THE MEDICALISATION OF CHILDBIRTH AND ACCESS TO HOMEBIRTH IN THE UK: COVID-19 AND BEYOND

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ABSTRACT

In this article, we explore how the law has perpetuated the medicalisation of childbirth, and outline why this may limit the ability of birthing persons to access and opt for homebirth. We argue that this is inherently problematic because it restricts choice and autonomy in childbirth. We suggest that the widespread blanket withdrawals of home-birthing services by National Health Service trusts during the Coronavirus (COVID-19) pandemic serves as an illustrative example of the broader failure to recognise, both socially and legally, the significance of homebirth for some. We argue that, if framed correctly, the law has the potential to support, rather than restrict, choice regarding place of birth.

KEYWORDS: Autonomy, Birth, COVID-19, Freebirth, Homebirth, Human rights

I. INTRODUCTION

‘Homebirth’ refers to planned birth which occurs at home and is attended by health professionals (usually a midwife). Only 2% of UK births are homebirths.1 However, COVID-19 seemingly made homebirth an increasingly popular choice due to unease

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1 Office for National Statistics, Birth Characteristics in England and Wales: 2017 (ONS 10 January 2019) <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/bulletins/birthcharacteristicsinenglandandwales/2017> accessed 14 June 2021.
about hospitals, concerns about restrictions on birth partners and visitors, and about being separated from the newborn post birth. There is emerging empirical evidence demonstrating this increase in popularity of homebirth during the COVID-19 crisis, and there is substantial anecdotal evidence this too of. In March 2020, Birthrights (a charity which advocates for human rights in childbirth) and the UK Private Midwives Group both noted increased requests for information about homebirth, and media outlets reported that many people who had been planning hospital birth were instead considering homebirth.

Despite the increasing interest in homebirth, National Health Service (NHS) homebirth services became increasingly difficult to access during the COVID-19 pandemic. During the first acute wave of the pandemic (March–June 2020), it was estimated that around one third of trusts suspended their homebirthing services, which resulted in a substantial number of pregnant people in the UK being left without homebirth as an option for much of 2020. And in response to the spread of mutated strains of COVID-19 in early 2021, some trusts in South East England suspended their home-birthing services.

Legal literature considering a person’s right to access services supporting homebirth is limited. The existing literature is either outdated or focused on jurisdictions other than the UK. Thus, rather than focusing solely on the NHS’s handling of homebirth during the acute first wave of the COVID-19 pandemic, we use this as a platform to begin a broader discussion about issues with access to homebirth. These are important, but under-interrogated, aspects of choice in childbirth discourse. These pre-existing issues, we suggest, contributed to the swift decisions to remove/reduce homebirth services in response to the pandemic.

2 Those who desire a hospital birth but are worried about attending hospital during a pandemic, must be given the appropriate reassurances about the safety measures that are in place.
3 M Greenfield, S Payne-Gifford and G McKenzie, ‘Between a Rock and a Hard Place: Considering “Freebirth” During Covid-19’ (2021) 2 Frontiers in Global Women’s Health 1.
4 ‘Record Number of MK Home Births for One Month’ (Milton Keynes University Hospital 2021) <https://www.mkuh.nhs.uk/news/record-number-of-mk-home-births-for-one-month> accessed 29 June 2021.
5 Birthrights, Human Rights Charity Calls for Protection of UK Women in Childbirth During National Emergency (31 March 2020) <https://www.birthrights.org.uk/wp-content/uploads/2020/03/Final-Covid-19-Birthrights-31.3.20.pdf> accessed 16 June 2020.
6 L Bryceland, ‘Coronavirus Strategy Document: Advice for Clients and Staff Working with Private Midwives’ (Private Midwives, 26 March 2020) <https://privatemidwives.com/wp-content/uploads/2020/03/Coronavirus-strategy-V3.1.pdf> accessed 10 July 2020.
7 K Brewer, ‘Birth in a Pandemic: “You Are Stronger Than You Think”’ BBC News (London, 1 April 2020) <https://www.bbc.co.uk/news/stories-52098036> accessed 10 June 2020.
8 H Sherwood, ‘Midwife Shortage Doubles as NHS Staff Diverted to Tend COVID-19 Patients’ The Observer (London, 29 March 2020) <https://www.theguardian.com/society/2020/mar/29/midwife-shortage-doubles-as-nhs-staff-diverted-to-tend-covid-19-patients> accessed 25 June 2020; N Davis, ‘NHS Trusts Begin Suspending Home Births due to Coronavirus’ The Guardian (London, 27 March 2020) <https://www.theguardian.com/world/2020/mar/27/nhs-trusts-suspending-home-births-coronavirus> accessed 25 June 2020.
9 ‘South East NHS Trusts Suspend Births at Home and in Midwife-Led Units’ BBC News (London, 5 January 2021) <https://www.bbc.co.uk/news/uk-england-sussex-55545882> accessed 14 January 2021.
10 We use the term ‘person’ to reflect the fact that not all people with the physiology to get pregnant are women.
In Section II, we address the (misplaced) concerns raised about the safety of homebirth, and demonstrate why access is important. In Section III, we outline the law surrounding homebirth, illustrating that it is complex and piecemeal. Section IV considers how the law perpetuates the medicalisation of childbirth and why this may limit birthing persons’ ability to choose/access homebirth. Since medicalised childbirth is generally considered the norm, academic discussion of legal rights in childbirth has somewhat neglected homebirth.\textsuperscript{11} We address this gap, and demonstrate how the existing legal framework has contributed to reduced access to homebirth in the UK. In Section V, using the COVID-19 restrictions as a case study, we propose that human rights law provides a useful framework through which to better centre the individual birthing person and their choices when making decisions and policies about birthing services.

Much of our critique is based on an argument that birthing is both socially and legally hyper-medicalised. We do not suggest that all medical interventions in birth should be (innately) criticised—we endorse no hierarchy in birth methods and places. Where performed with proper informed consent, medical interventions are important to save the lives and respect the preferences of birthing people. Medicalisation does not refer to the use of medical procedures or medical assistance \textit{per se}, but to the coercive assumptions that birthing with medical assistance/intervention is the only appropriate means of birthing.\textsuperscript{12}

\section*{II. HOMEBIRTH}

Planned homebirth (attended by a health professional)\textsuperscript{13} must be distinguished from freebirth, which is the ‘active decision to birth without trained health professionals present but where maternity care is readily available.’\textsuperscript{14} Before examining how the law interacts with, and frames, homebirth, we demonstrate why access to homebirth matters and why it should be permitted as a reasonable alternative to hospital birth.

\subsection*{A. The Importance of Access to Homebirth}

Each birthing person has their own experiences and values that influence their opinions on childbirth. There are a wide range of reasons why people desire a homebirth. For some, birthing in a familiar environment,\textsuperscript{15} where they can move about freely and can be surrounded by loved ones,\textsuperscript{16} provides a sense of comfort, control, and dignity

\begin{itemize}
  \item Focus is usually directed to refusing caesarean sections or maternal request caesarean sections.
  \item G McKenzie, ‘Understanding Consent in Maternity Care: Offers, Threats, Manipulation and Force’ (2021) 24 The Practicing Midwife 8, 10; C Quarini, ‘Coercion in Maternity Care’ (2016) 338 The Lancet: Correspondence 1277.
  \item See National Childbirth Trust, \textit{Home Birth: Who Will Look After Me?} (NCT 2018) <https://www.nct.org.uk/labour-birth/deciding-where-give-birth/giving-birth-home/home-birth-who-will-look-after-me> accessed 1 July 2020.
  \item C Feeley and G Thomson, ‘Tensions and Conflicts “in Choice”: Womens’ Experiences of Freebirthing in the UK’ (2016) 41 Midwifery 16, 17.
  \item S Morrison and others, ‘Constructing a Home-Birth Environment Through Assuming Control’ (1998) 14 Midwifery 4.
  \item S Fordham, ‘Women’s Views of the Place of Confinement’ (1997) 47 British Journal of General Practice 415.
\end{itemize}
that they do not believe they would be afforded in hospital. Many describe homebirthing as empowering.\(^\text{17}\) For others, homebirth is a means of avoiding unwanted restrictions and medical interventions associated with hospital—\(^\text{18}\) including birthing in a supine position, continuous electric monitoring of foetal heart-beat, and, potentially, the over-cautious use of instrumental delivery.\(^\text{19}\) Desire to avoid interventions may arise from a fundamental belief in the power of one’s own body and intuition,\(^\text{20}\) or as a result of previous birth trauma associated with medical intervention,\(^\text{21}\) or sexual trauma.\(^\text{22}\) Concerns about unnecessary obstetric interventions and the associated consequences are not unwarranted. A 2020 systematic review of ‘high-quality cohort studies’,\(^\text{23}\) concluded that low-risk persons ‘who planned to give birth at home were less likely to experience any . . . intrapartum interventions . . .’\(^\text{24}\) than those who planned to birth in hospital.\(^\text{25}\) Homebirth (where desired) increases the likelihood that a pregnant person has a birthing experience that is ‘both satisfying and safe’.\(^\text{26}\) This is important, as positive birth experiences (characterised by feeling safe, supported, respected, and listened to) are associated with better post-birth mental well-being.\(^\text{27}\)

The benefits of offering homebirth are recognised by UK medical bodies. The Royal College of Midwives (RCM) and the Royal College of Obstetricians and Gynaecologists (RCOG) support homebirth for uncomplicated pregnancies recognising the considerable benefits (outlined above) for pregnant people and families.\(^\text{28}\)

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\(^{17}\) R McCucheon and D Brown, ‘A Qualitative Exploration of Women’s Experiences and Reflections upon Giving Birth at Home’ (2012) 10 Evidence Based Midwifery 1.

