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► To cite this version:

Raphaël Perrin. The medical construction of gestational age and its effects on abortion access. *Social Science & Medicine*, 2025, 382, pp.118377. <10.1016/j.socscimed.2025.118377>. <hal-05157997>

HAL Id: hal-05157997

<https://hal.science/hal-05157997v1>

Submitted on 11 Jul 2025

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The medical construction of gestational age and its effects on abortion access

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ARTICLE INFO

Handling editor: Medical Sociology Office

Keywords:

Abortion
Gestational age
Health inequalities
Biomedicalization
Medical work
Reproductive health
Ultrasound

ABSTRACT

This article examines how medical practices construct gestational age and affect access to abortion care. While abortion laws typically establish gestational limits, the clinical determination of gestational age remains a medical responsibility, requiring healthcare professionals to interpret and apply these limits through various dating methods and practices. Based on ethnographic observation in three French abortion centers and interviews with 133 healthcare professionals, this study reveals significant variations in dating practices. These variations occur at three levels: the moment chosen for dating (consultation versus procedure day), the method chosen for dating and the measurement rules applied when pregnancies are dated by ultrasound. The study demonstrates that these technical choices result from negotiations and sometimes conflicts among physicians with different dispositions regarding women's reproductive autonomy and fetal interests. Consequently, a woman might be considered eligible for legal abortion in one center but beyond the legal limit in another. This creates a previously undocumented form of inequality in abortion access that operates through seemingly objective medical instruments. The analysis contributes to understanding how healthcare professionals serve as "legal intermediaries" who must interpret the law through technical devices to apply it. It also reveals how medical instruments, while appearing as objective clinical tools, function as political devices that define in practice what abortion and the right to abortion are. These findings have significant implications for reproductive health equity and policy implementation beyond the French context.

1. Introduction

Over the past fifty years, the number of countries authorizing abortion has steadily increased, and the constraints on accessing it have eased. As of January 2024, 77 countries allow abortion at a woman's request with no criterion other than pregnancy duration (Center for Reproductive Rights, 2024).² The gestational limit up to which abortion is authorized varies from country to country. This limit is not based on embryological reasons but on political decisions made when abortion laws were enacted or reformed. It represents a balance between two contradictory issues: women's autonomy and control over their bodies versus the recognition and defense of fetal interests. In France, for example, the law authorizes abortion on request with no condition other than gestational age, defined as 10 weeks of pregnancy by the 1974 law,

extended to 12 weeks by the 2001 law, and to 14 weeks by the 2022 law³ – though additional grounds exist for later gestations, including fetal abnormalities and maternal health risks.

However, for a law to be effective, it must be implemented. In abortion care, healthcare professionals, generally gynecologists, are responsible for its application. Although in many countries the law defines a gestational age up to which abortion is authorized, it remains silent regarding the methods of measuring this age. In France, it stipulates that abortion is permitted up to 14 weeks of pregnancy without defining what constitutes a pregnancy of 14 weeks or how it should be measured. This is to be expected, as legislators are not presumed to possess medical expertise. To apply the law, physicians must therefore, to some extent, interpret it.

Research has been conducted on the subject of healthcare

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² However, this figure should be interpreted with caution, as other databases exist and some countries classified as 'on request' may include additional requirements such as mandatory counseling or written statements of distress, which constitute additional criteria beyond gestational limits.

³ Healthcare professionals tend to refer to amenorrhea, which is the absence of the last menstrual period. Fourteen weeks of pregnancy corresponds to 16 weeks of amenorrhea.

professionals' and women's perceptions of time during pregnancy (Beynon-Jones, 2012, 2017; Fletcher, 2024). Fletcher's work on the temporal regulation of reproductive labor demonstrates how abortion law creates hierarchy between 'timely reproductive subjects' who are entitled to abortion, and 'untimely subjects' must make a special case for exceptional circumstances or who are denied abortion altogether. Research has demonstrated the health and rights implications of gestational age limits. These limits result in delays to abortion, are associated with recourse to unlawful and potentially unsafe abortion, and have discriminatory effects on sub-populations of pregnant people: namely people with cognitive disabilities, adolescents, younger women, women with less formal education, and women with fewer resources (De Londras et al., 2025). Other studies have analyzed the reasons that lead women to have second or third trimester abortions within the UK (Ingham et al., 2008; Marie Stopes International, 2005; Purcell et al., 2014), the United States (Drey et al., 2006; Finer et al., 2006; Foster et al., 2008; Janiak et al., 2014; Kiley et al., 2010) or Europe (De Zordo et al., 2016; De Zordo et al., 2020; Mathieu and Avarguez, 2023).

