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Heinsen, Laura Louise

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Laura Louise Heinsen
Department of Culture and Learning
Aalborg University, Denmark (E-mail: lauralh@hum.aau.dk)

Shouldering Death: Moral Tensions, Ambiguity, and the Unintended Ramifications of State-sanctioned Second-trimester Selective Abortion in Denmark

This article is based on an ethnographic study of pregnant couples' embodied, emotional, and moral experiences of second-trimester selective abortion in Denmark. Drawing on 16 selective abortion stories, I unpack the intense, often highly accelerated, days that follow from the moment a fetal aberration is detected to the moment of fetal disposal or burial. I show that although prenatal screening and diagnostics have come to occupy a routinized part of pregnancy in Denmark, when women and their partners opt for termination, they are faced with a series of bodily events and actions they are entirely unprepared for while at the same time feeling essentially alone in grappling with the moral confusion that ensues. I argue that despite widespread medico–legal sanctioning and social endorsement of selective abortion, the specificities of how such terminations are done in Denmark in ambiguous, and conflicted, ways situate women and their partners in a series of moral tensions around how to relate to the abortion, the dead fetus, their grief, and their entitlement to such mourning. By chronicling the core struggles that the process of termination catalyzes, I point to the social and moral ramifications of the embodied practices and medico–legal choreographing of selective abortion in Denmark. [selective abortion, moral tensions, embodied practices, responsibility, death]

Introduction

It only took two pushes and then Lillebror was born at 2.30 PM. The midwife wrapped Lillebror in a blue blanket and placed him on the windowsill while managing my bleeding. Then I got to see the tiny boy. The most beautiful little boy with no visible sign of illness. It was incomprehensible to us that you could look this fine and hide such a big secret. An extra chromosome. We were devastated. OUCH how it hurts to see our own flesh and blood lying there dead because we had made a decision that was best for us all (see Figure 1).

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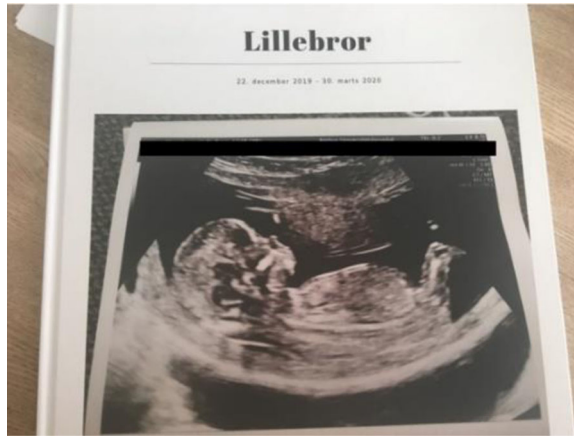

Figure 1. Camilla's photobook [This figure appears in color in the online issue]

I met Camilla and her husband Toke in their suburban home located on the Peninsula of Jutland, Denmark, in the summer of 2020, three months after Camilla's second-trimester abortion. The abortion was set in motion at gestational week 14 after Camilla and Toke learned that the fetus had Down syndrome. In congruence with Danish medical guidelines, it took place as a medically induced birth at a local hospital in the presence of a midwife and Toke. Camilla wrote the above words in a photobook called "Lillebror" [Little brother], which she made in the weeks following the abortion. She did so to gather her ambiguous emotions and thoughts about the decision to terminate and the events it set in motion. In images and text bits, the book details how, like most prospective parents in Denmark, Camilla and Toke took it as a matter of course to undergo prenatal screening, leading to a high-risk assessment followed by invasive diagnostics. Two days later, the doctor called to inform them about the positive diagnosis. To receive post-diagnostic counseling, pregnant women and their partners must return to the waiting room of the ultrasound clinic filled with expectant couples waiting their turn to have "baby's first picture" (Mitchell 2001). From there, they are escorted to a consultation room. When Camilla and Toke arrived at the hospital the day after receiving their diagnosis, they were asked what they wanted to do—continue or terminate the pregnancy? Camilla and Toke opted for abortion to spare their existing child from growing up in the shadow of a disabled sibling, as well as from fear that having a chromosomally different child would threaten their marriage. As I asked Camilla to elaborate on her feelings about the abortion, she said: "The problem is that he was viable. That's what makes it so hard, that we've actually killed something that was viable."

When the Danish Board of Health issued new guidelines for prenatal screening and diagnosis in 2004, the board replaced a former "paradigm of prevention" with a new criterion of success: The aim of "informed choice" (Danish Board of Health 2004a, 2004b). The idea was that by introducing an ethics of informed choice, any conflation of prenatal testing with past state-mandated eugenics would be obsolete.

