

1 **Prenatal diagnosis: Women’s interactions with practitioners when severe abnormalities**
2 **are discovered at birth**

3
4 **Authors:** Caroline Lafarge, University of West London, UK; Ecole des Hautes Etudes en
5 Sciences Sociales, France, PhD; Sophia Rosman, Cermes3, France, PhD; Isabelle Ville,
6 Ecole des Hautes Etudes en Sciences Sociales, France, PhD.

7 **Corresponding author:** Caroline Lafarge, School of Human and Social Sciences, University
8 of West London, UK, Tel: +44 208 209 40 88, E: caroline.lafarge@uwl.ac.uk

9 **Funding:** This study was part of the programme “Partenariat Institutions - Citoyens pour la
10 Recherche et l’Innovation” (PICRI) funded by the local Authority Région Ile de France,
11 France. Agreement n° 13020600. Caroline Lafarge was a Research Fellow of the Ecole des
12 Hautes Etudes en Sciences Sociales at the time of data collection and analysis.

13 The funder had no involvement in the study design, data collection, data analysis, report
14 writing, or on the decision to submit the report for publication.

15 The authors have not conflict of interest to report

16 **Keywords:** prenatal diagnosis, doctor-patient interactions, fetal abnormalities, disability,
17 wrongful birth, interviews

Abstract

18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36

Background: In an increasingly litigious medical environment, this study examined women's experiences of their interactions with practitioners when severe abnormalities are discovered at birth.

Methods: Eight in-depth interviews with women were conducted in France. Data were analysed using Interpretative Phenomenological Analysis.

Results: Four superordinate themes were identified: the importance of attunement to women's emotions and needs; the possibility of litigation but no direct accusation; reasons for not resorting to litigation; and reframing and positive transformations. Despite experiencing distress, women were reluctant to make a complaint against practitioners. Several factors may account for this, but practitioners' ability to relate to women with humanity was particularly significant.

Conclusion: Women understood the limits of technology and of the care practitioners can provide, but greatly valued practitioners' empathic and honest communications. Thus, adopting a transparent and open approach may foster trusting relationships with women/parents. In turn, this may lower the prospect of litigation being brought against practitioners when severe abnormalities are discovered at birth.

Introduction

37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61

Routine pregnancy care in France comprises three ultrasound examinations and several screening tests, of which combined screening for Down syndrome is possibly the most well-known. Down syndrome screening uptake in France is one of the highest in Europe (87%) compared to England (74%) and the Netherlands (< 30%; Crombag et al., 2014). However, not all anomalies can be detected prenatally and prenatal detection rates vary greatly according to the technology available and the operator's level of expertise (European Surveillance of Congenital Anomalies [EUROCAT]). For example, EUROCAT reports a prenatal detection rate for combined congenital anomalies of 61% for the Parisian registry compared to 43% in Brittany between 2013 and 2017 (EUROCAT, n.d). In France, 2.7% of live newborns are affected by congenital anomalies (Santé Publique, 2019), and a significant number of these diagnoses are made at birth.

Discovering a severe abnormality at birth may have negative long-term impacts on women. It may lead to a series of psychological and practical crises, challenge individuals' values about the world, and generate practical difficulties (Kandel & Merrick, 2007) such as requiring caring activities (feeding, dressing) and navigating complex healthcare pathways (Van Wyk & Leech, 2016). Evidence also suggests that women consider the transition to motherhood to be complete once they feel fully able to care for their child, which in the case of a child born with a severe impairment, might be protracted (Azad et al., 2013).

In the past 20 years, there have been significant advances in screening technologies, including the combined Down syndrome screening test (combining maternal serum values with fetal nuchal translucency ultrasound measurement), non-invasive prenatal testing (using fetal cells in maternal serum), and higher definition ultrasound equipment. These have led to higher detection rates of fetal abnormalities, particularly for Down, Edward and Patau syndromes (trisomies 21, 18 and 13). As screening technologies improved, societies have

62 also faced ‘wrongful birth’ and ‘wrongful life’ litigation (Giesen, 2012; Hassan et al., 2014).