This article complements that research, by considering gestational age in the context of abortion requests not only from the perspective of its use (and in particular restrictions on access to abortion), but also from the perspective of its technical and medical construction and its effects. It accounts for the diversity of techniques and practices in pregnancy dating, traces their evolution over recent decades, and explores the negotiation processes (Strauss, 1978, 1985) that lead to their selection within gynecology departments and abortion clinics. It questions the effect of these practices and their variations on access to care and the resulting health and political inequalities.

Research on the medical regulation of sexual and reproductive health has largely been situated within a theoretical framework inspired by Foucault. This includes the evolution of modes of governmentality from the power to bring death to individuals to controlling the life of populations for collective benefit, that of the nation (Foucault, 1977, 1978, 2008). This biopower is partially delegated to physicians, whom the State establishes as a component of the civilization process (Elias, 1975). Their role is not only to heal but to "govern bodies" (Fassin and Memmi, 2004), to instill through speech (Memmi, 2003), at the individual level, a form of moral and health responsibility, self-control, and reflexivity (Rose, 2007) promoting the normalization of behaviors, particularly regarding sexuality and reproduction (Memmi, 2011, 2014). The development of biopower manifests in the medicalization of social problems (Zola, 1972; Conrad and Schneider, 1980; Conrad, 1992, 2005; Fassin, 1998) and the development and widespread use of biomedical technologies (Casper and Clarke, 1998; Clarke et al., 2003).

Some of the works analyzing the biopolitical role of medicine tend to consider the medical profession as a homogeneous entity, a mere component of state biopower, particularly in controlling women's reproductive behaviors. This article aims to complexify the analysis in two ways.

First, by considering the relative autonomy and discretion physicians have in applying the law. This involves studying healthcare professionals as street-level bureaucrats with discretionary power (Lipsky, 1980). In many aspects, they appear as "legal intermediaries," agents who, without being legal professionals, manipulate the law daily in their activities (Talesh, 2015; Pélisse, 2019). We must consider not only physicians' awareness of the law (Ewick and Silbey, 1998) but also their use and interpretation of it in their daily work. To apply the law, physicians must interpret it, translating it into "secondary application norms" (Lascoumes, 1990)—applicable devices intermediating between the central formalism of state law and individual arrangements. These include care pathways, protocols, and medical instruments such as ultrasound dating techniques and rules. Medical techniques should be conceptualized as inseparable from their uses (and vice versa) (Latour, 1987; Akrich, 1990). In this article, using the example of ultrasound dating of pregnancies, I show how medical technologies actively mediate the clinical encounter, as has been demonstrated with other

medical technologies such as X-rays (Pasveer, 1989), duplex technologies in the detection of diseased leg vessels (Mol and Elsmann, 1996), or medical records (Berg, 1996).

Second, this article aims to complexify the approach to the mechanical delegation of biopower to the medical profession by demonstrating the diversity of practices among physicians and hospitals. It attempts to capture the potential effects of logics related to different directions their training might take (Becker et al., 1961) as well as their non-professional socialization such as their political orientation, religious beliefs, age, and generation (Darmon, 2023) on choices made regarding ultrasound dating.

2. Materials and methods

2.1. Data collection

This article is based on a qualitative mixed-methods investigation combining six months of observation of medical work conducted in three French "abortion centers", with 140 semi-structured interviews with gynecology professionals.

