

**OBSTETRIC VIOLENCE IN ARGENTINA: A STUDY ON
THE LEGAL EFFECTS OF MEDICAL GUIDELINES
AND STATUTORY OBLIGATIONS FOR IMPROVING
THE QUALITY OF MATERNAL HEALTH**

by

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Abstract

Obstetric Violence is a pervasive phenomenon that affects women's maternal health worldwide. It has been recognized by the WHO that abusive and disrespectful treatment in facility-based childbirth is a contributing factor in maternal and infant mortality, and the global community has adopted steps in attempting to identify and eliminate all forms of obstetric violence. Within Latin America, Argentina has taken proactive measures legislating the proscription of obstetric violence. This thesis seeks to examine the development of the concept of Obstetric Violence in Argentina, its organic evolution from internal medical regulations and guidelines to national legislation. The thesis will also track evidence about the degrees of success that Obstetric Violence definition, assessment and regulation have had in preventing violations of women's rights—both on a practical level and in the legal redress of these rights through tort claims.

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1 Introduction

In 1990 the United Nation's 193 member States committed to achieving the Millennium Development Goals (MDG) by 2015 with the objective of fighting the many dimensions of poverty.¹ In particular, MDG No. 5 (target 5A) was dedicated to improving maternal health by: reducing the global maternal mortality ratio (MMR) by three quarters between 1990 and 2015, increasing skilled personnel birth attendance, and improving antenatal care coverage.²³ In light of the most recent data, Latin America will be among the regions that will fail to comply with Millennium Development Goal (MDG) No. 5, target A. Latin America only reduced the maternal mortality ratio (MMR) by 40% between 1990 and 2013.⁴ Among individual Latin American countries, Argentina will not comply with MGD No. 5⁵; despite some progress, lowering the maternal mortality ratio to a 3.2 in 2013 from a 5.2 MMR in 1990, Argentina has still only achieved a 40% decrease.⁶ Maternal mortality analysis in Argentina shows that its determining factors are: the persistence of subordination of and violence patterns against women, discontinuous application and monitoring of quality of care of childbirth assistance in health facilities, lack of mechanisms for control and enforcement of reproductive health laws, and scarce practice of perinatal interventions proved to benefit maternal mortality and morbidity reduction, among other factors.⁷ These factors play a part in the abuse and mistreatment exercised against the women receiving maternal healthcare generally; but they also contribute directly to maternal mortality in Argentina, as well.⁸

Among the key strategies for reducing maternal mortality is the increase of skilled birth attendants and facility-based childbirth. Such strategy demands that health systems improve the

¹ United Nations, *The Millennium Development Goals Report 2015* (New York: UN, 2015) at 4. [UN]

² *Ibid.* at 38.

³ Maternal Mortality Ratio (MMR): maternal deaths per 100 000 live births.

⁴ World Health Organization et al. *Trends in maternal mortality: 1990 to 2013* (Geneva: WHO, 2014) at 25. Online: WHO <http://apps.who.int/iris/bitstream/10665/112682/2/9789241507226_eng.pdf?ua=1>.

⁵ Ministerio de Salud [Ministry of Health], Argentine Forum for Health Research, *Executive Summary, State of the Art, and Priority Setting, decision making agenda for the maternal morbidity-mortal in Argentina* (Buenos Aires: Academia Nacional de Medicina, 2007) (Argentina).

⁶ Ministerio de Salud [Ministry of Health], Dirección de Estadísticas e Información de Salud [Directorate of Health Statistics and Information], *Estadísticas Vitales: información básica – Año 2013* (Buenos Aires: Ministerio de Salud; 2014) (Argentina).

⁷ Ministerio de Salud [Ministry of Health], Argentine Forum for Health Research, *supra* note 5, at 10.

⁸ *Ibid.* at 9.

quality of care provided to women, contemplating respect and protection of women's reproductive rights.⁹ With relation to this, researchers and health systems analysts show that critical maternal health knowledge gaps persist, especially on information about the quality of care at the facility level, the over-medicalization of the birthing process, and the prevention and elimination of disrespectful practices and abuse during maternity care.¹⁰ Currently more than 99% of childbirths in Argentina already occur in health facilities.¹¹ Beginning in the 1990s measures began to be taken addressing these lapses: the National Congress began to enact legal statutes,¹² while the Ministry of Health started producing clinical practice guidelines and public policies to ensure women quality maternal care at health facilities.¹³ ¹⁴ Notwithstanding these policy initiatives, in 2009 the Argentinean Congress admitted that the provision of maternal care in health facilities had become a source of the violence against women, defining this perverse phenomenon as “Obstetric Violence.” In light of the Argentine reproductive health context, this thesis will answer the following questions: what explains the emergence of legislation proscribing the abuse and mistreatment of women in maternal care as obstetric violence? Does this emergence illustrate deficiencies on the legal effects of medical practice guidelines and statutory obligations suggesting improved standards of maternal healthcare?

In this thesis I argue that, on the basis of the Argentine experience, the design of reproductive health clinical practice guidelines and Statutes for quality of care for pregnant women has had little legal effect in redefining the legal standard of maternal care as well as misleading implementation for ensuring effective prevention and eradication of abuse and

⁹ Meghan Bohren et al., “The Mistreatment of Women during Childbirth in Health Facilities Globally: a Mixed-Methods Systematic Review” (2015) 12:6 PLoS Med. 1-32.

¹⁰ Tamil Kendall and Ana Langer, “Critical Maternal Health Knowledge Gaps in Low-and-Middle-Income Countries for the Post-2015 Era” (2015) 12:55 Reproductive Health 1-4.

¹¹ Ministerio de Salud [Ministry of Health], Dirección Nacional de Maternidad e Infancia [Directorate of Maternity and Infantrty], *Recomendaciones para la Práctica del Control Preconcepcional, Prenatal, y Puerperal* (Buenos Aires: Ministerio de Salud, 2013) (Argentina).

¹² Law No. 25.929, Law of Humanized Childbirth, B.O. 30489, 21 September 2004 (Argentina). [Law of Humanized Childbirth]

¹³ Ministerio de Salud [Ministry of Health], Dirección Nacional de Maternidad e Infancia [Directorate of Maternity and Infantrty], *Propuesta Normativa Perinatal Tomo IV: Atención del Parto de Riesgo* (Buenos Aires: Ministerio de Salud, 1998) (Argentina); Ministerio de Salud [Ministry of Health], Dirección Nacional de Maternidad e Infancia [Directorate of Maternity and Infantrty], *Guía para la Atención del Parto Normal en Maternidades Centradas en la Familia* (Buenos Aires: Ministerio de Salud, 2004) (Argentina).

¹⁴ Miguel A. Largaúa, Cecilia C. Lomuto & María Aurelia González, *Guía para transformar Maternidades tradicionales en Maternidades Centradas en la Familia* (Buenos Aires: Ministerio de Salud-UNICEF; 2007).

mistreatment of to women. Public policy directed to restructuring the woman patient-health personnel relationship, traditionally understood as a dependency relationship, must effectively ensure pregnant women's security and dignity, as well as empower their capacity and autonomy during maternal care. To such end, this thesis will critically assess state implementation and legal effects of its guidelines and Statutes. Particularly, this thesis will analyze the effectiveness of the Health Ministry's guidelines in restructuring medical standards of care towards safe, respectful and autonomy-empowering quality of maternal care for pregnant women. In contexts where such clinical practice guidelines receive poor state monitoring of their implementation and their effectiveness in transforming medical standards of care is ineffective, legal remedies for women against abuse and mistreatment in childbirth are needed in order for health professionals to effectively improve the quality of care. The examination of these issues in reproductive health shows that public policy should be grounded in a perspective that involves all stakeholders, in particular health professionals.

For the purposes of explaining the above, this thesis is organized in three chapters. Before developing the content of these chapters, it is necessary to establish some clarifications that will guide this thesis, as well as clarify what will not be covered. What is "Obstetric Violence"? The 2009 Statute from Argentina ensuring legal remedies for women against abuse and mistreatment in pregnancy, labor, childbirth, and post-partum care defined obstetric violence as,

“[v]iolence exercised by health personnel on the body and reproductive processes of pregnant women, expressed through dehumanized treatment, medicalization abuse, and the conversion of natural processes into pathological ones...”¹⁵

With this definition in mind, this thesis will not examine obstetric violence that may occur in home-based settings. Argentinean law does not contemplate abuse and mistreatment of women receiving home-based maternal care. Despite the fact that the definition of obstetric violence alludes to health personnel, it does not expressly determine that its perpetration will be focused solely on health facilities. That is, health personnel may well inflict obstetric violence during home-based maternal care. However, given that, on the basis of the Ministry's of Health

¹⁵ Law 26485, article 6(e), Integral Law for the Sanction, Prevention, and Eradication of Violence against Women, 1 April 2009, (Argentina) (reproductive processes is understood as pregnancy, labor work, childbirth, and post-partum periods). [Law on Violence against Women]

data, 99% of childbirths occur in health facilities, it would seem that the need for reflection should be directed to obstetric violence happening in health facilities. Thus, scenarios where obstetric violence may occur in home-based setting will be omitted from this analysis.¹⁶

With relation to the term “obstetric violence,” as defined under Argentinean law, it contemplates a set of narrow conducts by health personnel that constitute violence against women. However, for clarification purposes, the term “obstetric violence” is rarely used in the global context for referring to abuse and mistreatment suffered by women during maternal healthcare. The WHO issued a statement requiring governments and development partners to increase research for achieving consensus on how to define and measure “disrespectful and abusive treatment” of women during childbirth.¹⁷ In response to this, recent literature has emerged maintaining that the abuse and mistreatment inflicted on women is best captured and easiest to conceptualize under a broader concept: “mistreatment of women.”¹⁸ This concept, the result of a “global review” of research on the experience of women during childbirth considers that “mistreatment of women” is broad enough to measure the experiences of women in childbirth under the following general metrics:

- health systems conditions and constraints;
- poor communication between women and providers;
- failure to meet professional standards of care, stigma and discrimination, and abuse.¹⁹

For the purposes of this study, the thesis will adopt the definition under Argentinean law and analyze the abuse and mistreatment suffered by women as obstetric violence. Recognizing that Bohren’s approach in terminology might be best, this thesis does not want to misrepresent of the scope given by the Argentinean legislator or policy-maker to the State actions for preventing and eradicating “obstetric violence” by using the broad definition “mistreatment of women.”

