood (Conklin and Morgan 1996), and thresholds of birth and death may be of less relevance in different cultural contexts where forms of persons can and do exist posthumously and before birth (Morgan 1996, Han 2013, Lupton 2013, Howes-Mischel 2016). Such possibilities are also recognised through the use of concepts adjacent to personhood, such as the 'self' (Hockey and Draper 2005) or beings with a 'social existence' (Mulkay 1992).

Posthumous personhood possibilities are also noted in interdisciplinary death studies, through the concept of continuing bonds after death (Irwin 2015, Klass 1997, Walter 1996), drawn upon in relation to negotiations about the place and role of the dead (Mathijssen 2018) and in the context of stillbirth (Murphy and

Thomas 2013, Hayman, Chamberlain and Hopner 2018). This book therefore also contributes to literature in the field of death studies in which more than one idea of posthumous relationality exists in the UK (Walter 2019, Howarth 2010, Valentine 2007). As Strathern (1992) has shown, whilst persons in the English system are understood to be embodied individuals, the boundaries of life and death are not continuous with the definition of a person, and personhood can continue after death. In my research site, not only does pregnancy loss involve disruption to the production of persons, where personhood has been attributed to foetal beings, it also involves the end of personhood through death. Studies of death produce knowledge about the living, personhood and embodiment (Mellor and Shilling 1993, Shilling 2012) and problematise the relationship between physical death and social death (Valentine 2007, Glaser and Strauss 1965, Mulkey 1992). They concern how social relationships between persons are built, maintained and divested (Miller and Parrott 2009).

This social, and primarily anthropological, concept of personhood and its possibilities is an approach which is distinct from, and yet contains overlaps with, legal approaches to personhood. Naffine (2003) argues that there are divisions in legal thinking about what a legal person can be, which can be summarised in three distinct approaches to the concept. These include the legal person as a fully abstract legal artifice, which could include any beings or entities which might be granted status in law (such as foetuses, or animals). Alternatively, the legal person is sometimes understood as coterminous with living humans only, bracketed by birth and death and defined by an ontological position which understands persons to be naturally given beings with innate properties. This type of person is defined by live birth as the necessary condition for their recognition by the state in relation to civil registration and citizenship. Finally, the legal person is sometimes understood as a subject who has moral agency, a position which potentially excludes some living humans from legal personhood. These types of person resonate with those used in arguments about abortion, for example whether foetuses have no personhood because of lack of consciousness and separate life (Warren 1973), or whether they do have personhood because they have a 'natural' human potential which is curtailed by abortion (Marquis 1989). Recently, legal theorists have also used relationality in talking about the legal person (Foster and Herring 2017, Herring 2011). In this book, I show that the legal person is relevant to the possibilities of personhood which are available to

women who seek to define their own foetal beings. The law lays out some options for them, and curtails other options. It also intersects with biomedicine in the field of pregnancy, as others have noted, for example, in relation to the status of embryonic beings and abortion rights in specific jurisdictional contexts (Franklin 1999b, Sheldon 1997, Memmi 2011). Furthermore, because legal personhood is so widely understood and performed, both in biomedicine and in other social contexts, it dominates ontological understandings of personhood and crowds out alternative formulations of what a person is, and what beings can be classified as persons.

As all these possibilities of prenatal or posthumous personhoods imply, kinship and family are intimately connected to ontological positions on personhood. Pregnancy loss also involves disruption to those who are primarily responsible for making the new person, particularly the categories of pregnant woman, mother and parent. In pregnancy loss, there is also 'motherhood lost', as Layne's eponymous book (2003) has shown in the US context. In England, the first social science investigation of pregnancy loss addressed it as a classificatory issue involving inclusion in categories of 'baby' and 'mother' (Lovell 1983). Forty years later, English biomedical-legal models of personhood still formally exclude various women and foetal beings from these categories which are understood as binary and defined by the threshold of live birth. This is despite the fact that foetal personhood and matrescence (Raphael 1975) can come about through multiple social relations in different contexts, including biomedical diagnoses, governance arrangements and kinship. The relationship between pregnant woman and foetus may fluctuate or develop over the course of a pregnancy (Schmied and Lupton 2001, Han 2013) or may be uncertain and ambiguous (Ross 2016). This challenges the supposed binary model of foetal beings as either persons or non-persons (Casper 1994) and also of pregnant women as either mothers or non-mothers. This ambiguity also exists in biomedical practice, where the personhood of the foetal being may not be constructed as a binary, but may exist on a 'human/non-human continuum' (Williams 2006, 13).

