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From Clinic to Grave: Women's experiences of 'pregnancy remains' disposal following an early miscarriage in England, UK

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Author notes

The author declares they do not have competing interests.
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Other publications using data set

Kilshaw 2024a and b used data from the overall research. Whereas those focused on the 'consent' process, this paper explores the disposal pathway itself: burial. Both papers explore the way in which women experience and navigate clinical practices around pregnancy remains disposal this paper focuses on the nature of the disposal and the ongoing presence of the remains. The argument and suggestions for change also differs in that this paper calls for the need to introduce sensitive incineration to clinical disposal options. The paper also comments on the fact that the research has informed change with two UK NHS trusts have just this week implemented change in their practices as a direct result of this research. The research also informed revisions in national policy (HTA and RCN) in Autumn 2024

Ethics

The research had full ethics approval from NHS HRA Ethics Committee (Integrated Research Application System (IRAS) Reference: 261330, Research and Development Reference: PID14448-SI001, Research Ethics Committee Reference: 19/SC/0428

The research was supported by the Wellcome Trust as part of a University Award in the Social and Historical Science (Award number: 212731/Z/18/Z)

Note: if the paper is accepted for publication I would like a truncated ethics statement, if possible in order to protect the site of the research and maintain anonymity

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ABSTRACT

National guidance, particularly that issued by the Human Tissue Authority (HTA) informs UK clinical practices around managing pregnancy remains prior to 24 weeks gestation. This guidance stipulates that women should be offered options for disposal: cremation, burial, or incineration. Based on 20 months of ethnographic fieldwork between April 2020-September 2022 in one National Health Service (NHS) Trust in England, including participant observation, observing clinical consultations about pregnancy remains disposal (n28) and interviews with women (n27), this paper argues that current clinical practices appear discordant with the views of some women experiencing miscarriage and therefore are not conducive to inclusive care. Most women had not considered what would happen to the pregnancy remains prior to the formal discussion around disposal in the hospital and found the discussion unexpected. Many participants expressed disbelief about disposal pathways offered with most suggesting they were inappropriate, particularly given the early stage of their pregnancy (≤12-week gestation). Some women expected the pregnancy remains to be treated as clinical waste and were surprised and, at times, upset to not have this option. The research provides further evidence of the diversity of responses to miscarriage including some women's dissatisfaction with practices around pregnancy remains disposal. It shows that some women would prefer to have a choice that does not include ceremonial disposal. A person-centred approach to pregnancy remains disposal is recommended to accommodate a diverse range of attitudes. This should include incineration as a disposal option to ensure practices do not imply meaning of the pregnancy tissue that conflicts with women's perspectives, including their notions of foetal personhood or its absence. The study can inform and refine local and national practices as well as develop consistency across NHS Trusts.

INTRODUCTION

National guidance, particularly that of the Human Tissue Authority (HTA) (HTA 2015) and relevant bodies such as the Royal College of Nursing (RCN) (RCN 2018) informs pregnancy remains disposal in clinical settings in the UK. Guidance outlines that women should be given disposal options (burial, cremation, and incineration) (HTA 2015, RCN 2018). The HTA and RCN regard incineration as an appropriate method, yet many clinical settings do not provide this option (McGuinness and Kuberska 2017) including in Scotland where the national administration deemed it unacceptable although legal. Cremation, often associated with a service, involves burning remains in a registered crematorium, allowing for the collection of ashes. Incineration is a waste disposal method where ashes are not collected, typically at a licensed waste site. Sensitive incineration, a specific type of incineration, involves treating remains separately from other clinical waste during the process of incineration. Sensitive incineration was not available in the National Health Service (NHS) Trust where the research was conducted. Women were offered a choice of three options: hospital disposal via communal burial, release of the tissue to a funeral director, or to the patient for private arrangement. Whilst there is variation in approaches in different NHS sites, disposal practices at this hospital were typical of other NHS settings in England, including the lack of incineration as an option, although hospital disposal via burial is less common with the majority using communal cremation. By using an anthropological approach, I seek to understand the notions of value and personhood afforded remains by clinical practices and how women interact with such meanings.

A note on language: where relevant I mirror the language used by clinical documents and guidance, primarily using the term “pregnancy remains.” However, I acknowledge the problematic nature of the term due to its closeness to “human remains” and implications of value. The term “tissue” is also used. Women referred to “remains”, “tissue”, “baby”, but also “stuff” and I have used their terms wherever possible. Health care providers often used “pregnancy.” In some cases, I use “material” to connote that the woman did not refer “remains.” I prefer “pregnancy endings” as a more inclusive term (REMOVED).

Drawing on different medical anthropological research projects about miscarriage spanning 14 years, my work reflects on persistent themes; recent work [REMOVED]. Instead of conceptualizing the foetus as an absence or as a highly politicized object, I explore its construction in different contexts and temporalities, as something processual and defined by interactions. I draw on other scholars of miscarriage who explore personhood assemblies, including through the collecting and purchasing of material goods (Layne 2000, 2003), naming practices (Layne 2006b), and intentional kinship (Middlemiss 2024). Informed by Aimee Middlemiss' (2024:23) work introducing nuance, contestation, and diversity into constructions of personhood in the English context and her problematising notions of personhood as homogenous, my work looks at points of tension and ambiguity around personhood when clinical practices are negotiated by those for whom they are meant to care. I broaden my enquiry into the foetus to include pregnancy tissue and associated matter as these are often undifferentiated in clinical practices around disposal as well as women's experience of them in early pregnancy endings.