¹⁶ Nevertheless, it is important that further research contemplates and gathers data on the experiences of women receiving home-based maternal care during childbirth under the assistance of health personnel. The 1% of women that give childbirth not in health facilities may not only receive poor maternal healthcare, but also subjected to abuse and mistreatment for belonging to vulnerable insular minorities (i.e. indigenous pregnant women). These victims of obstetric violence would also have the poorest access to channels for legal redress, as well.

¹⁷ WHO Statement: the Prevention and Elimination of disrespect and abuse during facility-based childbirth, WHO/RHR/14.23 (2014). Online: WHO <http://apps.who.int/iris/bitstream/10665/134588/1/WHO_RHR_14.23_eng.pdf?ua=1&ua=1>.

¹⁸ Meghan Bohren et al., *supra* note 9, at 21.

¹⁹ *Ibid.* at 9-20.

Chapter 2 of this thesis will explain the global initiatives studying the experience of women in childbirth and protections offered them against abuse and mistreatment. This chapter continues to review the sociological and medical research on the provision of maternal care to women during childbirth, influenced by this global initiative, warning of the fact that the traditional culture of maternal healthcare during childbirth is inflicting violence on pregnant women. In turn, I examine the production of clinical practice guidelines issued by the Ministry of Health, which were informed by the previous sociological and medical research. Afterwards, I analyze the effectiveness of these clinical practice guidelines by studying their adoption by obstetric societies and associations from Argentina as clinical practice protocols and ethics protocols in maternal care. This section will identify gaps in the effectiveness of the Health Ministry's guidelines by showing that such policies do not translate entirely into the recommended standard of care by OB-GYN Societies and Associations in Argentina. Lastly, this Chapter will show that the Health Ministry's measurement of its policy implementation might be misrepresenting its own effectiveness; this may serve as a measure of the type of effective monitoring that is required.

Chapter 3 will examine the legal effects these clinical practice guidelines with the objective of determining whether such protocols have been able to serve as a persuasive source for measuring the legal standard of care in maternal health by courts. To this end, I review tort case law that specifically analyzes the infliction of obstetric violence by health personnel in health facilities. This analysis will show that courts fail to apply clinical practice guidelines for determining the professional standard of care in cases where obstetric violence has been occurred; this fact widens the gap between the guidelines' sought for outcomes identified for achieving a quality standard of care and their real effectiveness. This chapter will also illustrate that courts fail to enforce statutory obligations for adequate and safe quality of maternal health care, hence, contributing to women's inability to perceive judicial relief for the violation of their rights.

Lastly, this thesis will present its findings and determinations in a conclusion.

2 Medical Standards of Maternal Care: a Study on the effectiveness of National Medical Guidelines and their Implementation

The emergence of the legal concept of obstetric violence (proscribed by law as obstetric violence in 2009) in the provision of maternal healthcare has revealed two important issues: it paints a portrait of the provision of maternal care as incapable of ensuring the protection of women in health facilities and, simultaneously, structures women as victims of health professional's clinical practice.

A. Does this mean that prior to 2009 Argentina has not issued any medical standards for maternal care with the intention of protecting women's health?;

B. Are women's security and comfort during maternal care concerns that have arisen only in the first decade of the 21st century?;

C. What effectiveness has the translation of the Ministry of Health guidelines into recommended professional standards of care by OB-GYN Associations and Societies from Argentina had? What effectiveness has the Ministry of Health policy implementation had on public and private health facilities?

This Chapter will argue the following thesis: to a great extent Argentinean public health policy has incorporated the international and regional clinical practice guidelines recommending both improved medical standards of care and provision of humanized care in maternal health with the objective of protecting women's security, comfort, and dignity. However, this chapter will argue that such reproductive health policies had little effectiveness in modifying the professional standard of maternal care as reflected in OB-GYN Associations and Societies clinical practice and professional ethics guidelines.

In order to explain this, the Chapter will be organized as follows: it will first describe the international and regional recommendations issued by the WHO, the Pan American Health Organization (PAHO), the International Federation of Gynecologists and Obstetrics (FIGO), and the Latin American Center of Perinatology and Human Development (CLAP). These organizations have advocated for improved quality of maternal healthcare in two ways. On the

one hand, their recommendations are framed as clinical practice guidelines that discuss and determine obstetric practices, intended to set improved medical standards of maternal healthcare. On the other hand, these organization's guidelines seek to ensure that maternal care is exercised in a more humanized way, for example, by not structuring pregnancy and birth as an illness, guaranteeing women their right to participate in, plan, execute, and evaluate the decision-making of the maternal healthcare received, or by eliminating the physical and verbal abuse (i.e. slaps, pinch, insults or threats) to women by health personnel during childbirth. These recommendations, then, reveal that the challenges for better quality of maternal healthcare in childbirth require a twofold action: standards that both benefit and protect of the security and autonomy of the woman, as well as ensure that the provision of healthcare by health personnel to the pregnant woman is exercised in a respectful and dignified way.

A second section of this chapter will discuss Argentina's incorporation of these international and regional recommendations through the elaboration of clinical practice guidelines prior to the legal proscription of obstetric violence. Preliminarily, this chapter will first present the burst of sociological and medical critiques on the way manner of exercising provision of maternal healthcare by health care professionals.²⁰ This sociological and medical research was based on capturing the testimonies of women receiving maternal healthcare and the practice culture of health institutions. Among its findings, this critique showed how health professionals conceived of the pregnant woman as an object of healthcare instead of a subject of maternal care. This understanding by health professionals was intended for the protection and safe birth of the newborn, which explained the use of obstetric practices that were not beneficial to the woman or that were abusive or disrespectful towards her. This thesis will then delve into the creation of clinical practice guidelines that were informed by this sociological and medical critique and issued mandatory recommendations to health facilities, setting improved standards for obstetric care and instructions for providing humanized care.

²⁰ See Joanna N. Erdman, "Bioethics, Human Rights, and Childbirth" (2015) 17: 1 *Health and Human Rights Journal* 43-51 (for a human rights reading on the sociological critique on the disrespectful and abuse provision of maternal healthcare in childbirth.) See also, Rebecca Cook and Bernard Dickens, *Advancing Safe Motherhood through Human Rights* (Geneva: World Health Organization; 2000) (on the way social science research explains or identify social or behavioral practices preventing safe motherhood.)

A third section of this thesis will consider the effectiveness of Ministry of Health issued maternal health policies created in order to shift past professional medical practice. In order to determine their effectiveness, the section will, on one side, analyze the impact of this clinical practice protocols on the obstetric professional practice governance. To such end, the section will review the clinical practice guidelines as well as the professional ethics guidelines issued from such Obstetric Associations and Societies as transparently publish this information on their Internet webpages.²¹ Then, this chapter will analyze the aforementioned effectiveness in impelling the legislative production of legal standards of humanized care for pregnant women by health professionals during the provision of maternal healthcare during childbirth. I will introduce and explain the enactment of the 2004 Statute on the Rights of Pregnant Women in Health Facilities during Childbirth. Lastly, the chapter will end with a conclusion enumerating the findings determined through its sections.

2.1 Global Initiatives for Safe Motherhood: Guidelines on Safe Clinical Practice and Humanized provision of Maternal Care

The 1987 International Conference on Safe Motherhood in Nairobi is considered to be the starting point of the Safe Motherhood Initiative.²² The Conference meant to be a call for action to strengthen health systems through better access and more skilled birth attendance and basic obstetric care in cases of emergency in pregnancy, birth, and post partum.²³ However, already in 1985 the World Health Organization (European Region) and Pan American Health Organization issued the “Fortaleza Declaration” on “Appropriate Technology for Birth,” which has served as an advocacy platform for the change of perspective on the provision of care during birth.²⁴ This declaration states that birth should not be considered an illness for the woman, but a natural and normal process. It further recognizes that women have a right to quality perinatal care, and that women should play a central role in participating and evaluating the provision of care. Furthermore, the declaration confirms that even low risk pregnancies may encounter

²¹ Due to difficulty accessing such information, though not comprehensive, the available information should suffice to offer an idea of the limited effectiveness of the Ministry of Health’s policies for the implementation of guidelines on medical obstetric associations.

²² Carla AbouZahr, “Safe Motherhood: a brief history of the global movement 1947-2002” (2003) 67 *British Medical Bulletin* 13-25, at 16.

²³ Olivier Weil and Hervé Fernandez, “Is Safe Motherhood an Orphan Initiative?” (1999) 354 *Lancet* 940-43, at 940.

²⁴ WHO, “Appropriate Technology for Birth” (1985) 2 *Lancet* 436-437, at 435.

complications, which may be best addressed through medical technology interventions. However, the declaration emphasizes that the application of such medical technology in perinatal healthcare must be evidence-based and its assessment should include the participation of women. Lastly, this declaration established that cesarean delivery rates above 10-15% are unjustified.²⁵

After the Safe Motherhood Initiative and the “Fortaleza Declaration,” International and Regional Health Institutions began to research and discuss improving both medical practice in maternal care and provision of more humanized maternal healthcare to the woman. On the one hand, the improvement of standards of medical practice in maternal care aim at adopting clinical practices which are useful and beneficial to the woman. With this aim, these guidelines intend that women not to be dissuaded from seeking medical assistance in facility-based childbirth out of fear of high numbers of ineffective or unnecessary medical interventions that could be ultimately harmful to the woman or fetus. On the other hand, other guidelines emphasize the importance of health professionals providing more humanized maternal healthcare in a way, that is, respectful and attentive to their preferences, feelings, dignity, and including companionship during care.²⁶ Humanized treatment in maternal care by health professionals seeks to prevent (verbal among other forms of) abuse to women during childbirth and to ensure women’s participation in assessing the provision of care that they receive, among other characteristics.

Among the guidelines that aim at improving the standard of obstetric care in childbirth are those of the WHO, that through the Safe Motherhood Program, issued in 1996 its first practical guide: “Care in Normal Birth.” This practical guide sets recommendations for processes of normal birth (non-complicated labor and delivery) by evaluating certain interventions as unhelpful, untimely, inappropriate, or unnecessary according to the soundest available evidence.²⁷ Such recommendations respond to the phenomenon, recorded in the guidelines, of births being routinely treated with high level of interventions without regard to whether the pregnancy is high or low risk. In this sense, these WHO guidelines warn that such routine

²⁵ WHO, *supra* note 24, at 436.

