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Childbirth Rights: Legal Uncertainties under the European Convention after Ternovsky v. Hungary

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"Childbirth Rights"?: Legal Uncertainties under the European Convention after Ternovszky v. Hungary

Caitlin McCartney†

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I. Introduction

Childbirth has emerged as a new battleground for competing political camps.¹ While some groups push for increased state

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¹ See Rebecca A. Spence, Abandoning Women to Their Rights: What Happens When Feminist Jurisprudence Ignores Birthing Rights, 19 CARDOZO J. L. & GENDER 75,
regulation of medical care during childbirth, others argue that women should have a greater choice in how and where they give birth.\(^2\) Women’s rights during childbirth, however, have not received the same degree of consideration and advocacy as other reproductive rights, such as contraception and abortion.\(^3\)

The use of medical technologies in childbirth has facilitated a decreased mortality rate for women and newborn children over time.\(^4\) However, most medical advances that contributed to lower mortality rates were developed in the second half of the twenty-first century, well after hospitalized births became standard practice.\(^5\) Today, the World Health Organization reports 28 maternal deaths per 100,000 live births in the United States\(^6\) and 8 maternal deaths per 100,000 live births in the United Kingdom.\(^7\) In the Netherlands, which has a state-promoted system of home birth, the maternal mortality rate was 6 per 100,000 live births.\(^8\)

75-76 (2012).

\(^2\) Id.

\(^3\) Id. ("Scholars and students in the fields of law, bioethics, anthropology, and sociology have reviewed [issues of women’s freedom to give birth safely and with dignity in the location of choice], yet these studies remain curiously absent from gender discrimination and feminist jurisprudence texts commonly used in American law schools... Meanwhile, women’s rights have been subtly and less-subtly violated by state actors—from legislatures and administrative agencies that restrict access to care providers, to courts and child welfare authorities that punish women for their birthing choices.").


\(^5\) See Judith Walzer Leavitt, Brought to Bed: Childbearing in America, 1750-1950 194 (1986) (noting that maternal mortality in hospitals was high until the 1940s and 1950s, when rates fell due to increasing regulation, prenatal care, and the availability of antibiotics and blood transfusions).


Despite the established safety of planned home births today, childbirth remains widely consigned to the medical industry.\(^9\)

Dominant thought has shifted from viewing pregnancy and childbirth as primarily physiological to primarily pathological.\(^10\) The medical model of pregnancy and childbirth can have adverse consequences for women who want to give birth free from unnecessary medical interventions. Hospital births are more likely to entail medical interventions, sometimes performed without informed consent.\(^11\)

Women who seek to give birth at home with the assistance of a midwife often meet legal obstacles inhibiting this choice. Various factors, including a lack of insurance coverage\(^12\) and laws or regulations seeking to protect fetal life\(^13\) or the health of the


\(^10\) See, e.g., Elizabeth Kakura, *Choice in Birth: Preserving Access to VBAC*, 114 PENN ST. L. REV. 955, 996 (2010) (explaining that the "medical model of pregnancy and children repackages female reproductive processes as pathological conditions"); see also Laura D. Hermer, *Midwifery: Strategies on the Road to Universal Legalization*, 13 HEALTH MATRIX 325, 336–37 (2003) (explaining that race and class prejudices drove obstetricians and physicians to adamantly oppose midwifery in the early 20th century, and that one successful strategy to curb the practice of midwifery was "to convince the legislature and the public that childbirth is not a normal act, but instead a pathological one").

\(^11\) E.g., Spence, *supra* note 1, at 82 ("[M]any courts have deprived women choosing between different modes of delivery of their rights to informed consent and refusal by over-relying on evidence from medical providers, and by misapplying abortion law to women not seeking abortions.").

\(^12\) AMNESTY INT’L, *DEADLY DELIVERY: THE MATERNAL HEALTHCARE CRISIS IN THE USA* 81 (2010) (explaining that in the United States, public and private insurance companies often fail to reimburse for midwifery care options); Paul Stracansky, *East Europe: Midwives Struggle to Deliver Home Births*, IPS NEWS AGENCY (Jan. 19, 2011), http://www.ipsnews.net/2011/01/east-europe-midwives-struggle-to-deliver-home-births ("In many countries across [Eastern Europe] home births are allowed by law but heavily discouraged . . . . In some cases, such as Poland and the Czech Republic, they are not covered by state health insurance – putting the practice out of financial reach of many parents.").

pregnant woman, often contribute to women's lack of access to a midwife. Regulations restricting women's ability to choose to give birth at home frequently conflict with the right to bodily autonomy and the right to refuse medical treatment.

This comment addresses recent international developments in the legal arena of childbirth, with specific focus on privacy rights encompassing home birth under the European Convention. These rights, tentatively established in the 2010 case, Ternovszky v. Hungary, continue to be sources of ambiguity due to the margin of appreciation the State has in the regulation of home birth, a process that has no clear consensus among member states, and which many states classify as a matter of public

Interventions on Pregnant Women in the United States, 1973-2005: Implications for Women's Legal Status and Public Health, 38 J. Health Pol'y, Pol'y & L., 299, 299–300 (2013) (offering examples of initiatives to grant fetuses 'personhood' status and explaining how efforts to cast fetuses as having a separate legal status than the women who carry them has led to hundreds of documented attempted and actual deprivations of women's physical liberty through forced medical interventions or incarceration).

See, e.g., Judith A. Lothian, Risk, Safety, and Choice in Childbirth, 21 J. Perinatal Educ. 45, 46–47 (2012) ("There is a moral imperative to follow established ways of doing things and to buy into the societal view that managing risk improves outcomes. If a woman chooses something different, for instance home birth, refusing to be induced or opting out of prenatal testing, the powerful obstetrician counters with 'You are endangering your baby.' It is a rare woman who has the confidence to refuse to comply.").

See, e.g., Benjamin Grant Chojnacki, Pushing Back: Protecting Maternal Autonomy from the Living Room to the Delivery Room, 23 J.L. & Health 45, 69–70 (2010) (emphasizing studies that found that the majority of women receiving interventions during birth, such as cesarean section and induction, could not identify the risks posed by these procedures, which raises concerns that consent to birth interventions is not always informed); see also Spence, supra note 1, at 82 ("Feminist scholars have argued that depriving women of their rights during pregnancy deprives women of legal personhood, diminishes women's autonomy, and derogates women's claim to full citizenship.").


Council of Europe, http://hub.coe.int/ (last accessed Feb. 22, 2014) (listing all forty-seven member states of the Council of Europe that have ratified the European Convention: Albania, Andorra, Armenia, Austria, Azerbaijan, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia,
health.\textsuperscript{19}

There are currently two ongoing cases about home birth before the European Court of Human Rights (ECtHR): \textit{Dubská and Krejzová v. the Czech Republic}\textsuperscript{20} and \textit{Elena Kosaitė-Čypienė and others v. Lithuania}.\textsuperscript{21} These cases raise legal issues of home birth, which the ECtHR, in deciding \textit{Ternovszky} on narrow grounds, has not yet addressed. This Comment provides an analysis of issues that \textit{Ternovszky} left uncertain, including questions about privacy and health rights under the European Convention. The complaints for \textit{Dubská} and \textit{Kosaitė-Čypienė}, as well as the September 2013 chamber hearing for the \textit{Dubská} case, have illuminated these issues. This comment also addresses related legal issues that could be impacted by future ECtHR decisions about home birth, including policies of informed consent and the pregnant woman’s right to refuse medical treatment. Because non-European states, including the United States, have looked to decisions by the ECtHR in developing their domestic law,\textsuperscript{22} ECtHR decisions about home birth could profoundly impact how legal systems, including that of the United States, regulate home birth internationally.

The Comment proceeds as follows: Part I discusses the debate about rights during childbirth; Part II provides a legal framework for these rights, showing some of the immensely varied ways state governments deal with the regulation of childbirth domestically.

\footnotesize


before explaining the sources of reproductive rights, including childbirth rights, under the European Convention; Part III offers an analysis of *Ternovszky v. Hungary* and three ongoing cases in the ECtHR; finally, Part IV explains the legal uncertainties left by the ECtHR in *Teronovszky* and discusses the continuing logistical obstacles standing between European women and their access to self-determination in childbirth.

II. Childbirth Rights

A. Medicalization of Childbirth

The first use of anesthesia during childbirth in the United States occurred in Massachusetts in 1847. Fanny Appleton Longfellow and her husband, Henry Wadsworth Longfellow, searched for a physician willing to administer anesthesia during the birth of their child after hearing about a Scottish physician who had successfully administered ether during a birth. After a long search, the Longfellow couple found a Boston physician who agreed to administer the anesthesia. Both Fanny and her physician deemed the birth a success, with Fanny even writing to a friend that she felt proud to be a "pioneer to less suffering for poor, weak womankind." Fanny's words are telling. Certainly, anesthesia eased the pain of childbirth. Also apparent in Fanny's statement, however, is the reigning notion of womanhood in the mid-nineteenth century, at the beginning of Queen Victoria's reign. The Victorian era overemphasized and even romanticized the idea of the invalid woman. Physicians of the time period


24 Id.


26 Id.

27 Maev Kennedy, *Queen Victoria's Journals Published Online*, *The Guardian* (May 24, 2012), http://www.theguardian.com/uk/2012/may/24/queen-victoria-private-journals-online (illustrating Queen Victoria herself, when recounting the anesthesia-assisted birth of Prince Leopold in 1853, praised "that blessed chloroform").

28 See WOLF, supra note 25, at 14–15 (explaining that mid-nineteenth century physicians harbored different attitudes toward puberty as it affected boys and girls, viewing girls' bodies as aberrant, inherently weak, and greatly susceptible to disease). Wolf also describes the popularity of infirmity among women during this time, and suggests that this had a "corollary" in the idea that working-class women, Native
developed theories that too much mental stimulation could cause a
girl's reproductive organs to fail to develop properly and began to
diagnose diseases, such as neurasthenia (nervous exhaustion) that
affected only women.\textsuperscript{29} Such trends among physicians reinforced
ideas about the intolerability of childbirth for upper-class women,\textsuperscript{30}
and led to a system of care in which social norms, rather than
medical necessity alone, influenced women's childbirth choices,
casting childbirth as a clinical matter and pregnant women as
patients in need of physician-directed regulation and intervention.\textsuperscript{31}

Anesthesia use and the practice of hospitalizing women for
childbirth became popular in the following decades.\textsuperscript{32} In 1900,
very few births took place in hospitals.\textsuperscript{33} By 1969, the percentage
rose to 99\%.\textsuperscript{34} Different factors, including not only medical
technologies, but also an increase in health insurance and
Medicaid coverage, led to this increase in hospital births.\textsuperscript{35}