Social science interest in pregnancy loss in the UK began with the work of Alice Lovell whose key work published in this journal (1983) remains relevant to pregnancy loss analysis four decades later. As Lovell's work establishes, miscarriage is connected to fundamental anthropological categories of personhood, kinship, and motherhood. Twenty years later Lovell's work was followed in this journal by two publications by the most well-known and influential scholar of miscarriage, anthropologist Linda Layne (2003a and 2006) who showed how mourning practices around pregnancy loss in the US intersect with social and cultural notions of personhood (2003b).

Situated amongst anthropological and social science scholarship about how personhood is constructed, experienced, negotiated and resisted, particularly in clinical settings, this paper explores women's encounters with hospital disposal practices, contributing to ontologies of foetal beings in different ethnographic settings (Middlemiss 2024, Lupton 2013, Memmi 2011, Kaufman and Morgan 2005). This paper is situated within literature on foetuses, embryos, and dead bodies (i.e. Han et al 2017, Pfeffer 2008, Pfeffer and Kent 2007, Scheper-Hughes 1993, Michaels and Morgan 1999). A

feminist academic literature has explored the cultural nature of the foetus (Morgan and Michaels 1999, Newman 1996, Taylor 2008, Roberts 2012) including historicising and problematising the foetus as a stable entity and assumptions of foetal personhood (Morgan 2009; Han, Betsinger and Scott 2017). Scholars have explored how the foetus is represented in anti-abortion propaganda (Petchevsky 1987, Duden 1993). My work engages with the few scholars who focus on what happens after 'death' (Pfeffer 2008) although more attention is being paid to the 'dead' foetus.

with the advent of the US pro-life movement's successes in recent years most startlingly illustrated by the overturning of *Roe v. Wade's* federal protection of abortion rights in the 2022 *Dobbs* ruling.

Anthropologist Lynn Morgan shows how the regulation and handling of foetal remains is historically, culturally, and geographically contingent (Morgan 1999, 2002). In her historical exploration of the social significance of the pre-viable non-living foetus, she forefronts the need to understand them in their sociohistorical contexts. Foetuses and/ or pregnancy tissue may be understood as an anatomical specimen, (un)important tissue, waste, or a human corpse. Scholars have shown how handling and regulation of this material shifts with consequences for how they are perceived, interacted with, and their value. Regulations in France changed to allow post 15-week foetuses, once considered waste, to be buried in cemeteries (Charrier and Clavandier 2019). The possibility of a funeral produces them as persons (Memmi 2011) changing their classifications and significance. The transformation of hospital practices in France and other European contexts since the 1980s and 1990s increasingly has focused on mourning with the foetal body central to bereavement practices (Memmi 2011). Morgan argues (2002, 2009) that contemporary US contestations around the "proper" disposal of foetal remains has not always been a topic of debate in the US. As "grievability" is not ascribed to all foetal subjects cross-culturally or historically, Risa Cromer and Sophie Bjork-James (2023) assert the construction of dead foetuses as grievable human life in US law is "an anthropological curiosity". The authors have expertly explored the attempts at mandating "foetus funeral" bills by US anti-abortion strategists as means to legislate for and normalise mourning based on perceptions of and legal positions on foetal

personhood (2023: 11. My research shows how hospital practices that are intended to be sensitive may inadvertently have similar unintended effects.

Background

Historically, pregnancy tissue was treated as clinical waste in UK clinical settings and incinerated with women not involved in decisions about disposal. However, following a series of scandals in the 1990s and 2000s, including the Alder Hey Organs scandal and a Channel 4 *Dispatches* documentary ('Exposing hospital heartache', March 24 2014) the practice was discontinued despite being legal. *Dispatches*, a popular and influential investigative journalism programme aired a documentary investigating the incineration of miscarried and aborted foetuses, referring to the practice as "burning babies." The programme revealed that foetal remains were incinerated by 27 NHS trusts some of which were incinerated in "waste-to-energy" facilities used to heat hospitals, causing public outcry. The controversy led to a ban on the practice by the Department of Health. These scandals coincided with a general cultural shift in how pregnancy loss was perceived.

Scholars have produced insights into women's experience of pregnancy endings; however few have addressed the concerns women may have about the management of tissue. Women's opinions regarding donation of foetal tissue for research purposes (Pfeffer 2008, Pfeffer and Kent 2006) found women wanted reassurance that the foetus no longer existed in any material form (Pfeffer 2008); research into women's experiences following an elective abortion (Myers, Lohr and Pfeffer 2015) found women wanted access to information but did not welcome being required to make decisions about disposal. Research assessing the impact of the HTA guidance on practices around disposal found significant variation with women's needs not always being met as well as confusion about what incineration means and whether it is a legitimate option for disposal (McGuinness and Kuberska 2017 10-11). As Sheelagh McGuinness and Karolina Kuberska (2017) found, many NHS trusts did not offer incineration contra to the guidance.

Misunderstandings about incineration are likely due the HTA wording. Although this states that women should be offered burial, cremation and incineration, it distinguishes the latter by advising, in places, that:

> Incineration should only occur where the woman makes this choice or does not want to be involved in the decision, or does not express an opinion within the stated timescale (see para 19), and the hospital considers this to be the most appropriate method of disposal (paragraph 6).

The RCN 2015 guidance (first published in 2007, revised following HTA guidance updated by the Women's Health Forum in 2018 and 2021) was clearer about incineration as a legitimate option:

> The incineration of pregnancy remains should also be an option… and may be the preferred choice for some women; for example, where a woman does not wish the remains to be afforded any special status; expressly prefers this option; or does not wish to be involved in the decision, preferring to leave it to the care provider to make the necessary arrangements. It should be acknowledged that this option can be viewed as challenging for some people; however, the woman's choice must always be the priority in this decision-making.