63 Wrongful birth actions occur when a child is born with an impairment for which
64 parents hold the medical team responsible (e.g. failure to identify the abnormality in utero)
65 and seek compensation (Raposo, 2017). Wrongful life actions are brought on behalf of a child
66 (usually affected by a severe impairment) for having to live a life of suffering when the birth
67 could have been prevented (Giesen, 2012). At the core of these actions lies the notion that
68 parents were denied the opportunity to terminate the pregnancy, and thus that their
69 reproductive rights have been violated.

70 The 2001 Perruche lawsuit in France represents an important milestone in prenatal
71 screening practices. The case concerned a child (Nicolas Perruche) born severely
72 handicapped after his mother contracted rubella, undiagnosed, during pregnancy. The child’s
73 representatives initially won a case for ‘wrongful’ life, but the judgement was later
74 overturned by the French Supreme Court following uproar from professionals and the public.
75 The impact of the Perruche case was to open a public debate on the right to ‘not be born’, the
76 rights of disabled individuals and, more broadly, on the judicialization of medical practice
77 (Costich, 2006; Mameri et al., 2015). The case also durably influenced prenatal screening
78 practices in France and beyond, with practitioners becoming increasingly fearful of litigation,
79 intensifying the use of ‘defensive medicine’, and a tendency to recommend and/or to
80 increase the number of medical acts to protect the practitioner against potential litigation
81 (Mameri et al., 2015; Moyse & Diederich, 2007). Yet, despite an increasingly litigious
82 environment, the number of prenatal diagnosis related lawsuits remains small (Anumba,
83 2013; Mameri et al, 2015). In France, 10 cases were recorded in 2018 (Mutuelle d'Assurance
84 des Professionnels de la Santé, 2019).

85 Little is known of women’s experiences of their interactions with practitioners when
86 severe abnormalities are discovered at birth. This insight would, however, be valuable to

87 practitioners caring for women during and after pregnancy. This article aims to address this
88 gap.

89

90

Methods

91 *Study background*

92 This article reports qualitative data gathered as part of a project investigating women's
93 experiences of prenatal screening and diagnosis in France. The project comprised an online
94 questionnaire followed by in-depth interviews. Women who completed the online
95 questionnaire were asked whether they wished to be re-contacted to further explore their
96 experiences. Altogether, 1527 women completed the questionnaire with 564 (36.9%)
97 agreeing to a follow-up interview. Using purposive sampling, 99 women were invited for an
98 interview and 67 (67.6%) interviewed. Of those, eight had had a baby with a severe
99 abnormality discovered at birth or with an abnormality more severe than anticipated, which is
100 the article's focus. Data were collected between May 2015 and May 2017.

101 *Participants*

102 All women (n = 8) who had reported that their baby had been born with a severe abnormality
103 discovered at birth (or with one more severe than anticipated) and who had agreed to be re-
104 contacted, were interviewed. A further eight women would have been eligible for interview
105 but either did not agree to be recontacted (n=2) or left incomplete contact details (n=6).
106 Women were aged between 29 and 41; all were married or in a relationship and all were
107 educated at university level. Most abnormalities had been discovered at birth. In one case, the
108 woman had received a diagnosis of clubfoot in utero, but additional abnormalities were
109 identified at birth. Four babies were diagnosed with genetic/chromosomal anomalies and four
110 with structural anomalies. Two babies did not survive beyond five weeks, two were severely

111 handicapped and four experienced various levels of impairment. All women except one had
112 undergone Down syndrome screening and all had attended routine ultrasound examinations.

113 *Procedure*

114 Six interviews were conducted over the phone and two face-to-face. As participants had
115 completed the online questionnaire, researchers were familiar with their circumstances.

116 Women were told that the aim of the study was to further explore their experience. Interviews
117 followed an open topic guide, including questions such as “how did you feel about the
118 abnormality being discovered at birth?” or “what was your relationship with practitioners
119 (providing antenatal and/or postnatal care) like? Interviews were conducted in French by
120 researchers experienced in gathering sensitive data. Interviews lasted between 35 minutes and
121 1 hour 45 minutes. All were digitally recorded and transcribed verbatim. Quotations used in
122 this paper were translated into English.