²⁶ See White Ribbon Alliance, *Respectful Maternity Care: The Universal Rights of Childbearing Women* (Washington, DC: White Ribbon Alliance; 2011). Online: White Ribbon Alliance <whiteribbonalliance.org/wp-content/uploads/2013/10/Final_RMC_Charter.pdf>.

²⁷ WHO, Department of Reproductive Health & Research, *Care in Normal Birth: a Practical Guide* (1996), WHO/FRH/MSM/96.24, at 1. Online WHO <http://apps.who.int/iris/bitstream/10665/63167/1/WHO_FRH_MSM_96.24.pdf>. [Care in Normal Birth]

practices may bring about complications in low risk pregnancies and harm the mothers and newborns. Consequently, the WHO guidelines note, this practice may deter pregnant women, fearing high level interventions and unnecessary and potentially harmful practices, from seeking the care they need from health professionals.²⁸

Regional Institutions such as the Latin American Center of Perinatology and Human Development (Centro Latinoamericano de Perinatología y Desarrollo Humano, CLAP) also issued principles on perinatal care in line with the proposed WHO recommendations. Such principles were published in 2001 as: “Prenatal Care and Low Risk Pregnancy.” In this report, the CLAP recommends that for low risk pregnancies, the prenatal visits or monitoring should include as many prenatal monitoring practices as possible and achieve adequate prenatal care for keeping the pregnancy low risk.²⁹ In 2005, the CLAP issued a declaration of objectives for maternal perinatal health for Latin America and the Caribbean. These objectives emphasize the importance of doing proper epidemiology studies on pregnant women in order to differentiate low risk from high-risk pregnancies.³⁰ Lastly, along the line of the recommendations established by WHO, the CLAP also recommends that women be included in the healthcare process and decision-making.³¹

Lastly, the International Federation of Gynecologists and Obstetrics (FIGO) Committee for Safe Motherhood and Newborn Health also issued guidelines in 2012 for adequate and safe care in the second stage of labor, considered a crucial moment in the birth process.³² Later in partnership with other institutions, FIGO launched the “Mother-baby friendly birthing facilities” initiative, which states a set of criteria and indicators for determining that a health facility is friendly to the mother and newborn. The criteria mentioned include: that health facilities should allow women to adopt preferred positions and place no restrictions on the intake of foods and beverages; health facilities should assure privacy during delivery; allow the presence of a trusted

²⁸ *Care in Normal Birth*, *supra* note 27, at 2-3.

²⁹ Ricardo Schwarcz et al, *Salud Reproductiva Materna Perinatal: Atención Prenatal y del Parto de Bajo Riesgo* (Montevideo: CLAP-PAHO/WHO, 1996).

³⁰ José M. Belizán et al, “Goals in Maternal and Perinatal Care in Latin America and the Caribbean” (2005) 32:5 *Birth* 210-218, at 213.

³¹ *Ibid.* at 215.

³² International Federation of Gynecology and Obstetrics, Safe Motherhood and Newborn Health Committee, “FIGO Guidelines: Management of the Second Stage of Labor” (2012) 119 *Intl’ J. of Gynecology and Obstetrics* 111-116. [FIGO: Management of Second Stage Labor]

birthing partner; prohibit routine practices as they are not guided by evidence-based protocols; include non-discriminatory policy for HIV-positive women, family planning, youth services, or ethnic minorities, among others.³³

In order train health professionals in providing more humanized maternal health care, the internationally prominent initiative by the White Ribbon Alliance for Safe Motherhood can be highlighted. Its charter “Respectful Maternity Care: the Universal Rights of Childbearing Women” emphasizes the importance of broadening the concept of safe motherhood beyond the issue of maternal mortality and morbidity, by additionally focusing on and understanding that it involves “deep personal and cultural significance for the woman and family,” as well.³⁴ Consequently, the charter advocates that safe motherhood be treated as a women’s rights violation and not only as a public health issue. In this sense, the charter establishes that abusive and disrespectful treatment in the provision of maternal healthcare may involve the violation of the following rights: to non-discrimination; freedom from cruel, degrading, and inhumane treatment; right to information; right to informed consent and refusal; right to self-determination; and right to the highest standard of physical and mental health, among others.³⁵

This section has explored some of the different guidelines issued by international and regional institutions aimed at improving the standard of obstetric care for women and the provision of more humanized maternal healthcare in public health systems and by health professionals. The connecting factor was the shared assessment that women’s security, comfort, and dignity were not being guaranteed and, consequently, risks of harm and (preventable) mortality were affecting not only women’s and the fetus’ (newborns’) health, but also constituted a violation of women’s human rights. In response to this international elaboration of medical standards for the protection of women’s reproductive health in maternal care, how has Argentina’s public health system responded? I will explain this in the following section.

³³ FIGO et al, “Mother-Baby Friendly birthing facilities” (2015) 128 Intl’ J. Gynecology and Obstetrics 95-99, at 96.

³⁴ White Ribbon Alliance for Safe Motherhood, *supra* note 26.

³⁵ *Ibid.* at 2.

2.2 Maternal Health in Argentina in the 1990s: a Critique from Social Science and Medical Research

Medical care for pregnant women in Argentina changed perspective with the introduction of “Family Centered Maternity and Newborn Care.”³⁶ This perspective on the provision of medical care to pregnant women was, however, already under consideration in some hospitals and maternity clinics in Argentina. Family Centered Maternities and Newborn Care perspective came into consideration in health institutions through studies by health professionals and sociologists on the provision of health care at this maternities around the 90’s a beginnings of the 2000’s showed important deficiencies.

In “Ramón Sardá,” the Pediatric-Maternal Hospital, Family Centered Maternities was being studied for implementation.³⁷ Based on a 1998 study considering what measures the Hospital should adopt for Family Centered Maternity, Dr. Miguel Larguía drafted a plan for allocation of material and human resources.

Diagnosing the condition of maternal wards in Argentina, Larguía found that most pregnancies and childbirth were hospitalized and pregnant women were being defined as individuals with illness.³⁸ Hence, hospitals constructed their provision of care without assuring security and comfort for pregnant women, rather as services that women were compelled to endure. Further, Larguía generally described most maternity wards as uncomfortable, ugly and uninviting, factors that made women hesitate to return to these wards in future pregnancies. Moreover, Larguía showed that the maternal wards were not then offering any family support to the pregnant women during childbirth: open visitation was generally prohibited in labor rooms and family visits were allowed with severe time restrictions.³⁹ Lastly, Larguía found that even in 1998 maternity wards (health professionals) already inflicted mistreatment and “violence” on pregnant women, events he characterized as “institutional violence” and human rights violations.⁴⁰ This violence, he described, expressed itself through: prolonged waiting times,

³⁶ See Adriana A. Greco, *Las Voces Acalladas en la Maternidad* (Buenos Aires: CEDES-FLASCO, 2008), online: at 11 <http://www.cedes.org.ar/Publicaciones/Coltesis/ColeccionTesis_6.zip>.

³⁷ Miguel Larguía, “Maternidades Centradas en la Familia” (1998) 3 *Rev. Hosp. Mat. Inf. Ramón Sardá* 103-109.

³⁸ *Ibid.* at 103.

³⁹ Larguía, *supra* note 37, at 104.

⁴⁰ *Ibid.* at 109.

refusal to give women information, separating pregnant women from their families, failing to obtain consent for the practice of specific procedures, verbal mistreatment, and inappropriate conduct.⁴¹

Another analysis from 1996 by sociologist Susana Checa studied the provision of prenatal care to pregnant women in the Pediatric-Maternal Hospital “Ramón Sardá.” Her study revealed that the quality of prenatal care was gendered, since pregnant women were cared only on the basis of their gestational capacity.⁴² That is, health professionals did not bother informing women about the kind of health care being provided or obtaining their consent on care of the gestating fetus.⁴³

Later on, Checa highlighted the importance of health professionals incorporating a gender perspective when providing reproductive healthcare for women.⁴⁴ Checa raised concerns regarding the quality of reproductive healthcare that women were receiving in 2000 from health professionals. For example, Checa observed that the institutionalization of births and pregnant women (low risk pregnancies) in hospitals diminished women’s participation and decision-making in relation to their reproductive health and that these problems were structural issues in the public healthcare system.⁴⁵⁴⁶ Checa identified that consequently health professionals tend to expect pregnant women to adopt a passive and submissive attitude to the provision of reproductive healthcare. She identified that generally maternal wards, obstetricians, and gynecologists regularly fail to meet adequate standards for the demands of reproductive health care, leading them to provide impersonal healthcare and presume that pregnant women should be submissive.⁴⁷

As a response, in 2000, Checa advocated for the a more humanized provision of reproductive healthcare that would respect the pregnant women’s right to participate in the

⁴¹ Largaña, *supra* note 37, at 109.

⁴² Susana Checa, “Uso y Gestión de los Servicios de Salud Pública en la Atención del Embarazo y Regulación de la Fecundidad” (1996) 1 Rev. Hosp. Mat. Inf. Ramón Sardá 12-16, at 16.

⁴³ *Ibid.*

⁴⁴ Susana Checa, “La Perspectiva de Género en la Humanización de la Atención Perinatal” (2000) 19:4 Rev. Hosp. Mat. Inf. Ramón Sardá 152-156, at 154.

⁴⁵ *Ibid.* at 155.

⁴⁶ *Ibid.*

⁴⁷ *Ibid.*

decision-making as well as her right not to submit to an authoritarian relationship with her physician. Checa argued that including a gender perspective in the provision of reproductive healthcare would allow health professionals to comprehend the importance of recognizing the woman as a self beyond her gestational and reproductive capacity. These professionals would then envision the provision of healthcare to pregnant women not as a tradeoff, but rather consider that women's participation in prenatal care or healthcare during childbirth also works in favor of the protection of the pregnant woman and the future newborn.⁴⁸

In addition to the findings of physicians and sociologists in reproductive healthcare settings, social workers, and legal activists also identified similar situations of abuse and mistreatment of pregnant women by health professionals around the 2000's. The Institute of Gender, Law and Development (INSEGNAR) and Latin America and the Caribbean Committee for the Defense of Women's Rights (CLADEM) published a report documenting the abuses and mistreatments suffered by pregnant women in hospital in the city of Rosario, Santa Fe.⁴⁹

This report "Con todo el Aire" presents thirty-one testimonies from among a group of three hundred women interviewed over one year during sexual and reproductive health workshops in Rosario who decided to share their personal experiences with the workshop. In general, these experiences revealed that pregnant women lacked security, comfort, and privacy in hospital settings. The testimonies expressed the degrading and cruel treatment pregnant women suffer during childbirth, as manifested in, for example, aggressive and humiliating remarks from health professionals to pregnant women when they expressed pain during childbirth.⁵⁰

Furthermore, the report also discusses testimonies that reveal that pregnant women in hospital settings feel their privacy controlled by the authority of health professionals either during childbirth or prenatal care. The report presents these violations of privacy as due in part to public health limitations in material and human resources in which hospital labor rooms or maternity wards were unable to assure privacy for each pregnant woman and various women

⁴⁸ Checa, *supra* note 43, at 155.