\(^{18}\) G Chamberlain, A Wright and P Crowley, ‘Choice and Satisfaction’ in G Chamberlain, A Wright, and P Crowley (eds), Homebirths: The Report of the 1994 Confidential Enquiry by the National Birthday Trust (Parthenon 1997).

\(^{19}\) A Reitsma and others, ‘Maternal Outcomes and Birth Interventions among Women Who Begin Labour Intending to Give Birth at Home Compared to Women of Low Obstetrical Risk Who Intend to Give Birth in Hospital: A Systematic Review and Meta-Analyses’ (2020) 21 EClinicalMedicine 8. For exploration of the unintentional over-cautious use instruments in birth, see S Burrow, ‘On the Cutting Edge: Ethical Responsiveness to Caesarean Rates’ (2012) 12 The American Journal of Bioethics 7.

\(^{20}\) M Nolan, Homebirth: The Politics of Difficult Choices (Routledge 2011) 14–15.

\(^{21}\) H Keedle and others, ‘Women’s Reasons For, and Experiences of, Choosing a Homebirth Following a Caesarean Section’ (2015) 15 BMC Childbirth and Pregnancy 206.

\(^{22}\) R Schiller, ‘Instead of Judging Women Who Want a C-Section, Why Not Listen?’ The Guardian (London, 21 August 2018) <https://www.theguardian.com/commentisfree/2018/aug/21/women-c-section-birth-planning-caesarean> accessed 23 August 2020.

\(^{23}\) ibid 4; A de Jonge and others, ‘Perinatal Mortality and Morbidity in a Nationwide Cohort of 529688 Low-Risk Planned Home and Hospital Births’ (2009) 116 British Journal of Obstetrics and Gynaecology 9.

\(^{24}\) See Birthplace in England Collaborative Group, ‘Perinatal and Maternal Outcomes by Planned Place of Birth for Healthy Women with Low Risk Pregnancies: The Birthplace in England National Prospective Cohort Study’ (BMJ Research, 25 November 2011) <https://www.bmj.com/content/343/bmj.d7400> accessed 21 June 2020.

\(^{25}\) Guys and St Thomas’ NHS Foundation Trust, Home Birth—Why Not? (2015) 4 <https://www.guysandsthomas.nhs.uk/resources/patient-information/maternity/home-birth-why-not.pdf> accessed 1 July 2020.

\(^{26}\) Birth Trauma Association, What is Birth Trauma? (2020) <https://www.birthtraumaassociation.org.uk/for-parents/what-is-birth-trauma> accessed 30 June 2020; A Horsch and S Garthus-Niegel, ‘Posttraumatic Stress Disorder Following Childbirth’ in C Pickles and J Herring (eds), Childbirth, Vulnerability and Law Exploring Issues of Violence and Control (Routledge 2019).

\(^{27}\) Royal College of Obstetricians and Gynaecologists, RCOG Statement on BMJ Home Birth Study (Royal College of Obstetrics and Gynaecologists 14 June 2013) <https://www.rcog.org.uk/en/news/rcog-statement-on-bmj-home-birth-study/> accessed 16 June 2021; Guys and St Thomas’ NHS Foundation Trust (n 26).
National Institute of Health and Care Excellence (NICE) guidelines published in 2014 recommend that healthcare professionals discuss homebirth and birth in a midwifery unit (as opposed to a hospital) with pregnant people during prenatal care.29

B. Homebirth Is Not Sufficiently Unsafe to Justify Restricting Access

Given the importance of choice, and the value that some individuals place on homebirth, there would need to be substantial justification to legitimise restricting access to it. In this section, we demonstrate why arguments presented in favour of limitations on homebirth fail to establish that it is sufficiently unsafe to justify limiting access.

1. Risks to the future child?

One common line of opposition to homebirth focusses on the purported risks to the ‘future child’. De Crespigny and Savelescu argue that ‘the long-term disability [for the future child] that can result from homebirth ... weighs heavily against homebirth’.30 This opposition rests on a belief that ‘the interests of children who will exist in the future are of great moral importance, and need to be given priority’;31 thus, those steps available to avoid ‘foreseeable, avoidable disability’ ought, morally, to be taken.32 Although not proposing a legal ban on homebirth, De Crespigny and Savelescu suggest that opting against homebirth is necessary for the fulfilment of the ‘moral obligation to lower risk to the future child’.33 They argue that pregnant people should be actively counselled against homebirth and suggest that ‘limiting patient access to health funding for homebirth may be appropriate in some countries’.34 Chervenak and others argue that healthcare professionals should inform birthing people who enquire about homebirth that ‘it incurs significantly increased, preventable perinatal risks’ and should recommend ‘strongly’ against home birth and for ‘planned hospital birth’.35

The empirical evidence to ground such opposition is lacking. The large ‘UK Birthplace study’, examining outcomes and interventions in labour by planned place of delivery, concluded that:

our results support a policy of offering healthy nulliparous and multiparous women with low risk pregnancies a choice of birth setting. Adverse perinatal outcomes are uncommon in all settings, while interventions during labour and birth are much less common for births planned in non-obstetric unit settings.36

29 National Institute for Health and Care Excellence, Intrapartum Care for Healthy Women and Babies Clinical guideline [CG190] (NICE 2014) para 1.1.2. <https://www.nice.org.uk/guidance/cg190/chapter/Recommendations#place-of-birth> accessed 24 June 2020.
30 L De Crespigny and J Savelescu, ‘Home Birth and the Future Child’ (2014) 40 Journal of Medical Ethics 807, 807.
31 ibid 809.
32 ibid.
33 ibid 810.
34 ibid.
35 F Chervenak and others, ‘Planned Home Birth in the United States and Professionalism: A Critical Assessment’ (2013) 24 Journal of Clinical Ethics 184.
36 Birthplace in England Collaborative Group (n 25).
Regardless, this opposition is fundamentally unconvincing as the focus of the argument is misplaced. Birth is a process which is undertaken by the pregnant person. Prior to and during the birth they are the only legal person.\textsuperscript{37} Therefore, risks to the ‘future child’ cannot provide justification to override their autonomous preferences. Of course, pregnant people can themselves opt to centre the future child’s well-being in their decision making. And it is imperative that all pregnant people are provided with the information to make an informed choice about place of birth. However, where an informed decision is made to refuse hospitalisation, this must be respected \textit{regardless} of the reasoning or the consequences.\textsuperscript{38} Furthermore, the information must be presented in an unbiased manner that aims to educate rather than frighten.

2. \textit{Risks to the pregnant person}

Though opposition based on concern for the pregnant person’s safety does not have the same inherent flaw as to risks to the future child arguments, there is again simply not the evidence to support the claim that homebirthing is sufficiently unsafe to justify restricting access. The Birthplace Study concluded that ‘maternal outcomes’ (measured as ‘third or fourth degree perineal trauma, maternal blood transfusion, and maternal admission to higher level care’) had ‘no consistent relation with planned place of birth’.\textsuperscript{39} This conclusion sits alongside the fact that homebirth significantly reduces the incidence of obstetric intervention—with the study concluding that those who had a planned homebirth were ‘significantly more likely’ to have what they termed a ‘normal birth’.\textsuperscript{40} This is important as obstetric interventions carry their own risks.

Nevertheless, there is a high incidence of hospital transfer during, or after, birth for those who opt for planned homebirth for their first birth (around 45%), but this drops significantly for subsequent births (to around 12%).\textsuperscript{41} Although birthing people must be informed of this when deciding about place of birth, these figures do not provide convincing reasons to restrict access to homebirth given that an ambulance service is integrated into the UK healthcare system.

3. ‘Risk’ and the hospital as a place of safety

The conception of ‘risk’ that is central in opposition to homebirth, frames hospitals as comparatively safer birth locations. However, hospitals might not always be safe environments, particularly for those who have previously been victims of, or are aware of others’ experiences of, obstetric violence. Obstetric violence is:

\begin{quote}
the appropriation of women’s bodies and reproductive processes by health personnel which bring with it a loss of autonomy and the ability to decide freely
\end{quote}

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\textsuperscript{37} Paton v Trustees of British Pregnancy Advisory Service [1979] QB 276.  \\
\textsuperscript{38} Montgomery v Lanarkshire Health Board [2015] UKSC 11.  \\
\textsuperscript{39} Birthplace in England Collaborative Group (n 25).  \\
\textsuperscript{40} Birth without induction of labour, epidural or spinal analgesia, general anaesthesia, forceps or ventouse delivery, caesarean section, or episiotomy (ibid).  \\
\textsuperscript{41} Birthplace in England Collaborative Group (n 25) Table 2.
\end{flushright}
about their bodies and sexuality, and which has a negative impact on the quality of women’s lives.42

This can range from interventions such as vaginal examination or episiotomy without consent,43 to coercive control,44 and emotional abuse on the part of staff. Obstetric violence particularly impacts on minoritised people in UK obstetric care and many black birthing people report feeling that they were not ‘listened to’ during their delivery.45 Black people who birth in UK hospitals are four times more likely to die in birth than white people,46 so it is easy to understand why minoritised groups may not recognise hospitals as safe places. Given this, what happens to arguments based on the relative safety of hospitals if we consider that they are not always places that are safe, or perceived as safe, because of the risk of obstetric violence/compulsion and the known harm that can result?47 Asking this question does not prove that homebirth is safe (or safer than hospital birth), but is important to displace the widespread and frequently unquestioned notion that hospital birth is always safe in the conversation about birth settings.

