FLESH AND BLOOD

(A Memoir)

and

Products of Conception, Imaging and Imagining the Maternal-Foetal Relationship

(A Critical Analysis)

A Thesis Presented

by

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Abstract

Via creative-critical methodology, this thesis explores maternal and clinical narratives. The memoir, *Flesh and Blood*, investigates my experiences of recurrent miscarriage while working as a medical expert witness in the Family Court. *Flesh and Blood* takes the reader on a journey through a medicalised pregnancy, which unfolds under the bright glare of medical examinations, alongside a parallel, professional journey with three families eviscerated by illness, adversity and addiction. Tracking the conflicts, collisions and concerns of medical professionals, social workers and lawyers, *Flesh and Blood* asks readers to consider what it would mean if clinics and courts were places of greater compassion, and whether emotional bonds stall the difficult and often devastating interventions designed to keep children safe.

The critical essay, *Products of Conception, Imaging and Imagining the Maternal Foetal Relationship*, considers depictions of obstetric ultrasound in three contemporary works: *Queenie* (2019) by Candice Carty-Williams, Hilary Mantel's memoir, *Giving up the Ghost* (2013) and Maggie O'Farrell's personal essay "Baby and Bloodstream", from *I am, I am, I am: Seventeen Brushes with Death*. In each text, ultrasound represents a contested site where obstetric and maternal narratives collide. Core themes examined in the critical essay have informed the composition of *Flesh and Blood*.

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Acknowledgements

When I embarked on this PhD in September 2019, the story of a novel, often deadly, coronavirus that could be spread rapidly and asymptomatically, that would be managed by governments closing schools, workplaces, university campuses, theatres, libraries, locking playgrounds and urging the population to stay at home, would have sounded like dystopian fiction. While my primary school-aged daughters were homeschooling during school closures, I wrote my thesis with them next to me. I will always be thankful for the studious, supportive atmosphere they cultivated during lockdowns. I treasure the post-it notes of encouragement that were stuck on my screen and their unionised insistence on “Friday long-break”. I am also grateful to my husband Simon for his friendship and for everything he did to support this PhD.

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Introduction

Between the births of my two daughters, I experienced recurrent miscarriages. At the time, I worked as a consultant psychiatrist in a small team commissioned to conduct expert witness assessments of children subject to care proceedings. Almost all my professional conversations were about motherhood and maternal attachment, about what makes a good-enough mother and what causes harm. In my personal life, I was alternately preoccupied with any hint of possible pregnancy or with signs that might herald impending foetal death.

I wrote *Flesh and Blood*, with two goals in mind: to tell the story of a medicalised pregnancy under the care of an NHS recurrent miscarriage clinic and to bring to public attention the experiences of an expert witness assessing families undergoing care proceedings in a court system that was (and remains) closed to the public. Many of my experiences as a patient enabled me to re-examine things I had previously taken for granted as a medical practitioner. Attending appointments with the recurrent miscarriage clinic, I increasingly noticed the oddities of medical language and of clinical consultation styles. For example, my obstetrician used military metaphors to describe his treatment plans. My immune system, he postulated, was "mounting an attack on embryos". He suggested I had high numbers of "natural killer cells". Throughout that pregnancy, I lived with my husband, an army officer, at a large military headquarters in London. War language was part of my life.

I have mined my medical and maternity notes and have dramatized this personal history to draw parallels between the rigours of fortnightly ultrasound imaging with the process of medico-legal scrutiny in the family court, as well as to portray some of the unintended cruelties of these probing systems. To do the latter, I chronicle lives of three families referred for expert witness assessments. I explore real themes and dilemmas, but names, identities, sibships, occupations and other details that could identify a family have been made up. In her Wellcome Prize-winning medical memoir, *It's All in Your Head: Stories from the Frontline of Psychosomatic Illness*, Susanne O'Sullivan (2016), also describes fictionalised, rather than actual, cases.[1] Rachel Clarke (2017) describes her experiences as a junior doctor in *Your Life in My Hands*, *A Junior Doctor's Story* through fictional patients.[2] In Christie Watson's (2019) Costa Award-winning memoir of her nursing

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[1] O'Sullivan, Suzanne. It's All in Your Head: Stories from the Frontline of Psychosomatic Illness. London: Vintage, 2016.

[2] Clarke, Rachel. Your Life in My Hands: A Junior Doctor's Story, 2017.

career, *The Language of Kindness A Nurse's Story*, Watson not only fictionalised patients, but colleagues as well.[3] Following these established clinical memoirists, I also created fictional patients.

There are several other memoirs about miscarriage. Almost all are stories that sociologist Arthur Frank (1997) described as "quest narratives" in his study of illness narrative, *The Wounded Storyteller,* in which he described the quest narrative as: "the ill person meets suffering head on; they accept illness and seek to use it. Illness is the occasion of a journey that becomes a quest." [4] Emma Mellon's (2016) memoir, *Still Life: A Parent's Memoir,* about her experience of stillbirth and the aftermath is typical of the genre.[5]

Flesh and Blood is different for several reasons. Firstly, to use Frank's terminology, it offers a "restitution narrative", about my body returning to my previous image of it, as a fertile body, through a relationship with obstetrics. Secondly, it closely examines the personal-professional interface. Throughout the memoir, I explore how healing and hurting are often intertwined. For example, drawing on reminiscences from medical school and memories from my years as a junior doctor, I consider how detachment comes to be widespread in medical practice. A third, important, point of difference is that *Flesh and Blood* provides a rare insight into family court proceedings. In 2011, the Independent Family Justice Review made wide-ranging recommendations for reforming the family justice system. It then underwent significant and wide-ranging reforms during the timescale covered in *Flesh and Blood*, including a maximum 26-week time limit for completing care and supervision proceedings. I am not aware of any other expert witnesses who have written about our work during these historic reforms.

In *Flesh and Blood*, I write about my maternal relationship with my unborn during pregnancy, even before my foetus reached gestational viability. However, in the contemporary British obstetric literature, miscarriage is almost always presented as a biological process, akin to a disease state to be medically or surgically managed. The language I use as a medically-qualified memoirist, especially the relational frames of maternity and the language of grief and bereavement, is at odds with the contemporary obstetric terminology of miscarriage, embryo and foetus. I wondered, therefore, how are other women writing about similar experiences?

To answer this, I examined the language used in three texts that describe the protagonist's experience of undergoing obstetric ultrasound: Candice Carty-Williams's novel *Queenie* (2019),

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[3] Watson, Christie. The Language of Kindness: A Nurse's Story, 2019.

[4] Frank, Arthur W. *The Wounded Storyteller: Body, Illness, and Ethics*. Second edition. Chicago: The University of Chicago Press, 2013.

[5] Mellon, Emma. *Still Life: A Parent's Memoir of Life after Stillbirth and Miscarriage*. Santa Fe: Sunstone Press, 2016.

novelist Hilary Mantel's memoir *Giving up the Ghost* (2003) and novelist Maggie O'Farrell's personal essay "Baby and Bloodstream", from her collection of essays about near-death experiences, *I am, I am, I am: Seventeen Brushes with Death* (2017).[6] Through close reading, I made discoveries about visually-mediated maternal feelings and the clash between maternal and obstetric narratives. These discoveries are presented in the essay, *Products of Conception: Imaging and Imagining the Maternal-Foetal Relationship,* but are also threaded throughout *Flesh and Blood*.

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[6] Carty-Williams, Candice. *Queenie*. London: Trapeze, 2019.
Mantel, Hilary. *Giving up the Ghost: A Memoir*. London: Fourth Estate, 2013.
O'Farrell, Maggie. *I Am, I Am, I Am: Seventeen Brushes With Death*. London: Vintage, 2019.

Flesh and Blood (A Memoir)

Your absence has gone through me

Like thread through a needle.

Everything I do is stitched with its colour.

Separation, WS Merwin

HOPE

I saw her just once, the girl called Hope. She took me by surprise, suddenly there with her spine still curled as if she had been sleeping. I thought about the nerve cells in her brain, reaching out to connect with each other. What last messages had they passed on? How did her tiny mind, that had only seen darkness, make sense of it? Her right hand, with small, webbed fingers, curled around over her heart, the heart that had stopped beating. Her left hand was missing, perhaps she never had one, or it was wrenched off. Her slender legs felt rubbery, hanging lifeless, like a pheasant on a hook. Turning her gently, as if to avoid harming her more, I could see her spine, part exposed. I could feel metal at my side. My bra, the new one from Aubade that fitted before I went on holiday to Crete, was too tight. During the flight home to London, strained under-wiring had pierced through the side and was digging into my flesh. I turned Hope back over and for the first time noticed her eyes, bulging like frog′s eyes near the top of her skull. Just the impression of an eyelid on either side. Not enough for me to close them, to give her any dignity, this little light, snuffed out.

Not that there was much dignity for either of us in the supermarket toilet cubicle. My jeans stiff with blood, as if from a stab wound in a teenage gang fight. Looking down I saw that there was blood on the bottom of my running shoe. I looked as if I was fleeing a crime scene. My bloody shoe made me think of the teenager, Eve, and her mother Helen. Eve was the one patient who was often in my mind. When we had met, her nights were filled with dreams of the day she′d had blood on her running shoes, bloody imprints that linked her to a man who had been kicked to death just after pub closing time in a quiet market town. I cried then, for Eve′s mother, who had described herself as, “staunch, yet broken” when her daughter was sentenced, and I cried for Hope, because nobody else would ever look into her eyes or know her name.

“You're making a bit of a habit of this,” said the midwife Sarah, after the ultrasonographer, who neither made eye contact nor warmed her gel, had scanned me, spun away on her swivel chair, handed me some scratchy paper to stem the bleeding and typed up her report, confirming that not only was there no longer a heartbeat, there was no longer an embryo, after I had struggled back into my too-tight jeans and fumbled with my laces.

“You're lucky,” Sarah continued, “because of your age, you won't have to wait until you lose another one and then be referred.” In the NHS, when something unutterable happens, there is a form. As Sarah transcribed my back catalogue of pregnancies onto the recurrent miscarriage clinic form, she continued to chat: “What a pity it happened on holiday. You didn’t time that well. Hope it didn’t spoil your break.”

It was my third miscarriage.

The second in six months.

As she filled in her form, I said, “I saw two little eyes on a tiny head.”

Sarah didn’t look up but reached across the NHS-issued laminate desk for a second form and peeled the pre-printed label that bore my demographic details from where it had been hanging at the end of her right index finger. She handed me a letter for my GP. Gesturing at the referral form, I nodded my thanks. Sarah stuck my name and address at the top and stamped it like a certificate with the date, 16th September, 2013, followed by her name and credentials. It was official. I'd made a habit of it.

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Take some time off work this time. Sarah's advice replayed in my mind.

Work. It wasn't the sort of job I could just duck out of. I am a child psychiatrist, and in 2013 I was working as part of an expert witness team in London. An expert witness is not an eyewitness, who was there at the time and tells a court of law what they heard and saw, but a professional witness. It was my role to assist the Family Court and to give my opinion, based on the knowledge and experience gained during my many years working in clinical practice. Specifically, my job was to meet children, alone and with their parents and foster carers, and answer questions which would help the Family Court decide if children could live with their family of origin or if it was in a child's best interests to continue their formative years elsewhere.

I spent my days looking for signs and symptoms of mental illness, scrutinising the patterns of attachment between parents and their children and tracing the roots of parental attachment styles back through the generations. I met women who had given birth to babies they were unable look after. I met children left without food, without care and without any sense of who they were and who they might count on. I visited the homes of mothers who gave birth to children they couldn't take to school because they were too drunk, or too sad, or too afraid to leave their flat. Some mothers who had child after child removed by the Family Court and placed in care, conceived one after another, after another, in hope.

The Court Assessment Service, where I was a member of a multidisciplinary team, was independent. We didn't work for the local authority, nor for the legal teams representing families. Our job was to look, with impartial eyes, at the best interests of each referred child. Emotional distress can be glaringly obvious, but over time I came to see my role as probing the unseen and the overlooked and to bring what I saw into the scrutiny of the court room, where a judge would turn my opinions over in the light. When I came home, before collecting my daughter Liberty from nursery, I sometimes wept for the mothers, fighting in court against the expert evidence in our reports, and I felt guilty for my part in their heartbreak. And yet, in my mind, it was clear, that sometimes the most life-saving act was to remove a child from a family where they were likely to be seriously harmed.

So it was with trepidation that I called the team manager, Ben, when I got back to HQ to tell him that I needed to take some time off.

HQ. The headquarters was Simon's workplace, a military headquarters, in northwest London, the base of several operational headquarters. Our home was in the hamlet of houses for military personnel, just outside the headquarters, in a cul-de-sac of other near-identical houses, all redbrick, built in the 1950s. These houses collectively were known as "the patch".

The patch was separated from the headquarters by a high perimeter fence, topped with barbed wire and patrolled by armed guards. This security fence was known on the patch as "the wire". Our garden backed onto the wire, which was patrolled by Gurkha guards, sometimes with dogs. The patch was home to many military personnel, including Simon. Simon to me, Colonel Simon to his colleagues; and The Colonel, inflected with irony, when I was talking about him to my friends, friends who knew me as an anti-war demonstrator, before I fell in love with an army officer and set up home at his headquarters.

After I had moved in, I learned that the number of bedrooms are assigned by military rank. We had more space than we needed. Lower ranking staff with larger families were more cramped, less entitled. Although I had lived there for many months, the poetics and politics of military life still felt unfamiliar. I found it strange that, when I looked out of the kitchen window, in the mornings, my neighbours wore camouflage.

Since I had moved in, during January 2013, I had used the abbreviation HQ as a nickname for the entire caboodle, including our home on the patch, an act of sarcastic subversion, one of many that I used to distance myself from the uncomfortable emotions evoked by patch life. Defence, I could live with and be thankful for. I was grateful for those defending the country from terrorist attacks, for soldiers keeping the peace, for everyone who was making it possible for me to live a life without tyranny. But notions of attack, of wounded flesh and spilled blood, distressed me. I couldn't bear to think of the many women and children displaced by wars, trafficked by criminals, bound by trauma.

I laughed my discomfort away with the humour I had learned at medical school. Subversive humour was a core component of what medical educators call the hidden curriculum, those unwritten, unofficial lessons about clinical culture, values and perspective that my classmates and I absorbed. We′d learned how to become detached from emotionally uncomfortable situations and referred to the sarcastic, snarky, variant of emotional detachment as "piss-taking". They proved useful, these untimetabled lessons, when I had to wear a pass marked "Dependant" as an open-sesame at the sniper-guarded barrier when I needed to collect my daughter from nursery. My jokes about living at HQ helped me to distance myself when I watched Simon going to work at a desk in London wearing camouflage and a beret bearing a white feather hackle with a blood-red tip. However many times Simon explained that the salutes were a recognition of "rank not person," I still found it absurd when I saw my camouflage-clad neighbours stiffening their backs, pausing and offering one another salute as they passed each another outside the HQ hairdresser. My mocking humour kept me at a comfortable distance from the daily sexism at the headquarters. It felt painful to see so many intelligent, committed servicewomen leaving their careers after maternity leave, because there was no provision to work less than full-time, as they were usually married to another officer and the cost of dual deployments with young children was invariably the woman's military career. I routinely overheard men appraising women's appearances: "she's got legs like upside down champagne bottles," or making homophobic comments, "any woman who wants to be in the infantry is a lesbian, not a real woman." I complained about male officers routinely referring to female colleagues as "the girls" but was told the girls didn't mind.

I minded.

"They're getting cold," Liberty had said, sitting in her buggy, looking at a row of naked women, the so-called "lads mags" on the middle shelf at toddler-height. We had gone to buy an ice-lolly in the shop adjacent to the cafe at HQ, opposite her nursery. Afterwards, I had made what was known on the patch as "a fuss." I didn't want my daughter and her friends to grow up accepting this economic and physical coercion of women as normal. It felt abusive to her and to the other shoppers to see women presented as enjoying themselves, when they most likely had very limited choices. The jury is out on whether pornography breeds misogyny and normalises domestic abuse and rape culture, but I couldn't see how it raised the status of women living among and working with the armed forces. The magazines were removed, but the sexist attitudes did not come down so easily.

I could have painted over the regulation magnolia walls for the duration of Simon's posting, and painted them back over with military-dictated neutrality when we left, but I couldn't see the point. Simon was due to retire from military service in two years' time. HQ was not a home; it was a place we occupied for a time. This was the story I told myself so that I could detach from my discomfort of being badged "dependant" on an armed warrior.

I sat in that home, my toes rubbing against a worn patch of the hardwearing military-issued carpet, and dialled Ben′s work number on the old-fashioned landline phone, because the mobile signal on the base was unreliable. Poor mobile comms on the military headquarters. It was a standing joke.

"We′ve missed you. How are you?" Ben said. Ben, Dr Binjamin Rosenberg when he was giving evidence in the Family Court, but always Ben to his colleagues, is one of those rare people who asks, “How are you?” and waits for a response. Maybe he learned to do this during his ten years as a residential-home social worker, or later, during his doctorate in family therapy. Maybe Ben now teaches his masters students to ask, “How are you?”, and to pay close attention to the reply. Learned or not, the warmth in Ben's voice felt unrehearsed and that made me feel treacherous. I'd already been on annual leave in Crete for four weeks. The family court team would be struggling without a psychiatrist.

“Ben, I'm going to need some time off. I’ve had another miscarriage. I feel awful.”

“Oh, I am so sorry,” he said, “Look after yourself and let us know when you are up to coming back.” I could imagine him in the office, worrying a paperclip back and forth until it split, the way he did when he was concentrating on a problem that had landed on his desk.

ROSEMARY FOR REMEMBRANCE

Later that same day, Ben sent me an email, confirming our conversation. I will always remember his opening line, "I was so sorry to hear you have had a miscarriage," because Ben was the only person I told who responded like that.

We were just back from Crete, The Colonel and I, a holiday taken in part to recover from the miscarriage I'd had that Spring. Successive deployments to Iraq, Afghanistan and Djibouti meant that Simon had a lot of annual leave he'd been unable to take in war zones, and now had to take during his London-based desk job, so we rented rooms in an old villa for most of September, with two-year old Liberty.

Once I had called Ben, on that warm September afternoon after the appointment at the early pregnancy advisory clinic, I started unpacking my hand luggage and came across a small clay pot. A souvenir. As I held it, I remembered the day I had bought it: I had been walking up from the pharmacy in Chania, past the terracotta Maritime Museum, hearing a male choir singing in the Cathedral of Assumption. I had looked back across the ancient stone wall, reaching round the Mediterranean Sea like a woman protecting her brood.

On that old Venetian side of the harbour, there is a lone toilet cubicle, which on that day had a broken light. After gnawing the foil packet open with my teeth, pulling a stick out, taking the lid off with my teeth and trying to aim at the correct part of it, all while holding my bag in the other hand, came the hard part. The instructions were in Greek, but I'd done this many times. Pee on stick. Wait three minutes. One line not pregnant. Two lines bingo.

Simon was still in the narrow Italian cafe opposite the pharmacy. I'd felt light-headed on the bus, so we stopped for coffee. My espresso tasted as if it has not been brewed from single estate beans, as the sign had promised, but from iron filings. “‘Is your coffee tinny?” ′I asked. He shook his head and sipped mine, ″they′re the same. They′re fine.”

Three minutes is a long time to occupy the only toilet in the market. A small square of daylight came through the high window, and I could hear two small boys squabbling outside, taking turns to rattle the door latch, all three of us equally impatient. I leant against the cool stone wall, standing on tiptoe to angle the stick against the light. There was one clear pale blue line, but was there a second, or was I imagining it? Squinting in the dim light, I thought perhaps I saw a faint second line. Outside, a late summer breeze ushered a caravan of clouds along. Viewed in the bright beam now coming from the window, high as Rapunzel′s, the second line had gone. I′d imagined it, willed it.

Leaving the cubicle, I stuffed the stick into the top of my bag. The mother of the whining duo, the smaller one now clutching his groin and hopping from foot to foot, scowled and said something in Greek that wasn’t in my Berlitz phrasebook. I stumbled in the wrong direction, catching my flip flops on cobblestones, mistakenly turning away from street with the Italian cafe and friendly pharmacist. I wandered among artisan shops until I found myself surrounded by ceramic misshapen pots, displayed on shelves labelled in English block capitals, “seconds, all cheap shelf.” At the third row of wonky pots, I felt sea-sick. Sitting on the floor in the aisle of second-rate oil burners, I took the pee-stick out of my bag. In the small results window, there were two blue lines. Bingo.

For the next ten days and nights, I oscillated like an unweighted metronome between giddy excitement that I was going to have a baby, and sickening horror that she too would die before she was born. After a spring spent mourning, in a year of trying again and again and of failing again and again, to become pregnant, after a summer of guilt and of blaming each other, Simon and I were laughing again.

His sons Alex and Ranulph flew to Crete to join us, bringing their cousin Jono, whose father had recently died. Their school friend, Fabian, came too, celebrating the end of sixth form. We had big family feasts, where everyone, toddlers and teenagers, contributed to picking lemons, slicing bread and poking out pomegranate seeds. One night we sat at around a large table on the beach eating Souvlaki at sunset, the boys necking every drop of complimentary ouzo. As our lazy afternoon turned to toddler bedtime and teenage bar-hopping time, I was Queen Bee, surrounded by a buzz of young men, playing with our little girl. I daydreamed about the additional highchair at next year′s table.

″Rosemary for remembrance," was an unexpected email header when I checked my messages the following morning. My friend, an octogenarian New Zealand professor, had written to tell me about his late mother′s tennis doubles partner who had been killed, ″defending the Old Country" and was buried in Crete. When he′d heard I was spending a month there, he wrote and asked me to lay rosemary on the doubles partner′s grave.

My first thought was that it would be a fruitless search, but as soon as I saw the war graveyard, rows of white headstones ordered with military precision, I knew we would find the grave. Simon found an alphabetically-ordered register of the dead, each name paired with a letter and number, like seats at the cinema. No films for those young conscripts, although the view from their resting place was like the opening to a Scorcese film: an endless sweep of azure sea, a backdrop of grey-green mountains, a few small pastel-painted fishing boats bobbing below.

″They′re in such a beautiful place," said Simon.

″Not that they are alive to see it," I said, ″Dead so young. So far from home."

Our oldest argument, the futility versus the inevitability of war, simmered, but didn’t come to full boil. It’s a fight we both lose, every time. I placed the rosemary, stopping to photograph the grave. Simon intervened. There is, I learned, an accepted form of war-grave photography. First a sweeping shot of the row, then a close-up, portrait style. In that latter one I am kneeling by the grave, a bouquet of lilac-flowered rosemary in my hands, already looking bloated, my cheeks showing the pallor of early pregnancy, my eyes rimmed with first-trimester tiredness. When I got up, I looked over at The Colonel who stood crying among the Cretian war graves.

“It’s the lives not lived,” Simon said, “that′s what gets me. When I was in my early forties, I remember losing young soldiers and thinking, “I’ve lived twice as long as you and you’ll never be able to experience those years.” He gestured at a row of graves, “they′re the same age as my Alex and Ranulph.”

On our way back, we stopped at the small corner deli whose owner had come to know us and who called Simon, “Strategos,” meaning General. He gave us samples of honeyed wine and generously sliced salami and told me to bear more daughters who would look after Strategos in his old age. We stopped too at the butcher, where we mimed requests and the butcher mimed what had been slaughtered, a soundless Old MacDonald sketch. We bumped into the family we were renting rooms from, who greeted us by saying “festival, festival,” and took us towards a small stone-built church. All the families in the village had gathered in the churchyard and were lighting candles on the headstones of their departed relatives. Many were crying. We entered the church, which, though white and stark outside, was painted in gold, the blue of the sea and deep crimson. Simon and I lit candles under an icon of Madonna and Child and gave thanks for the new life I was carrying.

An elderly lady spoke to me in Greek and we were given a quarter of a loaf of bread by another group of women, who all hugged us. We had no idea what was happening. Outside in the graveyard, I found our landlady and asked about the meaning of the festival. “The bread has been blessed,” she said, “as today we are remembering our dead.”

All around us, extended families were sharing loaves with one another, visiting graves and lighting candles. Although I didn’t understand the entireity of the ritual, I was struck how these villagers, like the military, understood the importance of mourning and remembering.

A week later, we waved goodbye to Simon's sons, their friend and Simon's nephew, as they shoved oversize rucksacks into the battered taxi that drove them to the airport. We passed their taxi again at the traffic lights and waved; but they were chatting, a four-headed, eight-legged octopus under a sea of jackets. Two of the legs belonged to the schoolfriend, Fabian.

"Fabian is a lovely name," I said to Simon.

"I like it too," he said.

We were doing what I'd promised myself I would not do: fast-forwarding my positive pregnancy test into a live baby who needed naming, allowing ourselves to believe it was going to be fine. Simon saw me panic, "Don't worry, it will be fine this time. We've had a holiday, you're relaxed and can just take it easy."

We played on the beach with Liberty, building sandcastles with huge moats and turrets topped with tiny Greek flags, salvaged from ice-creams. Simon was smiling, reliving memories of his blended, extended family at the same table. With a mother's instinct, I knew at that moment that I was carrying another daughter. As we watched the waves, I named the baby, not Fabian, but Hope, our wish-come-true child.

At 3am I woke with a strong sense of foreboding.

"I feel scared," I said, waking Simon, "I feel scared that the baby will die."

"No," he said, "this baby won't die." Miscarriage was not yet part of his everyday. "Did you have a dream?"

"I keep thinking something bad will happen," I was crying.

"Relax. Go to sleep." When Simon felt out of control, he gave orders. I suspected that Simon had been giving orders since his gap-year commission to Cyprus. As an eighteen-year-old infantry officer responsible for the lives of others, he had to be certain, with the possibility of fatal consequences if he was wrong. How did the young school-leaver learn to live with uncertainty? Not in the same way as I did. In psychiatry, even as a senior clinician, my uncertainty was shared. My colleagues and I named our doubts, rolling them like marbles around our multidisciplinary meetings. Simon seemed to have learned long ago that giving short, sharp commands gave the illusion and likely, the feeling, of control. Losing control that night would have meant contemplating losing an unborn child. It was a catastrophic thought. Simon did not cultivate catastrophic thoughts. He ordered them out of his head. Useful skills on a battlefield where his soldiers lived or died on a command. Less useful at night when I felt alone with my dread.

But I did go back to sleep. At 5am, I was awake again, bleeding, lightly, as if I had caught my finger on a pin.

I woke Simon again. He was harder to rouse.

"I′m bleeding, I don′t want it to happen again," I said, still lacking the courage to name my fear.

"Don′t think the worst," said Simon, his eyes still shut, "you bled a bit last time."

"Yes and we lost the baby," I said. I was losing patience with him. As a psychiatrist, I recognised his avoidance as an unconscious mechanism to protect himself against fear and sadness. As his wife, I felt like screaming about his cold detachment.

"Try to sleep," he said, "I am sure it′s all going to be fine."

"Sure?" I thought, "You're sure, are you?"

Instead of sleeping, I emailed my GP, asking him to organise an appointment at the early pregnancy advisory unit. There are many reasons for bleeding during pregnancy, not all of them serious or fatal. A scan was the only way to find out. Scans aren't available on the NHS at all the times of day and night when pregnancies go wrong, but are bookable, between nine and five, Tuesday, Thursday and Friday, when ultra-sonographers look for heartbeats and midwives offer congratulations or commiserations. I wondered which it would be, as I watched the sun rise from our balcony and noticed that the bleeding had stopped.

Later that morning, Simon drove us for an hour uphill, away from the still-warm September sea. The road grew narrower and steeper, until it became just a single stone track, with no passing places. He needed to drive so slowly that the mountain panorama had a hypnotic, soothing effect.

“Milia” read the hand-painted sign on roughly hewn wood. The stone track became a gravel path. Milia is hard to reach for good reasons. We looked around at a village that did not seem that far from its seventeenth century incarnation. This village had provided safe-haven and shelter during numerous wars; her fertile ground and smallholding giving nurture and refuge until peril had passed.

“Milia is not a job. It is a way of life,” said the owner Pathos to me, as he played hide-and-seek with Liberty. “My father-in-law found it in a terrible state forty years ago. His plan was simple. Save it. Make it into an ecolodge, the Milia you see today.” Under his watch, the stone houses were restored simply, fitted with woodburning stoves. Hammocks were strung for reading and relaxing. Pigs and goats wandered Milia′s hills.

“Cretans live longer,” the Milia cookery teacher said to our group as we gathered around the kitchen. Liberty picked a small tomato off a vine on the table and bit into in, smiling, pips dribbling down her chin. The cookery teacher was a Cretan food evangelist. Under his guidance, we made tomato and peach soup. While the soup cooked, a lamb was submerged in olive oil and slowly braised with large bunches of rosemary. When he cut the lamb, I started bleeding again, heavily this time, and excused myself, grabbing bandages from the hire car′s first aid kit to try and absorb all the blood. When I returned, honey was being drizzled onto potatoes.

“See what I makered,” Liberty said, cutting small biscuits out of pastry made with flour, olive oil, honey and cinnamon. As we sat with tourists from all over the world, talking about which recipes we′d try at home, toasting one another at a large table salvaged from a monastery, nobody knew that I was silently, invisibly dreading a loss that hadn't yet happened.

At the end of the road, the following morning, the bus arrived exactly at the time I reached the stop, taking me to the Athenian GP who had looked after Liberty a few weeks earlier when her mosquito bites were infected. He didn't smile so broadly this time. "It doesn't sound promising, as you will know," he said, before explaining that there was no possibility of an early scan and that my best option was to fly home as planned and see what happened.

On the small plane home, as I sat sandwiched between Liberty sleeping in her window seat and Simon snoring in his aisle seat, mild contractions started. Liberty′s head was on my shoulder. I didn't want to startle her, trying to keep still as I lost another sibling she wouldn't see. I clamped my legs together, not in any vain hope of changing what was happening, but because I was worried about making a bloody mess on the aeroplane seat.

On the way home from Heathrow, we stopped off at the supermarket. Simon stayed in the car with our sleeping toddler while I went to do the post-holiday milk, bread and super-absorbency maternity-pad run. In the bread aisle, I felt a pain so sharp it made me double over, then a gush of blood. In the customer toilet, I saw her and briefly cradled her on my hand, Hope, my tiny frog of a child. Less than a metre away, strangers were washing their hands in the crowded space, bumping against those in the queue.

"Yeah, someone′s in that one," an older woman said to a younger one.

I rushed out, washing blood from my hands, leaving a bloodied heel print from my flip-flops. I remembered Sarah′s words after my previous miscarriage, as my eyes had been fixed on her miscarriage midwife badge. *Try not to get too upset about it. It wasn't really a baby. It was only 20mm. Just a ball of cells.*

No mention of the tiny heart, like the developing hearts I had once pencilled in. Flush her down the loo, like a dead goldfish and carry on.

EMBRYOLOGY COLORING BOOK

Every time I was pregnant, I could visualise my embryo like a pencil sketch. At the end of my first year at medical school I failed all my exams, all of them except embryology. My first year had been mostly disappointing. Afternoons seated at tables of eight, as if at a dinner party, but around a cadaver, were not all I had hoped for. St Bartholomew′s liked to think of itself as a progressive medical school and had run a "preparation for dissection" morning, where we sat, groups of school leavers and the odd mature student, in circles, while an anatomist, a dentist-turned-priest, and a surgeon rotated among us.

We learned where the cadavers who lay in the dissection room came from. "All were donated, explicitly for this cause, while still living," the anatomist said, keen to stress that grave-robbing was long in the past. The dentist-priest told us families would hold funerals after we had learned our anatomy. I remember thinking that this was a long time to remain in suspended grief, without a service or public farewell. We were cautioned to be respectful, "at all times" and directed to "keep Anatomy Atlases closed when travelling by Tube from Charterhouse Square to Mile End." The *Anatomy Atlas* was a large photo book, in coffee-table format, of head-to-toe slices of cadavers and their organs, dissected; and the important anatomical landmarks, labelled. As we practiced looking nonchalant at these dismembered people, their flesh pinned back to expose veins marked like motorways, someone read a poem by an anatomical donor, which began: "This is my body, the shell of my being, which is given to you in final offering to the world." There were echoes of Christ′s broken body, the ultimate Christian sacrifice. How different these words were from the martial language I would hear in my clinical years, "we fought to keep him alive" or "she lost her battle with cancer.” Finally that morning, after hearing the liturgical poem, we learned how to change a scalpel blade on our dissection knives without cutting our fingers.

Head and neck anatomy was covered in the second year, so our cadavers were decapitated for our peers in the year above. The horror of a beheaded woman on a metal gurney, formaldehyde burning my eyes, her skin like a frozen wax crayon, as my classmates and I gawked, stiff as our starched white coats, absorbing the sickly scent of undecomposed death, put some aspiring doctors off. One of my fellow freshers had left medicine by the time we celebrated my eighteenth birthday the following week.

There were many days when I felt like leaving too. Anatomy repelled me. Physiology was tough. Microbiology, baffling. Biochemistry taught at such a rate that I regularly got left behind. Most weeks I wondered if I would be happier reading English. Despite those doubts, I wanted to make sick people well. I told myself that these pre-clinical years would pass and that my years on the wards were not long off. Colouring embryos was one of the few pre-clinical activities that I enjoyed.

Embryology lectures were delivered to two hundred students in a naming-of-parts manner. We were given A4 sheets with line drawings. The same line drawing appeared on acetate on an overhead projector. Our lecturer, a woman with a large grey bun and bright blue glasses, squiggled on the acetates and named each blob and line. I loved it. It was like watching a weekly drama series, at the end of which there would be a baby. On autumnal evenings, I would sit with sharpened watercolour pencils and bring line drawings to life.

On week six, we were taught about the formation of the notochord.

“Those of you who believe in the soul, this is when the soul is said to enter the embryo. Before this, it's not a life.”

Our lecturer was wrong, I was certain. Life began when the two cells merged, shared all they had with each other and began their dance. Loving the colouring sheets provided, I was greedy for more. In Dillon′s bookshop on Gower Street, I found the *Embryology Coloring Book*. On the front cover were two images: a small foetus, like a figure from a dollhouse, probably at the sixteen week stage; and a ball of cells, a blastocyst.

Three hundred pages of embryos at various developmental stages followed. These line drawings were labelled in childish bubble writing. The theory was that colouring the labels as well as the diagrams would help kinaesthetic learners. In practice, colouring was relaxing, calming the jittery buzz in my brain and gave me lasting awe for the beauty of embryonic development, and respect for the miracle of life. Embryology colouring sheets also gave me one of the few legacies of my pre-clinical years. I can no longer recite the stages of the Krebs Cycle. The names of the bones of the foot elude me. But the names for each stage of the dance of life - zygote, morula, blastocyst, primitive streak, notochord, lens pits, nasal pits, ossification -whirl in my memory like childhood verse.

JAM TOMORROW

On my second morning home from Crete, out of the kitchen window at HQ, the crab-apple trees bewitched me. Something about the crimson peel of the fruit wouldn't let me leave them on the tree. I went out, filled a bucket, then a second, then our sink. By the end of the afternoon, both large trugs we used for collecting weeds and leaves in the garden, every mixing bowl, salad bowl, the mop bucket and Liberty's toy wheelbarrow were all full to overflowing with crab apples from around HQ. That evening, after Liberty had gone to bed, I spent hours simmering the tough skins, ladling sugar, stirring as it dissolved, boiling the sweetened fruit pulp for hours, dripping blood-red jelly spurts onto chilled white plates, looking for a set.

I sterilised load after load of empty glass jars in the dishwasher and filled them with jelly. As they cooled, I went online and ordered one hundred glass jars on overnight delivery. I spent my sick-leave preserving and bleeding, stirring my way through cramps, boiling my anguish out in the 1950s army kitchen. Liberty and I went to Hobbycraft, where we chose gingham patterned jar lids and sticky labels, "from the kitchen of..." decorated with delicate watercolour images of fruit. When we got home, the sight of rotting fruit on the ground all around HQ made me cry. Liberty helped me gather the fallen apples with her dimpled fingers.

The following morning, I woke early and saw the fruit on high branches outside the bedroom window. I climbed a stepladder and shook the crab trees, then borrowed the neighbour's buckets to hold all the fruit. When Simon woke, I was pushing boiled crab apples through muslin, my fingers stained crimson, my dead unborn still oozing out of me. Walking Liberty to nursery that morning, I noticed for the first time a small orchard behind the barbed wire surrounding the headquarters. There were damsons, like the ones in our neighbour Sally's garden, but also pears, apples like the apples that had grown in Milia: cookers and eaters. After filling my fridge with jars of scarlet jelly, I went back behind the wire and began an all-day relay of gathering and preserving. I spent two evenings making apple sauce, apple pies, apple crumbles and preserving pears in sweet syrup. During the week, after nursery, Liberty and I walked in the woods, filling baskets with blackberries. In the evenings, I made hedgerow jam, blackberry crumble, apple and blackberry pies. There were pears behind the wire too, out of reach. On Saturday morning, as the sun crept through the gap between the curtains, I woke Simon.

“Can′t we have a lie-in?” he asked.

“I need you to help me with a ladder,” I explained. It felt urgent, akin to a life-or-death intervention I′d have woken a senior colleague for when I was a junior doctor in the accident and emergency department. We took the ladder behind the wire and Simon helped me get the pears that had been beyond my reach. Someone had pipped me to the plums.

THE COLONEL

Two years earlier, I'd fallen in love with The Colonel despite my pacifist principles. I'd clocked him at my former schoolfriend Catherine's birthday lunch as a distinct possible for another friend, Nadia. Nadia's husband had died suddenly when their three children were all under four. Nadia had had a tough time and since her eldest had turned thirteen, she had hinted she was ready for a new romance. We were all on the lookout for a new man for Nadia. I'd invited them both to a New Year's Party. Nadia wasn't sure.

"He's military. He'll be too posh for me."

"He's not posh," I said.

"He went to public school," said Nadia.

"He was the scholarship boy," I said.

"Papa won't like me seeing someone from the army," she said.

"The desi aunties will love him," I said.

Although she had lived in London all her thirty-six years and was a consultant pathologist at a London teaching hospital, Papa, a retired pharmacist, still cast a deciding vote. Nadia had a lot of first dates, but not many second ones. Nonetheless, she came to my New Year's Party. The Colonel called me the day before.

"What shall I bring?" he asked.

"Something wild and peaceful," I said.

He arrived at 1900 hours sharp.

"Military precision," I thought. Though he stood tall, with his shoulders thrown back, he looked nervous under the porch light: the startled twin of the self-assured man who had opined about his anti-piracy mission in Djibouti at Catherine′s birthday lunch. He handed me two, slim, hardback books of poetry: WB Yeats and John Clare.

"Wild and peaceful," he said, "I do hope these are alright."

I didn't rush to introduce him to Nadia. When I did, later that evening, my hand on his arm made clear to her that the anti-war demonstrator was going to keep The Colonel for herself.

After the party, Simon called, saying, "meet me at Eros" and took me to a play about Byron, in a tiny theatre off Piccadilly. In the interval, I asked Simon about his work at HQ. He told me about his regiment, The Royal Regiment of Fusiliers, who he had joined after finishing his A Levels as an eighteen-year-old and served with in Cyrpus and then later, after reading history at university, in Northern Ireland.

Simon explained that during a commissioned officer′s career, it was usual to rotate between battlefield jobs, which he referred to as "operational" and desk jobs, which he called "staff". This rotation of officers between frontline and back office, he explained, dated back to the First World War. Simon had been on operations to Sierra Leone, Oman, Iraq, Afghanistan and Djibouti and was now at HQ in London as a staff officer. His official title was DACOS, Deputy Assistant Chief of Staff, and that role involved many meetings in Paris. In 2010, the governments of the UK and France committed to creating the Anglo-French Combined Joint Expeditionary Force. This involved all three services: land, maritime and air and was to be a deployable force, to defend against multiple threats. Simon's role involved working with his French counterparts to make sure the force was available at short notice for UK-French operations by NATO, the EU and UN. The Anglo-French Combined Joint Expeditionary Force were working to develop shared values, joint training and equipment.

I told him about my career, about the medical professors who had said, “don’t just do something, stand there” and how I’d been taught to observe and stay quiet. I explained that after two years of lectures and dissection, I’d rotated with groups of students around different specialties, for a few weeks at a time: medicine, surgery, obstetrics, paediatrics, pathology, psychiatry, ophthalmology, neurology. I told him about “see one, do one, teach one”, about taking patient histories and learning to examine, but mostly about how I’d stood quietly at the end of many patients beds over three years, looking and later trying to make sense of those observations, always ready to declare what I had seen, in case I was called out of the group of students to “present your findings” to someone higher in the medical hierarchy.

After Byron, Simon and I had whirlwind weeks of rooftop Martinis, dinners in little places he knew, where he seemed to be known well-enough for flutes of champagne to arrive unbidden. I′d escape to the ladies, to text Nadia.

“Military updates,” we′d called those texts, escaping into our younger, medical school selves again, a giggly refuge from our other conversation, about teenage gang fights. One night she′d been working late, finishing the post-mortem of a teenage girl killed by stab wounds. Other teenagers had been arrested, children just a few years older than her own.

“Kids barely into their teens carry knives now and they′re not scared to use them,” she said, “Tell me, what makes a child do that?”

On our third date, Simon and I talked until the trains stopped running and he hailed me a black cab. He responded to my “home safe” text with an elegant paragraph, including a semicolon. I’ve always had a weakness for a well-placed semicolon, so edited him from weekend margins, to the main-text of my life.

CITY OF LIGHT

"What are you doing next weekend?" Simon′s text had made my phone glow green.

"Nothing really," I texted back.

"I have to go to Paris for work; why don't you catch the Eurostar and join me for the weekend. I've never been to the City of Light with a lady before. Please say yes."

I thought he was forward.

"Reports to finish, sorry," I texted, "Too much work to do."

"Paris will always be there," my phone buzzed.

The Colonel went to work in Paris on his own that week. That Friday evening, he caught the train south to Limoges, where an army colleague lived. By Saturday evening I was regretting not taking up the offer of Paris, so I called him on the number he′d left for me.

His friend′s wife answered my call. "They′re both in the garden," she said, "looking at the stars."

Stargazing sounded romantic. When Simon came on the line and told me all about the constellations, I decided to be on the Eurostar the next time he asked me. I didn't know then that I would join him for every subsequent Anglo-French meeting over the next two years. I also didn't know then that, as a young officer, Simon had been dropped out of a helicopter, without a map, in the middle of the night and so had learned to navigate by the stars. He still reads the night sky in the same way he reads poetry or Ordnance Survey maps, with wonder.

HOUSE OF MIRRORS

On the eighth day after flying home from Crete, the bleeding subsided. I felt well enough to take Liberty to her friend′s birthday party. It was a Saturday and our next-door neighbours had been getting ready to host the party. By the time we arrived, the paddling pool in my neighbour Sally′s garden was filled with red plastic balls, some of which had spilled out and were rolling down the sloped garden and gathering in the military-issued flowerbed. I imagined the pool full of water, giving respite in this unusually hot, late September afternoon. I lay back on the grass, looking up at children from the military nursery who were laughing on the rope swing. I cast a covetous eye on the damson tree. The damsons were plump, almost ripe. I wanted them for jam but heard Sally had already promised them to an RAF wife. Next to the damson tree, several toddlers shrieked on a tiny bouncy castle. Liberty was holding hands with Sally′s daughter, Isabella, the birthday girl. Both girls had blonde hair in ribboned bunches, which bounced as they jumped, their squeezed hands accentuating the toddler dimples between ten tiny knuckles.

Sally came out of her house, a near-identical twin of the house I lived in. The first time I had been inside her home, it had reminded me of a fairground house of mirrors, with obstacles where walls ought to be. Everything was uncannily similar, yet not the same. Her kitchen had the same dimensions, same beige Formica worktops, same magnolia walls, same 1950s electric white oven. Yet, her kitchen was on the right of her front door, not the left, her back door faced the other way, towards our home, as if looking at ours. It wasn't just her kitchen, our entire homes were mirror images of each other. I was always temporarily disorientated, whenever dropping off, or collecting Liberty, who loved to play with Isabella.

Sally and I both had two-year-old daughters who went to the nursery on the base. We were both the partners of army officers who had reached the rank of colonel. From the outside, our lives looked similar, yet there were differences. Sally was an army officer too. She understood the conventions of this life on the patch. She didn't do double takes when a camouflage-clad officer threw his arm up in a salute, but stiffened her spine and saluted back.

"How are you coping in the heat?" I asked, as Sally refreshed my glass.

"Alright," she replied, "glad it's not long now."

Sally was in the blossoming, blooming stage of last trimester pregnancy. In a few weeks, she would give birth to baby Archie, while I looked after Isabella overnight. We had a plan. I had her house key. I knew her due date.

What Sally didn't know was that her due date fell in the same week as the due date I had been given earlier that same year. That unborn was confirmed dead just as Sally was having her 12-week scan. Seeing her so close to giving birth reminded me of all I had lost when I went to Paris in the spring that year.

PARIS IN THE SPRINGTIME

As patients have told me after they have been in a road traffic accident, I didn't see it coming. It happened in a flash, my professional and personal worlds colliding, throwing me off, onto the wrong side of the patient-doctor interface.

The collission began in the first week of 2013. My period was late. At least a week late, maybe ten days, twelve at a push. I've had periods since I was ten years old, but I still haven't found a good way of keeping track of them.

"What was the date of your last period?" still feels like a trick question whenever a doctor asks. My best bet is to try and remember what I was doing and then work backwards. That January, in 2013, I kept looking at Ben's calendar on his desk in the attic office, trying to reconstruct the date of my last period from court report filing dates. Late enough, I concluded, to buy another pregnancy test from the supermarket after work. The woman at the checkout wished me luck. Had I bought so many tests that she recognised me? When I saw her the following week, she was catching my eye and making a thumbs-up, thumbs-down gesture. Before I started adding pregnancy tests to my shopping basket on my way home, our only conversations had been about the weather. I flicked her a quick thumbs-up.

"We're going to have a baby," I'd said to Simon, because even though it had gone wrong previously, I did not say, "I've got a fertilised ball of cells, let's wait and see if it's viable." I was excited, wanted to call my friends and swear them to secrecy and make them promise that this time it would be ok. But I didn't call my friends. However much I wanted to share the joy and excitement, the dread was mine alone. After the twelve-week scan, I'd tell people then. I'd do this properly. I'd only tell the people who needed to know. I called my GP.

“I’ve got a positive pregnancy test.”

“Congratulations!” No ball-of-cells talk from my GP either. “What was the date of your last period?”

My GP wrote a letter to the obstetric team, asking them to “accept this lady for her confinement.” I didn’t see his letter at the time, but looking at it now, it is the first hint of the power imbalance that I would come to experience in obstetric consulting rooms.

On the morning of the week before my twelve-week scan, 16th March 2013, I was getting ready to go to Paris with Simon.

“Do you remember the name of that place where we waited for a table in a downstairs lounge and drank cocktails?” Simon had asked that morning. I shook my head. He wanted to recommend it to a colleague who was being posted to Paris for several months.

“It′s opposite that shoe shop,” I said, “Down the road from the gallery with the pop art in the window.”

“Can you remember the road name?”

I shook my head. My navigation technique was not honed in the dark, by the North Star. I do not read Ordnance Survey maps for pleasure. Over the two years of visiting Paris, I found my way by turning left at the violin makers, right at the Italian stationer, down the narrow path between the two patisseries until I saw the pink-striped awning, you know the place, next door to the subterranean cave of a bar with the punched metal pavement tables. Because of the Anglo-French meetings, I got to know Paris so well, that Simon and I had a favourite restaurant. I just didn’t know its coordinates.

I was getting ready to go to Paris with Simon when I got into HQ from work on that memorable afternoon in March 2013. I had run in to the house to get changed out of my work clothes before collecting Liberty from nursery and dropping her at my parents’ home. Usually, we walked home through the back way, along the small parade of shops at HQ, passing the military chapel, stopping in the small glade to look at woodlice and daffodils, but on that day I planned to drive to the visitor′s entrance, put Liberty in the car with a snack and drive straight to my parents'. I was rushing in the hope that we would avoid getting stuck on the motorway at rush-hour.

I changed, grabbed her bag, set it down by the front door, popped to the loo. As I wiped, I saw the faintest spot of light pink. There was a lurching sensation in my lower abdomen, as if I was a back seat passenger and the driver had performed an emergency stop. I wiped again. Nothing. I stared at the paper. Nothing. It was nothing.

Ignoring my dread, I drove to the visitor′s entrance of the military base, where I was allowed in after I had flashed my dependant′s pass at the armed guard. I waited for him to unlock the heavy metal gate and guide me in. I nodded hello to the sniper in the tower, passed the serving parents wearing camouflage. Liberty was playing in the toy house when I arrived. It was given regular makeovers by the nursery room leader. For several weeks it had been a space-station where children became astronaut explorers. On that day, it was a café.

"Hello Mummy. Thomas makered me a nice cup of cino." Liberty made slurping noises and smiled.

"Cappuccino, yummy," I said.

"Yes, he makered me a cup of cino."

Danielle, Liberty′s nursery key-worker, ran through the highlights of the day, while helping Liberty put on her coat, pack her water bottle into the rucksack, and wiping her hands in what felt like one movement.

"Liberty′s had a good day. Ate all her lunch. Two helpings of pudding. Sticky toffee. Done some small world play outside with Thomas and Isabella. Four nappies. We'll need some more next week."

Liberty hugged me, and Danielle stroked her hair, tucking stray wisps behind her ears.

“Bye Pickle, see you Monday,” said Danielle.

“Bye Danielle. See you later alligator.”

“In a while,” said Danielle.

“Crocodile!” said Liberty.

Danielle was key-worker to three other two-year-olds in the Ducklings room. Her hands were always occupied, wiping mashed potato from around a mouth, gluing soap-flake snow onto cardboard igloos, changing a nappy, yet her face was calm and unchanging. Danielle never looked bored or distracted or irritated. She knew the children under her care, their little quirks, their big fears, their favourite puddings. There must have been squabbles in the Ducklings room. I don′t remember them. I remember Danielle saying often, at the smallest hint of discord: "We are all friends in nursery.” It was a mantra Liberty repeated at home.

As we were walking to the door, I felt the break-slamming lurch again.

“Just going to use your loo before we go, Dani. We’ve got a long drive to my parents’.”

My heart was racing. I checked my underwear for any drips of blood. I felt paranoid. This was no way to go to Paris, full of dread and checking my knickers every 10 minutes. There were two small watery-looking pale pink spots, as if someone had washed a raspberry red paintbrush in water, and then flicked a drop of the water across my knickers. Was this spotting? Would I have noticed if I was not checking anxiously? Probably not. I wiped one more time. A pinprick of barely-there pink. One tiny burst segment of raspberry. Nothing.

Liberty and I walked to the car.

“Bye Charlie. That′s Charlie. They′re going to the hairdresser. Having a haircut. He′ll get a lolly. Can I have a haircut? I like haircuts. I like a lolly from the jar.”

“Not today. We′re going to see Omi and Opa. You′re having a sleepover. Remember? I′m going to Paris.”

“Hooray. Three cheers for Paris. Can I have a Paris lolly?”

“I′m sure I can find you one.”

I smiled. I smiled even though I felt as if I had a wet mop-head inside me and it was being rung out against the sieve holes on a metal mop bucket. Instead of reversing, I sat in the carpark and called my GP. His wife, the practice nurse, answered the phone. She cut me off mid-sentence:

“Hywell′s just walked into reception,” she said. I could hear her relaying my story and then passing the receiver over. I could picture them, in my old childhood surgery, a short walk from my parents’ home.

“Are you bleeding?” my GP came straight to the point.

“Not exactly, It′s like a very light sort of spotting.”

“Pain?”

“Not pain, I feel wrung-out, like a mop.”

“Do you want to come for a scan tomorrow?”

“I′m supposed to be going to Paris in the morning.”

“Lucky lady. Where are you now?”

“Just leaving HQ. I′m about to drive Liberty to my parents.”

“Well, I’ll be here for a bit finishing some admin. If you get here before six this evening, I’ll scan you. If not, give us a call when you′re back and I’ll scan you then if it hasn’t settled down. Don′t worry. Chances are it′s fine.”

This isn’t most people′s experience of general practice. A stroke of luck meant I was able to register with this GP, who had once been my childhood doctor. Was it luck that he seemed particularly interested in this pregnancy? Was he treating me differently because I was also a doctor? Or because he had looked after me as a child? His son, also a GP, and his daughter-in-law, also a doctor, were expecting their first child. Did I remind him of them? Was he like this with all his patients? Maybe we were all lucky.

This GP is the son of my first childhood GP. I remember walking with my mother through our local park, to a beautiful house with its own clock tower. I remember her telling me that it would once have been a family home but now it was a family medical practice. As I got Liberty′s snack out, I thought of the inner-city GPs who saw the patients sent to see me by the family court. Those GPs tended to have overfull patient lists and cramped consulting rooms. I thought of all the notes, clinically accurate but sparse, written between eight-minute appointment slots by locums who didn′t know the backstory, notes that became part of the jigsaw of a child′s "contact with services" but never made a complete picture. I thought of the continuity my family had with the practice in the park. The father who had been my childhood GP, his son who became my GP on his father′s retirement, his grandson who was now my parents' GP. My GP′s wife, the practice nurse who answered the phone, had syringed my ears when I was a little girl. Thirty years later, she had given Liberty her baby immunisations. My oldest medical records are in my GP′s father′s handwriting; my body′s mishaps and malfunctions have been catalogued by one family, from copperplate to computer.

"Shush now, Annabel, sleep, sleepy baby," Liberty sang to the doll on her lap.
I glanced at the car clock, 17:05. If the motorway was clear, we′d go straight to the practice in the park. Liberty could watch Peppa Pig on my phone while I had a scan. I′d see the foetal heartbeat. I′d drop Liberty at my parents. Cup of tea. Drive back round the M25 to HQ. Paris in the morning.

"Remember the enemy has a vote." Even as my plan was forming, I could hear Simon coloneling in my head. On that afternoon, the enemy was the traffic. At the airport junction there was a standstill. The wrung-out sensation came back. What was it? Anxiety? A dying embryo? All in my head? All in my womb? I wanted to call the GP to say we wouldn't make it on time, but there was nowhere safe to pull over. The journey might take twenty minutes or another hour. We finally arrived in my parents' neighbourhood at twenty past six. Liberty had fallen asleep in her car seat. I pulled up outside the park. The trees that lined the path where I had learned to ride a bike were dripping pale pink blossom. Some of it blew onto the windscreen.

I phoned the surgery, but knew I was too late to have the dread of losing my unborn confirmed or allayed. I apologised to the answering machine and turned the car round to my parents' home, where I handed over my slumbering toddler, her doll falling to the floor, her coat sticky with juice, wishing I had some of Danielle′s unhurried calm.

It was past nine pm when I came back into the kitchen at HQ. The 1950s oven and chipped melamine always gave me the sense that I was walking onto a stage set, a miscasting. The house was quiet. Simon was packing. I could hear half of the conversation he was having with his sister Yvonne, whose husband Paul was dying. We had seen Paul a few days earlier.

"He′s not in this world for much longer," Simon had said to me in the car as we had driven back from the hospital. As a young infantry officer, he had stood by the hospital bedsides of his injured men, he had repatriated the bodies of his fellow Fusiliers, he had sat with their mothers and widows and felt his mouth forming the words, "I'm so sorry," and stopping himself from crying. I knew he was right about his brother-in-law. As a junior doctor, I had also looked into the eyes of dying people, holding their hands as their life ebbed away. Yvonne′s retinas had not yet been burned by the glare of untimely death. Their conversation on that evening was about renting a special bed, so Paul could come home from hospital. The sight of Liberty′s empty cot made me feel sad. I was distracted, convinced I was going to lose the baby and would start bleeding. I checked my underwear obsessively. No bleeding. No pale pink raindrops. After Simon came off the phone, we talked about his sister and her dying husband. I didn′t say anything about the dread or the offered scan. It was magical thinking. If I don′t mention the worst, it will not happen.

“I′ve set the alarm,” Simon said, switching out the light.

*****

Over breakfast pastries at St Pancras, Simon introduced me to his new boss who was wearing bright yellow and black tartan trousers. They looked just like Rupert Bear′s trousers. Simon and his boss tossed a word salad of defence strategy between them, dressing it with three-letter acronyms. I tried to listen, to make intelligent responses to their in-speak, but my mind had been hijacked by anxiety. I was a bad hostage. Instead of thinking my way out of it, I was sick.

I was sick in the terminal, sick on the Eurostar and sick in the Parisian hotel. It felt disrespectful to be sick there, in ensuite with the Fornasetti faces on the walls. I couldn’t tell if it was morning-sickness sick or everything-is-going-wrong sick. My GP had picked up my message from the evening before and left a voicemail while I was regurgitating my *pain aux raisins*. If there was no more bleeding, I shouldn′t worry, he′d said. If there was bleeding, I′d be rescanned on Friday when I returned. I should enjoy Paris. Try not to panic. I washed and decided to walk. The day was mine, with no medical or mothering commitments. How often could I say that?

Simon describes his French as “hotel French”. He is modest, having acquired an impressive level of conversational fluency when he was in Morocco learning Arabic before a deployment to Djibouti. Several of his colleagues spoke flawless French, like Ed from the Marines, slipping from Geordie to Parisian as the train pulled into Gare du Nord. Next to theirs, my school French is rusty. Simon′s colleagues made jibes about my fluency when it came to shopping. There was a little truth in this. I polished my GCSE vocab in a tiny boutique, next door to a violin workshop, filled with rails of clothes for young children.

“Bonjour Madame. The Colonel is working again in Paris this week?”

“Oui, exactement Claudine,” I said.

“Liberté, she is well?”

“Très bien, merci. Liberty lived in that red pullover all winter.”

“Madame, I think Liberté will adore this blue tunic. With her jolly pattern, quite perfect for your little girl in the English springtime.”

Claudine started to corral a selection of hair accessories, blouses, a cardigan with buttons shaped like ducklings. As she wrapped the tunic in layers of pale pink tissue paper and unfurled a gingham ribbon, my eyes lingered on a display of crocheted baby cardigans in sugared almond colours.

“Oh Madame! Perhaps you have some happy news?”

“Maybe next time, Claudine.”

“Doigts croisés.”

“Thank you. Could you tell me, is there a sweet shop nearby?”

Even though I wanted to buy a crocheted cardigan, I did not. It was a magic spell: keep my secret for twelve weeks, all will be well. I went to find a Paris lolly.

Walking down the street from the *magasin de bonbon* to the Trinité Metro, I felt as if I had been punched in the stomach. It left me folded like a collapsed camping chair, as I propped myself up against the railings. When I was twenty and at medical school in London, someone mugged me outside Covent Garden station. My bag, which I had worn across my body, was gone. The slash in my coat was the only sign that it had been cut from me. It happened so quickly, I did not notice. But afterwards, it was as if I had been turned upside down and emptied, in the way that the mechanised bin lorries shake upturned bins. I′d forgotten that sensation, until I felt it again in Paris. My first thought was that I′d been mugged again. I still had my bag, still had my phone, still had the boutique bag with its gingham-ribboned parcel, still had the Paris lollies. There had been no mugging, no miscarried shopping. Why did I feel upended? Did I still have my baby? Was it all in my head? Was it all in my womb? My abdomen felt sore where I thought I′d been hit. I was telling myself things I′d read in medical textbooks, “An expanding uterus can feel sore in a normal pregnancy. A few drops of blood can be normal.”

I walked away from the Metro with a fearful purposelessness. I saw a church, the Eglise de la Trinité and went in to sit quietly and pray. In the church there were several different stations to light a candle, shrine-like stops on a carousel of faith. I ended up plea bargaining, lighting a candle at the statue of St Jude, the patron saint of desperate cases and lost causes. My candle was one of many flickering lights in the dark nave, like the light of a heartbeat in a darkened ultrasound suite. I wanted to believe that lighting candles in front of a stone statue would keep my own little light from being snuffed out. I heard myself making promises to be good, to be a more patient mother, a better doctor; if only I can keep this baby, I will be all those good things, if you let me hold onto it, onto life.

The going rate was €2 for a candle. I took three and, as I put my coins in the metal box, I was reminded of the coin-slotted photo-booths in railway stations that my teenage friends and I used to squeeze ourselves into, memorialising our youth before it faded. St Jude′s statue was the most popular of all the candle stations in the church. Lighting my candles, I was squeezed in between other plea-bargainers. The woman next to me had that desperate, exhausted-all-boulevards face, that I recognised from the faces of the mothers I met in my work. Despite the many lights in front of us, we were in the shadows, pilgrims bound by loss.

*****

Every jolt of the metro seemed to upend my uterus. I hung onto the grab bar, imagining tiny hands hanging onto the walls of my womb.

“Enough,” I told myself, “enough.”

At the hotel I lay on the bed scanning my body for pregnancy symptoms: nausea, good; metallic taste, good; jeans tight, good; weeing a lot, good. Wee. Wipe. Check. Dots this time. Tiny dots of pale pink. It looked like the spray-painted poppies each child had made in the HQ nursery. They became a field of blood-red spattered poppies decorating the windows during November, some smudged with red toddler-fingerprints. Soldiers walked past with tears in their eyes. It was a relief when the poppies came down and the soap-flake snowmen took their place.

I′d arranged to meet Simon after his meetings at 1600 hours outside the Musées d′Orsay. On my way, I passed a family of bicycles in various sizes chained to railings. I thought of our bikes at HQ, his mountain-urban hybrid, my vintage-style shopper, the wicker basket swapped for a toddler-seat. Liberty loved to sit at the front but would be riding her own bike soon. Would there be another child in the toddler seat?

“You look tired, are you all right?” Simon was waiting for me at the entrance to the gallery.

“Just a bit wrung out,” I said.

If I keep silent, I told myself, the worst will not happen.

*****

Gare d′Orsay was converted into a museum by the Italian architect Gae Aulenti in the nineteen eighties. While I was a schoolgirl learning to ride a bike in the park, Aulenti transformed the cavernous beaux arts Gare d′Orsay building into a museum of impressionist art. In the book left for tourists at the hotel, I read that Aulenti was a rebel architect, studying against her parents′ wishes, bringing her glamorous style into what was then a male-dominated profession. It said that she was proudly countercultural. The year after being mugged in Covent Garden, I saw Monet′s waterlilies in Berlin and was looking forward to seeing them again. As we entered the barrel-vaulted station gallery, I felt dizzy.

“Can we sit down for a moment?”

“Let′s get a coffee,” Simon suggested.

“Makes me heave.”

“Tea then. Tea and a cake, darling. You’ve been rushing around all week, you must be shattered, love.”

“Choose me something lovely. I’ll just pop to the loo.”

A slight smudge of blood. Darker now, a smear of crushed blackberry against a hand. I looked for coins for the sanitary towel dispenser, but I had given all my change to the saint of lost causes. A woman came out of a stall, washed her hands, refreshed her red lipstick and pressed a two Euro coin into my hands. The machine malfunctioned, spewing out three packs instead of one. What did it know? Was it a sign?

Simon had bought eclairs and mint tea, fresh leaves swirling in a glass pot. The Anglo-French meeting had gone well. No point in jinxing us both with news that might not be any news at all. As I sat sipping tea, looking up at the rosettes on the ceiling, the industrial beams and new walls, everything started to look out of focus.

“Monet looks blurred.”

“It′s meant to be blurred.”

“Not like this. I’ve seen them before; I can′t see the edges properly.”

My eyes could not rest anywhere. We went back outside for fresh air. Simon hailed a taxi. We cancelled the table at our favourite restaurant. I lay feeling queasy in the hotel bed, unable to stomach any of the Chinese take-away.

*****

The following morning on our return journey, as the Eurostar slowed down through the South Kent countryside, I slalomed my way around the overnight bags in the aisle to the toilets. I definitely had the bladder of a pregnant woman. After emptying my bladder, I felt a hot gush of blood and reached into my bag for the Musee D'Orsay towels. But there was no blood to see, nothing at all. Was I imagining it? Was I losing my mind? Simon was sitting a few rows from me with his boss. I could see the Rupert Bear tartan flapping into the aisle and tried to catch the Simon's eye. Even at the station, Rupert Bear trousers was lurking, continuing a conversation about Anglo-French resource sharing. Simon was travelling back to HQ with him, and I was going to catch a train to my parents. He'd collect me and Liberty in the morning.