The RCN's position also goes further than the HTA guidance in reminding readers of the variation in response to pregnancy loss:

> For some women, regardless of the circumstances of the pregnancy loss, this could be a devastating life event, while for others there may be minimal or no attachment to the pregnancy; some women may experience a range of emotions between these two stances.

However, earlier communications in relation to the 2014 *Dispatches* programme (Parliament briefing 2014) suggested the RCN position was that incineration was 'completely unacceptable,' a stance also expressed by The Institute of Cemetery and Crematorium Management (ICCM) (Myers, Lohr, and Pfeffer 2015). ICCM has been influential in discourses around the disposal of pregnancy remains,

issuing guidance for the funerary industry (2011) which informed the position of other organisations. The ICCM guidance further suggest that at the very least foetal tissue should be incinerated separately from clinical waste, but also stipulated that women should also be offered 'ceremonial disposal.'

The controversies touched on above have resulted in a general perception of incineration as a socially unacceptable method of disposing of pregnancy remains (McGuinness and Kuberska 2017:17). Indeed, many health professionals interviewed by McGuinness, Kuberska and their research team mentioned the scandals surrounding the incineration of early pregnancy losses (McGuinness and Kuberska 2017:17). The *Dispatches* programme remains fresh in institutional and individual's memories, as do patient complaints and upset around disposal. This has resulted in a risk-adverse approach to avoid attracting vitriol from those advocates who equate pregnancy loss with the death of a baby. Health care institutions and professionals are working in a context where cultural and public discourses largely frame pregnancy loss in this way.

My research engages with interdisciplinary scholarship that revealed that discourses of bereavement and memorialisation practices mobilised by charities and others play a significant role in how pregnancy loss is understood in England and has informed clinical care (Fuller and Kuberska 2020). There are contradictions in UK legal categories, national guidance, and institutional practices related to pregnancy tissue and the foetal body (Pfeffer and Kent 2006, Kuberska 2020, Middlemiss 2021). Hospital practices and forms of governance in the UK have been shown by Middlemiss (2021, 2024) to be inconsistent and contradictory with disposal practices producing foetal personhood that may not be supported by other procedures (see also Kuberska 2020) and may not be in keeping with women's lived experience (REMOVED). Hospital practices such as ceremonial disposal frame miscarriage as the death of a baby (Kuberska 2020) meaning women who do not want foetal personhood recognised are obliged to take part in practices which enact it (Middlemiss 2021). The paper supports my previous work, which argues that assumptions of bereavement structuring clinical care is problematic, as it overlooks the complexity of experiences (REMOVED). Focusing on clinical

disposal methods themselves, this paper argues that lack of choice and, particularly, an emphasis on ceremonial disposal is not conducive to inclusive miscarriage care.

Previous publications (REMOVED) and earlier research documented diversity in responses to miscarriage (REMOVED) and its remains, revealing that when personal and cultural frameworks resonate with those of the clinic women feel supported and cared for, but when practices diverge from women's understandings it can cause distress (REMOVED). Earlier work focused on experience of the 'consent' process around pregnancy tissue disposal and argued that many women were unprepared for the discussion, had not considered its need, and felt it was inappropriate in relation to their (early) pregnancy duration or foetal development and/ or where they were situated in their miscarriage journey. REMOVED illustrated the notions of value contained in hospital practices and argued that these become legitimated as the normative response leading some women to feel abnormal. This paper takes the discussion of the absence of incineration further, situating hospital practices (or their absence) in a broader movement of clinical miscarriage care and argues that such approaches produce personhood that some women resist. The anthropological research explored women's experiences of disposal and adds to previous research findings by focusing on the method itself: burial. Hospital disposal took the form of burial, with interment in the ground providing a physical, traditional place of remembrance, while incineration involves the burning of the tissue, often without ashes produced. I argue that incineration should be also be offered as a disposal option to meet women's needs and to ensure that hospital practices do not imply value or attributions of personhood that may be assumed to be normative (REMOVED)

METHODS

I conducted extensive fieldwork including participant observation and interviews with women experiencing miscarriage and those involved in their care over a 20-month period (Table 1) at one NHS Trust. The NHS is divided into regional areas; a trust is an organisational unit within the NHS services of England and Wales that serves either a geographical area or specialised function. Women were

recruited from this large teaching hospital in England made up of four main hospitals with specialist services, several community hospitals, clinics and health centres. Most services are accessed via referral but the main fieldwork site, the Early Pregnancy Assessment Unit (EPAU), offers self-referral. Primarily based at the EPAU, I also conducted fieldwork in two other hospital settings including gynaecology and surgical wards. Fieldwork involved immersing myself in the everyday environment of the setting, observing routines as they naturally occur and interacting with those present.

I observed all elements of miscarriage care including ultrasound scanning sessions, diagnosis of and management of miscarriage, and procedures around disposal. Observed consultations were not audiorecorded, and no personal information was collected. Staff were informed of the research and invited to participate. Participating staff would provide women with the study information and after verbal consent I would be invited into the session. Some participants took part in both observations and interviews.

Interview participation was invited via posters and flyers displayed in the site and by clinic staff familiar with the study who handed the study information sheet to women. Women eligible for inclusion were 18 years of age or older and had experienced a miscarriage in the previous 6 months prior to 22-week gestation; those experiencing recurrent miscarriage defined as more than three consecutive miscarriages were not included. I also interviewed health care and other professionals (n38) involved in the care of women who were miscarrying and/ or those involved in pregnancy remains handling.

Full ethics approval was granted. Following an expression of interest, I sent potential participants the study information sheet and consent form and gave them the opportunity to ask questions and discuss involvement. I recorded consent to participate recorded prior to interview. I conducted interviews between April 2020-September 2022; the research was suspended June 2020-May 2021 due to the COVID-19 pandemic. Between April 2020 and September 2022, 27 women made contact agreeing to participate and were subsequently interviewed. No participants withdrew consent. I interviewed ten

women from my previous research who were treated in the trust to explore the long-term remains of miscarriage to probe their experience of disposal practices.

