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# Orchestrating moral bearability in the clinical management of second-trimester selective abortion

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ABSTRACT

In present-day Denmark, second-trimester selective abortion has become a regular medical event, which has turned selective abortion care into a routinized task for health staff. In this article, we explore what forms of care practices abortion providers in Danish public hospitals engage in. Using in-depth interviews, medical documents and social media data, we show that at the center of selective abortion care provision is not only securing safe medical outcomes, but moral labor orientated towards achieving a morally manageable medical event, permeating institutionally developed clinical guidelines, relational face-to-face care, and ideologically driven encouragement of parental-fetal attachment through the use of material objects and visibility practices. We propose to view these entangled realms of practices as aiming towards generating what we term "moral bearability", meaning that selective abortion care is orchestrated in particular ways to make the abortion, and the implied making and handling of death, simultaneously bearable for couples *and* health staff.

## 1. Introduction

> When we don't offer surgical abortion here it is primarily because it's an unpleasant procedure to perform because the fetus is so large, so you have to use forceps to push through the cervix, and crush the skull. And a procedure like that, where you have to mutilate the fetus, most doctors don't want to do that. So therefore, we've decided that it should take place medically, because that's gentler on everyone.
>
> [Bjarne, gynecologist]

In 2004, the Danish Board of Health issued new guidelines for prenatal screening and diagnosis, launching non-invasive prenatal screening—consisting of a first-trimester prenatal risk assessment for chromosomal anomalies and a second-trimester malformation scan—as a standard offer to all pregnant women, on a routine basis and free of charge (Danish Board of Health, 2004). Though the Danish Board of Health refused any associations with past prenatal diagnostic programs, which had had prevention of the birth of children with handicap as their goal, by introducing the bioethical panacea of "informed choice and self-determination" (Parliamentary Decision on Prenatal Diagnosis, n.d.; Schwennesen et al., 2008), statistics show that termination for fetal abnormality increased from 320 in 2005 to 618 in 2019 (Abortion Appeals Board, 2006, 2020). Following Wahlberg and Gammeltoft's notion of selective reproductive technologies (SRTs) as aiming towards preventing or promoting the birth of "particular *kinds of children*" (Wahlberg and Gammeltoft, 2017, emphasis original), the linkage between high uptake rates of routine prenatal screening (>95%), high rates of couples opting for termination following the detection of a fetal anomaly (99%), and an efficient medico-legal system authorizing around 94% of the approximately 600 annual applications for abortion for fetal anomaly (Abortion Appeals Board, 2020) has turned 'late' abortions into regular medical events (Ekelund et al., 2010; Lou et al., 2018a,b; Petersen and Herrmann, 2021). Denmark is often highlighted as the first Western country to establish a right to free abortion in the first trimester of pregnancy, yet since the timing of routine prenatal diagnostic tests typically place them *after* the first trimester, most selective terminations take place during the second trimester and must therefore be approved by a specialist committee (Petersen and Herrmann, 2021) and be managed under supervision of health staff. In effect, care for couples and individuals who selectively terminate a pregnancy has entered public hospitals as a recurrent task for health staff. Yet, what it entails, how it is done and what social and moral responses it provokes are seldom

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discussed outside clinic walls. Second-trimester selective abortion care involves ensuring the physical safety and well-being of the patient during the procedure. However, because abortion is also highly morally charged, there is much more to abortion provision than securing safe medical outcomes. As the opening quotation with Bjarne, an older gynecologist working in one of Denmark's largest obstetrics and gynecology departments, illustrates, the stipulation that second-trimester abortion is best managed through induced labor encompasses concerns that exceed strictly medical arguments: it elicits the moral dimensions of abortion provision.

In contrast to, for instance, the United States, Denmark is strongly in favor of abortion, proven as recently as in January 2023 when 24 organizations joined together in the Alliance for Free Abortion to mark the 50th anniversary of the right to free abortion, including The Danish Board of Health (URL 1). At the same time, since 1989, it has been possible for hospital staff to reject performing abortions for reasons of conscience (Herrmann, 2007), underscoring how abortion is approached politically through an acceptance of ethical pluralism while obligating the healthcare system to deliver abortion services without delay. Because abortion—theoretically as well as practically—balances on the border of life and death (Jensen, 2011) and taps into unresolved ethical questions about when life begins and what value anomalous fetuses have, selective abortion care is an interesting case study for demonstrating not only what moral questions and practical solutions have emerged in response to the "normalization" of prenatal diagnosis and selective abortion provision, but also for pushing current discussions within anthropology about what constitutes morality (Fassin, 2011, 2012, 2014; Laidlaw, 2002; Mattingly and Throop, 2018).