“I'm bleeding,” I whispered, “just little drops.”

If I whisper it, nothing is really happening.

“Try not to worry, love. I'm sure it's nothing. Get it checked out, if you're not sure? I've got to run. See you in the morning.”

I called my GP from the station. He was at a training day, but there was a locum who would see me at the end of her afternoon clinic.

*****

Although the locum GP I saw was not trained in ultrasound, she was reassuring.

“This doesn’t sound at all like a miscarriage,” she said, “a miscarriage is not usually a bit of spotting. It is usually a gush of blood with lots of clots. But I think a scan is a good idea just to put your mind at rest.”

I nodded.

“We don′t do early scans here, so you need to go to A&E. There′ll be a gynae reg who′ll do one. Don′t worry. I′ve seen loads of women, we′ve all seen loads of women, who bleed a bit in early pregnancy and have healthy pregnancies with babies. It happens all the time.”

I nodded and she started to write a referral letter on a piece of paper, looking up when she needed additional details.

“Do you have any pregnancy symptoms?”

“Nausea, morning sickness, sore breasts, can′t stand coffee, chilli cravings.”

“Well that’s good,” she said, “this is all very reassuring, because when you have a miscarriage, those pregnancy symptoms stop.” She handed me the letter and told me to go to A&E, have a scan, put my mind at rest.

OTHER OBSTETRIC CONDITION

“It depends,” said the triage nurse, “on the registrar. Some have done the ultrasound course but a lot of the new ones haven′t. They might send you to the early pregnancy advisory unit. They′re shut now for the weekend, closed at 5 o′clock, back on Monday.” Another nurse put her head around the door of the triage room, “I′m not missing my break again, Shirley,” she said.

My unscheduled spotting could have been better planned. I′d arrived in A&E at five past five on a Friday afternoon. There were patients waiting on all the chairs in the waiting room and others were leaning against the wall along the corridor. Because there were no clinical areas free for me to have bloods taken, the triage nurse had put me in a small side room with pine-veneer furniture, which I realised must be the room used to break bad news to relatives.

Discordant noises are the mood music of A&E. The C-sharp crotchets of an electric thermometer and the E-flat quavers of the pulse oximeter forming part of the orchestra of electronic monitoring equipment; the health care assistant′s crocs drumming the lino. I heard a medical student with a voice like a hesitating beginner violinist, her tentative authority pulled tight across her vocal cords: “Have you got Bay 5′s X-ray back yet?” Then the baritone phlebotomist belting, “I have come to take your blood,” as if it were a barbershop quartet number. Attuned to this urgent cacophony, a trained ear knows the worst sound is silence. Silence is what is left after the monitors have been switched off. Silence fills the space between the resuscitation team departing and the newly bereaved relatives arriving. Silence means it′s over. I was glad that the door was left ajar, that I wasn’t waiting in silence.

“Ill be in trouble with the ward staff if Bay 12 goes up without it.”

“He got left off my list...”

“Just to make you aware...”

Two nurses were inserting a penile catheter into a patient across from me. They spoke in their mother tongue across their patient as if he wasn't there. When they came through the curtain, I looked at them, they looked away, laughed, nobody met my eye. I had been trying to phone Simon, who was driving to Somerset to collect his younger son from his first marriage, Ranulph, for the Easter holidays, but I couldn't get through. Liberty was sleeping at my parents' house for an extra night.

Hours later a newly-minted registrar in obstetrics called me into a bed in a bay and drew a blue, concertina curtain around it. The curtain gaped at the ceiling and floor, only an illusion of privacy. The obstetrician did a speculum examination and while I was still half-naked on the bed with a speculum in my vagina, told me that I was oozing a slight trickle of blood from my womb. He told me that I would get a call with the blood results and that I needed an ultrasound scan to be sure of what was going on.

"What do you think is going on?" I asked.

He seemed to be struggling with the handle of the speculum.

"You need to loosen the thumb screw a bit more, then it will come out more easily," I told him.

"Cheers, yeah," he slid it out, "a threatened miscarriage, that's what this is," he said, looking pleased with his clinical acumen and peeling off his gloves.

I left A&E with a scan date for the following Tuesday. The GP's reassuring words and the registrar's phrase, "threatened miscarriage", comforted me. It was a threat, nothing to be afraid of.

Threatened miscarriage isn′t the term he wrote in my A&E notes, nor in the letter to my GP, but I didn't see those at the time. I have since discovered that in my clinical records, my diagnosis was "other obstetric condition". He also wrote, "this lady denies clots". I didn't deny anything, there just weren't any blood clots. I wish he had written down my words, instead of glossing them in a way that made me sound both defensive and unreliable.

*****

Simon collected me and Liberty the following morning. I was silent in the car.

“I know you′re upset,” he said, indicating to join the same motorway junction that I′d been stuck on with Liberty a few nights earlier.

“I′m not upset. I am angry with you.”

He was silent. I sat forming and unforming phrases in my mind for two junctions.

“I′m angry with you. You should have been there.”

“I came to collect you.”

“The next day. You should have taken me to the doctor. You should have been at the hospital. I couldn’t get hold of you on your phone.”

“The signal is often bad across the Mendips.”

I rolled my eyes. As a registrar I had completed a certificate course in family and couples therapy. Eye rolling was not on that curriculum.

“You′ve no reason to be angry with me, Sabina. You are angry about what is happening. But you′re not angry with me.”

“Stop telling me how I feel.” I swore at him, another intervention that had not been on the couples therapy syllabus.

“I′m no good at medical stuff. You didn’t seem worried,” he said, “so I thought you were just going to the GP to get checked out. I didn’t know they would send you to hospital. I had to collect Ranulph. You knew about that.”

“His mother could have collected him. When I told you I was bleeding, you should have come with me, made another plan.”

“You didn’t say bleeding, you said spotting. I’ve never been pregnant. I don′t know what spotting is. If you′d asked me to come with you, of course I would have come.”

“I felt ill in Paris. You knew they might say it was a threatened miscarriage.”

“I didn’t know that. I’ve never heard of a threatened miscarriage. I thought you felt sick because you′re pregnant. You′re the doctor, Sabina. I don′t understand how these things work. You need to explain it to me. All you had to do was to tell me you wanted me with you.”

“We are all friends in this car,” said Liberty from the back, parroting Danielle. We could see the barbed wire that surrounds HQ. I looked at the house, the curtains still drawn in the upstairs bedrooms. Ranulph would still be asleep. We were like strangers to one another. Usually he visited with his elder brother, Alex. Alex and I just got on like old friends, from the moment I′d met him in the middle of the night, crossing a style in a muddy field in my dressing gown and wellies to welcome him to a camping holiday after he and Ranulph had been stuck in traffic for hours. Alex had laughed loudly at the impossibility of trying to make mutual good impressions while squelching through the mud at midnight, and after that, our relationship was effortless. I hadn’t got to know Ranulph equally well. I didn’t want anyone else in the house today. I wasn’t being the woman I′d promised to be at the statue of St Jude. Simon parked on our driveway and put his hand on my arm.

“I′m not a mind reader, love. You’ve got to tell me.”

“Let me tell you now. You need to come to all medical appointments about babies. I′m not doing this on my own.”

*****

When Ranulph woke later that Saturday morning, it had started snowing. I could hear Simon speaking to him, “Sabina′s having some women′s problems.”

“Women′s problems?” I said later, “Why can′t you say it’s a threatened miscarriage?”

“It′s private. He′s just a boy, he′s come for some peace and quiet to revise for his A Levels.”

That afternoon, Simon took Ranulph for a walk to break up the revision monotony while I made paper Easter decorations with Liberty. We cut out pastel-coloured paper doves for each window that could hang by a light thread, so that they seemed to be flying.

“I want to say I′m really sorry, Sabina,” Ranulph came up alongside me, “for what you are going through.”

“Thank you. Not knowing, that′s the worst bit,” I said.

He helped cut and hang paper doves and we chatted, about his A Level revision, about his hopes to go to Cambridge to read theology, about his upcoming Duke of Edinburgh Gold expedition, about his take on St John′s Gospel. By the end of the afternoon, every window had a paper dove in it and Ranulph didn’t feel like a stranger anymore, but more like one of my own. His kindness stilled the uncertainty that hung over me.

*****

The following morning, on Palm Sunday, we went to process with the congregation of St Mary′s in the nearby village, Harefield, behind Mikey the donkey, from the village green to church. Simon found St Mary′s by chance one evening, following a sign for the Anzac war graves. St. Mary′s Churchyard is home to over a hundred First World War graves, mostly Australians who died in No. 1 Australian Auxiliary Hospital at Harefield Park. Every Anzac Day, village school children lay flowers on each soldier′s grave. Some of the school children had joined the Palm Sunday procession. More snow had fallen overnight. Liberty′s new blue tunic stayed in the wardrobe for a brighter day. I wrapped a blanket over her, her small face peeking out from her coat looked even smaller under her scarf and bobble hat.

“I'm cold in the buggy.”

“Do you want to walk with me?”

“No walk. Carry me, carry me.”

We took it in turns, Ranulph, Simon and I, to carry her and coax her to wear her mittens.

“No mittens, no mittens.”

“Now, I've been wondering whether you might be pregnant?” Dawn, the vicar's wife, slipped in beside me, crouching by the buggy to put Liberty's mittens back on.

“Oh?” I said. I wasn’t going to tell anyone and jinx it. I was going to keep it secret for twelve weeks. I wouldn’t get any baby clothes down from the loft. I wasn’t going to tell anyone.

“Last week I wondered. Today when I saw you coming across the green with the buggy, I saw your swollen tummy,” she said.

I didn’t deny it.

“Come on sausage,” she said to Liberty, “keep your mitts on. It's snowing.”

Liberty took them off again, “cold hands,” she said, “cold hands.”

“I'm having an early scan, next week, just to check everything is alright.”

“Think positive, it is going to be good news,'” Dawn said, “a tiny heartbeat. I remember seeing those with mine. Flickering like a little star.” Dawn made and unmade her fist like a starburst. Liberty had her mittens off again and was copying her, making starbursts with her dimpled fingers.

I thought of all the lights at the feet of St Jude, all the desperate cases. I couldn't shrug off the dread that wrapped itself around me like a blanket in the cold. After the service, Simon sat quietly in one of the pews while Liberty ate biscuits with her octogenarian friends.

“Is she allowed another biscuit?” Daphne, who organised the refreshments, asked me.

“How many have you had, Lib?” I asked.

“Daphne is actually ninety, which is nine and zero,” Liberty said, dodging the biscuit question and grabbing two chocolate fingers, jamming them into her mouth.

“I didn’t know about ninety,” she said, crumbs falling onto her coat, “I thought after eighty you get dead.”

“I hope not young lady. I'd like my telegram from the Queen,” said Daphne.

On our way to the car, Liberty skipped through the churchyard surrounded by the dead of all ages.

“People can die at any age,” I said.

“Not children,” she said, “before you can be dead, you have to grow.”

*****

On Mondays Liberty did not go to nursery and I did not go to work. She called them “Mummy Mondays.” We were on our way to the park when I had a call, from a nurse in A&E.

“Just to let you know your HCG is 14,942.”

“What does that mean?”

“You're definitely pregnant.”

“I know I'm pregnant. I'm trying to find out if I'm having a miscarriage.”

“The HCG needs to be rising.”

“How do I know if mine is rising?”

“Have you had it measured before?”

“Only in A&E.”

“Well this is your result from A&E. They might measure it again in the EPAU. They′ll want to see if it′s rising, so write this number down.”

“What′s EPAU?”

“Early pregnancy advisory unit.”

“But is the HCG high enough for eleven weeks?”

“The most important thing is the trend. Try not to get too fixed on a single number.”

“But I only have a single number.”

“I wouldn′t get too worked up about it, if I was you,” she said.

The following morning, the early pregnancy advisory unit had a waiting room full of women, our eyes down as if we were studying bingo cards, foreheads folded into creases, many of us picking at cuticles, or worrying a hangnail, all of us waiting for a scan before twelve weeks. Some of the women came with partners who looked around startled, as if they′d wandered into the wrong changing room. We all avoided meeting each other′s eyes. The social custom of keeping a pregnancy secret until the twelve-week scan begets isolation. If women conspire to keep first trimester pregnancies secret, who do we have to turn to for support when the foetus dies, or threatens to die?

My name was called, and I entered a dark room with an examination couch in the centre, upholstered in black wipe-clean vinyl, was told to take my top off and asked if I had a full bladder.

“This is the place where I am undone,” I thought, “where the probe prises my skin away and bores into my flesh.”

Simon was hovering like a dragonfly. He was directed to sit at the back, away from me and the screen. The ultrasonographer stood to my right, her screen by my right shoulder. She didn’t introduce herself and didn’t make any effort to find out if I had any medical knowledge. She squirted some gel on me that was so cold it made me recoil, involuntarily. She didn’t acknowledge it was cold. As soon as she put the ultrasound probe on me, I could see a small baby on the screen, like a tiny comma. But where everything around the comma was moving, the comma was quite still. I was about to ask if the baby was dead when suddenly someone burst into the room, wearing surgical scrubs but no name badge. She barged past me on the examining couch and slid in behind the ultrasonographer.

“Is that the placenta?” the visitor asked. I looked at them. Surely someone was going to explain who this woman was.

“This is just my colleague. Hope that′s ok.” said the ultrasonographer, without any hint of the rising inflection that would make her statement a question. They talked then, among themselves, and from the level of questioning, I concluded that the anonymous intruder was most likely a newly-qualified doctor, on rotation in obstetrics.

“Right,” said the ultrasonographer, “because we can′t see a heartbeat, you need to go and empty your bladder and then pop back and I’ll do an internal scan for you, just to have a bit of a better look.”

She showed me down the corridor where the loos were. On my way back, I took a wrong turning, and ended up lost in a different corridor, with a gown over my top half, jeans filling with blood and no shoes. A cleaner asked me if I was ok and I started crying. “I′m lost,” I said, “I was having a scan. I think my baby has died. I need to go back and I can′t find the room.”

“Don′t worry pet,” she said, and squeezed my arm. She was the only hospital employee to touch me that day. Her kindness comforted me just as Ranulph′s acknowledgement had. She led me around a small maze of corridors and through a set of double doors that she needed a swipe card to open. We passed several nurses and midwives, all stared at my shoeless feet, but said nothing.

When the internal scan confirmed there was no heartbeat, neither the ultrasonographer nor the intruder spoke to me. I was given some thick blue paper, which looked like a refill pack of the paper hand towels you get at service stations and airports, to clean myself up with. Simon and I were directed to a trio of plastic moulded seats, bolted together and fixed to the floor in a cul-de-sac corridor outside a pair of consulting rooms.

“I don′t understand,” I said “I’ve still got pregnancy symptoms.”

The locum GP had reassured me that this was a good sign.

“The midwife will explain, when I have written my report,” said the ultrasonographer, cold as her gel. It took her twenty-three minutes to type a few lines in her own words and cut and paste a lot more from my A&E notes. She wrote that there was an intrauterine pregnancy with a foetal pole, but no foetal heartbeat. By her measurements, the foetus had stopped growing at ten weeks and six days.

“Hi, I′m Sarah,” said the bright-eyed woman who appeared like a jack-in-the-box from one of the consulting rooms, her voice better suited to calling bingo than to breaking bad news. She wore an Oxford-blue uniform with a fire alarm-red belt and a badge outing her as “miscarriage midwife.” Simon was staring at the badge. I realised then that he didn’t know.

“So, obviously, there′s no heartbeat and the pregnancy has finished,” she began, and continued in an unbroken monologue of which I remember little. I remember looking across and making sure Simon understood and was alright. He was crying. She pushed a box of tissues across the desk at us and I took one out for him. I wanted her to stop talking for a minute so I could hug him. She kept talking.

“I’ve still got pregnancy symptoms,” I said, wanting to make sense of it, hoping she would realise there must be a mistake.

“I’ve still got morning sickness.” Sarah smiled at me as if I was a slow learner. Somehow I had graduated from medical school, having missed what it is like for a woman to miscarry her unborn child. I find it curious that I can still now, decades later, recall the features of transverse myelitis, a neurological condition so rare it affects one in two hundred and fifty thousand people. I can describe the differences between Paget′s disease of the nipple and eczema of the nipple, conditions that are both uncommon. I spent many hours as a student holding surgical retractors and keeping abdominal organs out of the way, observing procedures that I would never carry out. I met and can recall the names and faces of patients with Cushing′s disease, Crohn′s disease and acromegaly. I met pregnant women, new mothers, women undergoing abortions. I must have met women who miscarried. I can′t remember them.

“So, just to talk you through it,” said Sarah, “you′ve got a couple of options. There′s natural, which we′d recommend you go for, where it all comes away on its own or you can have surgical removal of the products of conception, where you have an anaesthetic to recover from and the risk of infection is higher, so we don′t recommend that, but some women prefer it. So, if you go for natural, which we recommend, it′s just like a period and we scan you in two weeks’ time to see if it′s all come away and if it hasn’t we give it a bit longer and scan you again and that′s it for most people.”

“And for others?”

“What do you mean?”

“If the scan shows there is still something there?”

“So, if all the products of conception aren’t gone, then there′s an infection risk, so, we make another plan but it rarely comes to that.”

“How often does it come to that?”

“Not often at all.”

“It was tiny,” she said, showing me the ultrasonographer′s report, “really small, so when it comes away you won′t see anything that looks like a baby. It will just be blood and a few clots.”

I didn’t tell her I had once been really good at embryology.

“Try to jiggle work about a bit so there′s no pressure.”

A court-imposed deadline. Children who needed to know if they were going home to their mother. A mother desperate to have her family back. No jiggling about.

“Natural?” Sarah interrupted my thoughts.

Natural it was then. We went to the hospital canteen before driving home in silence and the smell of coffee still made me retch.

GOOD FRIDAY

I didn’t bleed for the rest of Holy Week. The morning sickness waxed and waned, but my bras were still too tight. I kept thinking maybe there′d been a mistake, maybe the heartbeat was there, imperceptible, but there. But I also knew, that this was wishful thinking. These twin thoughts, a stream of logic and a trickle of hope, flowed through my days.

Throughout Holy Week, St Mary′s choir had been practicing John Rutter′s Requiem Mass.

“You don′t have to go, you know,” Simon didn′t understand why I was stubbornly insisting on a three-hour requiem, intended to accompany reflections on Christ′s suffering on the cross. I wanted to sit in church to honour the child I had carried, the unborn I was still carrying in my womb tomb. As the choir sang, I cried for the life unlived, for Liberty′s sibling.

During the service, there was an invitation to light a candle. I lit a candle for all the moments I′d imagined I had two children playing on the swings, splashing together in a paddling pool. I lit a candle for all the times I′d unpacked the nursery bedding, only to pack it up again. I lit a candle for all the daydreams I′d had of myself singing lullabies, while nuzzling a soft, downy head. I lit a candle, flickering like an ultrasound heartbeat, as the choir sang, et lux perpetua luceat eis, and may eternal light shine on them.

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PRODUCTS OF CONCEPTION

“You may experience some spotting and cramping,” read the miscarriage leaflet, “a miscarriage can start like a period, with bleeding and mild cramps or backache.”

Apart from the on again, off again, microdots of blood that I′d had since the eve of our trip to Paris, no period-like symptoms had yet declared themselves, so after the long Easter weekend, I decided it was business as usual and carried on with my work for the family assessment service. I parked in a side-street that I knew well, as I′d often gone buggy running here with Liberty. Although I knew this part of London, I had never met Mrs Work or the twins before. I re-read the letter of instruction:

Please advise whether it is your view that the children have suffered emotional harm and neglect as a result of the care given to them by their mother. Please assess the quality of the sibling attachment. Please advise on the extent to which there should be contact between the mother and the children and how such contact should be managed.

“She was only popping to the shops,” said Mrs Work, as she opened the door to her studio flat, “so of course I agreed to watch the twins for her. But then she didn’t come back for two weeks. Two weeks. Didn’t know what to think. Was going out my mind. Didn’t know what was going on.”

Mrs Work carried on talking, an unbroken tide of troubles, as I entered her home. I saw that her flat overlooked the supermarket that Mrs Work′s stepdaughter had been “popping to.” As I took off my coat and folded it over the back of the chair, she gestured for me to sit on, she told me that wasn’t the first time that her step-daughter had run away.

“The first time she was fifteen. I didn’t know her then, but her dad told me she′d run away after her mum died. Ran away again after Mr Work and me got married. We often had the police looking for her.”

She passed me a typed list of dates.

“You can keep that copy. I typed it for the social workers, so it stops at seventeen. She did seem to settle down a bit for a couple of years. We didn′t see her for nearly a year after her twenty-first. One day to the next, she was gone. She came back at Christmas to surprise us.”

Francesca, the slightly smaller of the twins was peeking at me from behind the sofa, hiding again when I caught her eye.

“Boo!” I said, when she peeked out again.

“And that was a surprise,” remembered Mrs Work, “that Christmas, especially with her bringing the twins. We had no idea she was expecting.”

Molly, Francesca’s twin, was climbing over the back of the two-seater sofa, jumping over the back to her sister who had upturned a box of Duplo bricks. Four small hands worked together to build a brick tower and then fought to demolish it. At first glance, Francesca and Molly looked as if they might have been little friends from the Ducklings room, laughing and squealing and pulling each other′s limbs.

“Gently, gently,” said Mrs Work.

On my way home, after meeting the little girls and their step-grandmother who had picked up the shards of their lives, I popped into the supermarket. Suddenly, someone jabbed me hard in the lower abdomen with the handle of their shopping trolley. When I looked up to see who it was, there was nobody but me in the baking aisle. The pain stabbed me again and only then did I realise it came from inside me. As it subsided, a new pain started, pulling at my lower back, as if pulling a cork from a bottle, twisting against stubborn resistance. Blood gushed, pouring down my legs, pooling on the lino. I noticed that the lino was camouflaged, a military-house magnolia background with an overlay spatter pattern in various shades of blood. I imagined supermarket designers selecting floors that would disguise spills from the deli counter.

I called Simon, “I′m in Waitrose up the road. I don′t think I can drive home.”

“What′s wrong love?”

What could I say? That I was having a miscarriage? I′d been having one for over two weeks.

“I don′t feel well. I think it′s all coming away.”

“Jump in a cab,” he said, “I’ve almost finished here. Let me pick up Liberty and we′ll see you at home. I can pick up your car later.”

But I was afraid to make a mess in the back of a minicab. Leaving my basket by the cheese straws and my car in the carpark, I walked the short distance to HQ. When I got in, sticky with blood, I ran a bath. I lay in the bath and blood gushed out of me, like a garden hose. Then I started passing clots the size of fifty pence pieces.

“Is it meant to be like this?” Simon asked, “were you expecting so much blood?”

“I don′t know.”

I was a doctor. I was a woman. I couldn’t help but think that I ought to know how much blood there is from a dead foetus. As I cleaned the bath, I fished out the clots from the drain and looked down at the pieces of notochord. I turned the hot tap on again and scrubbed the products of conception from under my nails.

Later I lay on the bed with a hot water bottle, bleeding and reading the miscarriage leaflet I′d been given by Sarah.

“Well, that′s the miscarriage over,” I thought, as I went to sleep.

Except that it wasn’t. For the next ten days, I bled, on and off, at inconvenient times and in inconvenient amounts, soaking through pads, seeping into underwear, staining work clothes and the driver′s seat of my car. Oozing my uterine contents out over the weeks was a social transgression. I am meant to end at my skin, that is my boundary, not to leak blood on the Underground and in supermarkets, not block the bath plughole with pieces of flesh. Simon, alarmed at the amount of blood and the many days of bleeding, wanted me to go back to the hospital.

"This daily bloodbath doesn't seem right," he said. The leaflet was vague, telling women to contact the hospital if the blood loss was "offensive." I agreed to call for advice, but the following morning, the bleeding and pain stopped.

"I didn't realise what a miscarriage was," Simon said, that evening.

"What do you mean?"

"I didn't realise it was the loss of another human being. I thought it was just a bad period."

"A bad period?"

"Mum′s Irish Catholic. In our family we didn't talk about women′s problems," he said.

"For goodness sake, stop calling it women′s problems," I said.

"I didn't recognise what we lost, I didn't recognise it as a human being, until that scan room," Simon said, "I did it badly. I got it wrong."

That evening, I typed up my notes from my home visit and began to draft an opinion section. I wondered what the judge would decide. My shirt began to feel wet as I typed. My breasts had begun to leak milk. Nothing I had read warned me about this possibility, but it made sense. Oxytocin, the hormone that triggers contractions during labour, also triggers milk production. My body was doing all the right things at entirely the wrong time.

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The following afternoon, I went for my repeat scan at the early pregnancy advisory unit. When I arrived at the clinic, there was a new poster on the wall, "How we are improving the patient journey." The patient journey of a miscarrying woman was full of roadblocks. Inadequately informed doctors giving false reassurance. Junior doctors left on call in obstetrics with no recourse to an ultrasound scanner and no knowledge about how to use one. Women, bleeding out of hours and having the gall to call it an emergency, when really, it was no big deal, just a threatened miscarriage. The allotted clinical slot for scanning those is next Tuesday. Tuesday, before midday, just past the waiting room full of women waiting for their 20-week scans, go up in the lift with women who looked overripe with pregnancy, massaging their bumps between contractions as they made their own patient journey, from canteen to labour ward.

I lay on the examining couch in another darkened ultrasound room, my jeans unbuttoned and shoved down to my hips, bracing myself for the cold gel on my abdomen. The gel was warm. I looked over to the small screen, saw my empty uterus in pixellated monochrome and caught the sonographer′s eye.

“Thanks for warming the gel.”

“A miscarriage is bloody awful enough,” she said, “You don′t need cold gel as well. All the foetal tissue is gone. No sign of an infection.”

As I left the room, the sonographer squeezed my shoulder.

“I′m really sorry. I wish you a better outcome next time.”

In the adjacent room, the miscarriage-midwife was cheerful.

“Your products of conception are all gone, so that′s good news. You won′t have to come back again.” Sarah closed my file.

“I had labour pains,” I said, “and that took me by surprise.”

Sarah remained upbeat, “Yeah, a lot of women get cramping. All normal.”

She looked back down at the cover of my file, resticking my name label where it was curling at the edges and coming away from the cardboard.

“No, not cramping,” I said, “it was exactly like labour.”

“Yeah, like a heavy period,” Sarah said, “most women tell us it′s like a period.”

She looked at me as if that settled it.

It was labour, I wanted to say, with big clots and my baby′s notochord stuck in my nails.

But I said nothing. Spineless. Like my unborn.

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In the early summer of 2013, in the months following the Paris miscarriage, I started waking up at or before four am every morning and could not get back to sleep. I found myself in tears over small things: a lost rabbit in a children′s story and when *Never Gonna Give You Up*, by Rick Astley that had been top of the charts on my 13th birthday, played on the radio. I didn’t want to see my GP, who I imagined would only have time for a tick box questionnaire that would confirm I was depressed and lead to a prescription for antidepressants. I was worried that antidepressants might harm a growing foetus.

Two weeks later I found myself in the waiting room of a private mood disorder specialist. I′d looked him up online. He′d had a distinguished career as a clinical academic in a London teaching hospital and his website showcased an imposing collection of peer-reviewed publications about depression. I thought I′d be in good hands. So it was a surprise when he hurried me through a tick box questionnaire, designed to be used by time-pressed GPs, and handed me a prescription for antidepressants.

“So if these don′t do the job in six weeks or so, give my secretary a ring,” he said, getting up to see me out.

“The thing is,” I said, “the miscarriage I mentioned, I think this depression is related to that.”

“Do you?” he said, pushing his gunmetal-grey half-glasses along the narrow bridge of his nose. “Do you really think that? Because your presentation seems biological to me, it can be quite simply managed with an SSRI.”

“The miscarriage, it wasn’t the first one,” I said, noticing his nasal hairs curling like the electroencephalogram cables used for measuring the rhythmic electrical activity of brain cells. Maybe I had an unconscious wish that he could look into tiny tangled neurons and identify which ones were misfiring, and why. The mood disorder specialist looked at his watch.

“Miscarriages are quite common. It was quite early, wasn’t it? I′m sure you′re not still upset about that.”

“I′m nervous,” I said, ignoring his pointed glance at the clock. If I′d strayed over the allowed time, his secretary would add it to the bill.

“About antidepressants? But you′re a psychiatrist!”

“I′m nervous about taking them if I get pregnant. Before I know I′m pregnant. I′m worried about damaging the foetus.”

“It will be fine,” he said.

Although I accepted his prescription and paid his bill, I listened to my gut instincts over his expertise and did not take antidepressants while I was trying to conceive. Sixteen months later at an International Congress organised by the Royal College of Psychiatrists, I would attend a lecture on psychiatric drugs in pregnancy. They were called “generally safe”, but the ones the mood disorders specialist had prescribed came with an increased risk of heart defects and spina bifida when taken in early pregnancy. I was glad I had trusted my instincts.

NETWORK

Like a mole emerging from an underground tunnel, I came out of the Underground station onto Finchley Road and glanced at the grocer's swollen Turkish figs.

"Later," I called to the grocer, knowing I'd eat them straight out of the bag if I bought them in the morning. My heels made cantering clicks as I hurried past Karnac bookshop, scanning the A4 fliers that fluttered like colourful Tibetan prayer flags in the window, advertising conferences on "Lust and Power" and study afternoons about Winnicot. A fifties playbill font shouted out about a Jung Reading Group, but my eyes were already flicking over the rows of zeros in the neighbouring estate agent windows.

My right hand reached for the metal handrail that I used to hoik myself uphill in shoes chosen for style over commuter comfort. Halfway up the hill was a small primary school advertising Mandarin lessons. The school had no garden, so once a week, schoolchildren came to plant seeds, tend vegetable beds and see what creatures inhabited the wildlife pond in the gardens at numbers 12 and 14 Maresfield Gardens. Their joyful shrieks and the stage-whispered shushing of their teachers, a welcome interruption to the silent writing of reports for the Family Court.

There was a woman at the top of the hill, turning into Maresfield Gardens. She had dark shoulder-length hair and wore smartly distressed jeans. She held her burgundy leather folder with French-manicured hands. The woman was striding towards a flock of MSc students. I recognised them from the library across the road from the clinical teams. My colleague and team manager, Ben, was an academic as well as a clinician and he convened their modules on infant attachment.

The woman was a lawyer. I didn't know her, but I recognised the type: casually elegant, professional blow-dry, taking calls from clients while getting a weekly manicure, incisive mind, lacerating prose. I wondered if we were going to the same meeting, the one about the Winchesters.

I crossed to the other side, not to avoid the lawyer, but to admire the house along the street. Slowing down, passing the plane trees now flecked with yellow, I looked up and ogled the big house. Since coming to work in Hampstead, I had become an interiors voyeur. I knew the house's secrets and patterns. A giant Christmas tree, one that pulsed with lights like a hundred embryonic hearts seen on ultrasound, would be delivered soon. The annual festive tree lit up hallways and a stairwell to the upper rooms. The window boxes had been freshly planted. On some days, uniformed staff would be taking a food delivery inside and I would steal glances at the art in the hallway, but this morning their front door was shut. I looked again at the black window boxes crammed with pansies, their jolly faces looking back at me. They'd caught me. A peeping Thomasina. One of my colleagues once asked me if I thought domestic interiors gave biographical clues. I had said not, thinking of our military-regulation magnolia walls at HQ.

As I entered the neighbouring gate to workplace, I saw Ben's bicycle chained to the bike rack. Ben, who had been so kind to me on the phone when I called from HQ, was the team's only full-timer and was also tasked with managing our team, negotiating with lawyers, social workers, parents, commissioners and many others on our behalf, sorting out everything from annual leave requests to contract negotiations. When he went on holiday, cycling through Devon, I had some small insights into just how much bureaucracy and frustration he dealt with every day, so we could focus on our individual assessments and thrash out joint recommendations.

Each member of our team came from a different professional background. Although we typically paired up to see families, with one clinician seeing the children and another focusing on the adults in the family, the entire team's experience and expertise was drawn upon in our weekly clinical discussion and we consulted each other throughout the week before reaching recommendations. The family court asked us to consider children's current health, development and how they were getting on at school, at home and with friends. We were asked to explore significant changes, like the death of a parent, the impact of fleeing from war to seek asylum in the UK, the adoption of younger siblings, the sudden loss of health, of financial status, of hope.

I thought about hope a lot. Our clinical service represented the last resort for many families, perhaps it was the last place where there was hope. The people a child should be able to depend on more than anyone in the world should be their parents. When that trust is broken, there can be fatal consequences. Nobody makes the decision to refer a child to the local authority lightly, just as no social worker in the local authority made the decision to go to court and ask for a care order lightly. Social workers were often vilified in the media when children were not removed from abusive homes. Most child homicides are caused by a child's parent or stepparent. Usually, mothers act alone. And usually, someone in authority, the police, social workers, teachers, paediatricians, child mental health professionals, school nurses, health visitors, someone, somewhere, knows something isn't right. Fatal abuse can be one violent incident, like shaking a baby or can be as a result of prolonged extreme neglect, including malnourishment, starvation, little children drowning in the bath because they were unsupervised.

While my team tried to hold on to hope for every family we saw, we also read the headlines about social workers failing to protect children, saw paediatric colleagues resigning, read enquiry after enquiry concluding that poor coordination and communication between services meant that opportunities to prevent fatalities were missed.

In 2000, during my first job as a junior doctor in child psychiatry, the world learned the news that the eight-year-old girl, Victoria Climbie, was starved and tortured to death by her great aunt and the great aunt's boyfriend. Several health and social care agencies knew about Victoria. After Victoria died, an enquiry found that numerous chances to intervene and prevent her death were missed. Professionals were urged to be more sceptical. Children can seem happy in abusive homes. The parents who neglect and kill their children do not look like monsters. Extreme abuse is easy to recognise, but the grey areas that our team worked in, were harder. The legal framework, the

Children Act, was updated in 2004 in the aftermath of Victoria Climbie's tragic death. The courts we gave expert evidence to, used the Children Act to ask us specific questions. We were tasked with identifying parents who could benefit from help, and also those children who needed new caregivers.

I looked up at the two purple-bricked, gable-topped Victorian semis, Numbers 12 and 14, connected at all levels except the second floor, like a pair of conjoined twins. Anna Freud′s father, Sigmund, bought a house along the street, number 20 Maresfield Gardens, when he and his family fled Austria in 1938 and came to Hampstead. It was in the house that I was about to enter that Anna Freud observed the effects on children of deprivation of parental care. I climbed up the stone steps and wondered if Anna had ever felt as daunted as I did about what she′d find across the threshold. Anna Freud was one of the mothers of child psychoanalysis. Anna Freud, who had lived with her family down the road, set up the Hampstead War Nurseries for children made homeless by bombing. Anna bought the twin houses in 1952 and set up the Hampstead Child Therapy Clinic. The clinic was renamed The Anna Freud Centre a year after her death in 1983 and, in the houses that bore her name, the team I worked in was commissioned by a north London borough council to assess children and parents who were in court proceedings with the Family Court. I punched in the door code and made my way to Room 12.

In the middle of Room 12 was a boardroom-style table, facing large windows with views onto the gardens. The room was probably a dining room when Maresfield Gardens was a home and I could imagine guests at a dinner party. The rest of the room was set up like a playroom: a wooden dolls house, boxes of board games, tubs of pencils and a small table all had set places. As I checked the toy supplies, my eyes were drawn to the recessed balcony where the winter sun was highlighting ornate twists in the iron railings and made the skeleton trees in the garden beyond look like x-rays on a light box. Although the rooms bore the impressions of domestic life, they had not been family homes for many years.

While I was setting out the chairs, Jessica Hebblethwaite, Jess to her colleagues and patients, arrived, her cheeks flushed pink from her brisk walk from the station. Jess, a nurse by background, with many years of experience on an inpatient unit for teenagers with eating disorders, was also a trained psychotherapist and worked part-time in an epilepsy clinic. This diverse skill set meant that this workload often flipped from manageable to overwhelming. When this happened, she became quieter and her court reports grew longer. Jess loved to dress in the vintage fashions of the 1940s and wore a uniform of polka dots, apart from her court appearances when she wore a black skirt suit. On that morning Jess was chatty and took out a drawing done by one of her children:

"Can I show you this? It's meant to be me. Can you see the likeness?" I smiled in agreement. Other drawings by her two young children were on the wall above her desk. I loved working with Jess: so sensible, kind and pragmatic.

"I'm going to pop up to the office and get the case file. Shall I take that picture up for you?" I asked.

Jess nodded and I climbed the three flights to our team's attic office, passing signs explaining that the Anna Freud Centre was a national children's mental health charity. There were other signs and a leaflet making clear that the team are a specialist, independent expert witness service, bringing together expertise in social work, therapy, psychology and psychiatry. We saw all our patients downstairs, but the administrative work took place upstairs in the attic office. The attic office was like a four-man bell tent. Five, sometimes six of us worked there, sitting facing three walls of the room, a balcony spanning the other. As I came through the slit-like door, warped out of its frame, I saw our colleague Marco, sitting with his back to me.

"Good morning," said Marco, without turning round, when he heard me coming into our attic office, "Are you any good at sudoku?" The Guardian was spread out in front of him, covering his keyboard like a blanket, the sudoku half-completed. In the time it took me to hang up my coat and find some blank paper, he′d taken a call about giving a second opinion about a teenager′s fitness to plead and a second call about organising a training workshop in Rome. I pulled out my chair from the desk next to him. He cradled his phone under his chin, pushed a news article across at me.

“You should read this,” he said, pushing a G2 feature about post-menopausal women, successfully conceiving in an Italian clinic, onto my desk. Marco grinned like a boy with a secret in his school bag.

“I′ve got cake,” he said. Marco′s wife Lizzie, a sculptor who we often heard about but didn’t meet, baked.

“To fill the empty nest,” Marco said. His eyes were dark brown, and he narrowed them for emphasis.

“I won′t,” he said, opening the tin and patting his stomach, which had waned like an old moon over the summer, since he started swimming in the men′s ponds. Marco regularly brought cake to our weekly team meeting, cake which he declined while patting his shrinking tummy.

″Swimming,” he said, ″making a real difference.” The badge on a lanyard that was slung across the back of Marco′s chair read, “Consultant Clinical Psychologist”. It didn’t say that he loved art house films, was wise and thoughtful and started his days with a swim on the Heath and a sudoku and multitasked like nobody I′d ever met before. It didn’t say that Marco’s breath always smelled of mints and or that Jess had once confided that she wondered if he ate mints to sweeten the bitter taste of all the sorrows that he often said he that could taste when he read aloud from the case files.

After grabbing the file from my in-tray, I came back downstairs. Although there were many moments when I felt at home in Room 12, sometimes more at home than I felt at HQ, whenever I left the room, nothing of myself was left, no jacket slung across a chair, no part-read novel at the foot of the sofa, no half-drunk coffee. Room 12 was like a theatre stage set, going upstairs was visiting backstage. Yet even in the attic office, where the team did not see patients but discussed cases and wrote reports, none of us had the usual family photos that my medical school friends have in their workspaces. Jess had the drawings by her children, Marco shared his wife′s baking, but that′s as far as we let our families in. They were with us in these token forms, held in mind, but never seen.

As a team, we spoke a lot about children being "held in mind." It was a core part of the attachment theory that scaffolded so much of our decision making. Children need to feel known, understood and safe. Babies who experience this are able to explore the world with confidence and form good relationships when they are older. When children had not experienced a secure attachment in their earliest lives, other caregivers and therapists helped those children feel held in mind and cared for, to try to repair the emotional damage of their early experiences.

When I arrived back in Room 12, Jess had moved a chair so the sitter wouldn′t have the glare of the winter sun in her face, raided the biscuit tin for unbroken ones and put them on a plate. I poured water into beakers, a gesture of ersatz hospitality as Jess was bringing the attendees from the waiting room, for what we called the network meeting. Jess introduced herself to the family′s social worker and her boss, who had together recommended making the application to the family court; to the children′s guardian, who was appointed by court to make sure that the local authority arrangements and decisions about children protect them, promote their welfare and are in their best interests; to the manager from the residential foster home where Mandy had been placed; and to Mandy′s key worker. Mrs Winchester, the children′s mother, and her solicitor hadn't arrived.

They′re scripted, these meetings, at least the beginnings of them are. One of us will introduce the Family Assessment Service and explain that we are independent court-appointed experts, nothing to do with the local authority. I wonder what families made of this, especially as the team had come to know many of the local authority social workers through previous cases and they often greeted us with obvious recognition. Our standard practice was to introduce our administrator Kathleen and then go around the table, making further introductions. We explained how we would work, that one of us will see the child or children and the other team member would see the adults: parents, foster parents, grandparents, teachers and health professionals.

As the team′s psychiatrist, my job was to diagnose pathology that could otherwise be missed or mistaken for something else. When I trained in psychiatry, I was taught to ″take a history.” Something in the phrase sounds like an interrogation and calls to mind the police taking statements. I′ve adopted something less interrogative and more maternalistic over the years. In many clinical encounters, there is a story exchange. Parents tell me about their teenagers in the domestic gothic genre: all the horror in the home. Teenagers tell me their side of it in a close-confiding confessional, often in whispers, if I′ve got it right. When I′ve got it wrong, it′s like a detective story with clues cleverly hidden and many false trails. My role involved teasing apart of stories, listening out for patterns, searching for causes. My job too was to keep quiet instead of speaking over,. It was a job of listening to ideas rather than rushing in with my own. I wish I was better at that.

Jess and I had arranged that for this case. She would "do the intros" and I would sit quietly and get a feel for how the meeting would unfold. In the assessment service, most of the stories were in conflict. Often the strain between social workers and parents was palpable. Fear flickered across most parents' faces; many became angry. Social workers had their lines too. They often spoke about how they have tried to work with a family, to offer support. They talked about non-engagement. The parental script was of being misunderstood, of trying to access help and of receiving the wrong type, too late, of being vilified and blamed, and let down by the system. We held network meetings to allow everyone a shared overview of the case, an opportunity to lay the cards on the table. It was also a business meeting, where we coordinated diaries, set up appointments and noted deadlines from court. We told families we would meet them to discuss the report before filing it.

My job was to read between the lines of these scripts, to begin to discover implied meanings. It was also my first chance to make a good impression on a family, there because a judge had ordered an assessment. Jess and I didn′t have unbounded time to make recommendations that might change a life forever. The court deadline was ten weeks hence. Minutes mattered. The more rapport I could build at the network meeting, the easier the assessment would be.

As well as building rapport, I build walls of distance, between the families' lives and my own. I see patients in rooms that are homely, but not home. I feel at home in clinical surroundings, perhaps because I grew up in them. I was seventeen when I went to medical school and twenty-three when I first lived in hospital accommodation as a newly-qualified doctor. But feeling at home was a world away from being at home. Whenever I left a clinical room, I took everything of myself with me, stripping the space for the next inhabitants: there was no jacket slung across a chairback, no part-read novel at the foot of the easy chair, no half-drink coffee forgotten on a table.

The room at the Anna Freud Centre looked as if it could be someone′s living room, but it was a clinical space we inhabited, the families and I, for a time that was directed in law. In the past, care proceedings could drag on for many months, even years, leaving children′s futures hanging, uncertain. The wheels of justice are often said to turn slowly, but for too many children, they had ground to a halt. These proceedings take place in private; the public are not permitted to be present.

In 2011, the Independent Family Justice Review made a significant number of recommendations for reforming the family justice system, aimed at cutting delays to children. As a result of these recommendations, the system underwent significant and wide-ranging reforms, including a maximum 26-week time limit for completing care and supervision proceedings.

My team, and others, including the local authority, referred to these 26 weeks as ′the child′s timescale′. It meant in practical terms that the time allowed to us from the network meeting to filing our final report was ten to twelve weeks. Everything we did had to fit into those weeks.

I felt under time pressure too, caught up in the hands of my biological clock. I'd had a blood test that measures a woman's reproductive time not in hours but in measures of ovarian reserve. While I worked against the court's clock, my own egg timer was slowly running out in the background, shaming me for my years of being a poor watchwoman.

I was pulled from these thoughts when the tall woman with the burgundy bag walked in. I recognised her as the solicitor I′d seen outside. It wasn't just the briefcase and suit, her hair in a chignon, but the way she strode in with confidence and sat at the head of the table, took out her notebook and ink pen. Before anyone else could speak, she said, "I don′t yet know everyone here. May I suggest we go round and introduce ourselves?"

It was Jess′s line, and being off-script so early might have flustered someone less experienced.

"What a good idea," said Jess, "Would you like to start?"

"I′m Victoria Winchester; my solicitor is running late. My children are in care and I′m here to get them off the interim care order and back home."

An interim care order is an order the court can make before the final hearing of an application by the local authority for a permanent care order. Both of Victoria′s children were in local authority care while Victoria attended mental health and addiction services.

"Jess Stephens, I′m a mental health nurse and therapist. I work with Dr Dosani," she said, pointing over at me. I was cringing at my misjudgement. I hadn't passed the lawyer on my way to work, I′d passed our new case. It was a presumptive conclusion, based on my value judgements about appearances.

I thought of how I'd been taught to look at patients. The heading *Appearance and Behaviour* is the first line of psychiatric mental state examinations. The ability to describe how patients look and act is something we learn as medical students and are examined on as postgraduates. These trained observations start the moment I see someone. Simon would probably call it a drill: Is that patient up and dressed, or still in bed or in nightwear? Are we able to greet one another, make introductions, shake hands? Are their hands warm, sweaty from anxiety, cold from poor circulation? Are they dressed appropriately for the weather and the occasion? Is there a tremor? Is it fine or coarse? What is the frequency? Can they sit still or are they pacing? Are there movements suggestive of side effects of medication? Does their face react when we speak about sad and difficult things or is it mask-like? Do they giggle out of nervousness or laugh in a way that is persistent, giddy and infectious? When they speak, do they take turns in conversation? Monosyllabic or uninterruptible? If the patient hears voices, do these voices address the patient, or speak about them in the third person? Do the voices provide a running commentary on their actions? Does what they say reflect the patient's mood?

How much do appearances matter? Sometimes a lot. Depression, for example, can be a distinct diagnosis or it can be part of other physical conditions. A person who feels depressed, but also has a thinning hairline, missing eyebrow hairs, a slow pulse and thickened neck has several tell-tale signs of hyperthyroidism. In a different patient, a fatty hump between the shoulder blades, together with purple streaked stretch marks tell me that the patient has probably got Cushing's syndrome. I was taught to look for these visual signs when I trained in medicine at Barts, and have kept the habit of making a brief visual assessment of everyone I meet.

Psychiatry is a branch of medicine, so it is perhaps unsurprising that I was again taught to look at and comment on the appearance of every patient. In court and in clinic, the evidence of my eyes and my interpretation of what I see were given weight. But looking back over my training, I realised that I had learned the unhelpful and often pejorative practice of making value judgements based on what I was seeing. When I first met Simon at Catherine's birthday lunch, I observed his booming voice and surmised it to be indicative of early sensorineural hearing loss. This turned out to be true. It was brought on by exposure to repetitive blast noises during military combat. But I got something else wrong. When I heard his confident staccato speech, I incorrectly assumed he was a surgeon, used to giving clipped instructions so that an operating team could work quickly to save a life.

Ironically, it was my own experience of being looked at and misjudged that inspired me to become a psychiatrist. As a medical student, I spent six months being treated for depression at Guy's Hospital. Towards the end of my time as an inpatient, a mock exam was being organised for doctors training in psychiatry. The junior doctors were practicing for their membership exams of the Royal College of Psychiatrists. I was offered £20 to take part in the mock exam as a patient. The doctor-in-training who had been assigned my case rattled through a formulaic series of questions and then abruptly leant across, grasped my sweatshirt and fired a trio of questions at me, "Why do you wear this? And why don't you wear make-up? Don't you like to look feminine?" I tried explaining that being an inpatient wasn't the sort of social occasion that called for lipstick, but he wrote down, "Does not like to appear feminine."

"Do you have any job?" he had asked me next.

"I'm a medical student," I replied.

"What?" he asked, "What are you studying?"

"I'm studying to be a doctor."

"What?" he asked again, "You want to be a doctor like me?" He grabbed my sweatshirt again, as if he wanted to hold on to his preconceptions.

No, I thought to myself, I want to be nothing like you.

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Yet here I was, almost twenty years later, looking and making value judgements. Had I forgotten how vulnerable it was to be a scrutinised? Becoming an object of obstetric scrutiny reminded me.

“We are from the Family Assessment Service,” Jess continued, “and our role is to assess the emotional needs of your children and your capacity to meet those needs. The judge has asked us to give an opinion on treatment and placement options, that the family court will consider. Dr Dosani and I understand that this can be a very frightening time for families, but please know that you are not on trial. We go into this with open minds.”

“I′m June and this is my manager, Nicole. We′re social workers from the local authority. We’ve been working with the Winchester family for two years. Victoria has two children, Mandy, aged fourteen, and Adam has just turned five. The children are subject to an interim care order and there is a final hearing on 23rd December.”

This rehearsal of facts stripped of feelings was usual, serving as a marker to the professionals in the room to retain their professional detachment. Jess and I knew from the court reports that Mandy′s school attendance had been patchy since her move to secondary school and had dwindled to her being in school around a third of the time. Her brother Adam had started primary school but had been in class only a handful of times. When he was in class, he was described by his teachers as disruptive, unable to sit still for carpet time, wandering around the classroom and disturbing other children. More than once, social workers had found both children at home, their mother lying drunk on the floor. Over the past year, Mandy had started to cut her arms. She had stopped playing hockey, having previously been on the school team. She ran away, staying away from home overnight. The police said she was associating with a gang on a local estate. Victoria couldn’t keep her in. Mandy had been sexually assaulted by a man in the gang who she thought liked her. When the police tried to tell her mother, Victoria was too drunk or stoned to understand what was being said. Mandy had told the social worker that she felt so sad, she wished herself dead. After a year of supportive interventions, this represented a turning point for the local authority. The social workers, June and Nicole, had gone to court to initiate care proceedings.

By the time of the network meeting, Mandy was living in a secure residential home for teenage girls, while the court adjourned for expert evidence to help the judge to decide whether she and Adam could go home to their mother. Adam had been placed with a foster family and was said to be settling in there. It was written that they found him lively, but they liked him. He was attending school, but struggled to learn, sit still and focus. It was unusual not to have a father at the network meeting. It was more usual be for a father to be assessed as well. The Family Court was not concerned with finding fault or apportioning blame to parents and stepparents, but made decisions in the child's best interests. The Court was concerned with where, and with whom, those interests would best be met.

My work was full of stories that didn't make sense at first reading. Taken at face-value, it would have been hard to reconcile the story of the inebriated woman lying on the lino with the woman who sat across the table from me. That dissonance sent questions running through my mind. What cruel fates had brought Victoria to this table? Why was this happening at this time? Had there been any concerns about her mothering when Mandy was younger? Would Victoria be able to use any help offered now?

"I'm pleased to meet you," I said to Victoria, "although I am sorry it is under such difficult circumstances for you and your family. Although you will meet the two of us, Jess and I are part of a wider team. We meet as a team regularly, talking to our colleagues about you and your children. When we write our recommendations for the court, our colleagues will work with us to consider whether those recommendations are the right ones, if anything needs to be added or changed, that sort of thing. As Jess has said, she will assess Adam and Mandy, including seeing them together, and I will try my best to get to know you, Victoria," I said.

The reports that Victoria held in front of her were damning, but it was my role to examine everything critically, to see if words matched behaviours, to look for patterns and also to use psychometric tests and some standardised measures. After the meeting had ended and social workers and solicitors had negotiated umbrella shares for the walk back to the station, we stayed behind, Victoria and I, to find a mutually convenient time to meet. She looked at my raincoat,

“Lovely coat,” she said, “from M&S?”

I nodded.

“Emerald, suits your eyes. I tried that one on, but it′s too bright for my colouring.”

She smiled at me.

“This time next week any good?” I asked, covertly sniffing to see if I could smell alcohol or cannabis. I couldn’t.

Her diary was a line-up of assessments with drug and alcohol counsellors, AA meetings, appointments with social workers, briefings with solicitors, a review at her son′s school, health checks at her GP, therapy with the community nurse, outpatient follow-up from the psychiatrist, visits to the residential unit that was a two-hour train ride away.

“I′m glad I got you. You’ve got kind eyes,” she said. “Feels like I can trust you. Really talk to you.”

“I′m glad you feel you can trust me, but I need to be really clear. Please keep in mind that there′s something different about coming here. This isn’t like seeing a psychiatrist in an outpatient clinic, where everything you say stays within those walls. Here, nothing is confidential; everything we talk about is for a report for the judge.”

″I get it,” she said.

Although I explain this to every family, many families express a sense of betrayal when they see the court report. I grappled with how I might convey how intimately I would probe her life, how emotionally confiding that might feel on her part contrasted with the detachment with which I would make my assessment.

‘This isn’t therapy,” I said, “it′s an assessment, but I always hope that talking and thinking through might feel therapeutic. Some parents find that even though this is for court, the chance to talk, to be open to challenges, to try to make sense of it all, is helpful.”

I entered the appointment time into my diary and she wrote down my name in hers.

“What′s your first name?” Victoria asked.

“Sabina.”

“Can I call you Sabina?”

I nodded. Titles can reinforce hierarchies that can get in the way of a good assessment. At HQ I was usually introduced as “-and Sabina”, as in “Colonel Simon and Sabina”, an appendage, or as my security pass insisted, a dependant. In court, I was Dr Dosani and sometimes Ma′am. As a mixed-race woman, I didn’t always fit their appearance template. In courts and in hospitals, I often needed to use my honorific where my male colleagues didn’t, or I would be misidentified.

“Call me Vicky,” she said, shaking my hand with her freshly manicured one. I saw her out, the stone steps shiny with rain, her eyes wet with tears.

STORY STEMS

Although Jess was assessing the Winchester siblings, Adam and Mandy, the Court specifically asked if Adam had an attachment disorder or attention deficit hyperactivity disorder. Making these diagnoses was my expertise, so I arranged to see Adam and then observe the family jointly with Jess at some of Victoria′s family contact sessions, supervised by the local authority.

On my way to Adam′s primary school, I stopped off for a blood test of my own. I′d been feeling tired, and my GP wanted to check that I wasn't anaemic from all the blood lost during the miscarriages. When I was a newly qualified doctor, one of my jobs each morning was to take blood samples and label the laboratory forms and samples with patient names and their dates of birth. Writing their names over and over, my gloved fingers sometimes smeared bloodspills across the laboratory test request forms. In the next hospital I worked in, there was a phlebotomist who took the blood and a machine that printed small labels, that I stuck on the forms and put in the phlebotomist′s tray. I can still remember the names of many of the patients from the first hospital. The act of writing, inking names on the blood-smeared forms, is a materiality that I lost when sticking labels. Of course, pre-printed barcode labels are safer, cleaner, more accurate, but my hand had not traced those patients' names, they too became lost to me.

After my own blood sample was drawn, scanned and processed, I walked to the Underground. I remembered Mosque Auntie teaching me that in Arabic, blood is "Al Dam", which she pronounced "Ad Dum" or Adam. At my Church of England school in religious studies lessons, I learned that in Hebrew, "Adam" means the first human, made from the earth, then condemned on earth.

Adam Winchester′s short life had been one of witnessing violence between his parents, then his father′s arrest and imprisonment, seeing illegal drugs used in his home, criminality within the wider family, two uncles in prison and many missed schooldays. I had read in his report that no learning disabilities had been identified by educational psychologists and that the developmental paediatrician had noted poor dental hygiene.

I had read too that, after the interim care order, Vicky had run away with her son and hid him in a B&B on the South Coast. The owner wondered why Adam wasn't in school and had told the police the boy looked "feral and uncared for". When the police came, Adam was pulled out from Vicky′s arms. The police thought he had eczema, but when he was medically checked over, he was found to have scabies, a skin infection caused by mites that burrow under the skin, causing a very itchy rash. Severe scabies, as Adam′s was, can be a sign of neglect. His headteacher had made a bulleted list of challenging behaviours, which included threatening to jump out of the classroom window, pushing other children, and grabbing the throat of a reading volunteer. Adam was five years old.

I lurked outside his school playground, leaning against the railings, trying to blend in. A teaching assistant had shown me Adam′s photograph and I scanned the playground for a boy matching the picture. There were dozens of five-year-olds, all in grey trousers and red jumpers, moving in Brownian motion. I spotted Adam ricocheting off a wooden fire engine, bouncing towards a hopscotch area. We hadn't met before. I wanted to observe him playing and in class but didn't want him to know I was watching him, so that he didn't change his usual behaviour. Two girls were playing hopscotch. He grabbed the marker they had thrown down to hop around and flung it towards an Astroturfed area where other children were playing with a football. During my training in neuropsychiatry, a nurse or occupational therapist carried out the school observations, reporting back to clinic with a short, written report, that formed part of a wider picture. In the expert witness service, I did the observations myself and I appreciated being able to see, first-hand, what was happening.

I saw Adam thump a boy who was playing football, push past others, trying to join in games but struggling to take turns. At the end of break-time, he ran away when his class were called to line up. The teacher called Adam and he stuck his tongue out at her, making some of the other children laugh. He carried on pulling faces in the line.

In class, I saw his teacher reading Roald Dahl's *George's Marvellous Medicine*. I watched Adam listening, captivated. Suddenly, he got up from the carpet, started playing with a display of toy coins, running his fingers through them. I made a mental note: unusual sensory interest? He opened a tub of playdough and the teacher asked him to come back to the carpet. Adam kept some playdough in his hand, rolling it into a sausage shape. Other children sat cross legged, but he put his feet out, then started kicking his ankles out and accidentally kicked a girl, who told him off. Adam hit her, was removed to have some thinking time and lay sprawled on a giant beanbag, his fingers worrying at the seam, pulling at the threads, eyes darting back to the teacher, but he had lost the thread of the story. Other children were answering questions, he pulled faces at them, mimicked the teacher, made them giggle. Back at the table, Adam lost his pencil, poked a hole in his jumper, swung back on chair, wriggled in his seat. When the teacher asked a question, he kept blurting out answers, but didn't put his hand up.

That morning was the first of several times I would see Adam. The team's administrator Kathleen had sent other components of the assessment, including psychometric tests and asked for copies of physical assessments, to social workers and the school. The following week, Adam's foster carer brought him to see me at the clinic. When I see children, they are often scared. Many understand there are court proceedings and that a Judge will decide on their future. By the time we meet, children have usually met multiple social workers and mental health professionals. I'm another pair of professional eyes who leave when they have seen what they came for. You can see why children feel let down.

In the expert witness service, I planned my clinical assessments to seem like a chat, to be as unintimidating as possible. With young children, I often started by playing, moving on to drawing and painting. With teenagers, we usually went for a walk, or sat on a bench. It can be easier for young people to talk if they don't have to make eye contact. When I wrote notes, I make sure patients could see what I was writing. The lives of children who came before the court are complex. Their caregiving had often been interrupted by parental mental illness, violence and abuse. I encouraged families and children to tell me their own stories, in their own words, before I asked questions to help me discern patterns. My questions came from research tools, a set of gold standard instruments, but the most valuable tools I had were my eyes and ears.

I collected Adam from the waiting room that morning for a Story Stem Assessment. He followed me up the stairs, which became narrowed and twisty after the second flight and he looked around to take my hand, seeming used to being guided by strangers, and paused to look out of window at the local school children gardening. Adam's trusting grip reminded me of being a teenager and minding my then five-year-old cousin Ayub in the local library. I grew up looking after my younger cousins. I was seven when I soothed my baby cousin Tanzil to sleep on my lap. The same year, my cousin Jaan was born; a few summers later, I was wheeling Tanzil's brother Hunain in a buggy through the park. When I was fourteen, I made up bottles for my baby cousin Mustufa in California. His brother Misbah was born when I was doing my A Levels. I carried all these little boys on my hips, wheeled them in prams, refereed their fights, built Lego worlds with them. Climbing the stairs with Adam, another lively, inquisitive boy, I thought of my cousin Hunain, who used to love looking inside radios to discover how they worked. When Hunain was six, I'd nicknamed him The Engineer. Six-year-old Adam had been labelled feral, a tyrant.

Usually in child psychiatry, to understand a child, we also speak to their adult caregiver. Adam's foster carers were highly experienced, but they were not yet experienced in looking after

Adam. Children who are newly placed often have a so-called "honeymoon" period when, out of fear of being sent away, they are on their best behaviour. Only when children are relaxed and feel safe, do the patterns of behaviour suggestive of disturbed attachment emerge.

I also wasn't planning to ask Adam directly about his experiences. Being looked after by his sister was as normal for Adam as another child being cared for by a grandparent. And yet, my colleague Ben often said that children almost always know what is going on among the adults in a family. Ben taught this to his family therapy students and reminded me of it in our work. Adam might not have had all the vocabulary to explain it, but Ben′s theory was that Adam understood that he might be removed from his mum′s care and that he was loyal to her. If I asked Adam how things were at home, he would probably say everything was ok.

Children of Adam′s age make sense of the world by telling stories about themselves and others. My plan was to give Adam a brief introduction to a story, known as a "stem" and was interested in how he completed the rest of these stories. What experiences would he draw on to complete them? Playing like this with Adam was intended to be much less threatening than asking him about life at home. Story Stem Assessments would help me understand Adam′s attachment to his mother and sister. I was using a standardised set of stems, developed at Great Ormond Street Hospital for Children as an assessment tool for professionals working as expert witnesses. In a clear plastic box sold for carrying fishing tackle, I carried farm and jungle animals, playmobile people, dolls' house furniture and a tiny football. As the afternoon unfolded, I presented Adam with the beginnings of a sequence of set stories. As I described each story, I played it out with the dolls and animal figures. I was taught to do this dramatically, to activate Adam′s attachment system.

In 1973, the year before I was born, psychoanalyst John Bowlby was developing his theory about the relationship between inner worlds and outer reality. Bowlby believed that we make internal models of ourselves and of attachment figures, that we all internalise early parent-child relationships and that these inner attachment models affect and influence the adults we grow up to become and all our future relationships. According to Bowlby′s theory, Adam, like all children, had an internal model of attachment, based on his past experiences with Vicky, with his dad and with other adults who had looked after him. Adam′s internal models didn't just hold clues to the past, they were a sort of crystal ball for the pattern of future relationships. This model of inner workings is a metaphor. Parents who respond to their baby′s needs are represented in the child′s inner world as available and dependable. When a parent is repeatedly unable to respond to an infant sensitively, denies anxious or angry feelings, the child will create an internal representation of that parental unavailability, and see themselves as unworthy of care, protection and security. When something stressful happens to a child, when they feel in danger, the attachment system is activated. The purpose of each story stem, was to recreate some of that sense of danger, but in a playful environment. The story stems were windows into Adam′s life. They allowed me to look inside at his scripts for human relationships.

"This is a story about this little pig," I began, hopping the pig across the carpet, "it lived over here with all the other pigs, big ones and little ones: and one day it went for a long walk. It went past the cows, and past the camels, and past the crocodile, and past the lions and tigers – it went a long way, and then it said 'Oh! I′m lost! I can′t see the other pigs! I don′t know how to get back!' Show me and tell me what happens now…"

Adam grabbed the pig.

"He′s going to his teacher, 'I can′t go home now and I am lost Miss' and the teacher throws the piggy like this, up, up and he lands in the water with the crocodile."

"Ok, Adam, let′s play a new one. The little girl is at school, the rest of the family are at home. The girl makes a drawing at school. She says 'This is really good, this picture I made! I′m going to take it home when I finish school.' So, when school finishes, she takes her picture and she goes home and knocks at the door. Show me and tell me what happens now."

"Her big brother answers the door. The girl comes in and puts the picture on the Mum's lap, and she says 'look what I done'. Mum has a sore head so she can′t open her eyes. The girl eats beans with her brother. They cook them in the microwave. Some of the beans splashed on the picture and when the girl wiped it, it spoiled it and Mum said, 'never mind you can do another one.'"

"Does Mum say anything about the picture?"

"Mum said it looks good."

It took about an hour to play our way through the thirteen story stems. I filmed us doing this using a camera that was set up in the room. Afterwards I would play it back and notice things I hadn't seen when we were in the middle of playing. Later, I also transcribed it, noting down all the things Adam did and all the things he said.