The participants ranged in age from 25-47 years and had a mean age of 35.4 years old. They were drawn from a range of ethnicities and backgrounds: 22 White, 3 Asian and 2 Black (Black Caribbean and Black African) women. Six of the participants were not born in the UK and came from Europe, Australia, Russia, Uganda and the Caribbean. Participants volunteered a variety of reproductive histories: for 12 the miscarriage was their first pregnancy, 15 had previous pregnancies, 5 had experienced a live birth and had living children. One woman had experienced one previous miscarriage whereas 9 had experienced multiple pregnancy endings including miscarriages, ectopic pregnancies, abortions, and one stillbirth. These experiences were often used by participants as points of reference or comparisons and several participants had experiences of both home and clinically managed miscarriage.

I conducted interviews in person (due to COVID-19 restrictions a small number were conducted online) during or soon after the miscarriage and follow up interviews conducted 3-6 months later with interviews lasting 45-90 minutes. Semi-structured interviews were conducted as 'guided conversations' (Lofland and Lofland 1984) and I encouraged interviewees to give their narratives and meanings in relation to the research questions; their experience of the remains of miscarriage broadly defined and their experience with disposal in clinical and domestic settings. Fieldnotes were recorded after each interview. Audio recordings were professionally transcribed verbatim. I reviewed transcripts were reviewed for accuracy and familiarity. A thematic analysis approach was used; the method was iterative and based on a grounded theory approach (Strauss and Corbin 1990). Participants were assigned an enrolment number and pseudonym.

The overall research project explored the remains, remnants, and residues of miscarriage broadly conceived and was informed by previous comparative research, involving ethnographic fieldwork and interviews with 80 women in Qatar and the UK (2014-2016). Whilst not focused on the biological

remains of miscarriage, this was a key element of participant's experience and is the topic of this paper. The paper reports on one aspect of the study design: 28 observations of clinical discussions for pregnancy remains disposal and interviews with 19 of the participants who had experience of the process (17 had direct experience and 2 were shown the consent form with permission). All but one participant experienced first trimester miscarriage, which is the focus of the paper. First trimester miscarriage in the UK is defined as one that happens in the first 12 weeks of pregnancy. The participant who experienced a later gestation miscarriage has not been included in the analysis for this paper. There is a variation in the UK with different clinical settings having different approaches to remains disposal. The approach of the host clinic was typical in that a 'consent' form was used to guide discussions and produce and audit trail but atypical in not providing communal cremation.

This research is grounded in a feminist anthropological approach (Abu-Lughod 1990, Davis and Craven 2022) that recognises knowledge as situated, embodied, and relational. As a researcher who has personally experienced three miscarriages, my positionality is not peripheral to this project: it informs my intellectual and emotional investment in the work. As a feminist researcher, I am committed to reflexivity, acknowledging that I bring not only my academic training but also affective and embodied knowledge into the research process. My approach centres the voices of participants, not as data to be extracted but as complex and agentive accounts of reproductive life. Ultimately, the research seeks not only to document experiences of miscarriage and ensure a diversity of voices, but to improve public understandings and clinical care.

Table 1 Ethnographic research project study design

RESULTS

Experience of Pregnancy Remains Disposal Practices

Early stages of analysis pointed to pregnancy remains disposal being a focus for participants. The analysis is organised under three related themes around the experience of disposal: the meanings of the tissue/ foetus/ remains, attitudes to hospital practices, and notions of personhood. All women expressed surprise and described being unprepared for the discussion of disposal. Some women expressed relief or positive feelings of surprise and were accepting of the options on offer, as Helen (see Table 2) did:

> I felt like these people were miles ahead of me, of what I would imagine would happen in a miscarriage… I'm pretty happy for them to do whatever… [but] the way people carried the foetus mattered… that they didn't handle it in the way that they were handing the other objects. That they put it down carefully, that they always gave distance to it and that was important to me. I guess I read into the silences that they would handle it- in disposing of it, they're not going to just chuck it in the bin. They might *place* it in the bin… I don't know how that disposal would take place. I assume it would be similar to other bodily matter, but I assumed that they would do it in the similar way with a similar dignity that they were showing around me. That performative aspect. So, I don't actually mind if it was incinerated or if it was put into the same bags as other bodily matter that they have to throw out of hospitals but that it was just done with respect.

Mary described the paramedics who responded to her call for an ambulance as "absolutely lovely," but explained that when she told them what she believed to be her "baby and placenta" were in the bathroom they gave her a clinical waste bag to collect it. Whilst she acknowledged that this was an understandable receptacle for it, it started a "cycle of worry" in her mind:

> I don't want it being treated like clinical waste. [At the clinic] I handed it over to the nurse to examine …and I was so worried but not confident enough to say… what will happen to it? And then she came back, and she gave me a form with options to choose and I was absolutely thrilled that they did that. There was no question that they were going to [treat the baby as waste]. To know that it would have been treated respectfully and not to have to worry. And the option I chose was that it should be buried … I think you could also elect for the remains to be released to a funeral director or to me and I didn't feel and [my husband] didn't feel we needed to do that. But we did need to know that it was being treated respectfully as human remains… I don't really know how I feel about the needing to have a grave, have a physical resting place. It doesn't seem terribly important to me.

The women above report surprise at the hospital practices around disposal: in their case the surprise and experience of care were positive. However, a negative experience of care arose for some women, particularly for those who did not wish to engage in discussions around disposal and/ or who were dissatisfied with options offered, as will be further discussed below.