123 *Ethics*

124 The project was registered to the National Commission on Informatics and Liberty
125 (Anonymised). As women were participating in the research in a private capacity, no other
126 permissions were required. Women interviewed had already consented to participating in the
127 research when completing the online survey. To protect participants’ identity, names have
128 been changed and identifiable information removed. References to women’s babies and
129 professionals involved in their care have been made using masculine descriptors.

130 *Analysis*

131 Interpretative phenomenological analysis (IPA [Smith et al., 2009]) was used to analyse the
132 data. Through its ideographic focus, IPA is appropriate to examine the experiences of a small
133 purposively homogeneous sample. Its phenomenological and hermeneutic underpinnings also
134 enable researchers to access and interpret participants’ inner world and the meaning they

135 attribute to their experiences (Smith et al., 2009). In accordance with Smith and colleagues'
136 guidelines, the analysis was conducted case by case, separately by members of the team. The
137 authors then devised a coding framework which was used to code all interviews.

138 **Findings**

139 Four superordinate themes were identified as best conveying women's experiences of their
140 interactions with practitioners when severe abnormalities are discovered at birth.

141

142 *The importance of attunement to women's emotions and needs*

143 Women reported mixed experiences of the care they received. When describing positive
144 interactions, women underlined practitioners' ability to attune to their emotions and respond
145 to them in an empathic manner as critical to their experiences: "*Everyone, from the doctors to*
146 *the midwives, to the assistants, really everyone was very, very good to us (...) These people*
147 *are devoted body and soul*" (Julie). "*They [the midwives] were adorable. We have only come*
148 *across people who were full of good-will and very kind*" (Lise).

149

150 However, women also reported a lack of empathy from some professionals. For example,
151 Sarah evoked the blunt manner in which her baby's Down syndrome diagnosis was disclosed
152 to her:

153 *The midwife was sewing me up while the consultant was looking at my baby. I still*
154 *had my feet in the stirrups! She put the baby on me and, then, there is the gentleman*
155 *who comes: "well then, we suspect a trisomy 21."*

156 Similarly, Anna recalled a consultant consistently referring to her baby using the wrong
157 gender, dismissing her concerns about the baby's lack of movement in utero and accusing her
158 of being "*over-protective.*"

159

160 A lack of empathy could cause professionals to read women's emotions inaccurately. This is
161 the case of Sarah who after being told that her baby had Down syndrome was visited by two
162 hospital psychologists. She recalled being taken aback by the psychologists' gloomy
163 demeanour, which seemed to frame her baby's birth as a negative experience:

164 *They came, they had very long faces... we were wondering what was going on. We*
165 *had more or less digested the news. For us it was OK, we were right in our heads. We*
166 *had accepted it.*

167 Conversely, Camille felt that some professionals had failed to grasp the severity of her baby's
168 condition and the depth of her sorrow. Recalling an interaction during which she was told her
169 baby had severe genetic anomalies, she said:

170 *[He said] "He's had a good life up to now." And I got angry, because my baby, who*
171 *was 6 months old, regurgitated every day, had epileptic fits every day. I said: "No, he*
172 *doesn't have a good life."*

173 A lack of empathy could also result in practitioners failing to adequately respond to women's
174 needs, in particular with regards to information. Noemi recalled some practitioners
175 withholding information from her, which she interpreted as a sign of contempt: "*I cruelly*
176 *lacked information (...) I had zero information. Ultimately, what was I? A number that*
177 *gave birth, that had a problem afterwards?"* In that instance, Noemi experienced
178 practitioners' attitudes as dehumanising and disempowering. Similarly, Anna found herself
179 'kept in the dark' and yearning for information. She expressed anger at the fact that
180 information had not been forthcoming:

181 *What makes me angry is that all the things that were useful, that help move thing*
182 *forward, I found them myself, through looking on the Internet or into [Town and*
183 *hospital]. It's not normal really that we were not given the right advice. It's not*
184 *normal.*

185

186 ***The possibility of litigation but no direct accusation***

187 Women expressed anger and sadness that the anomalies had not been identified prenatally:

188 *“A part of me resents him [the gynecologist]... well resents him, yes and no, but I mean he*

189 *could have been less “lax” I don’t know. With him it was always ‘all is good, all is good’”*