The use of medical technology during childbirth has not

\begin{flushleft}
\textsuperscript{29} Id.
\textsuperscript{30} Id. at 14.
\textsuperscript{31} See id. at 9 ("Social change ... continues to shape women's vision of the ideal
birth and physicians' treatments."); see also Chris Hafner-Eaton & Laurie K. Pearce,
Birth Choices, the Law, and Medicine: Balancing Individual Freedoms and Protection of
the Public Health, 19 J. Health Pol. Pol'y & L. 813, 831 (1994) ("Often social norms
are not based on epidemiologic data that show long-term health trends or outcomes in
large populations; rather they are shifted, manipulated, or maintained by key power-
holding groups who may have vested interests. The key to changing inaccurate social
ideas about the safety of childbirth at home and about lay midwives as birth attendants is
to continue to conduct scientifically rigorous studies, educate about the findings, and
enact legislation that reflects an acceptance of alternatives."); see also Hermer, supra
note 10, at 366 ("While birth technologies have led to further medical control of
women's bodies and desires with respect to conception, pregnancy and childbirth, this
control is not secured primarily through violence or coercion, but rather by producing
new norms of motherhood.") (summarizing Jana Sawicki, Disciplining Foucault:
Feminism, Power, and the Body 81-82 (1991)).
\textsuperscript{32} Marian F. MacDorman, T.J. Mathews & Eugene Declercq, U.S. Dept. of
\textsuperscript{33} Id.
\textsuperscript{34} Id.
\textsuperscript{35} Adrian E. Feldhusen, The History of Midwifery and Childbirth in America: A
articles/timeline.asp.
\end{flushleft}
always meant an increase in safety for women and their babies.\textsuperscript{36} The use of anesthesia in childbirth led to an increased use of forceps, which created risks of hemorrhage and infection and contributed to a rise in maternal mortality rates in the United States well into the 1930s.\textsuperscript{37} Compared with European countries that approached childbirth with the attitude that less medical intervention produced the best outcomes for mothers and infants, the United States had—and continues to have—higher mortality rates.\textsuperscript{38}

Hospitalization for childbirth created an environment ripe for cording women from their ability to exercise control over their childbirths. By the 1950s, the primary procedure for childbirths in the hospital setting involved using anesthetics to put women into a “twilight sleep,” rendering them unconscious for the final stage of labor.\textsuperscript{39} As Jacqueline Wolf explains, physicians often described childbirth as “pain free” to garner women’s cooperation, but they did not always fully inform women of the side effects of the medications they were receiving:

\begin{quote}
Given their ignorance of birth and contemporary birth practices, most [women] had not necessarily equated painlessness with oblivion and thus many were surprised to find out that they could recall little of their labors, remembering only that at some point, often shortly after hospital admission, they received an injection of some unknown substance and then—nothing. These women tell the same cryptic story about the births of their children: ‘I was unconscious.’ ‘I was out.’ ‘I don’t know what I had. But whatever it was, it knocked me out.’\textsuperscript{40}
\end{quote}

Ironically, later studies suggested that twilight sleep did not actually alleviate pain for laboring mothers; rather, women experienced pain but did not remember it after they awoke.\textsuperscript{41}

\textsuperscript{36} Wolf, supra note 25, at 76.

\textsuperscript{37} Id.

\textsuperscript{38} Id. (noting that in the 1930s, the maternal mortality rate was 65 in 10,000 births in the United States, where doctors used forceps in 20% of births; 35 in 10,000 births in Denmark, where doctors used forceps in only 4.5% of births; and 23 in 10,000 births in the Netherlands, where doctors used forceps in 1% of births).

\textsuperscript{39} Id. at 46-47.

\textsuperscript{40} Id. at 115.

\textsuperscript{41} Anne Finkbeiner, Labor Dispute, N.Y. Times (Oct. 31, 1999), http://www.nytimes.com/1999/10/31/books/labor-dispute.html (“[T]he small dose of morphine only disinhibited the patients and didn’t actually prevent pain, so patients had...
Although the medicalization of childbirth made childbirth more convenient and profitable, the practice of rendering women unconscious during childbirth eventually began to decrease as backlash against the practice rose. The rise of second-wave feminism in the 1970s and 1980s, decades in which a surge of women entered the workforce and remained there even after the births of their children, led to a resurgence of certain obstetric practices that were abandoned during years of birth reform, such as induced labor. These practices were praised by the women who wanted to choose the circumstances surrounding the births of their babies. Indeed, there has been a tremendous rise in induced labor and caesarian sections in the United States over the past several decades. This increase is one of the more prominent examples that scholars use to analyze medicalized childbirth in today’s society, and which we can use to consider agency in childbirth.

B. The Debate

Today, 99% of women in the United States continue to give birth in a hospital setting. Percentages vary in European countries. In the United Kingdom, 3% of births occur at home.


43 WOLF, supra note 25, at 13.

44 Id. at 171.

45 FAY MENACKER & BRADY E. HAMILTON, U.S. DEPT. OF HEALTH AND HUMAN SERVS., RECENT TRENDS IN CESAREAN DELIVERY IN THE UNITED STATES 1 (2010), http://www.cdc.gov/nchs/data/databriefs/db35.pdf (showing an increase in Cesarean sections from 21 per 100 births in 1996, to 32 per 100 births in 2007).

46 E.g., Lothian, supra note 14, at 46 (“The consequences of creating, exaggerating, and managing risk in pregnancy and childbirth include a 33% cesarean rate, an ever increasing induction rate, and neonatal intensive care units filled to capacity. It has led to pregnancies fraught with worry, an ever increasing fear of labor and birth, and a reluctance of women to make choices that reflect putting risk in perspective and deciding for themselves what ‘acceptable’ risk is.”).

47 MACDORMAN et al., supra note 32, at 1.

48 Frank A. Chervenak et al., Planned Home Birth: The Professional Responsibility
In the Netherlands, which has instituted an official system of home birth, 23.4% of women give birth at home.\textsuperscript{49} This variance indicates how culture and tradition are closely linked to women's childbirth choices.

Midwives and physicians approach pregnancy differently.\textsuperscript{50} While the focus of obstetrics deals with diagnosing, treating, and managing the complications of pregnancy in pregnant women and the fetuses they carry,\textsuperscript{51} midwives generally believe that pregnancy and childbirth are normal, rather than pathological, processes that should be treated as such.\textsuperscript{52}

C. Arguments against Home Birth

Proponents of hospital birth often use risk and safety discourse to support their arguments. Many problems, both foreseeable and unpredictable, can occur during childbirth. These include problems with the umbilical cord, fetal distress or malpresentation, uterine rupture, perineum tear, pulmonary embolism, and hemorrhage.\textsuperscript{53} While the vast majority of births do not result in these problems,\textsuperscript{54} the possibility of such issues arising often leads physicians to make preemptive interventions and to require that women under their care give birth in a hospital. In the past, various medical organizations have publicly rejected the practice of giving birth at home; the American College of Obstetricians and Gynecologists (ACOG) and the American Medical Association

\textsuperscript{49} Id.


\textsuperscript{51} JUDITH PENCE ROOKS, MIDWIFERY AND CHILDBIRTH IN AMERICA 4 (1997).

\textsuperscript{52} E.g., id. at 5.

\textsuperscript{53} AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, COMMITTEE ON OBSTETRIC PRACTICE, PLANNED HOME BIRTH (2011), available at https://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Obstetric_Practice/Planned_Home_Birth [hereinafter ACOG COMMITTEE OPINION].

\textsuperscript{54} Birthplace Study: What Are the Main Results of the Study?, NCT (UK's Largest Charity for Parents), http://www.nct.org.uk/professional/research/pregnancy-birth-and-postnatal-care/birth/birthplace-study/what-are-main-result (last visited Feb. 18, 2012) [hereinafter BIRTHPLACE STUDY] (estimating that adverse outcomes occur in 4-5 births per 1,000 regardless of where a mother gives birth).
(AMA) have expressed several concerns about home birth, including conditions such as the lack of medical equipment or inadequate medical knowledge.\textsuperscript{55} In 2008, the AMA introduced a resolution asking for state legislation to require all births to be performed in a hospital setting.\textsuperscript{56}

Supporters of hospital birth note studies that show a twofold increase in risk of neonatal death in home births compared with hospital births and suggest that while certain observational studies of home birth do not find this increased risk, such studies describe home births occurring within "tightly regulated and integrated provincial health systems" and therefore may not be generalizable to women living outside of the reach of these types of health systems.\textsuperscript{57} Resources such as a safe, fast method of transfer to the hospital in case of an emergency is of critical importance in home birth, and whether a fast, safe transfer is available is a variable that may be skewing studies.\textsuperscript{58} Studies that have shown no increased maternal and perinatal mortality were conducted in Ontario, British Columbia, and the Netherlands, all of which have highly integrated health care systems with procedures for intrapartum transfer in place.\textsuperscript{59} Because not all health systems are equipped with the aforementioned resources, transfer to the hospital may not be as safe universally as these studies have shown it to be.\textsuperscript{60}

Many factors contribute to the safety of home birth. One study, for example, showed no increased risk in a home birth for mothers who had already given birth to one child, but found a slightly increased risk for mothers giving birth to their first child at home.\textsuperscript{61} Assessment of the safety of home birth should always take context into account—factors such as the location of the birth relative to a hospital, the outcomes of a woman's previous labors and births, and any medical risks unique to the pregnancy may make a hospital birth a better option than a home birth.

\textsuperscript{55} ACOG COMMITTEE OPINION, \textit{supra} note 53, at 2-3.
\textsuperscript{57} ACOG COMMITTEE OPINION, \textit{supra} note 53, at 3.
\textsuperscript{58} \textit{Id.} at 1.
\textsuperscript{59} \textit{Id.} at 2.
\textsuperscript{60} \textit{Id.} at 2-3.
In addition to safety in the face of unforeseen complications, proponents of hospital birth argue that medical technologies allow physicians to lessen risk of the labor and delivery, and increase convenience for the pregnant woman and the physician. In a hospital birth, women have access to pain relief. Hospitals are also better equipped to deal with emergencies and are able to quickly administer interventions during labor, such as medically necessary inductions or cesarean sections.

Currently, physicians in the United States are under scrutiny for soaring rates of cesarean sections. Physicians cite an array of reasons to favor surgical birth, including concern for fetal death or injury, a woman's fear of childbirth, the avoidance of pain, and nonmedical factors, including the convenience and availability of the desired provider. Malpractice premiums also contribute to increased levels of intervention during childbirth. The American College of Obstetricians and Gynecologists acknowledges the higher rate of intervention in hospital births but still discourages home births, maintaining that the absence of emergency medical equipment and specialists in the home could have dire consequences for the mother or baby.

Regarding non-medically indicated surgical birth (NMISB), the ACOG and the International Federation of Gynecologists and Obstetricians (FIGO) have come to different conclusions. The ACOG stipulates, "If the physician believes that cesarean delivery promotes the overall health and welfare of the woman and her fetus more than vaginal birth, he or she is ethically justified in

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63 See id. at 16 ("The use of surgical births in the United States is rapidly increasing: In 2005, 30.2% of U.S. births were accomplished surgically . . . However, it is difficult to distinguish between elective and medically indicated caesarean births.").

64 Id. at 18.


67 Id.
performing a cesarean delivery."\(^{68}\) FIGO, on the other hand, notes that because NMISB creates possible hazards for mother and child and requires more resources than a normal delivery, "performing cesarean section for non-medical reasons is not justified."\(^{69}\) These differences show that prevailing social ideas about the role of medical professionals in childbirth can impact the norms of intervention levels in different locales.