Table 2 Quoted participant's further details

Meaning of pregnancy tissue/ remains

Previous research revealed diversity in how women approach their pregnancy endings and pregnancy remains/ material (REMOVED). Women experience their miscarriage differently and reactions may vary for the same women for separate pregnancies or over the course of the same pregnancy. Responses may range from relief, distress, upset, feelings of inconvenience or of bereavement. Pregnancy tissue may be perceived as waste, a bundle of cells, tissue, or the body of a baby. Some women discuss pregnancy tissue as akin to waste and wanted it to be treated as such. Mary and Helen chose hospital disposal of their pregnancy remains and were appreciative of the disposal practices that

treated it as something significant. However, they were unconcerned about the mode of disposal, what was central was treating the remains with "respect." Helen suggests that the hospital staff might "*place* it in the bin" treating it as waste or as like other body fluids or tissue, which would be acceptable to her due the "dignity" and "respect" they were displaying towards it.

Alex, Nell, Scarlett, and Melanie assumed their pregnancy remains would be treated as waste and expressed surprise at the different approach. Alex expressed shock at the method, expecting a clinical waste pathway:

> That completely surprised me. I did not realise there was going to be discussion- I thought they take it out and it goes down a tube into medical waste.

Similarly, Nell thought the tissue would be disposed of in the same manner as other bodily materials:

> Treat it like any other kind of thing that you're removing from your body.

Scarlett expected her pregnancy tissue to be treated as waste and expressed frustration that there was no suitable option that aligned with how she understood it. She highlighted that had she miscarried at home, as she had intended, she could have flushed it down the toilet. Scarlett's experience illustrates a contradiction with how women manage their pregnancy tissue at home and how it is handled in clinical settings. Melanie describes treating a previous miscarriage as waste:

> [If I had miscarried at home] it would have gone in the bin like my sanitary towel. Like all the other ones, I just treated it like a period sort of thing.

Interviews revealed variation in how women expect their pregnancy tissue to be disposed of, however, most women thought it would be managed as clinical waste and expressed surprise and, at times, disquiet that it was managed differently. A central theme of interviews with women was the meaning of the material and how this should inform how it is disposed of. In this paper I highlight the theme of

wanting pregnancy tissue to be treated as insignificant material, as it was the dominant theme in interviews and observations and because it problematises the emphasis on ritual disposal in clinical settings.

Attitude to hospital disposal

Above, Nell describes understanding her pregnancy tissue as waste and expresses surprise and discomfort with the hospital practice of burying it, as illustrated by her full quotation:

> Treat it like any other kind of thing that you're removing from your body… maybe the part of me trying to process it was… this wasn't a baby…. It's just some cells and tissues. So, then to be told, "We're going to bury it." Treat it like it is a human being is totally opposite to how I'm trying to process it.

Other women reported shock and at times were uncomfortable with the fact that hospital disposal took the form of burial. Ruth's miscarriage was diagnosed at the clinic and she later miscarried at home where she discarded the material in the bin. Her path to the clinic reminds us that women's experiences are complex and nuanced, as she had been referred by the British Pregnancy Advisory Service (BPAS), one of the main abortion providers in the UK. BPAS, a charity providing abortion counselling and treatment at over 55 clinics across the UK, has over 93% of their clients' treatment funded by the NHS. Ruth had sought an abortion for her pregnancy, but when a scan at BPAS revealed a pregnancy of unknown location, she was referred to the EPAU where my research was based. When she had discovered she was pregnant, Ruth was certain about her need for a termination but felt ambivalent due to her religious upbringing that had taught her that abortion was "murder." Ruth's experience reminds us of the complexity of experiences and that for some a miscarriage comes as a relief.

During our second interview we spoke about how hospital disposal involved burial. As we continued our conversation, I suggested I could show her the form which outlined the options for disposal about which Ruth said:

> I think the term "burial" is problematic. [The language makes it] more meaningful, more tangible, more babylike and therefore, much more traumatic.

For Ruth, the form itself was producing foetal personhood due to its reference to burial, something she and Nell see as suggestive of personhood. As Nell says, burying the tissue means treating it as though it were "a human being," which conflicts with her understanding of it. Ruth sees the mode of burial as making the pregnancy tissue "more meaningful… more babylike." Perhaps relevant to note is that Ruth's miscarriage was diagnosed as an anembryonic pregnancy meaning there was no foetus yet had Ruth's pregnancy tissue been disposed of by the hospital it would have been buried. This is because the trust like many others do not differentiate between pregnancy tissue and foetal tissue, as recommended by the HTA guidance.

Previous research on women's experience of pregnancy tissue disposal following a termination found that women wanted reassurance that the foetus did not continue in material form (Pfeffer 2008). This is relevant for my discussion in that burial as a disposal method contradicts such approaches. Buried pregnancy tissue will continue in material form for some time with a lasting presence in the form of a grave or location. During her follow-up interview several months after her miscarriage, Scarlett reported ongoing discomfort with how her pregnancy tissue was disposed of:

> I really dislike the fact that there's some little grave. It really bothers me… I don't like to think about it.

As mentioned above, the trust was relatively unusual in having burial as the default hospital disposal method with most NHS Trusts offering communal cremation. In most cases cremated

ashes are scattered in a memorial garden in cemetery, meaning pregnancy remains have some form of ongoing presence in terms of association with ashes and a cemetery.

Whereas Mary conceived of and referred to her pregnancy as producing a 'baby,' the other women did not at the time of their interview. During our discussion Mary expressed curiosity about where her pregnancy remains were buried. I offered her the information, which she gratefully received and wrote down. Although she had previously said she did not mind how her pregnancy remains were disposed of as long as it involved respect, treating them as a body, and not as clinical waste, the knowledge of their burial place was a comfort to her. However, women who were not engaging in memorial practices and/ or personhood activities found it uncomfortable to think of the burial place of their pregnancy tissue. For those who were not thinking of the tissue as a 'baby' the concept of burial and/ or ceremonial disposal is unwelcome. Central to these linkages of meaning is notions of foetal personhood or their absence, as will be discussed in the next section.