Reproduction makes new humans and also makes kinship relationships (Edwards 1999). In this book, drawing on the experiences and cultural situation of my participants, I focus on the overlaps between English kinship and personhood, gender, bodies and materiality (Carsten 2007, 2004, 2000, Franklin and McKinnon 2001, Strathern 1992, Edwards and Salazar 2009). I use the term kinship because it is potentially more critical and challenging of normative

Euro-American ideas which have been associated with ‘the family’ (Morgan 2011) and it is used in sociology and anthropology with reference to the UK (Finch 2008, Holmes 2019, Strathern 1992, Edwards 2000). The openness of ‘kinship’ to human creativity, and its connection to equally diverse and creative concepts of personhood and gender (Carsten 2004), is particularly useful. It is, however, less meaningful to my participants, who would themselves use the term ‘family’.

A Feminist Ontological Politics of Reproduction

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

However, the contribution of this work is more broad than this. It concerns fundamental questions about what is a person, a mother, a kinship relationship, and who defines these. It grapples with ontological understandings of what pregnancy is and does, responding to calls for social scientists to pay attention to ‘ordinary’ pregnancy (Han 2013, Ivry 2010) alongside the assisted reproductive technologies which have dominated the field for many years. In this framework, pregnancy itself is considered as a biosocial phenomenon and meaningful cultural category, challenging Euro-American assumptions that the meaning of pregnancy is determined by the birth of a baby (Ivry 2010, Browne 2023) or that the prebirth period is ‘passively transitional’ (James 2000: 184). A challenge is also posed to the model, noted by multiple feminist scholars, of pregnancy or reproduction as a form of capitalist production, which normatively should end in the birth of a ‘healthy’ living baby (Taylor 2000, Martin 2001, Rothman 1993, Layne 2003).

Theoretically, I build on Franklin’s concept of foetal teleology (1991), whereby what the foetus is going to become, and its

developmental potential, determines its ontological reality. I also draw on analyses of shifts in the ontological status of reproductive material such as gametes, embryos, foetuses, stem cells and umbilical cord blood seen in assisted reproduction clinics (Thompson 2005), and research laboratories and tissue banks (Waldby and Mitchell 2006, Pfeffer 2009, Waldby and Squier 2003). The material products of pregnancy shift and mutate in different settings, in relation to future-focused temporalities which define what it is they are, can be, or will become. Here I make the case that it is not only the products of pregnancy which embody a teleological ontology, but the process of pregnancy itself. English ontologies of pregnancy are teleological, meaning pregnancy is understood through its normative ending in the birth of a new living person and reproductive outcome is determinative of the fundamental reality of pregnancy. The teleological pregnancy offers grounding principles which underpin discourses in biomedicine and governance, as this book will show. A similar concept of 'reproductive teleology' has recently been proposed by Ballif (2022: 11) in the context of pregnancies with an anticipated outcome of a living child. However, I argue that a focus on the teleology of pregnancy more clearly expresses the circumstances and events of my research, in which the normative outcome of pregnancy is disrupted. It is being pregnant, rather than intending to reproduce, or reproducing as a non-gestating partner, which is governed by teleological principles. Furthermore, ontological politics are implicated in the teleological ontology of pregnancy, because it acts a technology of power which is both patriarchal and biopolitical. It forms the ontological underpinning of biomedical and legal discourses which act together to valorise and reify certain reproductive endeavours, centred around the production of healthy living citizens through the body of another, pregnant, person, in an example of biopolitics (Foucault 1998, 2003, Rabinow and Rose 2006). In the English context, this is particularly visible because of the involvement of the state in healthcare and medical governance through the NHS. The governance of pregnancy is focused on the optimisation of outcomes in terms of the born baby at the end of pregnancy because it is based on the teleological ontology of pregnancy.