In addition to safety and liability concerns, justifications for encouraging hospital birth include expense and shortages in medical professionals.\(^{70}\) A medical system that integrates home birth has unique costs that include patient transport, midwife and obstetrician services, maintenance of an adequate transport system, legal fees, and the necessity to provide lifetime support to mothers and children injured or disabled through a home birth.\(^{71}\)

Many factors add to the contentiousness of the debate about childbirth, a natural process involving two lives, both of which can be jeopardized if a problem arises. Ultimately at issue is whether a


\(^{69}\) ETHICAL ISSUES IN OBSTETRICS & GYNECOLOGY, INTERNATIONAL FEDERATION OF GYNECOLOGISTS & OBSTETRICIANS, COMMITTEE FOR THE ETHICAL ASPECTS OF REPRODUCTION AND WOMEN'S HEALTH 88 (2012), available at http://www.figo.org/sites/default/files/uploads/wgpublications/ethics/English%20Ethical%20Issues%20in%2 0Obstetrics%20and%20Gynecology.pdf ("[A]vailable evidence suggests that normal vaginal delivery is safer in the short and long term for both mother and child. Surgery on the uterus also has implications for later pregnancies and deliveries. In addition there is also a natural concern at introducing an artificial method of delivery in place of the natural process without medical justification.").

\(^{70}\) See Barbara Hewson, Mothers Don't Have the 'right' to a Home Birth, THE INDEPENDENT (Sept. 9, 2013), http://www.independent.co.uk/voices/comment/mothers-dont-have-the-right-to-a-home-birth-8804703.html. But see John Weeks, Homebirth Midwives and the Hospital Goliath: Evidence Builds for Disruptive Innovation, THE HUFFINGTON POST (Mar. 29, 2012), http://www.huffingtonpost.com/john-weeks/homebirth-david-versus-th_b_1372854.html (quoting Jeff Thompson, M.D., M.P.H., chief medical officer of the state of Washington’s medical program) ("Of the $600 million Medicaid spends annually on hospital costs in his state, 30 percent reflects delivery costs. The unintended consequence of not pursuing something like [expanding the home birth option] is that we don’t have enough resources to spend in other ways.").

\(^{71}\) Kelly Fitzgerald, Home Birth Not As Safe, Cost Effective Or Satisfying As Previously Reported, MED. NEWS TODAY (Nov. 13, 2012), http://www.medicalnewstoday.com/articles/252753.php.
risk-safety assessment may override women's decisions about their bodies and the births of their babies.

D. Arguments for Home Birth

While there persists a stigma that home births are more dangerous than hospital births, home birth supporters argue that this is a misconception derived from social mores and misleading statistics. Certain studies, which have shown an increased risk in births that take place outside the hospital, have not accounted for "planned home births" and thus include emergency births that were not planned to take place in the home as home births with adverse outcomes. This skews statistics and public perception, because such emergency births do not receive the level of consideration, safety planning, and assistance of health professionals that generally benefit planned home births.

Several studies have shown no increased risk associated with planned home births. A 2002 study of planned home births attended by midwives and planned hospital births showed no increased neonatal or maternal risk factors in the home births. There were similar rates of perinatal mortality in home and hospital births. A 2005 North American study examined 5,148 planned home births attended by midwives and found that medical intervention rates were significantly lower in these births than in planned hospital births, including a cesarean rate of 3.7%. A 2011 study in the U.K. made several important findings, including: that 88% of planned home births were 'normal births' compared to

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72 See Lothian, supra note 9, at 44 (explaining that studies such as the 2002 study by Pang, Heffelfinger, Huang, Benedetti & Weiss, which created a stir by showing an increased risk for home birth, "creat[e] possible, and probably likely, inclusion of high-risk, unplanned, unattended home births" when they do not indicate whether the home births included in the study were planned or unplanned).

73 Id.

74 See id. (citing Benedetti et al., Outcomes of Planned Home Births in Washington State: 1989-1996, 100 OBSTETRICS & GYNECOLOGY 253, 259 (2002); Kenneth Johnson & Betty-Anne Daviss, Outcomes of Planned Home Births with Certified Professional Midwives: Large Prospective Study in North America, 330 BRIT. MED. J. 1416 (2005); Janssen et al., Outcomes of Planned Home Births Versus Planned Hospital Births After Regulation of Midwifery in British Columbia, 166 CAN. MED. ASS’N J. 315 (2002), and M. ENKIN ET AL., A GUIDE TO EFFECTIVE CARE IN PREGNANCY AND CHILDBIRTH (2000)).

75 Janssen et al., supra note 74, at 315.

76 Id.

77 Johnson & Daviss, supra note 74, at 1416.
about 60% of planned obstetric unit births; that for healthy multiparous women with low risk pregnancies, there were no differences in adverse perinatal outcomes between planned births at home and planned births in obstetric units; that healthy nulliparous women with low-risk pregnancies had a slightly higher risk of an adverse outcome in a planned home birth; and that transfer rates for planned home births were high for first-time births (around 40%) and low for women who had previously given birth (around 10%). These studies suggest that laws hindering home birth do not substantially, if at all, increase safety for women and babies.

Proponents of home birth argue that giving birth at home provides the greatest likelihood that a woman will maintain control over childbirth. Midwives tend to use a hands-off approach to the labor and delivery, intervening only where true complications exist. If problems that require medical attention arise, midwives transfer the woman or baby to the hospital, according to a pre-arranged transfer plan. At home, women are less likely to undergo unnecessary medical intervention or to be subject to such intervention without informed consent. Unnecessary interventions, common in hospital settings, often carry risks for pregnant women and fetuses. In 2007, the cesarean rate in the United States reached 32%, the highest rate ever reported. This followed a 53% increase between 1996 and 2007, despite little, if any, evidence to suggest an increase in birth complications. Cesarean sections, like all surgeries, carry risks: the maternal mortality rate of cesarean sections is estimated to be between two and six times higher than the rate for vaginal deliveries. Some

78 BIRTHPLACE STUDY, supra note 54.
79 Alexis Chmell, Home Sweet Home: A Place to Deliver, Care for, and Raise Our Children, 33 J. LEGAL MED. 137, 142-43 (2012).
81 Id.
82 Johnson & Daviss, supra note 74 at 1416.
83 Menacker & Hamilton, supra note 45, at 1.
85 David M. Smolin, The Jurisprudence of Privacy in A Splintered Supreme Court, 75 MARQ. L. REV. 975, 1066 (1992) (noting studies finding that cesarean maternal mortality rates are higher than vaginal birth maternal mortality rates).
doctors also routinely perform episiotomies, while midwives rarely use this procedure. Infections from episiotomies account for 20% of maternal deaths. Other consequences of episiotomies include prolonged pain, fecal incontinence, and inability to enjoy sexual relations for a prolonged time following the procedure. The World Health Organization has recommended limiting episiotomy use to strict indication.

At home, women have more freedoms than women who give birth in a hospital setting: they may choose to be attended by friends or family members; they may move around and eat at will. Home is a comfortable environment, whereas a hospital room may feel impersonal. Critics of hospital birth suggest that physician convenience plays too great a role now that birth is customarily subject to medical control and intervention.

Studies suggest that while hospital birth is now socially customary, many women believe it is medically necessary. This

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86 An episiotomy is a procedure in which the obstetrician cuts the vaginal opening to speed delivery. Forty percent of episiotomies lead to increase vaginal tearing, while only five percent of midwife-attended mothers tear. Danielle Rifkin, Note, Midwifery: An International Perspective—The Need for Universal Legal Recognition, 4 IND. J. GLOB. LEG. STUD. 509, 518 (1997).


91 Lothian, supra note 9, at 43; see also Sylvia A. Law, Childbirth: An Opportunity for Choice that Should Be Supported, 32 N.Y.U. REV. L. & SOC. CHANGE 345, 370 (“EFM [Electronic Fetal Monitoring] machinery limits the laboring woman’s ability to move and do other things that would make her labor easier.”).

92 See Lothian, supra note 9, at 43 (“[M]ost women go through labor shackled to monitors and intravenous lines—unable to eat or drink—and give birth on their backs and are routinely separated from their babies.”).

93 See, e.g., M. Sara Rosenthal, Socioethical Issues in Hospital Birth: Troubling Tales from a Canadian Sample, 49 SOCIOLOGICAL PERSPECTIVES 369, 372 (2006) (“[T]he historical male domination of obstetrics], combined with the routine omission of information regarding prenatal provider alternatives, such as midwives, perpetuates the model of medicalized pregnancy.”).
results from a deficiency in the free-flow of information between doctor and patient.\textsuperscript{94} Failures to obtain informed consent in the use of medication and obstetrical procedures during childbirth are prevalent and prevent women from having full control over their options during childbirth.\textsuperscript{95} For example, consent forms often fail to mention the side effects of medications, which can include slowing the labor.\textsuperscript{96} Additionally, doctors often recommend a procedure without offering information or alternate procedures.\textsuperscript{97}

Scholars and health advocates have questioned potentially harmful interventions that medical professionals present as "routine," including, historically, pre-delivery enemas, perineal shaving, and episiotomies.\textsuperscript{98}

Common interventions today include continuous electronic fetal monitoring, anesthesia, pharmaceutical inducement of labor, and cesarean sections.\textsuperscript{99} Medical interventions may lead to a "cascade" of interventions: fetal-monitoring, which confines a woman to a hospital bed, may slow labor; a slow labor may make an induction necessary; an induction may lead to increased pain and more intense contractions; and interventions may create a need for an epidural, which can cause fetal distress and compel a cesarean section.\textsuperscript{100} The "cascade" effect has increased public perceptions of how much can go wrong during childbirth, perpetuating the idea that hospital births are necessary—and safer.\textsuperscript{102}

\textsuperscript{94} E.g., id. at 373.

\textsuperscript{95} Torres & De Vries, supra note 62 (emphasizing the difference between information and knowledge: "Inundating parents with pages of information, standardized and presented in medical and statistical terms unfamiliar to laypeople, may meet the letter of the ethical requirement to respect autonomy, but it fails to provide the knowledge parents need to make an informed choice.").

\textsuperscript{96} Id.; NK Lowe, Context and Process of Informed Consent for Pharmacologic Strategies in Labor Pain Care, 49 J. MIDWIFERY & WOMEN’S HEALTH 250, 259 (2004).

\textsuperscript{97} Torres & De Vries, supra note 62.

\textsuperscript{98} Hermer, supra note 10, at 326.

\textsuperscript{99} Id.

\textsuperscript{100} Rosenthal, supra note 93 at 383; HENCI GOER, THE THINKING WOMAN’S GUIDE TO A BETTER BIRTH 96 (1999).

\textsuperscript{101} Goer, supra note 100, at 96.