Observation (72 full days) was carried out between September 2021 and July 2022. The three abortion centers are administratively attached to hospital gynecology departments. This is the type of structure where the majority of abortions in France are currently performed (Breton et al., 2023). The three centers were chosen from a comparative perspective, with an objective of contrast and maximization of expected variations: the aim was both to capture differences beyond regularities and to identify what resists contextual variation which might remain invisible in single-site studies. Center A is one of the most active in the country, handling several thousand abortion requests per year. Center B is attached to a hospital in the prefecture of a rural region poorly equipped with medical structures and abortion professionals—a "medical desert"—where 300 abortions are performed annually. Center C operates with an explicitly activist orientation—similar to the feminist abortion clinic studied by Wendy Simonds (1996)—toward maximizing abortion access, which distinguishes it from the other two centers. This activist approach, characterized by advocacy for women's reproductive rights and a commitment to providing care at the legal limits, influences the center's clinical protocols and dating practices, as will be detailed in the results section. They perform 1000 abortions per year. During my observations, I documented 150 pregnancy dating procedures that led to either acceptance or denial of abortion requests. The analysis also draws on interviews conducted between September 2020 and December 2022 with 133 healthcare professionals (including 88 physicians). The interview corpus was constructed with the objective of diversity in sex, age, advancement in medical career, place and mode of activity, region, position regarding abortion, and degree of involvement in practice. Interviews were conducted either by visioconference or face-to-face (depending on participants' location). They were recorded and transcribed.

Conducting this analysis requires familiarity with the medical scientific literature and the evolution of good practice recommendations (Cambrosio et al., 2006; Weisz et al., 2007; Castel, 2009; Timmermans and Epstein, 2010). In order to put local practices into perspective with professional norms, I analyzed the medical recommendations published in France regarding abortion since its legalization in 1975. It also requires understanding the functioning of health technologies and the logics guiding the development of medical protocols.

2.2. National context

The study was conducted in the French context where abortion at women's request was authorized up to 12 weeks of pregnancy at the time of the study. In France, abortion is performed by specialized professionals dedicated to it and by gynecologists who practice it alongside their obstetric activities. It is a relatively common practice today.

Numerous studies have shown the existence of an "abortion provider stigma" and negative repercussions of abortion practice on medical careers in certain national contexts—Australia (Ripper, 2001), United States (Joffe, 1996; Freedman, 2010), Spain and Italy (De Zordo, 2016), Colombia (Fink et al., 2016). In France, conversely, interviews conducted for this study indicate that it is the refusal to perform abortions, rather than providing them, that may be subject to stigmatization in the professional environment. Apart from this, the analysis made in this article is transposable to other national contexts where abortion at a woman's request is authorized with the constraint of respecting a maximum gestational term.

2.3. Ethics statement

The research plan was approved by the Institut national de la santé et de la recherche médicale (INSERM)'s ethics evaluation committee (opinion No. 22–902). This study comes under methodology MR004 of the Commission Nationale de l'Informatique et des Libertés (CNIL) relative to "the treatment of personal data for study, evaluation, or research purposes not involving the human person." In accordance with its requirements, prior verbal consent to a recorded interview was obtained. The research plan was also submitted to hospital management and discussed and accepted by all staff at the abortion centers and gynecology departments where the study took place. In the observational component of the study at the centers, one nurse refused to participate in an interview. In the interview component beyond the three centers, five people declined to be interviewed and ten people did not respond to multiple requests for an interview (all doctors). Centers' information has been changed so they could not be identified.

3. Results

The investigation reveals substantial variation in pregnancy dating practices across the three abortion centers, despite their operation under identical legal constraints. These variations occur at multiple levels: the timing of assessment, the methods employed for dating, and the interpretation of ultrasound measurements. It also reveals the collective negotiations among physicians that determine these practices at the institutional level.

3.1. The choice of when to date

Depending on the physician to whom women request an abortion, or according to the abortion center—A, B, or C—to which women make their request, they cannot abort up to the same term. Or rather, they abort up to the same nominal term (12 weeks at the time of the study), but this term does not designate the same thing. The three centers do apply the same law but not identically. This discrepancy occurs at two levels: the moment when counting is done and the method of counting.

