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Homebirthing in the United Kingdom during COVID-19

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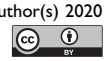

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Abstract

COVID-19 has significantly impacted all aspects of maternity services in the United Kingdom, exacerbating the fact that choice is insufficiently centred within the maternity regime. In this article, we focus on the restrictions placed on homebirthing services by some National Health Service Trusts in response to the virus. In March 2020, around a third of Trusts implemented blanket policies suspending their entire homebirth service. We argue that the failure to protect choice about place of birth during the pandemic may not only be harmful to birthing people's physical and mental health, but also that it is legally problematic as it may, in some instances, breach human rights obligations. We also voice concerns about the possibility that in the absence of available homebirthing services people might choose to freebirth. While freebirthing (birthing absent any medical or midwifery support) is not innately problematic, it is concerning that people may feel *forced* to opt for this.

Keywords

Homebirth, freebirth, birth, autonomy, COVID-19

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Introduction

The 2020 COVID-19 pandemic has had a significant impact on people preparing to birth[1] in the United Kingdom (UK). In response to the pandemic, National Health Service (NHS) Trusts have made changes to the maternity services that are offered and how these services are provided. Some NHS Trusts placed limitations on the presence of birth partners in hospitals,[2] placed limitations on maternal request caesarean sections,[3] and around a third of NHS Trusts suspended homebirthing services.[4] This has limited the options available to thousands of birthing people who may either feel forced to attend a hospital to birth, or some people may decide to freebirth at home (this is the 'active decision to birth without trained health professionals present' where there is an option to access maternity care).[5] The limitations that have been placed on choice in childbirth during the pandemic, we argue, are indicative of the reality that choice is not sufficiently centred within the maternity regime in the UK. Here, for reasons of space, we limit our scope to considering the limitations that were placed on homebirthing services and the impact this may have had on the physical and mental health of people preparing to birth.

In this article, we argue that blanket removal of homebirthing services during the COVID-19 pandemic has been inappropriate because of the significant impact that limiting these services has on individuals. While we accept that sometimes in a communal health system there will be circumstances where limited resources mean that some services will be limited, and this is of course more likely during a public health emergency, we do not believe that the pandemic necessitates a *blanket* restriction on homebirth. First, we will outline some of the practicalities and legalities of homebirthing in the UK. Second, we consider why COVID-19 may have potentially led to an increase in demand for homebirth, and we argue for the importance of a choice about place of birth for a pregnant person's health and well-being. We argue that the availability of a

1. We use the term pregnant people/persons instead of women as an acknowledgement that, while the majority of people who get pregnant and birth are women, not all people who are pregnant and birth or are able to get pregnant and birth identify as women.
2. See Birthrights, *Coronavirus – How Will It Affect My Rights to Maternity Care?* (12 March 2020). Available at: https://www.birthrights.org.uk/2020/03/12/coronovirus-how-will-it-affect-my-rights-to-maternity-care/ (accessed 25 June 2020).
3. See S. Lintern, 'Coronavirus: NHS Hospitals Accused of Using Crisis as Excuse to Deny Women Caesarean Sections', *The Independent* 17 May 2020. Available at: https://www.independent.co.uk/news/health/coronavirus-caesarean-sections-nhs-hospitals-maternity-a9514356.html (accessed 25 June 2020). We have considered some of the other limitations on maternity services during the pandemic in work that is under review elsewhere.
4. H. Sherwood, 'Midwife Shortage Doubles as NHS Staff Diverted to Tend Covid-19 Patients', *The Observer* 29 March 2020. Available at: https://www.theguardian.com/society/2020/mar/29/midwife-shortage-doubles-as-nhs-staff-diverted-to-tend-covid-19-patients (accessed 25 June 2020).
5. C. Feeley and G. Thomson, 'Tensions and Conflicts in "Choice": Womens' Experiences of Freebirthing in the UK', *Midwifery* 41 (2016), pp. 16–21.

homebirthing service for pregnant people is important at this time as a result of these potential concerns and that denying access to homebirth has potential damaging consequences on the physical and mental health of birthing people who may feel coerced into a birthing experience that is distressing to them (whether this is in hospital or at home). Third, we consider the response of NHS Trusts to the potential increased demand for homebirthing during the pandemic. Finally, we assess this response arguing that removing choice has and will continue to have a significant impact on pregnant people's health and well-being and may potentially be a breach of the UK's obligations under the European Convention on Human Rights (ECHR).

At the time of revising this article, an increasing number of NHS Trusts are now beginning to reinstate or have already reinstated their suspended homebirthing services, subject to some limitations.[6] We welcome the reintroduction of these services but will critique some of the conditions that have been placed on homebirthing. While homebirthing is now becoming available in some parts of the country where it has not been for some months, it remains crucial that the potential impact of the denial of this service may have had on pregnant people is investigated. This is also important to reflect on in advance of a potential second or third wave of the virus.

Homebirthing in the UK

Homebirth is the planned delivery of a pregnancy at home attended by health professionals (usually a midwife). Homebirth in the UK has consistently been found to be safe and to have comparable rates of safety to hospital delivery among people with low-risk pregnancies and second/subsequent pregnancies.[7] It has also been found to have some substantial benefits for pregnant people that we will discuss later in this article. At present, only 2.3% of births that take place in the UK are homebirths.[8] In the midwifery and social sciences literature, research conducted to ascertain the motivations of pregnant people who choose to birth at home illustrates that the reasons are wide-ranging. Some of the most common reasons indicate that people chose to birth at home as a result