It became a question of parental choice, not state intervention. Since the roll-out of the 2004 guidelines, offering all pregnant women a first-trimester prenatal risk assessment for chromosomal anomalies and a second-trimester malformation scan, regardless of age (Danish Board of Health 2004a), selective abortion rates have been rising (see www.berlingske.dk/samfund/flere-faar-tilladelse-til-en-sen-abort). Despite extensive rights and protections leveraged for people with disabilities in Denmark, such as access to health care, education, and housing, the annual birth rate of children with Down syndrome dropped markedly from an average of 65 before 2004 to an ensuing average of 33 annual births (see above URL). According to the Danish Cytogenetic Central Register (DCCR), 99% of prospective couples opt for termination when Down syndrome is detected in utero (DCCR).[1] Unlike, for instance, the American insurance-financed health care system, Denmark provides comprehensive tax-financed health care, including prenatal and abortion services, to all residents without charge. Pregnant women have a statutory right to first-trimester abortion, after which abortion must be approved by a regional abortion committee, consisting of a legal representative and two doctors. Second-trimester abortion may be granted on the ground that "there is a risk that the child will suffer a serious physical or mental illness due to hereditary predisposition, damage or disease in the fetal state" (Healthcare Act, Consolidated Act LBK nr 210 af 27/01/2022). Recent statistics show that 94% of the approximately 600 annual applications for abortion on fetal–medical grounds are approved by the abortion committees (Danish Appeal Court 2019). Grounds range from conditions deemed incompatible with life to conditions such as missing extremities and a cleft lip palate. As shown in a recent legal analysis of the Danish abortion committees, almost all cases of abortion due to fetal anomaly are granted approval through an "automatized" practice, while second-trimester abortion on social indication, where the fetus is healthy but unwanted, is more difficult to obtain (Herrmann and Petersen 2021; Petersen and Herrmann 2021).

Indeed, in a prior research project on pregnant women's motivation for having routine prenatal screening, I asked the women I followed to reflect on the hypothetical scenario of ending the pregnancy in the event of a positive diagnosis. Here, abortion figured as a seemingly morally unproblematic way out of the pregnancy, largely depicting termination as a solution recommended by "the system" (Heinsen 2018). Yet, when I began interviewing couples about their abortion experiences during 2020, I kept stumbling on a completely different terminology. To my surprise, in nearly every interview, I heard my interlocutors speak of abortion as the detrimental loss of a child that they had chosen to "kill" and had to assume responsibility for. As Christina, who terminated her pregnancy due to a rare genetic disorder, said: "I signed the paper. I took the pill. I killed my baby. That's how it feels, because really, I was the one who had to do all these things."

It is these consistent depictions of selective[2] abortion that will be explored in what follows. Bearing in mind the politically and religiously vexed issue of abortion in the United States (Andaya and Mishtal 2017; Ginsburg 1998), and elsewhere (De Zordo et al. 2016; Mishtal 2009), I wonder why a language of killing shows up in a cultural context where selective abortion is overwhelmingly socially endorsed and medico-legally sanctioned.[3] What produces the sense of individual responsibility that runs through the narratives of my interlocutors? And what is the signification of "all these

things" Christina refers to? In short, I ask: What moral tensions and ambiguities emerge in the process of terminating a desired pregnancy within a moral–political landscape of state-sanctioned selective abortion?

Drawing on 16 selective abortion stories, I unravel the intense, often highly accelerated days that follow from the moment a fetal aberration is detected to the moment of fetal burial or disposal. I show that although prenatal screening and diagnostics have come to occupy an expected part of pregnancy in Denmark, when couples opt for termination, they are faced with a series of bodily events and actions they feel entirely unprepared for while at the same time feeling essentially alone in grappling with the moral confusion that ensues. I point to how the process of termination entails initially a dehumanization of the fetus in the medical encounter followed by a humanization of the dead fetus during the abortion procedure itself, propelled by the midwifery-driven tenor of "to say proper goodbye, you need to say hello," and then followed by a lack of social recognition from the wider social milieu of the abortion as infant loss. I argue that these contradictory ways of managing and responding to second-trimester abortion within and beyond the clinical setting situate women and their partners in a series of *moral tensions* concerning how to relate to the abortion, the dead fetus, and their responsibility and/or entitlement to grieve. By moral tensions, I mean social situations in which legally sanctioned decisions and actions (in this case, to selectively terminate a pregnancy) remain ethically unresolved for those involved.

Writing on transnational flows of people and goods, van Schendel and Abraham (2005) contrast what states define as legal and illegal with what is socially defined as licit or illicit to grasp how actions that are formally defined as illegal nevertheless come to be accepted as licit. Building on this distinction between social (il/licit) and political (il/legal) constructions of legitimacy, I suggest that from the perspective of some of the couples who experience selective abortion first-hand, the procedure comes to reside in an unsettled terrain between that which is legal and "right" on the one hand, and illicit and "wrong" on the other. Following this line of thought, I draw on Cheryl Mattingly's neo-Aristotelian notion of moral selves as constituted relationally through "the *doing* of ordinary life" (Mattingly 2013: 305), where what is considered the best course of action might be messy, muddled, and difficult to judge. As Mattingly notes, "even if one is assiduous in trying to work on one's moral character, there is always the possibility of mistakes, unintended consequences, moral failure, or moral tragedy in which every choice and every action is somehow, morally, wrong" (Mattingly 2013: 306).