The first corresponds to the moment chosen by physicians as needing to be dated. The law does not specify whether the threshold it defines corresponds to the maximum term of a pregnancy at the time of the consultation preceding the abortion procedure or at the time of performing the abortion. However, according to the department's schedule and the waiting time needed to obtain a slot in the operating room, the first generally takes place several days (or even weeks) before the second. Centers A and B choose as reference the term that the pregnancy will have on the day of the abortion procedure. Thus, a woman whose pregnancy would be dated at exactly twelve weeks during consultation would be considered beyond the time limit since, in these departments, abortions are not performed on the same day. The same applies to a woman whose pregnancy would be dated at eleven weeks and five days but who has the misfortune to consult on a Friday. Since abortion centers are closed on weekends, she would not have a place in the operating room until the beginning of the following week, at the earliest, and would therefore exceed the deadline. Such situations occurred several

times during my observations. In these cases, either women were refused, or, with authorization from the head of the gynecology department, they were allowed to abort a few days beyond the deadline. The authorization of the department head is rarely and unequally granted to women according to their "social value" (Glaser and Strauss, 1965; 1968; Sudnow, 1967; Roth, 1972). The decision depends on moral judgments made by professionals. These are linked to women's behaviors, depending on whether they are aborting for the first time or not, whether they agree to adopt contraception deemed effective by physicians (pill, contraceptive implant, intrauterine device), whether they contest medical decisions or not, have the right relationship to speech (answering medical questions by speaking neither too much nor too little), respect feeling rules (Hochschild, 1979) according to which abortion should be experienced as an event of certain gravity. Moral judgments are also linked to women's social characteristics: precarious women, racialized women, allophone women, women with mental health conditions (or whom professionals believe have a mental health condition) have less chance of being accepted beyond the legal deadline.

With this calculation method, it is women who bear the constraints related to the organization of the service, closing hours, weekends and holidays, and overcrowded operating room schedules. Physicians at center C, conversely, consider that women seeking abortion should not have to assume the consequence of the waiting period related to the organization and possible saturation of the service. They consistently choose as reference the term that the pregnancy has on the day of the pre-abortion consultation, regardless of when the procedure will actually be performed. Physicians at Center C consider this choice of timing for dating as an engaged practice in favor of women, allowing them to maximize access to abortion. This practice, shared by other centers in France, is perceived by those who apply it as both legal and legitimate. Whereas physicians at Centers A and B, in the rare cases where abortion is performed beyond the legal deadline, alter consultation documentation to indicate that the woman just reaches the maximum gestational age on the day the abortion is performed, at Center C the actually calculated gestational age is recorded. This practice does not generate particular fear or tension within the team, unlike the choices regarding interpretation of dating methods (as I detail further below).

3.2. The choice of dating method

The second level where the discrepancy in pregnancy dating occurs concerns the method used to perform the dating. The law does not specify how physicians should date pregnancies. In theory, nothing would prevent relying solely on the declaration of the date of the last menstrual period by women or on their estimation of the date of the sexual intercourse that led to the pregnancy.⁴ Before the diffusion of ultrasound devices in French maternity wards during the 1980s and 1990s, the term of pregnancy was measured by combining the declared date of the last menstrual period with a clinical examination. The latter consisted of a vaginal examination allowing assessment of the uterine content according to its size, estimated by palpation. Physicians then referred to the "citrus range": depending on whether the uterus was the size of a mandarin, a small or large orange, or a grapefruit, the term was estimated as more or less advanced.

In practice, today, pregnancies are dated by ultrasound in all three surveyed centers, as is common almost everywhere in France. So where does the difference between centers come from? To understand this, we must detail the functioning of ultrasound.

⁴ Global guidance exists on the topic. The World Health Organization, 2022 Abortion care guideline emphasizes that gestational age assessment should be performed using the least invasive method appropriate in the circumstances, including last menstrual period alone or combined with clinical examination, with ultrasound available when other methods are uncertain (World Health Organization, 2022).

3.3. The choice of ultrasound dating rules

An ultrasound does not directly give the term of a pregnancy: it provides an image of the fetus in utero. The person operating the ultrasound attempts to measure, on this image, the size of a specific portion of the fetus. In the context of abortion, up to four weeks of pregnancy, this is the diameter of the gestational sac, then, between four and nine weeks, the crown-rump length (CRL, the length that separates the top of the head from the bottom of the buttocks), and after nine weeks, the biparietal diameter (BPD, the diameter of the fetal head). As the term of a pregnancy advances, the size of the fetus and, by extension, the CRL and BPD, increase. It is therefore according to the size of the fetus, and not to the term of the pregnancy, that physicians accept, or not, the abortion request.