Western society often privileges speech over nonverbal communications. But everything that Adam showed me through his play, was more important than any words on in that particular assessment. I kept notes about his fearful expressions when the pig was eaten by the crocodile and his flat tone when playing the mother, too unwell to look at the picture. His voice in that role conveyed no excitement or pride. Sometimes Adam showed when he played and what he said was at odds. There were several occasions when he seemed to be saying what he had to say, what was expected of him. Children are often reluctant to speak about their abuse, out of loyalty, or fear of losing their parent, or out of shame because they feel that the maltreatment indicates their own badness.

Playing with Adam freed me to be curious. When I was playing, there was no master sheet of ideal responses, no checklist of replies. After I had gathered information, I went somewhere quiet to think. Some of my thinking happened alone, among the trees of the Heath, but it was my colleagues who helped me to put flesh on the bones of my argument, folding their expertise, their experiences into my trained observations and reading of the case files. Although I had been trained to score the Story Stems, I didn't present the scores in court. In court, my job was to tell a story that made sense, to interpret all my observations and measurements and those made by colleagues and people from other agencies and present a synthesis.

I walked along Finchley Road, past the red-brick church, to the art supplies shop, where I bought a roll of brown paper and a pack of post it notes. Back at Anna Freud′s, I unrolled the paper, covering the length of the floor of the large conference room. At one end, I wrote "Adam born." At the other end, I wrote the court deadline. Just as in my first year at Barts in the dissection room, I had been taught to trace the course of each major artery and the tributaries of veins, I mapped the landmarks of Adam′s life, the contours, the rocky paths, the uphill struggles.

The trouble with mapmaking is that all cartographers have biases and blind spots. I am a trained surveyor for evidence of childhood trauma and other psychopathographies. Does this make me more likely to make mountains out of foothills? I would share this map with my colleagues, passing them post its, inviting them to annotate and redraw and reframe. The map was just one of several navigational tools that would inform my report, and the report was just one piece of evidence that the judge would weigh in the balance of in her final decision, but the responsibility to be accurate was rightly heavy.

I spent a lot of my professional life thinking about maternal attachment, but my experiences of recurrent miscarriage made me think for the first time about clinical detachment. It is a given in medicine, that doctors must remain emotionally detached. In clinical practice, detachment is almost synonymous with objectivity, with unbiased clinical acumen. At medical school, it was implicit that clinical detachment is good for doctors. It protects us from emotional harm and absolves us of the psychological toll that comes from caring too much. I′d always thought that a necessary degree of detachment leads to better clinical performance and better patient care. But what if it doesn’t? What if clinical detachment hurts patients? What if detachment stops us from listening to nuance? What if our fixation with taming our own emotional responses depletes our empathy? I started to think that maybe clinical encounters needed more, not less, human connection.

DEADLINE

Every Wednesday, a food market was held a few streets away from Anna Freud′s Clinic. After our weekly team meeting, I made my way to the pastel-coloured vans. Usually, I ate outside in the garden at work, but on that Wednesday morning, I was under pressure to finish Adam′s assessment report, so weaved my way through the small crowd and looked for something I could eat at my desk.

“Paella please.”

“Which one, love?”

“Chicken, please, a small one.”

“Fork, love?”

“Please,” I nodded.

“Where are you from, love?”

“London.”

“No, you know, where are you actually from, love, your people?”

I took a breath in.

“My mother′s German, my father was born in Burma, but his family fled during the war when he was a baby, to what became Pakistan.”

“How did they meet, then?′ he asked, tossing a lemon slice into the box of paella.

′London. I was born here.”

“Sounds very complicated, love” he said, passing me the paella in a brown paper bag, “you look Italian.”

I felt flustered. I hate recounting my family history to strangers. Often, replying "Londoner" stems the haemorrhage of inquiry. But not always. I gestured towards the van decorated with Greek flag bunting.

"Nico over there tried to claim me as his countrywoman," I said.

"Mediterranean. You look like us. Not Paki, never would've guessed."

"Thanks for the paella," I said, turning back to the road.

"Ciao bella, love," he called after me.

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Where's home? Where are you really from? But you don't look Indian. How interesting. Thank goodness we're seeing a doctor who can speak proper English. Just look at the appointment letter. Someone's put Dr with a funny foreign surname on it. That's my surname. *We're not racist, we live next door to a lovely Chinese couple, it's just that some of the Indians we've seen before, it's their accents, can't make out half of what they're saying. But not you, you speak nice and clearly. Where did you get that lovely suntan?* It's my skin colour. *How exotic. Where are you from? Let me guess: Italian, Greek. Eastern Europe?* No, I'm British-born, bicultural: German and Pakistani. *But you don't look Indian.*

People have asked me who I *really* am, where my parents *really* come from and whether I feel more German or more Pakistani, for all of my life. People of many different backgrounds have also claimed me for as long as I can remember. Working in London, I became used to colleagues telling me that I couldn't understand this or that culture "because you are white." There are many times when appearing as white seems easier. Appearing white means I dodge many racist bullets. I can avoid confronting everyday racism, a choice my darker-skinned cousins don′t have. But I don′t like it, because part of me remains in the shadows.

For several years, I worked in Auckland and was also a visiting psychiatrist to the East Cape of rural New Zealand. The more intense sun had turned my skin a shade of brown darker than my father′s. I remember a home visit to a Maori family, who were apprehensive about seeing the psychiatrist from Auckland. Mere, the nurse I was working with, came from the same iwi as the family. Mere went into their home ahead of me, while I was unfastening my sandals on the front step. She introduced herself and then said, “eh, you fellas, don′t you worry about our doctor. She′s not like the other Pākeha doctors. She′s a darkie, like us.”

Where′s home? Where do I belong? I identify as a Londoner, although I don′t feel English. I support Germany in the football, New Zealand in the cricket, unless they are playing Pakistan. My heart, as the song goes, is in Heidelberg. Home is the river Neckar, which flowed alongside me as I held my mother′s hand and learned to walk. Later I learned to ride a bike along her banks. Years later still, I cycled along the Neckar on my way to hear patterns of disease in the unsilent spaces between the first and second heart sounds, when I was in Heidelberg studying cardiology. The “at home” feeling that I have in London happens to me in other cities: Paris, Sydney, Auckland. Karachi? I haven′t visited family there for over twenty years, but if I close my eyes, I can transport myself to Clifton Beach, feel the warm sand, see the dinner-platter-shelled sea-turtles, smell the cumin on the breeze. In daydreams, I walk through Karachi′s markets, running my fingers through clothes that my father calls Sindhi and that are uncannily familiar. Home is reflected in the mirrored velvet fabrics, the beaded fringe and in the gritty henna paste on my hands. When I worked on the East Cape of New Zealand, my Maori colleagues spoke to me about tangata whenua, meaning local people. Tangata whenua literally means the place where your placenta is buried. Whenua, the Maori word for placenta, is also the word for land. The iwi invited me with a powhiri, a sung welcome ceremony and a hongi. When I think of the coastal communities on the East Cape, from Gisborne to Whakatane: Tolaga Bay, Wainui, Opotiki, I hear the waita of the iwi who alllowed me to offer healthcare to their rangitahi. When I think of the distance now between us, my heart speaks German: ich habe Sehnsucht.

The bag holding the box of paella bumped against my leg as I crossed the road and walked back towards Maresfield Gardens. Perhaps the paella stallholder was right to say, “it sounds very complicated, love.” I turned the corner and passed the school, where the playground was teeming with dual-heritage teenagers, second and third generation immigrants. Although we are born here, we are still immigrants, needing to find our way and pay our dues to our parents’ adopted motherland. My story is not unique. Sociocultural and ethnic diversity is the lifeblood of this capital city and it was ever thus. London, built by the Romans, developed by Celts, inhabited by the Anglo-Saxons, conquered by Normans, home to us all.

“I′m at home here,” I thought, climbing the steps to 12 Maresfield Gardens, a house chosen by Ann Freud′s fleeing family, who were seeking a safe haven, just as my father′s parents had once gathered up their children and fled from Rangoon. Perhaps my outsider heritage explains why I feel most at home among those who are said to have no voice, among members of our communities who are mentally distressed, dispossessed or socially vulnerable. Yet, I am equally at home in court, at ease with the mannered disagreements and polite formalities. Climbing the stairs to the attic office, I thought of how at home I had felt in the summer, sitting on the bedroom floor of teenage Bernice, who couldn′t get out of bed, but spoke from under her duvet, embodying an extreme sense of unbelonging that I had both sat beside and witnessed, without feeling compelled to look away.

As a patient of the recurrent miscarriage clinic, had I also begun to embody that sense of unbelonging too? Was my sense of being an outsider exacerbated by being treated as a failing reproductive object? My sense of objectification as a patient made me think about my own work differently. Perhaps court assessment work was the ultimate detachment? Patients like Adam were "seen" for an assessment. He saw me at the court's behest so I could provide an opinion. Did my clinical detachment allow him enough space to tell his important life stories? Adam was developing attachment relationships with his foster mother and with his long-term psychotherapist. My training taught me that any therapeutic attachment on my part in a brief assessment context would be harmful and could hurt Adam when it was severed.

But since being obstetrically scrutinised, I became less sure about this orthodoxy. When I lay on the ultrasound couch, hearing the muffled static sound of a loss that I wasn't permitted to grieve, being translated into anatomical jargon, I realised how much the sonographer's power depended on me suppressing my feelings and colluding in medicine's need to be all about cells and reason. What if I stopped colluding? What if being scrutinised closely by someone who remained at an emotional distance was harmful to Adam? When I wrote reports for court, I felt the tension that came from being succinct and clinically precise, often speaking for patients, transforming their words into my clinical judgments, and the need to leave room for their own words and stories on my report's pages. Who carried the burden of repairing these fractured stories? Was it me? Was it my team? Did it fall to the barristers to piece together cross-examined truths? Was it the role of the judge? I couldn't answer these questions neatly, any more than I could answer the paella seller about where I was really from.

I was the first of the team to arrive back in the attic office. A few moments after I sat down at my desk, Marco came in and peeled off one of the layers of merino that he swaddled himself in after swimming in the men′s pond on the heath, sipping his coffee to aid his slow thaw. Marco moved slowly, as if something unseeen was weighing him down.

"Good swim?" I asked, looking up from the paella and the report I was writing about Adam.

“The Ponds where boys to bathe delight, the fields of cows by William′s farm, shine in Jerusalem′s pleasant sight,” he said, standing to perform his lines, ending with a little bow, water dripping from his greying curls onto the carpet.

“Should a good Italian be quoting Keats?” I asked.

″A good Italian does not leave his motherland as lightly as I did,” he said, ″but I think I am a good Londoner.”

“Teasing you, Marco. Keep quoting the poets.” I turned back to the computer.

“You on a deadline, Sabina?” He asked,

Deadlines: a constant feature in the changing landscape of my work-life. When I was younger and more fertile, alongside my embryonic medical career, I had worked as an editor, my week structured around the weekly print deadline, a summit to be scaled. Later, as a freelance writer, missed deadlines came with the threat of cancelled contracts. In Anna Freud′s attic, writing recommendations that could change the lives of families forever, my deadlines were imposed by family court judges. I was intrigued by Marco speaking poetry as fluently as his own mother tongue. But I had to write up Adam that morning; we′d have to chat about the poetics of belonging another time.

“Yep, a deadline, Marco” I said, nodding, without looking back round at my colleague.

“In more ways than one,” he said, whooshing across the room on his swivel chair like a veteran skateboarder.

Marco was right. Women have reproductive deadlines, and I was up against mine, unfertilised eggs slipping through my womb for decades. In our professional discussions we talked about replacement babies, when we were referring to a baby conceived shortly after their sibling has died. After I began having miscarriages, I′d wince when professionals made “replacement child” comments about a child born to parents after the death of a child or after a foetal death. I understood the theory, which was that parents hadn't themselves healed from the trauma and were stuck in their grief, which risked them being emotionally detached from their new baby, who might grow up feeling in the shadow of the child who had died. Ben had worked with several teenagers who knew they had been born after sibling deaths. Several had struggled with survivor's guilt and an unclear sense of personal identity. But when we had these professional discussions, we didn't talk about any biological reasons underlying women quickly conceiving again. We didn't speak about fertile time running out, or egg freezing or dwindling ovarian reserves. Of course it was right that our focus was on the child's best interests and the child's time, but I often wondered, what about the mother's time? When is the right time to have a baby?

Marco teased me about biological clocks ticking, but mine was chiming for last-orders, like the copper bell swung by the barmaid in the Blue Posts pub, back in the days when time was still called in the pubs in Clerkenwell and sub-fertility was just a chapter in my medical school textbook.

'Time, gentlemen, please," the barmaid would call, swinging her uterine bell.

That's the sort of abrupt ending that there was to my first marriage. I wanted to have babies and my husband did not, not babies with me, at least. My fertility time-bell interrupted us, when it would have been easy to linger a little longer, its urgent clanging ushering me out of the rustic-woodburner comfort of our life and into an unknowable night. I had left with a stranger's politeness, after we had walked around our home and I had stuck yellow post-it notes onto half of our worldly goods. He saw me off with the warmth of a good host at the end of a party. I had sent a van for everything yellow-stickered.

"What's your deadline?" the man from the removal company had asked.

It's so obvious, I had thought, even the removal man can tell. I had started to mumble a response about going it alone with donor IVF.

"No love," the removal man had said, "your tenancy. What's your deadline for moving?"

When I unpacked the boxes in the spring of 2010, and peeled off the post-its, I had felt as if I′d left half of myself behind.

LADIES EQUIVALENT

The invitation for the military dinner on the first Thursday in October 2013 had arrived differently to the others that had come. This time there was no stiffie standing to attention on the mantelpiece above the military-issued electric-heater, but instead, an email which Simon had printed and waved at me so that it fluttered like a like a peace flag.

“Colonels, all,” it began, “General and Lady Treleaven would like to invite you,” it continued. It was a dinner, off-site, at the General′s house, “Dress: smart casual (chinos and open shirt, ladies equivalent).”

“What does that mean?” I asked. In the eighteen months I had been living at HQ, I found decoding military dress codes to be harder than neuroanatomy. At least the preserved brains I had struggled to understand at medical school came with guides that were unambiguously labelled.

“It′s smart casual,” Simon said.

“For you,” I said, “I get to wear ladies’ equivalent.”

Later, after we had settled Liberty with the babysitter and walked in the still-warm October evening across the few streets from HQ to suburbia, I noticed small swarms of men wearing well-pressed beige chinos and shirts. The shirts were almost all blue and white checked, all with unbuttoned collars. The men were walking quickly, not marching, but striding, coordinated by an unseen choreographer. All had short hair.

“Chino invasion. Your colleagues are all wearing the same outfit,” I said to Simon.

“Are they?” he said.

If he had told me then that checked shirts and chinos had been handed out earlier by the quartermaster, I would have believed him. What surprised me was that Simon didn’t notice the strangeness of uniform smart-casual in a north-London suburb. Between the ranks of chinoed men, were women. While the men′s clothes may as well have been military issue, “ladies equivalent” was not uniform: skirts of all lengths, party dresses, cocktail dresses and office wear.

″Yes,” I said. ″Doesn’t it seem weird to you? All the men in the same chinos and shirts?” Even after my year-and-a-bit on the patch at HQ so much of military life was curious to me.

“No, it′s informal, an informal evening,” he said.

I heard a crunching sound, like the static from the sonographer′s ultrasound probe, smart-casual footwear on the General′s grace-and-favour gravel path. Simon turned me by the elbow to introduce me to an Important Officer. The Important Officer′s fiancée was wearing a peach dress and matching shoes, in a tone that perfectly matched her skin colour. From across the General′s garden, she looked as if she had been denuded. After we had been introduced she didn′t speak, but was fluent in a broad range of approving glances.

Perhaps spotting my awkwardness, Lady Treleaven came over and invited me on a tour of the apple orchard. We passed abandoned tennis courts, partly covered in a latticework of weeds.

“My hens would love your orchard,” I told her.

“Good layers?” she asked.

“One egg each a day,” I said.

“We always used to keep hens, in Norfolk. Charming birds, they have such distinct characters. How is your family quarter, is it agreeable?” she asked. “I’ve heard some of the housing stock on the patch isn’t up to scratch.”

“You’ve probably heard, the house a few along from us collapsed last week. A whole wall just fell off. We woke up and could see into their bathroom,” I said.

“Shameful neglect,” she said, “of so many military houses.” Lady Treleaven shook her head and looked towards the crumbling tarmac of her tennis courts.

Uniformed men in khaki trousers and jackets with rows of gold buttons ushered us to a dining room. We queued, in a house that looked like an English Heritage attraction, for a buffet supper that had been set out in a room full of antique furniture. Oil paintings, of decorated officers and warships in flames filled the walls. Squads of silver-framed photographs, private family photographs, stood on polished tables. The curtain swags seemed to have been made from the same silk ropes that some officers wore at mess dinners. The dining table reminded me of the big oak table in the Maudsley boardroom, where I had been interviewed for specialist training. The men swapped HQ gossip, interspersed with forces jargon. I was asked over and again, if the nursery was satisfactory, had the quarter been maintained? As soon as I noticed what was on the table, I stopped paying attention to the conversation. Psychiatric training had taught me to listen and observe simultaneously, but this was so unexpected, that trained ability was lost. Lined up along the centre of the dining table, were twelve silver tanks, each the size of a butter dish.

I looked around. Surely, someone else would find this strange. But all around me, officers and their plus ones were eating their prawn vol-au-vents and vegetarian-equivalent unperturbed.

“There are tanks on the table,” I said to Simon.

“Strictly speaking,” said Simon, “they′re not tanks. They′re armoured vehicles.”

His colleagues became animated explainers.

“Tanks always have a caterpillar track,” said one, “these vehicles on the table have wheels.”

“Armoured vehicles take us to and from an operational theatre,” said another, “a tank stays and fights.”

“It′s easy to tell them apart,” said a man I recognised from the Remembrance Service. He’d had a parachuting accident that had compressed his spine, taking inches off his former height. His colleagues nicknamed him Lofty. Lofty was leaning across the silverware pointing with a hand that was missing two fingers: “Tanks have a big-gun barrels, a long pole that fires shells.”

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“That was a bit weird, wasn’t it?” I said later, to Simon, when we were back in the house at HQ. He was packing for a fortnight′s exercise in Cyprus and looked up from his camouflage backpack.

“What was weird?”

“The identical chinos. The tanks on the tables.”

“Armoured vehicles,” he said, counting out socks.

“Come on, it was weird to have silver replica-weaponry on a dining table.”

“It was a military dinner,” he said.

“In a private home,” I said.

“It′s an official residence. I am sure they have equivalent things at medical dinners.”

“No way. If there was a dinner, of say, obstetricians, I guarantee there would not be a row of silver speculums along the middle of the table with everyone casually chatting over them. Cardiologists definitely don′t dine with a centrepiece of silver stethoscopes. And my Freudian friends do not have small silver couches flanking their salad dishes. It was really odd.”

“It′s normal for us,” he said, “I didn’t really notice.”

The unspoken attachment to military ephemera surprised me. More than that, I found it ludicrous that the hallmarks of war, like tanks and men dressed uniformly, were stamped all over a non-work social event.

“You packed enough socks for two weeks?” How Simon lived out of one backpack was mysterious to me.

“Wash one, wear one, spare one,” he said, “I went to war with three socks once. Sierra Leone. Thought I′d packed three pairs but it was just three socks.”

“How long did you have just three socks for?”

“About three weeks, so I think I will be fine in Cyprus for a fortnight.”

PUNCTUAL ATTENDANCE

"Punctual attendance would be appreciated." I read the first line of my appointment card from the Recurrent Miscarriage Clinic. It was a line I read and reread in the hour-and-a-half that I waited on the bolted-down plastic seats. I was on my own; Simon was on his way to the fortnight's training exercise in Cyprus. I had seen him off on the coach, before dropping Liberty at nursery. Sitting in the waiting room, I thought of both of them: Liberty would be having morning snack with her friends at nursery and Simon would have flown out of Brize Norton.

There was a bank of windows with frosted glass on one wall of the waiting room, a row of noticeboards on the other, bearing date-stamped notices imploring the punctual attendees to breastfeed, to recycle nappies, to make an early appointment to visit the new delivery suite. There were photographs of happy home-birthed babies with exhausted mothers. There was a typed notice in block capitals, "A caesarean delivery is not a right, it is an expensive medical procedure and is only carried out for medical reasons. A previous caesarean delivery is not a medical reason." I tried not to keep looking at that notice, as my eyes scanned the room, but they were drawn back to it and my heart started to beat faster and faster.

Next to the closed coffee-cart, there was a flat screen television on which played a loop of adverts of night lights that played lullabies, expanding stair-gates and high chairs that metamorphosed into toddler chairs. A bored pre-schooler with a heavily pregnant mother was spinning a leaflet rack, clockwise, then anticlockwise, making public health warnings about pre-eclampsia and miscarriage awareness leaflets dance on their wire carousel. My thoughts spun with it, clockwise and anticlockwise, worrying that I was too old, too faulty, to contemplate expanding stair-gates. A double espresso would have calmed me down, but the coffee cart barista, like the consultant, was a no-show that morning.

Women trying to conceive are practiced at waiting. Waiting for the fertile window, waiting for body temperatures to rise, waiting for a partner to come home on the right night, in the right mood. Induction rituals for the sub-fertility sorority include waiting for clinic phone calls and waiting for embryo implantation. Then the longest wait, the two-week wait, a no-woman′s land where it′s too early to test for a successful pregnancy and too late to do anything to change that fate. A time of rumour and suspicion. A time of not running, and staying out of jacuzzies, and not eating meringues in case a raw egg infected with salmonella sabotages the pregnancy before it has properly begun. A time to keep away from all the cracks in the pavement, for fourteen days, thirteen sleeps, until weeing on a first-response test might give rise to hope. Or crashing disappointment and the counting and recounting of cycles and fertile windows and calls to clinic nurses and midnight posts on internet forums, where someone, somewhere, is waiting too.

The camaraderie that two-week-wait buddies share online isn’t there in the real-world waiting room, where I have begun to wonder whether Liberty, at two and a half years old, is too old for a night light that plays three lullabies or whether buying one might keep her in bed for half-an-hour longer in the mornings. This is a ridiculous thought, but the recurrent miscarriage clinic is a place where slim odds germinate.

The words “Recurrent Miscarriage Clinic” spooled on a dot-matrix sign loop above the notice board, as if any of us might forget why we were here. Miscarriage is a stupid word, I thought. It sounds as if the woman has made a mistake and has carried her baby incorrectly. I didn’t drop her, I had wanted to scream, she died, she died and I don′t know why and I want her back. The German word, Fehlgeburt, is closer to my experiences. Fehl sounds a lot like the English word fail. Both the English and the Germans recruited the word faillir, from the French. The first Germans who used the French word failler were knights and they used it to describe the specific act of missing your opponent or target, with a lance. Fehlen has evolved in German to mean missing in non-combat contexts too. My Omi used to say, “Du fehlst mir,” on the phone to me during our weekly international call. This does not translate as “I miss you,” but rather as “you are missing to me.” Fehlen was about Omi′s loss of her only grandchild, not my absence. Geburt is German for birth, so fehlgeburt carries a complexity of maternal existence and loss. Felgeburt means this was a birth, a birth that is missing to me, an absence I yearn for. Fehler in German also means a mistake, so Fehlgeburt is a mistake-birth, a birth happening too early, but a birth nonetheless, a birth and a loss that make me a mother, a grieving mother, a notion totally obfuscated by the word in my other mother tongue, miscarriage.

When my dog Monty died, friends sent me flowers and black-bordered cards of condolences. They called to see how I was and even those who were not dog owners understood and empathised. Months later, a friend saw a book that she thought might cheer me up, so she sent it in a parcel, complete with a dog-shaped bookmark, on which she had written warm words. I still have the bookmark and it reminds me that I was thought of and comforted during a time that felt unbearably sad. When I let the same friends know I had had a miscarriage, their responses were closer to that you might give an allotment neighbour on hearing that a slug infestation had damaged a crop of her heritage lettuces:

“Ah, never mind.”

“Wasn′t meant to be.”

“It was the wrong time.”

Since I′d been experiencing miscarriages, people I liked, some really good friends, disappeared. Many were my friends over decades, since we dissected a cadaver together and learned how to break bad news to actors. Some I′d met later, when we were breaking bad news to real patients and learning essential differences between grief and depression, cataloguing loss, despair, recognising the many faces and masks of madness. I guessed it happened because it was difficult for friends to know what to say and that they found it easier to wait until my misery passed. The first time I told my friends about having had a miscarriage, two of them sent cards. After subsequent miscarriages, no cards came. What I had really wanted were flowers: society′s shorthand for acknowledged grief.

How do you grieve for a clump of cells that isn’t a life yet? That, weeks ago, was just two blue lines on a pregnancy test. The non-life that makes your breasts swell so much you have to buy new bras. Bras you wear with pride because your body is carrying a happy secret. The non-life that gives you morning sickness. How do you come to terms with the loss of this, just the length of the tip of your little finger, that has made you so bone-crushingly tired, that you′ve gone straight to bed after your toddler? These millimetres of life, that gave you reason to celebrate, to decorate the nursery in neutrals, to plan how you will tell your other children, to imagine the faces of your parents when you tell them about their new grandchild. A due date you calculated and can never forget. But instead of telling them, instead of picking out paints for the nursery, instead of showing off your new bump and joining an NCT group, you have to tell them about a death instead. A death that wasn′t a life yet. A loss only a few people will come to know about and even fewer will acknowledge. And most of that select minority, they say the wrong thing.

My ears could not unhear those phrases. *Sometimes the womb just needs practice. These things happen for a reason. Never mind. It wasn’t your time. Heaven was missing an angel. At least you have your daughter. She must be a comfort to you. You can try again. What went wrong? There was probably something wrong with the baby. It wasn’t a baby yet, just a clump of cells. You must have known this could happen. Was it a planned pregnancy? Do you think it′s your age? Your body needed a good rest, not another pregnancy. You′re lucky it′s early. Better now than having a child* *born with a disability. It's God's way. Only the length of the tip of my finger. You're making a bit of a habit of this.*

At least you know you can get pregnant. That pearl from a close friend. We had met at medical school and I'd always appreciated her straight talking. But with those words, she may as well have grabbed me by the throat in an alleyway and shaken me. Do you talk to your patients like that, I had wanted to ask? Because it's easy, to get this right. *I am sorry your baby died. I know how much you wanted that baby. I know how excited you were. Can I call you? I don't know what to say but I am thinking of you. We can find a way to always remember this baby.*

When I see my medical school friends, I don't see the harried GP or the exhausted hospital consultant, struggling to balance the rigours of NHS leadership with being a good parent and a loving partner. I see the eighteen-year-old freshers at the barn dance, full of hope and kindness. I see the finalists at the ball in the Great Hall at Barts, nervous to be newly qualified, yet determined about being the best possible doctors. Over the years, I've witnessed my friends' disturbed sleep over difficult decisions about patients and seen their pain and grief when a patient dies. I know they are not cold automatons. These friends of mine, they are doctors I would trust with my own flesh and blood.

So why did they say such stupid things? Anna Freud was the first person to seriously study the psychological defence of denial. In her view, denial protects us from feeling emotional pain, but also diminishes our ability to cope with reality and to learn from it. She wrote that it was mostly used by "immature minds", with three exceptions. Denial does occur in what she termed "mature minds", when it was associated with death, dying and rape. As doctors, we are bad at facing death. Our hope is always for patients to recover from illness because of our actions. Death represents our failure and that often feels unbearable. Denial is the healer's carapace.

That the Recurrent Miscarriage Clinic was plainly named was a relief. Over my medical career, I′d seen infertility clinics rebadged as “fertility clinics” to give people hope, a false hope, as babies cannot be ordered and safely delivered every time. The success rates are low. No posters shouted in capitals about that.

My speciality, psychiatry, is resoundingly bad at naming wards and departments. Our patients are detained subject to sections of the Mental Health Act in “units” named after oaks, willow and beech groves, neglected woodlands of taboo at the back of hospitals, by the skips of broken swivel chairs and piles of pallet boards. Some units fail inspections. When unspeakable events happen in euphemistically named places, there is vigorous pruning of staff and rapid renaming: The Phoenix Centre, New Horizons, New Beginnings, New Hope.

The toddler who had been spinning the leaflets took a short break to eat a small box of raisins. I picked a leaflet about miscarriage awareness out of the stilled carousel. The leaflet said that one in five pregnant women would receive the news that her baby had died. I remembered my embryology colouring. I had once sat up late in the library at Charterhouse Square and coloured diagrams of the moment of fertilisation, shading the tadpole-like sperm binding to a receptor on the surface of the egg, initiating the development of a new life, containing genetic information from both parents. We had been taught that fertilisation induces a number of changes in the egg that are critical for further development. These alterations activate the egg, leading to the initiation of a type of cell division called mitotic cell cycles of the new embryo. Our lecturer had called this special cell division, “the dance of the chromosomes.” I remember that lecture, because I was sitting next to my brand-new boyfriend, who I had just met at the freshers’ week barn dance. Every time the lecturer said, “dance of the chromosomes” my new boyfriend had smiled at me and whispered three little words, “do si doh”.

“Do si doh, your partners now please,” the barn-dance caller had said. We had stood awkwardly opposite one another, my freshers’ week boyfriend and me. He had been lined up with all the men on the caller′s right, all the couples facing one another.

During a type of cell division called meiosis, pairs of chromosomes line up, like students at a barn dance, and exchange genetic information. During meiosis, two cycles of cell division occur to produce gametes -sex cells- with only half of the number of chromosomes of the parent that produced them. Just before the first division, the maternal and paternal pairs of chromosomes line up and cross over, like couples swapping places in a formation dance.

As I read the leaflet, I thought again of the freshers’ week barn dance, especially the dances where couples had been instructed to swap sides, my memory of it still entwined years later with our lectures on cell division.

“Do half a right-hand star in your current four,” the caller had said, “then do half a left-hand star with the next couple.”

The leaflet reminded me that this recombination leads to gametes with a unique combination of genetic material from both parents and is responsible for genetic diversity within populations. It’s why two sisters (or two brothers) from the same parents don′t look the same.

“Ladies, follow your partner in each star.”

The process of crossing over is tightly controlled. It doesn’t always go to plan. In any dance, feet can fall in unexpected places, out of time, out of sequence. When genes cross over at the moment of conception, choreography gets complex. Mistakes happen.

“Why does it happen?” I had asked the miscarriage midwife Sarah, when she had written my referral note to the recurrent miscarriage clinic.

“We don′t really know,” Sarah had said. For many women, there is no obvious reason why, pregnancy after pregnancy, unborn babies die. Medical science finds no fault with neither their eggs, nor womb, nor sperm. Hormone test results are normal. Doctors send women home from consulting rooms, to “try again.”

The barista arrived and a queue formed before the roller hatch had been winched up. Everyone in the queue before me looked at least 20 weeks pregnant. I felt like the last one picked for a sports team at school.

“Sorry, there′s no coffee. I can do you a nice cup of tea, love.”

There were some muffins, sweating palm oil, into their recyclable wrappers. A nurse called my name, sparing me a decision. I steeled myself to meet “the man himself”.

“The man himself” was in theatre. His registrar was apologetic, speaking in a tone of voice that would soothe a teething baby. The registrar asked lots of questions and then ambushed me with information. I remember that she repeated the phrase “natural killer cells” several times and gave me a leaflet, but I can recall nothing else that she said. I remember every word the nurse said:

“My name is Comfort, I am going to be here for you, for all of this,” she said, and we stored each other′s mobile numbers in our phones. Comfort took a sample of my blood to test. As if she could tell that I hadn′t taken in what the registrar had said, Comfort explained, as she pierced my skin with a needle, that in half of all miscarriages, immune mechanisms are at play.

“At the moment a baby is created, that baby takes half her genes from the sperm and half from the egg that her mum ovulated that month,” Comfort said, “following?”

I nodded.

“Thing being is, babe, in most pregnancies,” she continued, “a mother′s body does not reject the genetic material that comes from the baby′s father. The medics haven′t got their heads round it yet, but some women′s immune systems do reject the genetic material, they reject their newly formed baby.”

I nodded again.

“Thing being is, your immune system can cause a miscarriage either by sending, like a massive army, rallying the troops, so that the poor little embryo don′t stand no chance, bless it. Other times, women′s immune systems can sort of go nuclear. So we’ll get these tests done, for thyroid abnormalities, anti-phospholipid antibodies and natural killer cells and see whether you′re high natural killer or something else.”

Comfort wore a dark blue dress with a blood-red belt that immediately made me remember Sister Bridget, the senior ward sister, who had looked out for me when I had been a newly-qualified house-officer in Essex. Comfort′s face wasn’t that of a stern ward sister, though. She looked unafraid to laugh, like a nursing colleague that I might have drunk happy-hour cocktails with in Romford.

“Why don′t you get yourself an ultrasound probe from Boots? Lots of my ladies have them. A bit of reassurance,” Comfort said.

“Maybe′” I said, “it might help, I suppose.” I didn’t tell Comfort that foetal hearts had been elusive to me as a fumbling medical student. I wasn’t confident that if I did get pregnant again that I could find a foetal heartbeat. Foetal hearts beat faster than maternal hearts, making them easily distinguishable. But I thought that my heart might be beating so fast with anxiety that I wouldn′t find the foetal heart. This was irrational, I knew.

“Thing being is, even if fortnightly scanning is the only intervention from our clinic,” said Comfort, “the rate of first-trimester miscarriage goes down. So makes sense to check bub′s heartbeat yourself.”

Comfort′s words resonated with something I felt implicitly from my own work. Sometimes we need to bear witness. Sometimes we need to be seen. Before I left, Comfort saw me to the clinic door and said, “remember babe, text me as soon as you are pregnant, but don′t get pregnant before your February appointment when we will have all your results. We don′t want you to lose another one." Fertile windows and pregnancy stick windows. All this talk about windows of opportunity and windows of hope. I′m often thinking about openings, of new ways into a difficult conversation. When patients with damaged trust close doors, it is my job to look for an open window.

"I won′t," I said, "not a chance." I wasn't going to risk another miscarriage with Christmas around the corner, and besides, Simon was in Cyprus on exercise until after the fertile window. We would try in the new year.

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In the car park, my phone buzzed. It was a text from the children′s guardian.

"When r u assessing my client?" she asked.

"Saw Adam yesterday", I texted back, "can speak tomorrow."

Client. The word client makes me wince. Patients, always patients to me. The word patient goes in and out of fashion in medicine, but no other word conveys the suffering, the power asymmetry and the duty of care. I couldn′t think of Adam, nor of any other child who was mandated to see me by the court, as a client. Having just come out of the obstetric clinic, I felt even more certain that medicine is not a client-facing exchange. Obstetrics, like psychiatry, is intimate. And yet, looking at the waiting-room leaflets, obstetrics seemed to be a branch of medicine specialising in judgemental adjectives. Hostile cervical mucus. Uterine incompetence. Premature ovarian failure. Failure to proceed. Men are spared this. A man without enough viable sperm to fertilise an ovum is said to have azoospermia, rather than a pair of incompetent testicles. The medical journals I read were full of adverts for erectile dysfunction, not for penis failure.

Given this rich vocabulary, it seemed odd that there wasn't a pithy descriptor for a woman with a womb-full of natural killer cells. The adjective that was used most often by health professionals to describe me was "lucky". And I was. Lucky to be registered with a GP in the right postcode for the hospital where the Natural Killer Cell Protocol was used. Lucky to have a clutch of good eggs left at 39. Lucky to have my natural killer status interrogated before spontaneously aborting again. Lucky to be medically qualified, tilting the unconscious biases of medical referral systems in my favour.

NATURAL KILLER CELLS

When I got back to HQ, I looked at the leaflet from the miscarriage clinic. The instructions were to wait for the results, then take a cocktail of drugs for a month before trying to conceive, including high dose steroids and a progesterone pessary called cyclogest. At twelve weeks, I would stop the folic acid, Vitamin D and Omega Three and begin the process of weaning off steroids. At sixteen weeks, I would stop cycolgest. At twenty weeks I would stop taking aspirin. I couldn′t imagine getting that far. A list of side effects filled the back of the trifold leaflet: difficulty sleeping at night, feeling tired, mood swings, aspirin may worsen asthma.

I turned the leaflet back over and noticed the title, a line as incongruous as the tanks on the table at the smart casual evening. Natural Killer Cell Protocol: four words that would be more at home in one of Simon′s Ministry of Defence counter-terrorism policy documents than in a patient information leaflet from the recurrent miscarriage clinic. Sitting on the army-issued green sofa at home on the military base, I wondered: why was my treatment plan written in war language? Was it just my obstetrician who used military metaphor or was this a common way of communicating with obstetric patients? Where did these metaphors come from? What purpose did they serve?

After Liberty was asleep, I texted Simon but didn't hear back from him. This wasn't entirely unexpected. Simon was on exercise and when he was working, his phone was often locked in a drawer. On the rare occasions when it was in his pocket, he was often in a state of hyperfocus, that I called "exercise mode", when the outside world seemed to blur from his sight. I thought of his military exercises as dress rehearsals for war.

"Not just for war," Simon had said, as he was packing his rucksack a few evenings earlier, "it's troops training together in different places, but we practice responding to lots of situations that resemble what might happen in life."

“Like what?”

“Lots of things. Combat, humanitarian aid delivery, it could be a cyberthreat.”

Part of Simon’s role as deputy assistant chief of staff was to design and then run these exercises that unfolded in real time, providing more information as the days passed, responding to ever changing circumstances. Military exercises ran day and night. Adversaries don’t keep office hours. I wondered if training exercises might prevent the deaths of children at the hands of their parents. In my world, professionals coordinated our responses after a crisis. Could dry runs, where we collectively tested our communication skills, networks and decision-making abilities under pressure, help us to make the right decisions?

On the Friday after my appointment at the miscarriage clinic, Liberty spent the day with her grandparents, and I caught the train to London to visit the library at the Royal Society of Medicine. I wanted to learn more about natural killer cells. In an attempt to understand how typical my obstetrician′s language was, I also wanted to survey the contemporary British obstetric literature.

My intention was to approach this by undertaking a type of literature review that doctors learn to do in their training, a so-called systematic review. Usually, in a systematic review, doctors look at all the papers on a specific treatment intervention and pool the results of those treatments. My plan was to look not at treatment effect sizes, but at the language used to describe those interventions. As a psychiatrist, choosing words judiciously and paying close attention to the words used by others was part of my daily practice. I used a different register when speaking to Adam, than when I wrote about him in the court reports, for example. The team and I often spoke about what court language might be like for young people. We imagined children reading their court reports when they were older, likely trying to understand why certain decisions had been made that had changed the direction of their formative years. We had just begun a new project in the court assessment service, where we would write a letter for the children who were at the heart of each case, in child-friendly language, explaining the decisions we had reached and why we had written the recommendations we had made for the court. Because of this project, the language used to communicate with patients was at the forefront of my mind when I received the natural killer cell leaflet. Perhaps it was a one-off, written by a team who hadn't given as much thought to language. But what if it was more commonplace? Widespread problematic language in the recurrent miscarriage literature might be a clue to deeper issues. I wondered if the words used would betray a culture of obstetric misogyny, perhaps giving rise to iatrogenic harm.

The Royal Society of Medicine was undergoing an extension, so I entered through an archway of scaffolding. A large glass vase of lilies dominated the new reception desk and, instead of the receptionist waving me in as she had done many times in the past, I had to swipe my membership card along an electronic card reader to get past a new entrance barrier. It was on this unexpected wave of detached efficiency that I surfed from the lobby up to the library, pressing my card against another device to summon the lift.

The library was the haven it has always been to me. Softly lit, almost as if by candlelight, it still smelled of second-hand bookshops, wax polish and leather bindings. Like their colleagues on reception, the librarians too had a new desk and were sitting behind bullet-proof plexiglass. Behind the new facade, I was relieved to find it was business as usual. All three librarians were busy attending to their books and archives with an unflustered devotion and attention to detail that reminded me of the best maternal care. When I approached them about some help with carrying out a literature review on medical interventions for recurrent miscarriage, one of the librarians, Gail, nodded. Gail spoke in ways suggesting that she knew the topic as surely as a mother on a postnatal ward knows her baby's cry. Liberated from behind her plexiglass barrier, Gail directed me up a spiral staircase to a small meeting room and began to take careful notes of what I wanted to understand, simultaneously translating my questions into searchable terms.

"What years are you interested in?" she asked.

"Last ten, maybe, or last five?" I said, unsure and looking for her steer.

“Try both, if ten years has too many papers to look at meaningfully, we can narrow it down to the last five. We’ll eliminate animal studies?” she said.

I nodded.

“Could I print these?”

″It′s too many,” said Gail, “Let me make an electronic file for you.”

“You’ve been massively helpful, thank you,” I said.

“Your research is personal for me,” Gail said.

I looked up from the computer screen and silently up at her face, unconsciously shifting in my chair, uncrossing my legs and leaning back, a trained instinct, to make room for her burden.

“I′ve been trying, we′re trying, we’ve been having IVF,” Gail continued, “I had a miscarriage last year. We were so excited. I had a scan, we saw a heartbeat, then the next week I started bleeding. There was no heartbeat anymore. I′m not so young, the clinic couldn’t harvest as many eggs as they wanted. Now, I’ve only one embryo left. My husband thinks we should stop, we’ve spent over £50,000, but I need to give it one last go.”

“I′m sorry,” I said.

“It′s ok,” she said, blinking tears away, pushing a strand of hair from her eyes and turning back on her chair to face the database, “look, why don′t we limit the results to English language only, it′s unwieldy otherwise.”

“It′s not ok,” I said, “to conceive a child and lose it. It might be common,” I said, gesturing to the titles of hundreds of papers on recurrent miscarriage that her database search was unspooling onto her computer screen, “but that doesn’t make it ok.”

Tears pooled again in Gail′s eyes and she dabbed them dry with a cotton handkerchief.

“I′m so sorry,” she said, “for losing my professionalism for a moment there.”

“Not at all.”

With scholarly diligence and scientific precision, Gail helped me to collect a sample of three hundred recent obstetric papers on recurrent miscarriage. I thought of Gail as a midwife of the database, coaxing out the knowledge, delivering it into the sunlit office.

“Gail, do you know where the natural killer cell phrase comes from?” I asked.

“We can find out,” she said.

In the library, I read that natural killer cells were a type of white blood cell. A year after I was born, in 1975, Eva Klein, a professor at the Karolinska Institute in Sweden supervised three doctoral students who had demonstrated that, in mice and also in humans, special white blood cells killed viruses and also detected and destroyed cancer-causing cells. Klein saw that these newly discovered white blood cells were uniquely important in a person′s immune system. While I was still learning to walk, Klein named these white blood cells natural killer cells, because they seemed to seek out cells that could cause serious illness, and kill those cells, without any intervention from outside the body. I learned too, that afternoon in the library, that Eva Klein, born Fischer, was a Jewish refugee, who married a medical school classmate before fleeing their native Hungary for Sweden in 1947, where she completed her medical degree. She had taken some time out of medical school, to work in the theatre as an actor and later defended her PhD while eight months pregnant with her second child. By the time she was running her own laboratory, she′d had a third child. Klein, the mother of cancer immunology, who was spending her eighties translating poetry from Hungarian to Swedish, sounded like a woman who I would have loved to meet. I wanted to ask her why she had chosen the natural killer name and whether she had ever considered it problematic.

Natural killer cells, I was surprised to read, are present all over the body and have many roles. When a woman has a newly fertilised ovum, in order for that embryo to implant, the uterine lining has to become slightly inflamed. The natural killer cells present in her womb have an important role in that vital inflammatory process. However, when there are too many such cells in a woman′s womb, or too few, women have higher rates of miscarriage. The exact mechanism wasn’t clear to the obstetricians writing the papers. One hypothesis, seemingly shared by my obstetrician, was that too many natural killer cells attack developing embryos. There were many papers in the library about the association between high natural killer cells detected in a woman′s bloodstream and the increased rates of recurrent miscarriage among this unlucky sisterhood, but I didn’t read anything about whether the hypothesised embryo attacks have been proven.

For the rest of that Friday afternoon, I sat in the library with my notebook and began to categorise all the figurative language used in the obstetric literatures. Phrases like, “mother′s immune system attacking the embryo”, “prednisolone therapy as a counterattack”, “a more targeted treatment for recurrent foetal loss” and “intravenous immunoglobulin boosts the body′s defences,” lined the obstetric journals like the silver armoured vehicles bisected the General′s dining table. War language was as unremarkable in obstetrics as the tanks-on-the-table were to Simon and his colleagues.

Women were as invisible in the obstetric literature as the fiancée in flesh-coloured clothes was at the General′s party. Instead of pregnant women, the obstetric papers referred euphemistically to “a pregnancy.” It was almost as if we women were not there. Foetal death was not mentioned either in the miscarriage literature.

“Where are the women and our dead unborns?”

“Poverty of metadata,” Gail said, “Does the language matter so much, d′you think, if the medicine does the job?”

Why does it matter if obstetricians deploy military metaphor in their targeted treatment protocols? Surely precision is exactly what is needed? The problem, as I saw it as a patient in the recurrent miscarriage clinic, where I identified as a grieving mother, is this: obstetricians don′t just slip into military jargon covertly, between the covers of medical journals. My experience was that they speak it fluently in their consulting rooms, speaking of “hostile uterine environments” and of women′s bodies mistaking the embryo for a foreign invader, worthy of attack. The blood tests Comfort had taken in the clinic would show if my natural killer cells were an army amok, mistaking embryos for enemy invaders. The results might reveal my womb to be a war zone. My consultant obstetrician, who I hadn't met, but whose care I now came under, had been described by my GP as a pioneer, part of a small group of obstetricians who had devised this counterattack. He waged a war against women′s home-grown insurgents. The notion of a woman′s own cells mounting an immunologically mediated attack on an enemy embryo reveals a deeper issue. A woman′s womb is an unlikely setting for biological civil warfare. No mother wants her child to go to battle, least of all a battle she herself has unwittingly unleashed.

Looking again at my stash of three hundred papers that evening, after Liberty had gone to sleep, I noticed that several obstetric academics communicated in the language of cartographers, "charting patterns of first trimester miscarriage," understandable, perhaps, as they have likely studied Netter's Atlas of Embryology, a sort of Ordnance Survey of human development.

Simon called from Cyprus later that evening and, when I had told him about my trip to the library, he told me that, in military discourse, ordnance means ammunition. "The Ordnance Survey," he said, "was undertaken to enable soldiers to fire ammunition more accurately across the terrain."

"So that′s where Ordnance Survey maps come from," I said.

"Yes, and the senior logistical officer in the British Armed Forces is still known as the Master General of the Ordnance," he said.

As a doctor, I can understand the attraction of the warfare metaphor to Eva Klein, especially in work on immune responses to viruses and cancer cells. Battle language makes doctors feel powerful, in control. It casts us as victors against disease. Notions of attack invoke conflicts to be bravely fought, but there will be victors and losers. As a mother though, a further miscarriage, despite medical interventions, becomes not just a loss, a grief, but also a defeat. An obstetrician mounting a counterattack with a complex drug regime may be lured by this language into so called "aggressive treatment", using unproven drug protocols, with many side effects. As I knew from conversations on the patch, some collateral damage is inevitable in any war. In medicine, we call our collateral damage, "adverse effects". Interestingly, nobody spoke to me about the Natural Killer Cell Protocol′s adverse effects in clinic, but the leaflet listed them.

I had photographed the leaflet and emailed it to Simon.

"It will be alright, darling. It sounds good," he said on the phone, "good, apart from the steroids. Side effects sound nasty. I′d be worried about you taking those."

"From what I've read in the library today, it's the steroids that make the biggest difference," I said.

"Can we talk properly when I′m back?" he said. I could hear background noises: boots on a laminate floor.

"Let′s decide together when we go back to the clinic," I said, having already decided to take whatever I was offered, steroids, hormones, the full shebang. The leaflet said that aspirin might make my asthma worse, and that prednisolone carried some small risks to baby, mostly of developing a cleft lip and palate. A baby with a cleft palate would be better than another dead baby. We could work it all out in the new year.

ADVENT

"How's the Winchester case going?" Ben asked, leaning against the banister. We used the word "case" when we really meant the lives of a family that had attracted medicolegal attention, just as my obstetricians used the phrase, "pregnancy loss" but not, "bereaved mother." Victoria Winchester wasn't a case, she was my patient, but medical jargon didn't jar when I was on the professional side.

"I'm cautiously optimistic," I said, passing Ben on the hip-wide attic stairwell on my way to my third assessment session with Victoria. "I've met her twice on her own, seen her with her children at the contact centre with Jess. Seems really engaged with the alcohol service, wants to turn things around. Jess and I are seeing the family again this weekend, when Victoria has her next supervised contact with the children."

Ben slowly raised one eyebrow but didn't say anything. I wondered: was his raised eyebrow a sign of cynicism or experience?

After my meeting with Victoria, Jess and I sat together in the attic and reviewed past medical records, old notes written by health visitors and school reports; each piece helped us to make sense of the disparate stories about Adam and Mandy. Our team discussions offered a space I cherished, where we could challenge each other, disagree with one another, affirm difficult conclusions, reach new recommendations, but also care for one another. For all our disagreements, Jess, Ben and Marco cared deeply. I often quipped that they were my work family,

"It looks so damning on paper," said Jess, "but we've seen so many women where the papers look awful and then you meet them and they seem like good enough mothers. Adam's delightful, he's a joy, he really is, but he's lively, I can see that he'd be hard to manage. Mandy's a bit of a closed book to me, still."

“Speaking is dangerous for Mandy,” I said, “Last time she told anyone what was going on at home, her family ended up split. Not surprised she is cautious.”

“What′s your gut feeling about the Winchesters?” asked Jess.

“I′m optimistic,” I said, remembering Ben’s raised eyebrow, “Victoria′s looking after herself, going to therapy, the contact supervisor′s reports are quite sparse; it′s hard to get a sense of the times when she is with her children.”

“Be good to see them together,” said Jess.

When it came to writing our report, we would be commenting in detail on Victoria′s ability to meet her children′s needs. More often than not, we could see how families got on together by visiting them at home, on a weekend morning or after school. Earlier that year, a judge sitting in the family court had agreed with the social workers from the local authority that it was more likely than not that Adam and Mandy were at risk of suffering significant harm, indeed had already suffered significant harm. The judge made a legal order under the Children Act 1989. For Victoria Winchester′s family, the order meant that the local authority shared parental responsibility with her and could impose limitations on her, by removing Mandy and Adam to live in foster care. When this happened, the local authority had to make sure Victoria and her children had reasonable contact with one another. Jess and I went to observe them at the local authority′s contact centre, where the children saw each other and their mother every other Saturday and where local authority employees, called contact workers, took notes.

Just after 8am on the Saturday before the first Advent Sunday, I left the house quietly as Simon and Liberty were still asleep. I felt tired, my period had started, scant, but definite blood. After breakfast, Liberty and Simon had plans to pick holly in the woods, for the Advent wreath we′d make together in the afternoon. Four red candles and a hoop of oasis were already on the kitchen table.

“Advent is a time to wait, not a time to celebrate,” Liberty had been singing a new song from nursery when I had put out the candles on Friday evening. I remembered her song as I passed the candles on the table on my way out to the contact centre that morning.

A premise of the Children Act is that contact with parents is in the best interests of the child. Where there were child protection concerns, the local authority supervised parental contact in a dedicated centre. The local authority contact centre rooms were all similar. The one the Winchesters had been allocated that Saturday morning looked like an Ikea show room. Against one wall was a red sofa, opposite low-slung armchairs, framing a laminate-blonde table with drawers underneath that held games. A Billy bookcase held colouring books and jars of pencils with not a single broken lead. Jess and I sat on a large rug, an oversize plant in a resin pot between us. But all the things that make a house a family home - school photos, children′s art, scuffed shoes and half-dressed dolls - were missing. We had come to this room, one of six on the ground floor of a seventies concrete block, along a central corridor, where a series of doors all had to be unlocked by the contact supervisor. There was another door behind us, that led to a courtyard garden from which there was no escape.

We were the same age, Victoria Winchester and I, born a few months apart in interchangeable suburban commuter towns in the Home Counties. By further coincidence, I′d lived a few streets away from her when I was a junior doctor. For four years, we might have met friends in the same cafes or shopped in the same supermarket. Unimaginable pain unfolds in seemingly ordinary lives. The biogeographical coincidences made me feel closer to Victoria than was professionally comfortable. In different circumstances she might have been a friend.

On many days over the past two years, according to the reports, Victoria had been so drunk she couldn′t get the children to school. On other days she forgot to feed them. If it was unusual for Victoria to be up by 10am on a Saturday morning dressed, sober and playing Snakes and Ladders with her children, she didn’t show it when we were there. Her son Adam was impatient with his older sister. They were oscillating between bickering and playing in the contact centre.

How intrusive it must have felt to be watched. Who was Victoria Winchester? What did she hope for? What did she dream about? What happened to her, to remake her into such different versions of herself? She had read the same reports as I had. When she read them, did she feel sorrow or shame? Had she wanted children? Did she like being a mother? What happened when Mandy grew into a teenager? Why was it harder to be a mother then, than before?

Adam and Mandy had a few squabbles. They sorted it out. We watched as Victoria and her children took turns. Adam was winning. Then he landed on a snake.

“Dumb game, I hate this stupid game,” he said, kicking the leg of the table, “I′m not playing.”

“Come on, Ads,” said Mandy, “it′s a game, could be me sliding down a snake on the next roll.”

“Not playing,” he said, walking over to the plant. He tore a leaf off the plant and started to tear it up, dropping the pieces at my feet. I didn’t touch them, averting my eyes. It was Mandy who walked over to him and put a maternal arm around her brother.

“Come on love,” Mandy said, “come and sit back down.”

Adam shoved his sister against the pot plant, “I hate this game and I hate you.”

“We usually have fun on our Saturdays, Ads,” Vicky said. Her eyes were filled with desperation, as if we were seeing something she wanted to keep hidden. I wanted to tell her that it was nothing out of the ordinary, that children fight. What we were observing was how she dealt with it. But I kept silent. That morning my job was to sit on the sidelines, an awkward bystander. Victoria rubbed her son′s back. He sat down at the snakes and ladders board, where suddenly everything seemed to fall into place. There were other moments like this, when Adam lost patience with the game; sometimes his mother, but more often his sister, soothed him. Later he wanted to show his mum a card trick, that he had learned from the foster carer. The cards slipped from his hands.

“Stupid, slippy cards. They’re useless,” he said, shouting so loudly that Julie, the contact worker, who had been waiting in the corridor, put her head around the door.

“Everything ok?” Julie asked. Adam slipped past her through the open door, running down the corridor past the other contact rooms.

“I hate it here. I want to go home.”

“This is what you lot have done to him,” Victoria said to Julie.

Jess had run after Adam, the two of them trapped by the locked door at the end of the corridor. Jess sat down, her back to that door. Adam wriggled and ran back towards the room we′d just been meeting in, running past other supervised-contact rooms and banging on doors where other parents were having contact sessions with their children.

Victoria was crying. “It′s not usually like this,” she said, “it′s because you′re here watching. He′s good as gold with me. It′s other people he plays up to.”

“It happens,” I said, taking her off into a side room, “Adam may well be unsettled by us being here. Take a breath. Just do what you′d usually do when he is upset.”

Victoria paused for a moment and then strode along the corridor to the door where her son was sitting. She crouched down so she could look into his eyes without towering over him. I watched her lean her face towards him. I saw him flinch.

“If you want to come back home, don′t you screw this up for us, Adam. Pull yourself together and stop being a bad boy. Or social services never let you come home and you’ll be in care for the rest of your life. You know whose fault that will be.”

Adam screamed and hit his head against the wall. Mandy had come into the corridor, pushed past her mother and sat next to her brother, cradling him, “Sh, sh, s’okay, s’all gonna be alright babe. It′s not your fault. You just lost it for a moment. You calm down Ads, we got this.”

“He′s not right in his head,” Victoria said, making a screwing motion by the side of her temple, “90% of the time he′s lovely and then, boom. I can′t manage his mood swings.”

Later that morning, after the family had left, Jess and I sat at an identical laminate coffee table, in a smaller room, and bounced questions at one another.

“What was positive?” Jess asked me. I didn’t answer her but wrote my thoughts down and she wrote down her responses too. When we′d exhausted our questions, we′d look at each other′s responses, seeing where we agreed and differed.

“What worried you?” I asked.

“Were there any signs of mental illness?” she asked.

“What did you make of both children′s behaviour?”

By the end of the morning, we felt able to talk in detail about the family at our next multidisciplinary meeting.

“Time to be a mum,” said Jess, as we parted at the station, each taking different lines back to our own families. I stopped to buy a ribbon for the advent wreath and for a coffee at a cafe near the station. The coffee tasted tinny against the roof of my mouth.

MOTHER HEN

“Hello Mummy,” Liberty called on Monday morning as she came into the kitchen.

I jumped and some of the chicken feed I was carrying spilled out of the scoop, falling to the floor. I’ve kept chickens, on and off, since the day I found out that I had low ovarian reserve. That news had come on Maundy Thursday in 2010, an overcast, autumnal day in Auckland when I had listened to a message from the clinic on my voicemail, “Your bloods have come back. Swing by sometime today, a nurse will talk you through them.” When I phoned back, the obstetrician herself gave me the news:

“You’ve got amber ovarian reserve, darling,” she had said. Did she call all her patients darling, or only other doctors?

“What′s amber?”

“We use traffic lights. Red means your ovaries have packed up, time for donor eggs. Green, means you go girl. Amber, well amber is for you′d better get your foot on the accelerator,” she had said.

There had been roadworks on the way home, temporary traffic lights caused a delay, and then I had taken a wrong turning. When I saw a sign for a farmer′s market in a neighbouring town, I followed it, thinking that I knew my way home from there. On a whim, I decided to stop at the market, imagining rows of fresh veg. Perhaps I′d pick up a treat. It was my first Easter after leaving my first husband and I was finding it hard to cook for one.

There was a live sheep auction underway when I had arrived at the farmer′s market. Farmers markets in rural New Zealand were different to the ones I had frequented in London. Small cheeping sounds drew me to a farmer selling poultry. In the same casual manner in which I might have once bought a slice of Sachertorte on the way home from Camberwell to Islington, I bought an amber-speckled mother hen and her three fluffy chicks. An Easter treat.

“This chook′s a good mother, eh,” the farmer had said, passing me the box of poultry, which I balanced on the front of my belt buckle, where it protruded like a third-trimester abdomen.

“You got a run for them?” he called after me.

“Sure,” I called over my shoulder. There was a wire framed dog kennel, built by the previous owners. Should be fine, I had thought. I could get them a proper run over the Easter weekend.

I started the drive home along the backroad. Mother hen did not like being in a box. She flapped her wings until the top of the box opened, flew out and hopped around the backseat of the car. When she could not get back in with her brood, she flapped her wings and made a squawking noise that sounded as if she was being throttled. Her chicks cheeped their distress all the way home. I kept pulling over, stopping the car and lifting her back to her chicks. Each time I stopped her up, she flapped her wings as if she was trying to shoo me away. By the end of the journey, I had full knowledge of where the expression hen-pecked comes from. For the last mile, I drove with three chicks on my lap and their mother tucked under my left arm.

That night, I had been woken by screams. When I had looked outside, there was no sign of an intruder, but the wire dog kennel was empty. I had gone back to bed feeling foolish. How could I have a baby if I couldn’t even keep a mother hen and her chicks alive for 24 hours? As soon as the sun came up on Good Friday, I went back outside to investigate further. There was still no sign of the amber hen, but I could hear cheeping. Monty, my dog, sniffed them out: three fluffy chicks huddling under the broad foliage of philodendron, one large leaf acting as a surrogate wing. Monty nudged the chicks towards my feet with his nose. I carried them inside.

“Little ones, you′re on your own, but I will do my best to look after you,” I had said. My neighbours Lin and Richard, who were experienced farmers, suspected a possum attack and took me to buy a predator proof run.

“Someone′s gotta take you under their wing,” Lin had said.

Lin and I spent the Easter weekend feeding the orphaned triplets chick-crumb, warming them and watching how they took turns in pairs to huddle under the third chick′s tiny wings. For several weeks, the chicks stayed in the kitchen, snuggling, cheeping and eating. Their survival instinct impressed me. I spent hours watching the orphans mothering one another, giving each other warmth, shelter and comfort. It took many more weeks before they were old enough to lay eggs and the strong instincts that had helped them through their early weeks seemed to wane. Without a mother to show them what to do, they pecked holes in their eggs and ate them, laid eggs without shells, stood on each other′s eggs in the nesting boxes and cracked them. After a long fortnight wondering if they would ever get the hang of it, I was collecting fresh eggs daily before work. I loved seeing their different personalities emerge as they free ranged in the flowerbeds, my adolescent feathered friends. They moved like lurching toddlers, running as if bundled into large nappies, always seeming surprised to be on legs and untethered from their nests. With dinosaur-like claws they raked the garden for worms, which they ate alongside my veg scraps, thanking me with fertiliser. It made for a homely symbiosis that I couldn’t imagine being without. With a heavy heart, I gave my little flock in New Zealand up for adoption when I came home to London. They were collected by a friend of a friend, a stranger to me but no stranger to chicken rearing. Chickens have remained part of my life ever since.

“We can′t keep livestock in the military garden,” Simon had said, when I moved into HQ.

“Poultry,” I said, “not livestock.”

“S′chickens, we need chickens. We actually need chicky chickens,” Liberty had said, accentuating the choo-sound in actually, “in our ac-choo-al garden.”

“Do we achoo-ually, little lady?” Simon had said, laughing, making choo noises back at her.

The five hens that arrived in the military garden were point-of-lay, meaning they were about six months old, had lost their chick fluff and were bonded to one another. They didn’t peck crumbs from my hands like the chicks had, but waddled away from me and ran from Liberty. Every morning they squawked loudly for food.

On that morning in December, the Monday after seeing the Winchester family at the contact centre over the weekend, I was pushing my feet into my wellies, scoop of layer pellets in one hand, espresso in the other, nudging the door handle down with my left elbow. I did this juggling routine on most mornings, sometimes with Liberty hanging onto my leg, but this was my first spill.

“Come outside with me,” I said to Liberty, “let’s feed the hens,” the feed was still spilling, so I raised my voice over the sound of pellets percussing the army-issue lino.

“Yuck, look Mummy.”

One of the chicken eggs was watery, as if someone had peeled the shell away and left the liquid protein inside. It was perfect in every other way, but spilled a sticky mess when Liberty tried to pick it up, damaged yolk dripping onto her dressing gown.

It was Monday, a home-day. Simon went to work and after breakfast, Liberty and I had the day to ourselves. The September miscarriage had done something strange to my periods, since the slight bleed on Saturday morning there had been no more blood over the weekend, but I had the usual cramps and sore breasts. My head thumped pit-a-pat. I was late for my first morning coffee.

‘Do you want a gingerbread man after breakfast?” I asked Liberty, who was poking toasted soldiers into a runny yoke.

“Yay,” she replied, “cafe.”

We went to the craft cafe near Tesco, the same supermarket where I′d miscarried Hope. I guessed I might possibly have conceived and that another miscarriage was inevitable. The dates were wrong though, whichever way I counted them on my fingers. My body′s signs didn’t make sense either. I felt more pre-menstrual than pregnant: grumpy and tired with sore breasts. A period that was a day or two late seemed more likely than pregnancy.

In the craft cafe, Liberty glued buttons onto a plywood cut out and made a mosaic crown. I ate a flapjack and the left-over limbs of her dismembered gingerbread while I waited for the bleeding to restart. I couldn′t drink my coffee. It tasted of metal, like the one in the market in Chania. So I went back to the supermarket and bought a clutch of own-brand pregnancy tests. Until then, I′d always gone for the glossy, higher-end-of-market tests, at around £20 at time. These ones, value brand, £2.99 for two, seemed to offer the same deal. There was a display of advent calendars shaped like houses by the till.

“Want little house please,” Liberty told the cashier.

“They′re advent calendars, every day you can open a window until Christmas.”