The article is structured around three themes—*responsibility, incongruity*, and *killing*—which crystalize the core struggles that the process of termination catalyzes. To be clear, I do not suggest that termination equals killing. In fact, my interlocutors explicitly expressed support for the availability of abortion as a health service and felt fortunate that they lived in a country where they had the possibility of making such a choice. Thus, what is at stake in the following analysis is how legal and medical management, as well as the undergirding medical regulations and care norms of present-day practices of selective abortion, impact the social and moral experiences of those who avail themselves of such terminations. Thus, abortion *becomes* morally complicated for some through its practical and normative itineraries and embodied undertakings. It follows from this line of argument that fetal personhood

is not intrinsic nor universal (Gerber 2002; Morgan 1997) but *evoked* through these itineraries. But before I unfold my analysis, let me briefly situate my study in the field of research to which this article contributes, followed by a short description of my study.

Accounting for Selective Abortion: Embodied Experiences

Over the last decades, several pioneering ethnographies of "selective reproductive technologies" (Wahlberg and Gammeltoft 2018) have been undertaken, covering technologies ranging from amniocentesis in the United States (Rapp 1999; Rothman 1986), ultrasonography and sex-selective abortion in Vietnam (Gammeltoft 2014; Hằng 2011, 2018), and prenatal and genetic screening in Denmark as well as elsewhere (Heinsen 2018; Ivry 2010; Schwennesen et al. 2008, 2009; Shih 2018; Thomas 2016). This rich body of work has pointed to the excruciating dilemmas and troubling decisions placed on women and their partners by advancing prenatal diagnostic technologies. As American anthropologist Rayna Rapp writes in her groundbreaking ethnography of amniocentesis in the United States, the normalization of this technology forces women to "judge the quality of their own fetuses, making concrete and embodied decisions about the standards for entry into the human community" (Rapp 1999: 3). Yet such technologies also bring with them the concrete, embodied, and moral work of bringing such choices into action as terminations are set in motion. In a qualitative study of selective abortion in Norway, Risøy and Sirnes (2015) show how decision-making following the detection of a fetal anomaly is experienced as a "state of emergency," arguing that to understand society's regulation of selective abortion, it is necessary to study the logic of such decisions. I suggest that to understand what selective abortion means and, not least, *takes*, we need to go beyond the realm of the decision and examine how such terminations are experienced, done, and grappled with. The decision is part of that story, but not the whole story.

While social science scholars have been vocal in critiquing the proliferating medico–technical interventions into pregnancies through visualizing and diagnostic technology (Duden 1993; Petchesky 1987; Rothman 1986), there is a paradoxical absence in the anthropological literature interrogating the embodied practices involved in selective abortion.[4] As historian Ilana Löwy writes, researchers who study prenatal diagnosis, usually "stop short of asking what happened next to the women and the fetal remains" (Löwy 2018: 25). This dearth in the literature is undoubtedly linked to the highly politicized and contested topic of abortion in many parts of the world (McCoyd 2010; Miller 2016), not least in the United States, where the abortion debate is characterized by what Ludlow terms an "unbridgeable discursive gap" (Ludlow 2008: 28), and where the passing of new bills restricts access to abortion at a disturbingly unprecedented rate (Andaya and Mishtal 2017). Nonetheless, bearing in mind that termination is the typical response to fetal abnormality among Danes, it is highly surprising that the social and moral impact of selective abortion in Denmark remains largely unexplored. This article aims to fill a corner of this knowledge gap.

Hằng's study of sex-selective abortion in Vietnam is one of the few that portrays on-the-ground abortion practices, demonstrating how these processes are "marked

by pain, stress and, most notably, silence" as well as by the dismembering of fetal bodies through surgical abortion with body parts being pulled out in pieces (Hằng 2011: 91–92). Through her interviews and participant observation, Hằng shows how women "experience confusion as the cultural expectations that shape their decision-making clash with the potential sanctions against them, their maternal desires and duties, and the legal, moral and medical frameworks within which their decisions are made" (Hằng 2011: 88). In an article on practices of routinely offering aborting women in Canada contact with "fetal remains," Mitchell (2016) argues that these new visibility practices rest on professional care guidelines that tend to position women as needing contact with fetal remains as valued babies rather than as for instance biological waste, and that women's responses to this practice vary. This prompts her to ask how abortions are being framed today to create "particular spaces of visibility" (Mitchell 2016: 171).