In this article, we explore how second-trimester selective abortion care is orchestrated in Danish public hospitals, and what normative implications these care practices have. Drawing on the concept of "orchestration," which delineates an understanding of that which is being orchestrated to aim for a specific wanted result or effect (Jensen, 2011: 13–14), we show how health staff turn selective abortions into morally bearable events through three interrelated orchestrations of care: 1) *clinical guidelines*, 2) *relational care* and 3) encouragement of *fetal-parental attachment* mediated through various material objects and visibility practices. We argue that health staff orchestrate care in these ways not only to empower couples to go through the abortion procedure and live on from the termination in productive ways, but also to make the modality and materiality of second-trimester selective abortions morally acceptable for health staff themselves. To capture how these scripted and performed practices distill moral concerns and stakes, we propose the concept of "moral bearability." According to Merriam-Webster online dictionary, *to bear* signifies "to accept, tolerate or endure, especially something unpleasant" (URL 2, see Shih, 2017). Our use of the noun bear*ability* as opposed to the adjective form is central to our key argument. Moral bearability implies the ability of health staff to carry couples through the ordeal while bearing one's own complicity in the making of fetal death. In this way, moral bearability is less about moral turning points and decision-making (Ivry and Teman, 2019; Mesman, 2008; Navne et al., 2018; Zigon, 2007) than about *reconciling the everyday*.

We begin the article by placing our study within the rich anthropological literature that takes morality as an explicit object of study as well as within selected readings of studies of life and death. We then outline our study and methodology. Our subsequent analysis falls into three sections, analyzing how moral bearability is sought accomplished on three interrelated levels: on the level of the institutionalized script (clinical guidelines), on the level of relational care (face-to-face encounters) and on the level of the ideological (promoting attachment). We end the article by expanding upon our concept of moral bearability.

## 2. Studies of moral anthropology: beyond moral turning points

In recent years, a growing slew of social science studies has brought attention to questions of morality and ethics as a distinct field of empirical research (Fassin, 2012, 2014; Faubion, 2011; Kuan and Grøn, 2017; Laidlaw, 2002; Mattingly and Throop, 2018). Within anthropology, this burgeoning "ethical turn" has been fueled especially by existential and phenomenological anthropologists who approach morality from the vantage point not of moral order, codes and principles but from a Neo-Aristotelian approach to morality that privileges moral experience, being and becoming (Kleinman, 2012; Mattingly, 2013; Zigon, 2007, 2009; Zigon and Throop, 2014). One example is the work of Cheryl Mattingly, who has proposed the figurative trope of "moral laboratories" to capture how people conduct experiments on their own lives, arguing that the moral is located in the exercise of practical reasoning as people try to discern "what might constitute the morally appropriate action in the singular circumstances life presents" (Mattingly, 2013: 4). Another example is Jarrett Zigon's concept of the "moral breakdown" (Zigon, 2007), which refers to dramatic instances that interrupt a person's taken-for-granted way of being and forces that person to consciously think about how to act. Zigon makes the distinction between morality as the "unreflective moral dispositions of everydayness" and ethics as a "tactic performed in the moment of the breakdown of the ethical dilemma" (Zigon, 2007: 137–139). Central to Zigon's take on morality is his contention that studies of the moral cannot properly be called an anthropology of moralities unless they are limited to these moral breakdowns, as studying unreflective moral dispositions is equivalent to studying anthropology's conventional focus on "culture, tradition and power" (Zigon, 2007: 137–139).

Inspired by these lines of thinking, a number of medical anthropologists have explored the moral enterprise of managing life and death in differing biomedical settings, such as neonatal intensive care units (Mesman, 2008; Navne and Svendsen 2018a; Navne et al., 2018), and neuro-intensive care units (Jensen, 2011; Sharp, 2016), focusing on the intricacies of moral decision-making. For instance, Navne and Svendsen demonstrate how Danish neonatologists and nurses caring for extremely premature infants work to overcome their own ambivalences about withholding treatment through a commitment to balancing the good of the infant, the family and society at large—what they refer to as "decision as care" (Navne and Svendsen, 2018b: 254). STS-scholar Jessica Mesman (2008) has shown how health staff in a Dutch NICU relocated and distributed decisions on interrupting life-sustaining care to collectively share the responsibility for the decision, seeking to make the decision "robust" by leaning on, for instance, clinical guidelines and colleagues. And in a study on decision-making following the detection of a fetal anomaly in Israel, Ivry and Teman (2019) show how Halachic rabbis work to liberate couples, doctors and themselves from the moral burden of making ethical decisions by outsourcing and aggregating medical and religious expertise, and as such divide moral responsibility to reach and bear a ruling.