6. See Imperial College Healthcare NHS Trust, *Maternity and Obstetrics: Coronavirus Update for Maternity Patients* (2020). Available at: https://www.imperial.nhs.uk/our-services/maternity-and-obstetrics (accessed 30 June 2020); NHS Lanarkshire, *Homebirths Now Reinstated* (2020). Available at: https://www.nhslanarkshire.scot.nhs.uk/services/maternity-services/ (accessed 30 June 2020).
7. A. Reitsma et al., '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', *EClinicalMedicine* 21 (2020), p. 100319; A. de Jonge et al., 'Perinatal Mortality and Morbidity in a Nationwide Cohort of 529,688 Low-Risk Planned Home and Hospital Births', *British Journal of Obstetrics and Gynaecology* 116 (2009), pp. 1177–1184.
8. Office for National Statistics, *Birth Characteristics in England and Wales: 2017* (10 January 2019). Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/bulletins/birthcharacteristicsinenglandandwales/2017 (accessed 25 June 2020).

of previous trauma (including birth trauma in hospital),[9] to avoid unwanted restrictions and medical interventions during pregnancy that they anticipate in an obstetric setting (e.g. foetal monitoring),[10] because they would prefer to birth in a familiar and comfortable environment[11] and/or to have more freedom in selecting birth partners.[12] As well as personal preference, there are additional factors that influence whether a person plans to birth at home, including how much information they have been provided about homebirth by care providers, whether their primary care doctor is supportive of homebirthing[13] and whether they know others who have had successful and positive homebirthing experiences.[14]

The law pertaining to homebirth is piecemeal and complex. While there is no positive right to demand a homebirth, a person cannot be compelled to attend hospital at any point during birth[15] as part of the broader right any person has to make decisions about (including to refuse) medical treatment.[16] Midwives are also under a professional obligation to attend a childbirth at home in instances where they become aware that a birthing person or baby is or may be at risk without their assistance.[17] Birthrights, a UK charity that promotes the rights of pregnant and birthing people, asserts that Trusts have obligations under Article 2 of the ECHR because 'if a hospital refused to send a midwife and the mother or child suffered injury or died, there would be serious legal implications for the hospital and midwives involved'.[18] This of course does not mean

9. K. Viisainen, 'Negotiating Control and Meaning: Homebirth as a Self-Constructed Choice in Finland', *Social Science & Medicine* 52 (2001), pp. 1109–1121.
10. G. Chamberlain, A. Wraight and P. Crowley, 'Choice and Satisfaction', in C. Geoffery, A. Wraight and P. Crowley, eds., *Homebirths: The Report of the 1994 Confidential Enquiry by the National Birthday Trust* (Carnforth: Parthenon, 1997), pp. 129–153.
11. S. Morrison, Y. Hauck, P. Percival, et al., 'Constructing a Home-Birth Environment Through Assuming Control', *Midwifery* 14 (1998), pp. 233–241.
12. S. Fordham, 'Women's Views of the Place of Confinement', *British Journal of General Practice* 47 (1997), pp. 7–81.
13. J. Davies, E. He, W. Reid, et al., 'Prospective Regional Study of Planned Home Births', *British Medical Journal* 313 (1996), pp. 1302–1306.
14. R. Shaw and C. Kitzinger, 'Calls to a Home Birth Helpline: Empowerment in Childbirth', *Social Science & Medicine* 61 (2005), pp. 2375–2383.
15. *St George's Hospital Trust v. S* [1998] 3 All ER 673 confirmed that pregnant person can refuse any treatment during birth – and this includes admission to hospital; Birthrights, *Factsheet: Choice of Place of Birth* (April 2017). Available at: https://www.birthrights.org.uk/factsheets/choice-of-place-of-birth/ (accessed 1 July 2020).
16. *Re T (Adult: Refusal of Medical Treatment)* [1992] 4 All ER 649 (CA); we will discuss this point of law in more detail later in this article.
17. Nursing and Midwifery Council, *The Code: Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates* (10 October 2018), p. 15. Available at: https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf (accessed 24 June 2020).
18. E. Prochaska, 'The Home Birth Debate: Rights and Obligations', *Birthrights* (16 September 2013). Available at: https://www.birthrights.org.uk/2013/09/16/701/ (accessed 25 June 2020).

that a pregnant person has a right to demand a planned homebirth and the associated resources, but it does mean that if a pregnant person insists on birthing at home there are existing obligations on professionals to attend them in the event that it becomes necessary and they are made aware.[19]

Further, homebirth should be offered by NHS Trusts as a matter of policy. Current National Institute for Health and Care (NICE) Guidelines stipulate that healthcare professionals should discuss options of birthing in non-hospital settings, including at home and in midwifery centres, with pregnant people.[20] The guidelines explicitly highlight that homebirth and birthing in midwifery centres have comparable rates of safe delivery to obstetric units in hospitals[21] and are associated with a reduced rate of obstetrical interventions and can be more satisfying for birthing people.[22] The NHS Choice Framework references these guidelines and recommends that Trusts make sure that homebirth services are available. Despite this, the overall percentage of birthing people that deliver at home remains relatively low, and it is beyond the scope of this article to discuss why and how this is the case.[23] We note here, however, that even if this option is not routinely taken up by a large proportion of pregnant people it nevertheless remains an important option that *ought* to be offered to people planning their birth. Homebirth is preferable to some pregnant people for important and highly personal reasons that might reflect their past experiences or their well-being both during and after birth. The importance of the choice, therefore, should not be underestimated just because this option is not commonly sought after. We believe that the choice to homebirth has become increasingly important in the current climate as there are compelling reasons to believe that a homebirth might be sought after by more people preparing to birth at this particular time.