“We do need it. Please,” she told me and I tossed the small cardboard house with glittery snow on the windowsills into the shopping basket.

Liberty slept in the car all the way home and unusually didn′t wake when I lifted her into her cot. While she slept, I reread the Winchester family′s case summary and made a list of questions Jess and I still needed answers to. As I made the list, the waistband of my jeans dug into my flesh. I undid my jeans button, I started to feel cramps and so recounted on my fingers the 31 days that had passed since my last period. Miscarriages can cause menstrual irregularity, but my jeans feeling so uncomfortably tight didn’t feel right. While Liberty slept, I did a pregnancy test, just to rule it out. For the third time in ten months, I watched as two lines appeared on the little window on the pregnancy test stick.

Comfort, the miscarriage midwife had finished for the day. I left a meandering message on her work mobile:

"I'm calling to say…I am pregnant, before my appointment in February, which I was not meant to do, but the thing it, before I found out, I had a bleed, a small one. Thought it was my period, I wasn't planning to get pregnant now." I cringed. I sounded like an irresponsible teenager: "I'm sorry I got pregnant, Miss, when I wasn't supposed to."

My next call was to my GP, close to my parents' home, 40 miles away. I left a message with his receptionist. He called me back within minutes. Was he always this efficient or was it because I was also a doctor?

"Have you seen The Man Himself yet? I can't see a clinic letter."

"I've seen his registrar and specialist midwife."

"What did they say at your appointment?"

"That I've probably got high natural killer cells, but they're waiting on the results. I was meant to go back in February, find out the plan, then try to get pregnant. The thing is, Simon came home from his exercise in Cyprus earlier than planned, but later than last month's fertile window. I haven't been a very good patient," I said.

My GP laughed.

"Conceptions cannot always be planned with military precision. I've been looking but I definitely don't yet have a letter about you from the miscarriage clinic. Did they give you a treatment protocol?"

I read out the Natural Killer Cell Protocol over the phone.

"I'm not going to start you on any high dose steroids without their written say-so," he said, "but it seems sensible to start cyclogest pessaries until you can get hold of the clinic."

"Thank you," I said, "thank you. I'll drive over in the morning and pick up your script."

“Shall I book you in for an early scan?”

We counted dates, me on my fingers, while I could hear him turning pages on his desk diary. My four-week scan date fell on Christmas Eve.

“I really don′t want to scan you then, find there′s no pregnancy and ruin your Christmas,” he said.

“Please,” I said, “I want to know and if it′s bad news, well better to know than to worry all over Christmas.”

“Your decision,” he said.

“See you on Christmas Eve,” I replied.

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“Tonight, little one,” I told my embryo, “you′re on your own. But tomorrow, I will take some medicines that will help you to stay alive. But just for tonight, you have to keep going.”

The following morning, Liberty was excited to see what was behind the window, prising the paper shutters back carefully to reveal a picture of a wrapped gift.

“Danielle, I got a house and I open windows with numbers and it has a present inside,” she said, arriving at nursery.

“Hello Pickle,” Danielle said, as she ruffled Liberty′s hair, “We’ve got an advent calendar for the Ducklings room too, so let′s have a look at what′s behind today′s door, shall we?”

After dropping Liberty off, I waved at the sniper guard and drove forty miles around the motorway to collect a packet of waxy vaginal pessaries. I tried to call Comfort. When I couldn’t reach her, I drove a few more miles to her office at the hospital, but discovered she worked at a different clinic on that day. I drove back to HQ to collect Liberty from nursery. Just as I arrived at the nursery, my phone rang.

“I′d say you′re pregnant and you’ve had an implantation bleed,” said Comfort, without any preamble.

“What′s an implantation bleed?” I said.

“Where the embryo attaches itself into the lining of your womb, babe, some ladies have a bit of bleeding. Thing being is, babe, I was just about to leave work,” Comfort said, “when your blood results come up on my computer. As you weren’t taking prednisolone preconception, you′re not on our full Natural Killer Cell Protocol, but if you can get some cyclogest...”

“I started cycogest today,” I interrupted her, my mind wandering to the torpedo-shaped pessaries. Torpedo-shaped. That was how the patient-information leaflet described them, but it was a descriptor familiar from medical school. Battle language was one of the medical dialects I had picked up at Barts without noticing. *She was a brave fighter to the end. These cells attack the virus. Radiotherapy nukes the tumour. An army marches on its stomach.* How much military language do doctors pick up on the way to becoming healers? I hadn’t wondered before, but inserting a torpedo-shape into my vagina before breakfast had focussed my mind.

“You rockstar getting those pessaries, babe! Pop over tomorrow, pick up some pred?”

“Not tomorrow, I’ve got work.” The near ninety-mile round trip made it impossible. Posting a prescription might cause further delays. We discussed me taking prednisolone for the first time on Thursday.

“That decision′s well above my pay grade, babe. Let me talk to the reg.”

Comfort consulted with the obstetric registrar and as promised, called me back.

“The sooner the better”, the registrar had said to Comfort, “especially as she hasn’t been taking it preconception.”

I called Jess, “I′m sorry. I hate doing this to you, but I need to mess my day around tomorrow. I won′t be in until midday.”

After dropping Liberty at nursery the following morning, I drove. When I arrived, Comfort hugged me.

“Your bloods have come back as high natural killer cells,” she said and gave me a prednisolone prescription to take to the pharmacy. Since my call to the GP, professionals and I had stuck to the Protocol as if it were indisputable. As I had learned in the Royal Society of Medicine library, the Natural Killer Cell Protocol was unproven. There were women who my GP knew, who′d had miscarriage after miscarriage and then carried live babies to term on the Natural Killer Cell Protocol. Comfort knew many more women like that. But there were no large-scale studies to prove it works. This was not evidence-based medicine.

The way I went about it wasn’t evidence-based either. What I ought to have done, had I not become pregnant before my test results came back, was receive my diagnosis and then begun the pre-conception protocol. What I ended up doing was to start taking aspirin, Omega 3, high dose Vitamin D, folic acid and cyclogest from the day after I discovered I was pregnant.

“I’ve done it all the wrong way round, you told me not to get pregnant until February,” I said to Comfort.

Comfort smiled, “Did I say that, babe? Don′t look back, be positive. Today you are pregnant.”

I couldn’t remember learning about miscarriage in my embryology colouring days. What I did recall, was a lecture of “foetal anomalies” and one throw-away line: “only a few foetuses with abnormalities get to this stage of development. Mother Nature takes care of most of them in the first trimester.” I had come out of that lecture theatre knowing most miscarriages are due to foetal abnormalities, that one in four pregnancies ends in miscarriage. Medical school, especially the pre-clinical years, was full of numbers. Diseases happened to those others, the patients. Our job was to listen, record, learn, and later, try to alleviate suffering, sometimes even cure diseases. But a doctor's role was never, it seemed, to become one of the statistics we first rote learned, then met.

Two decades later, as I was waiting in the pharmacy to collect steroids to prevent another statistic, an NHS poster on the wall informed me that my miscarriages were part of a larger number. Every day, seven hundred babies die before they are born, or soon after birth. The pharmacist told me to start steroids immediately and take them in the morning thereafter, so I necked the prescribed handful in the car park before driving back towards London to the Anna Freud Centre.

"Sending reinforcements," I said to my passenger, unwittingly cooperating in the military vernacular. How much war jargon had I been using without realising? Might it ever be useful? My embryo seemed utterly helpless and vulnerable. Medication intended for shoring up her defences didn't seem so much violent as necessary. Would I have thought in war metaphors before living at HQ? Possibly. I think it had become part of the gallows humour, which was itself a survival mechanism, that I had learned at medical school, a survival mechanism that Simon had doubtless learned at Sandhurst. As a student I had been taught about laughing and dark humour. I remember a lecture where it was described as armour and that we shouldn't feel ashamed of laughing as it would protect us from suffering. If I didn't have medical heritage, would I have felt differently about the box of hormone-infused torpedoes to put in my vagina? I wasn't sure, but it made me think about the suitability of language that I used with my colleagues and how some of that language might keep patients as outsiders, perpetuating a sense of unbelonging.

The following Wednesday, as I passed the grocer's display of plump Spanish peaches outside Finchley Road station, I did a mental run-through of pregnancy symptoms. Tired? Yes. From the prednisolone? Possibly. Metallic taste? Maybe. Seemed to come and go. Waiting at the lights, I pressed my tongue up hard against my palate, trying to decide if it tasted like a spoon. I bent down to loosen my shoe strap. My shoes were tight. It was too early for swollen ankles. Too early for swollen everything. My dress felt crowded, as if my unruly body, like the over-filled grocer′s box jolted yesterday evening by an impatient commuter, would spill out over the crossing.

Across the road, outside the church, the red brick Evangelical one, an offshoot of Holy Trinity Brompton, German theology exchange-students in yellow t-shirts were setting up a pop-up pavement cafe. Their portable coffee machine perched on a vehicle that looked like a child′s milk float. The smell of their roasting coffee, mingling with the aroma of burning acrylic from the adjoining nail bar, made me heave. Nausea. Good. But I remembered the GP, the curly haired Scottish locum, telling me after the spotting in Paris, ″nausea is a good sign. If you′ve got any pregnancy symptoms, it′s not a miscarriage.″

She had been experienced. She had been confident. She had been wrong.

I knew Marco was making an early start when I came through the front door and smelled strong Peruvian coffee. The Guardian sudoku, mostly completed, was spread out across his desk to his right. To his left, he′d pulled the phone across my desk and was balancing the receiver between his chin and left shoulder as he typed. Marco had made coffee in the eight cup cafetière, a sign he was on a court deadline.

“Ciao Sabina, help yourself.”

He flashed me a smile, gesticulated at his open cake tin and carried on with his phone call, flipping from avuncular colleague to expert witness, reassuring a lawyer about his report being “formatted”, even as he typed his conclusions with his free hand. After their conversation, he returned to his screen, not to type hastily, as any of us others in the team would have done, but to Skype in Italian, with his old schoolfriend from Naples.

“His daughter′s left her boyfriend for a girlfriend,” Marco said, clicking shut the Skype window.

I nodded, my mouth full of Lizzie′s lemon drizzle.

"It′s a generational thing," said Marco. "My daughter′s friends are all trying a bit of fluid sexuality." He poured himself another coffee.

"How are things for you in that department?"

Twelve weeks had passed since I′d arrived in the attic office after my leave in Crete and told the back of Marco′s head that I′d had another miscarriage, told him that it happened in the supermarket, on the way home from the airport. Twelve weeks; a trimester, my life now measured in obstetric junctures, from the timing of ovulation, to the two-week wait, that fortnight of foreboding between possible conception and pregnancy testing. Afterwards, if I was lucky, lives, mine and the embryonic life, were counted in days, then weeks, then trimesters.

"Pregnant again, Marco," I replied, "Found out on Monday. The miscarriage clinic got me straight onto a ton of drugs: high dose prednisolone, low dose aspirin, cyclogest, omega 3, folic acid, load of vitamins." Flipping into medical jargon, talking doctor-to-doctor with Marco made me feel slightly less panicked about this pregnancy.

I didn't tell Marco that the Natural Killer Cell Protocol was to take all these for two weeks drugs pre-conception, rather than a day after a positive pregnancy test, nor that I′d been sent away from the miscarriage clinic with written instructions to avoid getting pregnant before my appointment with the consultant in the New Year.

"Early scan?" Marco said, interrupting my thoughts.

"At six weeks, on Christmas Eve."

Marco pulled a face. He thought that at thirty-nine, I was too old to be having babies. He'd married and had twins in his early thirties, his daughter was a junior doctor in Plymouth, his son head of modern foreign languages at an international school, his daughter-in-law was expecting his first grandchild, all in the anticipated order. Marco and his wife Lizzie were slowly renovating an Umbrian stone house. Lizzie, an accomplished potter, had plans to run courses for artists and to open a small gallery, Marco wanted to run creative retreats for burned out healthcare staff. Later, after Jess had arrived and Blu Tacked her daughter′s latest crayoned Pollock to the wall, and after Ben, our team manager, had bounced up the third flight of stairs and flung his leather jacket on the back of my chair, I tipped my cold coffee into the cactus and put my pen down to listen to Marco and Ben′s case presentation.

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"Put a little cross in the diary," my grandmother had said, when I started my periods, aged ten. I remember that grandmother had shown me to draw a cross and count forward 28 days, so that I′d always be prepared. My cycles were a bit all over the place. At ten, I couldn't keep track of where I′d left my diary. I made a few crosses, then gave up. Periods have often taken me by surprise. When I sought support online, I realised that most women do track fertility cycles. There is an app for tracking menstrual periods. Another app for predicting the days on which you are most likely to conceive.

There, I realised there is not only an app to track everything, but also an acronym for everything as well.

BFP, big fat positive (pregnancy test)

DTD, doing the deed

DH, Darling Husband

DP, Darling Partner

TTC, trying to conceive

AF, Aunt Flo, a euphemism for menstruation, not common offline, but known online, but I′ve never heard it in real life.

Between the acronyms, I found compassion and kindness. Women who were still raw with their own grief took time to explain and to commiserate with strangers online. Like shipwrecked women, with only a life-raft in common, we clung on to the fertility message board and hoped it wouldn't be for long. "Cycle buddies" was the term we used for women who were pregnant at the same time. Behind the masks of our usernames, we held virtual hands and posted each other daily encouragement. We shared stories of scans, of ultrasonographers who wouldn′t meet our eyes, nurses who said the wrong thing, hospital horror our shared genre. Online, I chatted to women who had waited for miscarriage scans in a waiting area with pregnant women waiting for their 20-week scans. I met a woman who spent her most fertile years working for UNESCO, had six miscarriages and was hoping, this time, to make it past 14 weeks. The reaper of unborn babies doesn't care if you've won the lottery, if you′re carrying the child of your dead partner, if you've decorated the nursery or waited, if you′re an NHS patient or if you felt safer going private. Irrespective, he takes his 20% toll.

My online friends were scared. Scared of not being referred, scared of drugs, scared of side-effects, scared of not becoming pregnant, scared they couldn't endure the grief of another loss, scared of what the obsession with a healthy, live baby was doing to their relationships. For the first few weeks, my cycle buddies and I were close confidants. When we had news: a scan, some blood spotting, we logged on and, always, someone replied.

Around week six, bad news started to spread among my cycle buddies. I felt helpless, as one cycle-buddy after another had a scan which showed no heartbeat. Kept awake by prednisolone, I lay awake thinking that it was only a matter of days or weeks for my own bad news. Losing babies made me feel like a failure. I′d been a failure before, at the end of my first year at medical school, when I′d failed every exam, but one, where the time spent colouring embryos and labelling their parts had slipped me across the finish line. After that I worked harder, did well enough. Suddenly, something that I imagined ought to have been in my grasp, slipped away. There were times when I felt like leaving the online group, times that the grief felt contagious, but I couldn't bring myself to jettison the women who had buffered me.

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There was a mismatch between what the leaflets said and what cycle buddies around the world experienced. For instance, my clinic leaflet said that nightmares occurred rarely, but among women online they seemed common, and this made me wonder whether they were underreported to medical professionals and how they had been asked about.

After three days of taking steroids, I started waking up between 3am and 4 am, with helter-skelter emotions from euphoria to grief. The steroids also made me feel exhausted in the evenings. And gave me nightmares. On the fourth morning, I woke at 4 am with a surge of energy, which faded by mid-afternoon, leaving me feeling spent. By the end of the first week of taking the Natural Killer Cell Protocol, Simon started bringing supper up on a tray, which I ate in bed after Liberty had gone to sleep. On some evenings, by the time Simon brought the tray up, I was already asleep, the steroids unspooling strange dream-reels. As my food grew cold, I dreamt repeatedly about the headless cadaver from my anatomy lessons. In several dreams, she was chasing me through Smithfield meat market, while butchers were wiping bloodied knives on their white coat, threads of embryonic notochord unfurling from my running shoes like untied laces.

Night after night, I ran in my dreams through the old meat market and into the square at Barts, where I heard the voices of my medical school professors, my mothers-in-medicine: "don't rush in, stand back, observe."

"Help me, help me," I screamed in my dream. My professors looked on, obeying their own adage, standing back, observing. Their junior doctors wrote things down, things about me that I could not read, in a thick file of notes, bound in a pink folder.

In my dreams, I strode past them, upstairs into the Great Hall, past Hogarth's *Pool of Bethesda*, a painting I hadn't seen for seventeen years. My old classmates were seated around tables, men in black tie and women in ball dresses. Some of them clambered up onto their chairs, drawing back from me as I cried for help. My running shoes left a trail of bloodied footprints.

Between dreams I lay awake, willing Liberty to wake too while I had so much energy to play with her. After the first week of steroids, I felt ravenous. Awake in the night, I ate toast. I was still hungry. I cooked pasta. I poached eggs. I made a set of mosaic coasters and glued all the tile fragments into place before Simon and Liberty woke up. But by the evening, I was bone tired. Liberty fell asleep quickly. I lay down, just for five minutes. Simon came up a few minutes later to see if I was going to eat. I was already dreaming.

Another running dream. This time, I was running down a long pale-green corridor. The paint from knee height down had peeled, revealing pale yellow paint behind it. Some of that paint had peeled as well, uncovering the plaster wall. Layers of NHS. I′d know that wall anywhere: Oldchurch Hospital, Romford, Essex, 1998. In my dream, the crash bleep was sounding. My patient, Mrs White, lay flat on her back. The on-call Med Reg compressed her chest. The SHO, Shahid, was inflating her lungs with a bag and mask. Shahid and I were friends. We were both hungover after a night that started with a group of newly qualified doctors and a jug of Pimm’s and ended with cocktails called Chocolate Monkeys. In my dream, Shahid joked that I need the oxygen more than Mrs White did. I laughed, but felt shocked to see her dissection-room cadaver pale. In my dream, I took over chest compressions.

On the television dramas I had watched when applying to medical school, patients like Mrs White recovered. On Ward 10, it was an ugly rite of death. As I pushed the heel of my hand down into her sternum, I felt something like a pea popping, “no,” I said, “no,” as it happened again. Shahid touched my arm, noticing how bad I felt for breaking Mrs White′s ribs.

“Relax mate,” he said, “happens all the time.”

Resus Annie, our plastic practice-patient, never fractured any ribs. In my dream, I stood back as the Med Reg administered electric shocks to Mrs White. He reported that he felt a faint pulse. Mrs White vomited blood and a nurse already had the suction machine at hand, sucking blood into a canister, making the sound children make with milkshake straws, when there isn′t much left. Mrs White vomited again and coughed, coughed up blood and bloodied lumps of lung. My legs were sticky.

An hour later, Shahid was filling in her death certificate and I went with the Med Reg to break bad news to her husband. I wanted to offer my condolences but no words came, only vomit. I vomited little pieces of flesh and blood. They looked like lumps of Mrs White′s lung, but when I looked closely, I saw tiny babies with arms and legs and heads. The broken babies started crying. The crying was so loud it woke me. It was 3am.

After that dream, I sat in the kitchen in HQ and cried, remembering patients that I hadn’t thought of in years. Shahid and I had lost touch soon after working together. We did have a patient called Mrs White. I once wrote her name on blood sample bottles and labels and remember her because she was kind to me. She used to ask the tea lady for an extra cup of tea for me, keeping it for me until I came round to take her blood.

“Cup of tea for my little vampire,” she would say.

Mrs White wasn’t the first patient of mine to die suddenly, but she was the first who I had become attached to. In 1998, unlike in my dream, I didn’t vomit as I was offering my condolences to her husband after the unsuccessful resuscitation, but I did look down and noticed a small piece of his wife′s bloodied flesh stuck to my leg. A decade passed before I accepted a cup of tea from a patient again. On the busiest days in that job in Romford, three patients might die in a day. My heart couldn’t break for them all.

BROODY

“There′s something wrong with the brown hen,” Simon said, a few days after my dream about Mrs White. He was unlacing his black boots by the back door of the kitchen at HQ.

“I noticed yesterday she wasn’t going into the run with the others,” I said.

“Same today,” he said, “she just sits in the nesting box. I′ve lifted her out but she just goes back in.”

When I lived in New Zealand, I′d have popped over to my neighbours Lin and Richard, who had answers to all chicken queries. There wasn’t anyone on the patch I could ask, so I went online. In the same forum as my cycle buddies, was a chat topic for chicken keepers, called The Henhouse. I submitted a short summary and then ran Liberty′s bath.

By the time Liberty was in bed, several people had replied.

“Sounds like your hen has gone broody.”

“Got yourself a broody hen there, hun.”

“Yes, definitely broody.”

“Thank you,” I wrote, “she′s not sitting on any eggs, I don′t think she is trying to hatch anything. Does anyone know what I should do?”

Again, the advice flew in.

“Leave her, as long as she comes out to eat and drink, she’ll stop after twenty-one days, that’s the length of a hatching cycle.”

“Definitely don′t leave her. She’ll get mites.”

“She needs a broody jail, a wire cage where she can′t nest, to break her broody habit.”

“You could pop some fertilised eggs under her. We hatched Muscovy ducks under a broody Leghorn last year.”

This piqued my curiosity.

“Didn’t that confuse the ducklings?” I typed.

“No, once a hen has hatched them, she gets attached to the ducklings and looks after them like her own. They followed her everywhere, lining up like soldiers. It was too cute.”

I remembered the three orphaned chicks and how much work they had been to care for. I′d keep lifting the broody hen out of the box. During my psychiatry training, once a fortnight, the other trainees and I attended a lecture series. Most lectures were about the conditions affecting the patients we looked after: schizophrenia, bipolar disorder, anorexia nervosa. One lecture had been about geese. The lecturer had shown us a film, made by the Austrian doctor, Konrad Lorenz. Lorenz had studied medicine and anatomy and kept poultry. Lorenz found that geese, after hatching, followed the first moving creature or even object that they see. He called this imprinting and concluded that attachment is innate, genetically set and believed it to be irreversible. Once a gosling had imprinted, she didn’t attach to any other surrogate parent. Lorenz was awarded a Nobel Prize for his discoveries, for describing a phenomenon that farmers had probably known for many years before.

Lorenz was pessimistic about humans. He saw us as too impulsive and acquisitive for our own good, always wanting things, like houses and cars, or a mother hen and her chicks at a farmers’ market. He thought our aggressive natures would lead to self-destruction. On the military base, adjacent to the garden where I was lifting the broody hen out of her coop and nudging her towards the feeder trough, there were destructive possibilities but it wasn’t Lorenz′s wanton destructiveness, impulsive and ill thought-through. As I encouraged the broody hen to eat, I thought that perhaps Lorenz was unduly pessimistic. I knew from my work that early attachments can have a serious impact on later relationships. Children who are securely attached as babies tend to develop stronger self-esteem and better self-reliance as they grow older. These children also tend to be more independent, perform better in school, have successful social relationships, and experience less depression and anxiety. I had seen too, that children who have had incredibly deprived beginnings, when placed with caregivers who respond quickly and consistently, learn that they can depend on those adults who are responsible for their care. This dependability is the essential foundation for human attachment.

I thought then, about how disrupted attachment patterns can pass from generation to generation and of how doctors can learn unhelpful consulting styles by mimicking our seniors. As a psychiatry trainee, I was often warned by my superiors about the need to "avoid dependence." I was advised to "guard" against patients becoming dependant on me, or on the hospital and especially on the emergency department; these were all very bad things. I thought of my embryo, who had to depend on medicines and medical investigations before her life had legally begun, in order that her life might be saved. It made me more certain that in medicine, and especially in psychiatry, we needed to fear doctor-patient dependence less and instead understand those dependencies more closely.

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I needed to see Victoria to complete the Adult Attachment Interview. This was a tool that helped me understand the enduring impact of her own childhood attachment bonds and how these might influence her parenting, her relationships and her psychiatric symptoms. In our last meeting, I had asked Vicky to "describe your relationship with your parents" and "think of five adjectives that reflect your relationship with your mother."

One of my most influential foremothers in psychiatry, Anula Nikapota, coached me to develop a style that was, in her words, more disarming. When I was a registrar working under her supervision in Brixton, Anula impressed on me that, by the time parents met a psychiatrist they were mandated to see for a court report, they have usually told their story several times, and that asking questions in the formulaic way I had been taught when preparing for membership exams of the Royal College of Psychiatrists was not the ideal approach.

I had Anula′s gentle rigour in mind on the morning of Victoria's appointment. The rubric of the Adult Attachment Interview was necessary to ensure nothing is missed, but I knew from more informal conversations earlier in the assessment that Vicky had felt disbelieved and invalidated. She had been given a diagnosis that she disagreed with. Rather than risk interrogating her and have her shut down, I had tried to let the conversation meander, which meant some questions were left. I still needed to ask, "did you experience the loss of someone close to you?" and "how do you think your experience affected your adult personality?" I felt relieved when she had agreed to return, so I could complete the formal assessment of her capacity to form attachment relationships.

I put a new ink cartridge in my pen and wrote "Winchester" and the date at the top of a blank page, pregnant with possibilities. Although I didn't ink patient names onto blood samples anymore, I still labelled all my contemporaneous notes with their notes and signed the end of each entry.

It wasn't like Vicky to be late. I left a message on her mobile. She was probably stuck on the Tube. While I waited, I took out a sheet of A4 and divided it into two columns: positives and negatives.

Under the negatives, I made a list.

- Minimises drinking
- Was too drunk to get Mandy or Adam to school.
- Neglected dental appointments for Adam.
- Didn't notice Mandy was gone overnight.
- Couldn't support Mandy after sexual assault.

1. On the other side of the paper, I wrote:

- Has stopped taking drugs

- Attending alcohol counselling
- Has come to all assessment appointments
- Was a good parent in Mandy′s early years according to health visitor and school records

I started a new sheet, which I titled, “unknowns.”

- Does Adam have a diagnosable psychiatric disorder?
- Is this ADHD?
- Insecure or disorganised attachment?
- Foetal alcohol syndrome?
- What happened to Vicky at secondary transfer age?

My ringing phone interrupted me, “I just thought you ought to know,” said the social worker, “that Victoria Winchester was in A&E last night. She was found collapsed in a doorway of an estate agent. Looks like she got really drunk.”

“Oh no,” I said, “she′d been doing so well.”

“Doing well?” said the social worker, “not really. She hasn′t been going to any of her appointments with the drug and alcohol counsellor.”

Vicky′s phone went to voicemail.

“I′m sorry not to see you today,” I said, “if you′re ok, could you come tomorrow, at half one?”

After I left the message, I texted Comfort at the recurrent miscarriage clinic with a query about my steroid dose. What Victoria Winchester didn’t know, couldn’t know, was that my prospective mothering was under a different form of scrutiny. While social workers, family support workers, teachers, paediatricians and expert witnesses pored over the meaning of her many maternal acts and omissions, my womb was being watched for signs of rebellion and uprising.

In the days that followed her missed appointment, Vicky′s social worker and the children′s guardian furnished my inbox with fragments headed, “cause for concern.” These emails came with red exclamation marks, often a sign of the sender′s distress as much as any urgency. I had sent similar emails as a junior doctor, when out of my depth. I opened the various attachments, until they fanned out on my screen like a tightly held hand of cards, and pieced together what had happened.

The information was damning. The undisputed facts were that Vicky had gone to Adam′s foster carer Sharmilla′s home at close to midnight and shouted ,“Mummy has come to get you,” through the letter box. In some reports, Vicky′s speech was slurred and in others she was described as “hostile and intimidating.” In the early hours of the morning, Sharmilla thought Vicky had gone away, but Vicky threw a brick through a downstairs window, switched on a garden hose and said she would flush Sharmilla out. Sharmilla called the police, Adam woke up and was terrified. Vicky was taken home by the police. On the following day she was asked to leave a pub in Clerkenwell because she was drunk and shouting. That evening she was found by a group of women on their way to after-work drinks, slumped in the estate agent′s doorway and they called an ambulance. I also had a summary of the opinion of the adult psychiatrist and took up his emailed offer of a chat on the phone.

“What’s your take on this?” I asked. “Is this mental illness or the actions of a desperate mother?”

“It was a maternally motivated act, without a doubt, but there is clear evidence of psychopathology. Firstly, she was quite unable to control her impulsive behaviour; she acted on her thoughts of needing to get Adam without thinking through consequences for him. She woke up her son and frightened him and his foster mother. She put him at risk. There was clear non-compliance with court order; she is meant to see him in supervised contact."

I was relieved, the following Wednesday, to see Vicky in the waiting room. I put out my hand to shake hers, a socially sanctioned embrace of palms.

"Sorry I′m late," Vicky said, squeezing my hand for a moment, glancing down at the rip in her jeans. Accidental? Designer? It was hard to tell.

"Slept in a bit," she said, "Then the trains. All over the place. Phone. Credit. You know. It runs low. Runs out."

Vicky′s lips were burgundy in the corners. Last night′s lipstick? Wine?

After pushing the door to the clinic room open, Vicky hesitated, as if she was holding it for someone to go in before her, even though she was on her own. When she came in, she looked straight at the wicker chair and seemed to fold up in it, as if she wanted to fold herself away. The chignon was gone; Vicky′s hair hung loose.

"I know what you′re thinking, Sabina," she said, looking up from under a long fringe, "I look like the ungroomed pony, whose teenage owner has tired of dressage." She laughed, but her eyes looked weary. I looked at her hands as she picked flakes of blood-red varnish from her nails. I thought, then, of the hands that held the pens that had written the clinical notes and the other reports in her court bundle. Many hands had reached out to help Vicky. Administrators' hands had posted letters bidding her to come to appointments. Social workers' hands had dialled her number when she hadn't made it through their doors. Family support workers' hands had rung her doorbell, hoping to meet her, leaving empty handed. Did Adam′s teacher pick her cuticles when the referral to social services was made? Did the social worker bite her nails when she applied for the court order? Did any professional hands tremble as they signed the reports in the bundle? Did the solicitor wring her hands when she saw the file? As the flakes of varnish fell from her nails to the floor like blood spills, I thought over and again of all the hands that had reached out yet never connected.

“Mind if I keep these on?” Vicky tapped the arm of her sunglasses. “Bit of a migraine. That sun doesn′t help.”

When she took off her cardigan, I saw dried scabs of blood on her arm, where the pavement had peeled the skin from her elbow. She laughed when she saw me looking and put her hand over the gash.

“Those stupid heels. Outside the estate agent. Trip down memory lane.”

The first time I′d seen her, just ten weeks ago, I mistook her for her lawyer. At that first meeting she′d hoped her children would be back in her care soon, “Home for Christmas.” I′d shared her optimism. Now, it was inconceivable. She searched her bag for a couple of hairbands, pulled her uncombed hair into a topknot and rubbed her head.

“Vicky, I know,” I said, “I know about yesterday, A&E.”

She waved my statement away with her hand, as if she wanted to bat off the intrusion.

“Fell over in my heels. Silly really. Sorry I missed my appointment. Didn’t pick up your message until I got up.”

We sat, the clock ticking. I thought of Adam. Adam was five years old. If he was to be removed from his mother′s care permanently, it had to be soon to optimise his chances of a successful adoption. Once a child has turned four, the odds of a successful adoption decrease. One of the most heartbreaking parts of my work was seeing adoption breakdowns, where adoptive parents were no longer able to look after children who had been so longed for, often after many years of fertility treatment. I often thought of the children who were handed back to the state, usually as teenagers, emotionally broken, our paths crossing after they had survived suicide attempts. For Adam, there was no time to spare.

“The drug and alcohol counselling,” I said.

“Yeah it′s going really well. That counsellor gets me. Like you do. I trust him. You will put in the report that I’ve sorted myself out, won′t you?” she said, her speech a stream of distress.

“I haven′t seen you like this before,” I said, “I′m worried about you.”

“Can I just pop to the ladies?” Vicky said. She looked as if she was going to be sick.

After fifteen minutes, I went to look for her. But Victoria had left the building. Her phone went to voicemail. Looking out of the window, I saw the wind was blowing leaves up, making the office attic like a child′s snow-globe. In children′s books, autumn leaves are red, but the leaves outside the window were green and purple, like Vicky′s bruises.

There were leaves in our military-issue kitchen too, when I came home. Liberty had been doing crafts at nursery, gluing fallen leaves to paper. Over the next fortnight, the leaves on Liberty′s collage would defy her glue, fluttering from fridge-door gallery, to the floor, until all that was left was the snail-trail of dried glue and a name written faintly in pencil on her denuded collage.

Over those two weeks, Victoria did not return to the clinic. I called first her solicitor and then social services, to see if they could persuade her to see me.

“Ms Winchester doesn’t have to talk to me, I said to her solicitor, “I′d just like to show her what is in my report.”

But Victoria never came back for any further assessment sessions. It meant that the next time I would see her would be in the family court, at the final hearing, where the judge would determine her children′s best interests and set out their future.

JUDGEMENT

On the 23rd December 2013, three weeks after I had last seen Victoria, I sat on the top deck of the bus from Finchley Road to High Holborn. It was the last day of work before Christmas and the day before my first scan. I was worried that the scan would show another miscarriage. Liberty had enjoyed peeking behind each advent calendar window and her nursery song was right, advent had been about waiting, but instead of sharing her excitement and hopefulness, I was cloaked in dread. Getting to know Victoria, hoping for her, imagining her children returned to her from foster carers, then seeing those hopes dashed, was haunting me, even as I was absorbed in my own troubles. I wasn't sure why. I kept thinking of the once accomplished woman who I′d glimpsed at the network meeting and wondering how she came to be drug and alcohol-dependent, at times barely conscious on her kitchen floor. What had happened to Vicky? Could someone have helped her in time?

The bus lurched around a bend and instinctively I reached for the grab handle, the metal smoothed by all the passengers before me, cold against my fingers like an unwarmed speculum. How life veers. I took out my purse, unfolded the September 2013 ultrasound, and sat staring at the unborn child I would never hold. It wasn't just ultrasounds of my unborns that I carried in my bag, but also pregnancy tests. I kept the ones with two lines: one test line, one life line, and later, after a scan that showed no heartbeat, I kept the hospital pregnancy tests, with just one line confirming foetal demise, a dead line.

The ultrasound print-out that I had unfolded on the bus bore my date of birth and recorded the unborn′s lifetime as 11 weeks. I was 39 and time, or more precisely, my ovarian reserve, was running out. The unborn I was carrying now wasn't legally a child yet, it wasn't even a foetus, just an embryo. Even my obstetric timeline was legally defined. It is the law that defines personhood, conferring it on born children, making it harder to mourn my unborns, so I carried evidence of their short existence.

I walked quickly from the bus stop to the Principal Registry of the Family Division of the High Court, passing several glass-fronted offices on Chancery Lane, where office workers had left their cubicles to congregate. I′d got off a stop early to walk and gather my thoughts. To think my way through the questions from court, I needed to mentally move back from the tangle of troubles and trauma.

“Mummy looks like an egg timer,” Liberty had said as I was getting dressed that morning. She was used to seeing me dressed in bright colours for clinic, but I always wear a black suit to give evidence, partly uniform, but also exoskeleton. I wear black in court, because whatever the judge′s decision, at least one person will be facing an unbearable loss. Getting dressed that morning, I made a conscious emotional detachment from Victoria Winchester. Somewhere during my years on the wards, I had acquired the skill of wilful detachment, just as I had unwittingly picked up military jargon. It felt akin to sliding my thumb into the small piece of metal that holds closed the lobster-claw clasp at the back of my necklace and unhooking it, a deliberate unfastening.

Detaching felt essential. Opinions offered to court arose out of close understanding. All the time that I was assessing Victoria, I tried to see and understand her life through her eyes. But here, giving evidence, instead of looking at the fear in Victoria′s eyes, the fear of losing her children, I needed to look through professional eyes at her children′s best interests and whether Victoria’s mothering met those interests or caused harm.

The Principal Registry of the Family Division, part of the High Court, was in a building that looked like a 1970s office block. As a registrar at the Maudsley Hospital, I had undertaken a mini-pupillage at the Royal Courts of Justice on The Strand, the imposing grandeur of the building as vivid in my mind as the lessons I learned there. For a fortnight I had shadowed Lady Justice Carr, while she heard a complex case, in which two parents were purported to have deliberately injured their three children, fracturing many bones. Sitting by her side on her podium, I watched experts from many disciplines, including emergency medicine, pathology and genetics give evidence. Like a real shadow, I had hung around her chambers, where she had deliberated over what she had heard and told me what makes a good expert witness.

“Clarity, sure of their limits, honest about where their opinion differs from that of their peers,” she had said. “Mostly, I value an expert who presents the medical facts in plain language. And I do not like doctors speaking fast, I take my own notes.”

A decade later, now as a more experienced professional, I remembered Lady Carr′s words and aspired to be a good expert witness that day. The Family Court hears cases in private, some would say secret. Whereas any interested person can sit in the public gallery of criminal proceedings, the Family Court is closed. This paternalistic approach, although well-intended to protect the vulnerable lives probed and laid bare, means that the power imbalances, the scant resources available for child protection, the stigmas of mental illness, and of alcohol and drug misuse were also unseen, critics would say, unscrutinised. I imagined being cross-examined by a bewigged barrister about my complicity in this.

″Would it be fair to say, Dr Dosani, that you didn’t pay much attention to this until you were also probed, your own body′s secrets laid bare?”

″Yes, that would be fair,” I imagined myself saying. I turned towards the judge.

The Family Court was a respectful place, officials mindful of not encroaching on professional time, an eye on the bill that could be running up. It was to manage costs and professional time that Jess had been asked to give her evidence about Victoria′s children, Mandy and Adam, that morning, whereas I had been called in the afternoon. Ben, in his role as team manager was a salaried full-timer, so he usually stayed in court when the team was giving evidence. It meant each of us had a colleague present for moral support and, later, for debriefing and learning. Ben and Jess were in the foyer when I arrived.

I looked at Jess, curious about how her morning had unfolded, but her face was still masked in professionalism. Her usual polka-dotted jersey dress had been replaced by a dark grey pencil skirt and jacket.

“How was it?” I asked. I wondered what had happened since Victoria had walked out of the clinic.

“The guardian′s rep asked me a lot about Adam and his foster placement. It looks like they′re going to support the local authority in pushing for permanency.” This wasn’t a rubber stamping then. It was never going to be. The children′s guardian had to analyse risk from all angles, including holding the local authority to account.

“And Victoria′s barrister?” I asked.

“Ex-nurse,” said Jess, “now does a lot of medical negligence, usually for the prosecution. Expect a grilling in there. He picks over all the clinical evidence.”

“As he should,” said Ben, turning to Jess, “You’ve worked a lot of Saturday mornings. Why don′t you go home and have an early Christmas?”

“I′m going to pop in to Covent Garden,” said Jess, “pick up a few stocking fillers.” Jess walked away quickly, unwinding her hair which she had pinned up for court, shaking it free across her shoulders.

“Jess did well giving evidence,” Ben said, as Jess walked away. His breath smelled of instant coffee. Coffee, even a whiff of instant, made me feel queasy.

“Did well?” I asked, “Is this something we′re assessed on now?”

"That's not what I meant, Sabina. Jess was clear; she presented her evidence well. No need to be tense."

"Give me a moment," I said. "I'll see you in there."

There was airport-style security. After being scanned, I went to the toilet to check my underwear for blood. How many times was it normal to check in a day? Whenever I went to the loo? Whenever I was worried? How often could I worry before it was a sign of madness? What-ifs buzzed in my head like flies at a picnic, bothering, irritating. When did those what-ifs become intrusive thoughts, that hallmark of anxiety disorders? When it comes to patients, I can answer these questions easily. As a junior doctor, I was taught to look for the impact of thoughts like the ones I now had. How many minutes a day are lost to these worries? What do they stop you from doing? In what ways do they interrupt the rest of your life? What do you need to do to stop them? It took several years before I discovered the most important question, the one patients, not professionals, taught me to ask: *What happened to you?*

I texted Comfort: "I keep thinking it's going to go wrong."

She texted back in seconds with a smiley emoji, "Babe, today you are pregnant!"

"Thank you. Scan at GP tomorrow."

"Hey!! Good luck :) "

Outside the loos, I looked at the sign on the court listings noticeboard, *Winchester v Local Authority, Courtroom B*. The family court is not meant to be a combative place, yet there are many invitations to be adversarial. That small v, versus. How could it not set a mother up in opposition to the state? There was adversary too, in the conversations between parents and lawyers, couched in the battle language of losing and winning, of parents fighting the local authority, lawyers defending their case. Sometimes, the decision didn't come before the judge. There were times when I'd arrived at court, and counsel called me in to a side room, where deals were struck between legal teams on behalf of their clients.

“Horse-trading,” Ben called those meetings. There would be no horse-trading in this case, but passing the rooms where I'd taken part in more collaborative, constructive discussions, sometimes on the same morning that a case was listed to be heard in court, made me wonder what might have been gained here. Ben had often teased me for being a Pollyanna, naively hopeful, right to the end.

Ben was already in the waiting area, filling two plastic cups of water from the dispenser. He passed me one, silently, knowing that my throat would be dry. When I'd snapped at him, he'd seen I was nervous about giving evidence. With such high stakes, I was anxious to get my part right. Ben knew too, that I like to sit quietly and read my report before going in. I knew it by heart, but the ritual helped me focus, like pausing before entering a hallowed space. I approached court with a sense of awe for the wisdom that justices apply to cases.

Across the aisle of the waiting room, Victoria and her lawyer were talking quietly, heads bent over a sheaf of papers that had been annotated with underlining, sticky notes and highlights. I wanted to lean across and ask her what had happened on the day she had walked out, but our conversations were now cordoned by a thick professional boundary, and this would have been trespassing. Victoria looked across to me and I met her eyes, deep reservoirs of dread. I didn’t smile, even though my heart felt warm towards her. When a mother may be losing her children, there is no place for smiles. I nodded at her, in the barely perceptible way the other Second World War widows used to nod when passing my Omi in their village.

The clerk called us in to a courtroom that smelled sharply of citrus cleaning fluids, as if all the mess and pain of the morning's evidence had been wiped away. Like Jess, the legal teams were dressed in dark colours, in sober contrast to the Christmas jumpers worn by the people in the offices along the road.

“Court rise.” Everyone stood facing the podium where the judge entered, our heads bowed as a mark of respect for justice. After some legal preliminaries, my name was called and I walked to the witness stand, put my hand on the Bible and swore to tell the truth.

I had been sitting behind the three barristers who would be cross-examining me. For the first time, I looked at their faces: Ms Miller, the barrister representing the local authority, Mr Barker, who was Victoria Winchester′s barrister and Ms Leonard, representing the children′s guardian. Victoria sat behind her barrister, head bent as if in prayer in the pew-like seat.

“Good afternoon, Dr Dosani. My name is Ms Miller and I represent the local authority. In your report, you have summarised both children′s development and the nature of significant changes in their behaviour. Your colleague Ms Jessica Stephens has this morning addressed the court in detail about Amanda, known as Mandy, and Adam. It would be most helpful if you focused only on Adam please, in your evidence. Could you please state your opinion for the reasons for his disturbances of behaviour and emotions?”

“Good afternoon, Madam.” A convention of court is that all evidence was addressed to the judge, so although the barristers questioned me, I turned away from their gaze and addressed my responses not to my interrogator, but to the judge. “In my opinion, Adam′s disturbed behaviour has multiple, interrelated causes. He has clinically significant impulsivity, poor concentration and emotional dysregulation, observed by teachers in school. I’ve seen this too, both in the contact centre and during a school observation. The family history of attention deficit disorder among his maternal uncles and cousins makes a genetic predisposition for neurodevelopmental disorders likely. However, the story stem assessment also shows clear evidence of an attachment disorder.

There are unconfirmed reports of maternal alcohol misuse during pregnancy. A diagnosis of foetal alcohol spectrum disorder is also likely."

"Are you saying he has all these conditions?"

"His current presentation and history mean that one diagnostic label alone cannot adequately explain his treatment needs. He meets criteria for both attention deficit hyperactivity disorder and an attachment disorder. It isn't possible to definitively rule foetal alcohol spectrum disorder out. Based on Adam′s facial measurements, I think it is more likely than not that he has it."

"What is the likely outlook for these conditions?" Ms Miller asked.

"ADHD has a well-evidenced treatment base. A combination of behavioural interventions, consistently applied, in a home environment and in school, is the first line of treatment in a child of his age. As he gets older, there may be a role for medication. The aims of treatment would be to diminish his impulsivity and improve his concentration and ability to sit and listen. Adam also needs a home where regular school attendance is prioritised. His attachment disorder, to put it simply, would be best treated by giving Adam an opportunity to form a high-quality, enduring relationship with an adult."

"An adult caregiver?"

"Or a therapist," I said, "although given his age, a consistent adult caregiver would be ideal."

"And what is the outlook for Adam, what are the risks, if his conditions are not addressed?"

"The intense physical and emotional outbursts he has, that others have described as tantrums, will get worse. Adam will deteriorate. He'll fall further behind in school, becoming a teenager with poor educational attainment and a voracious appetite for taking risks. He'll be much more likely than others of his age to develop serious mental health conditions that will persist into adulthood. He will most likely become a young person who is at high risk of offending, of becoming well-known to youth justice services.” Although I was speaking about theoretical possibilities for Adam, I was also thinking of the realities for Mandy.

“What is Ms Winchester′s ability to meet Adam′s needs?”

My throat was dry. I sipped the water that the clerk had poured for me cautiously, the increased blood flow to my pelvis from the hormones of early pregnancy agitating my bladder.

“Victoria Winchester loves her son, loves both her children.”

“My question wasn’t about love, Dr Dosani.”

The report of the independent adult psychiatrist bulged against the metal arch of the court bundle, straining the large ring-binder in front of me. In that report, Victoria was described as “chronically and severely depressed as a result of multiple traumatic loss experiences, developing maladaptive coping mechanisms including drug and alcohol dependence syndrome.” That psychiatrist had not been called to give oral evidence, his written conclusions speaking for themselves. Like the court, I too had accepted with ease his conclusion that that Victoria had alcohol dependence syndrome, psychiatric in-speak for an alcoholic. For the first time, it struck me how uncritically my colleagues and I accepted this reductive label. Alcohol dependence syndrome didn’t represent a biological fact, but a complex set of seemingly unsolvable conundrums, with deep personal roots in early experiences. Whatever miseries had befallen her, and various professionals involved with her case knew perhaps the bare bones of those, those miseries were no more visible from the outside, than my own uterine contents.

“In my opinion, Ms Winchester′s ability to meet the emotional and development needs of both of her children is currently impaired.” My hands gripped the ring-binder in front of me, as if I was trying to wring a more bearable truth out of the bundle of reports.

“Nothing further, thank-you.” Ms Miller returned to her seat.

Ms Leonard, the barrister representing the children′s guardian, was up next.

“This family has had many interventions from different services. Could you tell me the effects of these interventions?” she asked.

“Madam, a pattern I have noticed is that Ms Winchester attends all her early assessment appointments, whether with the local authority, with me or with the drug and alcohol services. I found her to be highly cooperative at the beginning of the assessment process, until the sessions became emotionally challenging. Then Ms Winchester withdrew, which coincided with an observed increase in drug and alcohol use. I'm unable to comment on the effectiveness of the drug and alcohol counselling as she has attended only the introductory individual and group sessions.”

“Would it be fair to say that Ms Winchester can be a good mother in some situations, but that she parents less well in the face of day-to-day stresses and the ups and downs of life?”

His question made me think of the observation in the contact centre. How I'd warmed to the woman sitting at the snakes and ladders board with her children. I had wondered what it would take for Victoria to be that relaxed and playful mother, for more of the time.

“Her parenting skills deteriorate markedly under stress,” I said, thinking how easily ladders can become snakes. “Eleven separate attempts at helping her with her habitual drug taking and alcohol dependence syndrome have been unsuccessful.”

I was still facing the judge, directing my answers to her podium, my back to the court, so couldn’t see Victoria's face. I didn’t imagine her face as I spoke. It was her children's faces I thought of. I imagined them, years later, asking why nobody had protected them, why the system had let them down. I imagined being in a different court, facing a coroner investigating the death of Adam or Mandy, questioning why services had not down more to protect them.

“Your report says that Ms Winchester was less than truthful about attending those sessions.”

“Ms Winchester made a good initial impression, not only on me, but also on her drug and alcohol counsellor. I see her untruth as an attempt to preserve that good impression. I believe that her intention was to attend the sessions, but something happened, something that I can′t explain, but it meant she felt unable to attend appointments, so she lied to me in an attempt to save face."

"Do you think she lied to you about anything else?"

"Madam, I have no evidence to suggest Ms Winchester was anything other than honest in the clinical interviews. I believe she was honest about her upbringing and past, but it was striking that when probed, whether by me, or by the drug and alcohol therapist, where there is much more of a necessity to engage in self-reflective emotional work, Ms Winchester absents herself, either physically, by walking out, or by missing sessions, or by becoming intoxicated. The tragedy is that Ms Winchester absents herself from parenting Mandy and Adam when their needs tax her emotional reserves. Something has left her unable to put her children′s needs first."

I noticed my nails digging into my palms, where I had clenched my fists so tightly, an involuntary action that meant I could talk about Victoria in this way, as if she wasn't in the room, without my own voice breaking. I heard a snuffling noise coming from the court that I still had my back to. Was Victoria crying? I tried to push the thought out of my mind, imagining it was a lawyer, blowing her nose, but the image of Victoria, biting her lip, blood seeping into lipstick, smudging her mascara with the back of her hand, replayed in my head despite my efforts. Was I to her as the ultrasonographers were to me: cold, detached, uncaring?

"In your opinion, what does Ms Winchester need, in terms of support from services, to make it work, so that she is able to meet her children′s needs consistently?"

"She needs a package of support that is mostly already in place, namely therapy both for herself as an individual, to address whatever traumas are causing her such difficulty, but also family therapy sessions to address the impact of the past few years on her relationship with both children. She would also benefit from parenting classes, assistance from a family support worker, but, and it's an important 'but', all these services and interventions need her to be sober, to be drug free and able to attend regularly. Without that, it's a theoretical wish list."

"You gave evidence a few moments ago that the drug and alcohol therapy hasn't worked. Is your wish list realistic?"

"The drug and alcohol community service wasn't enough, despite multiple attempts over two years. After speaking to those specialists, I share their opinion that a residential rehabilitation programme, where Ms Winchester can focus on her addictions, before attempting to simultaneously meet her children's needs, is the next logical step."

"Thank you. I have no more questions for you."

Mr Barker, Victoria Winchester's barrister, had under-eye bags that hung down almost to his cheek bones. His bloodshot eyes and clay-like complexion suggested that he ate at his desk, late at night. Despite his apparent exhaustion, he leapt up like a boxer in a ring, eager for the next round.

"My client," he said, jabbing his index finger towards me, "rejects your assertion that her attendance at appointments has been poor. There may have been occasional problems with transport and diary clashes, where she was booked in to see you and also the drug worker, so she quite naturally prioritised the drug counselling on those occasions." He gave me a look that I recognised from previous encounters with barristers. It was the look that often heralds a grilling.

"Frankly," he continued, "wouldn't you agree that too much is being made of the missed appointments? Is it not best practice, to allow a little leeway for a lone mother of a runaway teenager and a son, who you yourself have diagnosed with a complex neuropsychiatric condition that makes him challenging to look after?"

He was trying to rumble me, make me flustered and doubt myself, worrying a hole into my evidence so that it fell like rows of knitting.

I was still facing the judge, but I imagined Victoria in the rows behind me, perhaps sitting upright to give his cross-examination her full attention. I imagined her eyes, that I had seen lit with hope in the waiting room, but also cloudy from drugs and despair at our last meeting in the clinic. All I could hear was the shuffling of papers: no sniffs, no tears, just silenced emotions.

"You′re absolutely right," I said, "that there were good reasons for many of Ms Winchester′s missed appointments. However, it was precisely because there were so many plausible reasons for missed appointments that it took me a long time to notice that Ms Winchester′s missed appointments with me were part of a pattern. She missed twenty-eight of thirty-two drug and alcohol counselling sessions, did not attend three consecutive follow up appointments with the adult psychiatrist, leading to discharge from the NHS. Yes, she missed assessment appointments with me, and you have her explanations for those, but Ms Winchester also excused herself to use the facilities in the middle of an appointment and didn't return. There are unique stresses on this family, burdens Ms Winchester shoulders alone, but despite many offers of help, and - I read from my report: *four years of drug and alcohol counselling, group and individual, partial engagement with services, frequent relapse and avoidance of calls* - she has been unable to focus on her own mental wellbeing in order to meet her children′s needs."

"Knowing the unique nature of those burdens, what steps did you take to support her attendance?" he asked.

"As is my usual practice, I called her and visited at home. When there was no response, I called her social worker and your legal colleagues. I′m used to working with families that are often described by other services as chaotic. As a psychiatrist in the community, for many patients, coming to mental health appointments falls below other priorities, like finding a home where they feel safe, or making sure there is enough food to eat. Taking all that into account, the number of missed appointments here, for an assessment mandated by court, was exceptional. The context of those missed appointments matters. This isn’t accounted for by a chaotic, busy household with an overwhelmed parent. Ms Winchester's appointments were missed when emotional material was discussed or touched on. There was a clear pattern of avoidance.”

“Is it not also the case that you observed many instances of positive parenting, that you recorded in your report?”

“Although there were many positives, I observed inconsistent parenting. Those inconsistencies have put both children at risk of harm. When they went into foster care, both had been regularly left hungry…”

“That wasn’t my question. Thank you for clarifying that there were many instances of positive parenting. My client is proposing that she attends residential rehabilitation to treat her addictions and is then reassessed to demonstrate that she can build on the positives.”

He sat down.

The local authority barrister sprang back up asking permission from the judge to ask me about this theoretical possibility, “Even if there was a successful residential rehabilitation, can she do this in the children's timescale? Adam is already five years old.”

“Adam is at a critical deadline,” I said, “at the start of the interim care order, Ms Winchester declined residential rehab. She failed to engage with community rehab.”

For the first time, I heard myself through Victoria's ears, “declined residential rehab...failed to engage.” Didn’t I sound just like the on-call obstetrician, whose reduced my agony in Paris to, “patient denies clots”? Wasn’t my manner like the nurse in the early pregnancy advisory clinic, whose words of condolence were “obviously there's no heartbeat”? Hadn’t the obstetrician, the nurse and I once shared the same ideals: to heal or at least to relieve suffering? I was doing what I hated as a patient: speaking with clinical detachment, privileging facts over our common humanity.

“Is it not the case that both children are at critical junctures?” asked Ms Miller. “There is a five-year-old who would be left in limbo regarding adoption. Mandy needs stability to support her in becoming a young adult; she needs security. Mandy risks being put back into a caring role.”

“Yes,” I said, “I agree.”

“No further questions.”

The judge addressed me directly from her podium:

“If this court finds that Ms Winchester is unable to fulfil the children′s needs, could you outline alternative possibilities, including what sort of placement and what level of contact would be optimal?”

“Madam, I would respectfully recommend foster care for each of the children. They have different care needs. In order to address Mandy′s absconding and her significant risk of sexual exploitation, I would recommend that she is placed in a home with a higher degree of security than a usual domestic setting. Adam has settled well into his current foster placement. He would benefit most from being placed in a family environment, somewhere where there is good expertise in helping children with behavioural disturbances, where the foster carers have time to attend therapy and medical appointments, can work collaboratively with school and are supported to put a consistent programme of strategies into place. Ms Winchester has indicated willingness to attend a residential addiction rehabilitation programme. Any contact would need to be negotiated with her treatment provider. My recommendation would be for weekly contact, at a supervised contact centre, with contact between siblings happening as often as practicable.”

“Thank you and your colleagues for your assistance with this case.” The judge looked at me, “You are welcome to stay, of course, but free to leave.”

Ben folded his black jacket over his arm, the leather shoulders worn, exposing the soft part of the hide.

“I’ll stay,” I whispered, as he clambered over me. Ben had already stayed longer than necessary, as a witness to my evidence. My work was complete, but I felt a moral obligation to stay. I looked across at Victoria, my heart aching. It would have been wrong to gloss my assessment. My obligation was to the court. The court was focussed on the best interests of Adam and Mandy. For a moment, I looked across at her, one mother to another and all I saw was grief.

I was curious to know what the judge ruled. More often than not, the team gave evidence, returned to clinic, saw the next family, completed the next piece of assessment work and still we heard nothing. Our administrator Kathleen would call solicitors to chase up an outcome, but it was often months before we heard what had happened in court. This too fostered distance, between our clinical intimacy and the court′s decision, a distance that had its uses, like preventing emotional over involvement and heartbreak. But on that December day, I took the opportunity to wait and hear the decision directly from the judge, who had withdrawn to her chambers, after inviting the barristers to sum up. I would have liked to travel back in time to Lady Justice Carr′s chambers at the Royal Courts of Justice, to ask her if how it was possible to be a good medical expert witness without setting aside so much of my humanity. It came back in the days after giving evidence or filing a report, sometimes at tears in the shower, at others in flashes of rage at the casual sexism at HQ. When she returned, the judge leant forward in her chair and addressed the court, her decision unfolding with care and logic.

“Amanda and Adam Winchester are siblings who have been well known to the local authority′s social services department for two years, and who for the past six months have been subject to an interim care order due to concerns about neglect, poor home conditions and inadequate parental supervision. There are many tragic aspects to this case. Amanda′s father died of a drug overdose when she was two years old. Adam′s father is serving a life sentence. I accept Adam′s diagnoses of attachment disorder and attention deficit disorder and that this places unique stresses on the family. However, Ms Winchester′s role as a mother is to protect her children. For reasons that are unclear, Ms Winchester is herself fragile and needs looking after. Amanda has had to take on a caring role and needs careful parenting to allow her to relinquish these responsibilities and to be a child herself. It is the local authority′s case that it is unlikely that Victoria Winchester will be able to meet her children′s needs, even after therapeutic work to support her to do this. I accept that there is a possibility of rehabilitation, in the form of residential rehabilitation for Ms Winchester, but that remains a theoretical possibility and regrettably has not happened within the children′s timeline. I note that the maternal grandparents do not wish to put themselves forward as potential carers. Furthermore, the local authority have proposed that Adam should be put forward for adoption, given that he has turned five and his timescale for successful adoption has reached a critical deadline. After considering the expert evidence and balancing all of the realistic options for these siblings, I accept the evidence put before me. The local authority must find Adam a permanent home as soon as that can be done. Given her age and the risks of exploitation, Amanda should remain in a secure foster placement until those risks are better managed."

With the urgency of a fire siren and as loud, a sound somewhere between a howl and a wail, poured into the courtroom. The sound came from Victoria, from a place before words. The judge had made a permanent order, forever severing the legal bonds between the siblings and their mother. Mandy was to remain in residential care, her brother Adam would be placed for adoption, with a parent or parents who were waiting for a child to welcome as their own. It seems unthinkable, severing the blood ties of a sister and brother, but it wasn’t unusual. In the year that Victoria′s family were brought to court, almost half of the sibling groups in local authority care were split up. Within them, there is an unspoken hierarchy of siblings. I can′t imagine a judge ever separating twins.

As I walked to the Tube station, my exhalations hung like small rainclouds in the cold air. Coming out of court, after being submerged in a world of objective certainty, always made me feel like a scuba diver breaking the surface of the water. I made the journey back home to HQ like an automaton, the Tube carriage becoming a hyperbaric space to recalibrate. On my way there, I watched with giddy detachment as the people from the glass-fronted offices were travelling home after packing up their desk-parties. I imagined them at home with their families, perhaps around a tree, celebrating the birth of an infant and his unmarried young mother, hosting postnatal visits from shepherds and kings in an agricultural outbuilding. When I arrived at my final stop, a flower stall outside the station was selling bunches of glitter-sprayed twigs and wooden mock-ups of the holy family's temporary accommodation, a tenner for a replica-newborn in a livestock trough.

CHRISTMAS EVE

All three generations of the GP's family had looked after me. They were all doctors who took an extra moment to be kind, who were efficient and multitasked, but without hurrying and without speaking to their computer screens instead of addressing their patients. I wished healthcare systems allowed every doctor to practice like that family of family doctors.

"Yup," my GP said, looking from the grainy screen to my face and repositioning the ultrasound probe, "you're definitely pregnant."

"Come over here, Colonel, come and have a look." He beckoned Simon over and pointed at the screen, which looked like a cloudy nightscape. The doctor's finger stopped at a small star on the night sky, "There's your proof. That's a foetal pole. Just one."

It looked like a lodestar, one Simon might have navigated by as a junior officer on one of those training exercises when he had been dropped out of a helicopter in the night, into unknown terrain. Examination over, we shook hands and wished the GP a happy Christmas. He looked straight at us, "A foetal pole, it's not a promise, but it looks good," he said, with a confident smile. I knew better than to chart a pregnancy by a star on a scan. If my lodestar was not there on the next scan, I'd be a woman adrift, lost, untethered. I knew better than to chart a pregnancy by a star on a scan, but even before I had buttoned my jeans back up, I was doing it.

SCANS

Ever since I had seen Comfort to collect the Natural Killer Cell Protocol drugs, the recurrent miscarriage clinic midwife texted me every morning, even on New Year′s Eve:

“Today you are pregnant babe :-) !!!”

“Thirty-four days pregnant!” I replied.

Aside from the first scan at six weeks, which my GP did as a favour in his surgery, the remaining fortnightly scans were to take place under higher resolution at the hospital. A fortnight after seeing a foetal pole in the GP surgery, I was back in the same hospital waiting room where I′d sat at Easter and again in September and waited for the scans that showed my embryo had no heartbeat. How transparent my body became on the scanning couch.

“Why all the scans?” I had asked Comfort.

“We got you under surveillance, babe. Scanning is our superpower. If a pregnant woman who has had previous miscarriages has scans every fortnight in the first trimester, it boosts her chances of having a live baby. Just scanning on its own, with no other interventions, makes a difference,” Comfort explained.

It sounded magical: just looking into my uterine contents, without any other apparent action, could be life-saving. It was a familiar alchemy. My former boss, Anula Nikapota, taught me that at those times when a situation seemed hopeless, the most important act I could do for a patient was to bear witness.

When Anula told me this, she had just returned from Sri Lanka, where she had been helping children who had survived the 2004 Boxing Day tsunami.

“What is there that can be done?” I had asked her, feeling overwhelmed at the scale of suffering.

"Allow families to name what has happened. Look at the children's drawings. Many children were drawing pictures about 'being washed'. Families described the anguish of their relatives and friends and pets and possessions being taken away using that phrase."

Anula did not say, "washed away." She did not edit. She taught me the value of sitting with someone while they voiced their experiences, without recoiling, without rushing in to soothe them or stem the flow of tears. By example, she taught me that bearing witness can be life-changing.

"Name the emotion, say things like, 'I can hear the anger in your voice'."
As a junior doctor, looking at children's pain was like looking into the sun. My instinct was to shield my eyes and look away. My colleague Jess spoke of the compassion fatigue she had experienced as a ward nurse. Ben warned us about secondary trauma, which Marco called vicarious trauma. For me it was visual: sometimes a patient's vivid descriptions of trauma burned into my retina, leaving me with afterimages, which loitered like ghosts in unexpected places.

My eyes remembered Aveen, who had come to outpatients in Lambeth with a referral note saying just: "thank you for seeing this pleasant lady, ? depression." Aveen had lost her twin daughters in a bomb blast in Syria and described how she had felt frozen to the spot as she tried to choose which dying child to run to first. My eyes remembered seven-year-old Toby who I had seen after he had been sexually abused by his stepfather. My eyes remembered Toby's face when he told me his mother had taken her husband's side. In moments of professional hopelessness, the only gift I have to offer is to look into the abyss, to witness violence and its long trail of withered hopes and not look away. Bearing witness was an act of empathy, a show of support, it offered a promise that there would be a way to make sense of a senseless loss. Sometimes my looking had a different function. I thought of all the young patients I had once kept under six-monthly review, in shared-care arrangements with their GPs, where we had formed a tag team of surveillance for adverse effects and took turns in scanning for symptoms. Looking and seeing, healing and knowing were interlaced.

"Miss Dossynee?" called the ultrasonographer, interrupting my thoughts, poking her head across her threshold, her voice raised above the sound of teenagers chatting in the waiting room. An hour ago, I had been Dr Dosani, with an opinion worth listening to. Here, I was another high-risk pregnancy, another funny surname to mangle.