190 *(Sarah)*. Some women questioned the quality of their pregnancy care. This is the case of

191 Ariane who recalled that her gynecologist had not scanned her baby’s umbilical cord despite

192 the fact that this examination had been carried out for her first child: *“I was not going to tell*

193 *him what he had to do, but I remember that he had not checked it.”*

194

195 Women were aware that the discovery of a severe abnormality at birth leaves practitioners

196 vulnerable to litigation. Commenting on the fact that her baby’s Down syndrome had not

197 been detected in utero, Catherine reported:

198 *My gynaecologist said to me: “On ultrasounds, we could not see anything because the*

199 *nuchal translucency was good and he doesn’t have heart problems, he was growing*

200 *properly” (...) I think there are doctors who are a little freaked out and who say to*

201 *themselves: my god, we did not see the first trisomy, we are going to be taken to court.*

202 Similarly, Julie recalled professionals initially attempting to minimise her baby’s

203 malformations, only to inquire later if other practitioners had told her whether the

204 abnormality could have been detected in utero: *“They were worried enough to transfer me*

205 *(...) but they asked later – did they [at the other hospital] tell you that it would have been*

206 *possible to detect it?”*

207

208 Yet, none of the women filed a complaint against the medical team (antenatal or postnatal),

209 and only one, Noemi, considered it. Instead, women expressed loyalty towards professionals

210 who had cared for them during pregnancy. Ariane repeated several times “*having confidence*”
211 in her gynaecologist, and not resenting him. Most women remained under the care of the
212 same practitioner, including Noemi who said that she “*still trusted her gynaecologist.*”

213

214 ***Reasons for not resorting to litigation***

215 Instead of accusing professionals of malpractice and/or filing a complaint, women offered
216 their own explanations as to why the abnormality had been missed. Some women held the
217 rarity of the condition responsible for the failure in detecting it: “*it [the condition] is*
218 *sonographers’ worst nightmare... very difficult to detect in utero*” (Lise). Others underlined
219 human limitations: “*We ought to be realistic. These things happen*” (Julie), and heavy
220 workload: “*If I put myself in his shoes, he sees so many people, with problems, without*
221 *problems*” (Sarah). Lise described practitioners as fallible and drew parallels with her own
222 shortcomings: “*He’s not a god, he’s not a robot (...) I sometime mess up in my job.*”
223 Technology and professional expertise were also questioned: “*the scans in [other hospital], it*
224 *looks like they are much more detailed there... So maybe we need to revise doctors’ training*
225 *(...) and the ultrasound machines.*” (Ariane)

226

227 Women also reported various reasons as to why they did not consider/resort to litigation. For
228 some participants, the fact that professionals displayed genuine concerns and/or regret
229 following the discovery of the abnormality was enough to exonerate them. Ariane described
230 at length how her gynaecologist appeared affected by her predicament and how she took
231 comfort from it:

232 *The gynaecologist called me almost every fortnight to find out how I was doing. We*
233 *could see very well that he was feeling guilty (...) It is someone who is serious and this*
234 *has led him to question his entire work.*

235 For Noemi, the failure to detect the anomaly in utero was offset by the fact that it had been
236 identified, albeit postnatally, which saved her baby's life: "*It could have been detected, but*
237 *no, we didn't [file a complaint] (...) the fact that the paediatricians saw it, it saved my baby.*
238 *Had they not seen it, probably [baby] would no longer be here."*

239

240 Finally, some women alluded to the fact that making a complaint would negatively reflect
241 upon them. Catherine stated that "*[complaining] is not their style*" describing parents who do
242 so as "*bitter*" and "*vindictive*," while Anna refused to be drawn into what she considered to
243 be simplistic and opportunistic arguments: "*my goal is not to fight to say: 'you are bad guys,*
244 *I want money.'*" In these cases, a complaint was viewed as diverting resources away from the
245 real goal of improving their baby's situation and as an opportunistic endeavour.