What these approaches to 'the moral' share is that they tend to bracket out dominant norms and values and their material configuration as part of shaping moral life. Yet, as we shall see, our interlocutors mostly spoke about the moral stakes involved in abortion care through the idiom of "best practice", making neither the notion of moral laboratories nor the moral breakdown helpful analytical tools to grasp the moral labor exercised by abortion providers. We do not mean to question that abortion work is unquestionably messy and "tinkered with" (Mol, 2008) nor that health staff do not exercise ethical reflection as part of their daily routines, yet our empirical data called for an approach to morality that takes normativities seriously into account. As we will show in the subsequent analysis, in each of the levels of the orchestration of moral bearability—from the clinical guidelines to the material practices of promoting attachment—are embedded particular and highly conventionalized notions of 'the good'. In line with Fassin's politization of morality and ethics (2011), we are not concerned with whether these notions of the good are right or wrong, but with what *inclusions and exclusions* they produce.

Though social studies of abortion are rich in numbers (Becker and

Hann, 2021; Chiappetta-Swanson, 2001; Cignacco, 2002; Garel et al., 2007; Hằng, 2011; Harris, 2019; Kasstan and Unnithan, 2020; Roe, 1989; Simonds, 1996; Vinggaard Christensen et al., 2013), this study is the first to explore how moral concerns shape the clinical work of abortion providers in a Danish context. Our analysis contributes to moral anthropology by moving beyond the more common focus on the drama of moral turning points by rendering visible the laborious discursive, relational and material labor associated with settling and reproducing practices deemed morally unsettling, such as by leaning on conventions and ideologies, as well as by showing how 'the moral' is not solely located in, or flowing from, the subject. Rather, we take morality as co-constituted through the human, the bodily, and the material.

## 3. Methodology

This article builds on a collaboration between the authors which formed around a shared interest in the clinical management of selective abortion. Driven by our interest in how abortion procedures are "done" and why they have come to be assembled in certain ways, we immersed ourselves in different sources. We draw on semi-structured interviews with three nurses, four midwives and three gynecologists (undertaken by the first author in 2021); a semi-structured focus-group interview with four midwives (undertaken by the second author in 2020); and an in-depth interview with an initiator of the national organization for infant death, Parents & Grief, a private organization that offers grief counselling to bereaved parents (undertaken by the third author in 2021). The recruitment of nurses and midwives took place via self-referral—they responded to a call for participants circulated on an electronic mailing list and on a closed Facebook group for practitioners. The gynecologists were contacted directly due to their specialized knowledge about abortion procedures, and the initiator of Parents & Grief was recruited to shed light on the historically shifting approach to pregnancy loss care in Denmark. The goal of an in-depth interview is to give prominence to participants' narrative activity through open-ended "guided conversations" (Lofland and Lofland, 1995). Interview guides targeted at health staff were mainly used as a starting point, asking for example: "Can you tell me about the latest late abortion you assisted in?" and "What do you do when you meet a couple for the first time?" Additionally, we draw on clinical guidelines, medical instructions, and patient pamphlets from different hospitals, as well as a visit to a gynecological ward. In conjunction, these varied data were assembled to tease out how selective abortion care was discursively and materially exercised. All interviews were audio-recorded, transcribed, and analyzed using Nvivo. Coding categories followed a temporal frame of before (pre-meeting), during (labor-induction), and after the abortion procedure (post-abortion care). While the process of coding took place separately, analysis took place through sharing and discussing research data, such as interview transcripts. The ethnographic approach taken in this study builds on the premise that data are created through the researchers' empirical interests, methodological preferences, the negotiated realities of particular field sites, and the researcher's interpretation (Madden, 2010). Given Aalborg University had no Research Ethics' Committee for social science research at the time of our study, ethical approval was not required for this research, yet we obtained approval from the Data Protection Unit to meet General Data Protection Regulation obligations. All names used are pseudonyms.

## 4. "A concern for the surgeon": orchestrating moral bearability through clinical guidelines

> Evidence says that surgical abortions have more complications than medical abortions. You risk doing damage to the uterus. You might meet someone in week 13 who begs for one [Dilation & Evacuation], and then we explain to them that we don't think it's a good idea.