The first child I ever saw on ultrasound was in this same hospital. It was on an ultrasound screen that I first glimpsed my cousin Ayub, named for our late grandfather. Our grandfather Ayub fled Burma during the Second World War, and rebuilt his business from scratch. My uncle had ushered me in to the scanning suite. I was nine years old. I remember the tadpole-infant on the screen, the swoosh-splosh of his heartbeat and his dolls-house-sized limbs. That ultrasonographer seemed different from most of the ones I encountered as an adult. She seemed to be as full of wonder as I was. As well as wonder, I felt full of responsibility for my unborn cousin. That feeling didn't wane, even though his toddling collided like a bumper car into my teenage weekends, even though he is now a father himself, even though months can pass without us speaking, the feeling of responsibility remains. That feeling started when I saw him on a screen in this hospital, where I later received bad news and where I was being scanned every fortnight. Because recurrent miscarriage scans took place on Wednesdays, clashing with the family court service weekly meeting, Bex, the miscarriage clinic receptionist, offered me other options. I wondered if she was always this accommodating. This meant that I found myself waiting with women who had pregnancies that were deemed to be high risk for reasons other than recurrent miscarriage, grouped together by risk factor.

For the eight-week scan, the so-called foetal viability scan, Simon and I were waiting in a teenage pregnancy clinic. He had run out from work and needed to go back as soon as we returned to HQ, so was in uniform. A six-foot plus man, wearing battle camouflage, a beret with a white and red-tipped feather hackle and big black boots stood out in the teenage pregnancy clinic. When I first saw the hackle on his head at HQ, Simon had told me the story of how it came to be red-tipped.

"It's a battle honour," he had explained, "awarded in recognition of the defeat of the French in the Battle of St Lucia in 1778, where white hackles were removed from the dead by the Fusiliers. In 1829, King George IV ordered all infantry regiments to wear white hackles, but because our battle was won in blood, our plumes were red tipped ever after. There are other stories, about the Fusiliers dipping their white hackles in the blood of the defeated army, but that's just folklore." I thought that a hackled beret made for an absurd London desk uniform, but for Simon, carrying his regimental battle honour on his head was part of his identity. The hackle and his splodged green and brown camouflage that would have made Simon invisible in an enemy jungle, made him stand out against the greying white walls of the maternity wing.

Every passing nurse and porter wanted to hold doors open for him, a courtesy not afforded to the pregnant teenagers. The Colonel was not the only one in camouflage. My home counties accent, my pallor in this English climate, my expert witness work in mental health services meant that I didn't stand out. Others perceived me as a white, middle-class professional, who had, as Comfort would have put it, "got her shit together". The messy, sometimes melancholic aspects of my life that I tucked in and buttoned down, had begun to be undone by the steroids. Between the pills, the fear and the grief, I was unravelling.

While we waited, we chatted to a father whose two teenage daughters were both pregnant. While they went for scans, he looked after his toddler grandson, a smiling boy with a finger of melting KitKat in each hand. When his daughters came out, smiling with joy at their scan pictures, it reminded me of squashing into a passport photo booth with my friends in my teens. I felt sad, for the teenagers' lost freedom. The younger teenager looked up at me as I passed her on my way to the scanning room. I caught a glint of pity in her eyes when they met mine, perhaps feeling sorry for a child born to parents much older than her unborn′s grandparents, clearly lacking the energy of youth.

Like Alice in Wonderland, shrinking with every step, I approached the scanning room. My maternity notes were a shield across my abdomen. I gripped them so tightly the ultrasonographer had to tug them from me. The wrangle left me feeling defeated before she had begun. Ultrasound suites are quiet places, like the small side chapels in cathedrals, set aside for private prayer. Scans take place in the dark. The darker the room, the clearer the image. As my eyes adjusted to the dim light, I noticed the cubicle was frescoed with small, monochrome icons of life: mother and child, or more precisely, uterus and foetus. In these mysterious darkrooms, wombs become windows for the peeping probe. The probe sends sound waves down, penetrating the uterus, picking the waves up when they bounce back, translating them into imagery. The remaining maternal body disappears into the shadows, unseen.

At Barts, I was taught that ultrasounds are safe and painless, quite free of side effects. I don′t remember seeing any scans as a student, but I remember women in obstetric outpatient clinics talking about them, how excited they were to see their baby for the first time. Many friends who became parents shared their scan pictures. In the early days, friends fixed their monochrome mini-me to their fridges with magnets. In later years, scan pictures doubled as pregnancy announcements on social media. For every woman I spoke to, their first scan was a highlight of pregnancy. But there must have been scans that friends didn’t talk about. Black and white babies without a heartbeat were not posted on social media. I must have been oblivious to their existence and to my friends’ pain.

Feeling like a pilgrim in the church of St Jude in Paris, I stooped to unfasten my shoes, bargaining with God as I approached the scanning couch with reverence, hoping to witness signs of life. Although I couldn′t see him in the darkness, Simon was sitting in the corner. I heard the silence of him holding his breath. I was afraid to speak. What was it about this room that shrank me? Was it fear that made me so passive and quiet?

Eight weeks felt an important milestone. At eight weeks, an embryo becomes a foetus, meaning offspring. On the screen, I saw a small child, my own Thumbelina with a heart, beating at 160 beats per minute. Twenty years ago, I had coloured in diagrams of an eight-week-old foetus and made notes about brain cells branching and connecting to form the first neural pathways. I knew that tiny lungs would be developing and that my baby had fingers and toes, even though I couldn't yet see them.

The ultrasonographer broke her silence.

"S'all normal," she said, sniffing as I watched her type : "22mm foetus. Singleton. Heartbeat present," into a proforma on the screen. She saw me looking.

"D'you pay for a picture at the desk?"

I nodded. Bex had wished me luck when I handed £4 over: "You'll get your four quid back if there isn't, you know, an actual heartbeat."

"I'm so relieved," I said, as the printer produced two icons, one for me, one for the file, "I've been so worried. I had miscarriages," I said.

The ultrasonographer printed and handed me a second photo, gratis, a consolation prize.

"Shouldn't really be doing this," she said, as I zipped up my jeans. She'd thought I'd been haggling for an extra scan picture.

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At night, the steroid-nightmares continued. I dreamed about viewing homes with estate agents. They showed me children's rooms with twin cot-beds and a seesaw in the garden. In those nightmares, as I was looking out of a kitchen window, I saw Vicky's children, Adam and Mandy, jumping on the trampoline. I couldn't see their faces and wanted to know if they were unhappy. In another house-hunting dream, an estate agent showed me gardens with wildflower borders. Perfect, but for the bloodied pulp of a head, discarded among the ox-eye daisies. I ran and almost tripped over a headless body, which the estate agent did not acknowledge was there, even when police arrived and taped half the garden off. The estate agent raised her voice above the circling helicopter, to impress on me how safe the neighbourhood was, how good the schools were.

But that wasn′t my worst nightmare. In my worst nightmare the blood was mine. When I felt warm stickiness on my thighs and a certainty that the baby had died. After that dream, I became afraid to fall sleep again, in case it was a premonition. In case dreaming the worst would make it true.

Although her children appeared in my sleep, it was Vicky that I thought of in many waking hours. We met fleetingly, yet I thought often of her unspoken traumas and her anguish, the contemporary courtroom a poor shelter for her pain. I remembered her howl, all she dreamed her life would be, prised apart, eviscerated. I imagined her visiting Mandy at the contact centre, watching her turn from adolescent girl to adult woman. I imagined Vicky going back for more addiction therapy, in waiting rooms with plastic moulded chairs, fixed to the floor in groups of three. I imagined Vicky moving, far away from where anyone knew her as a mother and strangers asking her how many children she has. I imagined her hesitating, uncertain of how much to declare, how much to deny.

I had done what I wasn’t supposed to do. I had become over-attached to a patient. If I hadn’t been pregnant, I would have run until the memory of Vicky′s salty tears would wash away with my sweat in the shower. But I was scared to run. Scared I would dislodge the tiny life inside me. Scared of having blood on my hands. So before I went to sleep, instead of consciously detaching, I imagined that I could lean close and whisper to her, mother to mother, “for whatever happened to you, for whoever failed you, I am so sorry.”

CONFINEMENT

There are things I didn’t know until I had miscarriages. I didn’t know that I would become hypervigilant, scanning my body constantly for tiny signs that might mean foetal death. One of the things I scanned for was for the revulsion of coffee. I played mind games with myself. If I could walk past the open door of the cafe on Finchley Road without feeling repulsed by the smell of espresso beans roasting, was it all over? I could not wee without scrutinising the toilet paper for the smallest hint of pale pink. If my breasts were not sore against my bra, was I still pregnant? Was it a sign of a well-fitting maternity bra, or a dead baby? Scanning my body for signs of biological betrayal was a big task. If I didn’t notice pregnancy symptoms during a team meeting or during an assessment with a patient, I put myself on an observations schedule, scanning my body every fifteen minutes, as ward nurses watch suicidal patients. Fifteen-minute foetus watch: smell, cravings, blood, breasts?

I′d been doing fifteen-minute foetus watch when Ben came in to the office, holding the pregnant-worker risk-assessment form and asking, “this a good time for the form?” I nodded. I was used to filling in risk assessment forms with colleagues. I wasn′t used to filling one in about myself. Ben held his Parker pen, engraved “Dr Rosenberg”, over the first question: Expected date of confinement. *Confinement*. Did it really say confinement?

“Does that mean my due date?” I asked.

“Is it on any sort of letter or medical certificate?” Ben asked. Ben was my colleague in the court assessment team, but he was also my line manager. He signed forms authorising conference attendance, stamped his approval on the reimbursement of train fares, made sure we weren't all on annual leave at the same time, that sort of thing.

"Not yet. If all goes well, I'll get a MATB1 maternity certificate when I'm 20 weeks pregnant," I said. The MATB1 is issued as proof of the expected week of childbirth and I would need one, if I got to twenty weeks, to demonstrate my entitlement to Statutory Maternity Pay. The form Ben and I were hunched over was a workplace risk assessment for pregnant women and a included a section on reasonable adjustments. He held his pen over the question: "Is there anything your line manager can do to support you?"

"You'd tell me," Ben said, looking at the cactus on my desk. The office was cramped. He felt uncomfortably close. I nodded. It was hard to keep secrets in a close-knit team. He knew, for instance, about the first-trimester fatigue and how I had napped in my lunch break on the Freudian couch in the psychotherapy room. He knew too, how much diary mangling Jess had put up with when I started the Natural Killer Cell Protocol.

"Since Christmas, I've been having scans. I'll have them every fortnight until I'm 20 weeks, all being well," I said. I didn't like talking about the hypothetical future of the pregnancy. It was one thing Comfort texting me each morning with a cheerful, "today you are pregnant babe xx", but another to sit with Ben and imagine an unknowable future. I knew too, that Ben did so much more than absolving me of paper hurdles. He planned the court assessment service, matching professional expertise to the questions in the letters of instruction. There were three new cases on his desk. I knew that he had brought the pregnancy in the workplace planning form to discuss with me before allocating those new cases. Emotionally, it would have felt easier to keep my pregnancy to myself for a few more weeks, but Ben had a service to plan. First came the form.

"The thing with the scans," I said, "is that they'll take place on different days on different weeks. The early pregnancy advisory unit couldn't give me a schedule in advance, because they were short of sonographers over the Christmas holiday period, but I′ll have a list of scan dates after the twelve-week scan."

"When′s that?"

"All being well, in three weeks."

"Are you expecting other hospital appointments?"

Ben was doing his job, but I felt my face reddening.

"Some, yes, perhaps."

"Good to be transparent about that," Ben said, "it means we can plan for any uncertainty."

I didn't like the sound of being transparent, of my line-manager peering into my gravid uncertainty.

"Team and Dr Dosani both committed to flexibility," Ben wrote on the form, leaning across me, bending his arm awkwardly to avoid knocking the pile of paperwork off Marco's desk, the mountain of someone′s despair spilling down into the valley, where Marco's desk abutted mine. There it was: transparent flexibility, inked on the form. I signed it, knowing it was meant to be a helpful process, yet all the while feeling as if I′d signed a confession, admitting culpability for my faulty reproductive apparatus disrupting the usually smooth workings of the court assessment service.

In the loos I caught my reflection in the mirror. My eyes were underscored with grey, my cheeks like a pair of bake-at-home bread rolls, expanding every day in the heat of the attic office.

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"It was useful, that form this morning, and I think we can work together on this next case," Ben said, gesturing to the table piled with ring-binders and box files. I wasn't looking forward to working with Ben. It was no secret that Ben thought I saw families through rose-tinted glasses. I thought he was blinkered by pessimism.

On the whiteboard opposite the chair I was sitting in, Ben had drawn a family tree, some names with a thick black line through them, each black line annotated with “RIP”. In red, he′d circled a name, Serena, a twenty-eight-year-old woman, now pregnant with twins, who had birthed five children, their names circled in green, our colour code in the team for children in care.

“Serena was three when she found her younger brother, Jack, dead next to his cot,” Ben said, adopting the tone of a newsreader delivering grave headlines. “Jack was eighteen months old when he died. Their parents were heroin addicts, or as Serena′s first foster mother called them, “junkies”.

Serena’s birth mother had been prescribed methadone, an oral substitution treatment. Mothers who use opiates as a salve for their emotional wounds, sometimes soothe their children′s cries by giving them methadone. Whether Serena′s mother had so pacified Jack was never proven. She told police that she had used his drinking cup to measure her dose of methadone and had then lain on the bed exhausted and dozed off. Her toddler son, she supposed, had wandered in and drunk the dregs. She was surprised Jack had died. She thought he′d be tolerant to it. After all, she had used heroin while she was pregnant and breastfeeding. She was sent to prison for manslaughter, as was her boyfriend. Serena, brotherless and effectively orphaned, grew up in fourteen different foster homes, spending the closing years of her official childhood in a locked residential unit, after running away over and again from her foster carers.”

“It wasn’t fair, in the end, on the younger children,” according to the foster mother’s statement in the court bundle. The referral letter said that by her fifteenth birthday, Serena was pregnant by a residential care worker in his thirties. Serena, who had never been adequately mothered herself, struggled to look after her baby. Her son was neglected, left lying in dirty nappies and often hungry. The Local Authority appealed to the Family Court to remove him from Serena′s care, and he was placed for adoption, a week after her 17th birthday.

By the time the court assessment team were appointed as expert witnesses to assess Serena's capacity to be a good-enough mother to her unborn twins, she had borne four more children who had all been removed from her care. Ben proposed that he spend the next ten weeks assessing Serena, asking her questions about her history, observing her in different settings, examining her attachment style, finding out about her life and plans for the future.

"I think it makes sense in this complex case, for your assessment to be confined to the network," Ben said. The "network" was our shared shorthand for the tangled chorus of social workers, therapists, paediatricians, psychiatrists, whose ballad of pessimism filled the ring-binders on the table. Confined to the network. Confined by my confinement? I turned Ben's proposal over in my mind.

"We can, of course, be flexible," said Ben, "What do you think about seeing this mum?"

It was an invitation for me to say, *no, no, I did not think it would be appropriate for me to assess her, not for one moment*. But what stuck out, just as Ben's dislocated thumb had stuck out the previous summer when he came off his bike on Finchley Road and I had held his arm and walked him to the Royal Free, was his use of the word "mum." Are you still a mum if all your children have been removed from your care? Are you a mum if you are childless but pregnant? Are you a mum if your baby dies before she is born? My scans took place in a building called Maternity, but it wasn't until women were massively, obviously, unmistakably pregnant, that any midwife called them, "mum." My invisible-to-the-naked-eye pregnancy didn't qualify me. Serena had passed her 12-week milestone, when a woman can post her scan photo on Facebook, sign up for antenatal classes and enter all the social spaces of expectant maternity. Ben's use of the word mum stuck out, because mothering was so bound up with nurture and care and safety, three precious and essential things that Serena had not experienced enough of when she was a child, and had been unable to provide to her own children.

There were copies of letters in the ring-binders from hospital appointments. The foster-carer, who had looked after three of Serena′s children was described in some of the letters from the paediatricians as "mum" and the social worker had written back, saying Serena had been upset by this, when she saw the letters in a network meeting. A busy clinic. Previous notes missing. An assumption. An oversight, among all the overseeing. And hadn't the foster carer looked after the children since they were months old, giving them nurture and care and safety, as if they were her own flesh and blood?

"I can′t see her," I said, "you′re right, I′m going to start to look more pregnant each week, all being well. It would be wrong, getting to know Serena for this assessment and at some stage, obviously being pregnant, or being visibly pregnant in court."

"Of course. I was thinking too, I mean, heaven forbid, if something goes wrong with your pregnancy, Sabina, you′d need some time off, whereas Serena′s pregnancy is a timetable we don′t have any leeway with. If you work with the network, if it was necessary, we could slot another colleague in to meet certain professionals and then you could pick things back up," Ben said.

The word "network" sounded like the entwined tangle of cables that connected the computers in our team office. "Network" made me think, too, of the safety nets in circuses, preventing the delicate trapeze act that is motherhood from fatal falls. In the weeks ahead, I would meet professionals bringing differing perspectives. My hope was that they would help me complete a picture of Serena′s potential for successful motherhood of her unborn twins. Good professional networks had the efficient communications of a working computer system. They were also good safety nets. Too many professional networks were like overgrown blackberry briars, criss-crossed with thorny agendas.

"What′s your gut feeling?" I asked Ben, who studied the ring-binders before allocating the cases.

“A few in that network that I′d handle with kid gloves,” he replied, sliding his bicycle clips around his latte-hued corduroy trousers, a flash of hairy ankle exposed above his brogues. Like a flustered Victorian spinster, embarrassed by bare ankles, I left him to his afternoon and returned to the attic office.

There was no room for five ring-binders in the office. Space for these ledgers chronicling families who were eviscerated by illness, adversity and addictions was rationed. Unless we were actively consulting a file, it was kept in a locked cabinet in Kathleen, our administrator′s office. I call it a cabinet, but it was more like a metal bookcase, with a lockable roller front, a drawbridge that we pulled down on all the unhappiness piled onto the shelves. The only exception to this was when we were preparing case summaries. Then all the court bundles for a case were spread out on the round table in the centre of the office.

We all took different approaches to understanding the network. Marco drew large maps, on A1 paper using thick-nibbed pens and an abundance of exclamation marks, which he folded like an Ordnance Survey map and referred to throughout the case. Jess worked on the wall, sticking up Post-it notes, with an idiosyncratic colour-coding that eluded the rest of us, later transferring all the Post-its onto punched A4, kept at the front of the binder, like a key unlocking the mysteries that followed. Ben wrote notes in longhand, connecting his scrawl with lines, so that it resembled a spider′s web. In the middle of Ben′s webs was always the child, with those names on the near lines representing those closest to the child, while those on the furthest spokes were important, but not close.

My approach was to read. I read everything we were sent about a family and all I wrote down was a list of names and a descriptor in parenthesis, like “Jimmy and Martin (sons)” and “Balsam (foster mother)”. It′s deliberate, this simplicity. The more complicated a case appears, the more simplified my structures become. When I started court work, I prepared lists of questions for professionals in the network. That approach didn’t last long. Instead, I now ask an open-ended question, like, “what do you think is the most important thing for me to understand?” or “what is your worst fear about this family?”

Instead of focusing on what I am going to ask, I had learned to listen, not just to the content, but also to how a story is being told. As I began to listen to Serena's network, it sounded not like a discordant cacophony of voices, but like a choir, singing a lament in a minor key. After each verse, I heard the refrain, “she won't be able to manage twins”.

*****

Who can say, for certain, what kind of mother any woman is going to be? In my mid-twenties, a decade before I had Liberty, I wrote a parenting book. Though theoretically grounded, much of my younger self's well-intentioned advice turned out to be absolutely useless when I became a parent myself. A week after being allocated Serena's case, Liberty and I were sitting in the car on the driveway at HQ, waiting for the rain to slow down enough so we could get into the house without getting soaked. Liberty was exhausted after a tantrum at the soft play centre. Her determined “no go home” sobs had turned to hot tears. I looked in the rear-view mirror at the small child who could melt my heart, yet also break it, and wondered if I was a good enough mother for her.

On the morning after experiencing mothering doubts in the car, I drove to meet an experienced foster carer. It was still raining hard and my raincoat felt tight around my waist. I was looking forward to being inside when foster-carer Kelly Edwards opened her front door. Number 27 Beech Drive was a slim Edwardian terrace, in the middle of a row of similar houses. As I wiped my feet on the mat, I saw the same expandable baby gates that had been advertised on the loop that played in the waiting room in the recurrent miscarriage clinic. The gates were secured across the room at the front of the house. On the other side of the gate, I could see a young woman kneeling in front of a playmat that was shaped like a giant ladybird. A baby lay on the mat, holding a small squeaky giraffe in his hand.

“Kel, he′s drooling,” the young woman called out for help. She was slightly built, bobbing up and down on her knees, as if hovering with indecision.

“It′s just a bit of dribble where he′s teething, Flora,” said Kelly to the young woman, “just give it a dab with the muslin.”

Flora picked a muslin cloth up, her eyes narrowed with a surgeon′s focus as she slowly unfolded it. Her nails were bitten to the quick. After a moment of hesitation, she dabbed the baby′s mouth, lightly, deftly. Flora wore the hollow-eyed sallow-skinned tiredness that cloaks new mothers. I was used to seeing it, but not on someone so young. She looked around the same age as Mandy, whose guardian had argued so passionately for her right to a childhood.

Flora looked up at me and I looked away, embarrassed to be caught trespassing on her surveyed maternity.

“Well done,” said Kelly and then pointed to me.

“This is my professional visitor, the one I was telling you about. Doc, this is Flora, she′s learning the ropes here with me. Flora′s social worker is just looking for a parking space and once she′s here, you and I can have a chat in the kitchen.”

With calm precision, Kelly continued to support Flora to attend to her baby on the playmat.

“He′s giving you a lovely smile there, Flora. Be a good moment to flash him a big smile back. That′s right, you′re doing a great job, fantastic. Take your time, that′s right. Sit back again now, watch, wait, follow his lead.”

I inferred that Flora wasn’t yet assessed as safe to be left unattended with her baby boy. Flora′s social worker came through the front door and then through the expanding stair gate to meet her client. Kelly led the way along the short corridor, to the kitchen at the back of the house, where she pulled out two chairs and made a pot of tea. We both heard the baby′s cry at the same time. It made me jump, then almost immediately, Flora′s soothing voice came through the baby monitor and Kelly switched it off, detaching herself from keeping watch now that the social worker was with Flora.

We sat in an extension of the narrow Edwardian kitchen, a glass-walled protrusion at the back of the house, overlooking a toddler swing on a sliver of lawn. All the houses in the terrace had similar extensions. The original kitchens were designed when one woman was expected to do all the cooking for her family, allotted one small space.

Kelly poured me a cup of tea. She kept the teapot warm with a crocheted cosy, like my mother-in-law does. Jess had told me that Kelly was an experienced foster carer, with a specialisation in fostering teenage mothers and their newborns, usually because a pre-birth assessment by the local authority had indicated the need for additional support and care.

Kelly performed the daily labour of care for not one, but two, as she guided, supported and taught the young mothers. In the early days, she might do a lot of demonstrating how to make up a feed or change a nappy and then progress to observing the teenagers in performing these acts of maternal care. Occasionally Kelly fostered babies whose mothers had reached adulthood, but needed support with their mental health or were recovering from addictions and often hadn’t been well mothered themselves.

In the legal bundle, I had read that Kelly had fostered two of Serena′s babies. When Serena was fifteen, she lived with Kelly from her twentieth week of pregnancy, until the baby was born. When that baby was nine months old, Serena moved into a flat with him, but things fell apart quite rapidly and he was frequently hungry or lying in dirty nappies. From the legal bundle, I understood that Serena had said all the right things, didn’t send any distress flares. Even after her baby was removed from her care, Serena stayed in touch with Kelly, sending her cards at Christmas and on her birthday. Fostering relationships have no bonds of obligation or reciprocity. Kelly and Serena both nurtured their mutual attachment.

“I used to tell her, I’ll always be here for you,” Kelly said. When Serena was twenty-six, she returned to Kelly when she was seven months pregnant. That baby did not go home with Kelly.

“It wasn’t just her failure, it was my failure too,” Kelly had said to the social worker, words that had been reproduced verbatim in the court report.

“I'm really sad to hear about Serena. Twins. There's no words,” Kelly said to me as we sat in her kitchen, looking out into the garden, at the toddler swing on the remnant of lawn.

“What's the most important thing for me to understand about Serena?” I asked.

“That she's changed.”

Kelly's reply surprised me. I sat more upright in the ladder-back chair, my pen transcribing her words across the blank pages of my notebook.

“Serena has changed. She has gone through therapy. She has all the words now, the knowledge,” Kelly tapped her temple, “of what went wrong in her past. But, she put her hand over her chest, “hand on heart: it is not enough. What happened to Serena broke her. Nobody can live through that and come out unharmed, not you, not me, not anyone. The last time Serena fell pregnant, she had a new social worker, Maureen. Serena persuaded Maureen to place Serena back with me before the baby was born, to have a fresh start. So Serena came to me and ten days later she had the baby. She was a bit shell-shocked at first, glad to let me take the brunt of feeds and nappies. I worked hard on boosting Serena's confidence as a mum, to help her see she could take on that role. That's my job, but some girls need more help than others. Six months in, she was doing a good job with her baby. We didn’t see eye to eye on a few things, exchanged a few cross words. It was nothing I hadn’t seen before. My job is to help these new mums become independent, to take a back seat as they find their own way as mums, until they can safely fly the nest.”

“What happened?”

“Nine months in she was shouting at him. Not just losing her temper here and there, but on most days, I caught her shouting right in his face. Social services assessed her as fine to stay with me, but to be honest with you, I felt really scared for him. One day she was sitting where you are sitting, in the back of the kitchen. He was a bit slow to eat when she was feeding him. She was in a rush to go out somewhere, so she was shouting at him, ‘eat your fucking food.’ And she shoved the spoon so hard into his mouth, it made his gums bleed. I took him out of his high chair and cuddled him. She locked herself in her room with a knife from my kitchen, screaming she would stab herself if I called social services.”

“Did you?”

“I called the police.”

“Serena left that night with them. She called me every name under the sun. Nothing I haven′t heard before. She never got to the flat with her baby. It wasn’t just her failure, it was my failure too.”

″You′re very hard on yourself,” I said.

“I was on Serena′s side, I wanted so badly for it to work out for her. She used to message me, confide in me, I was the closest she had to a mum and what did I do? I let Serena down like everyone else in her life has. Breaks my heart to say this, Serena always starts off well, but once her babies start to grow into themselves, to become their own little people, it sets something off. Once they start to need her less, it brings out violence.”

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My fourth ultrasound scan was due at ten weeks. The early pregnancy scanning clinics were full, so the tenth week, by my reckoning, came and went. Bex, the receptionist, called

″I′ve squeezed you on to the obstetric obesity list,” she said.

What if I fitted in? My GP had advised me not to eat for two. I didn't. Instead, I ate for a growing family of four, attributing this to the steroids at any opportunity. I felt anxious arriving in the obesity clinic, and compared myself to women whose calculated body mass indices meant they had been assigned to high-risk pregnancy monitoring. I caught myself comparing, and my cheeks burned. When did I learn to fear fatness and to measure myself up against other women? As I flicked back through my memoires of being too fat for a catsuit for my thirteenth birthday after eating nothing but grapes for three days, I saw in my mind's eye my cheeks burning with fat-shame for the first time. It was the day when Dr Cameron, our school doctor, had lined my class up to be weighed and pronounced me sturdy. I was eight-years-old. From that day on, I realised that the pounds on those scales mattered as much as the grades on the report sheet. A growing girl's worth is also measured in quarter-stone increments and so I began to play, and lose, the complicated game of "slimming down", by dieting, comfort-eating, self-denial and self-loathing, finding myself too fat for the most fashionable clothes. In shop fitting-rooms, trousers regularly stopped mid-thigh. Rolls of fat spilled over the waistbands of my school tights. Sometimes I made it across the border from overweight to normal, a refugee from the fatlands among the svelte. By my thirties, I had to run fast and hard enough to have a normal body mass index. It didn't take much for me to be exiled to fatville.

Why was I afraid to be on the fat-list, even in pregnancy? All of us in that waiting room had high risk pregnancies, gambling our lives and those of our unborns by procreating. Why was there shame in this clinic? Unlike the teenagers waiting for scans, who had been excited and chatty, the women in this waiting room were library-levels of quiet. We averted each other's gaze, even as we surveyed one another's flesh.

Eventually, entering the darkened room, removing my shoes and observing silence until I heard my baby's heartbeat, gave me the sense of partaking in something sacred, even magical.

There is a theatrical aspect to the ultrasound examination, that began with me entering the dimly-lit room, taking centre-stage on the examining couch, and continued with the ritual drawing back of the concertina-folded curtains surrounding the bed, and culminated in the audience of expectant mother and scanning professionals, gazing at the screen. Pregnant. The word made flesh.

After the reassurance of another normal scan, I grasped my printout like a potential jackpot-winning lottery ticket on the drive back to HQ. In the image, my unborn looked tiny compared to the screen-sized projection I had just seen. For all the scrutiny my uterus had been under that morning, nobody enquired what sort of mother I was going to be to the unborn child. It′s rare to probe. It is what happens when things go wrong, after they have gone wrong. Most women don′t have fortnightly ultrasounds. It was extraordinary, this hypervigiliance.

I collected Liberty from our neighbour Sally, where she was watching Peppa Pig with Sally′s daughter, Isabella. Liberty was curious about the small monochrome print outs of the "baby in Mummy′s tummy," and called these scan pictures "the dark photos."

"You been late at work?" Liberty asked.

"Went to the hospital. I've got another dark photo."

"Well guess what? I got a picture too. Me and Issy painted our feet at nursery and we runned on big, big paper and we maked green feet prints."

I showed Liberty the scan while she wriggled her green toes.

"That never is a photo of a baby in your tummy. That′s a big blurry," she said.

Liberty was right. The ultrasound printout wasn't a photo of my unborn baby, but a ghostly image of where my unborn′s presence had been sonographically sensed. It was an image of my body, but I wasn't there. My ultrasound images are the only selfies I have in which I can′t see myself. Among all the obstetric scrutiny, I had disappeared.

And yet, my ten-week scan printout felt akin to a mother and infant portrait. If the ultrasound epitomised the obstetric gaze, reducing my uterine contents to an outcome or a diagnosis to be medically treated or surgically excised, at home, my fortnightly ultrasound images became mediators of my mothering. Somewhere in the shadows and light, I could see my unborn child reclining like the infant on the cover of the embryology colouring book. In the blur surrounding her, protecting her, nurturing her, was me, her mother.

Apart from immediate family and my colleagues, my pregnancy was invisible and secret. My unborn′s existence, her dependence on my uterine life-support and my love for her were unseen in the world. I kept the scan printout as proof, just as Liberty′s foot painting was a material reminder of her afternoon of painting and running and playing. The painting of her feet was not literally her feet, it was an imprint. Liberty′s running really happened, she had the green blurred picture to prove it, which she held out and showed with pride. Later, when Simon was home, I showed him the scan image with similar pride and excitement. Here was our proof. I could have put it on social media, where I would have been seen as an expectant mother, without a shadow of a doubt.

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The morning after my ten-week scan, I pushed my aching spine against the back of my chair in the attic office and called Serena′s psychiatrist. Dr Pradeep Ruhil and I had known one another for years. We met in the early 2000s when he had come to Lambeth Hospital to work as locum cover for me, when I went to sit my membership examinations at the Royal College of Psychiatrists. As I had handed over my bleep and gave him the key codes for the wards and on call rooms, he told me that he had completed postgraduate training in obstetrics and gynaecology. His chosen specialty was oversubscribed. Pradeep could have been waiting for many years to progress in his planned career. So, he left obs and gynae just before we first met, and was locuming as a junior doctor in various specialties to help him work out where else he might fit. It was a common scenario in psychiatry training at the time. My specialty was undersubscribed. On the training rotation in South London, I worked alongside colleagues from India and Africa who had begun their career in surgery or paediatrics, only to find there was high competition in that specialty in London and switched to pursue a career as psychiatrist, a word from the Greek for “soul healer”.

By the time I had returned from exam leave, Pradeep had found his new professional home in psychiatry and had made such a good impression on the bosses, he′d been encouraged to apply for the training programme. Pradeep′s warmth, wit and intellect made him a popular colleague. He invited me to his wedding when he married Iris, a charge nurse who had been widowed in her early thirties and was bringing up two young sons. Pradeep and Iris had a daughter, Maryam. He had sent emails when Maryam was a baby.

“Something isn’t right with our Maryam, Iris has a mother′s instinct about this, I cannot put my finger exactly, but we are having trouble in convincing professionals of this matter.”

Ten months later, Maryam was diagnosed with Down syndrome. The majority of children with Down syndrome have three copies of chromosome 21. Maryam was born with a condition called mosaicism. This meant that some of Maryam′s cells contained three copies of chromosome 21, but many other cells did not, like a mosaic pattern: some with the Down syndrome encoding, others without it. This meant that the text-book symptoms of Down syndrome were less evident in Maryam. Because she had fewer features of “typical” Down syndrome, her mother’s worries were dismissed. Iris was described as over-anxious, in one of the referral letters. I will always remember Pradeep telling me about that, because it was the only time I had ever heard him lose his temper. How blinkered were the medical eyes that looked at Maryam. Because she didn’t look like a “typical case”, her needs were simply not seen.

Several yearss later, we had bumped into one another at a conference on self-harm, where he gave a presentation about a service he led, for women who had experienced serious self-harm and other risk-taking that put their lives at risk. A former service-user stood at the podium alongside him. She spoke about having contact with psychiatric services from the age of eleven, of her near-fatal jump from a bridge over the Thames, the skin grafts she had needed after burning herself and her optimism for the future.

“Hey, good to hear from you.” Pradeep′s voice was so warm when he answered the phone, I could almost feel his hand squeezing my shoulder.

“How are you? How′s Iris? Your family?”

“All good with us. Maryam′s just started Year 2, can you believe it? Hey, have you got Skype or WhatsApp or something, it′s easier for me to talk when I can see you. I′m not skilful with phones,” he laughed.

Moments later I was looking at Pradeep′s broad smile pixelating at the corners on my computer screen.

“As you probably might know, Serena was with us in the intensive programme last year,” he said. “The intensive programme isn’t for everyone. Women have to work very hard; it′s a big commitment. We have a 17% drop-out rate. Most of the women who complete the programme subsequently present with fewer incidents of self-harm, with a marked diminution in risk-taking behaviours. Also the women are reporting higher levels of satisfaction with interpersonal relationships; we see they have better skills for living independently.”

“And Serena?”

“Serena is one of our successful graduates. Serena, in common, as you probably will know, with many women who have lived through traumatic abuses, is emotionally highly vulnerable. Relatively low levels of stress make her feel highly anxious. She came to us in a state of high alert.

She found it hard at first, had a bit of a wobble, you see what I′m saying, when her keyworker was redeployed due to pregnancy. However, thankfully, Serena established good rapport with the new key worker, and she stuck with the group programme and the individual therapy. There′s a useful report from her first social worker when she was a young child that gives many examples of how Serena grew up in a very invalidating environment. Serena feels emotions very intensely. We noticed here that after she felt anger, she would also be feeling guilty and worthless. She felt like a bad person for feeling any anger. In our unit she learned that all her emotions are real, valid and acceptable. Serena began to understand that life is rarely black and white, but that′s an ongoing lesson for her, one can say a lifelong lesson, I suppose. She got very involved in the community side of things. She set her own goals. Apart from that wobble during the key worker changeover, there were no instances of any drugs or alcohol, no positive urine drug screens in her final six months. She left last August on a wave of optimism. Serena had full insight into the fact that the feelings of worthlessness and sadness in the past have led to her harming herself and taking many risks, including risks to her children and the risk of them being removed from her care. She was unable to be the parent she wanted to be. She learned other ways to cope with sad and angry feelings. She wanted to make a better life for herself," Pradeep said, and I could see him looking down at a file and turning pages.

I nodded.

"I have discovered that I am not worthless. I want to make my life something I can look at and feel proud of." Pradeep read Serena′s hopes from his file.

"Is your service still in touch with Serena?" I asked.

"We had some routine follow ups, including with the community mental health team, as per transition protocol, and we discharged her to their care, with the agreement of her community psychiatric nurse, just after Christmas," he said.

"Serena has been referred to us by the family court for a pre-birth assessment, because she is pregnant," I said.

"I deduced she may be expecting, when I received your message," he said, "but when we discharged her, she didn't mention any pregnancy or any relationship."

For the first time in our conversation, Pradeep looked defensive, his arms folded in his lap, a pose I recognised from when he and I had practiced looking composed in front of an examiner.

"Serena may not have known herself that she was pregnant, when you discharged her," I said.

Pradeep was looking back at his notes.

"No, nothing here about a new relationship. I can′t recall if it was asked about, by our team or by CPN. I haven′t made any note about it."

"What I′m after, Pradeep, is your opinion, based on your extensive recent knowledge of Serena. She′s expecting twins," I said.

Pradeep′s smile was no longer pixelating in the corners. It was a small smile, professionally courteous. As I was scanning his face for clues, he was catching me doing this.

"Twins, double-blessing or perhaps a double challenge," he said, giving little away.

"What′s your take on it, Pradeep, honestly?" I asked.

"Is this for your team′s court report?"

"Yes," I said.

"As you would probably know, I run a flat hierarchy in my unit. Any formulation, I need to discuss first with my senior team members and then we can provide you a written response."

"You′re not optimistic about this, are you?" I asked.

"Serena made good progress, excellent progress I should say, but these are early days for a major life event. Even a singleton pregnancy will be major stressor for a woman with Serena′s unique vulnerabilities. In her case there is also the triggering of previous losses and grief. I will discuss with the multidisciplinary team in our risk review meeting, but I suggest you also speak to community nurses. My view will be along the lines that Serena would be needing intense levels of enhanced support."

"But you think it′s worth assessing her after the twins are born?"

"Your team has the expertise in this, more than mine," Pradeep said.

"Is there any possibility that Serena could return to your unit before she gives birth?" I asked.

"We do on rare occasions, with a clear clinical indication, take women who have graduated from our programme for a time-limited top-up course of emotional regulation skills-training," Pradeep said, speaking as if he was reading from a letter to service commissioners, "but pregnancy would be an exclusion criterion. Because of risk, you see, from the other women. Seeing a pregnant woman can trigger strong emotions in some service users and consequently lead to unsafe situations for the pregnant woman. Pregnancy is not something the unit is set up to manage. Even if it was, my opinion is that pregnancy is not the best time for a woman to be focused on the intense emotional work we ask of participants."

Pradeep gave me the number of the community team.

"Thank you, Pradeep, it was lovely to see you on my screen, almost in real life, until next time," I said.

"I don′t think I have been of much help today," he said, with characteristic modesty.

"You have, thank you. Give my love to Iris."

*****

"Mummy, Mummy," Liberty called the following Thursday morning when I was in the shower.

“What?” I asked, getting out, dripping, reaching for a towel.

“The fox has eated the chicken faces all up and Daddy has putted them in a box.” Liberty was so factual in the aftermath of the fox attack that it took me a moment to understand what had happened.

“No more hens,” Simon said when I came down, cradling the last of the beheaded bodies, laying the hen to rest with her anatomised sisters in a mass grave. “It′s too upsetting. I could understand if the fox took them for food, but this is just a massacre.”

I thought of all the things we wouldn′t do if we wanted to live a life without grief. After dropping Liberty to nursery, I drove to the clinic for my so-called “booking appointment” with the midwife. For most pregnant women, this is their first meeting with a midwife, when they are taken onto the books of the maternity services and their antenatal care is planned.

“Hello stranger,” said Bex, through the small window in the plexiglass that wrapped around the reception desk.

“Hardly a stranger,” I said.

“You gotta be in here almost as much as me these days,” Bex said, smiling and handing me a clipboard to complete my medical details on some forms. The forms were part filled in. Someone had ticked a box indicating that I was White British. The box marking me as high maternal risk was also ticked and annotated with asthma, high natural killer cells, polycystic ovaries and miscarriages.

“I′m not White British, Bex,” I said.

“You look it,” she said.

A midwife with bobbed brown hair invited me to “hop on the scales” and then together we made a guess at my height while she measured my blood pressure and handed me a little lidded pot. I took the pot to the loo, where there was a hatch in the wall, like the one we had in the military house, a serving hatch between the kitchen and dining room. I left the urine sample on a cardboard tray by the hatch and returned to the midwife.

“I′m Allison, by the way,” she said, “what meds are you taking?” Alison asked, pen poised.

“Prednisolone, cyclogest, aspirin, omega 3, high dose folic acid, zinc, magnesium, vitamin D,” I recited the Natural Killer Cell Protocol like a prayer.

Alison sighed. “Not enough room on this form for that lot,” she said.

“And inhalers,” I added, “asthma.”

Alison stretched across the desk for a continuation sheet before turning me back out into the waiting room to wait for the twelve-week scan. The twelve-week scan waiting room was busy. I sat holding the forms Alison had filled in and read the notes she had made. My ethnicity had been changed from White British to White (European, Middle Eastern, North African, Hispanic), an almost-all encompassing, inaccurate hedging that didn’t fill me with confidence about what was to come after.

“‘Sabina?” the technician called me from the waiting room. I followed her along the corridor and put my bag down on the chair. Familiar now with the scanning ritual, I began to feel that I was also playing my part in the performance. Pulling my top up, my jeans down, baring my midriff, lying on the bed, half of my body now exposed, the other half draped in hospital sheets, I felt like the helpful assistant whose role is to lie still in a box on stage, during the magic-trick illusion of sawing the lady in half. Enacting my role on the examining couch, I became part of a macabre sisterhood, half-stripped, unshod, recruited into the sorority of magician′s assistants. There was a flourish of showmanship from the ultrasonographer as she drew her cursor from one end of the baby to the other.

“You′re measuring 41.0mm, which means you′re 13 weeks + 6 days. That flickering is the heartbeat,” she said.

I realised then that every ultrasound examination I had undergone had a “ta-da” moment, whether the technician was pronouncing foetal life, commenting on the condition of vital organs, revealing gender, or confirming death. By my calculations, I was 12 weeks and 2 days pregnant, but it quickly became clear that my part here was to lie still, not to quibble.

“We always go by the scan dates,” the midwife explained, “this is your dating scan. I take these measurements to estimate when baby is due. Your due date is the 12th of August.”

“That′s eleven days ahead of my counting,” I said, “conception would have been impossible if we′re going by the scan dates. Simon was in Cyprus.” *I know*, I wanted to shout, *when I got pregnant, because I was there*.

She shrugged and I felt as if I was being accused of something. As an expert witness, I swear to tell the truth. What is the truth? Who gets to call it? Is the truth of what happened the version that I recalled? What I said in the witness stand would be judged to be true, because of my oath, because of the power that came with my role and my status as an officer of the court. The contemporaneous notes I made during clinical appointments were a legal record. If there was a discrepancy between accounts, medical notes would generally be judged to hold greater veracity than a mother′s recollection of who said what, and when.

In the scanning room, I held no such power. My story did not count here. I was an untrustworthy witness of my reproductive anatomy. It was in this darkened room that I was told how many weeks pregnant I was, based on measurements of the sonic representation of my uterine contents, made by the sonographer’s hand: a trick of the light. The dates I was given were untrue, I was certain of this. I was, after all, there at the conception. The clinically measured truth did not hold by my account.

Did it matter, the eleven-day discrepancy between my calculated due date and the date calculated from the scan? On the one hand, no. Babies are considered to be born at term any time after 38 weeks. The eleven days represented an unimportant margin of error. On the other hand, I was planning on asking for an elective caesarean delivery. Babies are delivered early by elective caesarean, to reduce the odds of going into spontaneous labour. What if my dates were the ones the obstetric team should be using to plan my delivery? What if my unborn was delivered too early because nobody believed me, preferring the evidence of the scan?

It mattered too because, implicitly, I was mistrusted. My innate sense of knowing my unborn child, was being undermined. I thought of Iris and how her account of Maryam's difficulties had been similarly discounted. How many of my patients shared that experience? What did I expect? I was the high-risk older woman with a hostile womb. Was I not already culpable? Had I not lain here before, at another twelve-week scan, listening for a foetal heartbeat and heard only muffled static? Was it not almost a year to the day since I had lain here and was told my dead foetus measured 7.3mm? I remembered the miscarriage midwife, Sarah's words from that day; "It was only the length of the tip of my little finger."

Yet here I was again, with another little fingertip of life, holding a paper form that defined me as a mother. *High risk on the grounds of maternal age.* The foetal nuchal scan measurements, combined with my age put me at low risk of trisomies 13, 18 and 21. The chart the ultrasonographer completed combined the risk from the scan with the risk from *maternal* age. What a strange in-between I occupied: expectant maternity, mother to an unborn with a beating heart, who wasn't legally considered to have a life, but if her heart stopped I would be told she was dead. Even my age wasn't my own anymore; it was shared with the unborn. My age was now "the maternal age", a numeral that had a bearing on my unborn's risks of survival. Fingertip and I, we were in this together. For better, for worse, the latter statistically more likely. Apart from one lucky break, I'd failed at childbearing. Even the child I did have, my maternity notes remind me that I "failed to deliver", leaving her to be rescued by an emergency caesarean. Not to mention the state of my ovarian reserve. I was the obstetric equivalent of planning a weekend roadtrip with a petrol gauge in the red zone. An “elderly multip”, as my obstetric notes bluntly put it. The clinical notes about me, or more correctly, the notes about my expectant maternity, were the official record of my pregnancy. They were, in medico-legal terms, the truth.

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The following Wednesday, on my way to the attic office where I was to meet Mary, Serena′s community mental health nurse, I stopped at the Tube station.

“Could I have a badge, please?” I asked, “that says I am pregnant.”

The woman in the office pushed a white disc, marked “baby on board” under the glass petition that separated us. She didn’t ask me for any proof. I pinned the badge to my coat, advertising the invisible, hoping I would be offered a seat in return for my transparency. When I arrived at my destination, I took care to unpin it, putting it away with my ticket, hiding the invisible. I thought about all the times when I really could have done with a seat on the Tube ; the morning after the hysteroscopy, or that lunchbreak when I’d had my interuterine device removed, all those early morning commutes when I had already crossed London to have an intrauterine insemination before dawn, all those commutes during the miscarriage that went on for three weeks. But there is no badge that says: “This woman is leaking her products of conception. Miscarriage is not always visible.”

Serena’s community nurse Mary had a face dotted with freckles and had offered to come and talk to me about Serena after visiting one of her patients in a neighbouring street.

“Does that work for you, coming here?”

“Ah sure, it′s no bother,” Mary had said.

“I′ve no new concerns over Serena′s mental health,” Mary said as she sat down on the sofa, overlooking the garden where the trees were heavy with blossom, “but she often says she feels frightened.”

“Could you give me an example?”

“Serena had a bruise on her leg. It was quite a large bruise, where she had fallen on the steps outside her front door when it was raining. She was anxious and wanted it documented that it wasn’t the result of any domestic violence. In the end the consultant wrote a letter saying the bruising was consistent with the explanation Serena had given. Serena sent the letter to me and also to the safeguarding lead. Usually if a woman slips and bruises her leg and there′s no other harm done, well, unless she falls against her bump, she′d never be in the ED.”

I was curious about whether being under surveillance had caused Serena to become hypervigilant. In previous pregnancies, she had been under additional oversight, yet the domestic violence was overlooked by several professionals at that time. For all my probing at the network, was I seeing Serena? Was I trained in looking for, and therefore finding, pathology? Was I looking for evidence of good enough maternity and seeing it? Was I looking at a pattern of attachments and deeming her attachment style disordered? Was my gaze blurred by my own expectant state or did my own precarious pregnancy sharpen my focus?

In the library, I split a sheet of paper in half. On one side I wrote the heading “Positives”. On the other, “Negatives”. Under positives, I wrote “pregnancy overseen by high functioning network with good interagency communication”. Under negatives I wrote, “are the positives being overlooked?”

*****

Liberty and I were up early and decorating for Easter.

“I hang them chickens,” she said.

“They’re doves, we made them last year, when Ranulph was here, remember?”

“Ranulph got a medal,” Liberty replied.

Ranulph had got his Duke of Edinburgh gold medal and was at Cambridge, studying St John′s Gospel as he′d hoped. He couldn’t visit us that Easter, but he wasn’t a stranger anymore.

Liberty stood on a stool and together we hung the doves in the windows, painted eggs, arranged willow branches in vases. The house at HQ was full of emblems of life when Simon and I dropped Liberty off at nursery and drove to my twenty-week scan. For most women, this is the second scan they will be offered during pregnancy. By twenty weeks, my pregnancy wasn’t invisible to other people anymore, but my unborn child was. The cold gel on the ultrasound probe enabled a virtual bisection, allowing the ultrasonographer and obstetric audience to look inside my body, in a way that was once only possible when a woman was physically cut open. The radiographer directed Simon to sit on a stool, close to my head so he could watch on the screen as she took still images of at our baby′s bones, heart, brain, spinal cord, face, kidneys and abdomen. She worked mostly in silence, looking for signs of several conditions, including some that might mean a baby would not survive outside her mother′s womb.

“Can you take a breath in and hold it? That′s right. Lie still for me, so I can take clear images.” The ultrasonographer spoke to me as a magician to her assistant. As I held my breath, I imagined myself lying alongside all the stilled women who had died in pregnancy, their bodies cut open in anatomy theatres, their uterine secrets revealed. By this stage of the pregnancy, it had become less comfortable to lie still on my back. The inconvenience of my consciousness, my involuntary acts of breathing, the small movements I made when shifting from an uncomfortable position to a more comfortable one, seemed to irritate the sonographer and slowed down her work of scanning.

“Lie still for me. Hold your breath for me,” she said,”“until I say breathe out.” When I was chastened, reminded to lie still, to hold my breath until instructed to exhale, I imagined my sisters: the unconscious women who lay perfectly and conveniently still, dead or under anaesthesia while their uterus and foetus were cut out and preserved in pickling jars in museums of pathology.

At every scan, I lay waiting for the words, “so obviously, there’s no heartbeat.” The ultrasonographer was silent again. I filled the silence with imagined bad news.

“Was you wanting to find out the sex today?” she asked.

“Is she a girl?” I said, craning my neck for a better look at the screen.

“Yeah, it’s looking like a girl to me.”

My ultrasonic vivisection complete, I was given a MATb form, which bore the official "date of confinement”. I left the clinic where I was a high-risk obstetric patient undergoing a twenty-week ultrasound examination and drove across London to the clinic where I was employed to scrutinise the lives of others. There in the attic, I sat at my desk and opened the file labelled with Serena's name, drawing my highlighter pen over phrases as I had once drawn a scalpel over a cadaver, bringing the gruesome findings to the table to dissect and pore over. By the end of the afternoon, I had anatomised Serena's maternity.

Serena's request to opt-out of the screening test was deemed a red-flag by her midwife, Annette. How easy it had been for me. The midwife had said to me, “we offer all women this blood test.”

I said, “no thanks, I’ve spoken to Simon and we’ve decided not to.”

“That's fine,” said the midwife, “Let me know if you change your mind.”

I’d told Simon, “it's a screening test. If it comes back above a certain threshold, I will be referred for an amniocentesis. That's where they put a needle in to take some blood from the placenta. There’s a risk of miscarriage with an amnio. I don't want to risk another miscarriage.”

"Makes sense," he had said, "but your body, your decision."

When I turned down a screening blood test, a test taken up by most pregnant women, nobody blinked. When Serena turned down the same test, it became a significant clinical indicator. On the one hand, it was right that there was a higher bar for Serena. She had already had five children removed from her care. Her inability to keep previous babies safe gave rise to her current scrutiny. Perhaps Ben was right to be concerned that I was over-identifying with her. Or maybe the professional eyes that examined Serena would always be left wanting. I felt unseen in the scanning suite, a non-woman, a walking uterus. At the other extreme of clinical surveillance, Serena was always seen, monitored, overlooked.

It was while thinking back to how I felt in the scanning suite that I realised Serena was in a double bind. If she was composed when she saw professionals, that might be reported in the notes as "oddly aloof". If she cried, she risked being described in official records as "over-emotional" and "hypersensitive". The court bundle described Serena lying on the floor sobbing, refusing to leave the courtroom, finally escorted out by security guards. I thought back to Vicky Winchester′s similar howl of anguish in the courtroom just before Christmas. The exact phrase I had pulled my highlighter pen across was "hysterical crying fit". The adjective "hysterical" was being used in the lay sense, to mean out of control. The term "hysterical" has been used since the 1600s, coming from the Greek hysterikos, meaning trouble in the womb. In Hippocratic medicine, women′s wombs were thought to wander around our bodies, like untamed beasts, causing untold problems. It was not until Anna Freud′s father wrote *Studies in Hysteria* in 1895 that the professional definition of hysteria, the tormenting of the body by a troubled mind, was recognised as arising from past traumas. Was it any wonder that Serena had developed emotional scar tissue to protect herself from living in daily agony? Were distraught fathers also described as hysterical?

*****

April turned the attic office window into a giant snow-globe. White blossom drifted like bridal confetti across the window as the court assessment team debated various options that would inevitably shake-up the lives of families, lives that had already been turned upside-down. By lunchtime, it was warm enough for me to sit outside, blossom landing on the table like foetal ballerinas, as I drew Serena′s family tree.

Ben came outside and sat across from me.

“Just wanted to flag it up. Are you confident you′re not over-identifying with Serena?” Ben asked.

“She′s pregnant, I′m pregnant, so now I can′t do professional distance? Is that it?” I bristled.

“Just want to flag that we’ve checked you are being detached enough to assess...”

“I am detached enough.”

“Obviously I haven′t been through a pregnancy, through all the changes...”

I turned around and looked back down at the papers I had brought outside.

“But as you said yourself, it wouldn’t have been appropriate for you to assess Serena. That′s why we allocated you to the network,” Ben reminded me.

“That was also for logistical reasons to do with my own clinic appointments,” I said, without looking back round at him.

“Look, I just want to cross the t’s, dot the i's on this, that there′s no risk of over-identification going on. That nothing is overlooked.”

“I did not see my parent murder my sibling. I did not grow up in care. I was not raped and pregnant at fifteen. I have not been judged to be an unfit mother to five babies.”

Ben looked at me.

Pregnant psychiatrist capable of rational thought. T's crossed and i's dotted, I thought, but did not say. I was too angry to speak.

I picked up my bag and started folding the family tree into it.

"Where are you going?"

"To the library, to write some reflections on my conversations with the network."

"Sorry I′ve upset you." Ben stood between me and the doorway.

All the things I wanted to say at that moment came under the category of inappropriate things to say to your line-manager. With a ring-binder under each arm, flapping like a chicken trying to go home to roost when the coop door has blown shut, I walked past Ben, out of the garden and crossed Maresfield Gardens to the library. It started to rain lightly, raindrops crushing the blossom to the pavement, and I imagined the rain rinsing my anger and dissolving Ben′s words. My steroid card was in my purse: *may cause tearfulness*.

*****

Although I′d been under his nominal care since my referral to the Recurrent Miscarriage Clinic in September 2013, I had not yet met the consultant obstetrician who had prescribed the Natural Killer Cell Protocol, the man my GP had referred to as ′The Man Himself′. Medicine, like the military was hierarchical. Although the expert witness team described itself as a flat hierarchy, I understood medical pecking orders. As a medical student, it was clear that we were at the bottom of the pile, often taught by humiliation, and teaching hospital consultants were often treated as god-like, mythical entities. My GP, who had trained a generation before me, used the same mock-deferential humour to allude to the obstetric hierarchy as I did when I my medical friends asked me about The Colonel.

I nearly didn't meet The Man Himself at my so-called twenty-week appointment on the Friday before the May bank-holiday weekend. There were roadworks and diversions, so Simon and

I sat waiting and looking at removal vans, family cars packed with travel cots and bored children bickering on the backseats. After making it to the hospital, the car park barrier was broken, and we were stuck in another line of cars. Once in the maternity building, I joined a queue to have my blood pressure measured and then had to rejoin the line to have it re-measured because it was so high the first time. Four hours after leaving Liberty with our next-door neighbour, Sally, I was called for an audience with The Man Himself.

"Sabina?" he called me in from the waiting room and strode back into his consulting room.

"You have asthma?" he asked, in lieu of introductions, from behind his desk.

The Man Himself asked me a lot of questions about my asthma, to gauge how well it was controlled. He appeared to have overlooked that I was high-risk for other reasons too, including my previous miscarriages. In his consulting room, I felt like a junior doctor, guiding the consultant through a patient history that I knew by heart. With practised efficiency, I talked him through the highlights of my obstetric past, my progress on the Natural Killer Cell Pxrotocol, my failure to progress during my last labour, the emergency caesarean, four days after being induced at 41 weeks. A scenario from an ethics exam question at medical school played through my mind:

> *A pregnant woman, who had been a medical student but did not qualify as a doctor, is asking for an elective caesarean. She says she remembers her obstetrics placement and does not want a vaginal delivery. Discuss.*

I had once been awarded a distinction in medical ethics and law. I should have been acing this consultation, but I was fluffing it. The words "elective caesarean" hung unuttered in the space between us.

The Man Himself nodded briskly.

"Yes, yes, I see what you want but the local clinical commissioning group is strict. Every caesarean costs this trust a lot of money. The commissioning group won′t fund it unless it is for a clinical need. Nothing you describe is a clinical need."

“Please,” I said, slipping from helpful medical student to high-risk, scared, expectant-mother.

“Not in my hands,” he said.

It was hard to believe. Wasn’t he the Medical Director?

“If I saw you privately,” I asked, “would it be different? Could I have a caesarean delivery then?”

The Man Himself spoke slowly, “private care isn’t straightforward,” he said, as if addressing a work-experience student, “it costs a lot of money.”

I started to say that I had researched the costs of private caesareans. Every time I opened my mouth, he said something else about how clinical commissioning works and I couldn’t get a word in.

“I′m scared of losing this baby,” I said. My voice wobbled like an oboe in need of a new reed, “all I want, after last time, is to get her out safely,” I said, “if I need to arrange finances for that, then I will, but I′d like to know if your clinical decision would be different if I saw you privately?”

The Man Himself looked up from my file but avoided looking into my eyes.

“Sometimes, women get anxious, excessively anxious about giving birth,” he said holding the edge of the desk. “If their anxiety doesn’t come under control, it can become a mental health issue, you understand? Mental health issues are a recognised medical reason why we might plan a caesarean.”

“Yes,” I told him, “I′m a consultant psychiatrist, I get it,” now sounding more like a teenager than a colleague.

“So, you have some understanding of these things,” he said.

“I do.”

"We will make an appointment for you to see Gloria. Gloria is a specialist counselling midwife. Plan is for Gloria to assess you, report to me and then we will write a plan for mode of delivery."

I watched as he summarised our consultation by writing two lines in my file:

"Referral to Gloria. For probable EC."

Simon looked expectant in the waiting room.

"He said 'no' outright," I said. "There is a lot of financial pressure on the hospital to reduce their elective caesareans. But he seemed to be brokering some sort of deal."

"Did you tell him about last time?" Simon asked.

"Doesn′t make any difference, but look, there is a plan. He hinted that I just have to appear mentally unwell."

What topsy-turvy world was this? I needed to be assessed as being clinically phobic of childbirth to be granted what I felt was the safest mode of delivery for my unborn child. The professional eyes on me, the eyes of the gatekeepers to an elective caesarean, would only be sated by evidence of a mental illness. What a different story for many mothers in the family court, who had to show that their mental illness had no impact on their parenting. The professional eyes that scrutinised Serena′s fitness for motherhood were seeking signs of sanity and stability.

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Gloria, the counselling midwife, was the gatekeeper to an elective caesarean. In the weeks that followed, I found that securing an appointment with Gloria was similar to winning the raffle at the spring fair at HQ. In the beginning, I waited as instructed for her call. Days turned to weeks. Comfort texted me a number for Gloria. I called on that number and for several weeks fell into a routine of leaving weekly messages.

"Hey Babe!! C-section sorted??!" Comfort texted.

"No appointment with Gloria yet."

“Call her!!!”

“Can′t get hold of her.”

“FFS. Want me to check she′s getting your messages??”

“Yes please.”

“No worries, babe xx”

A week later, my next routine ante-natal appointment happened to be with Maria, the supervisor of midwives and the home-birth lead. I wasn’t expecting to see her. It was luck of the draw. Maria had been my midwife during my pregnancy with Liberty, who was a planned home-birth, then, as my maternity notes said, a “failed induction”, followed by a “failure to deliver” and finally, an emergency caesarean and “born in theatre”.

“I′d like an elective caesarean,” I told her, expecting her, in her role as homebirth lead, to try to talk me out of it.

“I can understand why. Have you spoken to your consultant yet? The trust are under pressure to cut the caesarean rate so you need him on side.”

“He referred me to Gloria, but I’ve been trying to get an appointment for weeks.”

“Leave it with me,” Maria said, “I’ll sort it.”

Just after I arrived home at HQ, Maria called me:

“I’ve spoken to Gloria. She′s been really busy, but she is onto it.”

Another week passed. I texted Comfort again, feeling like a Victorian butterfly collector with a long-poled net in her hand.

“Seeing your boss for mode of delivery decision in ten days. Meant to see Gloria first. Need to be assessed for a caesarean before my appointment with him.”

“No worries, babe, I′m on it,” Comfort texted.

Moments later, my phone rang: “Gloria, counselling midwife from the hospital. Can you come tomorrow?”

Tomorrow. Wednesday. Multidisciplinary team meeting day. Bollocks. I began my now-honed round of rebooking appointments and meetings. This must be how life was for the families who came to the court assessment service: booking and rebooking clashing appointments with solicitors and therapists and social workers. The practicalities of multiple appointment attendance weren’t something I had thought about before. Then I caught myself. I had it so easy. I had childcare for Liberty, a supportive partner, caring neighbours who would collect my daughter from nursery and look after her with their own. I had security of employment, understanding colleagues, a car full of petrol and a smartphone on a contract. My patients did their own complex rescheduling with pay-as-you-go phones, insufficient money to cover food, fuel and public transport costs, precarious employment, zero-hour contracts, benefits sanctions for non-attendance at the job centre and often depended on family for childcare. I had options most mothers I met simply did not have, including even considering a private caesarean.

As I called Jess′s number, I felt sick at letting the team down again and felt especially bad that my appointments would mess up Jess′s childcare arrangements. If Jess was irritated to be inconvenienced again, her voice didn′t show it.

“Can you believe it, to get an elective caesarean, I have to be assessed as having mental health problems,” I told Jess.

“That′s ridiculous,” Jess said, “don′t they know you′re a doctor? Don′t they know about what happened last time? Can′t they speak to the miscarriage consultant?”

“It′s him that has referred me to the counselling midwife. It′s all about saving money. There have to be medical grounds and he said if the counselling midwife thinks my mental health is at risk, then I get one.”

“Well, good luck,” she said, “but remember that you′re on the other side now. You know your body and you have to go and push for what you want.”

*****

“Guess what, babe? Gloria’s gone and won an award. Photo in the nursing magazine. You′re in the best hands!” Comfort′s text arrived as I was crossing the threshold into the maternity clinic waiting room. Instead of sitting down, I paced the room. Bex, the receptionist with a warmer smile than any of the clinicians, greeted me:

“Hello stranger,” she said, looking at me and not at her computer, “here for a scan?”

“Not this time,” I said, “I′m here to see Gloria.”

“You′re a bit early,” she said, checking a large A4 desk diary. “I′ll let her know you′re here.”

Bex was the one consistent face at every scan, miscarriage and test result collection.

“You ok?” Bex asked, looking at my large bump.

“Good. Nervous. I really want a caesarean, but it isn’t straightforward,” I said.

“No,” she said, looking at the poster on the wall opposite the reception desk, that let everyone know, in shouty capitals, A CAESAERAN IS NOT A RIGHT, EVEN IF YOU HAVE HAD ONE BEFORE. IT IS A MEDICAL PROCEDURE AND NOT AS SAFE AS VAGINAL DELIVERY. Bex looked back at me and rolled her eyes.