Foetal Personhood

A central element of attributes of meaning of pregnancy and pregnancy tissue was in relation to notions of personhood: whether the women understood her pregnancy as containing a "baby" and/ or whether she perceived the pregnancy remains as being akin to the human remains, as Mary did. In a forthcoming paper, I explore how complexities and nuance around personhood in first trimester miscarriage extend to the relationship between the materiality of the pregnancy tissue and the symbolism of the loss of a pregnancy. For some women the biological material/ body is entangled with grief and becomes the focus of mourning. There may be a desire to retain the material and to dispose of it in a particular or ceremonial way. Such approaches align with clinical practices around miscarriage, which have increasingly focused on the pregnancy tissue as central to acknowledgements of and practices around bereavement (see Memmi 2011). Informed by notions of personhood, clinical

practices around disposal assume the entanglement of feelings of loss, the biological material of miscarriage (REMOVED).

Elsewhere, I have shown how some women found clinical disposal practices as inappropriate in relation to their care pathway, pregnancy gestation and/ or foetal development. Some women experiencing early pregnancy endings suggest that had their pregnancies been of a longer duration and/or the foetus more developed disposal practices would be more appropriate (REMOVED). Nina explained that she didn't understand her miscarriage to be the loss of a baby:

> I felt that… not that something wasn't alive, but it certainly wasn't a baby to me at that point… it wasn't a child. We didn't feel that there was a need for a more formal ritual around a goodbye… a burial or cremation. … So, yes, I suppose there was a surprise about the options… because for me it wasn't a baby.

Above, Nell discussed treating her pregnancy as one would other bodily material, which is linked to her understanding of it as not "a baby." Nell suggests that there is a protective element to this: thinking of it as "cells and tissues" was a means to help her "process" the experience. Scarlett also described such a protective mechanism:

> One of the ways I had been coping… it was very early; I was maybe six or seven weeks… with my personal belief system… is it's not a baby. It's a clump of cells that has a lot of hopes and dreams attached to it and it could be a baby, but it's not a baby …being asked to treat it like it was a baby became very upsetting… it's not a baby and I shouldn't be forced to confront it like that.

Framing the material as tissue was a means to cope with the experience, yet disposal procedures challenged this (REMOVED).

I observed Scarlett becoming distressed during the discussion about disposal prior to the surgical management of her miscarriage. During her subsequent interview, it became clear that her upset was related to a divergence between her framing of her pregnancy and that of the hospital disposal practices. Frictions derive from conflicting notions of the significance of pregnancy tissue and of personhood (REMOVED). Scarlett describes her miscarriage as "a clump of cells with hopes and dreams attached;" it is not the loss of a baby, but she imagines the child that could have been, and is upset about plans unmade, and the loss of a particular future. Scarlett, like most of the women I met, was upset about the end of her pregnancy but her sadness was disentangled from the biological material. Not the fulcrum of loss, the pregnancy tissue is not considered a body requiring mourning unlike with later gestational losses when the fetal body may be the focus of grief and memorial practices (Middlemiss 2024). As Meredith explains:

> I think they were quite separate. And I think the loss is more of a concept for me than a physical thing.

Alex did not have an "emotional attachment" to her pregnancy tissue,

> That's not to say I wasn't upset, there was a lot of crying and upset about what could have been but not really upset about [what it] was at that point.

Whilst sad about the end of her pregnancy, it was not a "baby loss" but the loss of "what could have been." Hence, there are limitations on the inferences we can draw on decisions regarding disposal and overall view of the pregnancy. Some women may wish to treat pregnancy tissue as waste and resist ceremonial disposal whilst engaging in notions of personhood of the pregnancy or ideas of a lost child. The subject of a forthcoming publication is the messy, non-linear notion of personhood which may ebb and flow during and for month or years following a pregnancy ending.

For many women the experience of loss is disentangled from the pregnancy tissue, yet hospital disposal practices assume their entanglement leading to discomfort for some.

As described above, during our follow-up interview, Scarlett expressed enduring disquiet with her pregnancy tissue having a grave. In the extended quotation, she expands on her feelings of discomfort, referring to her pregnancy tissue as "medical waste:"

> I really think there needs to be an option that is not treating it like a baby because I'm still uncomfortable with that. I disagree with it; I really dislike the fact that there's some little grave. It really bothers me… Maybe it needs to be up to a certain point in gestation … the right to have it treated as medical waste. Because I'm very uncomfortable with the way that it was handled… For me at that stage it was medical waste and that's how I felt about it. And I would have liked the option: "I think it's medical waste, please dispose of it as medical waste". That would have been my preferred option.

As Scarlett articulates, hospital disposal practices did not provide a suitable option for her. Instead, they contradicted her understandings of her pregnancy and the tissue leading to her discomfort. That there is a grave means her pregnancy tissue has some enduring presence which is unwelcome and unconnected to her. For Scarlett and others, the lack of a clinical waste route was problematic. In the discussion below, I explore the possibilities for disposal options that would provide for women like Scarlett, arguing that incineration should be offered, particularly as it is legal and advised by the relevant national organisations.