However, for the same term, fetal size differs from one pregnancy to another. This variation occurs not only because ultrasound measurements involve some degree of subjectivity, as different practitioners may obtain varying results when measuring the same fetus, but also because the rules by which physicians interpret ultrasound images and derive gestational age from them vary between centers and practitioners. A measurement of the cranial diameter (BPD) of 32 mm can correspond either to an eleven-week pregnancy with a particularly large fetus for “its” gestational age, or to a fifteen-week pregnancy with a particularly small fetus. An ultrasound can in no way provide an exact date. Dating a pregnancy by ultrasound is probabilistic. At a given term, fetal sizes follow a normal distribution, meaning they are distributed according to a bell curve. For example, 27 mm corresponds to the average BPD measurement for twelve-week pregnancies. If a BPD of 27 mm is measured by ultrasound, there is a one-in-two chance that the pregnancy is twelve weeks or less, and a one-in-two chance that it is twelve weeks or more. Let’s imagine that doctors make the average BPD measurement of twelve-week pregnancies (27 mm, therefore) the limiting size beyond which abortion requests are refused. This means that, among all abortion requests for which a BPD of 27.1 mm is measured, and which are refused, half probably date, in reality, to twelve weeks or less. Symmetrically, this means that half of the accepted requests with a BPD of 26.9 mm correspond to pregnancies that are more than twelve weeks. The more the measured size exceeds 27 mm, the more likely it is that the pregnancy actually dates to more than twelve weeks. The probability of overestimating the term of a “large” fetus and thus, by refusing the request, depriving a woman of an abortion to which she would otherwise be eligible, decreases. Conversely, the more the measured size is less than 27 mm, the more likely it is that the pregnancy actually dates to less than twelve weeks: the probability of underestimating the term of a “small” fetus (and thus authorizing an abortion for a woman who has exceeded the legal deadline) decreases. Setting a limit measurement therefore amounts to defining what will be the probability of refusing requests that are acceptable according to the law, and, in mirror image, that of accepting requests that are unacceptable according to the law.

In the context of pregnancy monitoring, the mean measurement (the 50th percentile) serves as a reference for sonographers who seek to predict the most probable date of delivery. The measurement issue is not the same in the context of abortion, where it primarily serves to establish a limit on the right to abortion. In abortion, the choice of a more or less high BPD limit is a balancing of two risks: that of refusing the request of a woman who is actually within the timeframe provided by law, and that of terminating a pregnancy when the fetus is more developed than the law provides. Finding it unfair to set a BPD limit that would statistically lead to refusing abortion to many women who are nevertheless within the timeframe provided by law, the three studied abortion centers set a BPD limit more favorable to women—but not the same one. For centers A and B, it is the 90th percentile, a fetal cranial diameter of 30 mm, and for center C, the 98th percentile, or 32 mm. In centers A and B, abortion is refused “only” for 10 % of requests that are actually at twelve weeks, and in center C, “only” for 2 % of these requests.

Abortion requests are thus accepted when the fetus is larger (and

therefore the pregnancy potentially more advanced) in center C than in the other two centers. In other words, a woman will be judged pregnant for a shorter time if she consults in center C than if she consults in the other two centers. A pregnancy dated at twelve weeks there will be dated at twelve weeks and four days in centers A and B, and at thirteen weeks and three days in centers that use the 50th percentile, as is still often the case (to which is added the gap related to the choice of the moment of dating).

The term of pregnancy is constructed by physicians’ practices. In a way, a woman will be pregnant for a longer or shorter time depending on whether the pregnancy is intended to be terminated or continued, and depending on the dispositions of the physician she consults—particularly according to their attachment to women’s reproductive autonomy or consideration of the fetus—according to their degree of specialization in abortion work and, especially, according to the negotiations between physicians at the abortion center in developing a common norm.

3.4. Negotiations, disagreements, and conflicts among physicians in pregnancy dating

By focusing on negotiations on the choice of term calculation method, I show here how physicians collectively interpret the law and define, at the service level, the conditions for abortion.