“It′s lovely to see you so pregnant. It suits you,” Bex said as I sat and waited for Gloria. Half an hour passed. I hoped my blood pressure wouldn’t be measured today. I was hoping not to be stuck in traffic on the way home, worried about being late to collect Liberty. I was in the same row of seats where I′d waited for bad news, after the scans that showed no heartbeat. My hands gripped the chair arms, as if to stop my feet from running away.

A slightly-built woman shuffled, with her head down, towards me.

“Here for Gloria?” she asked in a near whisper.

I nodded, thinking that Gloria must be delayed and had sent someone to collect me.

“How are you?” the woman asked me, looking at her feet, in the crowded waiting room.

Psychiatrists are taught not to ask patients how they are in the waiting room, until we reach a consulting room, as it is unlikely anyone can freely say how they really are, in such a public space. I excused the woman escorting me, realising that she was not a clinician.

“I′m fine,” I said, walking behind her, as she shuffled down a corridor, dragging her unpolished shoes along the wood laminate floor. She held open the door to a small cupboard of a room. The room was crammed with furniture, looking like a storage unit for unwanted desks and chairs. A gunmetal grey filing cabinet dominated the room. She indicated for me to sit down at a small low table. The chair was low slung, the fabric cover badly frayed at the arms, exposing a synthetic sponge filling beneath. With my bump, it was hard to sit down comfortably as my knees were pushed up. I hoped I wouldn’t be there long before Gloria came and took me to her counselling room. The woman escorting me sat down as well, which I thought was strange and then I realised we might be in her office. I looked around. The filing cabinet was covered in thank-you cards and birth announcements. On a large cork noticeboard, squished in between the filing cabinet and a small window, was an article clipped from a nursing magazine, announcing the award Gloria had won for excellence in bereavement midwifery. The woman in the accompanying photograph was the mirror image of the woman opposite me. Gloria had seen me scanning the room.

“We′ve tried to make it homely,” she said.

“Are you Gloria?” I asked, incredulous.

“Yes,” she nodded, “I told you in the waiting room. I′m Gloria, specialist counselling midwife.”

“Our appointment was at ten,” I said.

“You must of mixed up the times,” she said.

Replies formed in my mind, but I held my tongue, my teeth biting down in a way I′d only seen described in novels.

“I′m here for women who need a bit of extra support,” she said, “Tell me why you′d like some extra support.”

She hadn’t read my notes. Flipping into medical-student mode again, I gave her a quick precis of my previous pregnancies, induction with Liberty and the emergency caesarean, a parturient request for an elective caesarean this time.

“You’ll have to talk the consultant about wanting a section, but he will likely say no,” she said.

The word “section” confused me for a moment. To a psychiatrist, a section is a legal order for detention and treatment in hospital, not the surgical delivery of a child.

“Look,” I said, “that′s why I have come to see you. Six weeks ago, he referred me to you and said if you thought I needed a caesarean, I could have one. How do we do this?”

“Well,” she said, giving the impression she was making it up as she went along, “what happened last time, with you failing to progress and baby getting stuck, is unlikely to happen again. Why don′t you agree to a trial of labour. If there is failure to progress, you can be listed for c-section sooner than waiting for it to become an emergency.”

Trial of labour. What a phrase. It sounded like a trial of combat, that judicially sanctioned duel in medieval Germanic law to resolve serious accusations like murder, treason or rape, where there was no eye witness.

“No,” I said, “I don′t want a trial of labour. I want this baby to be delivered safely. I want to have a caesarean.”

I sounded like Liberty in the middle of a tantrum: “I want, I want, I want” and could hear myself saying to my child, “want never gets.”

Gloria didn’t appear to know that she was meant to be assessing my mental health, either. She asked me if I knew the risks of an elective caesarean and I listed them like a diligent medical student. I gave her the risks of a trial of labour for bonus points.

Gloria moved the conversation in an unforeseen direction. She started talking about the miscarriages.

“Lots of women get very upset,” she said, “talking can be helpful.”

I felt focused on getting a caesarean permission form out of her, so I nodded along like a good patient as she talked. My mind had wandered to Serena′s case that Ben and I were due to be filing soon. The team discussion was taking place without me and I wanted to call Jess to find out how it was going.

When I tuned back in to Gloria, it was more like an episode of Radio 4′s Gardener′s Question Time:

“If your garden isn’t big enough for a tree, you could plant a bush,” Gloria was saying.

“That′s a nice idea,” I replied, thinking of the rules about military gardens, the barbed wire fence at the back and the Gurkha guard patrols. I hoped that she would get her memorial talk out of the way. I didn’t want to think about the babies we had lost while I was pregnant again. I looked out of the window across at the building labelled Rose Cottage, the universal euphemism for the hospital mortuary, and hoped she would pick up my cues.

“Of course,” she went on, “if you buy plants, you have to make sure they are right for your garden. You don′t want to buy something that is for full sun when you have more shade. Or, you might be thinking, “that’s a nice compact bush,” but the next season it takes the garden over. And you have to consider what happens to your memorial tree if you move house.”

“Gloria, I will think about trees,” I said, thinking I must be a good patient and nod and get this meeting out of the way. I thought not of trees, but of my team, feeling guilty that they were left to manage a complex case discussion with my notes instead of my presence. My phone was in my workbag, by my feet. I was desperate to check it, to check in.

Gloria seemed pleased with the tree response. She shifted in her chair.

“We also do a service, for miscarriage. Didn’t the early pregnancy advisory clinic tell you that? They usually tell you when there′s no heartbeat. It doesn’t matter if you′re not religious,” she continued, assuming that I wasn’t.

She went on about the services, held in St Nicholas Church, close to the hospital and close to my parents’ home. I′d passed it daily when I was on work experience as a teenager, but it was far from HQ and far from what I wanted to do, which was not grieve, but nurture this little life in me and get her out alive.

I nodded and made enthusiastic murmurs about her memorial services, Gloria picked up my file, for the first time during the hour we had spent together.

“So,” she said, “can I write in the front here then, that you are willing to try labour?”

“No!” I replied.

“How about just trying for a bit?” she asked me, in the tone I used when coaxing Liberty to eat more than one kernel of sweetcorn.

“No,” I said, “no, thank you.”

Gloria had the zeal of an overenthusiastic beautician, “go on, have a Brazilian with your leg wax for summer. It can′t hurt.”

“Why won′t you try?” asked Gloria.

"Because," I said, "last time I went overdue and was induced, I spent four days in labour in this hospital. For the last two days of that labour, I kept asking for a caesarean and was told I was being premature for asking. I ended up having an emergency section at 5am. I was scared that whole time that my baby was going to die. I thought I was going to die. Liberty came out covered in meconium. She was in distress. Since then, I have lost babies. I am not going to lose this one."

Gloria looked as if she finally understood, "I could write on your notes that you have seen me and that there will be a time limit on your labour. The midwives won′t let the trial of labour go on for a long time."

"No," I said, biting my nails. I′d picked by work bag up from the floor and was holding it against my bump.

"What do you do to calm yourself when you are anxious?" Gloria asked.

"I′m not anxious. An elective caesarean feels like a logical decision to me."

And so it went on, a ping-pong of confrontation and refusal. I felt as if I was watching the consultation on a pantomime stage-set and was cheering myself on:

"Oh no you don′t."

"Oh yes I do."

When time was up on our impasse, Gloria sent me away to think about the risks and made me a new appointment to see her in a week. The follow up appointment with her fell the day before I was due to see The Man Himself for his final decision on my "mode of delivery."

These additional appointments would disrupt the coming week at work. We had a deadline, and this meant working into the evenings. My colleagues would be burdened with an even more unfair share of work. Again, I wondered how patients managed, balancing all their appointments with our team, for themselves, for their children, with lawyers and teachers and social workers. A life, squeezed, into the slender gaps between meetings with professionals who seemed to hold all the cards.

As I stood to leave Gloria's office, she said, “when you came in an hour ago, you were all stressed. Now you feel peaceful. Talking helps you calm down.”

I was too angry for words, all I could do was nod.

As I walked away from Gloria's office, I knew I wouldn’t be planting any commemorative shrubbery on the domestic side of the HQ wire. As I went back into the waiting room, I unexpectedly bumped into Comfort. She hugged me. Tears tumbled down my cheeks. Comfort took both of my hands and pulled me into her office, with the warmth of an old schoolfriend. Although she texted me every morning, seven weeks had passed since we'd seen each other.

“Babe, you look so, so pregnant,” Comfort said, “Thing being is, that bump suits you. Have you had a scan? Is everything ok?”

I told her about Gloria and the caesarean debacle. Comfort swore.

“We used to do sections all the time but now the hospital’s been told to keep the numbers down. Ask the medics on the army base, maybe they can help you? They must look after pregnant soldiers. And text me, babe, ok?”

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I was late back to Anna Freud's attic.

“We're filing next week,” said Ben as I came through the door, code for the pressure he felt, not only to get the report submitted, but also to get the recommendations right. My trip to the clinic to see Gloria meant I had missed the multidisciplinary discussions. Jess, Ben and Marco had already made the recommendation decisions. I came in to find them drafting the opinion section of the report, using my notes on the network. My conclusion, after consulting with the network, was that there was a penumbra of possibility around Serena. She might be a good enough mother to twins.

She might not. Based on the information I had gathered and considered, I could imagine it going either way. In my absence, the team were endorsing Ben′s conclusion, recommending removal of the as-yet unborn twins, after birth.

“So you’ve written her off, Marco?” I said to the colleague I felt closest to, his wife′s home baked flapjacks on the table between us.

“Sabina! We haven′t written anyone off. Ben has presented his detailed assessment of her.”

“You′re recommending that Serena′s twins, twins that haven′t even been born yet, are removed. I think you should see what kind of mother Serena is when they are born,” I said.

“How would that change things in this case?” Ben asked.

“You can′t conclude Serena hasn’t changed since her last pregnancy. She might be able to mother those twins. When they are born.”

“Sabina,” Marco said, pausing to stare at my own abdomen, “the instructions were for a pre-birth assessment.”

“She needs a post-partum assessment, when there′s actually a baby to assess her maternal relationship with,” I said.

“Could we ask the court for more time?” Jess wondered.

“Can′t she go to a mother-and-baby foster-carer and have an assessment there?″ I asked

“The local authority did that last time. We saw from your notes that she ended up screaming into the baby′s face when he wouldn’t settle. In front of the foster mother,” said Marco, “The local authority can′t take that risk with these new babies.”

“Then let’s get her admitted,” I said.

“Where?”

“Mother and baby unit.”

“Would they take her?”

“They won’t if we don’t ask,” I said. In truth, I thought an admission was unlikely to be granted but wanted to call and find out. On balance, they'd probably say no. *All beds full of suicidal mothers with postnatal depression or psychosis. Something treatable. Stable home to go back to.* Not multiply-traumatised women like Serena, who'd grown up in care and had little idea how to be a good mother, because they'd never had one themselves.

“We’ve got to look at the evidence,” Ben said softly, changing tack, “She's twenty-eight. There's no partner on the scene, no family support. In every previous pregnancy, she has gone back to taking drugs and self-harming after the baby is born. There is nothing to suggest she would cope with twins. Nothing's changed in that regard since she gave birth eighteen months ago.”

“That isn’t the opinion of the consultant from the personality disorder unit,” I said, “You don't know what would happen if she was properly supported.”

Marco looked exasperated.

“Remember Marilyn,” I said.

“We all remember Marilyn,” Jess said. “Don’t you think she stays in all our minds because her case was so unusual?”

Marilyn Newton had grown up in foster care. She had seven successive babies removed and placed for adoption, but surprised social workers by challenging the proposed removal of her eighth child. Marilyn won her case in the High Court. She was bringing her eighth child up herself.

“We could call Perry,” I said to Ben, more order than plea. Peregrine Appleton was consultant in charge of the psychiatric mother and baby unit.

“Perry won't accept a referral until there's a baby,” said Jess.

“Two babies,” Ben said.

“Let's call him. Set it up. Put it in our report,” I said to my three colleagues, firing orders at them like an army officer.

“You want us to have rethink?” Marco asked, forgetting his weight-loss plans and fingering a second flapjack.

“I want Serena to have a fair chance.”

I had my hands over my bulged belly, conscious that I was taking up more space than usual in the cramped attic office. Being the team′s only psychiatrist conferred a status that meant I never needed to raise my voice to be taken seriously by my colleagues. Ben was the team manager, the line manager of the multidisciplinary team. I had no official position of leadership, but as a consultant psychiatrist, it was woven into my role. I pulled rank. I grounded my optimism in my conversation with Pradeep and the midwife Annette, reminding my colleagues of Serena′s recent therapeutic success. Ben′s caution was frustrating to me in this case, but I also felt grateful for the many times he had encouraged me to sleep on a letter or a decision before sending it.

“It′s good that you can express this strongly, but we need to bring people with us,” Ben often said to me.

This time it was my colleagues that I needed to bring with me.

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A week later, I went to my appointment with The Man Himself. His room smelled unexpectedly of incense, I wondered who had been in there before me, what she had confessed, what she had been granted.

“You’ve seen Gloria twice for assessment?”

“Yes.”

He reached into my notes and pulled a pink form out. Gloria had written on it that I was “highly anxious”.

"Good," he said, reaching across his desk for a cardboard calendar, "we can book you for elective caesarean on medical grounds, on 4th August."

When I arrived back to Anna Freud′s attic an hour later, I passed Ben on the narrow staircase. He looked flustered.

"Serena′s in labour."

Seven weeks early. Prematurity is more common with multiples. The judge may have imposed a deadline, but pregnancy has its own timescale. I remembered the midwife who had taught me, almost twenty years earlier, that it is a baby who determines when she will be born. And I remembered the screams. The shrill stream of screams pouring from that room, directly opposite the room we were in, twelve obstetric disciples. I remember feeling useless. I remember the screams made it hard to concentrate. The staccato strike of suffering in my ears while the midwife talked to us about the beauty of natural birth. Right from day one, obstetrics wasn't going to be for me. Other medical students had written prize-winning essays about the miracle of childbirth: "Suddenly I realised there were four, not three of us in the room," and tough-seeming young men from the Barts rugby club became teary when they had been allowed to deliver babies during "Obs and Gobs." I remembered thinking it was strange that everywhere else in the hospital, patients had been relieved of their pain. Anaesthetists had devoted afternoons to specialist pain clinics. Yet there, in the peeling-paint maternity wing, unassuaged torment from the era of barber surgeons rang out.

Nobody else, neither my fellow medical students, nor the midwives who had tolerated our presence, nor the doctors teaching us, openly shared my view. We had been taught about gas and air, about pethidine "to take the edge off" and had been told that some women opted for epidurals, which left them numb on their backs, catheterised, more likely to need their baby wrestled out by forceps, wrenched out by ventouse or, as a last resort, cut free.

At an antenatal class I had attended as an observing student, the facilitator had talked about empowering women and how a well-managed labour, in which a woman was in control, need not be painful. Empowering seemed to mean a choice of music and a page in her maternity notes to write a "birth plan". Like writing to Father Christmas.

On the top deck of the 56 bus, back to Barts from the Homerton where I was undertaking my pacement in obstetrics, I had studied the "firm timetable" that charted the rhythm of an obstetrician's week. There were antenatal clinics, which took place in hospital and in the community, specialist clinics for women who had diabetes, other medical conditions, sub-fertility clinics, renamed from infertility clinics, to give hope. On Thursday mornings, there was a TOP list.

TOP stood for termination of pregnancy. It wasn't compulsory to observe, but having been interested in embryology since my colouring-in days, I went. It was miserable. I was sent to observe the admissions. A woman tucking two photos of young children under her pillow as she was wheeled into theatre told me, "I'm doing it for them." The only man in the clinic was the consultant who "did the list". He had lectured us on "subfertility" the previous week. I thought of his curious dual relationship with embryos, harvesting them on one day, suctioning them out on the next.

He sat on a stool with wheels while I stood, hands behind my back so as not to contaminate any blue-draped sterile fields. Blood and the products of conception were vacuum-suctioned into an unseen receptacle. Nobody judged, nobody commented, apart from on the length of the list, on what there was to get through.

"Not a lot to see," said the consultant, "here's a bit of notochord, you see that?"

He showed me a sliver of bloodied flesh and continued in this way, pausing to look at what came out, to see if he could demonstrate a bit of foetal anatomy. At the end of the list there was an ERPC, which I learned stood for "evacuation of retained products of conception."

"This woman suffered a miscarriage and not all of the products of conception have come away," the theatre sister explained to me. The woman whose womb had held on to her dead unborn was wheeled in after the TOPs for the parts left behind to be vacuumed out.

“Ah look,” said the consultant, wheeling towards me on his stool, “another bit of notochord”. Then he wheeled his stool far back from the trolley, snapped off his gloves and said, “go and have some lunch.”

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The referral Ben and I made to “Acorn House,” the official name of Perry Appleton′s Mother and Baby Mental Health Inpatient Unit, was declined. Jess found a privately-run facility that would accommodate Serena for a year. It was a specialist placement, for mothers who had been diagnosed with personality disorders and their babies. In that placement, Serena could have the therapeutic support that Pradeep had envisaged her needing, and then be reassessed for court. We recommended that she went there, a recommendation that on this occasion would be endorsed by the judge.

LOST IN TRANSLATION

“Running late. Sorry. Bus problem. Now in cab, but bad traffic,” Asenath, the interpreter texted. We′d spoken after Noor′s network meeting and Asenath had asked how I like to work, but still I hoped for a few minutes, just to make sure we were in tune with each other, before we saw Noor and her baby.

Ben had earmarked Noor′s case for me when her troubles landed in his inbox.

“It a mum and baby,” he′d said. “There′s an older sibling that the local authority aren’t concerned about. Thought a short, focussed piece of work would fit in quite well, given her timeline. And also yours.”

Ben glanced at my now-bulging bump, as if I might have forgotten my cargo and the impending due date.

Jess′s case summary of the two legal ring-binders was bleak: Noor, a migrant from Egypt, abandoned her baby Azhara in hospital. Azhara was born by emergency caesarean section and was diagnosed with Goldenhar Syndrome. This syndrome, named for Maurice Goldenhar, who first described it in 1952, is rare. It is present at birth and severely affected Azhara’s jaw and ears.

Noor had a traumatic birth, with an emergency caesarean and Azhara was placed on the Special Care Baby Unit or SCBU, that as a student I had learned to pronounce as “scaboo”. Azahra was unable to feed as her upper lip and palate were divided with a large cleft. Paediatricians say it took “a great deal of professional resource to persuade mum to come in and learn how to feed her baby through a nasogastric tube”. When Noor came to SCBU, it was often hours after the agreed time, for example coming the day after the ward dietician, who had waited to meet her, wasn’t on duty. The nursing report said, “Noor refused to tube feed her baby and then refused to take her home”.

Jess knew from her years as a ward nurse that SCBU beds are in high demand. She had made a note of how the staff felt stressed as the baby was blocking a bed. The unit were having to send other babies to hospitals far away. On six occasions over two weeks, Noor was said to have repeatedly promised to collect her baby, then didn’t come. On the morning ward round, the consultant made a referral to the hospital social worker, who tried to contact Noor and noted several missed appointments with her before involving local authority. An interim care order application followed. Noor’s behaviour was said to have changed after the interim application was made. She now wanted to look after Azhara. The family court had allocated a hearing date ten weeks hence, when the judge would decide whether it was in Azhara′s best interest to remain in Noor′s care or whether to place her into foster care.

It felt like a judicial riddle for the biblical King Solomon. What superhuman expectations society has of judges. What was the cumulative effect of daily grappling with these heart wrenching questions?

Ben assigned Noor′s case to me, partly because my medical background meant I could decode the jargon in the case files and understand the concerns of medical professionals, but also because time was running out for me. I was struggling to haul my bump up the hill to Maresfield Gardens. My wrists had swelled, the accumulation of fluid pressing the median nerves that ran from my neck to my fingers against the small bones in my hand. The tingling and pain in my ring and little fingers were an annoyance, but the numbness across both palms made typing hard. Twice my pen slipped from my grip. I wasn’t yet finding it harder to concentrate on the attic team-meetings, but in early summer heatwave it was surely only a matter of time. After my mode-of-delivery appointment, I′d given Ben written notice of working to the Friday before the planned caesarean, but had recently reneged to bring my maternity leave forward by a fortnight.

Jess′s bare-bones summary was bleak, but I wondered what the flesh-on-the-bones of this case looked like. The sadness evoked by an apparently rejected baby because of her visible facial differences felt almost unbearable. As I pushed myself back in my swivel chair in the attic office after reading the case summary, pressing against the chair as if my spine needed reinforcing, looking out onto the pigeon traversing the balcony railings like an unlikely trapeze artist, I wished that the fluid pooling in my wrists would numb not just my fingers, but all of me, so I could read and analyse the contents of the case file, but not feel. Even before I met her, I began building a barrier between Noor and myself, as Liberty and her friend Issy might construct a Lego wall. Family court assessment work is both intimate and intense. If I didn’t build emotional boundaries between myself and my patients, the infinite sadness would break me.

I was taught how to construct these boundaries. Early on in my training as a child psychiatrist, I was shown how to deflect the question, “Do you have children?” It′s natural for parents to ask, to want to know if we share the experience of sleepless nights, of maternal worry, of grappling with a teenager′s need for both independence and protection. I riff off some version of, “every family is different and even if we have experiences in common, I want to understand what life is like for you.” My work happens in neutrally decorated offices, without any photographs of my own kin on display. If a patient asks, for example, if I have plans for the weekend, or for Christmas, I edit my loved ones out of my replies. Being pregnant disrupted those carefully constructed boundaries. There was no chapter in any of my textbooks about how to address the embryo in the room. For most of this pregnancy, in professional contexts, I didn’t acknowledge it. When I was assessing Vicky, it was too early to see, as it was when I met Serena in the first network meeting. But by the time I met Noor, my bump outed me as an expectant mother. There was no denying it. We had this between us.

While I was waiting for the delayed interpreter, I looked up to the fourth floor of the concrete block of flats. Noor saw me waiting outside. I waved. She came closer to her window and crooked her finger, beckoning me towards the main door. The door was metal and heavy. The orange paint had blistered, revealing flaky layers of blue and darker gunmetal below. I waited for the hornet′s buzz of the intercom, pushed the door open and felt it clunk behind me, reminding me of the doors in the youth offenders' institution I worked in before Liberty was born. As I came up the stairs. Noor was waiting in her doorway.

"Assalamualaikum," I said, "peace be with you."

"Wa-Alaikum-Salaam," Noor replied, "and peace to you too," a call and response familiar from my own childhood. She hung my coat on a peg in her hallway as I removed my shoes.

"I′m so sorry, the interpreter, she′s running late."

"No interpreter?"

"She′s coming. Later. Stuck. Traffic."

I gestured towards the Great North Road beyond the hallway window and followed Noor into the kitchen. The neatness was arresting. At the network meeting, Noor was described as a disorganised, somewhat chaotic woman who could barely care for her baby. Noor′s flat was orderly. The surfaces were clear of clutter and wiped clean. Her nine-year-old daughter′s bed was made, I noticed as I passed the bedroom coming along the hallway, the baby′s buggy folded by the front door. The carpet had those lines that suggested it was freshly hoovered. I mentally noted all this down, as I couldn't square it with the reports of a woman who was barely coping with her high-needs baby and was also a lone parent to her older daughter, Ayesha.

Azhara was in her highchair, her left ear missing, her right ear partially formed, her face lacking symmetry, yoghurt around her mouth, a thin nastrogastric tube worming out of her left nostril and taped to her cheek. She smiled and the cleft in her upper lip broadened. There was a photograph of Ayesha in her school uniform on the mantlepiece, next to a large print of Al-Masjid an-Nabawī, the Prophet's Mosque in Medina. My father's youngest brother has the same picture on his wall. My cousins and I used to build Lego walls while sitting beneath it.

At the network meeting I'd heard about Ayesha. She wasn't part of these court proceedings, meaning that the local authority were not interrogating Noor's ability to look after her. However, parents who neglect one child often neglect their siblings, so I was alert to any signs. The photo looked recent. Ayesha was wearing braces. Someone had taken her to the orthodontist. Her uniform was ironed. Her fringe neatly trimmed. In isolation, any of these details may be meaningless, but taken together, they suggested a pattern of maternal care and involvement. Either that or Ayesha, aged nine, had already learned to take care of herself. I've been in homes where primary-school-aged children do the housework before going to school. The professional term for children who take care of their adults is parentified. Children who grow up parenting their own parents are much more likely to become ill with anxiety disorders, depression, life-threatening eating disorders and obsessive-compulsive disorders. Although the court had only given instructions for an assessment of Noor and her baby, child protection matters are every professional's business. My mind was open to all explanations.

Azhara continued to smile. I smiled back at her.

"You are a lovely baby," I said, adopting a sing-song lilt without being conscious of it. This instinctive sing-song that people across all cultures speak to babies is called motherese. Often older siblings slip into it too. There is a theory that we speak motherese to babies as it exaggerates vowel sounds which helps babies learn languages. Speaking to babies, whether in motherese or monotone helps with maternal-child attachment, the sorts of signs of attachment that I was scanning for. In the legal bundle, Noor's struggle to feed her baby was highlighted as a "significant concern".

Noor sat across from her daughter and gently spooned her yoghurt, wiping up the drips and chatting to her. Although I didn't understand the language, I heard her exaggerated intonations. The sing, the song, the spoon, a soothing rythmicality. For twenty minutes, while we waited for the interpreter, I sat watching Noor mothering her daughter.

Usually during assessments, I make lots of notes, including of observations like the ones I'd made in the hallway, and I leave my notepad visible so that families can see what I am writing about them. Because Noor didn't read English, I decided not to keep notes that she couldn't read, trying to save as many scenes as I could in my mind's eye. When I was a junior doctor, I never took notes while I was with patients. We'd talk and I'd write it all down later, but when I started expert witness work, I began taking near-continuous contemporaneous notes, as if my memory had suddenly become untrustworthy. Writing mitigated my fear of misremembering a small detail that might turn out to have large implications. Writing this now, I can still see them like a ghostly after-image: Madonna and child on the fourth-floor of an inner London flat. I can see the red tablecloth, the black placemats, the framed picture of Medina, the dent in the yoghurt pot where Noor was holding it and the smallness of the spoon. I can still see the love in the mother's smile. The reflection in her baby's eyes. Her widening smile when she saw her own love reflected.

"Tea?" Noor asked.

"Can I make you one? I'll do it," I said patting my chest and smiling. These short, stilted phrases and hand gestures were how I'd communicated with Mummy Khatoon, my father's mother. A nod. A gesture. A box of tea bags. A tapped cake tin. The click of a kettle.

Asenath, our interpreter arrived as the kettle boiled, carrying the stress of the North Circular with her. When I started more formal questioning, Noor closed down.

“I am fine.”

“Baby is fine.”

“I can′t remember.”

“Now is Azhara nap time.”

“No for talk, not now.”

“Could you interpret this, Asenath? Noor I am grateful for your hospitality, for inviting me into your home.”

Noor nodded, but had her back to us, her baby over her shoulder.

“I′d like to come back, at the same time next week, with Asenath.”

“Okay, if you want come, you come,” Noor looked wary.

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The following week I was there ahead of Asenath. Noor was looking out of the window, and again beckoned for me to come up. My sandal straps were digging into my puffy ankles and I was glad to take them off. Asentah didn’t come and didn’t text. I rang the agency. There had been an administrative error. Asenath hadn’t been booked. They offered me someone else, a man, who could be there in about forty minutes.

“Not necessary,” said Noor, who was playing with Azhara on a rug shaped like a giant ladybird, “we will manage.”

Noor smiled. I was worried about how we would manage. If she misunderstood me, or I misunderstood her, there could be serious legal implications. Was it right for me to go ahead, knowing the language barrier? I made a snap decision to proceed with continuing to observe Noor and Azhara, and made a mental note to book in additional assessment appointments, working backwards from the court date, squeezing the timeline like a concertina.

It was a warm day. We had the best part of an hour ahead of us and I had mentally put aside my assessment questions for a future meeting with a female interpreter.

“Noor, would you like to go for a walk?”

‘You mean outside? With pushchair?”

“If you′d like to?”

Moments later, we were lifting Azhara in her buggy across the metal lip of the front door, into the sunlight. We were a few streets from Charterhouse Square, where I had lived in halls of residence as a medical student. There used to be a small park, years ago, when the big Waitrose was still Finefare.

“Is there still a park along here?”

“Yes, we walk.”

We walked in silence, stopping to work together to lift the buggy up a pavement step or around traffic cones. When I walk with teenage patients, I usually wonder out loud, letting them know what I′m thinking. It′s something I had watched my former boss Anula Nikapota doing, putting thoughts out there without making eye-contact, while looking into the distance. Anula taught me to offer these invitations to talk about difficult things lightly, but it now feels so natural that I can′t remember learning it. Everything in the notes and reports suggested Noor didn’t understand or speak much English. Working closely with Ben had taught me that the clinical notes are not a map, they are a guidebook, with all the truths and biases of a travelogue. It was for me to make my own discoveries about this family and their world.

“Lots of people, doctors and nurses from the ward, social workers, have said how worried they are about you, Noor. They’ve written those worries down for the judge. But I don′t know anything about what you feel. I wonder how it has been for you.”

We slowed down to cross over to the park. It was larger than I remembered, with a new play area and an outdoor gym.

“Ayesha′s school,” Noor pointed it out to me, “close by our home.”

“She looks like a lovely girl, in the school photo.”

“A good girl.”

“Can′t be easy, mothering a schoolgirl and a baby,” I said as Noor looked across at my bump, “from what I’ve seen today, you look after Azhara very well.’

“You know about Hafsah?”

I shook my head. In hesitant, but clear English, Noor told me about another baby, Hafsah, born after Ayesha.

″My daughter Hafsah was born sleeping. My husband and mother-in-law blame me. Even I blame myself as well.”

Terrified of losing another baby, Noor did everything she could to avoid conceiving one.

″My husband called me bad names. He find new wife who give him two son. My younger brother, say ‘why you don’t come London, stay my house?’”

Noor told me that she left Egypt and came to London on a student visa, to stay with her brother. His flat felt cramped with her and Ayesha there and she found his wife difficult to get on with. She lived with them until her brother′s family moved to Canada. She had lived in her flat, with Ayesha, for two years.

Noor told me that there was a man who worked at a market, the market she came past after dropping her daughter Ayesha at school. He was a businessman: markets, sim cards, import-export. She would stop to chat and he would offer her tea. He sold things that reminded her of home. He was a comfort to her and sometimes they were close. After many weeks she found the courage to tell him she was pregnant. He wanted her to have an abortion. He offered her money for one. Made an appointment for Noor at Marie Stopes.

Noor stopped walking through the market and took a different route. She felt ashamed when she was asked about the baby′s father at her first antenatal appointment. They′d already asked lots of questions because she was such a late booker. She lied. She told the midwife that she′d been raped. The midwife was kind. She said the police would help. Noor felt pressured to report a rape that hadn't happened and felt frightened about being found out. The midwives had written about the rape in her notes. Police came. She told the policewomen it wasn't rape. She also said she was afraid of the baby′s father. He′d given her money for an abortion, and she′d used it to buy a buggy. All the antenatal clinic staff knew she said she had been raped and then retracted it. She saw them talking about her. They thought she was a bad woman. A liar. A whore.

During Noor′s 20 week scan a possible abnormality was detected. Noor told me about lying alone on a bed, smothered in ultrasound gel, hearing the ultrasound technicians talking in the corridor outside, worrying about what they were saying and worrying about being late to collect Ayesha from school. Three different doctors came to look at the scan, one after another, each one more frowning than the last. They told her to come back for another test. She was so late for school pickup that Ayesha had to wait in the deputy head′s office. He told Noor off for coming late. Called it a child protection matter.

Noor talked about having blood tests and doctors putting needles into her pregnant belly for reasons that she didn't understand. She was scared of what the needles would do to her baby. She talked about the cost of travelling to hospital every day and how it made things tight financially. She missed two antenatal appointments because she couldn't afford the Tube fare. In her last trimester, Noor collapsed in the supermarket. She was life-threateningly ill with pre-eclampsia. Someone called an ambulance. Azhara was delivered by emergency caesarean. Noor was frightened that she would die. She was also frightened that her baby would die. There was nobody to look after Ayesha. Social workers placed Ayesha with an emergency foster family in Dartford. The deputy head told the social workers that Noor had been distractible, had missed parents' evening, had been late to collect Ayesha and seemed detached, not quite with it.

When Noor first saw Azhara, she was in an incubator. She looked like Hafsah, the baby who died, but her face gaped open and her ear was missing. Noor was certain then, that Azhara would die too. When Noor was discharged from hospital, she couldn't face visiting her baby on the special care baby unit. Ayesha came back from Dartford and Noor pretended that it was just the two of them again. She went back to bed after dropping Ayesha off and switched off her phone. Noor knew bad news was coming. Social workers buzzed the door to her flat. They said if Noor didn't go to hospital to learn to feed the baby, they would find another family to look after her. Azhara was fed by a special tube into her nose. Noor went to the hospital to learn to feed. She watched the nurses squirt milk into the tube but she was afraid she would choke her baby and get it wrong. If a nurse was watching, she could bring herself to do it. Alone, she was afraid.

"You cannot trust me. I cannot keep alive," Noor had said. When the paediatricians deemed Azhara ready to go home, Noor went onto her knees and begged them to keep her for a few more days. An interpreter was called for the first time. Through the interpreter, she was told her daughter may have a serious medical condition, that her heart and kidneys might be damaged, that she might never learn to read or write.

Noor asked for more information. The multidisciplinary team called a case conference meeting and invited Noor, but the meeting was at the same time as school pick-up and she was afraid that Ayesha would be sent back to Dartford. She felt the nurses judged her because she wouldn't take her baby home and she felt stressed and couldn't understand what they were saying. She could understand English, but not their accents.

Hospital court reports said Noor missed three meetings about discharging her baby, but as we walked back to her flat, she told me her story of picking her daughter up from school and then leaving her with a neighbour she didn't know well, of being delayed on the Tube and getting to the hospital late. She remembered the shame at being told the meeting was finished and that social services were being called. Noor said she was asked if she felt she could look after her baby. She replied that she said she wanted someone else to take care of her. She walked out of the hospital and turned off her mobile phone. She was terrified that she would lose this baby, in the same way she had lost Hafsah.

“Always, always I was afraid,” she said, as we arrived back at the metal door, “of Allah judgement.”

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What was I to make of this? Was this simply a case where a family had been brought before court over a series of misunderstandings? Paediatricians and nurses on special care baby units are used to seeing mothers who are terrified. A large part of their daily work is gentle reassurance, instilling confidence, patiently teaching how to give care to a tiny, vulnerable baby. They are skilled in helping scared new mothers, often mothers who are also recovering from major abdominal surgery while receiving the news of a life-changing diagnosis. The story with school didn’t make sense either. Parents have emergencies and run late. If every child who′d waited in a school office while their mother was delayed at an antenatal appointment was flagged as a child protection concern, well it just doesn’t bear thinking about. Back in Anna Freud′s attic, I phoned the author of the nursing report. It was a damning report, detailing dates and times of phone calls made to Noor, messages left and unreturned. There was a list of all the shifts she had promised to come in to hold and feed Azhara, all the days she did not come. The nurse remembered her immediately.

“It was a really busy time for us. SCBU was under massive pressure from management to discharge babies as soon as we could. The trust were having to send babies to other hospitals, who had SCBU beds, while their mums recovered here. Management were really unhappy. Every day we were asked why Baby was still blocking one of our beds. Our babies go home with feeding tubes all the time. There was no medical need for Baby to be in here.”

"I was wondering, did you have an interpreter when you spoke to Noor?"

The nurse sighed.

"Mum was a lot more able, with respect to language, than she let on. When Baby came to us, obviously it was handed over that Mum needed an interpreter. But us nurses could see Mum listening to us talking. Us nurses could see that she did actually understand a lot more than we were led to believe. There was a lot of 'oh, I didn't know there was a meeting' but Mum knew. Me or one of the other nurses, we wrote that stuff down for her and she′d say, 'I will come.' You know there′s a bit of history there. When Mum went to maternity she was saying she′d been raped, then she retracted it as soon as the police came. It′s not all what it seems with Mum. We have mums from all over England who come and stay in hotels and AirBnB to be with their special care babies. Our mums are here all day, single mums with older children too, but this one, she just disappeared when she heard the word disability. She came when she had to, roomed in, but did the bare minimum. She′d had an abortion booked, it said in her mat notes. I really think she didn't want Baby."

I was struck by how detached the nurse sounded when recounting Noor's allegations of sexual assault and how this made her sound cold. Her manner reminded me of Simon at his worst, firing out orders when under pressure, even in domestic circumstances where they were out of place and made him sound callous and indifferent. It made me think too, of how I had given orders to my colleagues about Serena. Did I do that because I lived with the poetics of war or because Simon and I shared the tendency to sound sharp and abrupt when we were emotionally detached from distressing situations?

How many premature babies had she nursed who had died, I wondered? How could she spend her days giving care to babies who depended on medical equipment for the most essential acts of human survival, like breathing and feeding, and not give all of herself away as she did this.

How does a nurse keep her humanity intact on a neonatal intensive care unit? How often did she give instructions to mothers waiting anxiously by the incubators? How often was her commanding presence a reassurance?

What was my role in the power imbalances that Noor was caught in. Noor and I shared female gender and uncertain, to-be-determined, maternal status, but the similarities ended there. What could I do to upend the medical culture and traditions that perpetuated misunderstandings while also maintaining the professional scepticism that was urged after the inquiry into Victoria Climbie's death? I couldn't simply dismiss the concerns of the hardworking, devoted colleagues on the paediatric ward who had cared for Azhara. Every inquiry into the death of a child known to health and social care criticised the lack of communication. With that at the forefront of my mind, I continued my phone calls.

The other staff I spoke to remembered Noor too. "My heart went out to that wee girl," said Emily, a health care assistant on the ward, "Noor loved that wee girl; she just didn't believe she could ever look after her. I was just the HCA, but even I could feel myself getting attached. Our ward team could meet all of the wee baby′s needs, except the one that mattered most: she needed her mummy. I've thought about her a lot. Imagined her finding out when she′s older than her mummy abandoned her and it′s bound to affect her, isn't it?"

The ward notes said that Noor was difficult to communicate with. She was described as "guarded", which made me think of the Gurkhas at the back of our garden. Her social worker was a young woman, Bea, working in London for a year, an overseas experience. Perhaps Bea took at face value Noor′s request to find someone more capable to look after her baby. Maybe Noor needed closeness, not detached objectivity? Maybe what Noor needed, was time, with someone she trusted, to tell her whole story and to gain confidence in looking after her baby. But time is in short supply in health and social care. Bea had a caseload four times higher in London than in Melbourne. She couldn't have a dead baby on her hands.

Jess and I were sitting in the attic office. Jess was writing up a Story Stem Assessment and I was finishing my report on Noor and Azhara. I felt heavy, heavy with my bump and heavy with the burden of assessing whether Noor was a good-enough mother, heavy too, with the gravity of any error I might make.

"The one thing I've heard over and over is that Noor behaved oddly when Azhara was on SCBU," I said to Jess, "and it bothers me. Noor gives a plausible and pitiful account of why she missed appointments. With the benefit of hindsight, it sounds as if she may have been depressed, but there is nothing to corroborate that, nothing in her maternity notes, nothing in the GP records about a postpartum illness."

"There wouldn't be, though, necessarily," said Jess. "My wife had a terrible labour with Juliet, and all it says in the notes is normal vaginal delivery."

"Even if I can explain it with hindsight," I said, "it′s foresight that I could do with. Whatever happened to explain why Noor′s behaviour stood out as odd on SCBU, will she be a good-enough mother to Azhara going forward?"

"Based on the assessment, it looks like it," said Jess.

"But it puzzles me that she was referred," I said. "What am I not seeing?"

"There are so many social expectations of how a mother is meant to behave and what is means when she doesn't conform," said Jess.

I thought of Noor′s cultural background, the stigmas that may have prompted her to lie and to hide and of the impossibility of being a mother split in two, expected to be with her elder child and also with her baby.

"Can I tell you something in confidence?" Jess interrupted my thoughts.

“Course you can,” I said, feeling like the team′s Mother Confessor, hearing secrets in the attic.

“I miss my children. They′re not little for long. When I took this job, it was three days. It′s easily four on most weeks, on Fridays I′m at home but just sort of zoned-out. I’v been thinking about setting up a room at home, developing a private practice.”

“Court work?” I asked.

“I miss doing therapy. Court work is heart-wrenching, I trained as a therapist to make things better,” she said.

“I′d miss you,” I thought, but didn’t say. I′d grown attached to Jess, as I was to Marco and Ben too, my work family. *Sie werden mir alle fehlen*. They will all be missing to me.

Like my other colleagues, Marco, confiding his retirement plans and Ben, sharing his shortlisting for the academic appointment, Jess prefaced her confession with the phrase, “I don′t want to destablise the team.” I felt guilty then, about contributing to that instability, the burden of all my additional medical appointments, my upcoming maternity leave tilting the balance. In truth, any sense of instability was no more precipitated by my pregnancy, than by Marco′s imminent departure or Ben′s new commitments, though either one of these events might perpetuate it. The culprit was the precarity of funding, the prospect of the local authority taking their contract, our expert witness team′s blood-supply, elsewhere. There had been a shift in contract review meetings, a sense that assessments might be carried out at less cost, if they were made by a single practitioner, rather than by a multidisciplinary team. This precarity came against the background of wider reforms, a step-change, which made the team look inwards, reflect on our values and consider changes.

The midsummer heat in the attic was stifling, so I typed my report in the Maresfield Street garden, sitting in one chair, swollen feet up on another, laptop propped up on my bump, an osteopath′s nightmare. I half-sat, half-reclined, eating pieces of melon and feeling over-ripe as I wrote up my conclusions facing a border of helleniums and lupins, a few fading peonies still in bloom. It was the last report I'd write before going on maternity leave and in addition to the usual pressure to get it right, a pressure that I felt more acutely through working on the case alone, I felt sad to be saying goodbye to my colleagues. The helleniums and lupins would be blooming in the border the following June, dependable, beautiful. What was less certain was whether the expert witness service would turn out to be perennial. The team's contract was up for renewal. Marco wouldn't be here next summer; he was retiring after Christmas and planned to spend more time in Italy. Whether Ben would be able to renegotiate a new contract, continue to lead the medicolegal work and take up his academic promotion in the autumn, left me doubtful. Not because I doubted Ben's good intentions, but because recently he had looked tired. His eyes, that had once sparkled with the challenge of each new case, only shone now for his social work students. After thirty-four years in social work, twenty-five years as a family therapist, Ben was ready to inspire a new generation. I wondered how long his plan to commute back from Devon for two days a week to lead this team, would work.

I wondered too how my life would be changed by having two children. Was I jinxing it, counting my unborn before she was born? My home would never have the neatness of Noor's, but I hoped to have some of her newly-discovered confidence and poise. I admired how unharried she now appeared, despite the stresses she was under. My notes were full of her sweet songs to baby Azhara, the little cues Noor waited for before offering a spoon of yoghurt, the gentleness of her practical care. Could I do all that mothering and this job? Did I want to this job and all that mothering? Was it a binary choice? Is mothering a relationship or a vocation? At the Anna Freud Centre, a child's *first thousand days* was being promoted as a vital time in a child's life. It was a phrase that was picked up by the media and endorsed by the Royal Family. How many of those thousand days was I sanctioned to miss? At what cost? By whose measure? The final stages of report writing often raise more questions than can be answered. The difference this time was that I felt sure about Noor and unsure about myself.

It was unusual to have worked alone on the case. Usually one team member saw the parents and another assessed the siblings. I realised how often we were sounding boards for one another. Was I retaining enough professional scepticism? Noor reminded me of my own Asian family. Despite the court case, despite the power imbalance, on the walk, we connected as mothers. Did I overidentify with Noor? Did I see a mother threatened with losing her baby and see myself? Not consciously, but it is possible. Did my pregnancy cloud my objectivity and make me an unreliable witness? Did my experiences as an obstetric patient make me less judgmental of Noor? Maybe my obvious expectant maternity made it easier for her to confide in me? As I wrote my report, I reminded myself that my overriding duty wasn't to Noor, but to the court, to Azhara's best interests. Despite the kicks coming from my own uterus as I wrote, I found I could still consciously detach. With practiced ease, I distanced myself from my emotions and looked at the facts.

"How's it going? You filing soon? I've brought you a tea, the flower one," Ben had joined me. He sat in the grass leaning back on his hands, his back to the lupins, the sun picked out all the worry lines across his brow.

"Ah, chamomile, thank you," I said, taking a sip, "Filing next Wednesday."

"How's the old carpal tunnel syndrome?" Ben asked, looking at my wrist supports.

"Flared up a bit, but not as much as my imposter syndrome."

"You're not on your own, you know. I'm here, Jess is around, if you want to bounce any ideas," Ben smiled.

"It's going to ruffle the paeds' feathers this report. There are things that don't add up. Lots of things. But Noor's a good-enough mother. A safe mother. A loving mother. Azhara shows signs of secure attachment in the stage situation test. They′re going to baby groups. She′s got help from a family support worker. This case shouldn't be in care proceedings."

"Noor can look after a baby," said Ben, "but will she cope with the emotional demands of a toddler who could potentially need quite high-level care. Would Noor walk away again? Tell me what you know about her attachment style and her mental health."

One of Ben′s unofficial roles was to test my optimism, to make sure I could justify my opinions and that they were theoretically grounded, just as one of my informal roles had evolved to challenge his pessimism. I showed him the scores from the Adult Attachment Interview, the Depression Inventory, the Attitudes to Parenting Questionnaire. I showed him the Strange Situation Test and recounted the final meeting I′d had with Noor, the sessions with the interpreter, the positive comments in Ayesha′s school reports, the upbeat meeting with the health visitor, the friendship that was blossoming between Noor and another mother.

"We don′t want to rock the apple cart with the paediatricians," Ben said, "I′ve known that consultant Eleanor Leonard for years. She′s a sound, sensible woman. She wouldn't make a referral without good reasons."

"It looked awful in the court bundle. But what I've seen over two months now, it doesn't match that. I think the social worker made the wrong call."

"Or she made exactly the right call with the information she had available at the time," Ben said. "Shall we hold a professionals meeting? Show them your draft report and talk these things through? Give them your view?" Ben asked.

"Invite them here?"

"Let′s go to the hospital. It′s hard for the paeds to get time away from their wards. If we meet in a room near the special care baby unit, we can invite some of the nurses who looked after Azhara."

“Are we inviting Noor?'”

“I reckon this one needs a professionals-only first.”

A professionals’ meeting to discuss a patient without involving the patient herself wasn’t our usual way of doing business. If I′d done it my way, I would have presented a translated report to Noor and filed the English language version with the court. My report would have gone to the paediatricians and local authority in the usual way, through legal channels. Chances are, if we′d done it my way, all the professionals involved who had good cause to be worried about Azhara′s safety and Noor′s ability to care for her, would have felt let down and unheard. They may have felt their concerns hadn′t been taken seriously or that risks were being recklessly minimised. Child protection is delicate work that relies on trust between different professionals and across agencies. My report risked damaging that trust. Ben was right to suggest a different approach. Sometimes a close perspective was needed. At other times there was a need for distance. That′s why we usually worked in pairs and talked all the time within the team about our cases. How do you measure this, when you cost a service for commissioners? What is the value of an experienced colleague apparently strolling into the garden for a chat? What is the price of a casual conversation by a perennial border? If all interprofessional discussions are costed to take place in preordained slots, what is left unsaid? What isn’t scrutinised? What is overlooked? At what cost? To whom?

The following Monday afternoon, I made my way across north London to the hospital for the professionals meeting. I flashed my ID badge at the hospital receptionist.

″The meeting rooms are downstairs,” she said, ″just by ED.”

ED, pronounced eedee, in-speak for Emergency Department. Nobody calls it A&E any more. But I could remember when A&E had been the new name for Cas, which had once been in-speak for the Casualty Department. These abbreviations tell generations of doctors apart. I am like those elders who remember decimalisation. Just after the turn of the millennium, trusts were asked to drop the “accident” from “accident and emergency” in an attempt to stop people “wasting medical time.” ED is not an acronym that slips from my lips. My mind edits the A back in, just as it slides the o back into fetus in the American obstetric literature. I made my way along the corridor, where vulnerable people were waiting for urgent medical assistance. The light here always felt over-bright, surprising my eyes as if I was stepping out of the cinema in the mid-afternoon. I blinked in the glare, an immigrant visiting my old country, admiring the progress, bones aching with loss.

I saw a psychiatric colleague striding towards the ED double doors and thought: I am so glad that′s not me. I felt guilty, because until recently, it was me. My mind went back to the last time I had been in ED, a few years earlier. When I came home after several years of working in New Zealand, I locumed in the NHS.

It had been a bit of a shock, and I had caught myself thinking, “It wasn’t like this in my day. The consultant didn’t come to review a patient in A&E without a junior doctor having seen them first and presenting the history.” How things change. The young and idealistic become elders reminiscing about the good old days of Cas officers.

“Good you′re here. She′s blocking our bed,” the staff nurse had said, when I had arrived and flashed my locum consultant badge.

“Doreen,” she had called to a health care assistant, “Psych′s here. Can you show her to the overspill?”

I cringed at being called “the psych”, a Hitchcockian epithet.

“Hello, I′m Sabina Dosani,” I said to Doreen, holding out my hand to shake hers, but she had carried on holding the patient′s notes across her chest like a shield, and was striding through the department. I walked faster to keep up with her.

“Glad you’ve come,” she said, “matron′s desperate to move her out. We’ve loads of sickies, just no free beds. We had her in resus when she came in. It′s not fair on patients who are really ill. It′s not the place for her. Too disruptive. And paeds won′t have her on the ward.”

The mind-body divide. The Maudsley hospital, where I trained, is opposite King′s College Hopsital, where I was often on call. The registrar who showed me round on my first day referred to the road, Denmark Hill, that ran between the hospitals, as the “mind-body divide.” Politicians like to talk about parity of esteem. As long as a teenager who wants to die is seen as a bed blocker, parity will remain a political wish, not a clinical reality.

Doreen pushed open the door of the “overspill”, leaning into it with her upper body. The room smelled of bleach and stale body odour. On the other side of the door, I was expecting a teenager sitting on a bed or possibly lying down. I almost didn’t see her. There was a blue, woven blanket on the ground, covering a human form, like shroud draped over a corpse. The human form was curled like a foetal shape on an ultrasound scan. I was reminded of London′s homeless seeking shelter in West End doorways.

I had guessed that overspill was a euphemism. I hadn′t imagined it to be a euphemism for the mop cupboard. In one of the most affluent parts of one of the world′s richest nations, a teenage girl who wished she was dead was being nursed on the floor of a mop cupboard. When the department was designed, this was the space set aside for buckets, for the yellow warning signs to prevent people from slipping on spilled bodily fluids. There was no window. It was cold. Is this what I′m part of now? Is this how we treat children who want to die?

At the foot of a mattress was a plastic chair holding a woman: a mother keeping watch.

“Mum′s been sat up all night, isn’t that right love?” said Doreen, nodding towards the blanket on the ground. “Night shift took away the bed because of her history of tying ligatures.” The mother looked up, hollow-eyed with fatigue and fear.

“Psych′s come to have a chat,” said Doreen, slipping back out through the door.

I crouched down next to the plastic chair, so I could look the mother in the eye. David Firth taught me this. He was my first trainer in child psychiatry. A tall man, who loved going on adventures on his motorbike and served in the Territorial Army, David always brought himself to eye-level with his patients and their families. He spoke gently, but with certainty. I only worked with David for six months, but he became a lifelong mentor and friend. When I meet a new family, I hear his Mancunian accent prompting me: “What do you think is going on here?” When I feel stuck, I hear him, “This little lad says everything he tries goes wrong, but I bet we can help him find an exception to that.”

It′s what the expert witness team looks for in our patients, evidence of a good attachment early on, and it strikes me that I had a good attachment, a dependable trainer and attentive role model, early in my training as a child psychiatrist. David let me watch and learn, but he also pushed me to do things myself, while being there as a safety net and a sounding board. If I can speak gently, yet with confidence to families in their moments of abject distress, it is because he taught me.

“I′m Sabina Dosani, consultant psychiatrist,” I had said to the mother, on that day in ED, that was to be my last. “I′m so sorry we are meeting in such difficult circumstances. I’ve come to make sure Stella can get the help she needs.”

When I first learned child psychiatry from David Firth, we could admit unwell patients to specialist adolescent mental health beds. David′s wife, Helen, was the consultant at the local inpatient unit for adolescents. Admitting someone in crisis, for the help they urgently need, happened routinely in my living memory, but increasingly it sounds like a fiction. I had come to tell Stella’s mother, who had sat and kept watch over her daughter all night, that there were no specialist adolescent mental health beds locally. These beds were allocated nationally by NHS England. Back in the day, I would have called a bed manager, there might have been a wait, but Stella would have been admitted to a bed nearby, most likely under the care of colleagues I knew. That didn't happen with the national allocation. Stella had been assigned a bed 160 miles from home.

"How will I visit her? I've got two other children," her mother asked.

I couldn't look Stella's mother in the eye. I wanted to give care that was at least as good as the care I had received as a young medical student. I wanted to give care that was at least as good as the care I had been taught to give. I felt hopeless, but worst of all, complicit in a broken system.

I decided that night in A&E, by the side of a suicidal teenager who was being nursed in the mop cupboard, that I needed to leave the broken system before it broke me.

"You just need to take some annual leave, mate. If all the good people leave," Bethany, my nursing colleague had said, "there'll be nobody left."

I left. I went to work in neuropsychiatric assessment services, in the judiciary and in the well-funded expert-witness assessment service, where I could practice in the way I had been trained to. I was once a young medical student, waiting in the casualty department of a London teaching hospital, after I had tried to end my life. The system that saved my life has since broken and I felt a deep sense of shame and failure, that I wasn't able to rebuild it, but walked away. If miscarriage reminds obstetricians of their failures, passing the double-doored entrance to ED does it for me. So it was with relief that I turned my back on the ED and pushed open the door to the professionals meeting.

"We've read your report about Noor and Baby Azhara," began the local authority social work manager. She pushed her glasses to the end of her nose, which made her looked stern and I felt queasy.

"We're not going ahead with care proceedings." I couldn't believe it. The local authority had just announced their intention to cease legal proceedings and instead, fund psychological support for Noor. The family′s social worker undertook to identify a therapist who worked in Noor′s mother tongue.

Alan, the paediatric registrar who had made the call to refer Noor to the hospital social worker, looked across at me as everyone was returning to their duties at the end of the meeting.

“We so rarely refer. You think we screwed it up,” Alan said to me. It was a statement rather than an accusation, offered lightly across the table after all the other attendees had left. When I looked at him, I didn’t see the cold, hard steely doctor that Noor had described. Alan and I had met before, once at a Christmas ball at a district general hospital and again recently, when he gave a lunchtime talk on rare mitochondrial diseases, that Ben had shepherded our team across north London to attend.

“You didn’t have time to get to know her, Alan. I had eight weeks, not twenty minutes in the middle of a busy shift. Nobody interrupts me to-“

“Put a venflon into a tiny vein or re-site a nasogastric tube. You have the luxury of uninterrupted time. We tried, Mum just didn’t turn up.”

“Don′t he hard on yourself. Azhara′s thriving. Noor is doing well. They’ll be ok. You didn’t know which way it would go.”

“It scares the shit out of me,” Alan said, “the idea of missing child abuse. We′re all so damn worried about the next dead baby scandal. When Mum told me she couldn’t keep her alive, it spooked me. We don’t have a retrospectoscope.”

A retrospectoscope is an imaginary medical imaging device, a pun on endoscope, that allows doctors to time travel and see once-unclear clinical situations with perfect hindsight.

Alan had tears in his eyes.

“You just don′t get it,” he said, “it′s what I was always prided myself on, the bedside stuff, communicating with parents. It’s almost textbook. Good communication could have really made a difference, but it turned into this omnishambles.”

I started to say, “Shall we grab a coffee?”, but the bleep that was clipped to his belt sounded out and he turned away to answer it, life or death urgencies obliterating the tiny moments that make us human.

“Got to run. Sorry. This is what it′s like.”

“I remember,” I said. Some things are never forgotten.

Alan was striding towards the ward, back to the busy medicalised systems that perhaps could not help but see Noor as an uncooperative presence on the special care baby unit. I watched him walk back to the systems of care that do not always have time to listen to mothers’ secrets and sorrows, yet give everything to save their babies’ lives.

Being a good doctor often means suppressing so much humanity. How can we tread this tightrope, of feeling enough for our patients to care, but not becoming so engulfed by their pain and fear, that it leaves us unable to help? Calm detachment is prized across medicine. It is a hallmark of a good doctor. *Don′t get too involved. Don′t cry. It′s not professional to be in tears. It′s the patient′s grief, not yours. Don′t take your work home. Don′t stay late too often. Make decisions with your head, not your heart.* All these don’ts and shoulds, but none of the how. How often I wobbled on the high rope-bridge spanning clinical distance and emotional proximity. I knew how easily detachment could tip into indifference. I wish I didn’t, but my heart is my witness.

Cataloguing the pitfalls of clinical detachment felt like a betrayal. Why did I cast myself as a betrayer? Unconsciously I had chosen a military term, originating from the Latin *tradere*, to hand over, as if I had found myself on the wrong side. My dual heritage, my twin mother tongues, had taught me there were no sides, only shifting perspectives. What was my perspective from my medical heritage? What debts did I owe as a patient to those whose care and oversight I was under? As an expectant mother on the Natural Killer Cell Protocol, I was in debt to the same medicalised systems that reduced Noor to an uncooperative presence on the special care baby unit. Were these not the same systems of care that saved my life and my baby Liberty's life with an emergency caesarean? Was it not the highly medicalised pregnancy that was giving me a chance to be a mother again?

Psychiatry seemed in many ways maternalistic: many moments of watching, waiting and observing. Obstetrics, in contrast, seemed an all-action specialty, a craft needing steady hands and The Colonel's certainty. The values in obstetrics seemed to be of paternalism, professional coolness, authoritarianism and self-assuredness. My obstetrician was under financial pressure not to offer caesarean delivery. Was his detached care his way of coping with that potentially dangerous rationing?

Did Alan and his colleagues have to numb their own feelings in order to be able to slide a breathing tube, the diameter of a pencil, up a small nostril and into a baby's lungs? Did those numbed emotions stop Alan from seeing Noor as a highly distressed mother, who was only temporarily incapable of making good decisions? I thought of my mothers-in-medicine at Barts, the best of whom were technically accomplished but also emotionally involved. I remembered Ana Rohatiner hugging her patients after eviscerating cancer treatment. I thought of Paula Domizio, talking about the emotional impact on a family as she showed us the pathology slides of a young man diagnosed with AIDS. I didn't think it was wilful discrimination but rather a systemic inability to envisage what Noor's life and her backstory might be. There was no ultrasound probe to make transparent the reasons that lay behind her missed appointments. I wanted to tell Alan that I didn't think it was binary, that just because he had become better at saving lives, it didn't mean he was now worse at talking to parents. I wanted to say that we all build fretwork between those we care for and ourselves. Sometimes those lattice-walls are safety nets and sometimes they are snares. I wanted to say all these things, but, as so often in health and social care, we didn't have the luxury of time.

As I walked away from my last professional commitment before going on maternity leave, I thought of Noor, of Serena and of Vicky and wondered what less detached medical and judicial systems might have meant for them. I thought of how the clinical structures of the NHS followed systems that were militarised. What would my experiences of asking for an elective caesarean have been like had I experienced a democratic, shared leadership system, with patients at the heart of decisions made about them and their unborn children? How might that system have changed the lives of Vicky, Serena and Noor? I wondered too whether systems that allowed professionals to get closer to families would have kept children safer or if closeness would have obscured those difficult judgements that save the lives of children who would otherwise perish at their parents' hands.

ARRIVAL

“See the little bunnies sleeping, till it′s nearly noon. Shall we try and wake them, with a merry tune? Oh so still; are they ill?”

Liberty and I were singing her favourite song as we drove to my parents on the first Friday in August 2014, in preparation for the elective caesarean the following Monday. Later, after Liberty had dozed off in the car, I noticed that the baby wasn’t as active as usual. The usual kicks, wriggles and squirms just weren’t there. By 2am on the morning of Saturday 2nd August, there had been no movement at all for several hours. Twelve hours. Maybe more. From week sixteen of this pregnancy, she had rolled, kicked and fluttered, early every evening from around 5pm until the following morning, the wiggles waning slightly around 5am, but always there. It was this near-constant wiggling, together with frequent scans, that contributed to my sense of knowing her well. As I lay awake through the early hours, I became increasingly worried. Reduced foetal movements can be the first sign of stillbirth. Prodding my tummy didn’t work. Drinking iced water didn’t work. Then I felt it. A surge of maternal instinct. I knew my baby had died. Or at the very least, she was in trouble. I called the labour ward.

“Come straight in,” said the duty midwife.

Simon drove in silence, only speaking to confirm where to park. A midwife strapped a monitoring belt to me. A second midwife was reading my notes. The first midwife pushed at my abdomen, to listen with her handheld Doppler ultrasound to see if she could find a heartbeat. We all heard one.

“No,” she said, “that′s your heartbeat I′m picking up, racing along.”

She strapped me to a cardiotocography machine, just like the one that I'd watched with increasing dread when I was in labour with Liberty.

"That's the baby," said the midwife, "I've got her. We'll leave you connected for a bit until we know all is well."

Simon looked stressed. It was the first time since we had seen the little scanned star shape on Christmas Eve, that I had seen his mask of assuredness slip to reveal a frightened face. The CTG trace hadn't reassured me. I went into doctor mode:

"Do you understand what this is?"

He shook his head.

"It's a CTG scan. That stands for cardiotocography. It's a special scan, see, through this belt, that gets used at the end of pregnancy. It looks at our baby's heartbeat, see that line there, and that other line is my uterus. There's nothing happening on that line because I am not having any contractions. When there are contractions, they show up there."

I hoped Katrina Erskine would have been proud of me. I told Simon we could feel reassured. He felt reassured. I didn't. The other monitor measured my pulse, ticking in time to it, affrettando anxiety. The first midwife noticed.

"Would you feel better if you could see the baby?" she asked.

"I'll call the registrar," she said, when I nodded.

Miss Peters, the on-call registrar had been napping in a room along the labour ward corridor. She stomped in, visibly irritated. It was just after 6 am and light outside. She didn't introduce herself or even look at my face. She squirted cold jelly onto the ultrasound probe, plonked it on my vast abdomen and hit the jackpot, the unborn's heartbeat, first time.

"There," Miss Peters snapped, "Baby. All fine. Happy?" I nodded, thanked her. She sat on the arm of the chair left for visitors and wrote in my notes, turning away from me. As she wrote, I thought of the many times I had been called out as a registrar, especially those times when I was exhausted and when I'd felt grumpy or irritable. In an attempt to make things a bit warmer, I asked her when her shift was over. She ignored me, or didn't hear, and instead began a conversation over the top of me, to the midwife who had called her, as if I wasn't in the room, an inconvenient call-out. She told the midwife that she'd been appointed as a consultant in a London teaching hospital. She left and I thanked her for her time and trouble as she left the room, thinking that if she had been a medical student, I would have failed her for her abysmal consultation style. Miss Peters was so detached from me, her patient, it was as if I wasn't there. I was as invisible in that consultation as I was in the scan photos.

I thought again about clinical detachment and how much it was valued in my medical education. As a trainee psychiatrist, my colleagues and I were chided for being over-involved. I attended lectures in examining patients' mental state with Pradeep, who became Serena's consultant at the specialist inpatient unit, Pradeep and I, and countless juniors like us, were taught to be objective in our observations. To this day, when I examine a patient's mental state, the convention is that I observe a patient's mood and also ask her how she feels. My patient's description is recorded in the notes as the "subjective" mood. My observations, the psychiatric gaze, are the "objective" mood. My objectivity, the theory goes, comes from my emotional detachment. Throughout my medical education, detachment was implicitly associated with optimal clinical performance, unbiased by emotions. Clinical detachment suggests a steady, focussed mind. These focussed medical minds lead to better patient care and protect doctors from psychological harm.