Resembling new trends in Danish abortion care, where practices of seeing, holding, and commemorating dead fetuses are gaining ground as a counter-response to the silencing of pregnancy loss of the past (Kjærgaard et al. 2001, see also Layne 2003; Memmi 2011), I follow Mitchell's train of thought that performativities, as these vary in different parts of the world, create different conditions for seeing and not seeing, as well as seeing in particular ways, as nurses and midwives work to "aestheticize" dead fetuses. Yet I disagree with the notion that what women give birth to can be depicted as merely representations that come to be given meaning as precious babies only via particular visibility "scripts." Such a rendering overlooks the fact that in places where second-trimester abortion is handled as medically induced birth, women go through labor and push out complete, fleshy, material fetal bodies. In Denmark, all abortions from gestational week 14 (but in many hospitals as early as in gestational weeks 12 and 13) are done according to a specific medical regime, combining a pill of mifepristone to block the production of pregnancy hormones, followed by 24–48 hours of waiting at home after which the couple is hospitalized for induction of labor with tablets of misoprostol inserted vaginally every three hours until the fetus has been birthed. While surgical abortion is performed much later in countries such as the United Kingdom and the United States, and though comparative studies of abortion methods show inconsistencies about which procedure is best (Lohr et al. 2008), medication followed by induced birth is the only procedure offered in Denmark. Following Ludlow's argument that disregarding the embodied nature of abortion risks excluding the complexities of women's abortion experiences (Ludlow 2008), I suggest that *embodied practices*, not only visibility, matters for the experience of these "chosen losses" (Rapp 1999: 225).

The Study

This article builds from ethnographic research undertaken intermittently between 2020 and 2022, exploring how second-trimester selective abortion in Denmark is legitimated, practiced, and experienced at the nexus of biomedicine, law, and everyday lives. The data I draw from more specifically come from 16 audio-recorded interviews with women and couples who had opted for termination due to fetal anomaly. In addition, my material consists of drawings made by my informants during the interview, as well as photos I have been given permission to use.

Inspired by anthropologist Li-Wen Shih (2018; Shih and Schrøder 2022), I asked my interlocutors to draw their abortion experience at the beginning of the interview to allow my interlocutors to guide my questions and probing. I interviewed 10 women, one man and five couples representing 22 persons in total. All identified as heterosexual, were primarily white, and were from middle-to-high income backgrounds. The interviews lasted between two and six hours, with most lasting three to four hours. Most took place in the homes of my interlocutors. Three took place online. Three of the women had been through the abortion only three months before the interview, while others had been through it several years prior. All interviews were anonymized and transcribed verbatim and subsequently analyzed thematically. The recruitment of my interlocutors is based on self-selection, responding to a call for participation posted on pregnancy and maternity websites, on my own Facebook page, and on a closed Facebook group mediated by the Danish Association for Infant Death. What unites them is that they all felt motivated to speak about their experiences. In fact, while a great proportion had attended some kind of counseling or therapy, several disclosed that the interview was their first occasion of voicing their experiences in depth, not least for those for whom bereavement counseling was cut off due to the COVID-19 pandemic. While what I experienced as a palpable hunger for speaking about their experiences benefited my research, it illustrates that my informants felt alone in dealing with the effects of the abortion.

Making Choices, (Self-)imposing Responsibility

The delivery of a positive prenatal diagnosis in Denmark inevitably forces a pregnant woman and her partner to make a decision about whether to continue or end the pregnancy. The trajectory from diagnosis to effectuated abortion is, of course, singular as each case is unique, each clinical encounter different, and each medically induced birth multifaceted, as well as experienced differently. What struck me while listening to the women and couples describe the entire process was the acceleration of the event. When Camilla learned that her fetus had tested positive for Down syndrome, it took only four days until the abortion was effectuated. While she had waited at home for the test results, giving her and Toke more time to process and think about what to do in case of "bad news," others were told about the abnormality at the malformation scan, which propelled an even more hurried process. In these cases, post-diagnostic counseling, signing the application, getting legal approval, the abortion-preparatory talk, and intake of the pill all happened within one or two days.

While a recent Danish study on the choice to opt for abortion due to Down syndrome concluded that parents arrive at the clinic with a decision at hand (Lou et al. 2018), my interlocutors generally spoke about not having considered carefully what to do in the event of a positive diagnosis. Most expected to be reassured that their unborn child was healthy and growing. In contrast to Lou and colleagues' conclusion that abortion decisions were shaped outside the realm of the clinical encounter, most of my interlocutors described vividly how doctors had prognosticated what life would be like if the affected fetus were brought to life. Peter told me that when he and his wife, Maj, showed up for their post-diagnostic consultation, Peter felt "the air was thick with expectations they would opt for abortion," with the

conversation circling exclusively on the potential burdens of caring for a child with Down syndrome:

> So we say that we've decided that we would opt for abortion. And they are really supportive, like "we understand and it's hard and difficult," and then Maj talks about our doubt and then they're like "well, most have a really difficult life, and those stories you don't hear about in the news," so they are really supportive about the decision we've made.