Birgitte is a chief gynecologist who has worked with abortion provision for decades. Sitting in her office, she gave—with penetrating authority—evidence-based research as an explanation for why public hospitals offer only medically induced abortion in the second trimester. Birgitte was not the only one convinced that labor-induced abortion carries less clinical risks. Across professional divides, doctors, nurses and midwives all highlighted the physiological benefits of the medical procedure as the "gentler" approach, often referring to the elusive notion of "evidence says" as justificatory bedrock. However, when probing our interlocutors about the background of this organization, something more than a concern for the physiology of the pregnant person surfaced. During an interview with Henrik, an older gynecologist who had pioneered the standardization of medical terminations across the country, he asserted that:

> When we in the old days set the threshold for abortion at 12 weeks, it was because it was unproblematic to perform the abortion [up until this limit], because you could evacuate the fetus through suction. […] As soon as we got suctions, we started using those, because for the one doing the procedure, using suction is much less confronting. And then obviously, if you do surgical abortion after 14 weeks, it demands a lot of practice. And most of my colleagues would say no. And that's because we're afraid of doing damage to the uterus, because it's a small, thin thing, and there are examples of accidents that have been very serious, where the uterus perforated. It can be very dramatic. But I think we must be honest and say that it's just as much a concern for the surgeon. And that very few surgeons want to do late abortions. And on an everyday basis, it's typically the young doctors who perform the abortions, and therefore no one has that kind of routine.

Second-trimester abortion was accomplished in the United States primarily by labor induction up until 1977, when David Grimes and colleagues published a study documenting the safety of Dilation and Evacuation (D&E) (Grimes et al., 2004). As D&E increasingly was accepted as a procedure superior to labor induction, the responsibility of performing abortions fell to the abortion doctors and stayed with them (Jones et al., 2017; Löwy, 2018)—although the United States' 2022 overturning of Roe v Wade has already seriously impeded abortion provision across the country (Londoño Tobón et al., 2023). Similarly, D&E predominates in England and Wales and has been described as common in the Netherlands and France (Lohr, 2008). In Denmark, the story is, in many respects, the opposite. As the extended quotation above illustrates, Danish gynecologists promoted medical second-trimester abortion both because surgical abortion demands a large pool of skilled providers unobtainable due to the way in which abortion provision is organized in Danish hospitals, that is, delegated typically to junior doctors, and because of the moral unease associated with the mutilation of fetuses required in surgical procedures. As such, when RU 486, also known as the "abortion pill" (Gerber, 2002), was implemented in Denmark in 1997, it became possible for doctors to release themselves from the unpleasant work of performing these procedures. Indeed, while studies have shown how American abortion providers are often politically motivated to perform abortions to empower pregnant persons to exercise reproductive freedom (Harris, 2008; Simonds, 1996), the doctors we interviewed said that abortions formed the part of their occupation that appealed least to them and hence considered low prestige (Ingerslev et al., 2012). Thus, while the notion of medical abortion as the "gentler" approach and hence as constituting good care was generally spoken of through the idiom of evidence, institutional labor divisions, lack of technical skills and moral sentiments were in fact all implicated in developing and cementing the medical abortion regime as "best practice."

Mattingly argues that "a portrayal of moral work which presumes that moral technologies are already firmly in place prior to being encountered by the apprenticing artisan misses the many ways people experiment with, critique and modify the very traditions they have inherited or in which they have 'schooled' themselves as part of their

self-making projects" (Ingerslev et al., 2012: 3). By this, she questions the normative constraints impinging on people's lives to, instead, render the ethical subject as one who has transformative powers to turn even the direst situations into quests for the good life. Yet, in our study, rather than modifying care to the individual patient's needs, most of our interlocutors did great efforts to stabilize the conventional care script. The nurses and midwives we interviewed generally worked to convince hesitant couples about the benefits of giving birth. One nurse explained:

> Why do I have to give birth? Many think like that, they don't want to, they cannot relate to it at all, because normally birth is associated with something good, not something painful where you don't get to bring anything home. But research says that the healing process is better, later on.

Mesman writes that "scripts imply more or less explicit directions for action […] foreground[ing] specific treatment options at the expense of others, if not blocking other options" (Mesman, 2008: 189–190). We might say that the script of the clinical guideline sets clear boundaries for what is *possible* to do within clinic walls, which then comes to configure a moral imperative of "proper" abortion care that health staff must align themselves with. The notion of "the good" at play is the perception that medically induced abortion—coming close to a natural birth process, which predominates Danish birth culture—is non-violent, humane and "gentle" on all actors and entities involved; the dead fetus, the pregnant person and, not least, the clinician herself. Though D&E is considered a safe method provided the clinician is skilled and has access to specialized instruments (World Health Organization, 2012: 41) and comparative studies have shown that it is associated with fewer post-abortion complications (Bryant et al., 2011; Grossman et al., 2008; Kaltreider et al., 1979; Peterson et al., 1983; Westhoff, 2011), none of our interlocutors knew about these studies and some doctors outright rejected their credibility. Some exhibited apparent unease about the prospect of organizing care in alternative ways. Thus, we might say that the script serves to maintain a kind of collective social order around 'late' abortion provision. In effect, couples and individuals who arrive at the hospital for second-trimester abortion are told that they must face the abortion as a bodily process for "their own good", not that medically induced abortion was formalized also to ease the moral discomfort of physicians. Yet, whereas the overall care script might be fixed, the care being exercised in practice must be negotiated and involves a different kind of moral labor. This is what we turn to now.