246

247 ***Reframing and positive transformations***

248 The reasons put forward by women to account for the failures to detect the abnormalities
249 prenatally may also constitute a way to reframe their situation. Some women depicted being
250 unaware of the abnormality as a 'blessing in disguise,' which had enabled them to experience
251 a stress-free pregnancy:

252 *I prefer to have had it this way, because to have known before, I think I would not*
253 *have had a good experience of my pregnancy; whereas I had a perfect pregnancy, a*
254 *perfect delivery. (Noemi)*

255 Being unaware of the baby's condition also meant that women did not have to make difficult
256 decisions about the management of the pregnancy, a thought that filled Julie with dread: "*It*
257 *was not diagnosed. If it had been, I don't want to think about what I would have done.*" For
258 Catherine, these questions would have conflicted with her religious faith: "*You can have the*
259 *strongest convictions, the day you are told during your pregnancy that your child has a*

260 *disability, the question of abortion inevitably arises. Honestly, this question... is a horrible*
261 *question.”* For Camille, the thought of having to ponder whether to continue or terminate the
262 pregnancy would have invalidated her child’s life; thus, she was relieved to have been spared
263 this dilemma: *“I didn’t want to have to choose (...) to think that we can ... that I can*
264 *terminate the pregnancy, it was as ifas if, on the other hand, I was regretting my child*
265 *being here.”*

266 Some women sought to derive meaning from their experience. Ariane’s baby only lived for a
267 few days but she was grateful for the opportunity to meet him. In this context, Ariane might
268 have been reluctant to taint her experience with negative thoughts about practitioners and a
269 potential complaint: *“We got some positive out of it – we have known him alive. I gave birth*
270 *to a child who was alive and we had him for some days, alive and in our arms.”* For others,
271 the experience triggered profound changes. Lise expressed the need to help others so that her
272 experience had not been in vain:

273 *I wanted for a long time to do something other with my life than the commute-work-*
274 *sleep routine, do something a little more useful to the community (...) I need to feel*
275 *useful, to tell myself that if this experience can be useful to other parents, to help them*
276 *through a difficult time, all is not completely lost.*

277 Camille also reported that her experience had enabled her to acquire a more mature vision of
278 life:

279 *The experience that we had has really helped me to develop. It remains difficult. I am*
280 *not going to say that disability is great and that we’re in Teletubby land! Far from it.*
281 *But it brings other things. It made me grow and look at life differently.*

282

283 Women also pointed to positive transformations among practitioners. For example, Anna’s
284 situation led professionals to reflect upon their practice, which she considered to be positive:

285 *He promised me – whether he does or not I don't know - that for the next patients, he*
286 *would systematically ask for an MRI, so no other moms have to go through what I*
287 *have. He told me that he would tell his colleagues, in their multidisciplinary meetings,*
288 *to be more attentive and to prescribe an MRI in this case.*

289

290

Discussion

291 This study investigated women's experiences of their interactions with practitioners when
292 severe abnormalities are discovered at birth. In line with the literature, women in this study
293 valued practitioners' empathy, particularly during the communication of the diagnosis and
294 their ability to read women's emotions accurately (Goff et al., 2013; Skotko et al., 2009).

295 There was also evidence of incongruence between women and professionals when
296 practitioners failed to acknowledge the birth as a joyful, albeit challenging experience.

297 Women also valued transparent information. These findings support research suggesting that
298 poor interactions with practitioners and a lack of transparency in complex obstetrics
299 situations can have negative consequences upon women's wellbeing (Fisher & Lafarge, 2015;
300 Graungaard & Skov, 2007; McCoyd 2009).

301 The study also shows that women were cognisant of the fact that failures to detect
302 abnormalities prenatally leave practitioners vulnerable to litigation. However, none of the
303 women chose to make a complaint, and only one considered it. Instead, they offered their
304 own explanations as to why the abnormalities had been missed, incriminating the care
305 system, the condition itself, technology or human limitations. Yet in seven out of eight cases,
306 the anomalies could potentially have been detected prenatally, giving women the opportunity
307 to terminate their pregnancy.

308 The reluctance to file a complaint may be explained by the fact that women were
309 grateful that the condition had been identified, enabling their baby to receive appropriate

310 care, and that they had been spared having to make difficult decisions during their pregnancy.
311 It may also illustrate women's desire to retain the moral ground in a 'rhetoric of blame',
312 epitomised by wrongful life and wrongful birth litigation, and underpinned by the concept of
313 'medical negligence'. Women may fear depicting their situation as intrinsically negative, as
314 this would leave little hope for positive emotions, and would somehow invalidate their child's
315 life. In choosing not to file a complaint, women may also assert their sense of agency over
316 their situation, thus gaining/regaining a degree of control over their narratives. This may also
317 enable them to distance themselves from the position of 'victim' and the concept of 'loss',
318 which are central to the medical approach to disability (Watermeyer, 2009).