The definition of the BPD limit is indeed a decision. While the Haute autorité de santé (the national scientific body responsible for writing good practice recommendations) does not recommend a specific method for dating abortion, the Collège national des gynécologues et obstétriciens français (CNGOF), the main scientific organization of the profession, issued abortion practice recommendations in 2016 indicating that pregnancy should be dated at the 90th percentile. This recommendation was then more favorable to women seeking abortions than the most frequent practice in abortion centers, which was (and still is, according to several abortion providers I interviewed) dating at the 50th percentile. The publication of recommendations does not lead to a standardization of practices in abortion. Their non-binding nature and sometimes vague formulations allow the maintenance of clinical judgment autonomy, and the safeguarding of “uncertainty zones” (Crozier and Friedberg, 1980) permitting play around the implementation of recommendations (Castel, 2009; Timmermans and Epstein, 2010). Following recommendations can be all the more flexible as controls are difficult, since they presuppose not only identifying deviations from recommendations but determining if these are “unjustified” (Castel and Robelet, 2009). However, recommendations can be mobilized by physicians to promote a change in local practices, at the scale of an abortion center. Relying on CNGOF recommendations, one of the now-retired physicians from center A “fought” (he tells me) a few years ago to evolve the measurement rule, from the 50th to the 90th percentile.

Within the medical team of abortion center C, its definition is the subject of a violent conflict. All physicians except one favor measurement at the 98th percentile. Not only does this seem to them a practice in line with the feminist commitment that they display as a “cutting-edge,” “activist” service playing a central role for women’s cause, but they derive professional benefits from it. It allows them to acquire technical capital: they are trained in the practice of “late” abortions, which allows them to give advice and training to other physicians in the context of profession-wide events.

But one of the physicians expresses difficulties in performing “late” abortions. In a team meeting, irritated, he urges his colleagues to stop naming abortions at “BPD 32” as “twelve weeks of pregnancy” (at the 98th percentile) and designates them as “thirteen and a half weeks, objectively” (at the 50th percentile), referring to the correspondence grid of the College of sonographers. Later, in private, he explains to me: “The most logical is to take the median. The service’s refusal to follow the ultrasound college is irrational. Between ‘BPD 27’ and ‘BPD 32,’ the fetal weight is doubled.” The reference to weight reflects the greater

attention he seems to give to the fetus compared to his colleagues. Revisiting this discussion a few days later, he insists: “I like to turn the argument around the other way: at ‘BPD 32,’ there are 1 % of women who are less than twelve [weeks of pregnancy], but also 1 % who are more than fifteen [weeks].” While his colleagues consider that their ultrasound measurement interpretation, though unconventional and “activist,” is nonetheless legal, he believes it constitutes an unlawful practice and fears its potential legal consequences in case of complications. He requests that his consultation reports be co-signed by a second physician in order to dilute legal responsibilities.

Department meetings are devoted to the issue, during which he criticizes the center’s measurement norm and the other physicians (including the unit head) defend it. Despite his disagreement, he is ordered to adopt the same pregnancy term calculation rule as the rest of his team and threatened with losing his position if he does not comply. He eventually does so.

A symmetrical situation is that of a 45-year-old general practitioner, responsible for an abortion center in which I did not conduct observation. In an interview, she regrets the lack of activism in her team: she herself favors adopting a BPD limit at the 98th percentile while her colleagues refuse to exceed the 90th. “Excessive activism in a team that isn’t activist, it’s not possible. It’s suicidal. You have to bite your tongue,” she comments, which doesn’t prevent her from sometimes performing abortions beyond the deadline in secret from her colleagues.

These different situations illustrate that practical norms and implemented devices are the fruit of negotiations and sometimes conflicts within services between physicians. These norms are not incessantly renegotiated but only when a physician becomes an entrepreneur of practices, advocating the adoption of a protocol discovered in training, suggesting the adaptation of the care pathway to the latest recommendations, etc.

Freidson already noted the greater dependence on their peers of hospital physicians than physicians working in private practice (Freidson, 1970). The work of physicians in abortion centers is framed by negotiation of practical norms among colleagues, whereas physicians performing abortions in private practice can interpret the law more autonomously—deciding alone on dating techniques and rules.

4. Discussion

The study of pregnancy dating practices in the context of abortion requests in France opens several avenues of analysis.