DISCUSSION

Hospital disposal takes the form of communal burial at the trust due to the inability to identify a willing local crematorium. There is no option for pregnancy tissue to be treated as waste in keeping with UK

practices. HTA and RCN guidance is clear that incineration is a legitimate method, yet some trusts misinterpreted this (Austin and McGuinness 2019). It may be that incineration is felt to be an inappropriate disposal method following the controversies mentioned above. Interviews with some health professionals suggested disposal in a respectful and sensitive way was a legal but also an ethical issue. Funerary industry workers suggest incineration was not an appropriate disposal (Austin and McGuinness 2019), a finding supported by this research. The role of the chaplaincy in revisions of disposal practices at local NHS Trusts may also have informed decisions about the inappropriateness of incineration.

Women expressed surprise and, often, disquiet that the mode of hospital disposal took the form of burial. Some women, including Ruth and Nell experienced the method of burial as contrary to how they understood their pregnancy tissue, identifying that burial conveyed personhood. Here, they are articulating what feminist scholars have attended to: in some contexts dead foetuses are constructed as human corpses, which frames the foetus as a person and this may extend to pregnancy tissue, as illustrated by Ruth's experience. Naomi Pfeffer's work (2008) on women's perception of tissue disposal for stem cell research following a termination revealed women found the capacity to reinstate and even develop the foetus's physical existence and social biography beyond abortion was troubling. This led women to refuse the practice once educated about it. Her later work with colleagues (Myers et al 2015) found disposal by incineration was thought to be acceptable after elective abortion, whereas ceremonial methods such as burial or cremation were not. It should be remembered that in most NHS trusts the method for disposal offered is the same as all pregnancy tissue regardless of circumstance.

Hospital disposal treats the foetus and pregnancy tissue as an individuated figure through storage, transit and burial logs in a way that is reminiscent of emerging disposal practices of aborted foetus in parts of the US as discussed by Cromer and Bjork-Jones (2023). As the authors point out, logging individual information deviates from standard practices for medical waste, which do not require

individualized documentation and permit their collective handling. Just as the classificatory shift from waste to human remains requires Indiana abortion providers to work with funeral services, the NHS trust that hosted my research worked with funeral providers and expanded their involvement just prior to the start of fieldwork.

Previous publications have highlighted the significant role location of the expulsion and/ or management of the physical material of miscarriage has in how it is interacted with (REMOVED). Women miscarrying in domestic settings are not presented with bureaucratic hierarchy and disposal options faced by those in clinical settings. The latter encounter their pregnancy tissue in particular ways and are subject to obligations to act upon and governance of the material. Pregnancy tissue that emerges in a domestic setting prior to 23 weeks and 6 days gestation may be disposed of how the person chooses, including as waste, although 'choice' is not always possible. Previous publications have explored domestic disposal practices highlighting that six women interviewed over the course of two research projects collected all or some of their pregnancy tissue for the purpose of ceremonial disposal either by home burial (N=4) or private cremation (N=2). Findings reveal that most women flush their pregnancy tissue or put it in the bin. The final stage of a miscarriage often occurs when the woman is on the toilet, leading to the blood and tissue passing into the vessel. For some women flushing is automatic, for others it is an active choice, and for others it is experienced as an unwelcome but necessary act in the absence of real choice. Some women who had flushed the pregnancy tissue at home required additional medical intervention due to retained tissue; expressing surprise at clinical practice that required discussion and decision about disposal of this tissue.

These findings complement previous research describing diverse attitudes towards the end of a pregnancy, pregnancy tissue; and its disposal (Austin and McGuinness 2019) and provides qualitative evidence of experiences revealing this aspect of miscarriage care may not accommodate such diversity. Disposal practices may construct pregnancy tissue as a baby, which contradicts how many women understand them. Research shows that women have varied positions towards their pregnancy

tissue with some women experiencing miscarriage not wishing to have the material afforded value. In line with previous research, it reveals that more could be done to ensure disposal processes meet women's needs. The research highlights the need to be vigilant about such processes, as clinical practices and the meaning they contain become legitimated and lend authority to ways of responding to miscarriage and to constructing pregnancy tissue.

Incineration is an important option for women including some experiencing an elected termination (Myers, Lohr and Pfeffer 2015) or the ending of a wanted pregnancy who would not find ceremonial disposal acceptable (McGuinness and Kuberska 2017), as this research supports. That some trusts do not offer incineration evidences a gap between expectations contained in guidance and trust practices (McGuinness and Kuberska 2017). In keeping with previous research (McGuinness and Kuberska 2017), the lack of availability of incineration may conflict with a woman's view about the status that her pregnancy tissue. As Scarlett said,

> I'm very uncomfortable with the way that it was handled… it's only because I had to have it in the hospital … that seems unfair. "Okay, if it's at home… you do what you want and we're not going to interfere." But now it's in a hospital setting… it should be my choice as to how it gets dealt with and there wasn't really much choice, if any.

Personhood is constructed, experienced, negotiated and resisted in clinical settings (Middlemiss 2024, Lupton 2013, Memmi 2011, Kaufman and Morgan 2005). Handling and regulation of pregnancy remains has consequences for how they are perceived, interacted with, and their value. The transformation of clinical practices has increasingly focused on mourning with pregnancy material central to this (Memmi 2011) producing foetal personhood that may not be supported by other procedures (Middlemiss 2021, 2024, Kuberska 2020) or in keeping with women's experiences. The data points to the implicit value and status of pregnancy, including a non-viable one, in a society where pregnancy and pregnancy loss care forefronts the foetus. The findings highlight paradoxical

hierarchies where dead foetuses/ pregnancy tissue are treated with more respect than the people from whom they emerged. Whilst pregnancy remains are afforded careful handling, women's opinions are not always considered. Whilst I observed responsive, sympathetic and expert care of women experiencing miscarriage, the bureaucratic mechanisms seemed inflexible to their diverse experiences. The practices make assumptions and conceptually connect miscarriage-bereavement-baby loss- corpse requiring respectful/ ceremonial disposal. In this model the pregnancy tissue is the locus of the experience and value is placed on it as a person. Clinical practices in England normalise mourning based on perceptions of foetal personhood.