## 5. Orchestrating moral bearability through relational care

With the normalization of medical abortion followed a transfer of the responsibility for providing abortion care to the nursing and midwifery professions. According to the script of the clinical guidelines, induction of labor involves two steps; the administering of Mifepristone, and second, induction of labor 24–48 h later when the couple are admitted to hospital. The initial meeting—where the Mifepristone pill is handed out—was referred to by our interlocutors as the "pre-meeting" and is typically handled by a nurse or a midwife. One medical instruction from one of the largest hospitals on Zealand outlines: "Before the treatment is initiated, the patient is informed about the course and, if any, side effects, as well as the fact that the fetus in some cases may show signs of life and how this is handled" (URL 3), thus highlighting certain medical and procedural information as vital information. However, caring for couples in this initial phase involves much more than such "factual" information. Frederikke, a midwife in her 30s, touched upon the importance of tuning in on the couple's specific emotional and psychological state:

> The couple will go first and then I try to register where they are in all of this. Because they might say: "This wasn't a difficult decision, because the child wouldn't be viable outside the womb," or "we knew beforehand," for instance if they had already decided to terminate if the results came back positive, so it's with those things in mind that I talk with them […] So it's about making them feel safe and reassured. That's my most primary task.

When the couple arrive at the hospital for labor-induced abortion, they are welcomed by the nurse or midwife in charge of their care, who follows the couple to a private room, offers them something to drink and hospital gowns, measures the pregnant person's blood pressure, and orders blood testing for emergency blood transfusion in case of excessive bleeding. As soon as the first Cytotec tablets have been inserted, the waiting begins as it can take hours before the contractions that will lead to the delivery of the fetus to begin. This waiting time is used to getting to know the couple (even more than during the pre-meeting). As part of this endeavor of getting to know the couple, it is standard to inquire how they relate to the event by asking: "What is this to you, an abortion or a birth, a fetus or a child?" Through such inquiring, conversations often circle around the decision to opt for termination, and the shame and guilt that haunt some couples (Heinsen, 2022), which nurses and midwives often attempt to help shoulder through narrative strategies, such as by emphasizing abortion as a responsible act. As one midwife said:

> I try saying, "I get it, I understand, and remember these and these things which are why you made this decision" […] and I try to turn it into a more everyday conversation about parent-child relations, because we feel love for our children, and we want to do good for our children. And we take on responsibility […] So I try to weave it together with love.

In *The Managed Heart. Commercialization of Human Feeling*, Hochschild ([1983] 2012) coined the term "emotional labor," which describes the attuning to and empathizing with the needs of another human being *and* the simultaneous management of one's own emotions to meet those needs. We suggest there is more to the relational care being done by nurses and midwives than juggling the needs of couples and one's own emotional response to those needs. Getting to know each couple or individual by listening to their story is pivotal not only to individualize care (the extent to which this is possible within the overall script) but to help couples feel they have chosen abortion for the concern of the "futile" fetus. Weaving selective abortion together with "responsibility" and "love" can be seen as moral labor that re-orients the event from one that is experienced as an uncaring act of discarding of an unwanted fetus to an act of benevolence and care for a desired child too ill for this world. Through such moral labor, the couple and health practitioners are all turned into ethically responsible subjects who take part in the making of death for the "right reasons."

Apart from expressing emotional support for the decision to terminate, most health staff used the time during the medical procedure to prepare the couples or individuals for confronting themselves with their dead "baby." Talking about how the fetus might look like at various gestational ages, how the fetal malformation might look like outside the womb, and how the fetal body could be handled and memorialized are considered important for the couples to be able to mentally prepare themselves for the profound grief assumed to ensue. Seeing the dead fetus is understood as pivotal for two ideological reasons. We return to the second in the next section, but the first ties closely together with our point raised above; that moral bearability is achieved by aiding the justification for abortion. Several of our informants told us that they would encourage couples to see the fetus to reassure them of the reality of the fetal abnormality. One midwife for instance said: "If there are visible malformations, then yes, you have a greater tendency to verbalize that they've made the right decision." Similarly, Marie, a nurse, explained:

> If it's a case of acrania for instance, where the top of the skull is missing, for the parents sometimes it's a relief, like, okay, I can actually see it myself. […] So, it becomes a kind of confirmation that it's okay it's being ended.