In this book, I also draw on feminist concepts of reproductive governance and reproductive justice. When official, legal personhood, motherhood and kinship recognition require the separation of a living foetal body from the pregnant body as diagnosed by state medical practitioners, pregnant women in England are excluded

from the possibility of prenatally or posthumously defining their own kin. This is an example of reproductive governance, whereby a multiplicity of actors ‘produce, monitor, and control reproductive behaviours and population practices’ (Morgan and Roberts 2012: 241). It intersects with ideas about the stratification of kin-making (Clarke 2018) and reproductive justice which concerns the ability to have or claim a child as well as the right not to have one (Asian Communities for Reproductive Justice [ACRJ] 2005, Luna and Luker 2013, Morgan 2015, Ross and Solinger 2017). The reproductive governance described here is a form of ontological politics, in relation to who has the agency to describe and define ontologies (Mol 1999). Ontological politics extends beyond the discursive into the realms of material and embodied knowledge and practices, through which social reality is made. When the ‘production’ of a living born baby is disrupted in wanted or accepted pregnancies, and this outcome does not occur, the processes of pregnancy, labour and birth can still have meaning to those who experience them. Pregnancy loss events thus contain possibilities of agency and resistance.

I set these feminist approaches alongside the analytic tools of Foucault, following in the footsteps of feminists in the fields of politics (Hekman 2009) and reproduction (see, for example, Sawicki 1991, Morgan and Roberts 2012, Bordo 2003, Lupton 1999, Tremain 2006, Memmi 2011). I start from the position that human reproduction is a site of the production of power which connects the individual, disciplined human body at the level of anatomopolitics with population level biopolitics (Foucault 1998, Rabinow and Rose 2006, Foucault 2003). Discipline is a process by which individual bodies are made into docile, conforming bodies through the use of space, time, examination and normalisation (Foucault 1991), recognised as a technique of power in obstetric practice (Arney 1982). I show how disciplinary techniques are used in the healthcare system to reinforce normative categories of personhood and kinship, as part of an ‘apparatus of truth’ (Rose 1999: 4).

Biopolitics involves strategies and contestations in relation to human life and death at an individual and collective level. Such strategies are focused on removing that which is perceived as degenerate and abnormal in processes of purification, aiming towards the optimisation of life and survival at a population level, which may be enacted at an individual level (Foucault 2003: 1998). Biopower itself may dovetail with, and use, disciplinary power. According to Rose and Rabinow (2006), reproduction is the ultimate biopolitical

space. In their explanation, the elements present in biopower involve truth discourses and authorities who can speak this truth, strategies for intervention in relation to life and health, and modes of subjectification in which individuals work on themselves to conform to truth discourses. All these elements apply in both pregnancy and pregnancy loss in England. The dominant teleological ontology of pregnancy in England is an example of biopower. It involves the discursive construction of pregnancy through governance and state biomedical apparatuses which actively exclude pregnant women from the definition of their experiences and kin when their reproduction does not result in a healthy, living baby. Cases of termination for foetal anomaly and pre-viability live birth in the second trimester are particularly clear examples of the creation of truth discourses around health and life. These are then implemented by strategies of intervention (or lack of intervention) at the level of life and death, when pregnancies are terminated or pre-viable infants are not offered medical treatment to prolong life.