319 Indeed, women's attitudes towards litigation may reflect a more holistic approach to
320 the disability experience (Priestley, 2001) and a move towards greater inclusion of people
321 with disability in societies, initiated by the disability studies movement. Research suggests
322 that parents tend to focus on their child's potentials rather than their lack of abilities
323 (Graungaard & Skov, 2006). Recent studies have also highlighted the positive consequences
324 of raising a child with a disability, with parents reporting emotions such as joy, hope and
325 pride in their children, as well as positive transformations such as an increased sense of
326 strength and stronger family cohesion (Beighton & Wills, 2017; McConnell et al., 2015).

327 Women's reluctance to file a complaint also needs to be considered alongside the
328 feelings of loyalty and empathy they expressed towards professionals. These feelings
329 appeared fuelled by the emotional connection between women and practitioners resulting
330 from having shared a difficult experience. It is possible that women felt emotionally invested
331 in their relationships with practitioners and unable to relinquish them. Together, these factors
332 might account for the fact that despite an increasing trend toward litigation in obstetrics, the
333 number of prenatal diagnosis-related litigation cases remains small (Mameri et al., 2015).

334 The findings also show that the experience of discovering a severe abnormality at
335 birth can be transformative. Some women ascribed meaning to their situation and/or
336 experienced positive growth as a result. Some reported that the experience had triggered a
337 change of direction in their career and enabled them to acquire a different life perspective.
338 These findings are consonant with research on challenging reproductive experiences (Lafarge
339 et al., 2017), indicating that following a traumatic experience, some women develop new
340 capabilities, a deepened sense of connection to others and a new sense of purpose. In this
341 study, the transformative nature of the experience was also manifest amongst practitioners
342 with some appearing eager to change their practice as a result.

343 Our study has limitations. With eight interviews, the sample size is small. However, it
344 fulfils IPA's ideographic criterion (Smith et al., 2009), and reflects the low incidence of these
345 obstetric situations. Participants were well-educated, therefore, the risk of bias cannot be
346 excluded. For example, participants' ability to engage in complex reasoning may be reflected
347 in their acceptance of human fallibility and of what can be achieved with technology. Given
348 that the study was conducted in France, the findings may not be transferrable to all settings.
349 However, the findings will be relevant to other Western countries because despite variations
350 in pregnancy care and practice (EUROCAT, 2010) these countries also have well-established
351 prenatal diagnosis care pathways and face wrongful birth litigation (Giesen, 2012).
352 Importantly, our study contributes new insights into women's experiences of their
353 interactions with practitioners when severe abnormalities are discovered at birth. It deepens
354 our understanding as to why women might not file a complaint against the medical team, and
355 highlights the significance of the quality of their interactions with practitioners in preventing
356 them doing so.

357 The study findings have important implications. Practitioners need to be aware of the
358 idiosyncratic nature of women's experiences and avoid framing the birth as a negative event.

359 Women understood the limits of technology and of the care practitioners can provide. They
360 also clearly valued empathy from professionals, as well as transparent information and honest
361 communications. Although practitioners may be hesitant to counsel women beyond their
362 sphere of responsibility, a perceived reluctance to share information or be open about
363 women's situation can undermine trust. Thus, adopting a transparent and open approach may
364 foster trusting relationships with women. This is particularly relevant because, in this study, it
365 was practitioners' ability to relate to women with humanity and their willingness to change
366 that mattered to women; elements that may have significantly contributed to lessening the
367 prospect of litigation.