First, it makes visible the fact that physicians must interpret the law to apply it. The diversity of choices of methods and dating practices, and more broadly that of medical practices, is not a freedom taken against the official norm, a scandalous initiative by physicians: it is the mechanical consequence of the very functioning of public action. Physicians must produce applicable secondary norms that frame their own work, choose and define instruments that both enable and constrain their work. This production operates individually or collectively according to modes of practice. It is not sufficient to analyze how physicians think about abortion and gestational age, but how they “do” it. It is these secondary application norms (Lascoumes, 1990) that define what gestational age, abortion and the right to abortion are in practice, not just the law. When physicians choose between the 50th, 90th, or 98th percentile for interpreting fetal measurements, they are not simply making clinical decisions; they are defining the material conditions under which women’s reproductive rights can be exercised.

Next, the conducted investigation confirms that medical instruments, such as ultrasound and its reading rules, are political as well as technical devices. They are not neutral. Once instituted, they produce effects by constraining medical work. They have an effect on the care provided and can contribute to producing inequalities: a consequence of the generalization of ultrasound dating by measuring fetal size (rather than by declaration of the date of the last menstrual period, for example) is that women who are tall (and/or whose partner is tall), because they

are pregnant with larger fetuses on average (Addo et al., 2013; Pözlberger et al., 2017), can abort only up to an earlier term than short women. Above all, medical instruments carry values and are nourished by an interpretation of the social and precise conceptions of the envisaged mode of regulation (Halpern et al., 2019). The choices and debates from which instrumentation derives are rendered invisible. The announced gestational age does not appear as an estimate, nor as a medical construction: the process that gives rise to dating is not discussed; it fades before the apparent objectivity of the result. In France, pregnancy dating methods and rules are not constructed as a political issue that reproductive rights activists could seize because they are not aware that it is a possible lever of action to define access to abortion.

Fundamentally, medical authority operates not only through explicit gatekeeping but through the invisible power embedded in technical protocols and devices that have for them the weight and apparent immutability that all structures have.

The technical development of ultrasound and the introduction of ultrasound equipment in hospitals have fundamentally changed the way pregnancy is understood and dated, shifting from a subjective experience for women (last menstrual period) to a technical measurement of the fetus. Ultrasound makes the body readable, with certain parts of the fetus (BPD, CRL) becoming the preferred markers of gestational age. In this way, it constitutes a form of control of the female body, allowing pregnancies to be dated independently of women’s statements. This object illustrates how the interpretation of biomedical information can be discussed, negotiated, and contested by healthcare professionals with different positions.

Finally, this analysis opens a new avenue for understanding health and political inequalities in access to abortion. These are not only linked to the fact that physicians differentiate care according to women. Certainly, the investigation shows that the legal maximum term is applied more or less strictly according to women’s “social value”. But inequalities do not rest solely on how physicians play with the rules on a case-by-case basis, but also on how they define the rules that apply to all their patients. For, as we have seen, depending on the physician or abortion center to which women make their abortion request, they cannot abort up to the same term, independently of their social characteristics and their own behaviors. Aborting at twelve weeks in abortion center C means aborting a week later or more than in the other two centers. So much so that the many women whose requests I saw refused in centers A and B for a delay of a few days would have aborted without problem in center C. The existence of different ways of dating pregnancies is just one example of variation in medical practices in the context of abortion care. In reality, the number, spacing, and duration of consultations, their content, the medical protocols followed and the methods offered, the term of pregnancy from which women are accepted, differ considerably. The existence of this margin of maneuver contradicts the norm of universalism in French public service – where individuals should theoretically receive equivalent treatment regardless of who they are and where they seek care (Prud’homme, 2016).

To understand health inequalities and consider the effectiveness of the right to abortion, it is not enough to consider the existence and lack of places and physicians who accept to provide abortion, from a quantitative angle. We must consider the heterogeneity of the care offer and pay attention to the difference in practices, to the different ways in which abortion is performed. The health and political issue of abortion is not only that of accessing it or not, but of what abortion women access.

Funding

This research was funded by a PhD grant awarded by the University of Paris 1 Panthéon Sorbonne.

Ethics statement

The research plan was approved by the Institut national de la santé et

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Declaration of generative AI and AI-assisted technologies in the writing process

During the preparation of this work the author used Claude.ai in order to correct text of the article that was not written in the author's native language. After using this tool, the author reviewed and edited the content as needed and takes full responsibility for the content of the publication.

Declaration of competing interest

The author declares that he has no competing financial interests or personal relationships that could have influenced the work reported in this paper.

Data availability

The authors do not have permission to share data.

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