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

Researching Pregnancy Loss

Moments of rupture and contestation in lifecourse events, such as when Holly's pregnancy loss was not acknowledged by her medical caregivers or her community, can be significant moments of reorientation for the woman experiencing them (van der Sijpt 2020). They also offer potential for the researcher. Conflict between naturalised categories and individual biography, such as when Holly questioned her daughter's classification as a foetus, can produce sociological insight (Bowker and Star 2000). Abu-Lughod (1990) talks of investigating resistance as a method of understanding power, as when Holly contested her daughter's exclusion from state person-making birth registration. Furthermore, social science studies of disruption in relation to reproduction can produce insight about 'taken-for-granted cultural constructs' (Becker 1994: 404, 1999), also noted in other cases involving reproduction disrupted by death (Simpson 2001). The classic technologies of assisted reproduction, such as IVF or surrogacy, have been repeatedly shown to be capable of denaturalising reproduction and offering critical distance for the analyst. Other biomedical technologies represented in this research, such as prenatal diagnosis and termination for foetal anomaly, 'assist' a particular type of normalised reproductive outcome when they offer the possibility of screening out certain foetuses, categorised as impaired in a system predicated on normalisation, and preventing their live birth (Tremain 2006, Wahlberg and Gammeltoft 2018). Still other reproductive technologies, such as ultrasound visualisation and foetal Doppler heartbeat listening, can produce the foetal being as dead or unviable and thus play a role in reproduction which does not 'assist' this particular pregnancy to the outcome of a living baby, but may indirectly 'assist' the live birth of some future child. And diagnostic technologies such as ultrasound measurements which establish the foetal being as being in the second trimester of gestation position the foetal being in legal and biomedical categories. I approach both biomedicine and the law as technologies of reproduction which are underpinned by, produce and perform ontologies of pregnancy, personhood and kinship which can be critically examined through consideration of their effects in the world. Second trimester pregnancy loss in England is a site where conflict between, and contestation of, these ontologies is particularly visible.

A Feminist Ethnography of Pregnancy Loss

My research which forms the basis of this book was a feminist multi-sited ethnography drawing methodologically and theoretically on the disciplines of sociology, anthropology and science and technology studies (STS) which form my academic background. Interdisciplinarity and permeability of disciplinary boundaries is common in the sociology and anthropology of Britain (Degnen and Tyler 2017, Lawler 2017) as well as in the field of social science of reproduction, as in much of the literature cited above. I conducted the fieldwork in 2018 and 2019 in South West England, attending pregnancy loss events and memorial locations, following online Facebook and Instagram accounts related to pregnancy loss in the South West, including some set up by my participants, following trails of legislation and regulations, and interviewing women in the administrative and historic counties of Cornwall, Devon and Somerset, and the suburbs of the city of Bristol.³ The fieldwork also encompassed London as the legislative and administrative hub of English politics, through my attendance at meetings of the All Party Parliamentary Group on Baby Loss and engagement with the then government's Pregnancy Loss Review. The South West region of England spreads out into the Atlantic into a long peninsula. Much of its population is dispersed over areas of rural landscape, separated by the semi-wildernesses of the moorlands of Dartmoor, Exmoor and Bodmin. As a consequence, it has some of the lowest population densities in England (Office for National Statistics 2022a). Some of my fieldwork trips were to small cities such as Bristol, Plymouth, Exeter and Truro, others were to rural houses and villages, or small and medium towns. Fieldwork in Britain is by its nature fragmented, as much social life takes place in indoor private spaces (Hockey 2002). This is particularly the case for the atomised, individual and invisible experience of pregnancy loss in South West England. Women outside the cities were usually unaware of anyone else in their communities who had had a second trimester loss.