Although precise information about the prevalence of obstetric violence is not available, there is sufficient (and increasing) recognition of such violence to support the assertion that any safety-based position against homebirth which fails to consider issues of obstetric violence is fragmentary. While no definitive conclusions can be reached, it is plausible that homebirth may reduce the incidence of such violence. This is not to say that obstetric violence cannot occur when birth takes place at home; however, the power structures embedded within the healthcare setting operate to enable obstetric violence to continue unchallenged in hospitals. Birthing at home weakens the link to such structures to some extent, by physically locating the patient–health professional relationship in a more neutral, levelled environment.48 Furthermore, birthing in a familiar environment can be empowering and people may feel better able to advocate for themselves.49

C. The Incidence of Homebirth in the UK

Despite the recognition by medical bodies that homebirth is important and sufficiently safe to be offered as a birthing option, and the integration of homebirthing
services in trusts across England and Wales, only 2.1% of pregnant people in England and Wales gave birth at home in 2017. One barrier to homebirth appears to be the culture of medicalisation normalising birth in hospital, resulting in a lack of access to information about homebirths. There is a substantial body of research which observes that people are not adequately counselled about place of birth. In 2016, the RCM Chief Executive highlighted that homebirths had the potential to offer a ‘real choice’ to pregnant people and were they to have access to the appropriate information, more people would choose homebirth than currently do.

That pregnancy and childbirth have, over the past few centuries, ‘become increasingly influenced by medical technology’, is not a new observation. From the moment a person realises they are pregnant (or before, for those who seek advice or assistance with conception) to the point of childbirth, they can expect regular engagement with healthcare professionals. This shift, termed the ‘medicalisation of pregnancy’, has led to a reconceptualisation of pregnancy as a ‘disruption to health’ which ‘requires expert medical intervention’. The result is that:

Pregnant [people’s] bodies are increasingly a site of surveillance and intervention, with an extension of the role of health care professionals, for example, into increased use of testing technologies to assess risk exposure.

Pregnant people may lack the confidence to break from the expectations of the medical model of pregnancy and childbirth. This model is propagated not only by health professionals but also the expectations of others including a pregnant person’s family, friends, and acquaintances. The social prevalence of medicalised conceptions of

50 Office of National Statistics (n 1).
51 There are a diverse range of reasons why people chose to hospital birth and we are equally supportive of this decision. However, at present, we contend that the choice to birth in hospital, for many, may be a ‘false choice’ in that they do not believe that there is another option at all.
52 Only 18% of birthing people in 2015 reported being offered homebirth as an option: Care Quality Commission, 2015 Survey of Women’s Experiences of Maternity Care (Care Quality Commission 2015) <http://www.cqc.org.uk/content/maternity-services-survey-2015> accessed 5 May 2016.
53 C Warwick, ‘Women Who Want Home Births Shouldn’t be Denied Them - Even Against Medical Advice’ The Telegraph (London, 10 October 2016) <https://www.telegraph.co.uk/health-fitness/body/women-who-want-home-births-shouldnt-be-denied-them—even-agains/> accessed 27 May 2020.
54 R Johanson, M Newburn and A Macfarlane, ‘Has the Medicalisation of Childbirth Gone Too Far?’ (2003) BMJ Education and Debate 892 <https://www.bmj.com/content/324/7342/892> accessed 15 June 2020.
55 Burrow (n 19); AB Wolf and S Charles, ‘Childbirth Is Not an Emergency: Informed Consent in Labor and Delivery’ (2018) 11 International Journal of Feminist Approaches to Bioethics 1; EC Romanis, ‘Addressing Rising Caesarean Rates: Maternal Request Caesareans, Defensive Practice, and the Power of Choice in Childbirth’ (2020) 13 International Journal of Feminist Approaches to Bioethics 1.
56 Johanson and others (n 54).
57 A Mullin, Reconceiving Pregnancy and Childcare: Ethics, Experience, and Reproductive Labor (CUP 2005) 54.
58 C Murray, H Trickey and R Blaylock, ‘Findings from a Roundtable Workshop on the Communication of Pregnancy and Risk’ (WRISK Project November 2018) <https://www.wrisk.org/wp-content/uploads/2018/12/Workshop-output_FINAL_Dec18.pdf> accessed 15 June 2021.
59 D Lupton ‘Precious Cargo’: Foetal Subjects, Risk and Reproductive Citizenship’ (2012) 22 Critical Public Health 329; K Coxon and others, ‘What Influences Birth Place Preferences, Choices and Decision-Making amongst Healthy Women with Straightforward Pregnancies in the UK? A Qualitative Evidence Synthesis Using a “Best Fit” Framework Approach’ (2017) 17 BMC Pregnancy and Childbirth 1, 10.
pregnancy and birth could explain why there has not been an increase in homebirth since the 2014 NICE guidelines indicated that pregnant people should be counselled about place of birth.60 Socio-medical factors may influence choice such that opting for homebirth is made more difficult.61 Such factors should not be used to discourage (or disallow) the making of particular choices; if pregnant people feel more comfortable giving birth in a hospital (or not)—that is their prerogative. Nonetheless, we must consider how choices are constrained by a (legally supported) culture of medicalisation.

III. NON-HOSPITAL BIRTH AND THE LAW
Pregnant people with capacity cannot be compelled to give birth by a particular method,62 or in a particular place. It is a fundamental principle of English law that any capacitous person can consent to or refuse any medical intervention,63 including obstetric intervention.64 That a person is entitled to determine what medical intervention or assistance they wish to accept, means that the law is theoretically supportive of the choice of where to birth (as well as how to birth). In Montgomery v Lanarkshire,65 the Supreme Court emphasised that pregnant people have a right to make decisions about their birth:

gone are the days when it was thought that, on becoming pregnant, a woman lost, not only her capacity, but also her right to act as a genuinely autonomous human being.66

In this case, emphasis was placed on a doctor’s obligation to disclose risks of particular childbirths, including vaginal delivery (VD). Given the emphasis placed on the need to inform the pregnant person about the non-medical birthing option represented by VD, it is a plausible interpretation of Montgomery that there is a duty to counsel about non-hospital birth setting alternatives regarding childbirth.67 This claim is bolstered by the judgment in Birch, in which an obligation to disclose alternative treatment options (that carry the same or fewer risks) was found to exist.68 Even if there is not a legal obligation to discuss non-hospital birthing settings with pregnant people, NICE guidelines recommend that a conversation about non-hospital options is initiated.69

60 National Institute for Health and Care Excellence (n 29).
61 S Burrow, ‘Reproductive Autonomy and Reproductive Technology’ (2012) 16 Teche: Research in Philosophy and Technology 1; Coxon and others (n 59).
62 They cannot be compelled to give birth by caesarean or to accept any particular medical intervention. This gets more complicated when thinking about whether pregnant people are compelled to give birth by vaginal delivery if maternal request caesarean is refused, see EC Romanis, ‘Why the Elective Caesarean Lottery is Ethically Impermissible’ (2019) 27 Health Care Analysis 249.
63 Re T (Adult: Refusal of Medical Treatment) [1992] 4 All ER 649 (CA).
64 Re MB [1997] 2 FLR 426 (CA); Re S (Adult: Refusal of Medical Treatment) [1992] 3 WLR 8; GSTT, SLAM v R [2020] EWCP 4; Re AA [2012] EWHC 4378 (COP); NHS Trust v JP [2019] EWCOP 23.
65 Montgomery (n 38).
66 ibid 117.
67 Romanis (n 55) 14–18.
68 Birch v University College Hospitals NHS Trust [2008] 104 BMLR 168.
69 National Institute for Health and Care Excellence (n 29).
And if a choice to give birth outside an obstetric unit is made, then it must be respected. In Montgomery, Lady Hale observed that:

A patient is entitled to take into account her own values, her own assessment of the comparative merits of giving birth in the 'natural' and traditional way and of giving birth by caesarean section, whatever medical opinion may say, alongside the medical evaluation of the risks to herself and her baby. She may place great value on giving birth in the natural way and be prepared to take the risks to herself and her baby which this entails. The medical profession must respect her choice, unless she lacks the legal capacity to decide.70

A capacitous pregnant person cannot, thus, be compelled to attend a hospital to birth. Therefore, English law recognises a negative right to homebirth.71 However, as homebirth involves the assistance of a midwife, this choice can only be realised if trusts provide an 'enabling' service. The NHS Choice framework recommends that such services are made available,72 which is consistent with NICE guidelines.73 However, there is no legal requirement for an NHS trust to offer this service as neither trusts nor health professionals have a specific obligation to comply with NICE guidelines,74 nor can an individual demand that a particular service be provided.75 Nonetheless, the Human Rights Act 1998 makes it incumbent upon the NHS, as a public body, to consider the patient’s right to life when making any decision. If a person who has chosen to birth at home without the attendance of a midwife (because no homebirth service is offered) encounters significant and potentially life-threatening difficulties during that delivery, which could be mitigated by the attendance of a midwife, and they alert the hospital to this (for example, by phoning the midwifery team), the trust may be required to dispatch a midwife in order to fulfil their duties under Article 2.76 Failing to do so would constitute a failure to provide emergency medical assistance. The Nursing and Midwifery Council Code of Practice emphasises the importance of offering help when an emergency arises in their practice setting or elsewhere.77 Midwives, thus, have a professional obligation to attend a homebirth if they know or believe that the pregnant person or

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70 Montgomery (n 38) 116.
71 B Dimond, ‘Is There a Legal Right to a Home Confinement?’ (2000) 8 British Journal of Midwifery 316, 316.
72 Department of Health and Social Care, The NHS Choice Framework: What Choices Are Available to Me in the NHS? (Department of Health and Social Care 14 January 2020) <https://www.gov.uk/government/publications/the-nhs-choice-framework/the-nhs-choice-framework-what-choices-are-available-to-me-in-the-nhs> accessed 24 June 2020.
73 National Institute for Health and Care Excellence (n 29).
74 ‘NICE Charter 2017’ (National Institute for Health and Care Excellence 2017) <https://www.nice.org.uk/about/who-we-are/our-charter> accessed 30 June 2020.
75 Burke, R (on the application of) v General Medical Council & Ors [2005] 3 WLR 1132; Montgomery (n 38).
76 ECHR art 2—right to life; Birthrights, Factsheet: Choice of Place of Birth (April 2017) <https://www.birthrights.org.uk/factsheets/choice-of-place-of-birth/> accessed 24 June 2020.
77 Nursing and Midwifery Council, The Code: Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates (29 January 2015) para 15. <https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf> accessed 2 July 2020.
their foetus/baby to be at risk without assistance, and they may face disciplinary action if they do not assist.