\textsuperscript{102} See Rosenthal, supra note 93, at 383 ("Once the first intervention is introduced, the laboring woman has the sense that she has lost control of the experience and that she is at the mercy of the hospital staff.").
A 2005 study found that women generally felt a lack of control over the process of childbirth in a hospital setting.\textsuperscript{103} Education about childbirth often fails to provide women with information about their options. Hospital-sponsored childbirth education programs have been found to emphasize information about hospital routines, rather than the process of childbirth and options that may arise throughout the pregnancy and during the labor.\textsuperscript{104} Shortcomings in prenatal education may lead a woman to consent to something during labor that she would not have consented to had she received full information about the procedure.\textsuperscript{105} Studies show that many women report traumatic childbirths in hospital settings.\textsuperscript{106} These women often feel discouraged if they voice these feelings, encountering suggestions by medical personnel and others that as long as the product of the childbirth is a healthy child, dissatisfaction with childbirth process is a trivial matter.\textsuperscript{107}

Feminist scholar Adrienne Rich in 1976 devised the term “alienated labor” to explain the emotional impact of hospital birth on mothers.\textsuperscript{108} Rich critiqued increasing physician control over all

\begin{thebibliography}{100}
\bibitem{103} E.g., \textit{id.}; Sarah R. Baker et. al., “I felt as though I’d been in jail”: Women’s Experiences of Maternity Care During Labour, Delivery and the Immediate Postpartum, \textit{15 FEMINISM & PSYCHOLOGY} 315–42 (2005).
\bibitem{105} Torres & De Vries, \textit{supra} note 62.
\bibitem{106} See, e.g., Cheryl Tatano Beck, Impact of Birth Trauma on Breastfeeding, \textit{57 NURSING RES.} 228, 229 (2008) (finding that up to 34% of women who give birth in a hospital have experienced some form of trauma during childbirth and defining birth trauma as, “an event that occurs during any phase of the childbearing process). The trauma can be classified as a negative outcome, such as a postpartum hemorrhage, or psychological distress. Experiencing this extremely traumatic stressor, a woman’s response can be intense fear, helplessness, loss of control, and horror.”) \textit{Id.}; see also Clare Goldwin, Libby Didn’t Know Whether her Newborn Baby was Alive for SIX HOURS and Needs Post-traumatic Stress Counselling Over the Birth Experience . . . So What IS Going Wrong in Britain’s Labour wards?, \textit{DAILY MAIL} (Jan. 30, 2013), http://www.dailymail.co.uk/femail/article-2270941/Birth-trauma-Libby-ORourke-Toni-Harman-Julie-Hainsworth-traumatic-labours-Britains-hospital-wards.html (noting a study from Tel Aviv University that similarly found that one in three women who give birth experience symptoms of PTSD).
\bibitem{107} See Goldwin, \textit{supra} note 106 (quoting human rights lawyer Elizabeth Prochaska: “What’s worrying is an increasing tendency for healthcare practitioners to view the mother as simply a vessel for the production of her fetus, and to say ‘as long as you get a healthy baby and a live mother out of it that’s all that matters.’ But it’s not all that matters.”).
\bibitem{108} ADRIENNE RICH, \textit{OF WOMAN BORN: MOTHERHOOD AS EXPERIENCE AND}
\end{thebibliography}
phases of reproduction, from contraception and abortion to intervention during childbirth. Obstetrics, an historically male-dominated field shaped and reproduced by the medical model, is, according to Rich, an illustrative paradigm of how women have historically been denied control over decisions relating to sexuality and reproduction.

In their descriptions of childbirth, some women use language that mirrors that which victims of sexual assault and rape use to describe their experiences; as many as 6.3% of women experience symptoms of Post-Traumatic Stress Disorder following childbirth. Several countries have seen lawsuits or have begun to develop legislation in response to such appalling stories of childbirth.

The relationship between a midwife and her client tends to be less hierarchical than one between a physician and her patient. The midwife delivers individualized care to the pregnant woman,

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109 See id. at 185 (concluding that, “As long as birth... remains an experience of passively handing over our minds and our bodies to male authority and technology, other kinds of social change can only minimally change our relationships to ourselves, to power, and to the world outside our bodies.”).

110 See id. at 168-70 (explaining attitudes prevalent at the time of the advent of obstetrics, particularly the identification of womanhood with suffering, and the centrality of childbirth pain to this identification, within Christian theology, and suggesting that shifting control over childbirth to male physicians was effectively a means of pathologizing the female body and reproduction).


112 See, e.g., The Organic Law on the Right of Women to be Free from Violence, (defining “obstetric violence”). Obstetric violence constitutes: “[T]he appropriation of the body and reproductive processes of women by health personnel, which is expressed as dehumanized treatment, an abuse of medication, and to convert the natural processes into pathological ones, bringing with it loss of autonomy and the ability to decide freely about their bodies and sexuality, negatively impacting the quality of life of women.” Id. Rogelio Pérez D’Gregorio, Obstetric Violence: A New Legal Term Introduced in Venezuela, INT’L J. OF GYNECOLOGY & OBSTETRICS, 201-02 (2010); see also Deborah L. Shelton, Doctor Disciplined for Allegedly Chastising Chicago-area Woman in Labor and Denying her Pain Medication, CHICAGO TRIBUNE (July 22, 2009), http://articles.chicagotribune.com/2009-07-22/news/0907210412_1_medical-staff-membership-disciplined-pain (“A doctor accused of mistreating a Chicago woman while she was in labor with her fifth child has been fined $500 and placed on one year’s probation by a state regulatory agency.”).

113 Alcorn et al., supra note 111, at 1849.
learning about her the relationships, choices, and social and economic environment that impact her pregnancy, in addition to details about the physical progress of the pregnancy. The midwife provides consistent support in order to promote the physical and psychological well-being of her client.

Proponents of home birth argue that protections other than obstetrical interventions more universally promote safe childbirth, including better nutrition, cleaner environments, a reduction in adolescent pregnancies, and women’s financial ability to care for the child.

III. Legal Framework

A. Domestic

Most births in the United States occur in hospitals. Pregnancy and delivery are the most common reasons for hospitalization in the United States, and about thirty percent of births occur by cesarean section.

The United States federal government has no laws that directly regulate women’s decisions about where to give birth; individual states, however, regulate midwives. The scope of this regulation varies and often curtails the option to give birth at home. Many states require physician supervision of midwives’ work; others require midwives to have a working relationship with a physician; still others require collaboration between midwives and physicians or restrict the means by which they may assist births. Some states proscribe midwifery through allowing it statutorily but without legal authorization.

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114 Hermer, supra note 10, at 333.
115 Id.
116 E.g., Goer, supra note 100.
117 MacDorman et al., supra note 32.
120 See Hermer, supra note 10, at 333-34.
refusing to issue licenses.\(^{121}\) A few states prohibit direct-entry midwifery, and in these states, women who wish to give birth outside a medical establishment are effectively unable to do so with the assistance of a health professional.\(^{122}\)

Importantly, the highly medicalized system of childbirth that the United States employs does not correlate to lower levels of infant and maternal mortality; on the contrary, of developed countries, the United States has one of the highest rates of infant mortality.\(^{123}\) While home birth is not common in the United States, it remains an option that many women pursue annually. In 2006, there were 38,568 births that occurred outside of hospitals in the United States.\(^{124}\) Between 2004 and 2009, after fourteen years of decline, the percentage of home births in the United States rose by 29\%, suggesting that women are increasingly interested in giving birth in a home setting.\(^{125}\)

While the Supreme Court has not found that a woman has a right to choose a home birth, several scholars have suggested legal grounds on which women may claim this right, including under Fourteenth Amendment protections of personal autonomy and bodily integrity.\(^{126}\) Additionally, coercion by doctors may infringe upon the right to refuse medical treatment.\(^{127}\) State restrictions on midwifery, insurers limiting choice, compelled medical treatment or detention, and policies protecting the fetus are all examples of how women in the United States find their ability to choose where to give birth restricted. If the Supreme Court concludes that

\(^{121}\) Id. at 353.

\(^{122}\) Id.


\(^{125}\) MacDorman et al., supra note 32.

\(^{126}\) See Chojnacki, supra note 15, at 56-57 (explaining that central to the privacy right is personal autonomy, which childbirth decisions implicate; additionally, the possibility of surgical intervention implicates the right to bodily integrity, which is also central to the privacy right); see also Cohen, supra note 87, at 875 (“Birth is one of the most private, intimate moments in a family’s life. The home is the most private, intimate sphere. It seems unreasonable both for the government to reach into the home with regulation and for it to forbid activities in the home that do not harm others.”).

\(^{127}\) Chojnacki, supra note 15, at 56.
choice in the circumstances of childbirth falls under fundamental rights conceived by cases such as *Casey* and *Lawrence*, such restrictions may be unconstitutional.

These cases emphasize the importance of personal autonomy; as the Court in *Casey* explained, "At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State." As Cohen explains, *Lawrence* opens up several arguments for advocates of home birth, including its protection of consensual activity within the home, its focus on historical fundamental rights, and its incorporation of a comparative law analysis in striking down *Bowers*.

**B. European Convention on Human Rights**

The European Court of Human Rights (ECtHR) is a judicial body established to protect fundamental human rights guaranteed under the European Convention. The ECtHR has the jurisdiction to examine and determine compliance with the Convention of Member states. An individual may bring a case before the Court if she believes a member State has violated her fundamental rights under the Convention, as long as she has exhausted domestic remedies. All Council of Europe States are

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130 Chojnacki, supra note 15, at 57-58 (noting that because Gonzales v. Carhart constituted a "pointed retreat" from Lawrence, it may be unlikely that the Supreme Court would recognize a "new" fundamental right such as the right to decide where to give birth).
131 *Casey*, 505 U.S. at 851.
132 Cohen, supra note 87, at 874.
133 See id. at 876 ("Midwifery's historical pedigree is, of course, as old as humankind itself. Certainly, in 1789, home birth was the norm, and to require a woman to leave the sanctity, privacy, and comfort of her home to give birth would have been unthinkable.").
134 Id. at 877 (noting that the argument above specifically looks at the comparative analysis of the European Court of Human Rights).
136 Id. at 5 (stating that "the European Convention authorizes both individual suits and interstate suits").
bound by the Court’s rulings. In its judgment, the ECtHR may ask a member state to compensate an individual or to grant an effective remedy, often a change in the law.

While the European Convention does not require the ECtHR to follow precedent, the Court routinely engages in extensive interpretation and citation of past cases, which indicates that its holdings do create precedent. In interpreting rights under the Convention, the ECtHR uses a consensus model that draws on Member states’ interpretations of human rights, domestic legislation, statutes, and treaties, as well as expert and public opinion.

The ECtHR has dealt with reproductive rights issues principally through Article 8. Since 1977, in the context of cases dealing with abortion, the Court has consistently held that pregnancy implicates the Article 8 right to privacy. The ECtHR has reached a judgment in just one case on the rights implicated in the context of a home birth, Ternovszky v. Hungary, decided in 2010. The Court decided this case under Article 8.

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137 See id. at 10 (stating that “a human rights treaty protects individuals only against offenses committed by nations”).

138 Id. at 5 (explaining that the courts are “unique in commanding near-total compliance by nation states”).

139 Id.


144 Id.

145 Id. at 4.
Subsequent cases under consideration in the ECtHR have also addressed the Article 2 right to life in the context of home birth.146

i. Article 8

Article 8 of the European Convention establishes the right of privacy, expressly stating, “Everyone has the right to respect for his private and family life, his home and his correspondence.”147 Article 8 also provides,

There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.148

The ECtHR has maintained that this right of privacy is a broad right that involves an essential aspect of individual autonomy.149 The ECtHR has held the privacy right as encompassing many aspects of private life, including among other interests, personal autonomy,150 physical and psychological integrity,151 the establishment of relationships,152 gender identification,153 sexual

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147 European Convention, supra note 16, art.8.
148 Id.
149 See Elizabeth Ireland, Do Not Abort the Mission: An Analysis of the European Court of Human Rights Case R.R. v. Poland, 38 N.C. J. INT'L L. & COM. REG. 651, 672 (2013) (“While the court has not conclusively defined “private life,” it has considered such issues as a person’s right to determine the circumstances of a child’s birth, a person’s mental health, and even a person’s business relationships.”).
151 A. v. Ireland, App. No. 25579/05, Eur. Ct. H.R. at 36 (“The Court considers it evident that traveling abroad for an abortion constituted a significant psychological burden.”).
orientation and sexual life, and finally, integral to home birth cases, decisions about family life and raising or not raising children.