Often, such foretelling transcended the mere medical horizons of a specific diagnosis. Frida and Lasse, who chose to terminate because of a severe heart malformation in the fetus, recounted how their doctor had said that in his experience "parents of children with this condition often get divorced." But what seemed to influence their decision most was when the doctor associated going through with the pregnancy with "child neglect." In contrast to Vietnam, where decisions to opt for selective and sex-selective abortion are shaped by pervasive social pressure to reproduce healthy and preferably male offspring (Hăng 2011)—decisions that are made not individually but on the basis of wider family councils (Gammeltoft 2010)—in my study, friends and family figured most often only either before a diagnosis had been made (e.g., when waiting for test results) or after the decision was made. The lack of involvement of relatives in the decision can be seen as an expression of the cultural depiction of these choices as inertly individual but also as an expression of the "structural directiveness" (Heinsen 2018) of these choices, meaning that the choice to opt for termination is shaped by adherence to societal norms rather than by adherence to filial duties. It is also possible that the lack of familial consultation is due to a lack of time. For instance, when the doctors assessed that Christina's fetus might have a serious genetic condition, genetic testing that could confirm the diagnosis would take three weeks to process, and, as Christina was soon approaching the "criteria of viability" in gestational week 22+6, the upper limit of access to later abortion in Denmark, she had to make a decision on the basis of diagnostic uncertainty under immense time pressure.[5] Despite the impact of prognostication, most often the couples I spoke to described decision-making as coming from themselves as autonomous, rational human beings, who took in and processed the "objective" medical facts they were presented with to reach *their* decision. For example, Sidsel, who terminated a twin pregnancy due to twin-to-twin-transfusion-syndrome explained that:

> She [the doctor] says that there are options, but none are really good. Sometimes with these twins, you can do surgery to cut off some of the blood vessels in the uterus because the thing is that twin A gets too much blood and twin B actually gets too little. So, she says that sometimes you can burn those blood vessels, but because I had this hematoma and because I'm overweight, the chances that it will pan out well is very slim. So, they wouldn't offer to do that. […] I can't remember exactly what she said, but she was very good at laying it all out. It was just a long list of "ifs," but the probability of things going well was so small. But she was really good at

> explaining the situation to us without like, and I really can't stress this enough, without putting *any* pressure on us. *We* asked [about abortion].

What Sidsel remembers most clearly from the situation in which the decision to terminate was made was that the doctor only delivered medical facts. What the above paragraph also highlights is that by *not* being offered the operation, the only trajectory leveraged for Sidsel was to either terminate or continue the pregnancy, knowing that the unborn twins were deemed so ill that they would likely never survive the pregnancy or birth without that exact surgery they were disallowed. Still, though the termination could be seen as the outcome of a much more complex trajectory of boundary making between eligibility or non-eligibility for surgery, and of medical probabilities through which the unborn twins were shaped into futile cases, Sidsel took complete responsibility for the decision.

Others were caught off guard when learning the decision was theirs to make. As Henriette said:

> They tell me the child is not viable, but then they tell me that I actually have to make a decision. I thought the decision was made. I didn't know I had to make the choice. It was only I who had to sign the paper. It hit me really hard. I don't know whether it was because we weren't married at the time or because it was my body, but you know [wells up], sorry… em. I had to sign the paper.

Informed choice is not only an ethical principle guiding clinical practice. It has concrete implications for how responsibility is perceived and experienced by women (and their partners). This responsibility is exacerbated by the concrete embodied chain of events set in motion as soon the words "we want to terminate" are spoken, and the concrete bodily acts women must take on themselves to effectuate the decision. This begins with a piece of paper.

Moments of Incongruity

As soon as a pregnant woman and her partner opt for termination, an application form must be signed by the abortion-seeking woman and subsequently by the fetal medicine specialist who sends the application electronically to the regional abortion committee. From there, a secretary prepares the case and contacts the three committee members on duty that specific day. My interlocutors responded differently to this moment of signing what some referred to as their child's "death sentence." Peter, for instance, remembers the moment as disconcertingly un-ceremonial, while others had difficulties recounting the details of the situation. In some weird way, the abortion committees and the legal dimension of second-trimester abortion figure as a small and insignificant "bump on the road," as no direct contact takes place between couples and committee members. I heard repeatedly that doctors had told them that the committee's case handling was a matter of "formality," yet despite the bureaucracy of the event, having to sign a piece of paper confirming a wish to end a pregnancy stands out as quite disturbing. Anja, who terminated a pregnancy due to a brain malformation, was unaccompanied by her husband at the time of signing