368

369

References

- 370 Anumba, D. O. (2013). Errors in prenatal diagnosis. *Best Practice & Research Clinical*
371 *Obstetrics & Gynaecology*, 27(4), 537-548.
- 372 Azad, G., Blacher, J., & Marcoulides, G. A. (2013). Mothers of children with developmental
373 disabilities: Stress in early and middle childhood. *Research in Developmental*
374 *Disabilities*, 34(10), 3449-3459. doi: 10.1016/j.ridd.2013.07.009.
- 375 Beighton, C., & Wills, J. (2017). Are parents identifying positive aspects to parenting their
376 child with an intellectual disability or are they just coping? A qualitative
377 exploration. *Journal of Intellectual Disabilities*, 21(4), 325-345. doi:
378 10.1177/1744629516656073.
- 379 Costich, J. F. (2006). The Perruche case and the issue of compensation for the consequences
380 of medical error. *Health Policy*, 78(1), 8-16. doi: 10.1016/j.healthpol.2005.08.007.
- 381 Crombag, N. M., Vellinga, Y. E., Kluijfhout, S. A., Bryant, L. D., Ward, P. A., Iedema-
382 Kuiper, R., ... & Hirst, J. (2014). Explaining variation in Down's syndrome screening
383 uptake: comparing the Netherlands with England and Denmark using documentary

384 analysis and expert stakeholder interviews. *BMC Health Services Research*, 14(1),
385 437. doi: 10.1186/1472-6963-14-437.

386 EUROCAT. (2010). *Prenatal screening policies in Europe* (Special report). University of
387 Ulster: EUROCAT Central Registry. Retrieved from [http://www.eurocat-](http://www.eurocat-network.eu/content/Special-Report-Prenatal-Screening-Policies.pdf)
388 [network.eu/content/Special-Report-Prenatal-Screening-Policies.pdf](http://www.eurocat-network.eu/content/Special-Report-Prenatal-Screening-Policies.pdf)

389 EUROCAT. Overall Proportion of cases prenatally diagnosed, 2013-2017. Retrieved from
390 [https://eu-rd-platform.jrc.ec.europa.eu/eurocat/eurocat-data/prenatal-screening-and-](https://eu-rd-platform.jrc.ec.europa.eu/eurocat/eurocat-data/prenatal-screening-and-diagnosis_en)
391 [diagnosis_en](https://eu-rd-platform.jrc.ec.europa.eu/eurocat/eurocat-data/prenatal-screening-and-diagnosis_en)

392 Fisher, J., & Lafarge, C. (2015). Women's experience of care when undergoing termination
393 of pregnancy for fetal anomaly in England. *Journal of Reproductive and Infant*
394 *Psychology*, 33(1), 69-87. Retrieved from
395 <https://doi.org/10.1080/02646838.2014.970149>.

396 Giesen, I. (2012). Of wrongful birth, wrongful life, comparative law and the politics of tort
397 law systems. *Journal for Contemporary Roman-Dutch Law*, 72, 257-273. Retrieved
398 from https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1424901.

399 Graungaard, A. H., & Skov, L. (2007). Why do we need a diagnosis? A qualitative study of
400 parents' experiences, coping and needs, when the newborn child is severely
401 disabled. *Child: Care, Health and Development*, 33(3), 296-307. doi: 10.1111/j.1365-
402 2214.2006.00666.x.

403 Hassan, M., Chitty, L., & Reardon, H. (2014). Wrongful birth: clinical settings and legal
404 implications. *Seminars in Fetal and Neonatal Medicine*, 19(5), 312-316. Retrieved
405 from <https://doi.org/10.1016/j.siny.2014.08.006>.

406 Kandel, I., & Merrick, J. (2007). The child with a disability: Parental acceptance,
407 management and coping. *The Scientific World Journal*, 7, 1799-1809. doi:
408 10.1100/tsw.2007.265.

409 Lafarge, C., Mitchell, K., & Fox, P. (2017). Posttraumatic growth following pregnancy
410 termination for fetal abnormality: The predictive role of coping strategies and
411 perinatal grief. *Anxiety, Stress, & Coping*, 30(5), 536-550. doi:
412 10.1080/10615806.2016.1278433.

413 Mameri, Q., Fillion, E., & Champenois, B. (2015). Le juge et le diagnostic prénatal depuis la
414 loi du 4 mars 2002. *ALTER-European Journal of Disability Research/Revue*
415 *Européenne de Recherche sur le Handicap*, 9(4), 331-353. Retrieved from
416 <https://doi.org/10.1016/j.alter.2015.09.004>.