There are further complex legal rules surrounding homebirth. Article 45 of the Nursing and Midwifery Order 2001 makes it a summary offence (across the UK) for a person ‘other than a registered midwife or a registered medical practitioner’ to ‘attend a woman in childbirth’ except where sudden or urgent necessity requires them to. It is not clear what constitutes ‘attending’ a birthing person. This lack of clarity may cause concern for some birthing people and their birth partners. While Article 45 is primarily intended to prevent individuals from falsely claiming to be professionals qualified to assist with birth, the wording of the provision technically encompasses broader circumstances than this.

There are also administrative legal requirements surrounding birth that could be more difficult for those who homebirth to navigate. All births must be registered within 42 days of delivery with the local registry office; however, there is an additional requirement that births that take place at home are notified within 6-36 hours (depending upon the exact circumstances). Birth notification and registration are different processes that can be confusing for families because they are administrative processes that people are unfamiliar with until the point at which they have to complete them. Moreover, the conspicuously short time frame for notification and the limited information available about how to notify about a birth, add to the administrative difficulties experienced by people who choose non-hospital settings to give birth. The administrative system is set up with hospital birth as the norm, and the involvement of a midwife as a given, which demonstrates the pervasiveness of birth as a medicalised process. The short time frame for notification is indicative of the suspicion surrounding unsupervised, non-hospital birth and gives the impression that authorities need to know about these births particularly quickly and that authorities believe they are more likely to need to intervene in these families. These administrative hurdles can be off-putting or a source of anxiety. One woman described her horror at the police turning up at her home explaining that she had been reported for ‘child trafficking’ after a registration error after her fifth child was born at home. Such experiences, where people are aware of them, may scare others considering homebirth. While we cannot know that people wanting to homebirth always hear the experiences of others, this is likely in instances where they do research or join support groups/social media sites where experiences are shared.

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78 Childbirth is not innately an emergency, but emergency situations can arise and midwives are compelled to attend when they do.
79 Nursing and Midwifery Order 2001, art 45(1), (2); there is an exception for student midwives.
80 Births and Deaths Registration Act 1953, s 2(1).
81 Notification of Births Act 1907, s 1; G McKenzie, ‘Freebirth, Unassisted Childbirth and Unassisted Pregnancy’ (AIMS, 30 March 2020) <https://www.aims.org.uk/information/item/freebirth> accessed 29 September 2021.
82 A simple Google search for how to notify a birth directs the search to the NHS digital site about birth notification, and it is written in terms specific to hospital births (regarding time frames, etc.) <https://digital.nhs.uk/services/birth-notification-service>. All other top hits relate to birth registration.
83 R Schiller, ‘The Women Hounded for Giving Birth Outside the System’ The Guardian (London, 22 October 2016) <https://www.theguardian.com/lifeandstyle/2016/oct/22/hounded-for-giving-birth-outside-the-system> accessed 14 May 2021.
There are criminal offences pertinent to non-hospital birth too. First, the failure to register a birth is a summary offence sanctioned by a fine. Secondly, the offence of concealment of birth is committed when a person secretly disposes of the body of a born child, whether the child was stillborn or died just after birth. The offence, punishable by a custodial sentence, is only committed if the child was capable of being born alive. There is no legal authority that clarifies the point in a pregnancy at which concealment is committed if a human entity was delivered and it was not reported. Milne suggests that the assessment is likely to be made in line with the legal definition of stillbirth - at 24 weeks’ gestation and beyond. It is necessary to register a stillbirth, but not a miscarriage. This provision is again shrouded in suspicion of people birthing outside of hospitals and their motivations.

Finally, for many who birth at home (whether assisted by a midwife or not), there are anxieties about the involvement of child protective services as a result of their birth choices. Birthrights emphasise, and we agree, that choice of birth place should not alone be justification to question a person’s capacity to parent to local authorities. However, this is the experience of some people. For example, one woman reported that she felt that she had ‘no option’ but to freebirth when it became clear a homebirth would not be available due to COVID-19 restrictions. She reported that her midwife, upon learning of her plans, warned her ‘that children’s services could be notified’. In a different context, the House of Lords has held that a person’s behaviour while pregnant was admissible evidence in care proceedings. In that case, substance abuse during pregnancy was found to be relevant evidence. We suggest that the same cannot be said regarding a choice about delivery, because pregnant people make these choices with their personal welfare and the welfare of their foetus in mind. Nevertheless, despite being legal and often safe, there are indications that opting for a homebirth could be used/accepted as evidence against a person’s capacity to parent, although it should not be.

As the above indicates, the law relating to homebirth is piecemeal. Homebirth is legal and NHS policy is that it should be facilitated; however, there are operative legal mechanisms that may create obstacles for some people, or at the least make the process more difficult. Much of the law surrounding birth has evidently been constructed with the assumption that hospital birth is the norm (for example, administrative processes assume this). Against the background of the medicalisation of pregnancy that we outline in the following section, and the suspicion of homebirth among some...
IV. THE PERPETUATION OF MEDICALISED CHILDBIRTH AND THE IMPACT ON HOMEBIRTH

The medicalisation of childbirth has long been observed in sociological literature. Rothman notes that the medical establishment has consistently pathologised the female body as oppositional to the male body, and thus childbirth has become a process that must be ‘managed’.94 It was with this attitude that the 1970 Peel Committee recommended that homebirth no longer be offered by the NHS, on the grounds that medical supervision on obstetric maternity units was safer.95 Shaw and Kitzinger explain that this recommendation was not supported by evidence,96 and was indicative of how childbirth was socially construed as ‘dangerous’ to the degree that health policy was framed around the necessity of medical supervision. While studies have repeatedly evidenced the factual inaccuracy of the increased relative safety of hospital supervised birth compared to homebirth,97 recommendations by professional medical bodies have shifted,98 and homebirth is technically available through most NHS trusts (outside of the pandemic).99 Yet, social and medical attitudes towards homebirth remain those of suspicion.

A significant body of work that explores how contemporary medical and social attitudes continue to perpetuate the hyper-medicalisation of childbirth, with the result of significantly impacting upon the autonomy of pregnant and birthing people, already exists.100 However, most of this work considers the hospital setting as a given, focusing on the extent to which childbirth has been framed as an emergency when medically supervised, increasing the likelihood of obstetric intervention (for example, caesarean section). There is far less literature on how the ongoing medicalisation of childbirth ‘others’ homebirth, entrenching doubt about it as a valid birthing option. In this section, we consider how the law has medicalised childbirth with this specific

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93 See Chervenak (n 35).
94 B Katz Rothman, In Labor: Women and Power in the Birthplace (W.W. Norton & Co 1982) 37.
95 ibid 60.
96 R Shaw and C Kitzinger, ‘Calls to a Homebirth Helpline: Empowerment in Childbirth’ (2005) 61 Social Science and Medicine 2375, 2378.
97 Reitsma and others (n 19).
98 National Institute for Health and Care Excellence (n 29).
99 Trusts impose their own de facto limitations on who can access planned homebirth, with considerations including age and weight of the birthing person, previous birth complications or multiple births.
100 Wolf and Charles (n 55) 23; Burrow (n 61) 31; Romanis (n 55) 10; S Halliday, ‘Court-Authorised Obstetric Intervention Insight and Capacity, a Tale of Loss’ in C Pickles and J Herring (eds), Childbirth, Vulnerability and Law Exploring Issues of Violence and Control (Routledge 2019) 178.
impact: limiting access to homebirth. The law, as an institution that is influenced by
social norms and interpreted in the light of social conditions, has an important role in
revealing trends about (and signalling) the social acceptability of certain practices.
The law has consistently framed birth as a medical procedure in need of medical su-
pervision. Deferral to routine obstetric practice is legally supported. In a system that
values and perpetuates medical hegemony, such signalling can make it difficult to opt
for homebirth without feeling that one is being difficult and/or irresponsible.

The dominance of the medical model of birth is evident in the summary offence of
‘attending’ a childbirth if unqualified,101 as this ‘is a formalised attempt to medicalise
pregnancy and childbirth and take away control from the labouring’ person.102 The
provision reinforces the medical nature of childbirth by labelling it as something exclu-
sively within the remit of certain health professions. While this provision does not
criminalise those who assist others delivering in non-hospital settings, it does prevent
them from ‘attending a birth’ (we take this to mean ‘acting as a midwife’) if they are
not qualified to do so. We are unaware of any prosecution resulting from this provi-
sion; the effect of the Article appears to be more in its signalling. Consideration of the
Article’s claiming childbirth for the midwifery profession, combined with the extent to
which the law has interfered in birthing people’s choices, reveals a powerful legal
norm. Childbirth is, in the eyes of the law, a medical matter.