This echoes one of the central findings of Chiappetta-Swanson's study of Canadian nurses' practices in relation to genetic terminations, as she notes: "Though they do it in subtle and non-directive ways, [nurses] feel it is their responsibility to counsel their patients and prepare them for the grief work they will need to do […] They know how easy it is for their patients to look at the baby and to be plagued with lingering doubts about whether the procedure had in fact been necessary at all. The nurses want to spare them that anguish (Chiappetta-Swanson, 2001: 154–156). Inspecting the malformed parts of the dead fetus together with the couple is exercised to reinforce that abortion is justified, hereby helping to carry the moral burden of the decision, and the abortion act itself.

Remarkably, the highlighting of the fetus's deformities is coupled with an accentuation of the fetus as a precious "baby," not as biological waste or a defected "product of conception" (Gerber, 2002). In the context of the Danish nationalized healthcare system, enactment of fetal personhood and enactment of abortion justification go hand in hand. One midwife told us how she made great efforts to "tuck the baby in" neatly because "the child, when it's a wanted pregnancy, then it's been made from love, and when they see two lines on the pregnancy test, you know, their whole life is unfolding in front of their eyes, and that's important to care about. So, it shouldn't just lie alone." Moral bearability is sought accomplished through aiding couples in legitimizing death, while simultaneously aiding the couple in confronting the abnormal baby's remains, indexing the good abortion-seeking individual as one who opts for termination and, at the same time, is willing to care for the aborted fetus. However, the practice of inspecting the body of a fetus may at times cause moral ambiguity. As Frederikke said: "Some of the most difficult processes are those where something is wrong with the brain and the couple has been told about all these diffuse estimates, like it might lead to some level of developmental disorder, but you cannot predict to what extent." Being confronted with a normal-looking dead fetus may in these ways work against the legitimacy of the abortion, which prompted health staff to do additional moral labor of reassuring the couples of the credibility of the prenatal diagnosis.

## 6. "To say a proper goodbye, you need to say 'Hello'": orchestrating moral bearability through promotion of attachment and grief

The practice of inspecting and memorializing dead fetuses through visibility practices is a recent invention in Denmark. Prior to the late 1970s, it was standard in Denmark as in most Western countries to encourage couples impacted by pregnancy loss to forget it happened and look to the future, which mirrored the then dominating grief model of "letting go" (Davies, 2004; Kofod and Brinkmann, 2017) Standard practice was to cover the woman's head with a veil during labor, whisk the dead baby away immediately after birth, and dispose of the remains as biological waste without consulting the woman (Bleyen, 2012; Hughes and Riches, 2003; Kjærgaard et al., 2001; Löwy, 2018). However, a shift took hold in Denmark from mid-1980 onwards, when the grassroots association Parents and Birth initiated a special group focusing on infant loss, which later developed into the national organization for infant death in 1992, now known under the name Parents & Grief. As described by one of the initiators, the organization pushed for a shift because bereaved parents were "desperate when they called because they had not received the necessary help. They had not been advised to see their child, no pictures had been taken, there were no one caring for making hand- and footprints. It was not even considered. Even being allowed to see one's child was a struggle." About the same time as patient advocacy took hold, novel literature on grief that stressed the importance of having contact with the dead child to facilitate the grieving process was published, much of which built on ideas about "continuing bonds" with the deceased child (Hughes and Riches, 2003; Klass et al., 1996). In effect, it became common to promote contact with the dead fetus or child. Thus, in the everyday clinical care, there is no difference between how health staff treat couples opting for termination from couples who experience involuntary pregnancy loss. A Facebook post posted by one hospital showing a picture of a healthcare worker holding two knitted Moses baskets (see Fig. 1) made this point poignantly clear, as the caption reads:

> When miscarriages and late abortions take place, it is important for us to give parents, who need it, good and concrete memories to take home. […] On the birth ward, one of our amazing healthcare workers has therefore begun knitting Moses baskets for the small fetuses. […] With the baskets, we can make a difference when it is most needed. The parents see a child they can touch and hold, not just a fetus. That means a lot for the grief process—and for the legitimation of the many difficult emotions that come along.