⁴⁹ Instituto de Género, Derecho y Desarrollo, *Con Todo el Aire: Observatorio de Salud, Género y Derechos Humanos* (Rosario: INSEGNAR-CLADEM, 2003). Online: INSEGNAR <<https://insgenar.files.wordpress.com/2012/04/con-todo-al-aire.pdf>>. [INSEGNAR]

⁵⁰ *Ibid.* at 27.

received reproductive healthcare simultaneously.⁵¹ The report also states that pregnant women suffered violations to their right to privacy when their treatment, including gynecological examinations, was displayed to medical school students without their prior consent. Pregnant women felt humiliation and shame by this treatment, generating feelings of anger and anxiety.⁵²

The report also documents cases in which health professionals excluded pregnant women's participation in the decision-making about prenatal or medical care during childbirth. Testimonies describe women moments before childbirth being instructed to sign release forms without any prior information about the treatments they were authorizing.⁵³ The report analyzes such testimonies as reflecting the structured as a power relationship between pregnant woman and health professionals and their knowledge. This relationship marginalizes the pregnant women's participation and/or consent to procedures, authorizing health professionals to deliver humiliating and degrading treatment.⁵⁴

Lastly, the Report focuses on testimonies revealing degrading and humiliating treatment towards women who sought post-abortion care at hospitals. Under the apparent excuse of the illegality and immorality of a self-induced abortion, health professionals become de facto judges, with authority and power to degrade women seeking post-abortion care. Treatments they received included curettage without anesthesia, inquisitorial remarks treating women as killers, or the denial of post-abortion care.⁵⁵

In light of these serious problems with reproductive healthcare for pregnant women by health professionals, Argentina decided to establish a new perspective for prenatal and reproductive healthcare during labor and birth: Family-Centered Maternity and Newborn Child Care.

⁵¹ INSEGNAR, *supra* note 49, at 28.

⁵² *Ibid.* at 29.

⁵³ *Ibid.* at 30.

⁵⁴ *Ibid.* at 30-31.

⁵⁵ *Ibid.* at 33-34.

2.3 Argentina's Production of Medical Guidelines in Quality Maternal Health

Informed by the global initiatives and the social science and medical research on the way maternities have been providing maternal care to pregnant women, the Ministry of Health began introducing clinical practice guidelines for implementation in Argentinean health facilities. At the end of the 1990s, according to the Ministry of Health 98% of births were in health facilities, highlighting “the need to elaborate medical practice norms with a guiding purpose for establishing a new model of healthcare.”⁵⁶ Consequently, the Ministry introduced clinical practice guidelines focusing on recommending practices that were safe and effective for protecting both maternal and infant health.

One example is Ministerial Resolution No. 647/2003, Clinical Guideline for the Healthcare of Normal Pregnancies in Family-Centered Maternities.⁵⁷ Its objective is to update current clinical practices in perinatal care for low risk pregnancies and low risk newborns from the perspective of “Family-Centered Maternities.”⁵⁸ Furthermore, this update is directed at health professionals involved in providing care to women and newborns during the perinatal period, namely: obstetricians, neonatologists, pediatricians with training in neonatology, general practitioners with training in obstetrics and pediatrics, nurses, psychologists, social workers, sociologists, nutritionists, etc. The guidelines also state that they must be adopted in every province, municipality, and health institution in the country, and adapted to local needs, emphasizing the importance of continual revision to employ cutting edge information.⁵⁹

Although dating from 2003, the Ministry of Health guidelines convey the most accurate indicators of clinical practices to date. They aim to reduce preventable harm to mothers and newborns that is caused by the high level interventions that increase risks, and which may be considered “unhelpful, untimely, inappropriate or unnecessary according to the soundest

⁵⁶ Ministerio de Salud [Ministry of Health], Dirección Nacional de Maternidad e Infancia [Directorate of Maternity and Infantrty], *Propuesta Normativa Perinatal Tomo IV: Atención del Parto de Riesgo* (Buenos Aires: Ministerio de Salud, 1998) (Argentina).

⁵⁷ Ministerio de Salud [Ministry of Health], Dirección Nacional de Maternidad e Infancia [Directorate of Maternity and Infantrty], *Guía para la Atención del Parto Normal en Maternidades Centradas en la Familia* (Buenos Aires: Ministerio de Salud, 2004) (Argentina). [Guideline for Healthcare of Normal Childbirth]

⁵⁸ *Ibid.*

⁵⁹ *Ibid.* at 9.

available evidence”.⁶⁰ In addition to assessing which interventions should be deemed unnecessary or harmful to women and newborns, these guidelines stress the importance of ensuring the security and comfort of the pregnant woman at the moment of birth, and provide broad protections to women with normal risk levels, in normal birth processes.

The guidelines warn against clinical practice of certain unnecessary treatments that are routinely employed as part of the pathological structuring of health care for women entering the birth period; on example is enemas routinely performed on women entering the birth period based on the obsolete idea that these were believed to protect the woman and the fetus during the birthing process by stimulating uterine contractions and reducing perinatal contamination. However, the guidelines consider their routine practice unnecessary, since evidence reveals that enemas are unpleasant and/or harmful to the women, and additionally are unnecessarily time consuming during the labor process.⁶¹

The guidelines also assess the treatments employed for the management of women’s pain during childbirth. The clinical indications first require health professionals to opt for non-medicalized treatments for pain management. The guidelines allude to the importance of healthcare professionals allowing women to choose more comfortable positions, as well as having the liberty to walk around, but healthcare professionals should recommend that women not adopt a supine position during the first stage of labor. Though practices, such as the intake of foods and liquids at the beginning and throughout labor can foster comfort in pregnant woman as a method for pain management, the usual practice is to prohibit women from eating and limit the administration of liquid during the birth period.⁶² The guidelines object to prohibiting foods, since available evidence does not show that restricting food benefits labor, specifically, there is no evidence that food restriction reduces gastric content. Similarly, the guidelines indicate that liquid intake should never be restricted, especially for prolonged birth processes. Lastly, the

⁶⁰ *Care in Normal Birth*, *supra* note 27, at 2.

⁶¹ *Guideline for Healthcare of Normal Childbirth*, *supra* note 57 at 21-22. *See also*, Lilia Blima Schraiber, Simone Grilo Diniz & Ana Flávia Pires Lucas D’Oliveira, “Violence against Women in Health-Care Institutions: an emerging problem” (2002) 359 *Lancet* 1681-1685, at 1681. The Cochrane Collaboration has also studied this practice and concluded that enemas do not improve puerperal or neonatal infections, that is, routine practice of enemas does not benefit the woman or the newborn, and there is no scientific basis for their routine application. *See*, Ludovic Reveiz, Hernando G. Gaitán & Luis Gabriel Cuervo, “Enemas during Labour” (2013) 7 *Cochrane Database of Systematic Reviews*, at 9 DOI: <10.1002/14651858.CD000330.pub4>.

⁶² *Guideline for Healthcare of Normal Childbirth*, *supra* note 57 at 20.

guidelines warn that restricting or prohibiting the intake of foods or liquids reinforces the idea of structuring childbirth as a medical process in which the woman lacks participation.⁶³ Similarly, the guidelines advise health professionals not to routinely administer glucose via tube feeding, since, on the one hand, this may increase glucose levels on the fetus, causing harm. On the other hand, the tubing severely restricts women's mobility around the labor room.⁶⁴

Moreover, the guidelines recommend that, before the start of the first stage of labor, health professionals should not restrict women from taking showers, baths or receiving massages from people they trust. Lastly, the guidelines also instruct health professionals not to place any restrictions on indigenous pregnant women performing prayers or rituals that may help them ameliorate pain.⁶⁵

As regards medicalized administration of pain, the guidelines instructs\ health professionals to first present all information to women regarding the consequences and risks of taking the epidural drug.⁶⁶ Further, it states that epidural treatment during labor requires skilled health professionals, as well as a health institution and equipment that will allow monitoring of the woman and fetus' health during the birth period.⁶⁷ The guidelines alert that the routine use of epidural drugs in birth processes unnecessarily medicalizes the labor and, consequently, structures labor as a medical event for normal births or low-risk pregnancies, which may endanger the woman's and fetus' health.

Regarding recommended medical practices at the first stage of the labor process, described as the start of regular contractions, associated with the leak of amniotic fluid, and the progressive dilatation of the cervix until fully dilated, the guidelines discuss vaginal examinations. This practice allows health professionals to reach a diagnosis of the labor work and its progress. Vaginal examination should be practiced with clean hands, covered by sterile gloves, and limited to cases of strict necessity.⁶⁸ Related to this issue, the guideline also states that rectal examinations, practiced to diagnose the status of the labor process so as to avoid possible

⁶³ *Guideline for Healthcare of Normal Childbirth*, *supra* note 57 at 22.

⁶⁴ *Ibid.* at 22-23.

⁶⁵ *Ibid.* at 24.

⁶⁶ *Ibid.* at 24.

⁶⁷ *Ibid.* at 25.