While the law is theoretically supportive of choice in childbirth, including home-
birth, medicalisation of childbirth has prevented the wholesale realisation of this prin-
ciple. There remains concern about the extent to which birthing peoples’ autonomy is
respected when their preferences conflict with obstetric advice. The (en)forced cae-
sarean cases reaffirm the principle of non-interference and the importance of con-
sent;103 however, they also reinforce a curious notion that the conditions of
pregnancy and childbirth impact on a person’s capacity to consent. Harrington
observes that ‘the right to refuse, conceded in such high terms as a matter of first prin-
ciple is frequently undermined by the courts’ use of available common law resources
in determining capacity’.104 And Halliday argues that:

the very fact that a [birthing person] has refused to accept medical advice opens
up the question of capacity; thereafter [their] disagreement with medical advice
raises questions about GH’s insight, rendering [them] yet more vulnerable to a
finding of incapacity.105

Hayden J recently noted in the high court that it is:

important to acknowledge... that judges in the past may have strained to con-
clude that women, in these difficult circumstances, lacked decision making

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101 Art 45 of the Nursing and Midwifery Order 2001.
102 EC Romanis and others, ‘Reviewing the Womb’ (2020) Journal of Medical Ethics (online first) 1, 10.1136/
medethics-2020-106160.
103 Re MB (n 64); Re S (n 64).
104 J Harrington, ‘Privileging the Medical Norm: Liberalism, Self-Determination and Refusal of Treatment’
(1996) 16 Legal Studies 358.
105 Halliday (n 100) 179.
capacity in order, for the highest of motives, to protect the life or health of the mother and her unborn child.106

The (en)forced caesarean cases often have the unfortunate implication that, by virtue of the conditions of labour, birthing people are not sufficiently capable of decision-making to have legal capacity with regards to decisions about their mode of delivery. In *Rochdale v C*,107 Johnson J noted that C was incapacitated because they were:

in the throes of labour with all that is involved in terms of pain and emotional stress... [and] a patient who could, in those circumstances speak in terms which seemed to accept the inevitability of her own death, was not a patient who was able to properly weigh-up considerations that arose so as to make any valid decision.108

This judicial sentiment that that being in labour is or could be a barrier to capacity in itself is rife. In *Norfolk and Norwich v W*,109 Johnson J (again) noted that labour can constitute a barrier to decision-making when the birthing person is ‘called upon to make [a] decision at a time of acute emotional stress and physical pain in the ordinary course of labour’.110 Such decisions seem to establish a lack of capacity merely by reference to birthing, which is, in itself, a way of pathologising the process because it renders the pregnant person ‘deficient’.111

More recently, in *GSTT, SLAM v R*,112 all parties agreed that R had capacity to make decisions about antenatal care and delivery, but the hospital sought an anticipatory declaration regarding the legalities of performing obstetric interventions were she to become incapacitated. They stipulated that there was a ‘substantial risk of a deterioration in R’s mental health, such that she would likely lose capacity during labour’.113 This judgment reinforced the familiar narrative that the process of birthing renders a person incapacitated,114 with Hayden J remarking that:

loss of capacity in the process of labour may crucially inhibit a woman’s entitlement to make choices. At this stage the court is required to step in to protect her recognising that this will always require a complex, delicate and sensitive evaluation of a range of her competing rights and interests.115

106 *GSTT, SLAM* (n 64) [56].
107 *Rochdale Healthcare (NHS Trust) v C* [1997] 1 FCR 274.
108 Ibid 275.
109 *Norfolk and Norwich Healthcare NHS Trusts v W* [1997] 1 FCR 269.
110 Ibid 272 (emphasis added).
111 S Fovargue and J Miola, ‘Are We Still Policing Pregnancy’ in C Stanton and others (eds), *Pioneering Healthcare Law: Essays in Honour of Margaret Brazier* (Routledge 2016); C Murray, ‘Troubling Consent: Pain and Pressure in Labour and Childbirth’ in C Pickles and J Herring (eds), *Women’s Birthing Bodies and the Law: Unauthorised Intimate Examinations, Power and Vulnerability* (Hart 2020).
112 *GSTT, SLAM* (n 64).
113 Ibid [2].
114 S Villermia, ‘When a Uterus Enters the Room, Reason Goes out the Window’ in C Pickles and J Herring (eds), *Women’s Birthing Bodies and the Law: Unauthorised Intimate Examinations, Power and Vulnerability* (Hart 2020).
115 *GSTT, SLAM* (n 64) [67].
These cases, and others, evidence that in practice birthing people seem generally unable to refuse medical intervention where doctors are willing to pursue legal action.\textsuperscript{116} Deference to medical opinion in these cases is evident. There are no reported cases in which a person ‘in the throes of labour’ has not been found to be incapacitated—and judgment not made in favour of obstetric intervention. Cases are usually brought in time-limited circumstances (once labour has already begun), which may distinguish them, to some extent, from a case about place of birth which is not raised as a matter of ‘emergency’. Nonetheless, the decisions demonstrate the extent to which the medicalisation of childbirth is pervasive and perpetuated by the law, as well as the fact that birth choices that do not defer to routine obstetric practice have been successfully challenged through the courts.

That the law operates in a manner which has a negative impact on pregnant people’s ability to have their choices about birth respected is further evidenced in GSTT, SLAM,\textsuperscript{117} which demonstrates a willingness to pre-authorise certain treatment in the event that a particular person does become incapacitated while labouring. This might be significant for someone planning a homebirth whose decision is not supported by the professionals attending to their prenatal care. This case does, however, illustrate a more compassionate and birthing person-centred approach to choices about delivery, as Hayden J commented that in this case the pregnant person’s:

\begin{quote}
instincts and intuitive understanding of her own body (which were entirely correct) led to her strenuous insistence on a natural birth... there is nothing at all to suggest that R was motivated by anything other than an honest belief that this was best for both her and her baby.\textsuperscript{118}
\end{quote}

Such an observation is promising for those who might seek homebirth, as there is recognition afforded to the birthing person’s motivations for resisting unwarranted obstetric intervention.

The year 2021 saw the first reported case in which a person’s choice of birthing location was disputed. In \textit{East Lancashire v GH}\textsuperscript{119} a woman with anxiety, depression, and severe agoraphobia opted for a homebirth as she considered her home her ‘safe space’.\textsuperscript{120} GH was initially deemed to have capacity to make decisions about her pregnancy and birth and had agreed to admission to hospital became necessary during the labour.\textsuperscript{121} GH went into labour at home but labour became obstructed and failed to progress beyond the first stage. Seventy-two hours after her waters had broken, she was advised to attend hospital urgently for treatment because there were significant risks to both her and the foetus in not doing so. GH refused consent to hospital transfer, and the trust made an out-of-hours application to the Court of Protection. GH was deemed to lack capacity to refuse hospital transfer. After considering GH’s

\begin{itemize}
\item \textsuperscript{116} Halliday (n 100); Fovargue and Miola (n 111).
\item \textsuperscript{117} GSTT, SLAM (n 64).
\item \textsuperscript{118} ibid [63].
\item \textsuperscript{119} \textit{East Lancashire NHS Trust v GH} [2021] EWCOP 18.
\item \textsuperscript{120} ibid [6].
\item \textsuperscript{121} ibid [5].
\end{itemize}
previously expressed desire to ensure healthy outcomes for her and her foetus, and her family's wishes, MacDonald J made the order for GH to be transferred to hospital 'by means of the use of sedation and reasonable force if further gentle persuasion fail[ed]'.

Several aspects of this judgment have similar innate problems as the (en)forced caesarean cases. First, GH’s case was heard as an emergency out-of-hours application—despite the emphasis placed on early management of cases involving birthing people with serious mental illnesses. GH’s agoraphobia was linked to a ‘distressing event’, the anniversary of which fell at the anticipated time of birth (as acknowledged in the judgment). It could, and should, have been anticipated that she may be unable to leave the home as a result, but the Trust was not criticised for failing to devise a management plan that was more attentive to this and, consequently, to the importance of avoiding an emergency application. This highlights how illusory previous rulings that direct a more pregnant person-centred approach are, since they do not appear to have directed better practice. More carefully considering the circumstances and anticipating potential issues would have enabled the relevant health professionals to gather a ‘great deal more evidence on GH’s considered views, priorities, risk tolerance and wishes’. This process is not only required when a patient lacks capacity, but could have better protected GH’s dignity by ensuring that her voice was centred if legal action became necessary.