The women who took part in interviews for this research, many of whom are credited at the beginning of this book, were aged between 25 to 48 at the time of the interviews, and most were in their 30s. This is the age range at which many women reproduce in England and Wales (Office for National Statistics 2020), though the age of interviewees may also have been structured by the predominantly online recruitment of a generation comfortable with using the internet and smartphones. Participants were recruited

through posts and resharing on local Facebook parenting and pregnancy loss sites, through resharing of my personal Facebook posts, through emails sent out by locally-based pregnancy loss charities, and through word of mouth. The form of the interviews was ethnographic (Hockey 2002, Hockey and Forsey 2013, Rapport 2013, Skeggs 2001), which allowed women's experiences to unfold in different ways, for example through the sharing of artefacts, the inclusion of other family members in the interview, or post-interview contact. This approach reflects overlaps between interviewing and ethnographic fieldwork noted by other researchers working in the British context (Hockey 2002, Hockey and Forsey 2013, Hampshire et al. 2012). Interviews took place in family homes, or in a café or pub nearby, and there were also informal conversations in other locations, for example whilst dog walking on the beach.

The 31 women I interviewed had experienced a total of 34 second trimester pregnancy losses. The second trimester losses occurred between 2003 and 2019, but most were in the last three years of the range. There was a relatively even distribution of types of loss across the categories of termination for foetal anomaly, spontaneous foetal death and spontaneous premature labour. Some women experienced multiple losses: Heather had experienced two foetal deaths at different times, Danielle had two spontaneous premature labours, and Tamsin lost twins to foetal death. Many of the women had also experienced live births, and losses or abortions at other times in pregnancy and this aided analysis because they could make comparisons across those experiences. For example, Holly, whose story began this chapter, had an early miscarriage several months after the second trimester death of her daughter which she does not memorialise or consider to be the loss of a person:

So I hadn't, like, got even used to the fact that I was pregnant. Like it hadn't sunk in. Like with [daughter who died in the second trimester], it was, I was, pregnant for such a long time. I could feel her move. Everything, yeah, it was just two different scales . . . I think it's because – it sounds awful, but – it's different when you're holding a baby.

Comparison like this was a key factor in understanding the particularity of second trimester loss for the participants in my research.

The South West of England is a region which is predominantly White British (UK Government 2020) with a relatively low foreign-born population (Krausova and Vargas-Silva 2013). This was reflected in the women who took part in interviews, who were

all British. Rachel was Chinese British, but all other participants were White British. In Cornwall and Devon in particular there is little diversity in terms of ethnic origin or religion. Although the UK census reports that 46% of people in England and Wales identify as Christian, 37% of people say they have no religion (Office for National Statistics 2022b). Amongst my participants, an even smaller proportion had any religious position, with 65% having no religion. Only 20% described themselves as active or inactive Christians. The remaining participants considered themselves to have a spirituality which was not part of institutionalised religion. This is very different to literature on pregnancy loss in other settings, for example in the USA, where a more actively faith-based response has been described (Layne 1997, 2003).

The area is mixed in terms of income, with Cornwall being one of the poorest areas of the UK (Cornwall Council 2017), and people in Devon and Somerset having lower incomes than the national average (Devon County Council 2019, Somerset Intelligence 2019), but with pockets of affluence around some cities. Defining class and class membership in the area is complex. For example, due to the life stages, gendered work opportunities and geographic locations of the women I interviewed, several interviewees were doing paid work not associated with their education class status, such as Amber working in a surf shop despite being a graduate former consumer law advisor, because of the flexible hours it offered to fit with childcare. Furthermore, class does not necessarily come from occupation but from factors like precarity, such as Danielle's partner who could not attend hospital with her because he was only three days into a new job and could not jeopardise it. I rely on my own long-term tacit knowledge of society in the South West for my assessment that overall I spoke to a broad range of women with different economic and social resources.