19. Although there is no single provision which dictates that a medical professional must attend a home birth, a number of different obligations come together with the effect that – where the pregnant person or their baby is in danger, and the medical professional knows about this – that professional is required to attend. For example, the Nursing and Midwifery Council's *The code of professional standards of practice and behaviour for nurses, midwives and nursing associates* (2015) para 15, places a professional obligation on midwives to attend a childbirth at home if they know or believe the pregnant person or their baby to be at risk without assistance. We explore the complexity of the provisions which govern the obligations incumbent upon midwives to attend homebirth in certain situations, and the problems associated with this, in co-authored work currently under review elsewhere.
20. National Institute for Health and Care Excellence, *Intrapartum Care for Healthy Women and Babies Clinical Guideline [CG190]*, para 1.1.2. Available at: https://www.nice.org.uk/guidance/cg190/chapter/Recommendations#place-of-birth (accessed 24 June 2020).
21. Op. cit., para 1.1.2.
22. Department of Health and Social Care, *The NHS Choice Framework: What Choices Are Available to Me in the NHS?* Available at: 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).
23. We continue to explore and reflect on this point in ongoing co-authored work.

Homebirthing during COVID-19: Increasing demand?

Birthing people may not feel safe entering a hospital environment during the COVID-19[24] pandemic, even as restrictions on our social lives are continuing to be lifted. In planning their place of birth, pregnant people may have concerns about exposing themselves and their newborns to perceived heightened risks of virus infection. While it is not currently the case that pregnant people are being advised to shield,[25] or advised that they are at greater risk if they contract the infection,[26] it is understandable that some pregnant people, much like many other people, will be continuing to take precautions to reduce the likelihood of their contracting the virus.

Grünebaum et al. note that there are no data that supports the hypothesis that out-of-hospital birth decreases the risk of COVID-19 infection for pregnant people or babies and stipulate that with effective infection control procedures in hospitals there would be negligible infection risks in the hospital birthing environment.[27] While we agree with their point to some extent,[28] we disagree with their conclusion that obstetricians should continue to 'recommend planned hospital birth and recommend against planned out-of-hospital birth during the COVID-19 pandemic'.[29] Their conclusions are based on the claim that planned hospital delivery is 'clinically superior', which we have outlined is not the position adopted by either NICE or the NHS,[30] or of recent empirical research conducted in the UK.[31] Moreover, we believe that directive counselling on this point

24. A. Nelson and E.C. Romanis, 'Homebirthing and Freebirthing in the Era of COVID-19', *BMJ Sexual and Reproductive Health Blog* (2 April 2020). Available at: https://blogs.bmj.com/bmjsrh/2020/04/02/home-birth-covid-19/ (accessed 26 June 2020); this observation is now increasingly being made in the midwifery and social science literature; see – with reference to the US – R. Davis-Floyd, K. Gutschow and D.A. Schwartz, 'Pregnancy, Birth and the COVID-19 Pandemic in the United States', *Medical Anthropology* 39 (2020), pp. 413–427; see – making some specific reference to the UK as well as the US – A. Grünebaum et al., 'Professionally Responsible Counselling About Birth Location During the COVID-19 Pandemic', *Journal of Perinatal Medicine* 28 (2020), pp. 450–452.
25. HM Government, *Our Plan to Rebuild: The UK Government's COVID-19 Recovery Strategy* (May 2020), p. 28. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/884760/Our_plan_to_rebuild_The_UK_Government_s_COVID-19_recovery_strategy.pdf (accessed 25 June 2020).
26. Royal College of Obstetricians and Gynaecologists, *Coronavirus Infection and Pregnancy* (2020). Available at: https://www.rcog.org.uk/en/guidelines-research-services/guidelines/coronavirus-pregnancy/covid-19-virus-infection-and-pregnancy/ (accessed 1 July 2020).
27. Grünebaum et al., 'Professionally Responsible Counselling'.
28. In work under review elsewhere we consider the reasons why the blanket bans on maternal request caesareans in some NHS Trusts and hospitals during the pandemic are equally problematic. We note that the justification of increased infection risk is insufficient to justify a blanket ban on this service.
29. Grünebaum et al., 'Professionally Responsible Counselling'.
30. National Institute for Health and Care Excellence, 'Intrapartum Care for Healthy Women'; Department of Health and Social Care, 'The NHS Choice Framework'.
31. Reitsma et al., 'Maternal Outcomes and Birth Interventions'.

undermines the importance of birthing persons *feeling* safe and fails to recognise the complexity of considerations that will have influenced the decision to birth at home.

Poor communication from some hospitals has resulted in fears that birth partners may not be permitted to be with birthing persons at all, even during active labour.[32] While this was not officially the policy adopted in any UK hospital, there are nonetheless a number of limitations that continue (at the time of writing) to be placed upon birth partners. Birth partners are generally only permitted to be present for a limited period of time (from the confirmation of active labour to the birth of the child) and in many instances only one birth partner is permitted.[33] Uncertainty about access to one's chosen birth partner at what may already be a very anxious time in and of itself has led some to consider homebirth to be a more suitable and stress-free option in the circumstances.[34] Alternatively, those who wish to have more than one partner present during birth (e.g. a partner and a parent or a partner and a doula) may have opted for a homebirth to ensure that this desire was fulfilled. Further, some people may feel worried about the support that will be available to them following childbirth in hospital as many NHS Trusts have instated policies that ban all visitors from wards other than during the period of active labour.[35]

Another issue that could be compounding the reluctance of some people to attend hospital for birth during the COVID-19 pandemic is a fear that they will be denied aspects of their birth plan which are important to them. As just one example, 26% of NHS Trust maternity services suspended *all* waterbirths in April 2020,[36] despite the evidence that delivering in a birthing pool does not result in any increased risk at this time to healthy people[37] – indeed, research indicates that the birthing pool 'presents a natural barrier between the woman and her midwife. Supporting women in the water