In their study of neonatal intensive care, Navne and colleagues show how health staff enact extremely premature infants as morally valuable "maybe-lives" that parents are encouraged to relate to despite the fact that health staff deem some of these lives not worth saving, pointing to how the philosophy of attachment is so pervasive that the enactment of "maybe-parents" is almost impossible (Navne et al., 2018). Indeed, the above quotation not only speaks to the kind of conflation healthcare providers make between chosen and involuntary loss, but also epitomizes a broader ideology of parental-fetal bonding as fundamental to experiences of fetal loss through selective abortion (Becker and Hann, 2021; Millar, 2016; Mitchell, 2016). The ideology of attachment guided the beliefs of most health staff we met, represented in a mantra we heard from several of our informants. Birgit, a senior midwife, is one example:

> Boiled down to one sentence, which we have learned to say since training is: "You can't say proper a goodbye before you've said 'Hello'." For me it's extremely important to find a way for these parents to embrace this child even though it's dead.

Though the routinized practice of fetal contact is contentious (Hughes and Riches, 2003; Sloan et al., 2008), and a recent Danish study has shown how not all individuals who go through selective abortion want to see their dead fetus (Heinsen, 2022), across professional divides such visibility practices are seen as a prerequisite for living on sanely and assuredly from the abortion. One gynecologist, for instance, said that he regarded the act of sitting with the dead fetus to be the most "dignified" way to approach these situations. Another gynecologist specified that it is better to see because "fantasy often haunts you more than reality." The practice of seeing and holding, aided through various personifying objects, such as knitted beanies, blankets and baskets, are invested in with these good intentions of securing psychosocial healing. Indeed, when couples did not comply with the advice of health staff, it

**Fig. 1.** Picture of health provider holding knitted "Moses baskets."

caused great worry. One midwife spoke about one couple who refused to see their dead fetus as "being in denial," meanwhile another said: "I'm challenged when they don't want to see. And you try saying, 'You can always change your mind and it's not something you have to decide right now.' Because you think it might not best in the long run."

Komaromy has astutely argued that dead babies do not need to be dressed and cuddled. Their need is "an assumed one by practitioners on behalf of bereaved women and couples" (Komaromy, 2012: 201). In this way, couples are encouraged to adhere to a "prescription of their own needs" (ibid.), regardless of how they might relate to the fetus (see also Heinsen, 2022). As Monica, a nurse, said:

> I came back with the little one in a Moses basket, and then I'd chosen a green blanket with a beanie attached, because he [the fetus] had a huge hematoma on the head […] And what I find so exciting about this, what's the right word … you know, I just feel a completely different sense of pride when I enter a room showing this […] the experience for the parents and also for us as nurses. It's a completely different experience going in and presenting the fetus or the child to the parents with the options we now have.

What this quotation shows is not only that Monica assumes that all pregnant persons seeking to terminate their pregnancy cherish objects like knitted blankets, beanies and Moses baskets (see Fig. 2). It also shows that *she* experiences such objects as mediating respectful care, making her own involvement in the procedure more tolerable. Yet knitted objects, combined with their ideological underpinnings, also hold the power to define the situation, aestheticizing the dead fetus in ways that simulates an "as-if-sleeping-and-alive" miniature baby, which leverages the aborted fetus personhood while curbing the possibility of dealing with the fetus in alternative ways, such as through detachment. Coming to terms not only with the decision but also with the loss of the actual fetus—not just the symbol of the fetus—is central to the moral labor performed within clinic walls. We might say that nurses and midwives evaluate their abilities against the extent to which they succeed in securing that pregnant persons and their partners grow positively from the ordeal. Indeed, for health staff, it becomes less bearable to send couples home if they feel they have failed to set the couples on such a healing track of attachment, grief and reconciliation; and staff anticipate that the loss will haunt the couples if they have not faced the "reality" of their dead "baby."

**Fig. 2.** Hospital cabinet stacked with knitted blankets and clothes offered to couples undergoing selective abortion on a routine basis. Photo taken by first author.

## 7. Conclusion: moral bearability as the reconciliation of the everyday

As has been the case in many other countries around the world, Denmark has experienced a tangible shift in the management of second-trimester abortion, from one of forgetting it happened to one imbued with deeply held beliefs in the benefits of medically induced abortion, and of bonding with and grieving over the dead fetus. Throughout this article, we have explored the moral drivers behind these shifts, as well as the "on-the-ground" care that is now being exercised. We have argued that selective abortion care is orchestrated in specific ways to make the acts of producing, handling and confronting fetal death morally bearable for both couples and staff. Caregiving in second-trimester abortion services takes on a particular moral urgency, because it involves direct actions to produce and handle fetal death. On the level of the institution, the discomfort of making death has been mitigated by stabilizing a care script that prescribes that abortion must be handled in ways that resembles a natural birth process, redistributing the responsibility for making death from the doctor's domain to the domain of nurses and midwives. In effect, nurses and midwives are (most often) those who insert the labor-(and thus death)-inducing medication into the pregnant person's vagina, but the moral stakes involved in their care goes much further than that. As we have shown, they work hard to help share the moral burden of termination by legitimizing the abortion decision by framing the event as an act of love and responsibility, as well as by relying upon a dominant grief paradigm that prescribes visibility practices and bonding with the dead fetus as paramount to coping, ultimately in ways that support both couples and healthcare staff in coming to terms with selective termination as morally permissible acts.