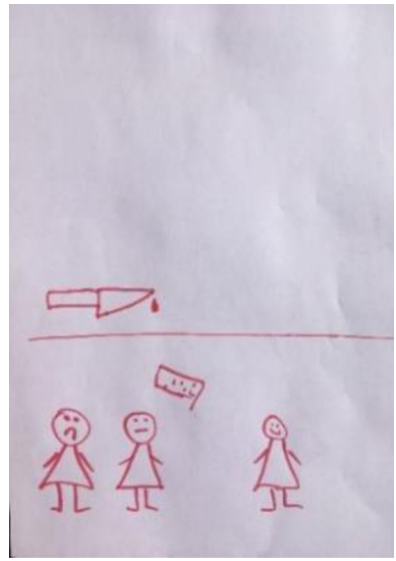

Figure 2. Rebecca's drawing of her abortion experience [This figure appears in color in the online issue]

the application. She said: "I think had my husband been there, I would have insisted that we draw a line for him to sign because I felt it was my responsibility, and I still do. I signed. I gave birth. I took the pill." Thus, abortion is both legally and bodily gendered. It falls on women to do the bodily labor of termination, beginning with picking up the pen and signing the application.

As soon as termination has been authorized, the gynecological or birth ward is informed that "a case" is under way. The responsible nurse or midwife then calls the pregnant woman and invites her and her partner for a preparatory talk at the hospital. In depicting her abortion experience, Rebecca, who ended a pregnancy in week 14 due to Down syndrome, drew three female people, symbolizing the health staff, and above them a knife with a drop of blood dripping down from its sharp point, symbolizing the pill (see Figure 2). This came to mind because she felt uncared for when her wish for surgical abortion was denied. She explained:

> It felt SO bizarre to have it at home and having to take it by myself. It was strange that I had to kill the fetus. Because it's the pill that makes life stop inside of you. We didn't doubt the decision but yeah, it was like my responsibility to take the medicine.

In a similar vein, Henriette recounted:

> I'm sitting on the couch at my parents' house with these pills in my hand and realize that now there's no going back. Now I'm going to take them, and they were SO difficult to take. They weren't big, but incredibly large to

Figure 3. A pill of misoprostol, also known as Cytotec. In all but one Danish hospital, misoprostol is inserted vaginally every three hours to induce labor until the fetus has been birthed. The woman who took this photo was handed misoprostol for oral intake. [This figure appears in color in the online issue]

> swallow. Because you know, then it's definitely over. I haven't given birth yet, but that was the moment I killed her, you could say.

While the moment of taking the pill stands out vividly in most accounts, the wait for hospitalization was mostly described as playing out in a fog. Some used the days alone at home, lying on the sofa crying and sleeping. Others felt they had to "do something." This time span where little but waiting is happening was experienced as an unsettling state of existential disintegration. As Cecilie said: "To know what you are carrying inside of you is SO physical. On Wednesday when I had taken the pill, it was horrible, I just sat on the edge of the bed and was paralyzed by this physical kind of grief I've never experienced before."

Signing the paper and taking the pill were two of the things that shaped Christina's and others' sense of responsibility not only for the decision but also for the production of fetal death and essentially their own loss. The bodily work of labor and birthing adds to this.

When a woman and her partner are admitted to the hospital, they are appointed a private room equipped with two beds, TV, and an adjacent bathroom. Couples who are admitted to the birth ward are often confronted with the noise from crying babies, the sight of new parents strolling down the corridors with their newborns, and other activity characteristic of a maternity floor. Immediately after arrival, the nurse or midwife inserts the first of a series of Cytotec (misoprostol) tablets to induce labor (see Figure 3).

Typically, the couple is asked; "What is this to you—a child or a fetus?" and "Have you considered a name?" The general belief held by health staff is that second-trimester abortion should be treated like involuntary pregnancy loss, accompanied by new ritualistic practices of seeing, holding, and commemorating the dead fetus,

such as taking photos and hand-and-foot prints. These practices are not done to dissuade women from obtaining an abortion. Rather, they are seen as proper and compassionate care. Health staff often nudge couples toward embracing the dead fetus as a lost child "for their own good," as one midwife said. Several of my interlocutors felt conflicted about the personification of the fetus through birth and these post-abortive performativities. When I asked how Peter and Maj responded to learning that Maj had to give birth, Peter said: "I think it gave like, okay, are we really able to execute this decision? Because the thing with birth is that you have to face it. It couldn't just be removed." Several of the women I interviewed had a strong wish to see and hold the fetus and embraced birth as a prerequisite for this. While most said that they initially just wanted to be sedated to flee from the situation, this changed during hospitalization. Several mentioned that the health staff had swayed them of the importance of giving birth by emphasizing not only the physiological advantages but also the psychosocial benefits, as giving birth would enable the couple to process the abortion better and make it possible for the couple to see the dead fetus, which seemed to have transformative powers. Sara, for instance, said:

> I think at first a lot think; "I'm not going through labor to deliver a dead child," but then I was like, I fought for you, like, I went through this because it meant something, that's how I feel anyway, that in spite of everything she [the fetus] was worth it. Like you were worth it, that you would fight for all your children even though it's painful as hell.