Clinical practices around disposal reveal the power-laden dynamics through which reproductive bodies are interpreted, governed, and often silenced. The disjuncture between the materiality of pregnancy tissue and the emotional experience of loss highlights a gap between biological substance and symbolic meaning—a gap often felt by those who experience early miscarriage, even as clinical practices assume their fusion. For many women, the tissue itself may carry little symbolic weight, or may even feel estranged from the emotional and relational significance they associate with their pregnancies. This tension calls for a theorization of pregnancy tissue not merely as biological matter, but as a site of contested ontology, where meaning is actively negotiated through cultural, affective, and relational frameworks. The paradox—of tissue that is framed as "not yet life" but is nonetheless linked to a profound sense of loss—demonstrates how materiality is always already entangled in social meanings. For many, the significance lies not in the tissue, but in what was imagined through, projected onto, or anticipated around it. This disjuncture underscores how clinical authority can obscure or overwrite the affective and embodied dimensions of miscarriage, reproducing a broader history in which reproductive knowledge has been extracted from women and redefined within patriarchal logics. Feminist anthropology challenges this imbalance by centering the narratives of those experiencing miscarriage, and by insisting on reproductive politics that account for the subjective, contested, and deeply social aspects of pregnancy and its loss. To theorise this separation

is to attend to the dislocation between embodiment and meaning in moments of miscarriage—and to examine how such dislocation is managed, contained, or disavowed within dominant social discourses of medicine, grief, and personhood.

Conclusion

Some women frame their pregnancy ending as bereavement and for some this includes a focus on the materiality of the pregnancy tissue. For others, feelings of loss are disentangled from the pregnancy tissue and for others still miscarriage is not experienced as a loss at all. Women should be supported in approaching their pregnancy ending and fetus/ pregnancy tissue in the way most comfortable to them and not compelled to approach their pregnancy and pregnancy tissue in ways that are assumptive of bereavement, loss and personhood. In framing miscarriage as the death of a baby clinical rituals such as ceremonial disposal (Kuberska 2020) mean women are obliged to take part in practices which enact personhood regardless of their position (Middlemiss 2021). Disposal practices should allow flexibility to accommodate diverse approaches. It is recommended that clinical settings include the option for incineration as a mode of disposal alongside options for ceremonial disposal. Offering incineration ensures that women are not to be forced to re-frame their miscarriage and pregnancy tissue in ways that are unwelcome to them. Understanding diversity in the way women approach their pregnancy endings will help ensure practices are able to accommodate varying reactions to miscarriage and its materials, thus limiting challenges to a woman's experience of and agency about their body and their pregnancy.

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Table 1 Ethnographic research project study design, 20 months fieldwork

This table details some of the relevant fieldwork activities

Characteristics		**Value**
OBSERVATIONS		Number of instances
	Patient assessments, diagnosis, treatment and follow up appointments	60
	Discussion and "consent" procedure for remains disposal	28
Semi-structured interviews		individuals
	Women experiencing miscarriage	37
	During 2020-2022 Fieldwork	27
	Encountered "consenting" process via:	19
	Surgical management of miscarriage	13
	Miscarried in clinic (manual removal of pregnancy tissue)	2
	Miscarried at home, remains taken to clinic	2
	Miscarried at home, flushed remains, shown documents by researcher	2
	During 2014-2016 Fieldwork (previous participant cohort) Participants from PIs previous project who had been treated in the same NHS Trust were revisited to explore the long term residues and remains of miscarriage and their experience of disposal.	10
	Health care professionals	38
	Host NHS Trust Staff	24
	Clinicians (doctors, nurses, midwives)	14
	Other clinical staff	4
	Other staff (counsellors, chaplaincy team, bereavement team)	6
	NHS staff from other clinical settings	7
	Other professionals (i.e. funerary and crematorium)	7

Table 2 Quoted participant's further details

Participant name	age	Reproductive history	Disposal method chosen	Disposal method preferred if different
Helen	40	First Pregnancy through IVF	Hospital disposal	
Mary	39	3 children, first miscarriage	Hospital disposal	
Nina	37	fifth pregnancy, third miscarriage incl. 1 ectopic pregnancy, 7-week pregnancy, 1 child	Hospital disposal	
Alex	37	first pregnancy, 7-week gestation	Hospital disposal	Clinical waste
Nell	30	first pregnancy, 12-week pregnancy	Hospital disposal	Clinical waste
Scarlett	32	first pregnancy, 6-7 weeks gestation	Hospital disposal	Clinical waste
Ruth	47	third pregnancy, first miscarriage, 7-week pregnancy 2 children; sought termination prior to miscarrying	Disposed as waste at home	
Melanie	38	Seventh pregnancy, 5th miscarriage incl. 1 ectopic pregnancy 1 child	Hospital disposal	Treated previous miscarriage as waste
Meredith	35	First pregnancy	Hospital disposal	

Women's encounters with pregnancy 'remains' disposal methods following an early miscarriage in England, UK

Main findings

- Many women experiencing early miscarriage found disposal pathways inappropriate
- Some women preferred their pregnancy tissue to be treated as clinical waste
- Clinical practices are discordant with some women's views
- Inclusive care should include incineration as a disposal option

Ethics

The research had full ethics approval from NHS HRA Ethics Committee (Integrated Research Application System (IRAS) Reference: 261330), Research and Development Reference: PID14448-SI001, Research Ethics Committee Reference: 19/SC/0428

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Note: if the paper is accepted for publication I would like a truncated ethics statement, if possible in order to protect the site of the research and maintain anonymity