⁶⁸ *Ibid.* at 27.

contamination of the vagina, are harmful to the woman and ineffective according to evidence-based research.⁶⁹ Their ineffectiveness has been shown insofar as both rectal and vaginal examinations present similar puerperal infection rates. Instead, the harmful characteristic has been determined through randomized control tests showing women's preference for vaginal instead of rectal examination.⁷⁰

At the second stage labor process, the guidelines further clarify that forcing women to deliver while lying on their backs with their feet in stirrups may contribute to fetal distress and offers no mechanical advantage for descent of the fetus.⁷¹ The guidelines also warn health professionals that perineum tears may happen, especially in first pregnancies. In turn, the guidelines classify what kinds of perineum tear should be expected and what treatments they require. In situations where the tear that may occur is serious, often denominated third-degree tears, the practice of an episiotomy is usually indicated so as to prevent the tear.⁷² An episiotomy is an incision made into the perineum for the purpose of enlarging the soft tissue outlet or decreasing the length of second stage of labor if the fetus is in distress.⁷³ If practiced or repaired incorrectly this major medical intervention may cause maternal anal sphincter and rectum injuries. The guidelines indicate that available evidence on episiotomies show that their routine practice does not reveal significant reductions in laceration severity, pain, or pelvic organ prolapse in comparison with a policy of restricted practice. Hence, the guidelines conclude that the routine practice of episiotomy is inappropriate; on the contrary, its practice should be performed on an exclusively "necessary" basis, under anesthesia (either already under the effect of epidural or local infiltration), and by trained attendants.⁷⁴

Notwithstanding the fact that the medical practices proposed by the by the Ministry of Health guidelines aim at providing secure, effective, and beneficial obstetric care to women during childbirth, the manner in which healthcare is provided may still be abusive or exert

⁶⁹ *Guideline for Healthcare of Normal Childbirth*, *supra* note 57 at 28. *See also*, *Care in Normal Birth*, *supra* note 27, at 35.

⁷⁰ *Care in Normal Birth*, *supra* note 27, at 35.

⁷¹ *Ibid.* at 33. *See also*, FIGO: *Management of Second Stage Labor*, *supra* note 32, at 113.

⁷² *Guideline for Healthcare of Normal Childbirth*, *supra* note 57 at 34.

⁷³ FIGO: *Management of Second Stage Labor*, *supra* note 32, at 114.

⁷⁴ *Guideline for Healthcare of Normal Childbirth*, *supra* note 57 at 34. *See also*, FIGO: *Management of Second Stage Labor*, *supra* note 32, at 114.

mistreatment. To address this, the Ministry of Health enacted a “Family-Centered Safe Maternities” (MSCF) policy for reshaping the provision of maternal care at maternities such that they become more humanized,

The “Family-Centered Safe Maternities” guidelines propose a shift in the traditional culture of maternal health care provision to women and their families. MSCF aim at providing integral care to women, newborns, and families, contemplating their physical, emotional, and psychosocial, and cultural needs, as well as women’s choices and preferences.⁷⁵ In this sense, MSCF departs from a conception of care that relates well-being (exclusively) to the provision of physiological needs.

To such end, the guidelines first determined that health professionals have as their subject of care the woman, the fetus (before birth), the newborn, and the woman’s family. As such, health professionals must provide this multiple subject healthcare in an individualized way, procuring their safety. The MSCF guidelines recognize the advantages for better quality maternal health that medical technologies implies, for example establishing a more precise diagnosis of events that compromise the health of the woman or the fetus. The progress in medical technology and knowledge, however, must be utilized in an individualized way in order to better establish the different treatment alternatives form among which the woman may choose, and foster the woman’s participation in deciding her preferred treatment.⁷⁶

In this sense, quality of care should be measured by also considering women’s experience of pregnancy, birth, and post-partum care. Given this, health providers should be aware of their power to influence long-term impacts on women’s childbirth experience. Consequently, health professionals must understand the importance of sharing information with women in order to foster participation and understanding in the decision-making process. With this in mind, health professionals, women, and families should be aware of the importance of the language being used in the relationship during the pregnancy, birth, and post-partum periods.⁷⁷ Lastly, MSCF

⁷⁵ Miguel A. Largaña, Cecilia C. Lomuto & María Aurelia González, *Guía para transformar Maternidades tradicionales en Maternidades Centradas en la Familia* (Buenos Aires: Ministerio de Salud-UNICEF; 2007).

⁷⁶ *Guideline for Healthcare of Normal Childbirth*, *supra* note 57 at 14.

⁷⁷ *Ibid.*

also demands that the provision of maternal care by health professionals be appropriate and respectful of different cultural customs.⁷⁸

After the enactment of the 2009 legal definition of obstetric violence by the National Congress, the Ministry of Health issued further guidelines to implement MSCF in hospitals in the country. Among the innovations proposed by these guidelines was, on the one side, introducing an intercultural perspective in the provision of maternal care, and on the other, structuring humanized care in maternal health on a human rights basis.⁷⁹

The 2011 MSCF guidelines state that the inclusion of an intercultural perspective to the provision of maternal care will allow the adequate and quality provision of healthcare, which will be friendly to women regardless of ethnic origin, nationality, or social status. In particular, the provision of maternal care under an intercultural perspective demands that health personnel understand and respect the “cosmovision and culture” of indigenous woman and their families, specially their customs about motherhood and childbirth.⁸⁰

Furthermore, the 2011 MSCF guidelines admit that indigenous women are not receiving quality maternal care due to lack of humanized care because of cultural barriers, such as lack of understanding of indigenous language and cultural customs around motherhood and childbirth. Additionally, these women more generally have poor access to maternal healthcare because of the long distances that indigenous women must travel to get to a health facility and poor route infrastructure for traveling such long distances⁸¹

To start remedying these factors, the 2011 guidelines established that policies for implementing the intercultural perspective of maternal healthcare provision must guarantee that indigenous communities participate in their drafting. In addition to this, the guidelines determine that there must be trained and skilled health personnel providing maternal healthcare with an intercultural perspective. Lastly, health facilities must procure the incorporation of a “bilingual intercultural aid”, trained health personnel that serve as a cultural bridge between health

⁷⁸ *Guideline for Healthcare of Normal Childbirth*, *supra* note 57 at 15.

⁷⁹ Fondo de las Naciones Unidas para la Infancia et al., *Maternidad Segura Centrada en la Familia (MSCF) con Enfoque Intercultural*, 2nd ed (Buenos Aires: UNICEF; 2011) (Argentina.) [UNICEF]

⁸⁰ *Ibid.* at 27.

⁸¹ *Ibid.* at 28-29.

professionals and indigenous women. This aid is an adviser for the provision of maternal healthcare, sensitized to intercultural beliefs and reducing language barriers between health personnel and the woman and family.⁸²

The 2011 MSCF guidelines address humanization of maternal healthcare on a human rights basis by recognizing that access and fulfillment of adequate and quality of healthcare protects the right to life of both the woman and the newborn.⁸³ Further, they state that the MSCF perspective on maternal healthcare aims at ensuring access without discrimination on the basis of age, race, or any other socioeconomic condition.

The 2011 MSCF guidelines also conceptualize the provision of humanized maternal health care as the protection of women's right to privacy. With this aim in mind, the guidelines determine that health facilities must ensure adequate spaces in maternity wards, such as ample and comfortable waiting rooms or adequately equipped, spacious, with curtain screen inpatient hospital rooms for women's labor work, childbirth and post-partum care.⁸⁴ Moreover, respect for the right to privacy of the woman is also conceptualized in the guidelines as prohibiting health personnel from providing impersonal treatment, "informal chatting" between medical colleagues while providing care, allowing pregnant women to be observed by other women and their companions.⁸⁵ The guidelines also state that health professionals should refrain from shouting or verbally abusing women and their companions while providing healthcare, or disrespecting cultural customs or reacting badly to linguistic barriers with indigenous women.⁸⁶

On protecting women's autonomy during childbirth, the MSCF guidelines determine that health professionals must respect and ensure women's right to choose a comfortable birthing position, since this is a proven, non-medicalized practice for relieving pain during childbirth.⁸⁷ In order to guarantee women's comfort and pain administration, the guidelines also recognize that

⁸² UNICEF, *supra* note 79, at 31.

⁸³ *Ibid.* at 17.

⁸⁴ Fondo de las Naciones Unidas para la Infancia et al., *Maternidad Segura Centrada en la Familia (MSCF)*, 1st ed (Buenos Aires: UNICEF; 2010) at 42 (Argentina.), at 131-132; See also, Ministerial Resolution No. 348/03, Organizational Norms for the Performance of Maternity Healthcare Services, 28 May 2003, B.O. 30159 (Argentina.)

⁸⁵ *Ibid.*

⁸⁶ *Ibid.*

⁸⁷ *Ibid.* at 51.

women have a right not to be restricted from ingesting liquids and eating during labor work and childbirth.⁸⁸ Lastly, the guidelines stress the health professional's obligation to provide timely information to women and their families on alternative treatments regarding unanticipated issues during labor or childbirth, or about the risks and effects of analgesics for pain relief, or on the option of providing cesarean or instrumental delivery. The provision of information guarantees the woman's control over the health treatments she receives and empowers women to exercise their autonomy.⁸⁹

This section has described the public health policies enacted by the Ministry of Health informed by the global initiatives for safe motherhood and improved medical practice in pregnancy, labor work, childbirth and post-partum care. Furthermore, the enactment of such policies by the Ministry of Health are also the result of social science and medical research critiques to the provision of healthcare to pregnant women in health facilities. Consequently, such clinical practice guidelines aim at determining harmful and ineffective medical practices that fail to ensure security, comfort and well-being of the woman and newborn during labor work and childbirth. Similarly, MSCF guidelines seeks to ensure that the provision of maternal healthcare does not solely focus on attending women's and the newborn's physiological needs, but also emotional, and psychosocial needs, as well as women's choices and preferences. Hence, proper care for satisfying such needs intends to guarantee that the provision of maternal care achieves humanized treatment of women and, conversely, prevents or eliminates abuse and disrespectful treatment. The application of both of these kinds of public health policies aims at providing better quality of maternal healthcare to women.

2.4 Implementation of Maternal Health Policies: a Study of their Effectiveness and Implementation

How effectively have the Health Ministry's guidelines been incorporated by Obstetric Societies and Associations in their medical practice guidelines and professional ethics codes? Have such guidelines been effectively implemented in private and public health facilities to provide good healthcare practices and humanized care? This section will argue that the Health

⁸⁸ Fondo de las Naciones Unidas para la Infancia et al., *supra* note 84. at 55.