The South West is relatively stable in population. Most of the women in this study lived close to other kin, either their birth families or affinal relatives. The consequences of living near close kin included the fact that their presence or non-presence in the crisis of diagnosis or at funerals could not be mitigated by distance and difficulty travelling. Relationship status and kinship details were complex. Twenty-one women were married and two engaged, one was single, and the others were in partnerships with men at the point of interview. I did not speak to anyone who was single when she became pregnant, in a non-heterosexual or non-binary relationship, or one involving multiple partners. Considering

relationships numerically and categorically like this would suggest a certain conventionality in relation to sexual relationships, kinship and parenting, or even monogamy. However, this is not necessarily the case when the ethnographic detail is added in. Some women had had the pregnancy loss with a previous male partner who was not the person now witnessing their grieving. Two interviewees were still married to their previous partners, who were not the fathers of the babies who died. One baby who died was conceived with a new partner in the middle of a divorce. Several interviewees had stepchildren through relationships with men who were already parents, or brought their own children to new relationships to be step-parented by new partners. Charlie's husband had informally posthumously adopted her dead daughter from a previous relationship, by giving the child his surname. Similarly, numerical indicators of the number of children women had did not represent the complexity of their kinship networks, for example where children had different fathers.

Personal Loss and Research: Feminist Positionality and the Impact on Ethnography

The research I present in this book, and the stories I tell here, are those of the group of women I broadly describe above, as they thought fit to share with me. However, the impetus to carry out this research at all came from the second trimester foetal deaths and subsequent births, induced using mifepristone and misoprostol, of my own babies Summer and Oliver in 2010 and 2011 whilst I was teaching the now defunct A-level Anthropology in Cornwall. Teaching about kinship, personhood and gender at the same time as going through my own reproductive losses and raising my three living children, Ida, Miranda and Felix, was an intellectual, personal and emotional journey. As such, this research follows in the footsteps of many other women who have drawn on their own lifecourse experiences, in different social contexts, to research and write about social, philosophical and historical aspects of fertility, pregnancy and reproductive loss (see, for example, Letherby 2015, Layne 2003, Lovell 1983, Sheach Leith 2009, Becker 1999, Thompson 2005, Kilshaw 2020a, Adrian 2020, Rapp 1999). Reflecting on the deaths and births of Summer and Oliver during this difficult time, it became clear to me that what seemed at first like a personal, private, medical event had resonances and

connections to broader ideas about the meaning and politics of pregnancy, mothering, personhood and kinship. Discussing my experiences with other women on a British online forum for second trimester loss prompted me to put together the research proposal.

During and since the fieldwork, situated both inside and outside the subject matter of my research (Griffith 1998, Oakley 1981, Hampshire et al. 2012), I have repeatedly reassessed what happened to me, and had my assumptions and blind spots in research challenged by the words of other women. The experience of hearing their stories was moving and deeply meaningful, and the care shown to me by participants, whether or not they knew parts of my experience, was gratefully received. Women sometimes expressed anxiety about whether I would be overwhelmed by their sadness or the stories I was hearing. At other times they thanked me for giving them space to speak of their experiences, just as I was thanking them for sharing them with me. Several of the participants mentioned that they had never had an opportunity to tell the whole story to anyone prior to their conversation with me. Hayley's daughter had died in 2004:

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

I had mentioned my own pregnancy losses in the online and email recruitment materials, and some women described how this made them more comfortable participating in the research. It is not enough to assume that having identities or life experiences in common will automatically lead to a non-hierarchical relationship in research (Tang 2002, Doucet and Mauthner 2007), and I have been conscious of differences between my lifecourse and others, for example in having living children and in relation to my privileged position as a researcher. However, it was helpful to me and many of my participants to have grounds on which we could meet. I felt that the knowledge of my own pregnancy losses, motherhood, or experiences of birth sometimes bridged more noticeable differences in age or class between me and participants, and they also drew on what they felt to be common experiences. A typical encounter was with Angela, whose first son, conceived through IVF after two previous early miscarriages, was born alive and then died after she

went into premature labour at 21 weeks. Angela shared photos and scan pictures of her baby with me, and pointed out the urn containing his ashes and a display of memorial objects in the living room as we talked. She explained:

It makes a difference knowing you've had some losses. A couple of times I've referred to, you've known what I mean. You've had that experience, or, I don't know what choices you had to make, and things like that.

You don't have to manage my introduction to [baby]'s picture, or anything?

No. I know you're not going to feel uncomfortable or embarrassed talking about him, or saying that his ashes are there [on the dresser].