32. Nelson and Romanis, 'Homebirthing and Freebirthing'.
33. Advice as of 30 June 2020 in the Hillingdon Hospitals Trust, for example, was 'we are currently only allowing one birth partner to limit the spread of Covid-19'. See: *Covid-19 Virus Infection and Pregnancy* (2020). Available at: https://www.thh.nhs.uk/services/women_babies/COVID-19_infection_pregnancy.php (accessed 30 June 2020).
34. It is worth noting that stress during pregnancy is associated with preterm birth: N. Dole et al., 'Maternal Stress and Preterm Birth', *American Journal of Epidemiology* 157 (2003), pp. 14–24.
35. See, Nottingham University Hospitals NHS Trust, *NUH Maternity COVID19 FAQ's* (2020). Available at: 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). Available at: https://www.uhdb.nhs.uk/information-for-visitors/ (accessed 30 June 2020).
36. The Royal College of Midwives, *RCM Clinical Briefing: Waterbirth – COVID-19* (23 April 2020). Available at: https://www.rcm.org.uk/media/3903/rcm-professional-briefing-on-waterbirth-in-the-time-of-covid-23-april-v41.pdf (accessed 10 June 2020).
37. Oxford Brookes University, *Coronavirus COVID-19: Supporting Healthy Pregnant Women to Safely Give Birth* (29 April 2020). Available at: https://www.brookes.ac.uk/WorkArea/DownloadAsset.aspx?id=2147622699 (accessed 30 June 2020); see also Royal College of Obstetricians and Gynecologists and Royal College of Midwives guidance that waterbirth should be avoided *only* identifies risks/applies to those who have COVID: Royal College of Midwives, *RCM Clinical Briefing: Waterbirth – COVID-19* (2020). Available at: https://

reduces droplet, aerosol and faecal contamination, presenting a low-risk transmission activity for the Coronavirus'.[38] For many, these sorts of restrictions on their plans might make homebirth, where these plans *can* be enacted and even just better guaranteed, preferable.

It is clear that many people preparing to give birth are experiencing some distress at the lack of clarity about what maternity services are available. Birthrights has estimated that enquiries to their advice line have increased by 464% during the pandemic.[39] This confusion may mean that there are instances where the potentially restrictive rule that a pregnant person is concerned about may not *actually* be in place in their local hospital; however, homebirth nonetheless is considered more desirable as it may provide greater certainty about what to expect and/or what one would be allowed access to during the birth. This also applies to the concern about increased infection risk; even though precautions are taken in hospitals to minimise infection risk, some pregnant people may just feel more comfortable in their homes where they can take more control over the precautions that they feel are necessary.

Although there is not yet any empirical data available about whether there has been an increase in demand for homebirth, there is anecdotal evidence which indicates that this has, indeed, been the case. Private homebirth services have reported 'receiving an unprecedented number of calls from women seeking reassurance, antenatal care, postnatal care and homebirths',[40] and newspapers continue to report the stories of pregnant people who either had changed their mind about homebirth in the wake of the pandemic or were more determined about their choice in light of the circumstances.[41] Moreover, there has been reporting that freebirthing has increased in the absence of homebirthing services, which also speaks to demand.[42] It would be interesting to see whether there is a change in maternity statistics following the pandemic, and we suspect that sociolegal empirical work that considers how choices about childbirth may have been influenced by the pandemic and by NHS responses to it would be really valuable.

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www.rcm.org.uk/media/3903/rcm-professional-briefing-on-waterbirth-in-the-time-of-covid-23-april-v41.pdf (accessed 30 June 2020).

38. Oxford Brookes University, *Coronavirus COVID-19*.
39. M. Oppenheim, 'Pregnancy Support Helplines Report Dramatic Spike in Urgent Enquiries as Coronavirus Turmoil Puts Mothers at Risk' *The Observer* 5 May 2020. Available at: https://www.independent.co.uk/news/uk/home-news/coronavirus-pregnant-women-birth-baby-nhs-a9498201.html (accessed 10 June 2020).
40. L. Bryceland, *Coronavirus Strategy Document: Advice for Clients and Staff Working With Private Midwives* (26 March 2020). Available at: https://privatemidwives.com/wp-content/uploads/2020/03/Coronavirus-strategy-V3.1.pdf (accessed 10 June 2020).
41. K. Brewer, 'Birth in a Pandemic: "You Are Stronger Than You Think"', *BBC News* 1 April 2020. Available at: https://www.bbc.co.uk/news/stories-52098036 (accessed 10 June 2020).
42. H. Summers, 'Expectant Mothers Turn to Freebirthing After Home Births Cancelled', *The Guardian* 5 April 2020. Available at: https://www.theguardian.com/lifeandstyle/2020/apr/05/expectant-mothers-turn-to-freebirthing-after-home-births-cancelled (accessed 25 June 2020).

The COVID-19 response to homebirthing in the UK: A critique

Despite there being reason to believe that demand for homebirth would increase as a result of COVID-19, by late March 2020 around one-third of all NHS Trusts had completely suspended access to homebirthing services in response to the pandemic.[43] A number of reasons were advanced for doing so – including ambulance and midwife shortages[44] and the diversion of resources towards the COVID-19 response.[45] Further, there may have been an underlying desire to discourage those birthing people who *did* have the virus from birthing at home, as the recommendation in confirmed/suspected COVID-19 cases is that birth takes place in hospital.[46]

We understand that the public health response to this pandemic requires that a number of incredibly difficult decisions are made regarding the allocation of staff and resources, patient choice and patient/staff safety. However, even during a pandemic 'public health concerns *must* be balanced fairly against the need to respect choice and autonomy in childbirth'.[47] As we will demonstrate, the imposition of *blanket* policies suspending all homebirthing services fails to achieve such balance, resulting in not only a number of potential harms to the physical and mental health of the birthing person but also *legal* harms as a result of the failure to respect the human rights obligations imposed by the ECHR.