State obligations under Article 8 are primarily negative obligations not to interfere with an individual's right to private life. However, the ECtHR has suggested that there "may in addition be positive obligations inherent in 'effective' respect for family life." Since making this observation in 1994, the ECtHR has found positive obligations in the implementation of Article 8 rights, and to assess whether this obligation exists, the ECtHR considers the "fair balance between the general interests of the community and the interests of the individual."

Article 8 rights are not absolute, and circumstances that allow a State to regulate or restrict the right to privacy include the safeguard of public morals or other rights. The level of deference that the ECtHR grants the State in comparison to the individual right is called the "margin of appreciation."
determining this margin, the ECtHR balances several factors, including the individual interest at stake, the State interest in restricting that right, and whether Member States have a consensus on the level of the interest. In the matter of home birth, the ECtHR has granted a wide margin appreciation to the State, citing a lack of consensus among Member States as to the legality and safety of home birth and the State interest in restricting the right due to health and safety considerations.

**ii. Article 2**

Article 2 of the Convention establishes that “no one should be deprived of his life intentionally.” While the ECtHR has examined reproductive rights issues predominantly under Article 8, Article 2 has become a point of consideration for applicants claiming violations of the European Convention that impact reproductive rights. For example, anti-abortion advocates have argued that a fetus should be considered a person. While the ECtHR has elected not to decide whether a fetus is a “person” under Article 2, leaving this question ambiguous may prompt

(discussing the concept of “margin of appreciation”).


164 European Convention, supra note 16, at art. 2.

165 Ireland, supra note 149, at 653.

166 See id. at 668 (“The ECtHR has elected not to decide whether a fetus fits under Article 2’s definition . . . despite the fact a case was brought on that specific issue in 2004.”).

167 See VO v. France, App. No. 53924/00, Eur. Ct. H.R. 19, 36 (2004), available at http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-61887 (considering two arguments as to whether a fetus is a person: “(i) human embryos are not considered as human beings and consequently have a relative worth of protection; (ii) human embryos have the same moral status as human beings and consequently are equally worthy of protection,” and concluding that a 21-week-old fetus is not considered a person under Article 2).

168 Jakob Pichon, Does the Unborn Child Have a Right to Life? The Insufficient Answer of the European Court of Human Rights in the Judgment, 7 GERMAN L.J. 433, 436 (2006) (explaining that in Vo v. France, “the ECtHR was convinced that it is neither desirable, nor possible” to abstractly determine whether an unborn fetus was a ‘person’ under Article 2 of the Convention); see FRANCIS G. JACOBs, ROBIN WHITE & CLARE
future litigants to use similar arguments as pro-life advocates in the argument that the State should be able to prohibit home birth. For example, in the United States, several courts have weighed fetal interests in determining that a woman may be forced to remain in a hospital against her will. In Texas, there was recent controversy over the state’s decision to keep a pregnant Fort Worth woman on life support in order to preserve the life of her fetus, which was 14 weeks at the time the woman became brain-dead and not yet viable. The Court in Ternovszky suggested that the State has a “wide margin of appreciation” in balancing the Article 8 right to private life, which encompasses a woman’s choice to have a home birth, with “other rights.” This is one of several areas in which the Ternovszky decision does not adequately protect Article 8 rights.

While Anna Ternovszky, the applicant in Ternovszky v. Hungary, did not claim that the State had violated her Article 2 rights in denying her the possibility of a home birth attended by health professionals; applicants in subsequent cases like Dubská and Krejzová v. the Czech Republic, Kosaitė-Čypienė, as well as others against Lithuania, have made such arguments. These applicants suggest that domestic laws restricting home birth deprived them and their children of their Article 2 rights to life, in addition to their Article 8 rights to privacy.
IV. Ternovszky v. Hungary

A. Facts

While pregnant with her second child in 2009, Anna Ternovszky encountered significant obstacles in the search for a midwife who would help her in a home birth. Ternovszky gave birth to her first child at home under the guidance of midwife Ágnes Geréb. She intended to give birth to her second child at home, but Geréb was being prosecuted under a regulation prohibiting health professionals from assisting in home birth.

While no legislation regulating women’s ability to choose home birth existed in Hungary, Ternovszky argued that the regulation prohibiting health professionals from assisting at home births effectively made it impossible to choose to give birth at home. Midwives were susceptible to prosecution in the case of an adverse birth incident; Geréb’s charge stemmed from her attendance to a woman who went into labor unexpectedly.

Ternovszky, fearing that her labor could lead to further legal consequences for Geréb or other midwives, filed an application with the ECtHR against the Republic of Hungary in December 2009. Ternovszky alleged that under Article 8 of the European Convention, read in conjunction with Article 14, the fact that she could not benefit from professional assistance for a home birth amounted to discrimination in the enjoyment of her right to respect for private life.

The Hungarian Constitution creates a right to the “highest possible level of physical and mental health,” implemented


176 Id.


178 See Ternovszky Speech, supra note 175 (explaining the role that the Ternovsky case played for women and that the costs associated with securing a license has made it difficult for women to choose home birth).

179 See id.


through government “organization of medical care.”\textsuperscript{182} Hungary’s Health Care Act of 1997 provides that a patient’s right to self-determination to be restricted as “prescribed by law,” including a provision that a competent patient may reject medical treatment unless this endangers life or limb of another person.\textsuperscript{183} Government decree determines that a “health professional who carries out activities . . . without a license” may be subject to punishment.\textsuperscript{184} An Act adopted in December 2009 amended Hungarian law to provide that “[t]he government shall determine . . . the professional rules and conditions governing birth outside an institution and the causes, excluding the possibility of such a birth.”\textsuperscript{185}

While the professional medical consensus in Hungary is that hospital birth is safer than home birth,\textsuperscript{186} this supposition is greatly disputed worldwide.\textsuperscript{187} Regarding place of birth, the World Health Organization (WHO) notes that factors such as the “cost of a hospital delivery, unfamiliar practices, inappropriate staff attitudes,” restrictions on who may attend the birth, and the absence of symptoms of illness lead women to choose to give birth at home.\textsuperscript{188} The WHO detailed reports of midwife-managed care in the U.S., Britain, Australia, and Sweden that found higher rates of women’s satisfaction with the care they received and lower rates of interventions such as obstetric analgesia and induction of labor, when compared with hospital births.\textsuperscript{189} The WHO noted that reports varied in comparisons of outcomes in midwife-managed care versus consultant-led care; while some trials showed higher perinatal mortality in midwife-led care, other trials showed

\textsuperscript{182} Id. at 2.

\textsuperscript{183} Id. See also A MAGYAR KÖZTÁRSASÁG ALKOTMÁNYA [Constitution of the Republic of Hungary].

\textsuperscript{184} Ternovszky, App. No. 67545/09, Eur. Ct. H.R. at 1; see also A MAGYAR KÖZTÁRSASÁG ALKOTMÁNYA [Constitution of the Republic of Hungary].

\textsuperscript{185} Ternovszky, App. No. 67545/09, Eur. Ct. H.R. at 1; see also A MAGYAR KÖZTÁRSASÁG ALKOTMÁNYA [Constitution of the Republic of Hungary].

\textsuperscript{186} Ternovszky, App. No. 67545/09, Eur. Ct. H.R. at 1; see also A MAGYAR KÖZTÁRSASÁG ALKOTMÁNYA [Constitution of the Republic of Hungary].

\textsuperscript{187} E.g., Ternovszky, App. No. 67545/09, Eur. Ct. H.R. at 5 (explaining that member states have not reached a consensus as to whether home birth is a safe option that should be an option available to all).

\textsuperscript{188} Id. at 3.

\textsuperscript{189} Id.
no difference in outcome.\textsuperscript{190}

\textit{i. Decision}

The Court dismissed Ternovszky’s Article 14 argument and examined the complaint under Article 8 alone. The court had to find, in a 6-1 judgment, that Hungary had infringed upon Ternovszky’s right to private.\textsuperscript{191} Article 8’s relevant provisions included § 1, providing that “Everyone has the right to respect for his private... life... “ and § 2, prohibiting government interference with this right.

\begin{quote}
[E]xcept such as in accordance with the law and is necessary [...] in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.\textsuperscript{192}
\end{quote}

\textit{ii. The Parties’ Arguments}

The Hungarian government argued that in light of fundamental limitations on the Article 8 right to self-determination, the passage of an Act regulating home birth in December 2009, and the continuing occurrence of home births despite restrictive legislation, did not violate Ternovszky’s rights under Article 8.\textsuperscript{193} First, the Article 8 right to self-determination did not create a positive obligation on the part of the government “to widen the range of choices within the health care system.”\textsuperscript{194} Article 8 rights, the government argued, can be restricted in several circumstances, when weighed against the State’s interests.\textsuperscript{195} First, as in the case of home birth, they may be restricted where there was no consensus amongst Member States of the Council of Europe as to either the relative importance of the interest at stake or the means

\textsuperscript{190} See \textit{id.} at 3 (examining The Netherlands, a developed country with an official home birth system that nevertheless sees varying incidences of home deliveries between different regions; a study conducted in the Netherlands showed no difference in obstetric results of home and hospital births and found no evidence that an increase in medicalization would improve the system of care for pregnant women).

\textsuperscript{191} \textit{Id. See} European Convention, \textit{supra} note 16, arts. 8, 14.

\textsuperscript{192} \textit{Id. at} 4. \textit{See} European Convention, \textit{supra} note 16, arts. 8.


\textsuperscript{194} \textit{Id. at} 5.

\textsuperscript{195} \textit{Id.}
of protecting it. For instance, when the interest raised “sensitive moral or ethical issues,” the State’s interest should receive a greater margin of appreciation for implementing restrictions. The State should also receive a wider margin of appreciation in cases in which it was tasked with weighing “competing private and public interests or Convention rights.” Hungary argued that home birth was not regulated in many Member States; further, there was no consensus as to how to balance the mother’s right to give birth at home with the child’s right to a safe birth. Hungarian professional consensus was that birth was safer in a health care institution than at home. While home birth was legal, the government did not encourage it because of inherent risks. The government noted, “there had been several instances in recent years where home births assisted by health professionals had ended in hospitals or resulted in death or serious injury to the baby.”

Hungary also submitted that the possibility of administrative sanctions did not effectively discourage home birth; while close to “150 planned home births took place annually” in 2008 and 2009, there was only one administrative procedure instituted in “connection with a home birth” during that time. Finally, Hungary argued that the specific regulation of home birth was already underway after an Act was passed in 2009 in response to safety concerns.

Ternovszky argued that “hospital and home births were equal alternatives.” She emphasized that childbirth and the circumstances surrounding it were intricately tied to the “hard core of self-determination” and were thus matters of private life.