Secondly, GH was deemed to have capacity until she refused to comply with medical advice. At this point, her anxiety and agoraphobia was determined to have ‘become the dominant feature in her decision making’ such that she lacked the capacity to decide whether to attend hospital. The professional undertaking the capacity assessment stated that GH was unable to use and weigh information about the reasonable foreseeable consequences of the available options to make a decision, as she was ‘fixated’ on the notion that the risks of not attending the hospital would not materialise for her provided she was in her ‘safe space’, which would, ‘by itself enable her body to successfully deliver the baby’. MacDonald J relied heavily on this evidence to reach his decision about GH’s lack of capacity, explaining that:

This is not a case in which GH has acknowledged the risk of serious injury or death, weighed that risk and then rejected that risk in favour of an unwise course of action but rather a case in which GH simply does not acknowledge

122 The ‘best interests’ assessments undertaken in cases where a pregnant person is found to lack capacity are limited; R Fletcher, ‘On Care, Coercion and Childbirth in the Court of Protection’ (Open Justice Court of Protection Blog, 5 July 2021) <https://openjusticecourtofprotection.org/blog-2/> accessed 8 July 2021.
123 GH (n 119) [40].
124 GSTT, SLAM (n 64).
125 Birthrights, Agoraphobia and Mental Capacity–A New Obstetric Intervention Case (7 April 2021) <https://www.birthrights.org.uk/2021/04/07/blog-agoraphobia-and-mental-capacity-a-new-obstetric-intervention-case/> accessed 15 May 2021.
126 Mental Capacity Act 2005, s 3.
127 GH (n 119) [5].
128 Mental Capacity Act 2005, s 3(4)(a).
129 This is an element of the functional capacity test outlined in Mental Capacity Act 2005, s 3(1)(c).
130 GH (n 119) [13].
the risk of serious injury or death or accept that the risk of serious injury or death is relevant to her as long as she remains in her ‘safe space’. ...this demonstrates that GH’s agoraphobia and anxiety has overwhelmed her ability to use and weigh the information required to decide whether to agree to be admitted to hospital. ...\textsuperscript{131}

This decision continues the trend of making harmful assumptions about pregnant people—particularly, with regards to the perceived objective irrationality of GH’s position being used as grounds to question it—or to suggest that she had not engaged in a decision-making process because she had not acknowledged risks in a particular way. She \textit{had} expressed a clear belief in the power of her own body, which was simply dismissed as evidence of a failure to engage with the reality of her situation. Other notable similarities to the (en)forced caesarean cases are the predominance of \textit{clinical} risk throughout the reasoning,\textsuperscript{132} and, arguably, a lack of emphasis on the risk to GH’s overall well-being and mental health if she was not only forced to leave her ‘safe space’ but also \textit{sedated}, and the repeated, explicit references to the safety of not only GH but also her ‘unborn baby’.\textsuperscript{133}

The (en)forced caesarean cases have long illustrated that law ‘on paper’ says that all capacitous people have the right to refuse interventions, but that in practice they rarely do. GH’s case clearly establishes that this is also true in instances where people seek to refuse intervention into their choices about where to birth.

\section*{V. HOMEBIRTH AND HUMAN RIGHTS}

The human rights of birthing people remain under-considered in the context of homebirth. We suggest that using a human rights lens has the potential to more fully centre the birthing person, and, as such, provides a counter-balance to the aspects of the law which have contributed to the medicalisation of birth. We test this hypothesis by critiquing the response to pandemic in the context of human rights, demonstrating that this aspect of the law is more responsive to the harms associated with the denial of access to homebirthing, particularly because human rights law has dignity as a core value. A human rights approach thus provides a valuable opportunity for the law to support, rather than undermine, autonomy and enhance access to choice about place of birth.

\subsection*{A. Homebirth under the European Convention on Human Rights}

Under the European Convention on Human Rights (ECHR), states are afforded a wide margin of appreciation regarding whether to permit homebirth. Chen and Cheeseman argue that the inconsistent approach of the European Court of Human Rights (ECtHR) to homebirth illustrates ‘the influence that existing domestic processes and regulations have on the willingness of the court to mandate change within

\textsuperscript{131} ibid [13].

\textsuperscript{132} ibid.

\textsuperscript{133} GH (n 119) [7], [31], [36]. In May 2021, another case concerning a pregnant woman with agoraphobia wishing to birth at home was heard in the Court of Protection under Holman J, but this case was brought \textit{in advance} of any emergency circumstances having arisen. It was held that she could be removed from her home on a specified date before her due date to give birth in hospital: \textit{A NHS Foundation Trust; A NHS Foundation Trust v An Expectant Mother} [2021] EWCOP 33.
a member state.\textsuperscript{134} Despite having reached different conclusions about the relative safety of homebirth in two conflicting decisions,\textsuperscript{135} the ECtHR has been clear that where homebirth is permitted by law, states have an obligation not to interfere with access unless this is necessary and in accordance with the law.\textsuperscript{136} In \textit{Ternovszky}, the ECtHR found that the applicant’s Article 8 rights had been violated where homebirth was unavailable to her, because the interference with her right to homebirth (given that homebirth was lawful in Hungary) was not done in accordance with the law.\textsuperscript{137} The ECtHR held that Hungarian laws surrounding homebirth were not accessible and foreseeable, as required by the Convention.\textsuperscript{138} As homebirth is legal in the UK, and guidelines and policies are in place to organise service provision, any denial of access to this must comply with ECHR requirements.

### B. Human Rights: Dignity and the Individual

Dignity plays a prominent role in the application and interpretation of the ECHR.\textsuperscript{139} It is a central pillar of the European human rights framework and the ECtHR has, on several occasions, ‘emphasised that respect for human dignity forms part of the very essence of the Convention’.\textsuperscript{140} While there is no clear consensus on the meaning of dignity,\textsuperscript{141} it is a concept that ‘encompasses the twin ideals of respect and autonomy’.\textsuperscript{142} Beyleveld and Brownsword explain that ‘dignity’ should be construed to encompass empowerment (to protect individual rights to make choices) and constraint (to protect individuals from the interference of others).\textsuperscript{143} Both of these elements of dignity are compromised when a person is denied access to the homebirth that they desire. By the ECtHR’s own admission, this is exactly the kind of situation with which it should concern itself, if there is any substance to comments about the centrality of dignity in human rights. While the concept of dignity has, undoubtedly, power in restating the self-determination of pregnant people, it has also been used to restrict the liberty interests of birthing people ‘in order to protect the foetus’.\textsuperscript{144} This relies, however, on a conceptually inappropriate framing of pregnancy as it subjugates birthing people—on some level—to ‘foetal containers’.\textsuperscript{145} Furthermore, it assumes that birthing people’s welfare and foetal welfare are mutually exclusive, and/or that pregnant people are not best placed to make decisions promoting foetal welfare. However, it is clear that birthing people are ‘most familiar with their own

\begin{thebibliography}{999}
\item C Chen and M Cheeseman, ‘European Court of Human Rights Rulings in Home Birth Set to Cause Trouble for the Future: A Review of Two Cases’ (2017) 25 Medical Law Review 115, 115.
\item ibid 121–22.
\item \textit{Ternovszky v Hungary} [2011] ECHR 6.
\item ibid.
\item ibid [7–8].
\item We thank the anonymous reviewer for encouraging the focus on dignity and human rights.
\item \textit{Bouyid v Belgium} (2015) App no 23380/09, para 89; \textit{SW v UK} [1995] ECHR 52, para 44.
\item S Halliday, \textit{Autonomy and Pregnancy: A Comparative Analysis of Compelled Obstetric Intervention} (Routledge 2016) 112.
\item Birthrights, \textit{Dignity in Childbirth: The Dignity Survey 2013: Women’s and Midwives’ Experiences of UK Maternity Care} (2013) 5 <https://birthrights.org.uk/wp-content/uploads/2013/10/Birthrights-Dignity-Survey-1.pdf> accessed 14 May 2021.
\item D Beyleveld and R Brownsword, \textit{Human Dignity in Bioethics and Biolaw} (Oxford University Press 2001).
\item Halliday (n 141) 113.
\item L Purdy, ‘Are Pregnant Women Fetal Containers?’ (1990) 4 Bioethics 273.
\end{thebibliography}
body, underlying health needs and values, [and therefore are best placed] to make the
decisions they feel best promote their own and their fetus’s welfare.\textsuperscript{146}

Even if we were to accept that some balancing was necessary, as Halliday explains:

a duty to accept treatment [including a particular type of birth in a particular
place] for the benefit of the foetus would require the sacrifice of her own pro-
tected interests such that cannot reasonably be expected of her.\textsuperscript{147}

We go further—interference with a person’s choice to have a homebirth fails to recogn-
ise the most fundamental and inviolable aspects of that person’s dignity (not to be
treated as a means to an end).

C. The Utility of Human Rights: The Pandemic Response as a Case Study
In this section, we demonstrate that the blanket suspension of homebirthing services by
some trusts during COVID-19 may have amounted to a breach of birthing people’s
Article 3 and Article 8 rights under the ECHR. This, we suggest, indicates that cen
tring human rights when making decisions and policies in relation to the organisation of birt
hing services would help ensure that greater weight is afforded to the dignity and autonomy
of birthing people, and could provide means for legal redress if there is a failure to do so.

1. Homebirth during the COVID-19 pandemic
As we have already noted, interest in homebirth increased during the COVID-19 pan
demic.\textsuperscript{148} There are a number of factors that contributed to this: fear that attending
hospital would increase the risk of infection, fear of being unsupported as a result of
restrictive policies introduced in relation to birth partners and visitors,\textsuperscript{149} concerns
about being separated from babies post birth, and fear about access to pain relief or to
water birth.\textsuperscript{150} Despite this, it became more difficult for pregnant people to access
homebirth services. During the first acute response to the pandemic, many NHS
trusts suspended their homebirth services.\textsuperscript{151} A number of reasons were given for this,
including midwife\textsuperscript{152} and ambulance shortages,\textsuperscript{153} and the diversion of resources to

\textsuperscript{146} Romanis and others (n 102).
\textsuperscript{147} Halliday (n 141) 153.
\textsuperscript{148} Greenfield and others (n 3); A Nelson and EC Romanis, ‘Homebirthing and Freebirthing in the Era of
COVID-19’, (BMJ Sexual and Reproductive Health Blog, 2 April 2020) <https://blogs.bmj.com/bmjsrh/
2020/04/02/home-birth-covid-19/> accessed 26 June 2020; Milton Keynes University Hospital (n 4).
\textsuperscript{149} eg Nottingham University Hospitals NHS Trust, ‘NUH Maternity COVID19 FAQs’ (2020) <https://www.nuh.nhs.uk
nuh-maternity-covid19-faqs> accessed 30 June 2020; University Hospitals of Derby and
Burton NHS Trust, ‘Visiting Restrictions in Our Hospitals – Updated Tuesday 16 June 2020’ (2020)
<https://www.uhdb.nhs.uk/information-for-visitor/> accessed 30 June 2020. Some trusts were only per-
mitting birth partners from the same household as the birthing person: see <https://twitter.com/birthright
sorg/status/1269997177574699012> accessed 20 June 2021.
\textsuperscript{150} Birthrights, ‘Coronavirus and the Impact on People with Protected Characteristics’ (Evidence Submission to
the Women and Equalities Committee Birthrights, April 2020) 3. <https://www.birthrights.org.uk/wp-con
tent/uploads/2020/05/Birthrights-Covid-19-Maternity-Briefing-women-and-equalities-committee-final.
pdf> accessed 5 July 2020.
\textsuperscript{151} Sherwood (n 8).
\textsuperscript{152} ibid.
\textsuperscript{153} ibid.
managing COVID-19. Many of these services resumed between April and June 2020, but reports again emerged in December 2020/January 2021 of services being suspended as part of the response to the rapid spread of the mutated virus in the South East of England. London local authorities stipulated that they were no longer in a position to guarantee an ambulance response, if it became necessary, for people birthing at home or in birthing centres.