At the time of writing, we are beginning to see instances of homebirthing services being reinstated – including, for example, Tameside[48] and North Cumbria.[49] However, it remains important to assess the fact that there was an initial decision to suspend these services. It is clear that the UK is still at risk of a potential second wave of coronavirus –

43. H. Sherwood, 'Midwife Shortage Doubles'; N. Davis, 'NHS Trusts Begin Suspending Home Births Due to Coronavirus', *The Guardian* 27 March 2020. Available at: https://www.theguardian.com/world/2020/mar/27/nhs-trusts-suspending-home-births-coronavirus (accessed 25 June 2020).
44. Op. cit.
45. Davis, 'NHS Trusts Begin Suspending Home Births'.
46. Hospital admission was advised as it allowed for regular monitoring during birth; both of the foetus and of the oxygen levels of the birthing person. It reflected a precautionary approach, as little was known about the true impact of COVID-19 on pregnancy and birth given the rapidly developing situation; Royal College of Midwives and Royal College of Obstetricians and Gynaecologists, *Coronavirus (COVID-19) Infection in Pregnancy: Information for Healthcare Professionals* (28 March 2020).
47. Nelson and Romanis, 'Homebirthing and Freebirthing' (original emphasis).
48. S. Williamson, 'Expectant Mothers in Tayside to be Able to Give Birth at Home From Next Week', *Evening Telegraph* 8 June 2020. Available at: https://www.eveningtelegraph.co.uk/fp/expectant-mothers-in-tayside-to-be-able-to-give-birth-at-home-from-next-week/ (accessed 10 June 2020).
49. ITV News, 'North Cumbria Home Birth Service Reintroduced', *ITV News* 5 June 2020. Available at: https://www.itv.com/news/border/2020-06-05/north-cumbria-home-birth-service-reintroduced/ (accessed 10 June 2020).

and as we write this a 'local lockdown' is being imposed in Leicester[50] (and as we revise this work further local restrictions have been imposed in parts of Greater Manchester, Lancashire and West Yorkshire,[51] and Aberdeen).[52] Furthermore, in the modern world, the risk of a future pandemic cannot be ruled out. Therefore, it is vital that public healthcare decisions and their impacts are interrogated, so that future responses can be informed and more considerate of the impact that blanket restrictions on certain services can have on the welfare of birthing people. Further, the reinstated homebirthing services are not simply returning to 'business as normal'. These services are only available with an increased number of restrictions, with the understandable intention of protecting the midwives who attend homebirths from COVID-19 infection risk as far as is possible. However, the nature of the restrictions imposed by some trusts raise potential issues in and of themselves. We will return to, and address, the impact of these restrictions in due course.

The impact of removing homebirth services

By removing the option for a homebirth, birthing people are forced either to attend hospital or to freebirth (i.e. birthing at home absent medical attention).[53] The specific issues that potentially result from 'forced' hospital attendance and 'coerced' freebirth will be addressed in the next two sections. However, we will firstly make some broad observations about how the circumstances will impact on the autonomy of pregnant people and thus have a significant impact on their welfare.

The importance of choice in childbirth, and the impact of this on a birthing person's welfare, is hard to overstate. It is clear that 'denying [birthing people] choices about childbirth forces them to relinquish [aspects of] their identity by surrendering to certain life-altering experiences over others'.[54] Birth is often an incredibly significant and emotive time in a person's life,[55] and if a person is supported to make their own choices about their birthing conditions (including place of birth) it can be a beautiful and positive experience. However, in those instances in which this process is instead shrouded in

50. BBC News, 'Leicester Lockdown Tightened as Coronavirus Cases Rise', *BBC News* 30 June 2020. Available at: https://www.bbc.co.uk/news/uk-england-leicestershire-53229371 (accessed 1 July 2020).
51. Department of Health and Social Care, *North of England: Local Restrictions* (31 July 2020). Available at: https://www.gov.uk/guidance/north-west-of-england-local-restrictions-what-you-can-and-cannot-do (accessed 10 August 2020).
52. Scottish Government, *Local Restrictions Introduced in Aberdeen* (5 August 2020). Available at: https://www.gov.scot/news/local-restrictions-introduced-in-aberdeen/ (accessed 10 August 2020).
53. Freebirth occurs when a pregnant person plans an unassisted birth (at home) that is not attended by medical professionals, though they are available. This does not include situations in which birth simply occurs before the planned arrival of a medical professional.
54. E.C. Romanis, 'Why the Elective Caesarean Lottery Is Ethically Impermissible', *Health Care Analysis* 27 (2019), pp. 249–268.
55. J. Herring, 'Identifying the Wrong in Obstetric Violence', in C. Pickles and J. Herring, eds., *Childbirth, Vulnerability and Law Exploring Issues of Violence and Control* (New York: Routledge, 2019), pp. 67–87, 74.

anxiety about what choices are and are not available in reality, and concern about a loss of control over the birthing process including place of birth, it can instead be a negative and potentially traumatic and harmful experience. The mental health of birthing people will undoubtedly be impacted greatly by how birthing people are supported. It is notable that 'feelings of loss of control' and a 'lack of dignity' in birth, which are clearly more likely to be experienced when faced with a lack of choice, are strongly associated with post-traumatic stress disorder post-birth.[56] We note that in the present circumstances dealing with the consequences of a negative birthing experience might be more difficult for some people, as social support networks remain very limited in pandemic conditions.[57] Furthermore, the fact that access during the pandemic has been a 'lottery' (where it is available in some parts of the country and not others) will have been a source of considerable frustration and anger to those who are denied agency and feel as if this is unfair.

It is also to be noted that as well as the mental health impacts of a birthing experience that involves feelings of loss of control because there was less choice about place of birth, there may well be physical impacts on birthing people's bodies as a result of the birthing experience they end up having. In the next two sections, we consider some of these impacts by considering the two options available to pregnant people living in areas of the country in which homebirthing services are or were not available.