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196 See id.
197 Id.
198 Id.
200 Id.
201 Id.
202 Id.
203 Id.
204 Id. (“[Parliament] adopted an act authorizing the Government to regulate the conditions of birth outside an institution.”).
206 Id.
Interests in protecting the child, Ternovszky argued, could not be weighed against this private interest, because it could not be proven that hospital birth was safer than home birth.\textsuperscript{207} Ternovszky finally noted that "despite the ongoing legislative process, the question of home birth had not yet been regulated.\textsuperscript{208}

\textit{iii. The Court's Assessment}

To determine whether there had been an interference with the Article 8§1 right to private life, the Court relied on precedent defining "private life" as broadly "encompassing, inter alia, aspects of an individual's physical and social identity including the right to personal autonomy [and to] personal development."\textsuperscript{209} Also included within this right, the Court noted, is "the right to respect for both the decisions to become and not to become a parent."\textsuperscript{210} The Court reasoned that the freedom to become a parent implied "some measure of choice as to its exercise," and held that the right to decide whether to become a parent "includes the right of choosing the circumstances of becoming a parent."\textsuperscript{211} Because personal autonomy is a fundamental principal under Article 8, the Court held that the circumstances of giving birth "incontestably form part of one's private life" under Article 8 § 1.\textsuperscript{212} Because having these choices requires the involvement of health professionals, legislation dissuading professionals from providing assistance constitutes an interference with this right.\textsuperscript{213}

Once the ECtHR determined that an Article 8 right was violated, it moved to an analysis of whether the violation was "not in compliance with the law."\textsuperscript{214} Important in finding that a regulatory scheme restricting Article 8 rights is in compliance with law, is the determination that regulations are accessible and

\textsuperscript{207} Id.

\textsuperscript{208} Id.

\textsuperscript{209} Id.; see also Pretty v. United Kingdom, App. No. 2346/02, Eur. Ct. H.R. at 33.


\textsuperscript{212} Id.

\textsuperscript{213} Id.

\textsuperscript{214} Id. at 2.
foreseeable.\textsuperscript{215} The Court determined that the Hungarian laws in question in this case were not accessible and foreseeable.\textsuperscript{216} While "sections 15 and 20 of the Health Care Act 1997 recognize patients' right to self-determination in the context of medical treatment, including the right to reject certain interventions . . . section 101(2) of Government Decree no. 218/1999 sanctions health professionals who carry out activities . . . in a manner which is incompatible with . . . their license."\textsuperscript{217} These legal provisions present a contradiction in the context of assisting home birth, an otherwise unregulated practice, which has created uncertainty in the law. Therefore, the law is lacking in accessibility and foreseeability.\textsuperscript{218}

The Court thus concluded that Hungary's interference with the applicant's Article 8 right was not in accordance with law and subsequently in violation of the Convention.\textsuperscript{219} While Hungary was correct in arguing that the State has a wide margin of appreciation in legally regulated areas, the Court held that for the State regulation to be in accordance with law, the regulation must properly balance societal interests with the right at stake.\textsuperscript{220} With regard to home birth, this means that the mother is entitled to an environment that "enables her choice, except where other rights render restriction necessary."\textsuperscript{221} A woman's right to choose the circumstances of her birth includes home birth being a lawful choice "not subject to sanctions, directly or indirectly."\textsuperscript{222} The landscape of relevant Hungarian law, the Court held, was contradictory in terms of a woman's right to a home birth, creating "legal uncertainty prone to arbitrariness."\textsuperscript{223}

\textit{iv. Separate Opinions}

The concurring opinion emphasized that "a minimum of positive regulation" is necessary to preserve the right to respect for

\textsuperscript{215} Id. at 7.
\textsuperscript{216} See id. at 7-8.
\textsuperscript{218} Id.
\textsuperscript{219} Id.
\textsuperscript{220} Id. at 7.
\textsuperscript{221} Id.
\textsuperscript{222} Id. at 7-8.
Because regulation of health care practices has become such a widespread custom in the medical industry, the ability to choose the circumstances of childbirth, a once “uncontested private choice,” can easily become obliterated in the absence of positive protections. Without the legal certainty of positive regulation significant consequences, such as “fear and secrecy” that may result in injury or death to women and infants, may result. The concurring judges elaborated upon what positive obligations may entail, including the “provision of a regulatory framework of adjudicatory and enforcement machinery protecting individuals’ rights and the implementation, where appropriate, of specific measures.” The concurrence goes on to note that the State does have a broad margin of appreciation in the matter of childbirth; the mother’s right to choose, however, is subject only to proportional restriction.

Judge Popović dissented on four grounds, arguing that: (1) the applicant did not exhaust domestic remedies; (2) the applicant could not prove a victim status in terms of Article 34 of the Convention; (3) there was no interference with the applicant’s rights; and (4) the applicant’s claim was an actio popularis. Judge Popović argued that because Hungary’s health legislation was permissive, unlike other legislation struck down under Article 8 for being “substantially restrictive and potentially harmful to the enjoyment of human rights,” Ternovszky’s rights had not been violated.

Though the ECtHR found that Hungary’s law impossibly violated Ternovszky’s rights under the European Convention, its analysis of what the law would need to accomplish in order to be in accordance with the European Convention is overly broad, leaving uncertain whether a woman’s right to choose the circumstances of childbirth is adequately protected. The ECtHR put forward two basic premises to find that Hungary’s legal system

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224 Id. at 11.
225 Id.
226 Id.
227 Id. at 12.
228 Id.
230 Id. at 14-15.
violated Article 8 rights. The first premise was that the laws were contradictory and prone to arbitrary enforcement. The second was that existing law did not properly balance a woman’s Article 8 right to choose the circumstances of her birth with “other rights.” Hungary’s law, which stipulated that health care professionals assisting at births taking place outside of a hospital could be subject to sanctions, indeed failed on both of these counts because it effectively eliminates a woman’s ability to have a home birth attended by the requisite health professionals. The ECtHR, however, did not create positive obligations for governments to create schemas allowing for home birth options. The ECtHR’s vague reference to “other rights” that may be balanced against the rights of the woman hints at a modicum of private and public considerations, including, most notably, fetal health and insurance considerations.

The ECtHR thus erred in analyzing Hungary’s violations of Ternovszky’s Article 8 rights solely through the lens of its negative obligations. As the concurrence explains, a State’s simple lack of interference with regard to a private right does not always ensure that citizens have a meaningful choice where that right is concerned. Indeed, in the matter of home birth, where the State does not have a health system that allows medical professionals to assist in home birth, families effectively no longer have a choice in the circumstances of childbirth. Even in the absence of laws that expressly restrict health professionals from assisting in a home birth, administrative difficulties may arise, and these also have the potential to remove meaningful choice from parents. The pregnant woman’s dependency on health professionals and authorities already make her vulnerable to infringements upon her liberty. Thus, a positive regulatory environment may be the only way to safeguard the woman’s right to choose the circumstances of childbirth. As the Ternovszky

231 Id. at 7-8.
232 Id. at 8.
233 Id. at 7.
234 Id.
236 Id. at 11 (Sajó, J. & Tulkens, J., concurring).
237 Id.
238 Id.
concurrency warns, "[w]ithout such legal certainty there is fear and secrecy, and in the present context this may result in fatal consequences for mother and child." 239

The Court’s refusal to acknowledge positive obligations, other than the need to create an environment in which citizens have legal certainty over the legality of the childbirth choices they are considering, has resulted in ambiguity regarding whether it is lawful for member states to restrict home births in the absence of arbitrary legislation. This decision did not determine what sorts of restrictions on home birth would or would not be proportionate in a democratic society. The ECtHR, thus, did not provide adequate guidance for Hungary and other countries. For example, while Hungary passed new regulations about home birth in the wake of the Ternovszky decision, which brought the State into compliance in terms of creating legal security in the area of home birth, the new regulatory scheme is still restrictive for midwives. 240

Anna Ternovszky has expressed dissatisfaction with the new laws, explaining:

If I were to have a baby now, I feel I would not be in a position to opt for a home birth. Why do I feel this way? Because even though the legislation permits midwives to seek a licence [sic] the underlying philosophy of the regulations is to limit the role and influence that midwives can play in the pregnancy period, to excessively restrict the number of women who are eligible for homebirth and to give the obstetricians and gynecologists the ultimate power of control in the birthing process. 241

Part IV(C), infra, provides a more detailed analysis of how home birth may fit into the scheme of other rights to privacy in family life, which the Court has found that the State has a positive obligation to protect.

B. Legal Issues after Ternovszky v. Hungary

Since Ternovszky, the ECtHR has accepted two cases dealing

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239 Id.


241 Ternovszky Speech, supra note 175.
with home birth.\textsuperscript{242} Importantly, in both of these cases, the restrictive laws under attack were passed after the \textit{Ternovszky} decision.\textsuperscript{243} The Czech Republic changed two of its relevant laws in 2012, which means that the laws under scrutiny with respect to the applicants, one of whom gave birth in 2010 and the other in 2012, include both prior laws and legislation currently enforced.\textsuperscript{244} While both legal schemes restrict home birth, the legislation currently in force is more explicitly restrictive.\textsuperscript{245} The Lithuanian law in question also explicitly prohibits health professionals from assisting in home births.\textsuperscript{246} These two cases raise several important legal issues that the Court did not answer in \textit{Ternovszky} and will be discussed in Part IV(C) following a description of the facts in each of these cases. \textit{Ternovszky} also left open theoretical questions, hinted at in the Chamber Hearing in \textit{Dubská}.\textsuperscript{247} These questions include issues of informed consent and the right to refuse treatment as they pertain to the pregnant woman, but have yet to be considered in depth by the ECtHR. Part IV(D) discusses these unaddressed legal issues and how they have arisen internationally historically and in recent years.

\textbf{C. Dubská and Krejzová v. the Czech Republic}

The ECtHR held a chamber hearing on this case in September 2013, but it has not yet communicated judgment.\textsuperscript{248}


\textsuperscript{244} See \textit{Dubská}, App. No. 28859/11, Eur. Ct. H.R. at 2-3; see also \textit{Kosaitė-Čypienė}, App. No. 69489/12 at 3.


\textsuperscript{248} Id.
Applicants Šárka Dubská and Alexandra Krejzová are Czech nationals who contend that it is impossible under Czech law to give birth at home with the assistance of a health professional. Dubská and Krejzová argue that this violates their Article 8 rights under the European Convention. Czech law offers no provision for the possibility of a public health insurance to cover the costs of a birth at home. Additionally, midwives are prohibited from assisting with births on premises that do not contain certain technical equipment. Also, legislation passed in April 2012 introduced a fine of up to one million USD for birth assistants who attend a home birth.

Dubská experienced a traumatic hospital birth in 2007, in which she was pressured into accepting various medical interventions against her wishes and was ordered to remain in the hospital longer than she wished. When pregnant with her second child in 2010, Dubská wished to give birth at home, but learned that Czech legislation did not provide for public health insurance to cover the costs of home births and that midwives could face sanctions for assisting in births on premises that did not have certain technical equipment. The Czech Constitutional Court dismissed Dubská’s complaint in February 2012. The medical consensus in the Czech Republic is that a hospital birth is safer than home birth.

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251 Id. at 2-3.


255 Id. at 2.

The other applicant, Krejzová, gave birth to her first two children at home with the help of midwives who acted in violation of Czech law by assisting the births. When she was pregnant for the third time in 2012, she could not find a midwife who was willing to assist the birth due to potential consequences for midwives who provide medical services without authorization.

D. Elena Kosaitė-Čypienė and others against Lithuania

There are four applicants in a communicated ECtHR case against Lithuania. Lithuania's relevant laws provide that the State pays for health care services provided to pregnant women and that a gynecologist may practice at a health care institution that has a license to provide gynecological services. While gynecologists may provide some services at a patient's home, assisting in home birth is explicitly prohibited. The applicants argue that these laws violate their rights under European Convention Articles 2 and 8.