The pandemic raised challenging questions in relation to resource allocation. Difficult decisions had to be made about what to prioritise. Complex questions of how best to protect the health of both those using and administering healthcare services underpinned every decision about what services to offer and to whom. We are not suggesting that there was never a legitimate justification for limiting access to homebirth, but rather that the blanket cessation of these services failed to strike an appropriate balance between people’s birthing preferences and resource preservation. The prevalence of blanket suspensions was indicative of the broader failure to recognise the significance of homebirth for some people. We argue that the approach that was taken to homebirth failed to sufficiently centre the autonomy and dignity of birthing people—falling short of human rights obligations. Consequently, we suggest that adopting a human rights framework when making policy about birthing services can provide an opportunity for the law to strengthen access to choice during childbirth.

2. Article 3: Freedom from torture and inhuman or degrading treatment

A state can never derogate from its responsibilities under Article 3, which reflects the seriousness of the failure to protect the right to freedom from inhuman and degrading treatment. The ECtHR has interpreted inhuman treatment to mean premeditated treatment of extended duration that causes serious physical and mental suffering or acute psychiatric distress, and degrading treatment as that which incites feelings of fear, anguish and inferiority, breaks physical or moral resistance, is humiliating, or drives a person ‘to act against his will or conscience’. Furthermore, for an act to amount to an interference with Article 3, it must ‘in some way, interfere with a person’s dignity’. To establish that treatment is inhuman or degrading a minimum

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154 Davis (n 8).
155 A Moore, ‘Covid Crisis Forces Suspension of Maternity Services’ Health Services Journal (7 January 2021). <https://www.hsj.co.uk/coronavirus/covid-crisis-forces-suspension-of-maternity-services/7029261.article> accessed 23 January 2021.
156 S Lovett and S Lintern, ‘Coronavirus: London Ambulances “Can No Longer Guarantee” Response to Home-Birth Emergencies’ The Independent (London, 25 December 2020) <https://www.independent.co.uk/news/health/covid-london-homebirth-cases-ambulance-b1778881.html> accessed 20 January 2020.
157 EC Romanis and A Nelson, ‘Homebirthing in the United Kingdom during COVID-19’ (2020) 20 Medical Law International 183.
158 ECHR art 15(2).
159 Ireland v United Kingdom (1979) 2 EHRR 25.
160 ibid.
161 Tyrer v UK (1978) 2 EHRR 1, para 31; D Long, Guide to Jurisprudence on Torture and Ill-treatment: Article 3 of the European Convention for the Protection of Human Rights (Association for the Prevention of Torture June 2002) 18 <https://www.apt.ch/content/files_res/Article3_en.pdf> accessed 6 July 2020.
threshold of severity must be demonstrated.\textsuperscript{162} Severity of treatment is determined by reference to:

all the circumstances of the case, such as the nature and context of the treatment, the manner of its execution, its duration, its physical or mental effects, and in some instances, the sex, age and state of health of the victim.\textsuperscript{163}

While the argument we make below that the blanket denial of homebirthing services could meet the threshold of an Article 3 violation is strong, it would be a difficult case to prove in front of the ECtHR. The state may be able to argue, as in \textit{Pretty},\textsuperscript{164} that it is the person’s condition and not the state’s failure to act that leaves individuals in the difficult positions described in these cases—especially as medical assistance has remained readily available in hospitals. Outlining the Article 3 claim is, however, important because it reinforces the severity of the potential impact of denial of choice in childbirth for the birthing person. Moreover, the ECHR is a living instrument, designed to be adapted with changing times and circumstances, and there is increasing recognition that failing to afford appropriate respect and dignity to pregnant persons has significant (negative) consequences, and that this amounts to an infringement of their human rights.\textsuperscript{165}

Childbirth is a hugely significant and life-altering event that has serious physical consequences for the body. Herring notes that birth is a ‘highly emotional and significant time’ and that:

\begin{quote}
For good or bad, it will be a highlight and a life-changing and dramatic event, which means that its understanding and form will be important for the identity and self perception of [person] concerned.\textsuperscript{166}
\end{quote}

As an identity-shifting experience\textsuperscript{167} that is potentially a difficult physical undertaking,\textsuperscript{168} it also has profound mental health implications.\textsuperscript{169} Post-Traumatic Stress Disorder (PTSD) is not uncommon after births characterised by experiences of ‘loss of control’, ‘lack of dignity’, and feelings of ‘not being listened to’.\textsuperscript{170} Failing to respect a birthing person’s preferences can have significant consequences for their long-term physical and mental health.\textsuperscript{171} Birthrights assert that ‘if caregivers fail to provide care

\begin{footnotes}
\footnote{162 Kudla \textit{v Poland} (2000) 35 EHHR 198.}
\footnote{163 ibid [9].}
\footnote{164 Pretty \textit{v UK} [2002] ECHR 423.}
\footnote{165 E Prochaska, ‘Human Rights in Maternity Care’ (2015) 31 Midwifery 1015; See also the work of organisations such as Human Rights in Childbirth <https://humanrightsinchildbirth.org/> accessed 10 June 2021 and Birthrights <https://www.birthrights.org.uk/> accessed 10 June 2021.}
\footnote{166 Herring (n 44) 74.}
\footnote{167 Romanis (n 62) 255.}
\footnote{168 HP Dietz and S Campbell, ‘Towards Normal Birth - But at What Cost?’ (2016) 215 American Journal of Obstetrics and Gynaecology 439.}
\footnote{169 M Redshaw and others, ‘Women’s Experiences of Maternity Care in England: Preliminary Development of a Standard Measure’ (2019) 19 BMC Pregnancy & Childbirth 167.}
\footnote{170 Birth Trauma Association (n 27).}
\footnote{171 K Cook and C Loomis, ‘The Impact of Choice and Control on Women’s Childbirth Experiences’ (2012) 21 Journal of Perinatal Education 158; Birth Trauma Association ibid.}
\end{footnotes}
which is needed to avoid preventable suffering... then this could amount to inhuman or degrading treatment in some circumstances.\textsuperscript{172}

Blanket suspension of homebirths may attain the severity of an Article 3 violation where it results in birthing people being coerced into birthing in a manner of location that they strongly desire to avoid—with profound physical consequences and associated mental distress. In such cases, birthing people are denied both the twin cores of dignity—respect and autonomy.\textsuperscript{173} For those who feel that attending hospital to give birth is not an option for them, as a result of a previous birth trauma,\textsuperscript{174} or because of fear about the safety of hospitals during the pandemic, the lack of access to any homebirth services may have created a situation where they felt that their only option was to freebirth, unattended by health professionals. In these instances, the blanket revocation of homebirthing services would have had the result of forcing them to act against their ‘will or conscience’, as one cannot truly be said to have ‘chosen’ a course of action if coercive circumstances exist that leave one with no other tolerable option.\textsuperscript{175}

Early data illustrate an increase in circumstantially coerced freebirthing in 2020.\textsuperscript{176} Unattended birth is not a problem per se; however, where birthing people feel forced to opt for freebirth, this represents a substantial challenge to their dignity. Knowing one will have to face birth without medical support against one’s will is likely to be frightening and traumatic. Many of the feelings associated with a ‘coerced’ freebirth are those that increase the risk of birthing people suffering birth-related PTSD, loss of control, lack of dignity, poor pain relief, and concerns about safety.\textsuperscript{177} It can also leave a person open to humiliating scrutiny from maternity services, despite being perfectly legal in the UK.\textsuperscript{178} Stress during pregnancy is associated with preterm birth and poor maternal/neonatal outcomes;\textsuperscript{179} thus, there could be further safety-threatening detrimental impact. Equally, if a person is (or feels) forced/coerced into giving birth in hospital they may experience physical harm and mental distress as a result of being denied their first choice of birth. The fact of the person’s pregnancy—and the circumstances of heightened risk and anxiety in which they currently find themselves—is relevant in assessing whether a violation has occurred, as these are material factors in determining the severity of the implications of such policies. We are not suggesting that the intention behind these policies is to degrade birthing persons; however, lack of intention does not preclude the finding of a violation,\textsuperscript{180} although it will have a bearing on damages.\textsuperscript{181}

\textsuperscript{172} Birthrights, Human Rights in Maternity Care (2017) <https://www.birthrights.org.uk/factsheets/human-rights-in-maternity-care/> accessed 3 July 2020.

\textsuperscript{173} Beyleveld and Brownsword (n 143).

\textsuperscript{174} See Summers (n 91).