⁸⁹ *Ibid.*

Ministry's guidelines on maternal healthcare have had some limited success in fostering Obstetric Societies and Associations to adopt them. However, an analysis of professional ethics codes from Obstetric Societies and Associations in Argentina reveals a gap in implementation of the Ministry's guidelines for achieving more humanized maternal health treatment for women.⁹⁰ Furthermore, this section will also argue that the implementation of such guidelines is poorly measured; the Ministry's claimed results are misleading in so far as maternity wards that have been registered as safe and humanized maternal healthcare providers may present serious flaws that demonstrate a failure of proper implementation of the guidelines.

2.4.1 Argentina's Obstetric Associations: Effective Adoption of National Medical Guidelines

The Federación Argentina de Sociedades de Ginecología y Obstetricia (Argentinean Federation of Gynecology and Obstetric Societies, FASGO) is a national medical private entity that includes thirty-one gynecological and obstetric societies around the country. Besides this, FASGO is also a member of international and regional gynecology and obstetric federations, such as FIGO and the Latin American Federation of Gynecology and Obstetric Societies (FLASOG). Since 2009, as indicated in their Internet webpage, FASGO has been publishing their guidelines on evidence-based obstetric practices on maternal health since 2009. Similarly, since 2010 FASGO's Sexual and Reproductive Health Commission has published reports that reflect the federation's activities or adherence to reports from international and regional bodies (FIGO/FLASOG) on ethical practices.

FASGO's clinical practice reflects, to some extent, the Ministry of Health recommendations on safe, effective and beneficial medical practices that protect the health of the woman and the future newborn. For instance, their consensus document on "artificial induction of labor" first clarifies that this must be performed under previous clinical instruction, that is, it should not be exercised routinely.⁹¹ Second, if amniotomy is administered with the use of oxytocin, their consensus determines that the woman should be subjected to strict monitoring,

⁹⁰ Such an analysis is conducted only on Obstetric Societies and Associations that have provided access to their medical practice guidelines and professional ethics codes to users via their Internet webpages.

⁹¹ Federación Argentina de Sociedades de Ginecología y Obstetricia [Argentinean Federation of Gynecology and Obstetric Societies], *Consenso Inducción al Trabajo de Parto* (Buenos Aires: FASGO, 2010) (Argentina). Online: FASGO <<http://www.fasgo.org.ar/archivos/consensos/coninducparto2010.pdf>>. [FASGO].

especially controlling the fetal heart rate every 30 minutes.⁹² Notwithstanding this consensus, FASGO's webpage did not show any consensus referring to safe clinical practices or recommendations on the exercise of episiotomies, organizational recommendations of inpatient labor rooms, medicalized pain administration, or diagnosis practices such as vaginal examination. Similarly, FASGO's Internet portal does not provide access to the professional ethics code of the Federation.

Despite failing to disclose a professional ethics code, FASGO's National Committee on Sexual and Reproductive Health does publish their adherence to regional practice protocols in the context of access to maternal healthcare: for instance a FLASOG report recommends obstetric practices for physicians at health units that are poorly equipped and in geographically remote areas covers issues not contemplated by Argentina's Health Ministry. Among the clinical practice recommendations for timely and adequate diagnosis for obstetric care and timely referral, the guidelines highlight that physicians should provide information to the pregnant woman or her family on why referral is best for her health and obtain informed consent.⁹³

Lastly, FASGO adhered to FLASOG's guidelines on a listing of key national protocols for achieving safe and effective medical practices in maternal healthcare during childbirth. In it, FLASOG pointed to Argentina's Ministry of Health clinical practice guidelines on: "Prevention, Diagnosis, and treatment of post-partum hemorrhage", "Diagnosis and treatment of hypertension during pregnancy", and "Better treatments during post-abortion healthcare."⁹⁴ FASGO's indirect incorporation of these guidelines as part of up-to-date information in the exercise of maternal healthcare omits or remains silent about the Health Ministry's guidelines on clinical practice for safe motherhood. Additionally, FASGO does not publish the adoption of either the Ministry of Health protocol on safe and effective practices in the provision of maternal healthcare, explained

⁹² FASGO, *supra* note 91.

⁹³ Federación Latinoamericana de Sociedades de Obstetricia y Ginecología [Latin America Federation of Obstetric and Gynecology Societies], Comité de Derechos Sexuales y Reproductivos [Sexual and Reproductive Rights Committee], *Prevención de la Muerte Materna en áreas marginadas y zonas de mayor riesgo en América Latina a través de Diagnóstico y Referencia Oportuna* (Perú: FLASOG 2010). [FLASOG]

⁹⁴ FLASOG, Comité de Derechos Sexuales y Reproductivos [Sexual and Reproductive Rights Committee], *Listado de Documentos Fuente para la Actualización de Protocolos basados en Evidencias de las Complicaciones más frecuentes que afectan a las mujeres durante el Embarazo y el Parto* (Lima: FLASOG, 2010).

above, or of FIGO's guidelines on "management of second-stage labor" or "mother-baby friendly facilities".

Provincial Obstetric Associations and Societies also are important institutions to analyze with regard to their incorporation of the Ministry of Health's guidelines on safe and effective clinical practice guidelines or requirements for more humanized treatment in maternal health. One example is the OB-GYN Society of the City of Buenos Aires (SOGIBA), which provides access to the code of ethics of OB-GYN professionals. The Code of Ethics establishes that obstetricians must maintain absolute respect for human life, and pursue the prevention, preservation, protection and recovery of the patient, with respect for her dignity as their main objective.⁹⁵ With regards to provision of treatment, the code determined that the obstetrician must treat the patient with loyalty, propriety, wisdom, and courtesy, with a profound respect for human dignity.⁹⁶ Furthermore, it sets out that obstetricians must respect the patient-physician confidentiality on data they have gathered from the patient, and whatever the obstetrician has heard, seen, or deduced during their practice. Likewise, the code states that obstetricians must respect the religious beliefs of patients without resisting their customs, and if such customs collide with the values of the obstetrician, the physician may exercise conscientious objection but must continue to provide basic healthcare until the referral. Lastly, the code establishes that obstetrician can withdraw treatment if: (1) the patient knowingly rejects the regimen prescribed by the physician, or (2) if, under the criteria of the physician, there is an inadequate patient-physician relationship which may impede effective healthcare.⁹⁷ Besides this, the Code of Ethics does not mention any ethical protocol for the provision of healthcare with a basis for the respecting women's human rights or guaranteeing that treatments are provided with informed consent. Notwithstanding this, SOGIBA publishes the Ministry of Health's guidelines "Clinical Guidelines for the Healthcare of Normal Pregnancies in Family-Centered Maternities" as the recommended practice of the Society, thus favoring its implementation.

⁹⁵ Sociedad de Obstetricia y Ginecología de Buenos Aires [Obstetric and Gynecology Society of the City of Buenos Aires], *Código de ética de la Sociedad de Obstetricia y Ginecología de Buenos Aires* (Ciudad de Buenos Aires: SOGIBA), ch 3.2. Online: SOGIBA <<http://www.sogiba.org.ar/index.php/profesionales/codigo-de-etica>>. [SOGIBA]

⁹⁶ *Ibid.* at ch 3.1

⁹⁷ *Ibid.* at ch 3.8(1)-3.8(2).

Similarly to FASGO, the Obstetric and Gynecology Society of the Province of Buenos Aires (SOGBA) does not provide access to their code of professional ethics. Notwithstanding, the SOGBA does publish their consensus on issues affecting maternal mortality. In their report, SOGBA identifies that currently the provision and timely access to maternal healthcare is exercised discriminatorily towards women, requiring an integral women's human rights based response.⁹⁸ The report further considers that strategies to prevent maternal mortality require more State intervention through monitoring and administration analysis, especially of the private health sector. Lastly, SOGBA reports awareness of the Safe Motherhood initiative, but claims that it is still a very technical concept for practice by health professionals in maternities of the Province of Buenos Aires.⁹⁹ Nevertheless, the SOGBA declares its commitment to progressively implementing the safe motherhood program in provincial hospitals.

Following the line of FASGO and SOGBA, the Argentinean Obstetric Association (AOA) does not provide access to their professional ethics protocol, but it is the only Association that have issued guidelines on “Intercultural Health and Indigenous Peoples Customs in Obstetric Healthcare.” These guidelines serve as key literature for understanding and learning how indigenous peoples practice healthcare in pregnancy and childbirth, but it also applies to professional practice.¹⁰⁰ In general, the guidelines advocate that professionals exercising maternal healthcare adopt more humanized care practices and inform themselves about appropriate care for indigenous women.¹⁰¹

The review of Obstetric Associations and Societies' incorporation of the Health Ministry's guidelines on improved medical practices for safe and appropriate as well as more humanized maternal healthcare revealed that some progress is occurring. In general, most Obstetric Associations and Societies do not provide access to their codes of professional ethics in their Internet web portals, which restricts analyzing the implementation of humanized care guidelines towards women in their exercise of maternal healthcare. However, OB-GYN Societies show

⁹⁸ Sociedad de Obstetricia y Ginecología de la Provincia de Buenos Aires [Obstetric and Gynecology Society of the Province of Buenos Aires], *Mortalidad Materna, Evaluación Local, Multicausalidad* (Ezeiza: SOGBA, 2010) Online: SOGBA <http://www.sogba.org.ar/links/Ezeiza_Mortalidad.pdf>. [SOGBA]

⁹⁹ *Ibid.*

¹⁰⁰ Marta I. Idart, *Salud Intercultural y Costumbres de Pueblos Originarios en Obstetricia* (Ciudad de Buenos Aires: Asociación Obstétrica Argentina; 2012). [AOA]

¹⁰¹ *Ibid.* at 20.

awareness about the importance of women’s experience in receiving humanized maternal healthcare, since some Societies produce consensuses or guidelines on implementing the Health Ministry’s guidelines on Family-Centered Safe Maternities with particular focus in intercultural health. It is also alarmingly that the national federation (FASGO), a member of FIGO, publishes no adherence to their Mother-Baby Friendly Birthing Facilities guideline.