Until I started leaking my products of conception out of hours, until I was on the receiving end of so much clinical detachment myself, I didn't question this. I felt irritable and angry with Miss Peters, partly because I recognised myself in her. Miss Peters exposed the foetal heart beating in my womb, but she also held a mirror to my past selves, the exhausted junior doctor, the distracted registrar, the overwhelmed new consultant. Somehow, in that sequence of professional reincarnations, I had become so detached that it anaesthetised me to feeling. It wasn't something I had planned, but was gradual, insidious, like a scar thickening over a cut. Does detachment really make us better doctors? How can we recognise those times when clinical detachment might harm our patients? Even if we do learn to notice those moments, is there anything that can be done about them?

"We'll keep you on the CTG until lunchtime," the midwife said.

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"Drive," I told Simon, who was looking from his watch to the CTG monitor. We didn't yet know it, but his life was about to change. That August marked Simon′s 32nd year in the military and was the month of his retirement from service. He′d had a long-held desire to have a political career. Unexpectedly, a local prospective parliamentary candidate resigned and Simon came home in the week before the elective caesarean to tell me, "I threw my CV into the pot." A week later, he was invited to hustings, on an estate in Watford, forty miles from the hospital. Simon was unshaven and had rushed me to the labour ward in Friday's crumpled shirt and so looked as if he′d been on a big night out. He was trying to work out whether I wanted to be a politician′s wife and looked at me.

"Just go," I said, "I'll be alright."

I didn't want to be responsible for him missing the hustings, but I was also sure that, as he hadn't been politically active and didn't know the local party, he was unlikely to be selected. I thought of male power and how it marches on, despite the labour ward, despite birthing women. I didn't much like being a military wife, I didn't think that I would enjoy being the wife of an MP, so I felt conflicted, wanting to support Simon's ambitions but also wanting a different future for my family. After he left, there was a gap between midwives as the morning shift came to receive a handover from the night shift. I read the notes the registrar had written in my notes:

“Foetal ultrasound NAD. Mum anxious +++”

They were sloppy notes. NAD stands for nothing adverse detected. Whenever I saw it in patient notes, I remembered Ginny Bowbrick, who had been the registrar when I was a surgical house officer. Ginny taught her juniors not to write NAD. I remembered her telling me it could be misinterpreted as “not actually done.”

The midwife on morning shift came in, looked at the CTG, looked at me and talked at me for twenty minutes about my “anxiety issues.” When her monologue ceased, she began an interrogation.

“What techniques would you use to help your patients? Why don′t you use them on yourself? Do you find it strange how you can′t calm yourself down?”

It was an unusual conversational style, her gun-fire of questions without waiting for a response. Anxious +++ was clearly labour ward in-speak. Between that and Gloria′s pink form, they′d got me down as bonkers. After our losses, being scared by absent foetal movements seemed a natural response, rather than pathological anxiety. Just as I was about to explain this, the midwife′s boss came in and unexpectedly allocated her to another room.

Next in to keep the crazy lady company, was a young midwife who also looked as if she had come in after a big night out. Perhaps she had worked a night shift on the bank. She sat down, leaned across and showed me videos on her of her pet tortoises mating. Just as she was showing me, for the second time, the squealing noise made by the climaxing male tortoise, my phone buzzed. It was Simon, “I’ve been selected.”

“Shit,” I said.

“Yeah,” said the midwife, thumbs poised for an action-replay, “he really goes for it, doesn’t he?”

By the time the newly-selected political candidate had returned, the day-shift obstetric registrar who had taken over from Miss Peters, sent me home.

“Dr Dosani? I′m Markus Bayley, registrar taking over from the night shift. Sorry you′ve had this scare,” he said scanning my notes and doing what Anula Nikapota would have called “bearing witness.”

“Thank you.”

“I saw you′re a patient of the recurrent miscarriage clinic. I imagine your mind might be on overdrive, but everything looks good clinically. I′m happy for you to go home. Are you happy to go home?”

I nodded, “thank you.”

“For everyone′s peace of mind, I′d like you to come back tomorrow morning, whenever you′re up and ready, so we can do a further episode of monitoring on Sunday morning. I haven′t seen anything worrying, but given your history, well it would be good for peace of mind,” he said.

How different he was from the detached Miss Peters. My encounters with the two obstetricians at similar career stages had long afterlives. Miss Peters made me feel like a nuisance who had disturbed her sleep. With Mr Bayley, Marcus Bayley, there was a human connection from the moment he introduced himself. He was skilled at the dance between controlling his own emotions and expressing empathy. How deftly he walked between empathic closeness and professional distance.

“If you feel worried,” he said, “at any time, please come straight back. Call us, come in. We are here.”

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The CTG trace on Sunday morning was normal. Miss Cole, the lead obstetric consultant, boss of bosses, exuded calmness. Her reassurance was contagious.

“It′s a beautiful sunny day out there,” she said, “and you are going to go home, enjoy the sunshine, enjoy your toddler and you will keep thinking, this time tomorrow, I will have a beautiful baby.”

I wondered if Miss Cole was Marcus Bayley′s educational supervisor. Having her as a foremother in obstetrics might explain some of his demeanour. Somehow he had kept his kindness, despite the brutalising experiences of working unsocial hours, delivering babies in precarious circumstances, making life-saving decisions, night after night, day on day. In one of my training sessions, there was a quote from Anna Freud on the handouts, “creative minds have always been known to survive any kind of bad training.”

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On 4th August, 2014, the hundredth anniversary of the outbreak of the First World War, Simon and I arrived, as if at an airport, two bags packed, one for me, one for the passenger we hadn’t yet met, nurses greeting us as if they were ground crew, looking over paperwork, giving out tags. After the weekend′s activity, the preliminaries were uneventful. We were dispatched to an ante-room, a departure-lounge with beds and institutional armchairs. The nurses checked off names, results, briskly efficient.

Nothing happened for the next hour. A registrar came in as I was reading last month′s horoscope in *Grazia*. I heard her shoes before I saw her, clip-clopping like a horse on a road. She was tall, slender, in black skinny trousers that my Omi would have called cigarette pants, with a black blouse and a name badge that dangled from a lanyard but faced inwards. She held her clipboard with both hands, UK Border Control style. I could hear Katrina Erskine, “Don′t grasp onto that clipboard. Don′t interrogate your patient.”

Instead of introductions, she launched straight in, from the end of the bed, within earshot of the other two patients waiting for their elective caesareans.

"I looked at your notes and I cannot see that two different consultants agreed this caesarean. Did two consultants agree it?"

"Yes," I said, adding Miss Cole, the name of the consultant I had seen the day before, to The Man Himself, thinking, surely they are not going to make me have a trial of labour now? Surely? She ticked an item on her clipboard.

"For what reasons?" she asked.

"Asthma," I said, "and psychological." The woman opposite looked up from her *Take a Break*. The notes from the weekend, about my "anxiety + + +" should help, I thought.

"Fasted?"

I nodded. She had a go at getting a venflon into me, ignored me when I showed her a good vein, had a half-arsed second attempt, ignoring me again when I showed her where to try, sighed deeply and gave up.

"Anaesthetist will see you shortly," she said, half over her shoulder, as she clip-clopped over to my bed neighbours.

The consultant anaesthetist and his registrar came three hours later, after both other women had been delivered of their babies. I was hot, nervous and dehydrated.

"Veins come and go," Shahid, the senior house officer, a junior doctor barely six months my senior, had taught me, when I was a house officer, leaving patients dripless, but covered in plasters; which shamed me and my failed attempts the following morning on the ward round. Shahid had lots of tricks, "Give them a cup of tea, then go and have one yourself," he'd suggested, "because people in hospital often get dehydrated and their veins collapse. Think about it," he said, "they've often been fasted for an operation that doesn't happen when it was planned. The list gets shuffled and they get drier and drier. Can't put a drip in a crisp."

If you could see me now, Shah, I thought, and wondered if he would give the reg a lesson in veins or chat her up. Probably both.

Drip needle in place, we processed to theatre. The operating theatre was painted in ice-cream parlour colours: a wall of sunshine yellow, another in candy-floss pink, a cerulean door with pillar box red door handles and hinges. Even the resuscitation trolley was a smart shade of pewter and looked more like furniture for transporting Duplo blocks than for bearing life-saving equipment. The daycare decor was different to the mint greens and surgical blues I was used to. Theatre was busy when my turn came. I walked on, like an extra in a TV drama, where regular actors all know what to do and where to stand. The consultant anaesthetist introduced himself again, and then re-introduced me to the anaesthetic registrar, the operating department assistant, two nurses, a midwife, the consultant obstetrician, her registrar who was clip-clopping in theatre clogs now, a paediatrician, a paediatric nurse, two student nurses. Theatre was cold. I was worried Simon would faint, as I had seen several fathers faint in theatre during my obstetric placement as a student, but it was me who felt ill when the anaesthetic induction agent started to take effect. The anaesthetist immediately tilted the bed so my head was lower than the rest of my body, and with my head dropped down, I could see one of the nurses looking after Simon and telling him where to stand. Quite quickly, I was numb to mid-chest level and could feel the obstetrician and her registrar pulling something out of me, as if they were reaching into the drum of a washing machine and hauling out wet sheets.

When Liberty was born, she was handed to me, screaming, bloodied and dripping meconium straight away. This time, I could only hear the low, continuous purr of the air-conditioner.

“The baby is out,” said the anaesthetist.

I worried that he hadn’t used the word “born”. I still couldn’t't hear her crying. I looked for Simon but couldn’t see him. Something must have gone wrong. Suction noises, like those made by a small child drinking dregs through a straw, broke the silence and I was reminded again of how Liberty′s screams had filled not only the operating theatre, but also the corridor outside, announcing her arrival to the waiting room where her grandparents were waiting. This baby didn’t cry and nobody handed her to me. I asked the anaesthetist, “What′s happened?”

He looked at me with a serious expression. I was certain my baby had died.

And all of a sudden, there she was, being put into my arms, looking like the porcelain dolls that had belonged to my mother and that I had been allowed to play with as a child. Those dolls had painted blonde locks, but baby Gabriella had sloe-black spiky hair, small unblinking eyes, set like currants on a gingerbread man. Slowly, she raised one eyebrow as she looked at me, as if she had been expecting me and was wondering what had kept me.

BUCKET OF EYES

“I know where the best blackberries are, come on,” I say. In moments, we are up and dressed, creeping out of the house in our socks, pulling on our wellies at the back step, running through the dewy grass with Jester, who is delighted by a dawn adventure. I am carrying an enamel bucket, the large one.

“Oh this bucket, Mum,” says Liberty, “I thought you meant my old bucket-and-spade bucket.”

We trot along the path, three abreast, at dog speed, stopping only when Jester stops to sniff and look quizzically. We hurry along until I stop at the bottom of the hill, catching my breath as they run ahead, the girl and the dog. I feel tethered by desk-bound legs. She has them before I reach the gate, her slim fingers weaving between thorny stems. A lifetime of foraging has taught Liberty to avoid getting caught. Her mouth is dripping blackberry blood, her fingers black. She′s wearing the crop top she nagged me for, with her cut-off jeans shorts and because it is summer, the long, lockdown summer during Covid-19, I have helped her dye the long blonde tips of her hair turquoise. My elder daughter, a rebel mermaid trying out a cross-country runner′s legs.

My hair hasn’t been cut in five months, giving me the unkept look of a detained psychiatric inpatient who has not been afforded leave to visit the hairdresser. Medical students sometimes mistake rumpled, bird′s-nest hair for the look of madness. It is the appearance of confinement. We look wild as the briars, cramming blackberries into our mouths, dropping them into the bucket, orgiastic freedom at the locked school gate. This brief respite from the house during lockdown is a visit to Eden. At first, each blackberry falls against the enamel with a loud thud and an echo, bouncing off the floor. Gradually the bucket fills and their falls are muffled. I look into the bucket of eyes and can feel the heat of boiling jam, sniffing the air like a dog as I imagine ladling it into the rows of jars.

A brown dog runs out of the bushes. Jester bristles. An intruder. The brown dog steps back and scrutinises us like a nightclub bouncer. His owner stumbles out towards us, scruffy, unshaven.

“Good morning, Headmaster,” says Liberty. He wasn’t expecting to see a pupil at the gate so early on a weekend morning in the summer holidays. He stoops to pet Jester, but doesn’t look up at us.

“We′re going this way, Max,” he calls his dog and they walk away.

“Do you think he noticed my blue hair? And my crop top? And my cut-off jeans? Do you think he saw my hair? Does he mind we are taking blackberries from the school gate?”

The bucket is full. We need to return in the direction that the headmaster has gone, but we give him a head start so he doesn’t have to avoid looking at us for a second time. When we arrive home, Simon and Gabriella have let the hens out of their coop and are eating boiled eggs for breakfast. Gabriella is on her father′s lap, their heads so close that their curls merge and I can′t tell where one head starts and another begins. I think Gabriella might feel sad to have been left behind asleep, but she shouts “hooray” when she sees the blackberry haul.

“The Headmaster saw my blue hair.”

Gabriella stands on a stool and helps to pour the blackberries into the maslin pan, and when the last of the fruits fall, there is a trickle of crimson. I boil the jam and fill the jars. My daughters and I have had a summer of jam-making: raspberries, wild rose petals, blackberries. Simon calls these jars an insurance. I line our cupboards with hope for the future, during a pandemic of loss. Loss calls to loss, each new loss echoing like the falling blackberries. Until the bucket fills, silent and heavy. So it is with my grief. Heavy, silent, a deadweight.

There are days when I bear the weight that I am carrying with ease and live as if unencumbered. There are other days when the deadweight of grief becomes molten and liquefied, bubbling like fruit boiling over from an untended maslin pan. On those days, I notice faces missing from the groups of children playing. I see the gaps in family photos, the spaces that mark their place. On my desk is a pen pot. Nestled among the pens are my old pregnancy tests, with dates in parentheses on each plastic case. I wrote the date of each positive pregnancy test and later, the date when a scan showed an unbeating heart, or the date of a fatal bleed. I used to carry these memorial sticks in my bag, now I just keep them close. I keep these pieces of scientific proof of life, because that′s all I have. There were no footprints, no death certificates, no funerals. In law, my unborns were not people. In medicine, they were miscarriages, just a ball of cells. With hearts that stopped beating. And eyes that never saw.

The Colonel’s military rituals around remembrance encouraged those left behind to remember the dead by name, to collectively mourn, but then to let go and move on. How can a mother ever let go of her children? Didn’t my work teach me that mothering is holding, protecting, keeping close? Late at night, when the house is quiet and I lie sill, I listen to the silence that is the sound of an absent foetal heartbeat. One night, in the silence, I read a paper in a medical journal and learn, for the first time, that placental cellular exchange is two-way. The paper describes foetal cells travelling through the placenta and into the mother′s circulation, the cells of the unborn mingling with her mother′s cells. This foetal infusion into the maternal bloodstream makes more sense to me than the textbook placenta, sending maternal nutrients to the foetus and shuttling waste back out, that I knew from the embryology colouring book. Perhaps mothers have always known that their children are part of them, even from a time before birth. Although my unborns lived only briefly, their cells will live in me for as long as my heart beats. Like nested dolls, my children come from me and I am made up of them. Their DNA is in my marrow. We are one flesh.

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My experiences and feelings in this book are based on real events, but the events themselves and the individuals involved have been changed to protect the identity of both staff and patients. Details of the medical and legal situations and the families I met have been changed, dramatised and reimagined to protect the privacy and confidentiality. Any similarities to actual individuals or events are both coincidental and unintended.

Products of Conception: Imaging and Imagining Maternal-Foetal Relationships

A woman, in the twentieth week of her second pregnancy, goes to hospital for an ultrasound scan. Her first child was stillborn. Coronavirus pandemic restrictions in England in January 2021 dictate that the woman attends the hospital appointment alone, just as she was alone for the twelve-week scan. Her partner has not yet heard their baby's heartbeat. In the scanning room, she takes out her phone to film the ultrasound of her baby, to record a milestone for her partner who can't be there. "That's illegal," says the scanning technician, pointing at a notice on the wall that reads: "women must not record or take photographs during the ultrasound." [7]

As I write this during the Covid-19 pandemic, all across England pregnant women find themselves banned from taking images of their foetuses. One of the pregnant women phones a national newspaper. They run a story. A barrister from Doughty Street Chambers calls the ban "unlawful". The Society and College of Radiographers defends the ban, saying, "a pregnant woman holding a phone leads to a taut abdomen which makes scanning very difficult." [8]

This argument, between healthcare professionals carrying out scans and pregnant women undergoing ultrasound examinations, has deep roots. However, Covid-19 pandemic restrictions mean that many more women have been attending ultrasound scans alone. Their isolation in pregnancy ultrasound scanning suites leads to a more frequent reach for a camera-phone to document a family milestone for an absent partner. When the medical profession "bans" this personal recording, the medical and legal narratives focus on the question of ownership of the ultrasound image. However, underpinning these arguments is a complex story about what the

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[7] Alexandra Topping, "Pregnant Women Going for Scans Alone Told They Cannot Film Baby," *The Guardian*, last modified February 2, 2021, https://www.theguardian.com/lifeandstyle/2021/jan/31/pregnant-women-going-for-scans-alone-told-they-cannot-film-baby.

[8] Ibid

ultrasound image of a foetus represents, and to whom. Is it a medical image, forming part of a clinical investigation, or is it an expectant mother's first photograph of her anticipated baby, perhaps already named? Scanned products of conception may form part of an inquiry into the success or failure of fertility treatment. Other scanned images inform clinical decisions, including whether a woman requires surgical interventions following a miscarriage. Women often use their first-trimester ultrasound images as proxy pregnancy announcements on social media. Sociologist Deborah Lupton summarises this argument, placing it in sociocultural context:

> More so than at any other time in human history, embryos and foetuses are represented in public forums as beautiful, precious, vulnerable creatures that require the utmost levels of protection. They are commonly positioned as already fully human, indeed as already infants, and hence as deserving of the rights and privileges accorded the infant. Paradoxically, in other contexts, embryos and foetuses have become increasingly commodified and dehumanised. In the marketplaces of in vitro fertilisation (IVF) services, reproductive tourism, commercial pregnancy surrogacy, gamete donation and human embryonic stem cell (hESC) science and regenerative medicine, embryos and foetuses are commonly configured and treated as valuable entities because of their monetary value. In some countries, women are now able to earn significant sums of money by acting as pregnancy surrogates or donating their ova to create embryos for other people. The stem cell industry makes use of human embryos in its experimental research, transforming them into clinical material to create stem cell lines as part of therapeutic treatments. These developments have required many jurisdictions to construct definitions around unborn entities and to legislate ways in which such entities may be used.[9]

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[9] Lupton, Deborah. *The Social Worlds of the Unborn*. Palgrave Pivot. Houndmills, Basingstoke, Hampshire ; New York, NY: Palgrave Macmillan, 2013.

At the heart of Lupton's linguistic and legal complexity, lies the question: how are women's uterine contents imaged and imagined? My curiosity about this began when I underwent fortnightly scans during my own medicalised pregnancy, following recurrent miscarriages.[10] During that time, in my professional life as a psychiatrist, I was working as a medical expert witness for the family court, where I examined mother-child attachments and made recommendations to judges who were deciding whether children could remain in their birth parents' care or whether it was in their best interests to be removed for their own safety. While carrying out that work, I experienced recurrent miscarriages and, in 2013, I was offered an unproven approach, known in obstetrics as the Natural Killer Cell Protocol in an NHS recurrent-miscarriage clinic.[11] From the fourth to the twentieth week of my medicalised pregnancy, the Natural Killer Cell Protocol dictated that I underwent fortnightly ultrasounds. By the time I gave birth, I felt as if I already "knew" my daughter, from the experience of "seeing" her so frequently during ultrasound examinations.

When I started writing about my experiences, I struggled to identify a fitting word for the babies who died in my womb before I could give birth to them. As a patient, I objected to the word

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[10] Contemporary British obstetrics uses the word "miscarriage" to refer to the unplanned death of an embryo or foetus before survival outside the uterus is possible. Various cut offs are used internationally, but in the UK, it applies to pregnancies up to 23 weeks and 6 days. Recurrent miscarriage is defined in obstetrics as experiencing three or more miscarriages. Stillbirth is the obstetric euphemism for foetal death after 24 weeks of pregnancy. When an unborn child dies after 24 weeks of pregnancy, parents of stillborn children are legally obligated to register their child's death, are issued a death certificate and usually offered funeral rites. These legal and social mechanisms acknowledge grief. However, when an unborn child dies earlier in gestation, parents receive neither a birth notification, nor a death certificate. Deaths of children dying before 24 weeks gestation are not usually marked with a ritual, leaving them prone to being overlooked.

[11] Natural killer cells are a type of white blood cell, produced by the bone marrow as part of a healthy, functional immune system. They are present throughout the human body. They are so-termed by immunologists as they "fight" cancer cells and infections. Too many natural killer cells are associated with miscarriage. The exact mechanism for this remains unclear. My reading of the obstetric literature suggests that the lining of the uterus has to become inflamed in order for an embryo to implant there. Too many or too few uterine natural killer cells can prevent the right degree of inflammation for embryo implantation. I was diagnosed as having abnormally high levels of natural killer cells and prescribed several pharmaceuticals at specific times, pre and post conception, intended to suppress these levels. The combination of pharmaceutical agents, vitamins, dietary supplements and ultrasound scanning schedule were referred to in my treating clinic as the Natural Killer Cell Protocol".

miscarriage, literally "to have carried incorrectly".[12] The language used by doctors to refer to embryonic and foetal death in early pregnancy changed during the late twentieth century. Prior to this, the medical term "abortion" was used for both deliberate ,medical termination of pregnancy and also for spontaneous embryonic and foetal deaths. In a letter to the *Lancet* in 1985, Richard Beard, then professor of obstetrics and gynaecology at St Mary's Hospital, London, and two of his colleagues wrote: "Doctors use the word 'abortion' regardless of whether it was a spontaneous or induced event, yet our patients always speak of 'miscarriages' unless they have had a termination of pregnancy. It seems likely that the words have been interchangeable for many centuries..."[13]

Beard's linguistic differentiation suggests that an unborn baby has been dropped or misplaced, rather than mourned, conveying a sense of carelessness. More than that, "miscarriage" reduced me to a faulty container and implicitly attributes blame, while also obfuscating any notion I had of a relationship with my unborn child. My memoir's opening line, "I saw her just once, the girl called Hope," alludes to an important maternal relational aspect to my miscarried children, rather than merely chronicling the biological expulsion of "products of conception".[14] As a memoirist, I felt comfortable depicting the maternal-foetal relationship in early pregnancy, even before my foetus reached gestational viability. As a medically-qualified writer, I didn't feel entirely comfortable using the word "baby" for an unborn child, as it is so at odds with the contemporary obstetric terminology, where a fertilised ovum is first an embryo and later, a foetus.[15] After a year of

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[12] Medical Subject Headings (MeSH), used by indexers to describe articles for Medline, a searchable medical literature. MeSH terms for the search, "miscarriage" are: foetal death, pregnancy outcome, spontaneous abortion, miscarriage, intrauterine death, foetal demise, stillbirth, spontaneous abortion and pregnancy loss. "Spontaneous abortion" suggests an abrupt ending, evoking emotions associated with intentional termination of pregnancy. "Pregnancy loss" acknowledges an ending of pregnancy, while contesting the death of a child. The clinical terminology changed in the mid 1980s, when doctors started using the term "miscarriage" instead of "spontaneous abortion"

[13] Beard RW, Mowbray JF, Pinker GD. Miscarriage or abortion? *Lancet* 1985:2:1122–23

[14] "Products of conception" is a medical term used to describe any tissues developing from a fertilised ovum. In miscarriages occurring early in pregnancy, it can be medically difficult to differentiate between the embryo, placenta and other tissues that have developed. Ultrasound examination after a miscarriage may refer to residual products of conception left behind in the uterus, for which surgical removal may be offered.

[15] In the first eight weeks of pregnancy, the dividing fertilised ovum is known as an embryo. From the eighth week of pregnancy, an unborn baby is medically known as a foetus, right up to the moment of birth, when it is called a baby.

experimenting with combinations of embryo, foetus and baby in my writing, influenced by Mantel who uses the term “unborn” for her never-to-be-born children, I adopted the adjective "unborn" as a noun for my miscarried children.

As part of the research for my memoir, I conducted a replicable survey of the contemporary British obstetric discourse about the treatment of women experiencing recurrent miscarriage[16]. In my memoir, I describe the afternoon I spent at the *Royal Society of Medicine*. It was there that I sought answers: Why was my treatment plan written in military language? Was this a common way of communicating about obstetric patients? I approached these questions by undertaking a type of literature review that doctors learn to do in their training, a so-called systematic review of the literature. With scientific diligence, I collected a large sample of secondary data and categorised all the figurative language used, illustrating each category with verbatim examples. What I found was that contemporary obstetric papers on the treatment of recurrent miscarriage, written by doctors for other doctors, are shot through with military metaphor. As I describe in my memoir, my survey detailed the full spectrum of war language.

It also surprised me to find that in the obstetric literature the deceased foetal existence was linguistically obliterated, the death folded into the unplanned ending of the mother’s pregnancy, which was itself generally written about using the language of disease. For example, in their paper, “A Randomized Trial of Progesterone in Women with Recurrent Miscarriages”*,* in the *New England Journal of Medicine*, British obstetricians Arri Coomarasamy, Helen Williams, Ewa Truchanowicz and colleagues, assert: “Miscarriage is the commonest complication of pregnancy: one in six

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[16] To address the question: “what metaphors are used in the contemporary British obstetric literature when communicating about recurrent miscarriage?” I searched the obstetric literature using the following MeSH terms: miscarriage, foetal death, pregnancy outcome, spontaneous abortion, intrauterine death, foetal demise, stillbirth, spontaneous abortion and pregnancy loss. I looked specifically at papers describing treatment interventions for recurrent miscarriage and restricted my search to work published in the years 2014 to 2019. Full details of my methodology are summarised in Appendix 2. My intention was to conduct a study of a replicable sample of obstetric literature, selected as described in Appendix 2. My identified corpus, listed in full in the appendix, was written by teams of clinical academics in obstetrics, and by obstetric clinicians, published in British medical journals, predominantly for other obstetricians, but also for other medical practitioners caring for women who have experienced repeated miscarriage. Appendix 2 also includes full details of databases searched and all search terms used, so that my search can be replicated by other scholars.

clinically recognised pregnancies ends in a miscarriage."[17] In medicine, the term "complication" refers to a secondary disease process that arises because of an existing disease. Using it in this context implies that pregnancy is a disease state in the reproductive machine.

In dozens of other recent British obstetric papers on recurrent miscarriage, I found that foetal deaths were referred to as "pregnancy loss". A typical and important example comes from the obstetricians and gynaecologists Maya Chetty and Colin Duncan, writing in *Obstetrics, Gynaecology and Reproductive Medicine*, that "Developmental and genetic abnormalities are frequently found when pregnancy losses undergo detailed examination." [18] The phrase, "pregnancy loss" is also used by British obstetricians Arri Coomarasamy and Helen Williams, when describing the largest clinical trial into recurrent miscarriage, "The PROMISE trial is the largest clinical trial ever conducted on the subject of recurrent pregnancy loss." [19]

The papers in the contemporary British obstetric literature on recurrent miscarriage that I studied were written about women's bodies and maternal experiences, but the voices and experiences of women are not on those pages. This obstetric language troubles me, as a patient and as a psychiatrist, because it does not countenance the possibility of a maternal-foetal relationship. When I was a patient, I experienced foetal deaths before anyone in my social circles knew I was pregnant. The medical silence about the death and the relative silence on the demise of the foetus, contributed to my sense of despair and isolation. Women posting first-trimester ultrasounds on

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[17] Coomarasamy Arri, Helen Williams, Ewa Truchanowicz, Paul T. Seed, Rachel Small, Siobhan Quenby, Pratima Gupta, et al. "A Randomized Trial of Progesterone in Women with Recurrent Miscarriages". *New England Journal of Medicine* 373, no. 22 (26 November 2015): 2141–48. https://doi.org/10.1056/NEJMoa1504927

[18] Chetty, Maya, and W. Colin Duncan. 'A Clinical Approach to Recurrent Pregnancy Loss'. *Obstetrics, Gynaecology & Reproductive Medicine* 28, no. 6 (1 June 2018): 164–70. https://doi.org/10.1016/j.ogrm.2018.04.005.
Obstetrics, Gynaecology and Reproductive Medicine is an authoritative resource for British obstetricians, gynaecologists and specialists in reproductive medicine. The journal covers the curriculum for postgraduate examinations leading to membership of the Royal College of Obstetrics and Gynaecology, so the language used here will influence a generation of new specialists.

[19] Coomarasamy, Arri, Helen Williams, Ewa Truchanowicz, Paul T Seed, Rachel Small, Siobhan Quenby, Pratima Gupta, et al. "PROMISE: First-Trimester Progesterone Therapy in Women with a History of Unexplained Recurrent Miscarriages - a Randomised, Double-Blind, Placebo-Controlled, International Multicentre Trial and Economic Evaluation." *Health Technology Assessment (Winchester, England)* 20, no. 41 (May 2016): 1–92. https://doi.org/10.3310/hta20410.

Facebook write, “I’m having a baby”. Nobody is gestating a ball of cells, or even a foetus. They are mothers-in-waiting.

This silence around the unacknowledged grief might underlie other presentations of distress. For example, what if some of the many women diagnosed with depression are grieving foetal deaths? How might that paradigmatic shift change the help that they receive? Miscarriage seemed to have higher status as a research object in the obstetric literature, than as a grief object in within my own discipline, psychiatry. During my experience of medicalised pregnancies, I became clinically depressed on two separate occasions. Although I offered my treating psychiatrist information about the miscarriages and their effect on me, my miscarriages were perceived to be of limited clinical significance. The "loss of a pregnancy", to borrow that reductive obstetric phrase, was not seen as "enough" of a loss in psychiatry to account for feelings of grief.

My experience was that it was a bereavement, not a pathological reaction. My own experience, of socially invisible grief for my unborn children who died, concurs with experiences of parents interviewed a decade ago, by paediatrician Maureen Kelley and paediatric ethicist Susan Trinidad who, in the journal *BMC Pregnancy and Childbirth* reported that, after miscarriage, parental grief is "deeply felt but not socially recognized.” [20]

My grief was deeply felt when the sonographer imaged my foetus without a heartbeat. At a subsequent scan, when I saw my empty uterus where there had previously been an embryo, I mourned the child who I had carried but would never hold. As a writer, I wondered: are other writers using the relational frames of grief and bereavement when writing about miscarriages? Are literary descriptions of maternal-foetal relationships visually mediated? How are other women writing about the imaging and imagining of maternal-foetal relationships?

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[20] Kelley, M.C., Trinidad, S.B. Silent loss and the clinical encounter: Parents’ and physicians’ experiences of stillbirth–a qualitative analysis. *BMC Pregnancy Childbirth* **12,** 137 (2012). https://doi.org/10.1186/1471-2393-12-137

Whereas my review of the obstetric literature had followed a preordained scientific process, the systematic analysis, which is designed to be replicable and to capture every relevant reference according to precisely defined search terms, I scoured the contemporary women's literature for references that resonated with my research questions. I read with a pencil in hand, annotating and underlining words and phrases about pregnancy, ultrasounds, encounters with obstetricians and midwives. In a notebook, I recorded phrases that were markedly different from the obstetric literature. I also kept records of repetitions, contradictions and similarities.

I was particularly interested in looking in this sort of detail at texts that had resonated with other readers and wanted to select books that represented diverse experiences. Miscarriage is both common and potentially life changing. It is perhaps unsurprising, then, that many writers have explored the death of an unborn child in their work. For example, through close reading I uncovered a subplot in novelist Emma O'Donohue's *Room* (2010)[21]. O'Donohue examines her protagonist's inability to mourn a stillborn child as she is preoccupied with caring for her living son. This state of being too busy to mourn is a theme that is explored in my memoir. It is a theme that recurs throughout novelist Elizabeth McCracken's memoir of her experience of having a stillborn baby and subsequent live birth, *An Exact Replica of a Figment of My Imagination* (2010).[22] McCracken's memoir can be read both as a hopeful story about pregnancy, with flashbacks of a stillbirth, but also as a memoir about a tragic loss, with flash-forwards to a more redemptive future. Through temporally juxtaposed vignettes, McCracken explores her relationships with her husband and her infant son, as well as her ongoing relationship with her stillborn son.

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[21] Donoghue, Emma. 2011. *Room*. New York, NY: Little, Brown & Company.

[22] McCracken, Elizabeth. *An Exact Replica of a Figment of My Imagination*. London: Back Bay Books, 2010.

In what I have come to think of as the "contemporary miscarriage canon", I found diverse personal stories.[23] Reading these engaging stories about other women's embodied experiences of miscarriage was one way of bringing me closer as a writer to understanding how maternal-foetal relationships might be characterised. Women writing about maternal-foetal relationships are clearly not a homogenous group, yet their stories describe their common experience of the premature severing of that relationship.

Of all the miscarriage accounts I have read, Irish-Book Award winning short story writer, Sineád Gleeson is the only writer to submit, at least partially, to the medicalisation of miscarriage and to write about her body as anatomically defective in her memoir *Constellations* (2019).[24] As a medically-qualified patient in the recurrent miscarriage clinic, I also felt grateful for "successful" treatment. In her chapter, *On the Atomic Nature of Trimesters*, Gleeson describes the tension between being a passive, yet desperate, recipient of medical care and her rage at her sense of powerlessness in a patriarchal healthcare system. This is a tension I recognise and one that I explore in my writing. Novelist Maggie O'Farrell explores similar themes to Gleeson in her essay on stillbirth in her memoir about near-death experiences, *I am, I am, I am: Seventeen Brushes with*

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[23] Throughout this essay, I refer to the contemporary "miscarriage canon". These are the texts I am referring to:
Carty-Williams, Candice. *Queenie*. London: Trapeze, 2019.
Clark-coates, Zoe. *Saying Goodbye*., 2017.
Dawson, Jill, and Margo Daly. *Gas and Air: Tales of Pregnancy, Birth and beyond : An Anthology*. London: Bloomsbury, 2002.
Day, Elizabeth. *How to Fail: Everything I've Ever Learned from Things Going Wrong,* 2019.
Donoghue, Emma. *Room*, 2011.
DuBois, Ellen M, Linda R Backman, and Anna Pizzoferrato. *I Never Held You: Miscarriage, Grief, Healing, and Recovery.* Charleston, SC: Ellen DuBois, 2012.
Faldet, Rachel, and Karen Fitton, eds. *Our Stories of Miscarriage: Healing with Words.* Minneapolis: Fairview Press, 1997.
Gleeson, Sinéad. *Constellations: Reflections from Life.* London: Picador, 2019.
LeMoine, Monica Murphy. *Knocked up Knocked down: Postcards of Miscarriage and Other Misadventures from the Brink of Parenthood.* Livermore, Calif: Catalyst Book Press, 2010.
Mantel, Hilary. *Giving up the Ghost: A Memoir*. Repr. London: Fourth Estate, 2013.
McCracken, Elizabeth. *An Exact Replica of a Figment of My Imagination*. London, 2010.
Mellon, Emma. *Still Life: A Parent's Memoir of Life after Stillbirth and Miscarriage.* Santa Fe: Sunstone Press, 2016.
O'Farrell, Maggie. *I Am, I Am, I Am: Seventeen Brushes With Death*. Vintage, 2019.

[24] Gleeson, Sinéad. *Constellations: Reflections from Life*. London: Picador, 2019.

Death (2019). Whereas McCracken explores her stillbirth in the context of a new birth, O'Farrell and Gleeson investigate their losses through creative non-fiction about life-threatening illnesses.

In order to explore these narratives with meaningful depth, while also giving context to my interpretations, for the purposes of this essay, I decided to focus in depth on texts that represent the diversity of women's experiences. I did this to capture a variety of interpretations across the lifespan and to include the intersection of race and racial inequalities. With this in mind, from the wider miscarriage canon, I selected three texts to study in greater detail: *Queenie* (2019) by Candice Carty-Williams, novelist Hilary Mantel's memoir, *Giving up the Ghost* (2013) and novelist Maggie O'Farrell's personal essay *Baby and Bloodstream*, from *I am, I am, I am: Seventeen Brushes with Death*.[25] and , I selected texts from different literary genres, by writers from different ethnic backgrounds and from across the reproductive lifespan. Mantel wrote her memoir in her early sixties, O'Farrell was in her mid-forties when *I am, I am, I am* was published. Carty-Williams was in her late twenties when she wrote *Queenie*. All three literary works share an intimacy of voice and stylistic directness that contrasted with the obstetric discourse. All three were critically and commercially successful, suggesting that the language used to depict foetal-maternal relationships resonated not just with me, but with literary judges and also with many readers. O'Farrell, Carty-Williams and Mantel all challenge assumptions about what foetal loss looks and feels like from a woman's point of view in obstetric clinical spaces.

Queenie is Carty-Williamss debut novel. Before writing *Queenie*, Carty-Williams worked as a journalist and a marketer in London, where the novel is based. Published at the height of the #MeToo campaign and at the beginning of the Black Lives Matter movement, *Queenie*, which is marketed as a BAME commercial fiction, would be genre-defining even if it did not begin with a

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[25] O'Farrell, Maggie. I Am, I Am, I Am: Seventeen Brushes With Death. Vintage, 2019.
Mantel, Hilary. *Giving up the Ghost: A Memoir*. London: Fourth Estate, 2013.
Carty-Williams, Candice. *Queenie*. London: Trapeze, 2019.

missed-miscarriage.[26] I chose *Queenie* because Carty-Williams tells heart-breaking stories with humour and specifically because she uses this humour to challenge the obstetric discourse.

In *I am, I am, I am: Seventeen Brushes with Death* (2017), novelist O'Farrell writes starkly, and in an often mournful tone, about the ultrasound scan that confirmed her miscarriage. The essay *Baby and Bloodstream* discusses that ultrasound and the aftermath. It is part a collection concerned with O'Farrell's own near-death experiences and the life-threatening illness affecting her daughter. Throughout the collection, O'Farrell questions doctors, using short, dramatic exchanges to challenge clinical orthodoxies. Other parts of her essay read more like a love-letter to her unborn child.

My third text, *Giving up the Ghost: A Memoir*, by the novelist and double Booker Prize winner Hilary Mantel, first published in 2003, was an immediate critical and commercial success. Mantel's memoir is a sad story of a non-traditional childhood in a deeply conservative Catholic community, and formative years marked by misdiagnosis of endometriosis, with secondary infertility and concomitant psychological injuries. Mantel, a writer of historical fiction with frequent supernatural subplots, subtitled her novelistic history of her formative life, *Giving up the Ghost*, with the words, *A Memoir.* Among the ghosts Mantel writes about are her unborn children.

In *Baby and Bloodstream*, O'Farrell also writes about "the ghost children we still carry in our minds, the ones who didn't make it".[27] There is an important intertextual conversation between O'Farrell's essay and Mantel's memoir, so much so that it did not make sense to me to write about one book without the other. The Mantel-O'Farrell pairing represents a conversation between two women who have both experienced the bereavement arising from unborn children, one writing as a mother in mid-life and the other writing as an older woman who became childless due to medical

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[26] A missed miscarriage is one in which the unborn has died, but remains in the woman's womb. Both Queenie and O'Farrell write about their experiences of missed miscarriage. For many women, there are no physical signs that anything is amiss, so the scanned revelation is shocking.

[27] O'Farrell, *Baby,* 105

misdiagnosis. My hope is that analysing these three texts together and considering the cultural and medical contexts, will reveal a new, nuanced perspective of imaging and imagining maternal-foetal relationships.

These three texts resonated with me because the women writing them were addressing questions that I am also asking in my memoir, questions that I first asked as a patient. For example, O'Farrell asks, "are you still pregnant if the baby is dead?"[28] On the one hand, this seems ridiculous. Pregnancy is defined in the Oxford English Dictionary as "the condition of a female of being pregnant or with child; an instance of this."[29] However, medically a woman is routinely confirmed to be pregnant if she has a positive urine pregnancy test. This biological pregnancy, which depends on levels of human chorionic gonadotropin (hCG), the hormone produced by cells that are surrounding an embryo, and on the clinical signs of early pregnancy, including swollen breasts and nausea, are often still present after a foetus has died. I know this because I had a positive hCG test, known in lay terms as a positive pregnancy test, with swollen breasts and nausea, in other words I was confirmed to be clinically pregnant, but saw during an ultrasound examination that my unborn had died inside me. The obstetric term for this, "missed miscarriage", does not encompass any of the relational complexity of simultaneously being-with and not-being-with child, nor of any emotional bonds being formed or severed.

These difficulties with definitions, including the binary definitions of whether a woman is pregnant or not, and of whether a foetus is a person or not, create linguistic difficulties in characterising the maternal-foetal relationship. Is it a relationship that exists biologically, as suggested by O'Farrell's title, *The Baby and the Bloodstream*? Or is it a relationship that exists only in the expectant mother's imagination? I have been using the term "maternal-foetal relationship" as if such a construct is widely accepted. It isn't. In medicine, the term "maternal-foetal interactions"

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[28] Ibid, 108

[29] *Oxford English Dictionary*, accessed September 15, 2021, https://www.oed.com

describes biological exchanges of maternal nutrients across the placenta. In psychiatry and psychoanalysis, the phrase "maternal-child" attachment refers to a constellation of maternal actions that would enable a baby to form trusted and close emotional bonds with her mother. There are no established phrases in the psychiatric literature for the emotional bonds that mothers might experience towards their developing, but unborn, babies.

In my textual-critical enquiry, I noticed an interesting pattern: in each of the three texts, life-altering revelations occur when each protagonist sees into her uterus during a medical examination in an ultrasound suite. Both O'Farrell and Carty-Williams open with scenes in which the protagonist finds out unexpectedly during an ultrasound scan that she is carrying a deceased embryo. In Mantel's chapter, *Show Your Workings*, in which she describes her endometriosis and subsequent loss of fertility, she describes becoming aware of the latter during an ultrasound examination. The woman's uterine anatomical revelation is followed immediately, in all three texts, with fantasies of mothering and expressions of maternal loss. The process of visualising their uterine contents mediates each protagonist's maternal emotions.

Nowhere else in these three texts, is the clash of meaning, between the maternal and the obstetric, more vividly dramatised than in descriptions of the ultrasound image. The frequency of my own ultrasound scans enabled me to reflect on various dramatic aspects of this medical scrutiny. Entering the darkened room, removing my shoes, and observing silence until I heard my baby's heartbeat, gave me the sense of partaking in something sacred, even magical. There is undoubtedly a theatrical aspect to the ultrasound examination, that begins with entering the dimly lit room, taking centre-stage on the examining couch, and continues with the ritual drawing back of the concertina-folded curtains surrounding the bed, and culminated in the audience of parents and professionals gazing at the screen. The dimmed, cinematic lighting served as a further invitation to project my hopes and plans for the unborn onto the image on the screen. There was usually a flourish of showmanship from the technician. In *Flesh and Blood*, I write, "perhaps every ultrasound examination has a ‘ta-da’ moment, whether the technician is pronouncing foetal life, commenting on the condition of vital organs, revealing biological sex, or confirming death.”

In order to better understand the significance of the ultrasound in mediating the maternal-foetal relationship, I sought to understand the history of how ultrasound came to be widely used as an obstetric tool. In the 1950s, a Cornish-born obstetrician Ian Donald left his post as an obstetric senior registrar and reader in a prestigious London teaching hospital and took up a consultant post in Glasgow, where it was his ambition to build a new maternity hospital. During the Second World War, Donald had been drafted into the Royal Air Force, which interrupted his medical career. His bravery was mentioned in dispatches and subsequently, in 1946, he was awarded an MBE for bravery. Before the war, Donald had invented a paediatric respirator.

James Willocks and Wallace Barr, Donald’s biographers, have made clear that it was while serving in the RAF, that he started to consider ways of adapting the military technologies of radio detection and ranging (radar) and sound navigation and ranging (sonar) technology, for obstetric diagnosis. For example, when Donald first came to Glasgow Royal Infirmary in 1955, he told his colleague Barr that he was looking for a research project. Barr recalled, “One day he [Donald] came in and said, ‘I think I’ve found it!’ and produced an article about submarine detection.[30] Willocks and Barr’s chapter, “Science and Serendipity”, in *Ian Donald, A Memoir*, describes the talks about marine surveillance that Donald gave to medical audiences immediately post-war. After reading their account, I understood that the invention of ultrasound was so intimately entwined with Donald’s military career, that I thought this might account for some of the abundance of martial metaphors used by my treating team and throughout the obstetric literature.

Months after taking up the new chair in Glasgow, working with the engineer Tom Brown, that Donald adapted the reflection of high-frequency sound waves known as ultrasound, from a technology that was used to detect industrial flaws in deep-sea submarines, and used it to examine

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[30] Willocks, James, and Wallace Barr. *Ian Donald: A Memoir.* London: RCOG Press, 2004, 67.

the uterine contents of pregnant women. Donald and Brown's clinical ultrasound was first used in Glasgow in 1956. For the first time, a foetus was visible while still growing inside her mother.

In a paper in the *Lancet* (1958), that has since become a medical classic, Donald and Brown describe clinical ultrasound imaging that involves bouncing sound waves above the audible range of human hearing, at human tissues, and detecting the echoes that bounce back.[31] These echoes are used to make the now-familiar monochrome images of foetuses that sparked O'Farrell and Queenie's maternal fantasies.

By the late 1950s, ultrasound was used by obstetricians in Glasgow hospitals to investigate possible obstetric abnormalities. Obstetric ultrasound was not widely used in English hospitals until the 1970s and did not form a routine part of maternity care in England until the late 1980s, following a recommendation by the Royal College of Obstetricians and Gynaecologists in 1984, stipulating that all pregnant women should be offered an ultrasound scan between 16 and 18 weeks. *Baby and Bloodstream* describes O'Farrell's experience of that recommended ultrasound, now generally taking place around twelve weeks gestation.

The Greek philosopher Aristotle used “quickening”, which he defined as “the moment a woman feels foetal movements for the first time”, to differentiate the developmental stage of an embryo from a foetus, ascribing more “personhood” to the ensouled foetus, than to the embryo.[32] For British women, this ultrasound scan has become the moment of transfiguration, replacing the “quickening”, after which they can enter social spaces of maternity.

This may sound far removed from contemporary medical practice, yet in the embryology lectures that I attended at medical school in London in the 1990s, I was taught about various historical theories of ensoulment. For my embryology lecturers, ensoulment was not linked to

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[31] Donald Ian, MacVicar John, Brown Thomas. Investigation of abdominal masses by pulsed ultrasound. *Lancet*. 1958;1:1188–95.

[32] Aristotle. “The Experienced Midwife.” *The Works of Aristotle*. http://www.exclassics.com/ arist/ariscont.htm (Accessed 18th August, 2021)

Aristotelian quickening, but to an anatomical phase of embryological development called "the formation of the notochord".[33] What my embryological-anatomist teachers had in common with ancient Greek philosophers, was a belief that a certain degree of embryological development needed to have occurred before the foetus could be considered an ensouled person.

Maternal ultrasound was one of the most important discoveries in obstetrics and its purported intention was to make the care of pregnant women safer. By visualising the unborn conceptus, doctors hoped they would be alerted early to factors that might cause difficulty during birth, for example: the position of the placenta, the lie of the baby, and signs like small foetus size relative to the dates of pregnancy which might indicate a foetus in distress, whose life could be saved by being delivered prematurely by caesarean section. As a patient of the recurrent miscarriage clinic, I learned that even when frequent ultrasound scanning is the only medical intervention in a pregnancy and the woman does not take any medication, the chances of miscarriage diminish. Being under frequent surveillance can be literally lifesaving, for both mothers and their unborn children.

The material products of this surveillance, the scan images, are seen in the context of each viewer's visual cultural context. When I saw my own ultrasound images, there was something uncanny about seeing an immortalised infant, illuminated by a single shaft of light from the omniscient ultrasound probe. In some of my images, the light forms a kind of halo around the infant's head, where the sound waves have bounced off the foetal skull bone.

In the sixteenth century, there was a proliferation of nativity scenes, known as adoration paintings, perhaps most famously exemplified by *The Adoration of the Kings*, by Pieter Bruegel the Elder, heralding the arrival of new life, new hope, and a new story unfurling. Looking at such images, for instance the collection of adoration paintings in the National Gallery in London, these

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[33] From my embryology lectures, I recall that the notochord is a midline, rod-shaped foetal structure. It has an important cellular organising role in the embryonic nervous system, including sending signals to neighbouring tissues.

paintings are clearly of an infant of significance, illuminated in a single shaft of light that appears to come from above, in some paintings forming an obvious halo, in others just the faint suggestion of one. Adoration paintings persist in reproductions on cards arriving during Christmastide, fluttering through the letterboxes of even secular households. The nativity tableau is one of the first pieces of theatre that most British children perform. Nursery or pre-school nativity plays, where the infant-King is deified, are a rite of passage.

In this particular visual cultural context, it is unsurprising that for many British women, the small prints of ultrasound images become cherished icons of life. Such is their importance, that ultrasound images are sent to friends as a proxy to announce pregnancy. These are the pictures that a woman waits for, in those twelve nail-biting weeks before the dating-ultrasound, living in that limbo of socially-undeclared pregnancy, a state of expectant-expecting.

The technical ability to visualise an ultrasonographic image of a foetus is entangled with ethical complexities. Ever since foetal imaging became widespread in the 1980s, campaigners from the pro-life movement have demonstrated outside abortion clinics with foetal images. These campaigners co-opt clinical ultrasounds as political propaganda props. Deborah Kirklin, a general practitioner and senior lecturer in medical humanities in London, has written in the *Journal of Medical Ethics* (2004) about the role of ultrasound in the abortion debate, with a particular emphasis on digitally enhanced video-loops where a foetus is apparently smiling or waving:

> Perhaps unsurprisingly, for those who are pro-life it appears that these images are nothing less than technologically generated visual proof that the unborn child is a living human being. [34]

Donald's technological advances uncovered a fault-line in obstetrics. Obstetricians have a curious dual relationship with embryos. The development of ultrasound technology was a precursor to other reproductive technologies, including in vitro fertilisation in 1979, where the phrase "surplus

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[34] Kirklin Deborah, The role of medical imaging in the abortion debate, *Journal of Medical Ethics* 2004; 30:426.)

embryos”, was coined.[35] After embryos became objects for research and could be frozen and then thawed when required for scientific experiments, the distinctions of when life begins and when it is viable became more malleable than when embryos were womb-dependent for survival. I wonder too, if it might be necessary for obstetric language to obliterate the possibility of a foetal-maternal relationship, indeed of any potential personhood of the foetus, in order for obstetricians to carry out the entire scope of their work, including the termination of pregnancies. Perhaps the process of ultrasound, which humanises the foetus for women, dehumanises it for obstetricians?

One thing is clear. The introduction of routine scans of pregnant women resulted in a shift in clinical focus. The development of routine obstetric ultrasound offered a new testimony of pregnancy, replacing the woman’s story of her changing body. The obstetric gaze which had been sharply focussed, certainly in early pregnancy, on the woman was now an embryo-centric gaze, leaving the pregnant woman in the shadows. For medical professionals, clinical ultrasound became seen as more valid and less prone to error than women’s clinical histories. In the obstetric-maternal power dynamic, ultrasound is a high-stakes intervention. The ultrasound probe turns the art of obstetric care into a discipline guided by visualising technology that inevitably separates the foetus from her mother. Contemporary obstetric discourse reflects this separation.

Little wonder, then, that the ultrasound is a contested site; for the woman it represents the first image of mother and baby, yet for doctors it offers the possibility of precision mapping uterine contents. Perhaps this explains the many references to map making in the contemporary obstetric literature?

The “gaze” of the scanner can be seen as an extension of the obstetric gaze, giving it greater omnipotence and power. The obstetric scanning room becomes a space where the performance of medical power is enacted. It is in the scanning room that authority, including authority over the

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[35] "Surplus embryos" refers to embryos created during infertility interventions, like invitrofertilisation When they are no longer required in infertility treatments, surplus embryos are either discarded or donated to research.

woman's body, is channelled by custom, including the custom of calculating the baby's estimated due date from ultrasonographic measurements, even when this estimate is in conflict with the mother's account of her date of conception.

I became acutely aware of this during my own experience of undergoing regular ultrasound scans during the medicalised pregnancy described in my memoir. In all my pregnancies, ultrasound images were a powerful intervention into my imagined and hoped-for mothering of future children and into the process of mourning the babies without heartbeats. As a pregnant patient of the recurrent miscarriage clinic, I underwent ultrasound examinations every fortnight until the twentieth week of gestation. I saw the resulting foetal images as a series of introductions to a liminal life. The ultrasound scanning suite, a place I had previously associated with dread and bad news, took on a numinous quality.

There is a disturbing footnote in the history of obstetric ultrasound. Donald, the medical co-developer was an active and outspoken pro-life campaigner. In a review of a biography of Donald published in the *Journal of the Royal Society of Medicine,* Geoffrey Chamberlain, former professor and academic head of the department of obstetrics and gynaecology at St George's Hospital, London, who at the time of writing was Editor-in-Chief of the *British Journal of Obstetrics and Gynaecology* (2005) and president of the Royal College of Obstetricians and Gynaecologists noted:

> Donald was selfish for all he believed in, and fought valiantly for it. Others could write of the strongly held Christian faith of the man and how it ruled his culture and attitudes to contraception and abortion and the battles this led him into. [36]

Donald must have known that seeing foetal images had the potential to evoke maternal emotions. Ultrasonographic mediation of the maternal explains why the depictions of ultrasound by Carty-Williams, O'Farrell and Mantel, in disparate medical contexts and across four decades,

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[36] Chamberlain, Geoffrey. "Ian Donald: a Memoir." *Journal of the Royal Society of Medicine* vol. 98,3 (2005): 133.

conjure similar images of maternal grief. Instead of using this realisation to benefit women, Donald weaponised it to advance moral arguments against abortion and contraception.

This social historical context helps me to understand why all three writers use the graphic registration experienced during ultrasound as their introductory narrative for depictions of the (in)visibility of maternal-foetal relationships. From its earliest beginnings, ultrasound, which gives clinicians privileged access into women's wombs, was used to suppress women's agency over their own bodies and sought to limit their reproductive choices.

Carty-Williams opens her novel with that physically intimate access and those reproductive choices. Queenie is texting her boyfriend: “In the stirrups now. Wish you were here,” from the examination couch as she undergoes a transvaginal ultrasound examination while having her intrauterine contraceptive device checked.[37] This sex joke represents the transformative moment when Queenie’s body changes, from a libidinal body to a maternal body. Moments later, her maternal body becomes the site of a death, when Queenie discovers she has a dead embryo inside her uterus:

> "Okay,” she uttered, after a pause and a prod. “I've asked another doctor for a second opinion. And having had another look, it's just that - well, is there any chance you were pregnant, Queenie?”
> I sat up again; my stomach muscles would be shocked into thinking that I was exercising at this rate.
> “I'm sorry, what do you mean?”
> “Well,” the doctor said, peering at the ultrasound, “it looks like you've had a miscarriage.”

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[37] Carty-Williams, *Queenie*, 1

> I lifted my hand to my mouth, forgetting that I was holding anything. My phone slipped out of my grip and onto the floor. The doctor paid no attention to my reaction and continued looking at the screen.[38]

From a medical perspective, the scan is evidence of the scientific triumph of Queenie's contraceptive device:

> "It can happen with most forms of contraception," she told me clinically, her eyes that I'd previously thought were kind still fixed on the screen.
>
> "Most women don't know about it. At least it's done the job."
>
> I lay back on the examination table long after she had left the room.[39]

Queenie passively leaks blood (and embryos and emotions), while her doctors exchange secret, coded knowledge about her body. For example, when Queenie is presented with the visual evidence, neither Queenie nor her doctor describe what is seen on the screen. They are both euphemistic and coy about the coil having "done its job". The clinician may have seen a thickened uterine lining, where Queenie's womb had prepared to nourish a growing embryo, perhaps a rudimentary placenta, possibly an embryo, whole with a non-beating heart, recognisably human or quite alien, but certainly tissue.

While clinically accurate, the doctor's pronouncement about the coil having "done the job" smothers any possibility for Queenie to express her maternal feelings about the embryonic death. My reading of this encounter is that Queenie lacks permission from medical professionals to acknowledge the existence of the embryonic life that she and Tom conceived and that she carried. The doctor's blunt statement about the efficiency of Queenie's contraceptive coil is immediately followed by the protagonist lying on a clinical bed while in gynaecological stirrups. I read it as a

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[38] Ibid, 7

[39] Ibid

quasi-natal scene, in which Queenie imagines motherhood, reminiscing about Tom's grandmother speculating about the beauty of future children:

> "Oh you two will have beautiful children," Tom's grandmother said, staring at us from across the table. Joyce had cataracts, but she could still see the future, it seemed.

Carty-Williams uses maternal language when Queenie responds to her missed miscarriage news. She uses the word "children" when recalling Joyce and in the maternal fantasies that follow the ultrasonically diagnosed missed-miscarriage. Throughout the text, Queenie uses the words "child" and "baby". This repetition emphasises that for Queenie, her "miscarriage" represents the loss of a relational person. This is discordant with the hospital's clinical term "foetal tissue", rendering Queenie's unborn child as a cellular inconvenience.[40] The divergent medical and maternal reactions to Queenie's ultrasound images represent the different interpretation of visual confirmation of an embryonic death. Imaging and imagining can be thought of as two distinct poles on the axis of understanding what is happening in the expectant mother's uterus.

The reminiscences of future babies while physically still carrying a deceased embryo, deliver Queenie's future imagined babies and the imaged deceased embryo into the clinic room. Back in the familiarity of her home after the scan, Queenie goes on to imagine embodied pregnancy:

> "Would I have been ready," I asked myself aloud, stroking my stomach. My mum was twenty-five when she got pregnant with me.[41]

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[40] Ibid, 61

[41] Ibid, 13

No specialist psychiatric knowledge is needed to understand that the juxtaposition of the doctor's pronouncement and Queenie's reminiscence makes perfect sense. Of course Queenie is thinking about babies. She has just been an eyewitness to her embryo's existence.

This gravid imagery becomes an important driver for Queenie's uncertainty over whether to share the news with Tom, as she wonders, "I guess he should know about the miscarriage because it's part of him?" This question prompted me to consider the uncertain status of parental-foetal relationships. Is Carty-Williams suggesting that the loss of Queenie's maternal relationship to her deceased embryo might represent a similar loss for Tom? Carty-Williams raises the possibility that the "it" is the loss of a paternal-foetal relationship and that Tom has the right to know about a matter which may grieve him. Posing this as an ambiguous question reflects the uncertain status of an unborn and thereby parental relationships to a deceased embryo. My reading is that this also reflects contemporary social ambivalence over the status of a father's relationship to an unborn child, reflected in the Covid-19 pandemic practice of banning of fathers from obstetric ultrasound examinations.

After Donald's invention, the mystery of a pregnant woman's body became a medically interesting case, subject to ultrasonic-scrutiny. The once-sacred site became a site of scientific enquiry. Queenie's doctor proposes a follow-up ultrasound scan as an investigation of a disease-like problem. It is an enquiry into whether products of conception have been retained following the missed miscarriage, a scenario requiring a medical intervention (antibiotics):

> The hospital was fine. Apparently all of the "foetal tissue has gone, lovely" but because some of the pain had come back after having sex with Adi [a casual sexual encounter] I needed antibiotics to ward off potential infection. [42]

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[42] Carty-Williams, *Queenie*, 61

Queenie’s ultrasound narrative subverts this purely scientific enquiry. Carty-Williams’ ultrasound screen is both the projection site of the image of Queenie’s unborn and an exterior, observing eye, an extension of the medical gaze. For example, Carty-Williams describes Queenie, lying on the examining couch, as “desperate for her [the doctor] to look at me, to acknowledge that this news might have affected me in some way.”

Carty-Williams repeatedly refers to the doctor's unbroken attention to the ultrasound image, rather than on Queenie, for example, “‘Well’, said the doctor, peering at the ultrasound, ‘it looks like you've had a miscarriage.’” [43] This scientific scrutiny of the now-public foetus, as if under a microscope, focuses on the cellular detail of embryonic death, but overlooks any relational possibilities. However, it is not just the medical practitioner who develops new knowledge from this transparency of the woman's abdomen. The expectant mother also gets to see her unborn child and imagine maternal possibilities.

In my memoir, I write about seeing my daughter Gabriella as a "foetal pole" on an ultrasound scan at four weeks gestation on Christmas Eve. Ultrasound enabled me to be an eyewitness to the fact of her existence. Seeing radiographic images of a developing foetus in my uterus every fortnight, meant that my emotional bond to my unborn was strongly visually mediated. Carrying her not only inside my body, but also on a monochrome printout in my bag, gave my unborn a materiality of her own. As my due date drew closer, I felt that I *knew* her better in utero than I had known my living daughter at a comparable stage of pregnancy. I had seen my living daughter just twice on ultrasound. Yet my knowledge was afforded no space in my obstetric record. A mother, in this obstetric context, is a voyeur.

Queenie's doctor does not look at her when she gives Queenie the news about the miscarriage, instead, “her eyes that I'd previously thought were kind were still fixed on the

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[43] Ibid, 7

screen".[44] When Queenie's clinicians focus on the scans, they stop seeing her as a person. In the examining room, Queenie's doctor can barely remember her name: "So what do you do… Queenie?" the doctor asked, glancing at my chart."[45] This erasure can have fatal consequences for some women. Queenie's encounter is a powerful testimony to the dangerous reality of Black British women in obstetric spaces. In a study conducted between 2014 and 2016, Black women were almost five times more likely than White women to die from pregnancy and childbirth related causes, and Asian women were nearly twice as likely.[46]

Carty-Williams challenges Black women's invisibility in clinical obstetric spaces by using humour to highlight how Queenie's experiences during an intimate examination, made curiously public, results in her being overlooked:

> "Let's get a closer look…" Dr Smith said, bending down and peering between my legs.
> "What's wrong? Can you not find it?" I asked, worried that the coil had maybe absorbed into my womb, the way that I still worried that every tampon ever inserted was still knocking about inside me.
> "What do you think, Ray?" the first doctor asked her colleague.
> "We might need to get Dr Ellison in here, you know," Dr Smith replied, standing back up and putting his hands on his hips.
> "I saw a cleaner mopping up some sick in the hallway, why don't you get him in here to have a look as well?" I asked all three hospital staff as they stared at the ultrasound image.

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[44] Carty-Williams, *Queenie*, 7

[45] Ibid, 7

[46] In November 2018 MBRRACE-UK (MBBRACE report: https://www.npeu.ox.ac.uk/mbrrace-uk/reports) documented the numbers of women who died in childbirth in the UK and Ireland between 2014 and 2016. This is a scientifically rigorous paper that also includes summaries of the circumstances in which women died, presenting a pattern of their symptoms being dismissed and minimised by medical professionals. The report suggests systemic racism in medical maternity systems.

> "Aha! Look, the coil is there!" the original doctor said, pointing at a speck on my onscreen uterus, with the excitement of someone who'd just discovered a new planet." [47]

Even as she is being vaginally penetrated by ultrasound probe, Carty-Williams' irreverent language highlights how Queenie is no longer a person, her questions hang in the air unanswered, while she becomes a womb-on-legs, being spoken to only to reposition the womb for the doctors' convenience, directed to "hop down" and "hop back up" for more scans.[48]

A woman with a missed miscarriage is neither a 'proper' obstetric patient, nor a gynaecological one. Perhaps this is why Queenie's doctors ignore her, as she represents a conundrum. From gestation to eight weeks of development, a fertilised human unborn offspring is legally an embryo. After eight weeks, an unborn human is medically and legally a foetus, right up to the moment of birth. At birth, the foetus becomes a baby and achieves legal personhood. From a psychological perspective, the absence of a term for the emerging bonds a woman has towards her developing foetus is also problematic. If pregnancy is conceptualised as purely biological, the foetus considered as a non-person entity; why would women feel sadness, grief and the need to memorialise after miscarriages and stillbirths?