\textsuperscript{175} Greenfield and others (n 3); Summers ibid.

\textsuperscript{176} Summers ibid.

\textsuperscript{177} Birth Trauma Association (n 27).

\textsuperscript{178} There is clear anecdotal evidence that pregnant people who alert maternity services of their plans to freebirth can face threats of being reported to child services, and they are often addressed in a manner that profoundly undermines their dignity: Feeley and Thomson (n 14) 19; McKenzie (n 12).

\textsuperscript{179} N Dole and others, ‘Maternal Stress and Preterm Birth’ (2003) 157 American Journal of Epidemiology 14.

\textsuperscript{180} Peers v Greece (2001) 33 ECHR S1.

\textsuperscript{181} Price v UK (2002) 34 ECHR S3.
3. Article 8: The right to private and family life

It is clear that ‘unreasonable state interference with a woman’s wish to have her baby at home could violate her right to private and family life’. When will it be reasonable to intervene with a person’s right to homebirth? To be deemed ‘necessary in a democratic society’—and thus justifiable—interference with an individual’s right to private life must be proportionate to a legitimate aim. While we do not question the legitimacy of the aim to protect the health of maternity staff, birthing persons, and newborns in the COVID-19 context, we argue that the implementation of trust blanket policies removing all homebirth services (with no possibility for individual exceptions) was disproportionate.

a. Safety

As we demonstrated in Section II, there is insufficient evidence to support the contention that homebirth is unsafe with regards to physical health, and there is evidence that it can better support mental health outcomes for some birthing persons. This may be particularly true given the heightened anxiety that many pregnant people felt about attending hospital during the pandemic. Respecting autonomous birth choices is a vital tool for protecting birthing people’s dignity. Given the links between loss of dignity and the likelihood of experiencing post-birth trauma, and the fact that respecting dignity is the very ‘essence’ of the ECHR, it seems counterintuitive that an action which undermines this principle can be justified in the name of ‘safety’. During the pandemic, there were undoubtedly additional resource-based safety concerns; for example, reduced ambulance availability might have prolonged hospital transfer times if things went wrong—time which might be critical in an emergency. Professionals should have been open about such concerns when discussing place of birth with pregnant people, and risks communicated in an honest and proportionate manner; in a way which genuinely aided the birthing person in making an informed decision, rather than one which sought to coerce them into complying with the course of action that was deemed ‘preferable’ by health professionals. And these risks should have been balanced against the potential benefits of homebirthing for those who desired it. We argue that ‘safety’ does not provide a sufficiently compelling justification for blanket policies ceasing all homebirths.

Furthermore, the removal of homebirth services may have actually jeopardised safety because there will have been those who felt so uncomfortable at the prospect of attending hospital for birth (either because of COVID-19 or because of a previously held conviction) that the absence of these services will lled them to have an unattended birth at home, without having had (sufficient) time to consider or plan for this. These instances may have led to a significantly increased risk of harm to

182 Equality and Human Rights Commission, The Right to Respect for Private and Family Life, Home and Correspondence: For Ombudsman Schemes <https://www.equalityhumanrights.com/en/advice-and-guidance-human-rights-multipage-guide/right-respect-private-and-family-life-home-and> accessed 20 January 2021.
183 The Royal College of Midwives, Birth Partners (RCM 16 April 2020) <https://www.rcm.org.uk/media/3887/birth-partners.pdf> accessed 25 June 2020.
184 Birth Trauma Association (n 27).
185 See eg. A Lyerly and others, ‘Risk and the Pregnant Body’ (2009) 39 Hastings Centre 34.
the birthing person and foetus/baby, and an increased likelihood of the need for emergency intervention. Birthrights have stressed that the removal of homebirth services could 'lead Trusts to be responsible for significant risk to life if women choose to birth without medical assistance'.

b. Necessity

For an interference to be proportionate, it must be no more than necessary to meet the stated aim. Where homebirth is, in certain circumstances, as safe as hospital births, or at least not so comparatively unsafe as to justify limiting its availability, blanket removal of these services goes beyond interference that is strictly necessary. That some trusts continued to provide all (or most) of their homebirthing services during the pandemic (March 2020 onwards), further strengthens the argument that the blanket denial of this service cannot meet the ‘necessity’ test and therefore cannot be justified. Blanket denial of access to home-birthing services in the UK could amount to a violation of Article 8. Human rights law affords recognition to the fact that restrictions wronged those affected, and provides support to the claim that birth choices outside of the medicalised ‘norm’ are important.

D. Human Rights and Homebirth: Beyond the Pandemic

Beyond identifying failures in pandemic policy, adopting a human rights lens when critiquing access to homebirth helps to identify broader issues with the current system. The first of these is the problematic nature of the complexity of the current, piecemeal law on non-hospital births in the UK. In order for interference with a person’s ECHR rights to be justifiable, this must be done in accordance with law that is sufficiently clear and accessible. There is scope to question whether decisions to deny access to homebirth are made on the basis of law that satisfies these requirements. Furthermore, even when interference occurs according to clear and accessible law, it must be proportionate to its legitimate aim. In Bank Mellat, Lord Reed set out a four-pronged approach to assessing proportionality in Convention cases. Crucially, this included the need to consider ‘whether a less intrusive measure could have been used without unacceptably compromising the achievement of the objective’. There are serious questions about whether such proportionality actually exists in many instances of denied access to homebirthing.

Where a request to homebirth is refused due to prejudices or (incorrect) assumptions on the part of the healthcare professionals, it seems plain that the denial of access to homebirth is not proportionate to the aim of ‘protection of health’. The negative consequences of failing to respect choices about birth have been made clear

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186 Birthrights (n 5).
187 See The Sunday Times v UK (1979) 2 EHRR 245, para 67.
188 Reitsma and others (n 19).
189 Bank Mellat v Her Majesty’s Treasury (No 2) [2013] 4 All ER 533, per Lord Reed at [74].
190 ibid [74].
191 ibid.
192 Parliamentary and Health Service Ombudsman, Midwives Failed to Properly Support a Woman’s Choice of Home Birth because of Her Epilepsy (2014) <https://www.ombudsman.org.uk/about-us/how-our-casework-makes-difference/case-summaries/684> accessed 10 February 2021.
throughout this article, and risking such harms on the basis of personal views cannot justify interference with a birthing person’s human rights. Indeed, courts must consider whether ‘the impact of the rights infringement is disproportionate to the likely benefit of the impugned measure’. Even where the refusal is based on genuine concerns about the availability of resources, a refusal may not be deemed proportionate unless this is demonstrably the only option left after alternative solutions are considered. The Parliamentary and Health Services Ombudsman has previously ruled that ‘an NHS Trust that refused to make contingency plans after it suspended its homebirth services was acting unreasonably’. While not every instance in which a person is denied access to home-birthing services will necessarily amount to an unjustifiable interference with that person’s Article 8 rights, it is clear that it could.

As human rights law places dignity at its core, thinking about access issues—and wider organisational policy about homebirthing—in human rights terms can help facilitate policy-making that is focussed on centring the individual birthing person and respecting their dignity. Embedding dignity meaningfully into birthing policy and practice would involve taking seriously people’s choices about where to birth, and human rights law provides legal impetus to do so. Ensuring that human rights plays a central role in the legal dialogues around choice in place of birth may enable law to be used in a manner which supports, rather than undermines, individual choice.

Examining the human rights implications of the restrictions on homebirthing demonstrates that the law may be a helpful tool in responding to these issues. While aspects of the law have contributed to the medicalisation of birth, the legal focus has the potential to create a culture that is more centred on the birthing person. Homebirth is an important element of choice in childbirth. Moving forward, homebirth should remain a component in discussions about choice in childbirth with due consideration given to the potential implications, both emotional and legal, of failing to protect this choice. The ways in which the law compounds the medicalisation of homebirth sits against another (developing) body of law which aims to centre the patient—including the birthing patient—in medical discourse. Framing the issue of homebirth in relation to human rights, and to patient-centric judgments such as Montgomery, might help to redress the balance and ensure the rights and choices of birthing people are protected.

VI. CONCLUSION

Choice in childbirth is of great importance for pregnant people, and choice about where to give birth is a fundamental component of this. As pregnancy and birth have become increasingly medicalised, it has become harder for birthing people to opt for homebirth despite the lack of sufficiently convincing safety concerns to justify restricting access. The societal and legal perpetuation of medicalised birth, coupled with the expectation that pregnant people do anything directed to ensure foetal well-being,
creates a societal barrier which limits the availability of the choice to homebirth. During the COVID-19 pandemic, these difficulties were compounded by practical barriers—as many trusts imposed a blanket withdrawal of home-birthing services during this time.

There is a decided lack of ethico-legal literature on homebirth and on the importance of protecting this as one of a range of important choices in childbirth. We suggest that the speed at which blanket suspensions were introduced during the pandemic illustrates that the significance of homebirth for some is not sufficiently appreciated. However, the pandemic has also provided a platform to begin a meaningful consideration of homebirth and its importance, and we hope that this renewed attention will be maintained beyond the pandemic restrictions. More socio-legal research, including empirical work, is needed to ascertain why and how homebirth has been precluded from mainstream birthing choices, even though the evidence indicates its importance. The legal framework surrounding homebirth needs to be considered in more detail, as we have begun to do in this article, to evaluate its coherency and the difficulties it poses for those who wish to choose homebirth. Greater attention must be paid to centring those legal frameworks that support, rather than undermine, choice in childbirth. We suggest that human rights law provides a useful foundation for this. Supporting people to make a meaningful choice about place of birth is a vital component of protecting their dignity, autonomy and well-being. The law should operate in a manner that reflects this.

196 Reitsma and others (n 19).