By adopting the logic of "birthing is best," Sara worked to legitimize her anomalous fetus as valuable and worthy of a good exit. Through this form of legitimation work, the painful work of birth comes to legitimate the act of termination, and to establish the parent as caring toward her fetus. Sometimes these births go smoothly and sometimes they turn complicated and even traumatic. Camilla, for instance, developed a fever, bled excessively, and had to be taken for curettage. Others developed nausea and hyperstimulation lasting for hours. Christina's birth is another extreme case in point:

> I've been told that it doesn't have to hurt. So, I have an epidural but nothing happens. And I get a fever. A high fever and I'm like shaking. And then I'm having a second epidural and this one works. But I feel poorly and vomit. I haven't eaten for days. I'm totally exhausted. But I get some sleep during the night and when I wake up, I'm 10 cm dilated, but I don't feel anything. So, they give me oxytocin, but nothing's happening. They try to put pressure on my belly to push her [the fetus] down, and one inserts her arm [in the vagina] and they begin discussing if she's sensing an arm or a leg. It was like being at the gynecologist, you know, you just close off everything from the waist down, because it's so violent [begins to cry]. And then they go to get one of those ultrasound machines to see where she is. And she's still alive, she's moving [cries excessively]. And then they ask me to lie on my belly, on my knees, on a stool. I've just given up. She doesn't want to come out. And then they pull her by her legs. And then she's out.

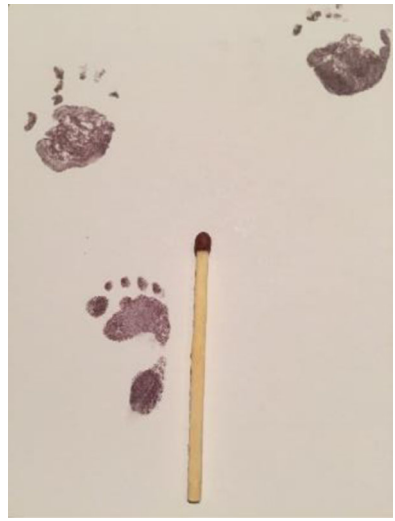

Figure 4. Hand- and footprint of aborted fetus [This figure appears in color in the online issue]

When Christina's birth was finally over, the fetus was dead at arrival. The midwife wrapped it in a knitted blanket. Hand- and footprints were made, and a series of photos taken (see Figure 4). Arriving home, Christina and her husband made arrangements for a private burial. Not all birth stories were as violent as Christina's. Indeed, most spoke about the birth itself as a "beautiful" experience with caring health professionals validating their experience as the loss of a baby rather than as an abortion. All but two of my interlocutors saw their dead fetus, and almost all took some form of memento. What takes place in the birth ward is ontologically very different from what happens before in the ultrasound clinic. What is turned into a precious baby through these new standards of "good" abortion care is initially constituted as something futile through sonography and genetics. Couples meet a health care system that, to put it bluntly, first requires them to terminate, then bond and "make family" with what they chose to terminate. Anja explained:

> It's all so clinical when you sit there with the doctors. They call it termination, they don't call it birth, they talk about it as a non-viable fetus, you know, all those words are all very rational, but it stops being rational when you birth the little child. Then rationality is like gone. When you see this little tiny creature you think, my God, what have we done?

This, I contend, is at the heart of the matter in the emic mobilization of killing. Post-abortive performativities turn the abortion into something more than just the loss of a possible person; it becomes a voluntary loss of a concrete, material being that resembles a real baby. These humanizing and personifying acts unsettle the

Figure 5. Burial of fetus at a private ceremony [This figure appears in color in the online issue]

procedure as a legitimate act. As Toke said: "When you call it a person, you commit a murder. When you call it a fetus, then it's an abortion."

Socio–Moral Accounting: Legal Abortion, Illegitimate "Killing," and the Question of Loss

Hằng writes that though sex-selective abortion in Vietnam was conditioned by external economic and social factors, most women felt ambivalent about going through with the procedure. They experienced confusion about the cultural expectation to terminate and the potential legal sanctions they could face (Hằng 2011: 88). My interlocutors in Denmark experienced confusion, but not in relation to the medico–legal legitimacy of their decision. Rather, they experienced a kind of socio–moral confusion, which emerged in the birth ward and was later exacerbated when they returned home. Indeed, the granting of fetal personhood in the birth ward was called into question as soon as the couples left the hospital. One informant said that her father-in-law had remarked that she "ought not turn her home into an altar." Another received a phone call four days after the abortion asking when she would resume her work duties. These social confrontations exacerbated the couples' already existing confusion by questioning whether their dead "babies" were babies at all (see Figure 5).