The first applicant attempted to give birth at home in 2009, but after complications arose, she had to be transported to a public hospital to give birth. The applicant reports that doctors on that occasion criticized her decision to give birth at home. Therefore, she chose to give birth to her second child at home, assisted by an unlicensed midwife, in 2011. That birth was a success, with no complications. During her third pregnancy, in 2012, the applicant asked health care authorities, including the Ministry of Health Care and public hospitals, if a doctor could assist her during a home birth. At the time J.I.Š. and B.K, two

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259 Id.
261 Id. at 3.
262 Id.
263 Id.
264 Id. at 1.
265 Id.
267 Id.
268 See id.
healthcare-providing members of “Gimimas L.T.,” a non-governmental organization for promoting home birth, were under criminal investigation and could not assist the applicant. Authorities refused the applicant’s request, maintaining that it was safer for her and her unborn child if the birth took place at a hospital, and refused to assume the responsibility for a home birth. In July 2012, the applicant gave birth at home without medical assistance, which she argues put her safety and her child’s safety at risk.

The second applicant gave birth in 2006, 2008, and 2011 with the assistance of J.I.Š., an unlicensed midwife. When the applicant became pregnant with her fourth child, J.I.Š. was under criminal investigation, and the applicant could not find a medical professional willing to assist with the birth for the same reasons as the first applicant.

The third applicant gave birth without complications in 2009 and 2010 with the assistance of unlicensed midwife, J.I.Š. When she was expecting her third child, she was refused medical assistance for the same reasons as the first two applicants. In her request to the Ministry of Health, the third applicant relied on the Court’s judgment in Ternovszky v. Hungary. Accordingly, the Ministry of Health consulted the Ministry of Justice.

The Lithuanian Ministry of Justice concluded that the factors that made Hungary’s legislation impermissibly in violation of Article 8 rights were: first, that under Hungary’s domestic law, the government was required to regulate home birth, and it had not regulated home birth at the time of the decision; and second, that the law regarding possible sanctions for health care professionals assisting home births gave rise to arbitrary enforcement. Furthermore, the ECtHR held that in the provision of health care

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269 Id.
270 Id.
271 Id. at 2.
273 Id.
274 Id.
275 Id.
276 Id.
277 Id.
services, the State has a wide margin of appreciation, and regulation must properly balance societal interests with the right at stake. 279 The Ministry of Justice also noted that the ECtHR, in centering its analysis of state obligations on curtailing arbitrariness and balancing rights, had not analyzed whether a prohibition on health care specialists assisting in home births was one way of proportionately balancing rights in a democratic society. 280 With these considerations in mind, and taking into account that Lithuanian domestic law did not sanction the provision of health care professionals for home births, the Ministry of Health Care concluded that the government was not obligated to provide medical professionals to assist women wishing to give birth outside of a health care institution. 281

At the time of the application and communications to the parties, the second and third applicants had not yet given birth, but both intended to do so at home with or without the assistance of health professionals. 282

The fourth applicant gave birth at home in 2001, 2003, and 2011, with the assistance of unlicensed midwife J.I.Š. 283 Unlike the other three applicants, the fourth applicant was not pregnant and facing the prospect of a home birth without the assistance of healthcare professionals at the time of filing; she maintains, rather, that Lithuania’s legal landscape has made it unmanageable for her to become pregnant again. 284 Although she is of reproductive age, she is afraid to give birth again because of the impossibility of finding healthcare professionals who will assist a home birth. 285

The applicants allege that Lithuania’s laws prohibiting healthcare professionals from assisting in home births violate their rights under Articles 2 and 8 of the Convention. 286 The applicants

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280 Id. at 1.

281 Id.

282 Id. at 2.

283 Id.


285 Id.

286 See id. at 3.
cite the concurring opinion in _Ternovszky_ to suggest, "without legal certainty [ . . . ] there is fear and secrecy, and in the present context this may result in fatal consequences for mother and child." The applicants do not ask for a legal framework that actively encourages home birth, but rather for an environment in which the State does not obstruct the provision of health care services to pregnant women in home births by specialists who are willing to help in these births.288

E. Analysis: Legal Issues Raised in _Dubska_ and _Kosaité-Čypienė_

The ECtHR put several questions to the parties in _Dubska_ and _Kosaité-Čypienė_, including whether the applicants were victims under Article 34; whether the applicants had exhausted the available domestic remedies; and whether the applicants' Article 8 rights had been violated. Other questions put to the applicants, upon which this analysis will focus, addressed the legal questions persisting in the wake of _Ternovszky_: whether it was proper to examine the Article 8 violations in light of negative or positive State obligations; and whether the interference with the private Article 8 right, if found to have occurred, met the following conditions, making the interference lawful: (1) the interference was in accordance with law; (2) had a legitimate aim; and (3) was necessary and proportionate.289 Specific issues that bear upon the lawfulness of State interference with the Article 8 right, in these cases, include first, whether "other rights" are implicated in a health care system that regulates home birth; second, what the State's obligations are to protect such rights under domestic and international law; and finally, the fairness of the State's means of balancing these rights.

i. Violation of Article 8 Rights

According to the applicants in both _Dubska_ and _Kosaité-Čypienė_, state laws effectively made impossible women's ability to control the circumstances of parenthood through safely exercising the choice to give birth at home. Because the

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288 Id.

289 Id.
Ternovszky court found that the right to choose the circumstances of childbirth was inherent in Article 8 rights concerning parenthood, laid out in Evans, and because the laws in question in both the Czech Republic and Lithuania, like the Hungarian law at issue in Ternovszky, severely restrict this right, it is likely that Article 8 rights will be found to have been violated for all of the applicants who were pregnant and gave birth, either in a hospital setting, having been deprived of meaningful choice (like Anna Ternovszky), or at home, unattended by health professionals.

Lawyers for the Czech Republic have argued that the applicants in Dubská did not experience a violation of Article 8 rights. The Czech Republic reasoned that Czech law was distinguishable from Hungarian law, because while the Hungarian law was unclear, arguably both allowing and restricting home birth, the Czech Republic never provided a legal establishment allowing for medical assistance in home birth. This difference, the Czech Republic has argued, makes its applicants distinguishable from Anna Ternovszky. Lithuania’s laws are similar to those of the Czech Republic, and it is likely to make the same argument that no Article 8 rights have been violated.

The applicants have a very strong case, though, that their Article 8 rights were violated, especially since the Ternovszky court specifically acknowledged rights pertaining to home birth under Article 8, without regard to whether they were created by positive measures on the part of the state. As the outcomes of the various applicants’ pregnancies demonstrate, laws that restrict home birth, whether they are simply unclear and susceptible to arbitrary enforcement, like the Hungarian laws that the ECtHR found violative of Article 8 rights, or whether they explicitly outlaw medical assistance during home births, like the Czech and Lithuanian laws, leave pregnant women with a problematic decision. Women can give birth in a hospital setting, where they

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290 See Hung, App. No. 67545/09, § 22, Eur. Ct. H.R. at 6; see also Evans, App. No. 6339/05, § 58, Eur. Ct. H.R. at 18 (“Article 8... incorporated the right to respect for both the decisions to become and not to become a parent.”).


292 Id.

293 Id.
will be able to receive the assistance of health professionals, but where they are more likely to be subject to unnecessary interventions, or they may give birth in an environment in which they feel comfortable but lack the assistance of a health professional.

*Kosaitė-Čypienė* raises an important question of whether a woman’s Article 8 rights have been violated because she views becoming pregnant as an unacceptable option, due to her refusal to give birth both in a hospital setting and without the necessary medical assistance. If the Court concludes that this applicant’s rights have been violated, it will greatly widen the range of prospective applicants in cases about home birth brought under Article 8.

**ii. Positive or Negative Obligations**

The ECtHR’s decision that Hungary’s laws violated Ternovszky’s Article 8 rights was grounded in the State’s failure to meet its negative obligations under the Convention (to not interfere with Convention rights, unless the interference is in accordance with law). The legal system in place in Hungary failed in at least one respect: because it did not meet the requirement that domestic law regulating Article 8 rights should be qualitatively accessible and foreseeable, it was not in accordance with law. The Court maintained that any further laws regulating access to health care during home birth must avoid unforeseeable outcomes. Additionally, any regulation must have a legitimate aim, and must be necessary and proportionate in a democratic society.

Because the applicants in *Dubska* were pregnant before the 2012 legislation was passed, their cases could be decided under the same narrow logic as *Ternovszky*; that is, the Court may determine that the indeterminate legal framework was impermissible but

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294 See Hung, App. No. 67545/09, Eur. Ct. H.R at 12 (Sajo, J. and Tulkens, J., concurring) (holding that positive obligations under Article 8 required Hungary to “provide adequate legal security which is needed for the exercise of a freedom,” but not specifically requiring states to go beyond providing “legal security” in the area of home birth restrictions).

295 *Id.*

296 *Id.*

297 *Id.*
decline to address whether the entirely restrictive laws currently in place are legal. At least one applicant has argued that the ECtHR may rule in her favor under the narrow grounds of *Ternovszky*, even if the Court finds that the restrictive legislation passed in 2012 is lawful.\(^{298}\) The legal system in place in the Czech Republic prior to the 2012 legislation prohibiting health professionals from practicing outside of certain medical facilities, the applicant argues, creates an environment of confusion around home birth, leaving midwives vulnerable to arbitrarily applied prosecution. This is a base argument, however; in addition to arguing that the Czech laws prior to 2012 were not in accordance with law because they made legal outcomes unforeseeable, the applicants in *Dubska* argue that the Czech Republic continues to violate both negative and positive obligations.\(^{299}\) Despite these arguments, it is possible that in its *Dubska* judgment, the ECtHR may view the applicant’s case narrowly and find the Czech Republic in violation of her Article 8 rights for the same reason it found Hungary to have violated Anna Ternovszky’s rights.

The Lithuanian laws under scrutiny in *Kosaitė-Čypienė*, as well as the 2012 laws passed in the Czech Republic, are very clear in their limitations on home birth and are unlikely to be deemed unlawful on grounds of arbitrariness. Thus, for the restrictions to be lawful, the governments must prove that the restrictions are for the advancement of “legitimate aims,” and that the restrictions are “necessary and proportionate in a democratic society.”\(^{300}\) However, the ECtHR has determined that since health care is a generally regulated area, the state has a “wide margin of appreciation” in its regulation of home birth.\(^{301}\)

There is no broad consensus among member states on the issue of home birth,\(^{302}\) and in *Ternovszky*, the ECtHR, after positing what a right to choose the circumstances of childbirth would entail, and how it may lawfully be restricted, cautiously noted that statistics on the comparative risks of home birth and hospital birth are still debated and not conclusive.\(^{303}\) These details suggest that

\(^{298}\) *See* ECHR Press Release, *supra* note 291.

\(^{299}\) *Id.*


\(^{303}\) *Id.*
while the ECtHR defined the right to choice in child delivery as encompassing the right to legal certainty that such a choice is lawful, this does not go so far to ensure that home birth will be more accessible for women, and it is far from clear that the ECtHR will find for the applicants in the cases currently before it, which involve legal schemes that are extremely restrictive but foreseeable to the citizens whose rights they limit.

The applicants in Dubská have argued, and those in Kosaitė-Čypienė are likely to argue, that the laws restricting home birth do not advance legitimate aims and are not necessary and proportionate. These alleged violations of negative obligations, as well as certain possible violations of positive obligations, fall under the Court’s analysis of other rights that the state may weigh against the right to choose the circumstances of childbirth, and of the fairness of this balancing. Other recent reproductive rights cases before the ECtHR offer some precedent for protecting citizens’ privacy rights regarding conception, pregnancy, and childbirth, against state or fetal interests.