The obstetric setting. For some, giving birth in an obstetric setting is what makes them most comfortable, and over time this has become the norm in most high-income economies.[58] The law respects a pregnant person's right to choose *where* and how they give birth, since a pregnant person with capacity cannot be compelled to submit to any medical intervention (including any particular childbirth) as part of her right to accept or refuse medical treatment.[59] The judgment in *St Georges Hospital Trust v. S* made it absolutely clear that the *fact* of pregnancy or labour could not be used, in itself, to call capacity into question or to influence the assessment of capacity.[60] Baroness Hale placed great emphasis in *Montgomery v. Lanarkshire*[61] on the observation that a competent pregnant person is legally entitled to determine how they would prefer to birth (which we take to be inclusive of where they give birth), and that decision must be respected.[62]

56. Birth Trauma Association, *What is Birth Trauma?* (2020). Available at: https://www.birthtraumaassociation.org.uk/for-parents/what-is-birth-trauma (accessed 30 June 2020).
57. For much of the pandemic, people living in the UK were not allowed to interact with those out with their own households, and even when the restrictions began to ease the options to meet up were restricted to those who were able to leave their houses (as entering the property of another was not permitted). This means that those who would usually rely on friends, family members or partners who are not in their immediate household as a support network were not able to access this resource.
58. We explore this point in more detail in ongoing co-authored work.
59. *Re MB* [1997] 2 FLR 426.
60. *St George's Hospital Trust v. S* [1998] 3 All ER 673.
61. *Montgomery v. Lanarkshire Health Board* [2015] 2 All ER 1031.
62. per Baroness Hale at para 116.

Despite the law being clear on this point, however, there is still some unease about the extent to which these principles of non-interference and empowerment in choosing how to birth are enforced. Some may be concerned that their autonomy and right to choose may not be appropriately protected, particularly when they are in an obstetric setting. These concerns are not unfounded when we consider how the law and the principles described have been *applied* in situations where pregnant people have sought to refuse medical assistance during birth, for example, caesarean sections.[63] Pregnant people risk being found to lack capacity to make decisions about their birth and treatment where their choices do not align with medical advice during labour,[64] notwithstanding the letter of the law clearly indicating that capacity – and therefore the right to refuse medical treatment – is not impacted by pregnancy or labour per se.[65]

Where a pregnant person would prefer not to birth in a hospital setting, feeling forced to do so by the circumstances can be profoundly distressing for several reasons. First, pregnant people may feel considerable anxiety in the run up to their delivery because of concerns about exposure to the virus in the hospital environment (irrespective of whether virus risk is actually increased). It is also the case that the other restrictions and limitations that we have already mentioned in the hospital environment, such as limitations on birth partners and visitors and so on, could also be a considerable source of pre-birth anxiety. Birth is far more likely to be a negative experience if a pregnant person is experiencing significant apprehension in advance of the event; moreover, anxiety and stress in pregnancy is associated with preterm delivery.[66] Furthermore, the feelings of loss of control experienced by a pregnant person who does not want to birth in hospital while birthing in hospital are likely to be significant, especially if they are not supported by their birth partners of choice.

Importantly, hospital delivery is associated with an increased rate of obstetric intervention[67] and there are a number of birthing people who specifically plan for homebirth in an attempt to avoid monitoring[68] and such interventions.[69] There should be the concern that for some birthing people at this time, they may be more likely to feel compelled to have specific obstetric interventions including, potentially, caesarean

63. *Rochdale Healthcare (NHS) Trust v. C* [1997] 1 FCR; *Re AA* [2012] EWHC 4378 (COP); *NHS Trust v. JP* [2019] EWCOP.
64. There is a significant body of literature which speaks to the way that the application of the law fails to protect autonomy in cases where a birthing person seeks to refusing a life-saving caesarean section. See, for example, E. Walmsley, 'Mama Mia! Serious Shortcomings With Another "(En)forced" Caesarean Section Case Re AA [2012] EWHC 4378 (COP)', *Medical Law Review* 23 (2015), pp. 135–143.
65. *St George's Hospital Trust v. S* [1998] 3 All ER 673.
66. Dole et al., 'Maternal Stress and Preterm Birth'.
67. P. Brocklehurst, 'Perinatal and Maternal Outcomes by Planned Place of Birth for Healthy Women With Low Risk Pregnancies: The Birthplace in England National Prospective Cohort Study', *British Medical Journal* 343 (2011), p. d7400.
68. See, for example, foetal monitoring throughout birth.
69. Viisainen, 'Negotiating Control and Meaning'.

sections when they would prefer not to.[70] The physical consequences of an obstetrically managed delivery, even if not surgical, can also be significantly different to those in homebirth and may be a significant source of discomfort and displeasure to some people who birthed in this way.

'Coerced' freebirthing. For those who are determined to avoid hospital birth at this time for a variety of reasons (whether their reasons are specific to the COVID-19 context or not), they may feel that their only option is to freebirth. 'Freebirthing', as noted, refers to the situation in which a person gives birth without any medical assistance. This is lawful in the UK by virtue of the right to refuse medical treatment.[71] We do not believe that there is anything inherently problematic with the choice to freebirth; where this is a genuine choice it can be an empowering experience, and an important affirmation of a birthing person's autonomy.[72] However, we are concerned that the response to COVID-19 in relation to homebirth may result in birthing people feeling like they have no option but to freebirth as a result of a desire not to attend hospital, when they would much rather have their birth-at-home (their primary concern being to deliver *at home*) attended by a midwife. In these instances, one cannot argue that choice is truly being protected; a coerced choice is not a maximally autonomous one.

Denying people autonomy and control over their birthing experience can have significant, and long-term, consequences for their mental health. The Birth Trauma Association has identified loss of control, lack of dignity, poor pain relief and concerns about safety during birth as some of the factors associated with birth-related PTSD;[73] notably, these feelings may all be associated with a 'coerced' freebirth.