I also want to note that my production of the knowledge presented here draws on other aspects of my identity and biography than the deaths of Summer and Oliver. I am influenced by having engaged with social anthropology since my undergraduate degree in my early twenties, which permanently orientated me towards feminist and critical approaches to social knowledge. Still other influences are more intimate, and based in my own kinship biography, including my experiences of pregnancy and mothering in my heterosexual marriage, and wider family histories of non-normative kinship. And life experience, such as my pregnancies and births in South West England, gave me contextual knowledge of the English antenatal and obstetric healthcare system, medical terminology, local hospital layouts, and the ability to more easily 'appreciate the connotative' in ethnographic work as a result of conducting research in my own social world (Rapport 2002: 7). Whilst my participants and I share some elements of our lifecourse, there are also many other convergences and differences between each of us, and many things have happened to us besides our losses. One of my aims for this book is to retain a sense of the diversity of experience and agential response, even as I demonstrate the structural constraints on experiences of second trimester pregnancy loss.

Disentangling Second Trimester Loss: The Organisation of This Book

In the chapters that follow, I explain the general consequences for pregnant women of a wanted or accepted pregnancy ending in the second trimester. The biomedical and legal governance discourses and the teleological ontology of pregnancy are intertwined and

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

The book is divided into two parts. Part I is an account of the practical consequences of biomedical-legal ontologies of pregnancy for women experiencing second trimester pregnancy loss in England. These findings can potentially apply to any women experiencing second trimester pregnancy loss, whatever her position on foetal personhood or the nature of her loss, because they limit action and agency in multiple directions. In Chapter 1, I show how biomedical diagnosis of the foetal body during the second trimester of pregnancy limits and structures the healthcare options available to women.⁴ In Chapter 2, I describe the healthcare management of the actual event of second trimester pregnancy loss, including the use of disciplinary techniques in healthcare which sometimes amount to obstetric violence to perform boundary work around ontologies of the second trimester foetal being. I then turn to governance to explain the consequences of legal aspects of the dominant English teleological ontology of pregnancy after second trimester loss. Chapter 3 explains the role and consequences of civil registration law as it applies in the second trimester, including limitations on the post-pregnant woman's access to resources where her pregnancy did not produce a living baby. Chapter 4 discusses the governance of the dead foetal body and its consequences for parental choices around disposal and post-mortem.

In the second part of the book, I provide an account of the political and ontological consequences of second trimester pregnancy loss for those women who experience conflict with the dominant teleological or biomedical-legal ontology. This part of the book is relevant to women who contest the ontological position that their experience did not produce a baby or person, or make them mothers. In Chapter 5, I describe how conflict between embodied experience and the dominant biomedical-legal discourse and practice produces ontological disruption for some women. In Chapter 6, I offer an explanation of how for some women ontological disruption is resolved, and the biomedical-legal teleological ontology of

pregnancy is resisted, through the agential use of English kinship ontology and practices related to it. The book concludes with the contributions it has made to the field of reproductive politics and to ethnographic knowledge about foetal personhood and kinship in England.

Notes

1. Mifepristone and Misoprostol are the medications used in medically managed second trimester pregnancy loss and abortion (Speedie, Lyus and Robson 2014, Royal College of Obstetricians and Gynaecologists 2010a).
2. The legislation which delineates abortion law is the criminalisation of abortion by the 1861 Offences Against the Person Act and the 1929 Infant Life (Preservation) Act, to which exemptions are only granted in specific circumstances by the 1967 Abortion Act and the 1990 Human Fertilisation and Embryology Act.
3. This research was approved by the University of Exeter Ethics Committee in 2018, reference 201718-104.
4. A version of Chapter 1 has been published in the journal *Sociology of Health and Illness* and a version of Chapter 4 has been published in the journal *Mortality* (Middlemiss 2021, 2022). Elements of Chapter 3 are drawn on in a publication in *Gender, Work and Organization* (Middlemiss et al. 2023).