Unlike conception and pregnancy, which are firmly defined as matters impacting reproductive rights, childbirth is arguably a hybrid issue, beginning in pregnancy and ending in the birth of a child who retains the same rights as her parents. Parental rights cases involving states taking children into care, while not directly analogous with home birth cases, make a useful model for comparison in that they deal directly with tensions between parental and state decisions about the safety and welfare of children. These cases have tended to favor granting parents’ rights to access their children and to be involved in decisions about their placement, and the ECtHR has found states in violation of negative obligations under Article 8 for disproportionately restricting these parental rights. Even more significantly, the ECtHR has also found a state to be in violation of positive

304 See ECHR Press Release, supra note 291.

obligations under Article 8 when the government could have taken positive measures to enable the parental right.  

Whether the ECtHR finds for the applicants or the governments, it might root its analysis in negative obligations, as it did in Ternovszky, through focusing on whether the restrictive schema was foreseeable; for legitimate aims; and proportionate in a democratic society. This kind of decision, if in favor of the applicants, would not greatly clarify rights regarding home birth under the European Convention.

The applicants in Dubská have argued that the ECtHR ought to analyze violations of their Article 8 rights in light of positive obligations of the state. In putting this argument forward, the applicants relied on the concurrence in Ternovszky, in which Judges Sajó and Tulkens maintained that changing regulatory landscapes demand greater positive protection of the exercise of the right to respect for parental choice. The concurrence explained the heightened dangers of rights being restricted in an area like home birth:

Where regulation is the default, as in the medical context, lack of enabling regulation may be detrimental to the exercise of the right, and traditional non-interference will not be sufficient. This may be one of the many unpleasant consequences of living in an overregulated world. It is here that an affirmation of a liberty in positive law is warranted.

The ECtHR has determined that the State is under a positive obligation to ensure its citizens' rights to respect for physical and psychological integrity, and home birth choices may implicate both issues.

While positive obligations do not lend themselves to precise definition, examples of positive obligations imposed upon states for the protection of Article 8 rights include the adoption of

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309 Id.

310 Id. at 12 ("[A State’s] positive obligations may involve the adoption of measures designed to ensure respect for private life.").
regulatory measures to protect family life.\textsuperscript{311} Cases instituting these positive obligations to enact measures that protect family life have dealt with parental rights to establish ties with their children.\textsuperscript{312} These cases dealt with providing citizens with access to their families. This access, fundamental to the exercise of other parental rights, possibly demands more positive protection than the right to choose the circumstances of childbirth.

In Ternovszky, the ECtHR majority opinion did not address positive obligations of the State; Hungary nevertheless argued that the Article 8 right to self-determination did not create a positive obligation to “widen the range of choices available in the health care system.”\textsuperscript{313} Likewise, the Czech Republic has argued that it is under no positive obligation to restructure its regulation of healthcare in a way that would promote home birth, which it views as significantly more dangerous than hospital birth.\textsuperscript{314} The Czech Republic relied on two ECtHR cases, which found that states did not have positive obligations to alter their laws and facilitate the exercise of rights, in the matters of a woman who wanted to use the frozen embryos derived from her eggs and the sperm of her ex-husband;\textsuperscript{315} and in the case of two couples who wished to use donated sperm or ova for in vitro fertilization (IVF).\textsuperscript{316}

Neither the ECtHR cases that have imposed positive obligations on states in protecting family life, nor those that have found no positive obligations, perfectly correspond to the issue of home birth. On the contrary, these cases have largely involved rights fundamental to family life, such as the right to be involved in the life of a biological child, or rights antecedent to family life, such as the right to make use of scientific technologies in order to reproduce. Yet, as is evidenced by statistical data on the high rate of medical interventions in hospital births,\textsuperscript{317} the potential for


\textsuperscript{312} Id.


\textsuperscript{314} See ECHR Press Release, supra note 291.

\textsuperscript{315} See Evans, App. No. 6339/05, Eur. Ct. H.R.


\textsuperscript{317} See supra Part I.
hospitalized childbirth to be extremely medically invasive for a woman in labor is very high. Thus, childbirth is an area that implicates the right to bodily integrity in addition to the right to privacy in family life, both of which are areas in which the ECtHR has created positive obligations on states.318

iii. Other Rights

Other rights, to be balanced with the mother’s rights to give birth at home, include public rights;319 other Convention rights;320 and international obligations.321 In the chamber hearing for Dubská, the Czech Republic relied on its obligations under international treaties to protect the life and health of both mothers and children.322 Though the ECtHR has declined to determine that the fetus falls under the definition of “life” under the Convention,323 the Czech Republic emphasized that its constitution protects human life even before birth and, moreover, childbirth involves the transition between fetal life and childhood.324 The Czech Republic, then, has adopted the converse of the Lithuanian applicants’ Article 2 claims. The Lithuanian applicants argue that in depriving expectant mothers of the choice to give birth at home, assisted by a midwife, the state violates the Article 2 rights of women and children who undergo unassisted births at home.325 The Czech Republic submits that restricting home birth is necessary for protecting Article 2 rights of childbearing mothers and newborn children.326 Allowing women the care of a midwife,

320 Id.
326 See ECHR Press Release, supra note 291.
it argues, is not an appropriate means of protecting the right to life because only in hospitals are health professionals adequately prepared to take all measures to reduce mortality, including interventions and the use of medical equipment. The current regulatory framework, the Czech Republic argues, maintains the high quality of care that the Czech Republic currently provides for the public, including free accessible care for birthing in appropriate facilities. The Czech Republic notes its low rate of infant mortality as compared to countries that provide access to home birth.

The Czech Republic also points to international commitments to protect the lives of children under treaties such as the Convention on the Rights of a Child which underscores the importance of a child’s life even before birth, creating obligations on states to reduce infant mortality and to intervene to ensure quality childbirth care. The Czech government argues that because a midwife does not always have the necessary equipment to deal with emergencies during childbirth, it cannot be in compliance with this treaty if it creates a regulatory framework that allows women to choose to give birth outside of a hospital.

The applicants in Dubska take issue with both parts of the Czech Republic’s argument that its restrictive laws are necessary for the protection of other rights. First, fetuses do not have rights under the Convention. More importantly, international obligations weigh on the side of protecting women’s choices in childbirth. The applicants note that the Convention on the Elimination of Discrimination Against Women (CEDAW) has urged the Czech Republic to consider steps to ensure the availability of home deliveries and has otherwise criticized widespread medicalization of childbirth. CEDAW explicitly

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327 Id.
328 Id.
329 Id.
331 See ECHR Press Release, supra note 291.
332 Id.
333 Id.
334 See Committee on the Elimination of Discrimination against Women, Concluding Observations of the Committee on the Elimination of Discrimination Against
notes that states should support women’s right to assistance during home delivery.\textsuperscript{335}

\textit{iv. Fairness}

A final issue in analyzing whether the state regulation of childbirth infringes upon Article 8 rights is the fairness in how the state has balanced private and public interests. The \textit{Ternovszky} decision did not provide guidance as to what a fairly balanced scheme might entail, instead noting only that the state has a wide margin of appreciation and that the balance must take into account various rights. Whether the ECtHR determines that the Czech and Lithuanian regulatory schemes, which prohibit home births, are fair will depend on how wide the state margin of appreciation really is in this scenario. If these schemes are held to fairly balance societal interests with private rights, however, it seems that the right to choose a home birth will be no more than a theoretical right, one which a state can easily eliminate through claiming to be protecting mothers and their children. Such a determination, rooted in the idea that mothers do not make choices that are in their children’s—and their own—best interests, could have potentially devastating consequences for women, promoting the idea of a dichotomy between a woman and her fetus, and laying the groundwork for violations of the physical and psychological integrity of expectant mothers through forced medical interventions.

\textbf{V. Recommendations & Conclusion}

An ECtHR decision holding that Article 8 rights to choose the circumstances of childbirth require a minimum of positive protection on the part of the state would be the most effective—and perhaps sole—means of ensuring that women are free to choose the circumstances of childbirth, including where to give birth. Given the safety of planned home birth in low risk

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pregnancies, it is illogical for the State to give less protection to a woman's ability to choose to give birth at home, which concerns both her body and her family, than it does to citizens making other medical or parenting decisions.

The decision of where to give birth is intensely personal, and misgivings about hospital birth can be so compelling as to induce women to choose to give birth at home without medical assistance, if they believe it is the only acceptable option. Indeed, this is exactly what one applicant in Kositá-Čypiené chose to do.\textsuperscript{336} To ensure the safety of women and children, it is imperative for states to make safe childbirth options legal and available.

In addition to ensuring that it is legal for midwives and health professionals to assist in home birth, states should take positive measures to protect the decision to give birth at home. These measures include, for example, allowing women to pay for home birth through health insurance that undertakes an individualized risk-assessment\textsuperscript{337} to determine whether home delivery is a safe option for a woman.

Also important is the regulation of the midwifery profession. In 2013, in the wake of Hungary's still-restrictive regulations on midwives, the United Nations Committee on the Elimination of Discrimination against Women harshly criticized the continuing obstacles to the choice to have a home birth in Hungary, specifically its failure to recognize midwives as independent professionals.\textsuperscript{338} The Committee specifically recommended that


Hungary recognize "trained midwives as independent professionals," produce a "legal framework and guidelines on security of home deliveries," and provide for the "training of obstetricians." Indeed, maintaining a status quo in which midwives are viewed as abnormal and substandard despite their historical role in providing guidance and assistance during labor, patronizes women and sends the message that the State is in a better position than the woman to understand her needs during pregnancy and childbirth. Of the midwifery profession, the World Health Organization has suggested that the following state regulatory actions are essential for the optimal protection of public health: "setting standards for entry to the occupation or profession; ensuring, as much as possible, the maintenance of standards; providing a mechanism for dealing with professional misconduct; [and] maintaining an effective public register of all those eligible to practice." Such regulatory efforts open up choices in childbirth without compromising safety. Many countries have already established regulatory bodies that govern midwifery; these include the United Kingdom, New Zealand, Malawi, Ghana, and several states within the United States.

Even if the ECtHR does not find that the State has positive obligations to create a regulatory scheme that promotes the choice to have a home birth, the ECtHR should clarify the extent of the State’s margin of appreciation, and find that laws making medical assistance during home birth unlawful disproportionately restrict women’s right to choose to have a home birth. The preemptive withholding of medical care from women who choose to give birth at home is punitive and rails against the logic of lawmakers who would harness all births to a hospital setting in the name of safety.

This Comment has examined the history behind the medicalization of childbirth to suggest that this is a cultural, rather than a purely medical, phenomenon. The ECtHR’s decision in Ternovszky was narrow and failed to sufficiently protect women who want to maintain control over how they give birth. In the

339 Id.
341 Id. at 10.
past, ECtHR decisions have proven to be persuasive authorities in other courts, internationally. A decision finding positive obligations on States to protect home birth could have a positive impact on women throughout the world. Lawyers arguing home birth cases should continue to argue that States have positive and negative obligations under Article 8 in the area of home birth. Article 2 arguments should focus on the risk of harm to mothers in hospitals, amplified by slippery informed consent requirements and pressure to accept unnecessary interventions. Rights during childbirth are an essential component to reproductive rights, and establishing these rights allows women to maintain autonomy, choice, and control during a time that is considerably meaningful and has the potential to be an either vulnerable or empowering experience.