2.4.2 A Study on Implementation and Monitoring of National Medical Guidelines

The Ministry of Health from Argentina claims that its public policy “Family-Centered Safe Maternities” has been incorporated in 102 public hospitals from 10 provinces of Argentina between 2010 to 2015.¹⁰² Furthermore, the Ministry reports that 9 out of 10 provinces where the policy has been implemented have registered a reduction of infant mortality, and 6 out of 10 also register lowered maternal mortality.¹⁰³

In measuring the effectiveness of the Ministry of Health implementation of its policies, it is important that most of the policies that have been implemented only in 2010, were already published and operative well before. In this sense, prior to 2010, clinical practice research conducted in the City of Buenos Aires and surrounding suburbs from 2004 to 2006 in 10 public hospitals shows that clinical practices recommended as beneficial and safe for the woman were systematically unused.¹⁰⁴ For instance, among the public hospitals studied, health professionals still practiced routine episiotomies, meaning that gaps persisted between scientific research and clinical practice. Moreover, such findings speak about the scant progress on implementation, since the legal and clinical practice guidelines do not translate into actual improvement in the quality of care.¹⁰⁵

¹⁰² Ministerio de Salud [Ministry of Health], Dirección Nacional de Maternidad e Infancia [Directorate of Maternity and Infantry], “Maternidades Seguras y Centradas en la Familia para Fortalecer los Derechos de las Mujeres y sus Bebés”, online: <http://www.msal.gov.ar/dinami/index.php?option=com_content&view=article&id=547:maternidades-seguras-y-centradas-en-la-familia-para-fortalecer-los-derechos-de-las-mujeres-y-sus-bebes&catid=6:slide-de-noticias547>.

¹⁰³ *Ibid.*

¹⁰⁴ Ariel Karolinski et al., “Evidence-based Maternal and Perinatal Healthcare Practices in Public Hospitals in Argentina” (2009) *Int. J. Gynecol. Obstet.* DOI: <10.1016/j.ijgo.2009.01.003>.

¹⁰⁵ *Ibid.* at 4.

Notwithstanding, if the progress claimed in effective implementation of safe motherhood initiatives highlighted by the Ministry of Health in the recent five-year span (2010-2015) is taken seriously, new field-based research on health personnel shows some important gaps. For example, research conducted by UNICEF-Argentina and the Center of Studies on State and Society (Centro de Estudios de Estado y Sociedad, CEDES) for analyzing the organizational culture in facility-based maternity wards' health personnel reveals attitudinal factors that affect implementation. This study aimed at discovering the knowledge and practices of health personnel at twenty-nine Province of Buenos Aires maternity wards relating to the policy "Family-Centered Safe Maternities."¹⁰⁶ The research took place in public hospitals from the Province of Buenos Aires between 2011-2013.

The results show, for instance, that among the health personnel interviewed, 52% stated that women are always informed of their health status and that of the newborns, but only 42% claimed that they always informed women on the clinical practices performed, while 33% responded they would only "sometimes" inform the woman.¹⁰⁷ In relation to clinical practices and humanized treatment, 46% of the health personnel say that women "sometimes" are allowed to walk freely in the labor room.¹⁰⁸ In the case of permitting women to ingest liquids and eat, 20% of the health providers answered, "they do not know," while 30% answered: "sometimes." Similarly, on the issue of whether health personnel encourage women to be accompanied by a trusted person during childbirth, 32% of health personnel answered "sometimes," while 22% responded: "never, but it is desirable and possible."¹⁰⁹ Moreover, regarding practices such as whether women can choose a comfortable birthing position, 30% claimed that "never, but it is desirable and possible", while 36% also answered that either "never, it would be desirable but not possible", "never, it is not desirable and also not possible," or "I do not know."¹¹⁰ Lastly, 42% of health personnel responded women "always" receive kind and respectful treatment at the labor

¹⁰⁶ Fondo de las Naciones Unidas para la Infancia-Argentina and Centro de Estudios de Estado y Sociedad, *El ABC de la MSCF: Manual para el diagnóstico de la Cultural Organizacional en las Maternidades* (Argentina: CEDES-UNICEF, 2015). [CEDES-UNICEF]

¹⁰⁷ *Ibid.* at 136.

¹⁰⁸ *Ibid.* at 138.

¹⁰⁹ *Ibid.*

¹¹⁰ *Ibid.* at 139.

room, and that 41% answered women are “always” permanently informed about the clinical practices that she and the infant receive.¹¹¹

This research shows that despite the fact that maternity wards in hospitals have incorporated “Family-Centered Safe Maternities” policies, their practices and clinical culture reveals some gaps in implementation. An illustration of this is reflected by the fact that 50% of obstetric department staff express that either they are “partially in agreement with the policy” or “does not know” if they agree with the policy. Likewise, 52% of obstetrics department in maternity wards claim that the “Family-Centered Safe Maternity” is “partially implemented.”¹¹² In particular, there persist implementation barriers to clinical practices that favor women’s comfort in the delivery room, which are proved to be helpful for non-medicalized pain administration.¹¹³ On the basis of these results, the Ministry of Health must conduct more research based on the experiences of health professionals but also on the experiences of women about the implementation of its programs in order to have a more faithful assessment of its effective implementation.

Since the end of the 1990s, the Ministry of Health has issued guidelines on research evidenced safe and effective obstetric practices for the protection of women’s security, comfort and autonomy during childbirth. Similarly, the Ministry of Health also issued practical guidelines for health personnel to provide treatment in a more humanized way, highlighting the importance of being respectful and attentive not only to women’s physiological needs, but also their emotions, feelings, preferences and choices when receiving care. As noted throughout this chapter, the quality of maternal healthcare has been on the agenda of the public policies of Argentina’s Ministry of Health even prior to the 2009 legislative proscription of obstetric violence.

Notwithstanding these important efforts for restructuring the provision of maternal healthcare in terms of better quality and more humanized treatment, little progress has been

¹¹¹ CEDES-UNICEF, *supra* note 111, at 140.

¹¹² *Ibid.* at 146.

¹¹³ *Ibid.*

observed from OB-GYN Associations and Societies in adopting such research-based standards. Argentina's OB-GYN Associations and Societies consensus on safe and effective clinical practices shows meager adoption of the Ministry of Health's clinical practice guidelines. Furthermore, in spite of the scant transparency of their code of professional ethics, there seems to be some awareness within the profession that the ethical exercise of obstetric care requires a more humanized treatment. In this sense, it is important to note that some OB-GYN Associations have taken this into consideration and issued recommended practices on adequate and timely obstetric diagnosis and referral at rural or geographically remote health facilities, and on intercultural perspectives for obstetric care of indigenous women.

Lastly, an analysis of the assessment of the implementation of the Ministry of Health policies for safe and humanized obstetric practices at maternity wards is misleading. As shown in this Chapter, more State presence is needed at maternity wards for actually monitoring the implementation of Ministry policies by measuring the experience of health personnel practicing recommended obstetric care, as well as the women's perceptions of the maternal healthcare they receive.

3 The Legal Effects of Medical Guidelines and Statutory Obligations in Argentina

As reviewed in the previous chapter, Argentina's Health Ministry has issued clinical practical guidelines on safe and effective obstetric care as well as treatment recommendations for health professionals on providing a more humanized care to women. To some extent, Argentinean Obstetric Associations and Societies have adopted national guidelines that recommended practices for establishing improved care standards, either through clinical practice protocols or their own professional ethics codes. These medical guidelines may play different legal roles in informing the legal standards of maternal healthcare for health professionals. For instance,

- A. Did the medical guidelines first issued by the Ministry of Health prior to the legal proscription of obstetric violence in 2009 later become translated into legal standards of medical care for health professionals?;

- B. Following the emergence of the legal proscription of obstetric violence, how does this legislation redefine health professionals' legal standards of medical care in maternal health?;
- C. How much have courts relied on Ministry of Health or OB-GYN Association/ Society medical guidelines on maternal care as persuasive sources for adjudicating tort cases related to obstetric violence incidents against women? Have courts enforced the obligations established by law on health professionals for the protection of women's rights in health facilities during childbirth?

This Chapter will argue that medical practice guidelines issued by the Ministry of Health or by OB-GYN Associations or Societies have had no legal effects as persuasive sources on which judges rely in order to assess clinical judgment or the woman's experience in receiving care. Thus, medical practice guidelines have had no legal effects in setting a legal standard of care through the courts since, in the tort cases reviewed, judges do not require practitioners to show how their practice has responded guidelines of medical care of patients. Furthermore, this Chapter will also argue that the tort case law reviewed fails to enforce the legal obligations on health professionals established by law for determining if there has been negligence or battery in following the legal standard of care. All in all, these findings show that court's failure to enforce State policies and rights obligations contributes to women's inability to receive judicial relief for the violation of their rights in accessing quality care.

In order to convey this, this Chapter will focus on establishing that the Ministry was a key advocator for legislative translation of its medical practice recommendations for a more humanized treatment by health professionals to the pregnant woman in health facilities into legal standards of care. The emergence of the 2004 "Statute on Humanized Childbirth" setting out the rights of women receiving maternal healthcare in health facilities and obligations of health professionals to the woman shows, to some extent, the legal effects of the Ministry of Health medical guidelines. This section will discuss how this Statute makes the legal standards of professional care for a more humanized treatment of women current.

Conversely, this Chapter will discuss the legal emergence of the concept obstetric violence and determine how the definition of this concept informs the legal standard of professional care. This Chapter will then discuss the effects of the enactment of a framework Statute on the Rights

of Patients on the legal professional standard of care for the prevention and eradication of obstetric violence.

Lastly, this Chapter will analyze the legal effects of medical practical guidelines as persuasive sources for determining health professionals' disregard or negligence of their duty to practice according to the standard of care in tort case law. Likewise, I will explore the degree to which courts have enforced health professionals' obligations set out in the aforementioned statutes.

With regards to the tort case law reviewed, this Chapter will only consider the tort cases where judges refer exclusively to the legislation on the rights of pregnant women in health facilities receiving maternal health care or to the perpetration of obstetric violence on women. After consulting several legal databases as well as NGO's jurisprudence databases focused on women's rights, only one tort law case was found where judges applied the aforementioned legislation.

3.1 The Legal Effects of Medical Guidelines on Maternal Health Legislation: Statute on Humanized Childbirth

As shown in the previous Chapter, in 2003 Argentina's Ministry of Health published the *Guidelines for Healthcare of Normal Childbirth in Family-Centered Maternities*, which set out recommended practices for health professionals in providing humanized treatment to women. The humanized treatment emphasized in the guidelines focused on shifting away from health professionals' relating to the woman as a reproductive object, and toward conceiving her as a subject with more than merely physiological needs at the moment of childbirth.¹¹⁴ It also established the importance of assuring women's participation in the decision-making process about the treatments she would undergo. This would require that health professionals give information to the pregnant women, and obtaining their informed consent prior to starting procedures.¹¹⁵

¹¹⁴ *Guideline for Healthcare of Normal Childbirth*, *supra* note 57 at 13.