As well as concerns about the well-being of birthing people, there are also potential legal ramifications of freebirthing in situations where those involved have not had the appropriate time and support to research this. Article 45 of the Nursing and Midwifery Order 2001 makes it an offence for any person other than a medical professional to 'attend' to the birthing person;[74] to do so carries a potential fine of

70. The dynamics of consent and compulsion in this context are complex. It is frequently observed, however, that some people feel coerced into consenting in the obstetric setting. For an analysis of the reasons why some birthing people feel compelled to acquiesce to interventions once birth has begun where they would perhaps prefer not to have that intervention, see: E.C. Romanis, 'Addressing Rising Caesarean Rates: Maternal Request Caesareans, Defensive Practice and the Power of Choice in Childbirth', *International Journal of Feminist Approaches to Bioethics* 13 (2020), pp. 1–26.
71. *Re T (Adult: Refusal of Medical Treatment)* [1992]; note the observation above, however, that while the principle of self-determination and right to refuse treatment is routinely reiterated in the context of decisions about pregnancy and birth, the application of this principle in individual cases often leaves much to be desired.
72. C. Feeley and G. Thomson, 'Why do Some Women Chose to Freebirth in the UK? An Interpretative Phenomenological Study', *BMC Pregnancy and Childbirth* 16 (2016), pp. 1–12.
73. Birth Trauma Association, *What is Birth Trauma?*.
74. Nursing and Midwifery Order 2001, Articles 45(1)–(2).

up to £5000.[75] The order fails to define what is meant by 'attends to' which can compound the confusion and anxiety potentially felt by those who have turned to freebirthing as a 'last resort'. Further, where birth takes place at home it must be 'notified' within 6 hours.[76] This is an additional requirement to the need to 'register' all births within 42 days of delivery,[77] and one which people who have not had the time to thoroughly research this kind of birth may not know about or sufficiently understand, including the relevant administrative steps.

Recent reports have indicated that as NHS trusts look to reinstate homebirth services, they may require the people who wish to access these to sign 'homebirth contracts'.[78] These documents, aimed at safeguarding midwives, cannot compel a birthing person to do anything they are lawfully permitted to refuse; it cannot compel her to accept certain treatments, for example. However, what these contracts do seem to do is introduce some 'hospital style restrictions' to the provision of homebirth services, such as restricting the number of birth partners to one.[79] Given that we have posited that some birthing people may be seeking access to homebirth to avoid exactly such restrictions, it may be that such an approach increases the incidence of birthing people freebirthing because they feel like they have no other option.

Human rights implications

There is increasing awareness that the treatment of birthing people during childbirth is a matter which falls within the remit of human rights law.[80] By virtue of the Human Rights Act 1998, NHS Trusts (as public authorities) must act in a manner compatible with the obligations set out in the ECHR.[81] Article 8 of the ECHR provides a right to private and family life, and the European Court of Human Rights has established that issues about the circumstances of birth – including place of birth – fall within the scope of this right.[82] While Article 8 does not dictate that States *must* offer homebirthing services,[83] where a State *does* routinely support homebirthing, any denial of these services will amount to an interference with Article 8[84] as a result of the State's positive obligations under the provision. We also add that it is innately concerning from a human rights perspective

75. Birthrights, *Factsheet: Unassisted Birth*.
76. Notification of Births Act 1907, section 1(1).
77. Births and Deaths Registration Act 1953, section 2(1).
78. BBC News, 'Coronavirus: Homebirths to Restarts With New Safeguards', *BBC News Scotland* 23 June 2020. Available at: https://www.bbc.co.uk/news/uk-scotland-edinburgh-east-fife-53141853 (accessed 30 June 2020).
79. Birthrights, *Home Birth Contracts* (25 June 2020). Available at: https://www.birthrights.org.uk/2020/06/25/home-birth-contracts/ (accessed 25 June 2020).
80. See, for example, C. Pickles and J. Herring, eds., *Childbirth, Vulnerability and Law Exploring Issues of Violence and Control* (New York: Routledge, 2019).
81. Human Rights Act 1998, section 6(1).
82. *Ternovszky v. Hungary* [2011] ECHR 6
83. *Pojatina v. Croatia* [2018] ECHR 328.
84. *Ternovszky v Hungary* [2011] ECHR 6.

that this service has been available in a postcode lottery at this time – for some birthing people access has been rightfully preserved, but some others have not had access by virtue of the decisions made by their local health service. While the State's positive obligation in this context is engaged, it does not necessarily preclude the Health Service from removing homebirthing services in certain situations as Article 8 is not an absolute right. However, any interference with this right must be carefully justified as being necessary and proportionate.

Article 8(2) states that interference may be justified if it is necessary for the 'protection of health'. However, it is not clear that removing homebirthing services does, in fact, achieve this aim. The impact of denying these services on birthing people's welfare has already been explained so we need not reiterate this here to demonstrate that removing homebirthing services actively causes more harm to birthing people's health. It is also not immediately clear that offering a homebirthing service has the potential to result in birthing people's health being compromised while delivering. It might be claimed, as some Trusts did in suspending services,[85] that the limited availability of ambulances as they are busier than usual with COVID-19 patients might mean that it is less safe to birth at home because emergency provision for transfer to hospital is less readily available. However, the empirical evidence on the relative safety of homebirth illustrates that the proportion of cases in which transfer to hospital for obstetric care in instances of planned homebirth is very small.[86] Furthermore, we are not inclined to believe that either the number of birthing people needing such assistance would or could be happening on such a scale to significantly divert ambulance attention away from COVID-19 patients, nor that this is sufficient justification given that the ambulance service ought to be, and presumably is, readily available for other non-COVID-19 emergencies that might occur at this time. Finally, we note that in the instance that homebirthing is routinely denied and this leads more birthing people to freebirthing, it is much more likely that this might result in more calls to the emergency services.

Further, we argue that it is illogical to assert that the blanket removal of homebirthing service meets the test of 'necessity' when two-thirds of Trusts have continued to offer some form of homebirth service throughout the pandemic. The blanket removal of homebirthing services is neither necessary nor proportionate, therefore these policies amount to a violation of the Article 8 rights of birthing people.