417 McConnell, D., Savage, A., Sobsey, D., & Uditsky, B. (2015). Benefit-finding or finding
418 benefits? The positive impact of having a disabled child. *Disability & Society*, 30(1),
419 29-45. Retrieved from <https://doi.org/10.1080/09687599.2014.984803>.

420 McCoyd, J.L. (2009). What do women want? Experiences and reflections of women after
421 prenatal diagnosis and termination for anomaly. *Health Care for Women*
422 *International*, 30(6), 507-535.

423 Moyse, D., & Diederich, N. (2007). Prenatal screening for anomalies: Between clinical
424 finality and selective finality. *Scandinavian Journal of Disability Research*, 9(3-4),
425 254-277. Retrieved from <https://doi.org/10.1080/15017410701680597>.

426 Mutuelle d'Assurance des Professionnels de la Santé. (2019). Rapport annuel sur la
427 sinistralité des professions de santé 2018. Retrieved from:
428 [https://www.macsf.fr/Rapport-annuel-sur-le-risque-medical/risque-des-professions-](https://www.macsf.fr/Rapport-annuel-sur-le-risque-medical/risque-des-professions-de-sante)
429 [de-sante](https://www.macsf.fr/Rapport-annuel-sur-le-risque-medical/risque-des-professions-de-sante)

430 Nelson Goff, B. S., Springer, N., Foote, L. C., Frantz, C., Peak, M., Tracy, C., ... & Cross, K.
431 A. (2013). Receiving the initial Down syndrome diagnosis: A comparison of prenatal
432 and postnatal parent group experiences. *Mental Retardation*, 51(6), 446-457. doi:
433 10.1352/1934-9556-51.6.446.

434 Priestley, M. (Ed.). (2001). *Disability and the life course: Global perspectives*. Cambridge:
435 University Press.

436 Raposo, V. L. (2017). Wrongful birth and wrongful Life Actions. *The Italian Law Journal*, 3,
437 421-450. Retrieved from [http://theitalianlawjournal.it/data/uploads/3-italj-2-2017/pdf-](http://theitalianlawjournal.it/data/uploads/3-italj-2-2017/pdf-singoli/421-raposo.pdf)
438 [singoli/421-raposo.pdf](http://theitalianlawjournal.it/data/uploads/3-italj-2-2017/pdf-singoli/421-raposo.pdf).

439 Santé Publique (2019). Anomalies et malformations congénitales. Retrieved from:
440 [https://www.santepubliquefrance.fr/maladies-et-traumatismes/maladies-de-la-mere-et-](https://www.santepubliquefrance.fr/maladies-et-traumatismes/maladies-de-la-mere-et-de-l-enfant/anomalies-et-malformations-congenitales/donnees/#tabs)
441 [de-l-enfant/anomalies-et-malformations-congenitales/donnees/#tabs](https://www.santepubliquefrance.fr/maladies-et-traumatismes/maladies-de-la-mere-et-de-l-enfant/anomalies-et-malformations-congenitales/donnees/#tabs)

442 Skotko, B. G., Capone, G. T., & Kishnani, P. S. (2009). Postnatal diagnosis of Down
443 syndrome: Synthesis of the evidence on how best to deliver the
444 news. *Pediatrics*, 124(4), e751-e758.

445 Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Approach:*
446 *Theory, method and research*. London: Sage.

447 Ville, I. (2011). Disability policies and perinatal medicine: The difficult conciliation of two
448 fields of intervention on disability. *ALTER-European Journal of Disability*
449 *Research/Revue Européenne de Recherche sur le Handicap*, 5(1), 16-25. Retrieved
450 from <https://doi.org/10.1016/j.alter.2010.11.002>

451 Van Wyk, N. C., & Leech, R. (2016). Becoming the mother of a child with disabilities: A
452 systematic literature review. *Community, Work & Family*, 19(5), 554-568. Retrieved
453 from <https://doi.org/10.1080/13668803.2016.1143806>.

454 Watermeyer, B. (2009). Claiming loss in disability. *Disability & Society*, 24(1), 91-102. doi:
455 10.1080/09687590802535717

456

457