A central repercussion of the abortion is that it forces parents to negotiate with themselves and their social surroundings about what actions and emotions are legitimate. This entails weighing what feels right against what others might think is right (Franklin and Roberts 2006), fearing that others might perceive one's response as "too much." As Cecilie's partner, Mikkel, put it: "It's your own choice so you're not

entitled to be upset. What would others think of me if I told I was upset?" Under the surface of this sense of illegitimate grief lie guilt and shame. Even though termination is medico–legally permitted and socio–morally endorsed by the wider social fabric of society, its legitimacy is questioned by those who embody it. While many insisted that "we know we made the right choice," this insistence was always accompanied by a "but." This but was not necessarily directed at the decision itself but at the struggles they faced following the abortion, which were far more profound than many first imagined. Following Mattingly's argument that the moral is profoundly relational, I suggest that in the interstices of how selective abortion comes into being in the clinic, is handled in the ward and socially responded to in the wider social milieu, my interlocutors felt split between differing social expectations: the expectation of society that you abort, the expectation of health staff that you grieve, and lastly, the expectation of family and friends that you get quickly over it and resume your life as before. The simultaneity of structural directiveness toward termination and the lack of a collective space for acknowledgment of what termination entails, makes it difficult for the couples to come to terms with what took place and how to relate to oneself and what was lost. As Peter said, "I like the recognition of her [the dead fetus] as someone who is part of me if I call myself a father of two. But what's hard about it is that if I acknowledge that, then I've killed my own child."

Conclusion

Much anthropological attention has been paid to the social impact of the expanding array of prenatal technologies for post-diagnostic decision-making. Studies have shown how, against the backdrop of differing cultural formations, the moral burdens of these choices are carried, dispersed, and divided differently. As I have attempted to show throughout this article, there is much more to selective abortion than choices. The decision-making that a positive diagnosis engenders is followed by a series of bodily events that is experienced as highly isolating and morally conflicted. Signing the application, taking the pill, giving birth, making mementos, and returning home empty-handed with the task of finding a way to live on in a cultural milieu that lacks a collective space for acknowledgment of the "chosen loss" that selective abortion embodies are as challenging as decision-making itself, at least in a society like Denmark where termination is almost a given. In the narratives of my interlocutors, it was the inescapable embodied undertakings as well as the after-the-fact moral self-reflection that stirred the most torment. Indeed, while a rhetoric of choice permeates the policy of fetal testing, women opting for selective abortion in Denmark are given no choices with regard to method of procedure. The legal bureaucracy of selective abortion and the management and performativity of abortion as birth have profound moral and existential ramifications for those involved. What is required of women (and their partners) physically, bodily, emotionally, and materially matters for the experience of abortion as morally troubling. Selective abortion sticks with people as an event that remains ethically unresolved.

My findings further suggest a gap in Danish abortion care. Despite efforts to offer what health staff perceive as empathetic care, women and their partners still feel alone in grappling with the unexpected moral and emotional turbulence that arises in the days, months, and years that follow. As Anja put it: "We thought it would be over

as soon as I had given birth, only to realize that, really, it had just begun." Women and couples confronted with selective abortion in a sense fall between chairs, not knowing who to reach out to for help and support. While contemporary abortion care is likely to fulfill many of the needs of abortion-seeking couples, the ways in which second-trimester abortion is managed, practiced, and responded to today is worthy of critical debate. More research on such terminations, and the social and moral implications of differing abortion procedures throughout the world has, I contend, great potential for raising critical discussion.

Notes

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1. In 2019 in Denmark, 18 children were born with Down syndrome. Of these, only seven were the result of pregnancies carried to term by expecting couples who knew the fetus was affected by Down syndrome. The remaining 11 cases were the result of either non-detection or false negatives (DCCR. See also Spalletta 2021: 37).

2. By the term "selective," I follow Wahlberg and Gammeltoft's (2018) definition of selective reproductive technologies as technologies used to prevent or allow the birth of *certain kinds of children* as opposed to the prevention of unwanted pregnancies. Selective abortion is thus my term for the act of selectively terminating a pregnancy, while my interlocutors used terms such as "abortion," "late abortion," or "birth."

3. See Gerber (2002) for an analysis of the embodied experience of medical termination of very early unwanted pregnancies and Purcell et al. (2017) for an analysis of the embodied experiences of second-trimester abortion for nonmedical reasons.

4. Several psychosocial studies have explored how couples cope with termination for fetal anomaly. See, for instance, Statham (2002), McCoyd (2007), and Lafarge et al. (2013).

5. An upper threshold linked to fetal viability was amended to the Danish abortion law in 2000. At present, the criterion of viability is set at gestational week 22+6. The Danish model for regulation of abortion thus reflects a gradualist ethical view of the fetus as well as a balancing between, at times, competing concerns, the autonomy of the woman, the health professionals performing abortions, and the increased ethical status of the embryo (Herrmann and Petersen 2021: 494).

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