If one is able to make the case that the right to have a homebirth is a 'civil right' there is also a potential to challenge the *blanket* nature of these policies under the procedural head of Article 6; the right to a 'fair and public hearing within a reasonable time'. We suggest that homebirth services ought to be considered as a civil right because of the NHS policies which indicate that this choice should be widely available and the

85. Op. cit.

86. On this point (though in relation to abortion services), see: R. Scott, 'Risks, Reasons and Rights: The European Convention on Human Rights and English Abortion Law', *Medical Law Review* 24 (2016), pp. 1–33; E.C. Romanis, J. Parsons and N. Hodson, 'COVID-19 and Reproductive Justice in Great Britain and the United States: Ensuring Access to Abortion Care During a Global Pandemic', *Journal of Law and the Bioscience* 7(1) (2020), p. 27.

professional obligations incumbent upon midwives which we outlined at the beginning of this article. Therefore, the ECHR dictates that birthing people ought to be able to challenge this policy. The nature of the blanket policy is that decisions are not made on a factual case-by-case basis, which also means that there is not scope for individuals to appeal against the decision not to allow them access to a homebirth. While judicial review may present an alternative avenue to challenge the policy, this is insufficient to fulfil the obligation incumbent upon States to ensure their citizens have 'genuine and effective' enjoyment of their ECHR rights. Judicial review is a lengthy and cumbersome process at the best of times, and the courts have not been immune from the impact of delays caused by COVID-19. Pregnancy by its very nature is a time limited process, and issues about care during childbirth are 'time sensitive'.[87] Judicial review does not, therefore, present an effective mechanism whereby birthing people can challenge the homebirth policies.

Homebirths 'contracts'

As mentioned, some NHS Trusts have begun to reinstate their homebirthing services as lockdown restrictions in the UK (at the time of writing) are generally easing (outside of local lockdowns). However, NHS Trusts are of course working to consider how they can make these services as safe as possible, in terms of COVID-19 infection risk, for their staff and for birthing people. An emerging pattern is the use of 'homebirth contracts' in which documents are used to, in writing, explain the obligations on incumbent on birthing persons who are attended at home to preserve the safety of midwives. Compulsory 'homebirth contracts' have been introduced by NHS Lothian,[88] and the relevant documents spell out the 'risks of birthing at home'. Birthrights notes that it is unfortunate that these contracts do not present a balanced picture of birthing at home[89] – since they often neglect to mention the specific benefits of doing so,[90] and also as there is the potential that the risks are overstated in the absence of mentioning these benefits.

Concerns about homebirth contracts are not new. Nolan wrote of the experiences of birthing people who were asked to sign 'disclosures' on Trust-headed paper with statements such as 'this is a disclosure to say that if anything happens at home, you will take full responsibility and that you will transfer into hospital if we deem it necessary'.[91] Birthrights has raised their concern about such COVID-19 'homebirth contracts' effectively making birthing people feel as if they are agreeing to any intervention that might be proposed by their midwife during a homebirth.[92] These documents do not carry any

87. C. Pickles, 'Leaving Women Behind: The Application of Evidence-Based Guidelines, Law, and Obstetric Violence by Omission', in C. Pickles and J. Herring, eds., *Childbirth, Vulnerability and Law*, p. 146.
88. Birthrights, *Home Birth Contracts*.
89. Op. cit.
90. For example, some benefits are being in a comfortable environment, having the freedom to move around, having more freedom with birth partners.
91. M. Nolan, *Homebirth: The Politics of Difficult Choices* (New York: Routledge, 2011), p. 51.
92. Birthrights, *Home Birth Contracts*.

legal weight when it comes to decisions during birth – the fact that a pregnant person preparing to birth has signed cannot compel them to have any intervention during their birth, such as transfer to hospital, to which they do not consent. A birthing person's right to refuse medical treatment, a fundamental principle of English law, will remain intact[93] as we have noted in this article. However, there is a clear intention by NHS Trusts in these documents to make these arrangements appear *as if* they carry such authority, and it is easy to see how they might be interpreted as doing so by birthing people; not least as the word 'contract' is usually used in reference to an agreement between two parties which is legally enforceable in some way. This is incredibly inappropriate. We see the value in information being given to birthing people about the COVID-19 context and about what birthing people and midwives can do together to minimise everyone's exposure to infection. However, if documentation is being used that mentions interventions and birthing person's 'obligations' to agree to the recommendations of their midwives this is both wholly inappropriate, and an affront to the principles of autonomy and empowerment in childbirth. This, therefore, displaces pregnant people's welfare.

Conclusion

COVID-19 has had a significant impact on all aspects of medical care in the UK, and the maternity services have been no different. In this article, we have focused on the restrictions that some NHS Trusts imposed upon homebirthing in response to the virus. While homebirthing is not a popular birthing choice in the UK, there are a number of reasons associated with the pandemic which have likely increased demand for this choice; fear (whether founded or not) about attending hospital, concerns about the choices available to birthing people during birth and fear related to the strict restrictions on birth partners and visitors. Furthermore, the reasons why birthing people opt for homebirth are often highly individual, meaningful and often determinative of that person's experience of childbirth.

In this article, we have outlined the potential harms – physical, mental and legal – associated with restricting homebirthing services at a time when demand for them may be greater than ever. We believe that choice about and in childbirth is imperative, and it remains so at a time when support networks for birthing people and new parent(s) are more restricted than they have been in living memory. The investigation of the impact that the pandemic has had on access to homebirth is incredibly important, to highlight the extent to which there has been a failure to centre the experiences of birthing people and their welfare in maternity services at this time (in a manner that we believe was not necessary or proportionate) and in the hope that lessons can be learnt going forward.

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93. *Re T (Adult: Refusal of Medical Treatment)* [1992]; *Re MB* [1997] 2 FLR 426 (CA); *Re S (Adult: Refusal of Medical Treatment)* [1992] 3 WLR 8.

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