These elements of the labor involved to create moral bearability elucidate how morality is not always about making morally loaded decisions, but also about making certain practices "doable" day after day. At the heart of such moral labor is an orientation towards *reconciling the everyday*: it is about overcoming the challenges of repeated production of death, and of living with those deaths that one has already taken part in. The kind of morality that we allude to is thus past-, present- and future-oriented. Moral bearability is achieved through the stabilization of "best practice," lending abortion providers a shared, agreed-upon approach to how things are done, through which ethical doubts and dilemmas are tamed. In essence, the notion of morality we propose is less about cultivating a virtuous character than about maintaining a sense of social order (Fassin, 2015).

Importantly, our take on morality does not exclude the notion that morality is grounded in achieving "the good" yet we approach it from a different angle than theories that privilege a focus on virtues. All of the both scripted and performed care practices we have analyzed—from the institutional, relational to ideological—are imbued with notions of the good; the abortion procedure must be as "gentle" as possible for all actors involved; the abortion-seeking individual must both choose termination *and* show affection towards the aborted fetus, and the abortion provider must master the art of setting couples on a generative path of coming to terms with the decision, the abortion itself, and the loss it has invoked. The conventions of how to perform good abortion care thus express strong ideologies that indexes what is considered "moral," such

as good and bad clinical procedures, good and bad encounters, as well as good and bad outcomes. Thus, unlike Mattingly, we argue that goodness is brought to bear not through trying out care provision case-by-case, but by making everyone aligned with these dominant care practices. By reproducing what is fervently believed to be evidence-based care, such as performing the abortion as an event akin to infant loss, health staff feel validated that they offer "good," "right" and "beneficial" care, which gives them a sense of personal reward and reassurance. While the notions of good at play across all levels share an orientation towards mitigating moral unease, they differ slightly in the kind of moral labor it contains. As the overall script sets the parameters for care provision, little room is left for anything else than adherence to and reproduction of the script, which calls for the work of *convincing* people to submit themselves to the benefits of labor and birth. The relational care being performed is dynamic, negotiable and relationally configured, thus what is done and said during one abortion procedure might be slightly different in another, as health staff attempt to adjust and individualize care as much as the script allows for, yet what they always seem to do is working towards *alleviating* both the physical and psychological pain that the abortion invokes. Lastly, the widespread subscription to the ideology of attachment invites for the work of *nudging* couples into confronting their dead fetus in the belief that validating the dead fetus as a valuable entity, and the couple as parents, is the most productive route to recovery. Importantly, while these different elements of the moral labor exercised by health staff all orient themselves towards the normative conventions for good care, they are no less laborious than the work of experimenting and trying things out.

Such care practices are, however, not neutral nor value-free but creates certain inclusions and exclusions of practice, subjectivities and moral responses. Firstly, because of the way abortion care is orchestrated, the fetus has taken center stage as an entity to be confronted—visually, viscerally and relationally. Because induction of labor results in complete fetal bodies, these bodies and their materiality are part of manifesting the moral stakes, questions and solutions. It is, we argue, the completeness of these bodies (as opposed to dismembered body parts or fetal tissue) that acts as a foundation for the moral imperative of fetal-parental attachment and for the moral labor of turning the dead fetus into a "precious" entity to be confronted and mourned while maintaining the legitimacy of its death. Secondly, the moral imperative of showing, ritualizing and commemorating the dead fetus casts all abortion-seeking couples and individuals as "bereaved parents", though they do not necessarily identify as such. This presumed collective identity as grief-stricken parents disqualifies other forms of dealing with the abortion, such as through detachment (Lou et al., 2021).

In these ways, the constitution of morality is not separate from but *contingent upon the material*. While much of the existing anthropological literature focusing on morality locates the moral within the subject as practical everyday acts of moral striving, experimenting and self-cultivation, we propose that morality—as an empirical phenomenon—is expressed and exercised through the coming-together of people and things. Morality is exercised by settling and reproducing scripts and ideologies and their inherent normative frames, within which these people and things conjoin. While our research is empirically limited to terminations for fetal anomaly, we suggest that moral bearability as heuristic is generative of how people work towards settling, reproducing and maintaining "best practice" to achieve a sense of social order, which has applicability beyond the specific case of selective abortion care, potentially enriching future ethnographic explorations of morality within and beyond anthropology.

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## Data availability

The data that has been used is confidential.

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