Queenie's sense of reproductive choice is further suppressed after the ultrasound examination. As soon as the doctor has made her detached remarks, Queenie laments her losses of choice and agency:

> "I wasn't going to have a baby. Obviously. But it would have been nice to have had the choice. Having a contraceptive placed in my body wholly suggests that I was not wanting to

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[47] Carty-Williams, *Queenie*, 2

[48] Ibid, 3

> have a baby, so yes, my choice would be to not actually carry a child to term and then raise it, but that isn't the point."[49]

Throughout the novel, Queenie has a series of short-lived relationships in which she has limited agency. Her repeated experience of violation by men she has sex with, including non-consensual violence that leaves her with significant injuries, arguably mirrors the loss of choice and agency she feels in encounters with medical professionals in the ultrasound scene.

After Queenie has seen the ultrasound of her reproductive body, her libidinal body remains transformed. Queenie cannot unsee her maternal body. For example, after casual sex with Adi, Queenie thinks back to her recent missed miscarriage. Later, when relating the sexual encounter to her friend and confidante, Darcy, Queenie uses the word "babies":

"We were careful," I lied. I opened my mouth to speak again, knowing that I should probably tell her about the miscarriage, "No sleazy babies on the way."[50]

As is evident from Carty-Williams' inciting incident, which chimes with the recent example at the beginning of this essay, women are overseen in obstetric ultrasound examinations, yet for all this oversight, women disappear, first in the scanner, then from the discourse. Queenie's questioning evokes the wider uncertainty over the status of her maternal emotions, arising from the tensions between the obstetric account (a contraceptive success) over the maternal one (what would our babies look like?).

O'Farrell also addresses this obstetric-maternal tension, as she opens her essay, *Baby and Bloodstream,* in media res in a clinic room. In common with the fictional Queenie, O'Farrell is undergoing an ultrasound examination and is looking at a screen depicting her uterine contents. In her opening lines, O'Farrell receives the news from a nurse in the ultrasound suite that her unborn

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[49] Carty-Williams, *Queenie*, 13

[50] Carty-Williams, *Queenie*, 59

baby has died, and then describes the scan image of her conceptus in terms that are undeniably human:

> “It was nothing you did,” the nurse says. “It's not your fault.”
>
> I am silent. I had not thought it might be. I look again at the image of the baby on the screen. There it is. Sitting up in its dark cave, as if waiting for something, as if on its best behaviour. If I sit straight, it seems to be saying, no one will notice.[51]

O'Farrell’s description of her baby, "as if" waiting in the dark, alludes to the lost maternal possibilities and the apparent animated child behaving so well in the womb. The ultrasound creates both the illusion of the child and her maternal imagination and longing. How starkly different this is from the biologically-factual clinical description that I read in my own obstetric notes: "products of conception consistent with 12 weeks’ gestation, no foetal heartbeat".

O'Farrell's descriptions of the foetus, including "sitting up in its dark cave…"give me a material sense of her deceased unborn child. She ascribes to him not just a corporeal self, but one that takes on the form of a developmentally older infant, capable of sitting up.[52] By imagining this advanced developmental state when she looks at the unborn deceased, O’Farrell suggests the possibility of mothering this specific child in the future. O'Farrell's narrative style when imagining this impossible possibility is marked by an abundance of foetal physical detail, reminiscent of a mother describing a living child. For example:

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[51] O’Farrell, *Baby*, 95

[52] Sitting up is one of the first physical milestones an infant will achieve, typically between four and nine months, when the neck and back muscles are developed enough to support the weight of her head. Sitting usually marks the beginning of a period of greater exploration and play. It is interesting that even though O’Farrell is familiar with accurate ultrasound representations of a foetus, in this passage, she has imagined a child who is able to look around and take part in to-and-fro playfulness, rather than a newborn, who is a more passive recipient of maternal care and attention.

> Your imagination keeps pace with your teeming body: you picture a girl, a boy, perhaps twins, because there are numerous twins in your family, both identical and fraternal - your own father is one. It will be blond, it will be dark, auburn, curly haired. It will be tall, it will be petite. It will look like you, its father, its brother, a melange of all three.[53]

By visualising the contents of her womb, the baby exists not just in O'Farrell's fantasies of a child with auburn or curly hair, but as a distinct person, with relational possibilities. Her first mention of her unborn, "…in its dark cave, as if waiting for something…" suggests that one of the relational possibilities is maternal mourning of the child in the dark womb-tomb. I read this also as an allusion to how O'Farrell was "in the dark" about the fact that her baby had perished inside her, assuming herself to be carrying a baby she would meet in the near future, until the darker truth was made visible by the ultrasound scan.

Immediately after imagining the physicality of her unborn baby, O'Farrell makes a more explicit reference to a physical maternal relationship with her future child:

> You will take it swimming, you will rake leaves and light bonfires, you will push it along the seafront, you will tuck it into the basket its brother used.[54]

The ongoing embodied experiences of pregnancy mean it is difficult for O'Farrell to come to terms with the biological fact of the foetal death:

> You will walk around looking pregnant, feeling pregnant, to all intents and purposes still pregnant, but the baby is dead. Sometimes your physiological inability to process the

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[53] Ibid, 99

[54] Ibid, 99-100

> death of the foetus infuriates you, devastates you, at others it seems only apt, sane. Why give up, your body is saying, why let go, why accept this end?[55]

The end of the missed miscarriage O'Farrell is experiencing is the stream of blood by which her body will expel the deceased foetus. Her titular bloodstream also refers to the maternal bloodstream into the placenta, that sustains a growing life. O'Farrell's unborn baby depended on this bloodstream, for nutrients, for oxygenated blood, for survival. Any impairment in maternal blood flow can be fatal to a foetus. Pairing baby and bloodstream alludes to the essential physical bond between them, to the nurturing aspects of the relationship, but also to the possibility of death.

O'Farrell's title can also be read as an inversion of the colloquialism, "mother and baby". By putting the "baby" first in this pairing, O'Farrell's emphasis is placed on her child, whose existence is erased by the obstetric language spoken in the scanning room. I am reminded too, that O'Farrell's imagined baby, "sitting up" is an autonomous one, appearing on ultrasound as if he is independent of her bloodstream.

By referencing the bloodstream, O'Farrell highlights the relational dilemma of physically mothering a foetus while not yet having attained the social status of motherhood, generally conferred on women after birthing a live baby. Writing about her feelings after an ultrasound diagnosis of a missed miscarriage, she says:

> Your body has failed at this most natural of functions; you can’t even keep a foetus alive; you are useless, you are deficient as a mother, before you were even a mother.[56]

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[55] O’Farrell, *Baby*, 101

[56] Ibid, 100

Repetition of the word “mother” may allude to O'Farrell experiencing maternal failings in this pregnancy, before attaining socially-recognised motherhood. To me, it also serves as an example of her exploration of the impossible temporal duality of pregnancy: O'Farrell is both a mother who has let her unborn baby down through her maternal failings, and is also not a mother, as motherhood is a status dependent on the presence of a birthed child. I could relate to O’Farrell’s experience of mothering my unborn child, nurturing it biologically, growing a new organ to sustain it, my expanding bloodstream feeding it, and yet not performing the acts mothering that women do for living children, that O'Farrell also imagined, like going swimming and raking leaves.

These observations, of Queenie and O’Farrell both imagining mothering in the aftermath of ultrasonic revelations of embryonic and foetal deaths, resonate with my professional experiences. In my clinical work, when I am looking for clues about the nature of mother-child attachment relationships, women often tell me about their experiences of seeing their babies on ultrasound. During my undergraduate obstetric placement as a medical student in London in 1996, first-trimester obstetrics had not yet become as ultrasonocentric as in Carty-Williams’s and O'Farrell's depictions. My fellow students and I observed the positioning of the consultant obstetrician’s hands on the pregnant woman's abdomen. We were then taught to warm our hands before palpating her abdomen. In our obstetric examinations, we were assessed on our clinical examinations, including feeling for the differences between the hard foetal skull and softer foetal rump to ascertain the position of the unborn, and we were awarded higher marks for looking at the pregnant woman’s face for any signs of discomfort, not at her abdomen.

In the nineteenth century, the French obstetrician Adolphe Pinard developed a hollow wooden horn, a sort of modified ear trumpet, that he used for amplifying sounds when it was placed against a woman's abdomen, putting his ear to the narrower end.[57] I was taught to auscultate a foetal

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[57] Robbie Davis-Floyd; Carolyn Fishel Sargent (1997). *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives*. University of California Press, 60.

heartbeat using a Pinard horn as a medical student in 1995. The eponymous horn is still used internationally.

Pinard's rudimentary apparatus undoubtedly improved aspects of obstetric care. Primarily, his auscultatory horn meant that for the first time, the health of a foetus could be monitored, from outside the maternal body, relatively non-invasively. Pinard's aim in monitoring was to reduce foetal mortality, by alerting doctors to the earliest signs of foetal distress. However, medically well-intentioned obstetric monitoring also had the effect of disenfranchising pregnant women and privileging obstetric knowledge about women's bodies over women's own experiences.

By 2010, during the first of my own pregnancies, the hands-on clinical examination with Pinard's horn and the palpation of the abdomen that I had been taught had been replaced by penetration with a cold probe. This medical focus on the application of cold gel followed by the detached insertion of a hard probe plays into the trope of the technically brilliant, emotionally detached doctor that the historian Agnes Arnold Forster describes. [58] There is a second, important distinction. Whereas Pinard's horn allowed auscultation of the foetal heart, ultrasound allowed doctors to see.

Seeing is important: the ultrasound transmits graphic knowledge. Neither Queenie's doctor, nor O'Farrell, can take their eyes off the ultrasound screen, for different reasons. Queenie's doctor, in common with the clinicians in the other two texts, is conducting a routine clinical-imaging procedure, one she doesn't need to glance up from; for O'Farrell, the scan is an introduction to her unborn: "I can't look away from the screen, even when the radiologist starts talking again, even when they say I can get dressed. I want to burn that image of that tiny ghost-pale form into my retina."[59]

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[58] Agnes Arnold-Forster is developing these themes in her forthcoming book, *Cold, Hard Steel: The Surgical Stereotype Past and Present*, (to be published by Manchester University Press, 2023)

[59] O'Farrell, *Baby*, 95

O’Farrell can’t look away from the screen because it carries the projection of the enormity of her loss:

> It seems to me that pregnancy at any stage is significant, life-changing enough to warrant telling those closest to you.How else do you explain the grief, the stunned pain on your face, the tears, the shock?

For women, ultrasound is a physically intimate experience and also a socially transfigurative one. While their respective clinicians imaged the “retained products of conception”, O'Farrell and Queenie imagined their unborn, never-to-be-born, children. O'Farrell, like Carty-Williams, depicts the emotional meaning of medical scanning technology for the woman undergoing the scan:

> You must adjust to this new picture. You must give it all up. You must somehow get past the due date: you will dread its coming. [60]

Adjustment is an intrinsic part of our ocular physiology. None of us can see in complete darkness, but in even dim-starlight, our pupils widen, letting in as much light as possible, enabling us to see in the dark. Once O’Farrell has adjusted to the darkness made visible, she has to “give it all up”. This reminds me of Mantel, whose titular ghost is being “given up.” I read Mantel's "giving up" as an act of thwarted maternity. Unmarried women of Mantel's generation spoke about "giving up" babies for adoption. Even today, the adoption and fostering organisation Coram, write, "If you decide to give up your baby for adoption you will no longer have parental responsibility for them. This will be

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[60] Ibid, 103

transferred to your child's adoptive family."[61] In contemporary discourse, women speak of "giving up" on in-vitro-fertilisation (IVF). "Giving up, in these reproductive contexts, is infused with maternal abandonment, defeat and loss, the shadow of giving birth, or giving life.

I am struck that in both O'Farrell's adjustment to the new picture of maternal darkness and Queenie's expressions of uncertainty, the ultrasound is a significant visual stimulus. Queenie imagines the physical appearance of the child she is not having, by recalling Joyce's racially charged language:

"Your lovely soft brown skin, Queenie, but lighter. Like a lovely milky coffee. Not too dark! And Tom's green eyes." [62]

Also focusing on imagined physical details, O'Farrell writes, "Gone is the child with the blond or dark or auburn hair; gone is the person they might have been, the children they themselves might have had." [63]

Hundreds of years before Donald's technological advances in ultrasound, medical men sketched imagined embryonic life in utero. O'Farrell prefaces her chapter *Baby and Bloodstream* with a series of such sketches. This plate of six singletons and two pairs of twins, representations of the imagined products of conception, is from *The Midwives Book* (1671), written by the midwife Jane Sharp.[64] Midwifery, Sharp asserts, ought to be an occupation reserved for women. At the Wellcome Library in London, there are records of eighty-two midwifery manuals published between 1540 and 1699. Eighty-one are written by university-educated medical-men who had no practical experience of attending women in labour. They had not touched pregnant women's bodies,

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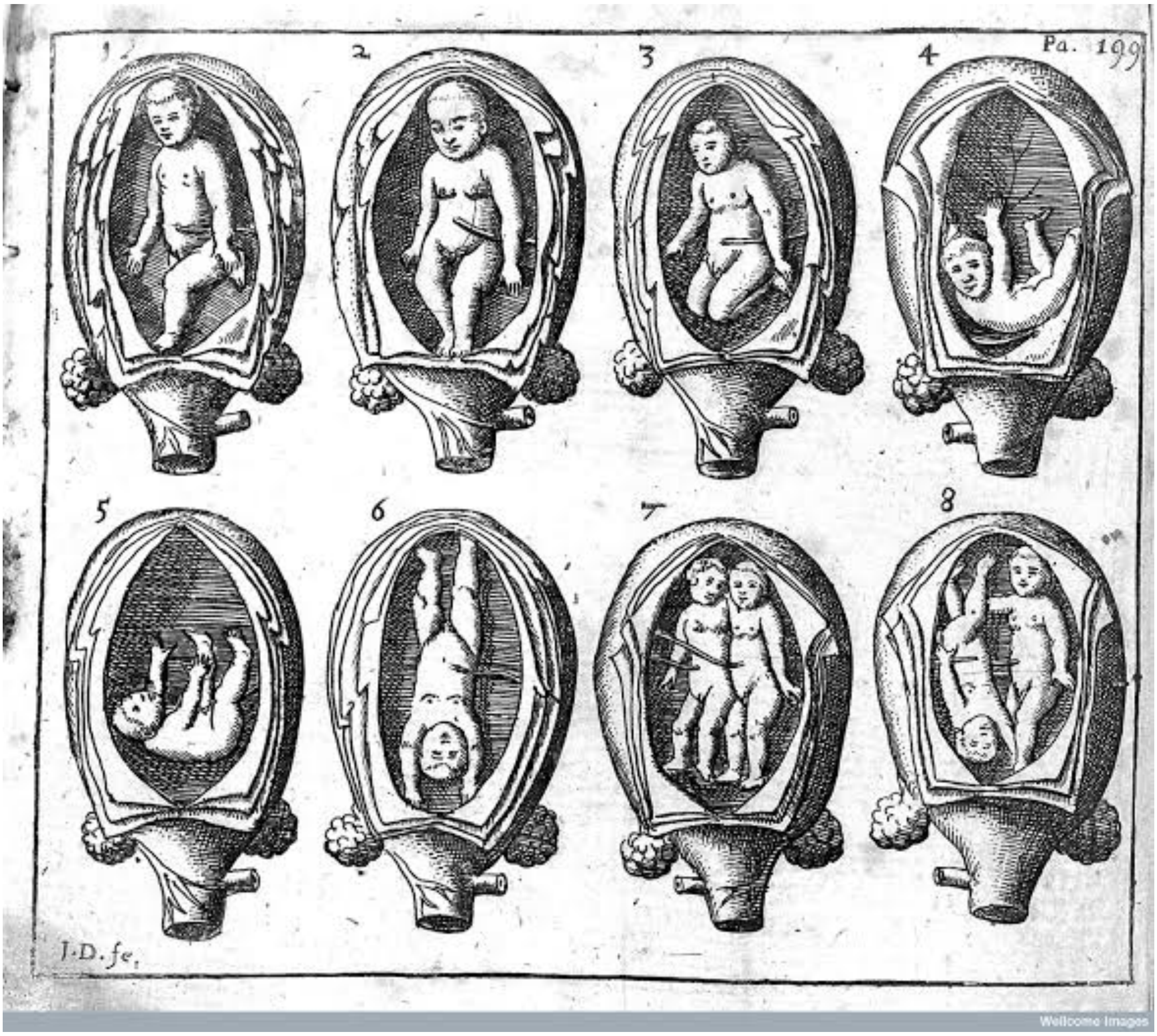
[61] The Coram Adoption and Fostering Agency is the successor to the British Adoption and Fostering Agency, and aims to secure the best futures of the 90,000 children living in the care system in the UK. https://corambaaf.org.uk/fostering-adoption/information-birth-parents/im-pregnant-and-want-my-child-be-adopted

[62] Carty-Williams, *Queenie*, 7

[63] O'Farrell, *Baby*, 102

[64] Sharp, Jane, and Elaine Hobby. *The Midwives Book, or, The Whole Art of Midwifry Discovered*. Women Writers in English, 1350-1850. New York: Oxford University Press, 1999.



from The Midwives Book (1671) Jane Sharp, Wellcome Images

nor delivered any babies. Midwifery was practiced solely by women until the seventeenth century. In her title page, Sharp claims to have practiced "midwifry" for over 30 years. [65] As the historian Ornella Moscucci notes, it is surprising, therefore, that her name does not appear on any witness signatures of surviving midwifery certificates from the time, nor on any parish records and perhaps is a pseudonym.[66] Given the radical nature of her book, through which she ended the gendered silence of women in medical reproductive text, she might have chosen to conceal her identity.

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[65] Ibid

[66] Moscucci, Ornella (23 September 2004). "Sharp, Jane (fl. 1641–1671), midwife". *Oxford Dictionary of National Biography* (online ed.). Oxford University Press. doi:10.1093/ref:odnb/45823.

Sharp's work differed from the prevailing medical texts in several important ways. She wrote in vernacular English rather than Latin or Greek. Her manual is illustrated with pen drawings and humorous anecdotes. Sharp included descriptions of anatomy as well as "the art of midwifry". Her book contained chapters that the men's manuals lacked, including sections on conception and the postnatal care of babies and mothers. This range of content and her informal style made the work accessible, not only to midwives who lacked formal education, specifically education in Greek, which made other anatomical texts unintelligible, but also to pregnant women. Sharp's book was popular, running to four editions, re-establishing midwives and labouring women, rather than medical men, as the experts in childbirth and infant-rearing.

Catherine Morphis (2013), in her essay "Swaddling England" in *The Early Modern Studies Journal*, observes that Sharp wrote with the broader aim of bringing agency to women who had been silenced in medical texts and risked being controlled even as they lay in their birth-chambers:

> When in 1671 Jane Sharp, the self-proclaimed "Practitioner in the Art of MIDWIFRY above thirty Years," published *The Midwives Book* or the *Whole Art of Midwifry* she ended the gendered silence of women in overt medical text. Sharp's medical manual was a confident trespass into the male world of academic medical tradition and writing and part of an innovative trend in late seventeenth century Europe that eroded boundaries between different types of practitioners.[67]

The evocative images of infants that O'Farrell uses to preface her essay were drawn when Sharp could only imagine how a conceptus might appear in utero. Miscarried and aborted foetuses may have informed some of her imaginings. Her animated, playfully posed drawing of babies in the

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[67] Morphis, Catherine, 'Swaddling England: How Jane Sharp's Midwives Book Shaped the Body of early Modern Reproductive tradition,' *Early Modern Studies Journal*, Vol 6: Women's writing/Women's work in early modernity/ 2014, pp166-194

womb suggest that Sharp was also influenced by the infants and toddlers she met in women's homes while attending deliveries.

Looking at Sharp's drawings in a contemporary miscarriage narrative caused me to pause and wonder: why has O'Farrell foregrounded her essay with Sharp's four-hundred-and-fifty-year-old images? These imagined unborn babies represent the genesis of written feminine knowledge about women's reproductive selves. Sharp's treatise was written in spite of, and perhaps in reaction to, medical men exchanging linguistically-coded secrets about women's bodies. By presenting Sharp's images to her readers, O'Farrell frames her essay as part of the long-established tradition of women writing about female bodies, contributing to the feminist, democratised obstetric knowledge that began with Sharp's book. O'Farrell opens with a moving description, strongly referencing Sharp's images: "There it is. Sitting up in its dark cave, as if waiting for something, as if on its best behaviour. [68]" In responding to Sharp's images O'Farrell references an unborn autonomous baby, impossibly independent.

O'Farrell's essay is concerned with the tension between what doctors and expectant mothers see and imagine. Referencing Sharp's images reminded me that these tensions have been part of reproductive cultures for hundreds of years. Who possesses the knowledge about the unborn in the womb? Who holds the power to make and circulate these images? These questions are at the heart of O'Farrell's essay. The images can be seen as a signal for O'Farrell's intention to upend the power asymmetry between a miscarrying woman and her medical practitioner.

When I was pregnant, it struck me as strange that I had to buy copies of the images of my uterine contents. The are they only photographs I have of myself in which my body is unrecognisable to the point of invisibility. In the 1980s, when ultrasound was routinely offered to all pregnant women, political scientist Rosalind Petschesky raised concerns about the widespread erasure of women from these new images of their bodies. She criticised the practice of ultrasound

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[68] O’Farrell, *Baby*, 95

technology for routinely generating a picture of pregnancy from which women are erased, while their foetus is presented “dangling in space, without a woman's uterus and body and bloodstream to support it”.[69] O'Farrell's title echoes Petchesky’s phrase, “woman’s body and bloodstream."

I began this essay by reflecting on the ease with which obstetricians and ultrasonographers guard the ultrasound as professional territory, delineating a woman's bared abdomen as a medical, rather than a maternal site. Throughout *Baby and Bloodstream*, it is clear that is not just seventeenth-century medical men who coveted the knowledge of women's reproductive bodies and sought to keep it for themselves. O'Farrell describes an encounter in which she extracted her deceased foetus from the doctor, who claimed it belonged to him:

> Each time, you will insist on having the body of the foetus, on being able to take it home. This always seems to cause consternation, wherever you are, whichever city you are in. One doctor says you can’t have it because he "needs it."
> You stare at him for a moment, wondering, did he really say that or was it my imagination?
> "I need it," you say.
> "No you don’t," says the doctor, shaking his head.
> "But it's mine, you muster, with rising menace, curling your hands into fists.[70]

Doctors are trained takers. At medical school and in postgraduate exams, I was taught to "take" a history from a patient and to "take" blood, urine and hair samples. Even now, in my clinical practice, I meet parents to "take" a developmental history of their child. These acquisitions are the clues which may lead to a diagnosis, just as a police officer takes a statement or a photographer

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Petchesky Rosalind P. 1987. Foetal images: The power of visual culture in the politics of reproduction. In *Reproductive technologies: Gender, motherhood and medicine*, edited by Stanworth Michelle. Cambridge: Polity Press, 63

[70] Ibid, 104

takes a picture of the scene of a crime. In the ultrasound rooms I frequented as a miscarrying woman, radiographers were there to "take an image".

When does it become trespass, all this taking? I ask this because trespass seems to be the end point of this culture of taking. Taking can lead to a sense of ownership and entitlement among some practitioners. O'Farrell's image of a newly bereaved mother curling her hands in preparation for a fist-fight, because a doctor has her dead child in his possession and will not yield it, evokes the anger and agony of the parents in the Alder Hey organ retention scandal. Between 1988 and 1995, children at Alder Hey Hospital were "stripped of their organs" at post-mortem examinations and subsequently buried without those organs, entirely without parental knowledge or consent. Fifty-four thousand organs were illegally kept by the Liverpool children's hospital. Most of the retained organs were hearts and brains. The specimen pots were kept in such poor conditions, that it became difficult to identify which child they had been taken from. A laboratory worker told the enquiry in 1999, "The cellar [under the pathologist's office] was filthy and there was so much material in some of the pots that it was in quite a bad condition. Some of the material was kept in pots with plastic lids and the formula in one or two of them dried out, which meant the samples deteriorated rapidly. In the end we had to abandon care of the pots because it was just too big a task." [71]

In casual conversations, I notice a tendency among my medical friends to see these gross violations of human dignity as errors made in the past, their repetition unimaginable now. However, as recently as September 2020, Derek McKinn, a surgeon from Birmingham, was found to have a private collection of bones, from over five thousand of his patients in his home in Edgbaston. There is no medical reason why he would need to take and hoard these bones in his home and there are

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[71] Bauchner, Howard; Vinci, Robert (10 February 2001). "What have we learnt from the Alder Hey affair?". BMJ : *British Medical Journal*. 322 (7282): 309–310.

strict rules expressly forbidding this. Simon Bramhall was criminally convicted of assault after branding his initials into the livers of transplant patients, using an argon beam machine.[72]

These are extreme examples and I am not suggesting this is common surgical practice. I would argue, though, that these rare thefts of human organs and bones are enabled by the culture of medical entitlement, where it has become an established norm "to take". The pathologist, Dick Van Velzen, who ordered the retention of children's organs in Alder Hey was not struck off the medical register. Neither was McKinn. The medical practitioner's tribunal argued that Bramhall should also remain on the register. This lack of sanctions by the medical profession's regulatory body in all three cases may be indicative of the prevailing attitudes in medicine over who owns the body and who is the rightful keeper of bodily secrets. In these extreme examples, illicit taking was carried out by male doctors, whereas almost all the retained organs belonged to women and children. This may be because there are more male pathologists and surgeons than similarly qualified women, or perhaps there is a gendered element to these bodily trespasses. Defacing a woman's liver and stealing bones from elderly women fitted with prosthesis after osteoporotic fractures are acts of interpersonal violence between a doctor and his patient. I do not think that the surgeons McKimm and Bramhall, or the pathologist Van Velsen, misperceived that their patients or the deceased children were inanimate objects. I think that they believed that, as medical practitioners, they were entitled to these body parts. I would argue that these violations are more likely to occur in contexts where patients' bodies are seen as sites of scientific interest to be mined by curious doctors.

O'Farrell's experience of fighting to have her foetus returned to her epitomises the flawed ethics of these medical trespasses. The grieving mother's need to bury and mourn her deceased child is dismissed because her deceased foetus is seen by the doctor as a medical object. He feels entitled to take her products of conception, and his acquisition compounds her despair. O'Farrell's

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[72] *General Medical Council and Professional Standards Authority for Health and Social Care v Mr Simon Bramhall.* [2021] EWHC 2109 (Admin). www.bailii.org/ew/cases/EWHC/Admin/2021/2109.html
Although the General Medical Council (GMC) suspended surgeon Simon Bramhall from the medical register, The High Court quashed this decision in June 2021 and reinstated Bramhall to clinical practice.

experiences echo in the Covid-19 pandemic experiences of women unable to record their own ultrasound scans. Her example illustrates the similarities between women's contemporary experiences and the period four hundred and fifty years ago, when Sharp wrote her manual to restore agency to the women she attended in childbirth and to equip her colleagues. Sharp's images of a woman's gravid uterus depict not just an anatomical body, but a maternal body, housing a living, animated child. That isn't the image the obstetrician sees on the ultrasound screen, but it is closer to the temporally-impossible image described in O'Farrell's fantasies of mothering.

O'Farrell sees her unborn infant in two dimensions, but cannot grasp or hold her unborn. Common medical terms for the biological process O'Farrell experienced, phrases like "missed miscarriage" or "retained products of conception" remove opportunities for grief and memorialisation. By reaching for supernatural, even sacred, language by referring to "spirits", O'Farrell can grieve her dead child, as a mother. Indeed, O'Farrell's conflation of the ultrasound image and ghost can be read as a deliberate act of maternal memorialisation: "I want to burn the image of that tiny, ghost-pale form into my retina. I want to remember it. To honour its existence, however short."[73] After being presented with the image of her deceased unborn child, an image viewed in a state of undress in a darkened room, following a period of gravid suspense, the spectre of foetal death looming, it is perhaps unsurprising that O'Farrell reaches for the sacred over the scientific. The image O'Farrell's doctor took simultaneously froze and immortalised her dead baby.

Ultrasonically-rendered images of infants, like ghosts, are dependent on extra-sensory perception: technological in the case of an ultrasound image and metaphysical, in the case of the ghost. The shadowy black-and-white embryo pictures that expectant mothers post on social media, these manifestations from frequencies higher than the range of human hearing, are imbued with an unreachable quality. Although O'Farrell is describing her experience of seeing her child on ultrasound, she could just as plainly be describing an experience of seeing ghosts, who also never

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[73] Ibid, 95

breathe air, never see light, and are evanescent. What O'Farrell could not see, she imagined, projecting onto the ultrasound screen, transporting her unborn's portrait from obstetric image to foetal ghost:

> To dismiss a miscarriage as nothing, as something you take on the chin and carry on, is to do a disservice to ourselves, to our living children…to those ghost children we carry in our minds, the ones who didn't make it.[74]

O'Farrell's word "carry" is unmistakably maternal. Physically supporting an unborn and then bearing and holding a baby, providing bodily and psychological containment over many years, is exactly what a mother does. I'm struck too, that O'Farrell's "carrying" might, at first reading, be considered as the opposite of Mantel's "giving up".

Both the memoirist O'Farrell and the fictional Queenie have reached adulthood in social contexts where ultrasound images are used as proxy pregnancy announcements, where there is both a relational meaning, and a social meaning, that are distinct from the technological meaning of the ultrasound, in obstetric contexts. The difference between a conceptus and a child may be a semantic difference, but it is one with unparalleled moral, legal and psychological implications.[75]

Immediately after her paragraph on carrying, O'Farrell overtly references Mantel, quoting her on unborn ghost children:

> During the week in which a miscarried baby of mine would have been born, I found the following passage in Hilary Mantel's memoir, *Giving Up the Ghost*:

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[74] Ibid, 105

[75] A conceptus is an embryo and its appendages and membranes, also known in medicine as the "products of conception". This medical terminology reflects the legal status of the unborn. A child is defined in England as a person under the age of eighteen. The status of the foetus in UK law is that it is not a legal person until birth, therefore, it follows that the unborn cannot be considered to be a child.

> [Children's] lives start long before birth, long before conception, and if they fail to materialise at all, they become ghosts in our lives…The unborn, whether they are named or not, whether or not they are acknowledged, have a way of insisting: a way of making their presence felt.[76]

O'Farrell's ghosts are overtly elegiac, but Mantel's are more complex. Although both writers invoke the ghost-child as a proxy for memorialisation, Mantel uses the ghost story as a frame for her entire memoir.

From an aesthetic perspective, I immediately admired the way in which Mantel's narrative is driven by her ghosts, who are glimpsed and revealed as her stories unfold. Mantel subtitled *Giving up the Ghost*, with the words *A Memoir*. I was initially curious about the need to subtitle her work with the genre. This need soon became clear. Despite the titular ghost, I was not expecting a book about non-traditional childhood in a deeply conservative, Catholic community, and formative years marred by misdiagnosis of endometriosis, with secondary infertility and concomitant psychological trauma, to remind me of gothic horror. Mantel's direct references to the supernatural that begin on her opening pages, give her work a fictive quality.

Mantel's ghosts occupy her home, their presence haunting moments of otherwise calm domesticity. For example, at the beginning of her memoir, Mantel casually introduces readers to her dead stepfather, Jack:

> I know it is my stepfather's ghost coming down. Or, to put it in a way acceptable to most people, I "know" it is my stepfather's ghost. [77]

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[76] O'Farrell, *Baby*, 105

[77] Mantel, *Ghost*, 1

Mantel quickly acknowledges she is used to reframing her apparent ease at living with the supernatural, recognising this is outwith most readers' experience.

> I am not perturbed. I am used to "seeing" things that aren't there. Or - to put it in a way more acceptable to me- I am used to seeing things that "aren't there."[78]

Mantel's apparent ease with the supernatural left me with both a frisson of horror and moments of incredulity. Why does Mantel depict maternal-foetal relationships (as well as other problematic relationships, including with her stepfather Jack) by telling haunted house stories? I was spooked by the ghosts when I first read Mantel's book. As a psychiatrist, I struggle with Mantel's depictions of the supernatural. Her ghosts and her belief in them are too similar to the visual hallucinations and the fixed, false beliefs I was trained to tease out during a mental state examination.

Perhaps some discomfort was attributable to feeling haunted during my own ultrasounds. Pulling my top up, my jeans down, baring my midriff, lying on the bed, half my body now exposed, the other half draped in hospital sheets, I felt like the magician's "helpful assistant" whose role is to lie still in a box on stage, during the magic-trick illusion "sawing the lady in half". The cold gel on the ultrasound probe enabled a virtual bisection, allowing the obstetric spectators to look inside my body, in a way that was once only possible when a woman was physically cut open. When I was told to lie still so as not to blur the image being taken, I imagined myself inducted into the sorority of stilled women who had died in pregnancy, their bellies cut open in anatomy theatres, their uterine secrets revealed. As weeks passed and my pregnancy developed, it became less comfortable to lie still on my back. During those scans, the inconvenience of my consciousness, my involuntary acts of breathing, the small movements I made when shifting from an uncomfortable position to a more comfortable one, seemed to irritate the sonographer and slowed down her work of scanning. When I

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[78] Ibid, 1

was chastened, reminded to lie still, to hold my breath until instructed to exhale, I imagined my sisters: the unconscious women who lay perfectly and conveniently still, cadaverous or under anaesthesia while their uterus and foetus were cut out and then preserved in pickling jars in museums of pathology. Given this abundance of grotesque tropes and gruesome imagery, I understand why Mantel frames her obstetric experiences as a haunted house story. What could be a stronger symbol of the family than the house?

Reading her apparently ordinary description of a dead stepfather coming downstairs, that is so far from ordinary, I am reminded of what O'Farrell says in the aftermath of missed miscarriage:

> It is not ordinary to conceive a life and to lose it. These passings should be marked. They should be respected, should be given their due. It is a life, however small, however germinal. [79]

“Not ordinary” suggests an event beyond routine clinical descriptions. O'Farrell's out of the ordinary loss, references Mantel's extraordinary supernatural experiences. There are echoes of Mantel's ghost child too, in O'Farrell's description of her deceased unborn, after she has seen the ultrasound. I've written "seen", as if O'Farrell was a direct eye-witness. O'Farrell did not literally see her deceased child on the ultrasound screen, she saw a representation and later imagined her child:

> These people, spirits, wraiths who never breathed air, never saw light. So invisible, so evanescent are they that our language doesn’t even have a word for them.[80]

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[79] O’Farrell, *Baby*, 104

[80] Ibid, 105

O'Farrell's description of "these people", in particular her reach for supernatural adjectives, including "ghost" and "wraith", encapsulate the impossible task of describing deceased unborns, their brief existence confirmed and preserved by a shadowy image. Her use of the word "wraith", defined in the Oxford English Dictionary as, “a ghost or a ghostly image of someone, especially someone seen shortly before or after their death”, offers the possibility of memorialisation. O'Farrell's ghost-child is a shadowy person, who has stepped out of the ultrasound, fully-formed, able to inhabit the toddleresque forms from the images that accompany her chapter, precisely because the child’s life, as imagined by O'Farrell, predates his physical conception.

It is here in particular that, I see the influence of Mantel’s work on O’Farrell. Mantel’s epithet to the memoir comes from Judy Jordan’s poem *Sharecroppers Grave*:

> My children who won’t hear.
> The night full of cries they will never make.

This epithet suggests the ghosts of babies that Mantel imagined but can never bear, who fill the night with their crying. Mantel’s night evokes the darkness of the ultrasound. Her children’s cries are beyond audible reach, like ultrasonic waves, yet leave ghostly traces. For me, the "sharecroppers grave" also evokes something fecund, as if a spirit-creature has been inadequately buried and is digging itself out to make its presence felt. Mantel’s haunting is ever present, and this is where Mantel's ghosts differ from O'Farrell's. Mantel's ghosts are visitors from an unlived past and also from an impossible future. In immortalising her imagined children, she condemns herself to being haunted.

I have come to understand *Giving up the Ghost* as a folkloric expedition where the reader is taken on a journey not only through "what might have been", but also "who might have been". If Mantel's ghost children can be said to have a moment of conception in her memoir, I would like to suggest it is the depiction of undergoing the pre-operative ultrasound examination at St George's Hospital.

Given that ultrasound scans were a long-established routine part of British obstetric care by the time that O'Farrell and Carty-Williams were writing, it should perhaps come as little surprise that they both foreground visions of mothering, maternal longing and losses of their unborns and their agency with scenes from the scanning suite. It did surprise me, however, that Mantel uses a similar narrative sequence. In her chapter, "Show Your Workings", Mantel is writing about gynaecological events that happened a decade before submitting to Donald's scanner had become a first-trimester rite-of-passage for British women. Nevertheless, she foreshadows the loss of her fertility with a powerful exposure: a junior doctor mistakes her distended abdomen for a pregnancy and investigates his misassumption with a foetal Doppler.

> The Senior Registrar examined me and thought I was pregnant. He winked at me. That's a baby in there, he said, confidently patting my swollen abdomen. He ran off to get a foetal heart monitor. But there was no baby. Not Catriona, not Modestine: not anyone, only the ghost of my own heartbeat, amplified to the outside world. Oh well the registrar said. Looks like I was wrong.

Mantel laments the loss of her future maternity through a description of a second ultrasound:

> He showed me the blossoming growths around my ovaries. For the first and last time, I saw my womb, with two black strokes, like skilled calligraphy, marking it out: a neat diacritical mark in a language I would never learn to speak.

Reading this aloud, I heard Mantel's description of the two black strokes as "killed calligraphy" and wondered if the murderous allusion was intentional. After looking at the surgically annotated ultrasound image of her womb, Mantel imagines and names the future babies she will not bear, repurposing her surgeon's annotations as the punctuation marks of their death sentence. Diacritical marks are not usually used in English. To me, Mantel is referencing the language of maternity, ever lost to her.

> When you turn and look back down the years, you glimpse the ghosts of other lives you might have led; all houses are haunted. The wraiths and phantoms creep under your carpets and between the warp and weft of fabric, they lurk in wardrobes and lie flat under drawer-liners. You think of the children you might have had but didn't. When the midwife says, "It's a boy," where does the girl go? When you think you're pregnant, and you're not, what happens to the child that has already formed in your mind? You keep it filed in a drawer of your consciousness, like a short story that never worked after the opening lines.

Abdominal ultrasound was not yet a routine examination in London hospitals when Mantel was an in-patient at St George's Hospital, Hyde Park, at the end of 1979. Mantel recalls crossing London for her ultrasound, as women's reproductive bodies were not yet routinely transparent to doctors:

> Two days after I was admitted I needed to have an ultrasonic scan. For this I needed to cross London. Saint George's Hospital at Hyde Park Corner was on its last weeks of occupation… for the high-tech stuff I needed to go to the new St George's at Tooting.

Lying under the ultrasound probe, Mantel experiences a fleeting, spectral image. Mantel is spooked by what she sees and by the surgeon’s annotations. After the ultrasound examination, her fertility was surgically excised, but her maternal attachment to her unborn children was not dissected out. The ghostly vacancy is emblematic of Mantel's grief, but also of her sense of failure as a mother who cannot give birth to her children. This physical loss of a uterus turns Mantel into a ghost mother, her maternal emotions still directed towards her (now impossible) children “whose lives begin long before they were born”.

The ghost-like waif in O'Farrell's ultrasound image and Mantel's visually perceived ghost child are both glimpsed in the shadows. The image seen by pregnant women on an ultrasound is a ghostly image, a representation of a child. Mantel's ghost, like all ghosts, is not visually perceptible by others, only by those it haunts. O'Farrell's imagined child and Mantel's ghost children are like spectral siblings, inexplicable within the limits of human physical parameters of sight and sound. Both the ultrasound unborns, and the ghosts of unborns, come from, and dwell in, a shadow world. The experience of listening for sounds made by a ghost in a haunted house is akin to the experience of listening for a foetal heartbeat in the ultrasound room. When the lights are switched back on in the dimmed ultrasound suite, the image of the baby on the screen fades. So it is with ghosts; they vanish in the light.

For this reason I consider her chapter, "Show your workings", critical to understanding Mantel's imagined maternal-foetal relationships. Mantel's experiences on the ward and in the ultrasound suite shape her subsequent grief for, and memorialisation of, her unborn children and her adaptation to her surgically-excised fertility. If, as I have argued, the ultrasound image has become a contemporary icon of life, it also serves as a symbol of fecundity. Mantel's experience in the ultrasound suite haunts her because it is the moment of transfiguration for her (ghost) children, from potentiality to (im)possibility. Mantel may have imagined having children at an earlier time, as suggested by the names she has already chosen for them, but the ultrasound conferred absolute proof of both their non-existence, at the time and in the future. Unlike O'Farrell, Mantel cannot write a redemption story, so carries her ghost-children, noting that "even adulterers" are allowed them:

> Even adulterers have their ghost children. Illicit lovers say: what would our child be like? Then, when they have parted or are forced apart, the child goes on growing up, a half-shadow of possibility. [81]

Reading these lines, I am reminded of Queenie, vividly imagining the physical details of the baby she and Tom might have had.

In *A short story that wouldn't work after the opening lines, Frustrated Maternity in First-Person Narratives*, Spanish literary scholar, Isabel Fernandes also reads Mantel's ghosts as emblematic of frustrated maternity, writing “the babies who would never be born are plaintive, poignant ghosts in this unrelenting story of losses and defeats.” [82] Mantel blames herself for not asserting herself better with the doctors who dismissed her symptoms of endometriosis, a medical neglect that cost Mantel her fertility, described in meticulously detailed memory which is full of self-doubt:

> But now I had to reckon with this: I hadn’t been smart at all. Like a cretin, like some dumb little angel, I had believed that the pains which ran through my body each month were part of the burden of womanhood. I didn’t say to my doctors, by the way, my menstrual periods are agony. I thought they would say, get away, you, little Miss Neverwell! And
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> when I had, timidly, approached the topic, they said, robustly, ‘whoah, now, you don’t want

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[81] Mantel, *Ghost*, 228

[82] Fernandes, *Frustrated Maternity*, 163

> to worry! Period pains? That'll clear up, my dear, after you have your first baby, just you wait and see.' [83]

Mantel's symptoms of endometriosis were dismissed by doctors for many years as "all in the mind". With more timely intervention and care, it is possible that the disease would not have spread so far and her reproductive organs may have been spared surgery. Several months after her surgery, Mantel confronted her general practitioner about her experiences of being diagnosed with endometriosis late and needing to be sterilised. There is no plea for sympathy from Mantel to her reader, just a bare statement of fact, "I went back to the GP who had been treating me, or failing to treat me, downtown." There is no sympathy, either, from the GP, nor any hint of regret for his negligence, no sense of responsibility for Mantel's childlessness. With remarkable cruelty, he twists the new knowledge of Mantel's sterility, presenting it as advantageous to her, thereby absolving himself of any culpability:

> "So," I said, " you see, in the end it turned out there wasn't much to be done, by the stage I'd reached. It turned out to be a bit of a catastrophe."
> "Oh well," he said. He shuffled his own sandalled feet under his desk. "There's one good thing anyway. Now you won't have to worry about birth prevention." [84]

Ghost stories are often about disappearances, particularly unresolved disappearances. Mantel's disappearing fertility remains unresolved because of Mantel's ongoing maternal relational emotions. Mantel's phrase, "there wasn't much to be done, by the stage I'd reached", calls to mind the expected stages of womanhood that would have been an explicit part of her strict Catholic

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[83] Mantel, *Ghost*, 18

[84] Ibid, 211

upbringing and convent education. When she arrived at the gynaecology ward at St George’s Hospital, Mantel was a young wife. The Catholic cultural expectation would be that her next life "stage" would be motherhood. Mantel's grief at having reached this expected milestone, but finding the option of motherhood taken from her, haunts her as it revisits her during other "stages" of her life.

I rather suspect Mantel is haunted too, by the invalidating response from the doctor she confided in. By absolving himself of culpability, he leaves Mantel to take the blame for her infertility. Although Mantel had fleetingly imagined future babies, she appears to blame herself for not having courted their possibility with greater strength and devotion:

> What I would have liked was a choice in life. Leisure, to reverse my earlier decision that children didn’t matter to me, to ask if the circumstances of my mind had changed. The time I fell in love is the time I should have acted, and now that era of my life is over, and my schoolfriends are becoming grandmothers, I miss the child I never had. I know what Catriona would have been like.”[85]

Mantel’s loss of maternal choice and agency is a loss that Queenie and O'Farrell also address in the immediate aftermath of their scans, but there are important differences between these women. Mantel was never able to have children, whereas O’Farrell had an older son and from other essays in her collection, it is clear she has gone on to have other living children. Queenie is young and on the balance of biological probabilities, she will have children in future.

Perhaps actively keeping the ghost child, Catriona, alive, by "seeing" her and devoting mental effort and attention towards her, is an unconscious attempt on Mantel's part to repair her regretted lack of maternal longing in her twenties. It is as if Mantel is saying "I didn’t imagine them

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[85] Ibid, 227

enough" and that if only she had imagined her babies into being, they would be here. It is impossible for Mantel to go back in time and, through her thoughts and actions canvass doctors more strongly, receive an earlier diagnosis, and restore her fertility physically. Instead, a shadow of these events happens in her fantasy and metaphysically. The first ghost-child Mantel introduces in her memoir takes the form of a memory of her seeing a ghost in the secret garden:

> It is as high as a child of two. Its depth is a foot, fifteen inches. The air stirs around it, invisibly. I am cold, and rinsed by nausea. I cannot move. I am shaking; as if pinned by movement, I cannot wrench my gaze away. I am looking at a space occupied by nothing.[86]

Neil Vickers, professor of literature and medicine, offers psychoanalytic, psychosomatic explanations for the ghost in the secret garden, ascribing Mantel's childhood perceptions of the ghost as her primitive defences against the ménage à trois in which her mother, stepfather and biological father lived.[87] This interpretation makes me as uneasy as the ghost does. Sociologist Arthur Frank, in *The Wounded Storyteller*, writes that illness narratives should be kept away from medical readers and warns especially against "reading into" a memoir. In the 2013 preface to his canonical work, he says, "storytelling is less a work of reporting and more a process of discovery."[88]

According to Frank, "telling stories is the attempt, instigated by the body's disease, to give voice to an experience that medicine cannot describe." As a psychiatrist, the question of how to

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[86] Ibid, 106

[87] Neil Vickers (2019) Illness and femininity in Hilary Mantel's Giving Up the Ghost (2003), T*extual Practice*, 33:6, 917-939.

[88] Frank, Arthur W. *The Wounded Storyteller: Body, Illness, and Ethics*. Second edition. Chicago: The University of Chicago Press, 2013, iv

respond to Mantel's "experience that medicine cannot describe", when that experience invokes the supernatural, is important and also tricky. How can I, a medically-literate, scientifically trained reader, respond to a ghost-story memoir, without pathologising Mantel?

Perhaps my tacit scepticism is exactly why Frank advocates keeping professionals like myself and Vickers away from illness stories, as a way for wounded storytellers to avoid being "diminished by illness".[89] My hope is that by discovering these three texts as an obstetric patient and memoirist, rather than examining them primarily as a diagnostician, I may be less likely to diminish Mantel's narrative, but I am conscious that it is precisely my medical background that makes aspects of her ghosts challenging.

Vickers articulates the challenge we share as medically-qualified readers, "Mantel gives us ghosts in an objective, hallucinatory form and it is these which are most troublesome." The garden scene is explained by Vickers as an impregnation fantasy of young Hilary.[90] I disagree with his explanation and read this passage differently. I think that Mantel writes about seeing herself as a ghost-child because her mental image of herself as a mother has been thwarted. Mantel does not have a functioning reproductive body, but has a body that is functionally pre-pubescent. I read Mantel's child-ghost in the secret garden as a metaphor for Mantel being unseen as a woman who is involuntarily without children. She slips like a small ghost through pro-natal society.

Grappling with the complex trope that is Mantel's ghost, I turned to the classic paper in the attachment literature, *Ghosts in the Nursery: A Psychoanalytic Approach to the Problems of Impaired Infant-Mother Relationships*[91]. In this paper from 1975, Selma Fraiberg, a clinical social worker and child psychoanalyst, introduced the ghost metaphor to refer to the relationship between the way in which a parent was brought up and their subsequent parenting style, writing: "In every

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[89] Ibid, vii

[90] Vickers, *Illness and Femininity*, 924

[91] Selma Fraiberg, Edna Adelson, Vivian Shapiro, Ghosts in the Nursery: A Psychoanalytic Approach to the Problems of Impaired Infant-Mother Relationships, *Journal of the American Academy of Child Psychiatry*,
Volume 14, Issue 3, 1975, pages 387-421

nursery there are ghosts. They are the visitors from the unremembered past of the parents, the uninvited guests at the christening". Fraiberg links loss, denial of loss and the mothering of subsequent infants; her ghosts representing trauma, reappearing through generations. Mantel's ghosts certainly seem to be born out of grief and trauma, often arising from the actions and inactions of the medical profession. I would speculate that there is trauma too, from the maternal parts of Mantel that have been silenced, by invalidating medical practitioners, but also socially. And yet, while it may be possible to overlook a traumatised, silenced woman in late life who cannot be a mother, it is impossible to ignore a ghost. Therein lies its power in this memoir. Like the ultrasound image that offered proof to Queenie and O'Farrell, confirming that they had each conceived a life that died, Mantel's ghost is visual proof of the "existence" of her impossible child(ren). It serves as her icon of motherhood.

Re-reading Mantel's memoir recently, I was no longer spooked by her ghosts. I knew exactly where they'd make their presence known and this familiarity diminished their former horror. Mantel's unborn ghosts offer a resolution to an impossible dilemma: how to maintain her maternal relationship with her unborn children, conceived in mind and held in mind. "Giving up" is implicitly related to "having carried". In my work as an expert witness, the ability of a mother to form a mental image of her child is valued as an important aspect of the maternal-child attachment relationship. Mantel's image of a ghost child, suggests an enduring maternal bond to the baby that could have been. Mantel's memoir provides her with the seemingly impossible thing that the ultrasound offers to pregnant women: a depiction that immortalises the life of the baby. Mantel's literary ghosts preserve her unborn children as unperishable beings, perhaps freeing her to "give up the ghost" that haunts her life.

In all three texts, the act of visualising her own uterine contents powerfully mediates a woman's sense of emotionally "knowing" a child existed and has died yet is held in her mother's mind even in death. For O'Farrell, "I know how it should be, how it should look: this is, after all my second pregnancy. I know the heartbeat should be there, flashing and flashing, like a siren. So when the radiologist says he's sorry, the baby is dead, I already know." [92] For Mantel, the visuality of the ultrasound scan imparts the knowledge that she will never carry a child of her own, bringing a sense of bereavement: "a language I would never learn to speak."

The lens of attachment theory helped me to understand the origins of that sense of knowing. Attachment theory was developed in the 1960s by Mary Ainsworth and John Bowlby. Ainsworth was a North American childhood-developmental psychologist who was the first person to investigate the attachment bonds between babies and their mothers. Together with her colleague Bowlby, a British psychiatrist and psychoanalyst, she developed a theory of infant-maternal attachment, postulating that new-born babies seek out the care of one main parenting figure, usually the mother, and that a mother's emotional responses to her baby influence many aspects of the baby's development. The depictions of maternal imagining following ultrasound examination in the texts I have studied, together with my own experiences as an expectant mother, make me feel certain that the emotional responses begin pre-birth, powerfully mediated by what is seen on the screen.

My thoughts about pre-birth attachment have also been influenced by Donald Winnicott, a paediatrician and psychoanalyst, working in London in the 1950s and 1960s. Winnicott argued that the emotional bonds between mothers and children are formed by "an ordinary mother who is fond of her baby" rather than by any special expertise or learned skills. [93] Winnicott is perhaps best known in medical circles for coining the term "good enough mother", reflecting his belief that mothers knew better about their baby's needs than experts and wrote about the "very subtle things that the mother knows intuitively." [94]

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[92] O'Farrell, *Baby*, 97

[93] Winnicott, Donald W (1952) Letter to Roger Money-Kyrle, 27th November in *The Spontaneous Gesture : Selected Letters of D.W. Winnicot*t London Karnac Books, 1987,pp 38-43

[94] Winnicott, Donald Q, *Babies and their Mothers* London, Free Association Books, 1988; 64

In my professional life, I was taught to look out for mothers who showed signs of intuitively responding to their babies. I observed mothers cuddling and gazing at their babies, attending to whether the babies respond positively, for example, by snuggling, babbling or smiling. This gaze and response creates a positive feedback loop of pleasure and satisfaction – the so-called "maternal-infant dance" – from which attachment develops. My work for the family court includes attending to those times when the emotional dance of maternal-infant attachment goes wrong. One of the most powerful clinical interventions is helping a mother to gaze at and attend to her child. For example, the *Watch, Wait and Wonder* programme helps parents develop positive images of their infant or toddler, increasing the likelihood of a secure parent-child attachment relationship. Attachment theory was developed before the advent of routine ultrasound examinations in pregnancy. However, these three texts have left me newly alert to the idea that seeing an embryo or foetus on a screen in real-time, directs an expectant mother's imagination about that child.

In her book, *Visual Methodologies: An Introduction to Researching with Visual Materials* (2001), sociologist Gillian Rose wrote "looking, seeing and knowing have become perilously intertwined" and gives examples of Western cultural ocular-centrality, including the phrases, "see what I mean" and "soliciting views." [95] Rose distinguishes between vision as "what the human eye is physiologically capable of seeing" and visuality, quoting the American art critic Hal Foster"s definition of visuality as "how we see, how we are able, allowed or made to see, and how we see this seeing and the unseeing therein".[96]

Reading these texts, I see in the protagonists' descriptions of imagined children a similar emotional dance, between a mother and her unborn baby. As a reader, I had a strong sense of the different meanings of foetal images in obstetric and maternal contexts, especially through the point of view of the women viewing their images. Rose described this process as "audiencing", defining it

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[95] Rose, Gillian, *Visual Methodologies: An Introduction to Researching with Visual Materials*. 3rd ed. London ; Thousand Oaks, Calif: SAGE, 2012, introduction

[96] Ibid, 5

as “the process by which a visual image has its meanings renegotiated by particular audiences in specific circumstances.”[97] Rose's definition makes me think of the women lying on examining couches as akin to a theatre audience: their role as observers rather than participants is clear from the moment the clinical curtain is drawn back. As the controversy with which I opened this essay makes plain: from the obstetric perspective, pregnant women are there to audience, not to act.

With Rose's definitions in mind, these three texts can be seen as refocusing the perspective from clinical-vision, to maternal-visuality. For fictional Queenie, as for the memoirists O'Farrell and Mantel, looking at the ultrasound, seeing uterine contents and knowing their maternal bodies and emotions have become perilously intertwined. While the ultrasound images used as social media pregnancy announcements are unmistakably of a baby, ultrasound images of a dead or dying embryo need to be expertly decoded, often in surprisingly ekphrastic terms, by ultrasonographers, for example:

> On ultrasound scans, using coronal and transverse sections, a “bag shaped” formation is observed, presenting irregular and hyperechoic images in its interior. Direct observation of the spine shows, in the axial view, a splaying of the posterior spinal ossification centres, and in the coronal plane, a widening of the usually parallel ossification centres. Because of meninges and nerve root adherences to the skin and bone structures in the affected area, an effacement of the cistern magna is observed…The cerebellum can take a peculiar banana-shaped aspect.[98]

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[97] Rose, Gillian, *Visual Methodologies: An Introduction to Researching with Visual Materials*. 3rd ed. London ; Thousand Oaks, Calif: SAGE, 2012, 30

[98] A description of the prenatal diagnosis of open spina bifida, apparent after 13 weeks gestation, from Chapter 4, *Neural Tube Defects*, V Bunduki, M Zugaib, Atlas of Fetal Ultrasound, Springer International Publishing, 2018

If the ultrasound represents the obstetric omniscient view of a woman's pregnant abdomen, how better to reclaim embodied experiences than women offering their own decoding, from maternal perspectives? In both O'Farrell's personal essay and Carty-Williams' novel, ultrasound is framed as an emotionally significant visual encounter between a woman and her deceased foetus or embryo. For O'Farrell, "seeing" is conflated with "knowing". For Queenie, "seeing" gives rise to imagined experiences and fantasies. When audiencing the image on ultrasound, an unborn baby exists in her mother's imagination, visible as a distinct person, all the child's future possibilities merged into the projection in the ultrasound room.

Conclusion

When I started writing my memoir, I struggled to find a word for the conceptus that conveyed relational as well as biological truths. Reading these three texts, I found it comforting that other women writing about their experiences of severed maternity had similar linguistic struggles. For example, in Carty-Williams' inciting incident, the miscarriage is almost brushed aside in the narrative. Carty-Williams' use of humour, intended to deflect attention away from Queenie's medical encounter, had on me the effect of drawing it into focus. Queenie's dry humour and sarcastic tone are devices I have experimented with in my memoir, employing a similar tone to draw attention to militarised language and to the nonchalant acceptance of depictions of violence, for example in my "tanks on the table" chapter. I used this chapter to ask questions about militarised language in medical contexts.

By presenting an array of lexical choices - "losing a baby, a foetus, an embryo, a child, a life…" - O'Farrell seems to be trying out words on the page, identifying a broad sweep of maternal relational possibilities and impossibilities, as if searching for the right term as she writes. Reading her range of possibilities drew my attention to the term "unborn" which Mantel also uses. "Unborn" became the best fit for my work as well. Mantel's act of naming her ghost child Catriona, similarly influenced me. The unborns in my memoir are characters, not anonymous balls of cells.

Mantel's references to the supernatural enabled me to explore the liminal nature of my own missed miscarriage in physical in-between spaces: in doorways, on thresholds, in the uncertain spaces in the family court, and in scanning suites.

In all three texts considered here, the ultrasound image functions as a "standard-of-proof" of pregnancy.[99] Scientific development has seen the standard of proof shift from the woman's embodied sense of quickening, to the technological assessment of a viable foetus. The burden of proof has shifted from the expectant mother, to the clinician. With this shift comes the risk that the mother's account is discounted or disregarded. This power asymmetry prevails. A woman in contemporary Britain is not able to declare herself pregnant to primary health care services, without first proving her claim with a positive pregnancy test, or by lying still to be probed in a darkened room, so that an ultrasonically-generated image of her embryo or foetus can be produced.

These three texts enabled me to examine the obstetric gaze from the critical perspective of the woman being scanned. This helped me to define the central tension in my memoir, between the medical need to be an emotionally attuned, yet clinically detached witness, and the mother's need to be seen as a whole person. Reading these texts, I came to appreciate that clinical detachment is inherent in any act of medical scrutiny. In light of that, I have paid greater attention, in my own writing, to the tension between the medical detached gaze and my own maternal attachment that was bolstered by gazing at my unborn child on ultrasound. As a psychiatrist, I was taught to observe mothers locking eyes with infants, but I have also come to appreciate the emotional significance of women gazing at their ultrasound prints.

In my memoir, I explored the detached-medic/expectant-yet-attached-mother divide, by interweaving stories of my protagonist undergoing repeated ultrasound scans while working as an expert-witness. By presenting the medical gaze, the gaze of the scanner and my perspective as a

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[99] In legal terminology, the standard of proof is the degree to which a party must prove its case to succeed. The burden of proof, sometimes known as the “onus”, is the requirement to satisfy that standard. In criminal cases, the burden of proof is on the prosecution, and the standard required of them is that they prove the case against the defendant “beyond reasonable doubt”. This is unofficially described as the 99% test. In civil cases, the burden of proof is on the claimant, and the standard required of them is that they prove the case against the defendant “on a balance of probabilities”. This is unofficially described as the 51% test.
In certain circumstances, the burden will fall on or shift to the other party. For example, in criminal cases in which a defence of insanity is raised, it is for the defence to establish it on a balance of probabilities, ie to the civil standard. There is an interesting parallel in obstetrics, where the “onus” to prove pregnancy has shifted from the pregnant mother, to medical science.
https://www.iclr.co.uk/knowledge/glossary/standard-and-burden-of-proof/

patient, I have arguably written more provocations than answers. The presence of my foetus on the ultrasound and the simultaneously temporal impossibility of the presence of my living child, both at this time and at some future time, living but not legally a life, not living yet legally undead, these children, these ghosts, are intertwined in the pages of the literary works I studied. They were intertwined in my mind, in my experiences.

What women see on ultrasound can change our lives in the blink. The heartbeat we don’t hear in ultrasound rooms can shatter our lives. In each text, the woman's maternal imagining is described in the immediate aftermath of the clinical image, each woman merging observations from the ultrasound with mental images of children who are not born. The protagonists do not imagine an unviable foetus, but their specific unborn. In each woman's imagination, the maternal-foetal relationship is plain. In the obstetric scan image, the woman′s presence is murky, her maternal status obfuscated, the maternal relationship obliterated. Our experiences in the ultrasound suite also change how we are seen and perceived by others, moulding us like unfired clay. In these texts, it is during, or immediately after, the experience of ultrasound that the scanned women form a mental image of their unborn child, including in Mantel's memoir, a ghost child. Perhaps these mental images existed before in women's minds, but they are certainly solidified during the experience of ultrasound. While the ultrasound gives vital clinical information to all three clinicians in the texts, it scaffolds each protagonist’s fantasies of mothering, giving them strength and durability.

Women's writing reclaims a much-needed sense of humanity from the obstetric discourse. These three literary texts were not written to present counterpoints to scientific papers, yet nevertheless, I hope that my analysis encourages clinicians to consider the relational aspects of miscarriage, perhaps reframing a medical event as a relational loss, a maternal grief. In the three literary texts I have studied, women audiencing their ultrasound scans after miscarriage conceive of themselves as bereft of the opportunity of motherhood. Even as ultrasound enables clinicians to image the unborn, it shapes maternal desires, mediates experiences of the maternal-foetal relationship, including maternal grief for the unborn. As Mantel asks, “What’s to be done with the lost, the dead, but write them into being?” [100]

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[100] Mantel, *Ghost*, 231

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Appendix 2 : Obstetric literature survey : sampling methodology details and full reference list

I am indebted to the *Royal Society of Medicine* librarians, who helped me to identify the most relevant databases and provided many helpful suggestions on how to limit the literature search.

Database(s) Searched:
Medline: Oct 2014 – Oct 2019
Embase: Oct 2014 – Oct 2019

When conducting searches in more than one database, the *Royal Society of Medicine* uses an automated duplicate checker to identify and remove duplicate records between databases. This process is approximately 95% accurate and therefore there were a small number of duplicate records in the search results, which I removed.

Summary of Search:
Treatment, intervention or management of recurrent miscarriage in papers written by obstetricians, gynaecologists, neonatal medicine/maternity/early pregnancy units
Limits:
Last 5 Years
English Language
Human Studies
Excludes Conference Abstracts in Embase

The search strategy was devised using three main concepts: (1) ‘Recurrent/repeated/habitual/ successive miscarriage’ including search terms to describe ‘spontaneous abortion’, ‘foetal death/ demise’, ‘intrauterine death’, ‘stillbirth’ or ‘pregnancy loss’ -AND- (2) Broad search terms to describe ‘treatment’, ‘intervention’, ‘management’ or ‘prevention’ -AND- (3) Terms to describe ‘obstetrics’, ‘gynaecology’, ‘neonatalogy’, ‘perinatalogy’, ‘reproductive medicine’, ‘maternity units’ or ‘early pregnancy units’ confined to the Author Affiliation field (i.e. this is the only way to isolate papers written by specific specialities or institutions but is solely dependent on author(s) providing details of the department/institution they work for on the corresponding address of the articles). Both thesaurus terms (where available) and textwords (words or phrases appearing in the Title or Abstract of references) were identified for each concept.

This search strategy initially generated 2,884 references published in the last 10 years 2009-2019. To reduce the results to a manageable number to manually scan references for relevancy, thesaurus terms for ‘recurrent miscarriage’ and ‘treatment’ were majored (the main focus of the articles) as were the textwords (confining terms to the Title field only). The results were further limited by removing conference abstracts (applicable to Embase only) and to articles published in the last 5 years 2014-2019.

The final 224 references (were then manually scanned for relevancy, identifying a total of 140 references as the closest match to my search question. A majority of the references excluded related to animal, in vitro and cell culture work. Many of the references retained are research-based (e.g. systematic reviews, RCTs, observational studies, reviews). Those papers read but not cited in my bibliography are listed in this appendix.

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