¹¹⁵ *Ibid.*

In 2004, a bill was proposed in the Senate of Argentina's National Congress. It was brought forward by former president Nestor Kirchner and drafted by the Minister of Health advocating the recognition of women's rights during labor and at the moment of childbirth in health facilities.¹¹⁶ In addressing the Senate on the bill, the Minister of Health emphasized that reproductive health demands that healthcare in childbirth be provided in a humanized way.¹¹⁷ Furthermore, the Minister argued that the provision of humanized childbirth by health professionals must involve respecting women's emotional needs, proper consideration for their religious, ethnic, or cultural values, allowing them assume a protagonist role in this process, and placing no restrictions on the person chosen by the woman to accompany her during the process. Similarly, senator Ada Maza, who took on the Bill in the Senate, argued that the provision of healthcare during childbirth should be considered a natural process, where women's psychological, affective, and social needs are taken into account. Lastly, Maza's version of the bill reflected that recognizing the rights of women in health facilities during childbirth seeks to achieve dignified and respectful treatment.¹¹⁸ In 2004, Statute No. 25,929 on the Rights in Health Institutions during the Process of Births, emerged from these discussions by structuring the legal relationship between the woman and the intervening health personnel in terms of rights and duties.¹¹⁹

The statute first enumerates a set of rights recognized for the pregnant woman. Among these rights, the pregnant woman has a right to be informed about the different possible medical interventions that may be necessary during reproductive processes, as well as the right to choose freely among the possible alternatives. Additionally, the statute also establishes the pregnant woman's right to respectful treatment, and to receiving individualized and personal medical assistance that guarantees her privacy and is respectful of her cultural customs. Most importantly, the statute establishes that, in order to guarantee respectful treatment, the pregnant

¹¹⁶ Proyecto de Ley No. 0003-PE-2004 [Bill], 8 March 2004, Senado del Congreso de la Nación [Senate] (Nestor Kirchner-Ginés González Garci), online <http://www3.hcdn.gov.ar/folio-cgi-bin/om_isapi.dll?advquery=0003-PE...ase=dae.nfo&record=%7B26F6%7D&recordswithhits=on&softpage=proyecto> (Argentina).

¹¹⁷ Proyecto de Ley No. 0003-PE-2004 [Bill], *supra* note 121.

¹¹⁸ Proyecto de Ley No. 0220-S-2004 [Bill], 7 April 2004, Senado del Congreso de la Nación [Senate] (Ada Maza), online <http://www3.hcdn.gov.ar/folio-cgi-bin/om_isapi.dll?advquery=0220-S...ase=dae.nfo&record=%7B26CE%7D&recordswithhits=on&softpage=proyecto>.

¹¹⁹ Law No. 25.929, 21 September 2004, Rights of Women in Health Facilities during Pregnancy, Labor, Childbirth, and Post-Partum B.O. 30489, at article 2 (Argentina).

woman should be considered a healthy person. The statute also recognizes her right to natural labor, which should be practiced with respect for her biological and psychological timing; such a labor process should avoid both invasive treatments and the unjustified provision of medication in relation to the fetus' or pregnant mother's needs. Finally, the law recognizes the pregnant woman's right to be informed about the evolution of her pregnancy, the health status of the fetus and newborn and, in general, to have unrestricted contact with the baby for developing post-delivery maternal bonding—through holding or breast feeding the baby, for example—unless a valid medical emergency implies imposing reasonable interventions.¹²⁰

Inversely, the statute considers that by recognizing pregnant women's aforementioned rights, the legislation is also assigning the medical personnel with duties of care to provide and facilitate each of these maternal rights. Hence, the duties of the medical personnel involved in providing healthcare to pregnant women during their reproductive processes would be: the medical treatment provided must be respectful and personal as well as individualized to the pregnant woman and it must accept the cultural customs of the expecting mothers. In this sense, any medical intervention that obstructs or disregards a woman's cultural customs must first be conveyed to the pregnant mother, and her free choice among existing alternative interventions must be guaranteed. Additionally, medical personnel have the duty to consider the pregnant woman as a healthy person and not as a patient. The statute also establishes the duty of medical personnel to respect the pregnant woman's entitlement to natural delivery, and provision of care that respects the pregnant woman's biological and psychological timing. On this issue, the statute also establishes that medical care during delivery should not unjustifiably prescribe drugs unless such a course of treatment is required for protection of the health of the mother or fetus. The Statute also establishes a particular duty on medical personnel not to place barriers that impede the pregnant woman from being accompanied during the reproductive processes by a trustworthy person of her choice. Finally, medical personnel have the obligation to provide the pregnant women with information regarding the benefits of breastfeeding, provide support for breastfeeding, childcare, and post-partum care, and inform the mother about the adverse effects of tobacco, alcohol, and drug consumption, as well as provide counseling on childcare.¹²¹ Lastly,

¹²⁰ Law No. 25.929, *supra* note 119.

¹²¹ *Ibid.*

any breach to the rights and duties established in the law, either by public or private health systems' medical personnel, their collaborators, or the institutions themselves, is considered serious misconduct, and does not impede civil or criminal liability.¹²²

To a great extent, this statute incorporates the recommendations established in the *Guidelines for Healthcare of Normal Childbirth in Family-Centered Maternities*, with the purpose of legally assuring that women receive humanized treatment from health professionals during childbirth. The statute sets as a legal standard of medical care the importance of not structuring women as objects of care, but rather as subjects. It also establishes obligations on health professionals to provide the women with information as well as inform her about the alternative treatments available, ensuring her participation in the decision-making process. Thus, the enactment of this Statute on Humanized Childbirth constitutes, to some extent, the legal effect produced from the Health Ministry guidelines.

3.2 Legal proscription of Obstetric Violence and the Statute on Rights of Patients: a New Legal Standard of Professional Care in Maternal Health

In 2009, the National Congress enacted the Law for the Integral Protection of Women for preventing, sanctioning, and eradicating violence against women. Article 6(e) of this law introduces the concept of obstetric violence as gender violence. The law defines obstetric violence as the treatment exercised by medical personnel on women's bodies and their reproductive processes, expressed as dehumanized treatment, abusive medicalization, and the pathologization of natural processes, in accordance with the rights established in the law of Humanized Labor.¹²³

In a 2010 executive decree, the President further refined the scope of certain concepts prescribed as obstetric violence. Firstly, the executive decree clarified that dehumanizing treatment should be understood as treatment that is cruel, dishonorable, dismissive, humiliating

¹²² Law No. 25.929, *supra* note 119, at article 8.

¹²³ Law 26.485, 11 March 2009, Integral Protection of Women for Sanctioning, Preventing, and Eradicating Violence against Women, B.O. 31632, article 6(e) (Argentina).

or threatening.¹²⁴ Furthermore, the executive decree determined that, as established by the law, medical personnel should be understood to include physicians, nurses, social workers, psychologists, obstetricians, and any other personnel in charge of providing hospital or administrative service.¹²⁵

Despite the purpose of clarifying the legal standard of medical maternal healthcare under this new Statute, the executive decree failed to establish the scope of what is understood as abuse of medicalization. However, the definition of obstetric violence makes reference to Statute No. 25,929 on the Rights of Women in Health Facilities During Reproductive Processes. In this Statute, the provision of medical care during delivery should not unjustifiably prescribe drugs unless such treatment is required for protection of the health of the mother or fetus on the basis of justified clinical indication.¹²⁶ Conversely, the prescription of drugs to the woman or the fetus the health status of either does not require this, or when not clinically justified, could constitute abusive medicalization. However, neither Statute 25,929 and nor the Statute on Violence against Women establish what is clinically justified or which clinical practice guidelines regulate the appropriate administration of drugs. Similarly, the executive decree does not set the scope of what can be understood by the conversion of natural processes of reproduction into pathological ones. This lack of regulatory sophistication in establishing legal standard of medical care fails to communicate the parameters of appropriate practice to health professionals.

The Statute on the Rights of the Patient No. 26,529 established the rights of patients in Argentina, and conversely, the obligations and rights of health personnel. Generally, patients enjoy the rights of medical care, respectful and dignified treatment, privacy, confidentiality, autonomy, access to one's own health information, and the right to medical inter-clinical consultation.¹²⁷ First of all, the Statute defines patients as the subjects who request medical care

¹²⁴ Executive Decree No. 1011/2010, 20 July 2010, Regulation of Law No. 26.485 for the Sanction, Prevention, and Eradication of Violence against Women, B.O. 31947, article 6(e) (Argentina).

¹²⁵ *Ibid.*

¹²⁶ Law No. 25.929, *supra* note 119, article 2(d).

¹²⁷ Law 26.529, 20 November 2009, Right of the Patient, Clinical History, and Informed Consent Law, B.O. 31785, art. 2 (a-g), (the right to medical inter-clinical consultation can be understood as the right of the patient to receive medical information and records from the health institution/professional in order to obtain a second diagnostic/opinion from a different health institution/professional) (Argentina).

from a relationship with health professionals.¹²⁸ For the purposes of exercising humanized treatment in maternal care, this definition is in accordance with the right of women not to be considered ill because of her pregnancy, as determined in the Statute on Humanized Childbirth. In this sense, the woman seeking healthcare assistance is a patient, but not a person experiencing illness.

In relation to the patient's right to privacy, the Statute on the Rights of the Patient maintains that all health personnel activities that involve obtaining, classifying, using, administering, guarding, and transmitting a patient's health documents or clinical information must be done with strict respect for the patient's human dignity and autonomy.¹²⁹ Law No. 26,529 also defines the patient's right to confidentiality as the obligation to maintain confidence incumbent on anyone who participates in compiling or handling of the patient's clinical documentation, unless a judge authorizes non-consensual disclosure.¹³⁰

The effects of this right in the context of obstetric violence can be illustrated through a criminal law case. *A., G. Y. s/ cassation remedy*, involves the legality of a criminal complaint against 'co-authors and intellectual authors of a woman's abortion,' which she performed on herself. The prosecutor became aware of the situation through the accusation filed by the physician who performed post-abortion care on the woman. The physician first denounced the woman for contravening the criminal law prohibiting the practice of an abortion. However, lower criminal courts decided that the physician's report of the crime was unlawful since the woman was protected by confidentiality. Consequently, the prosecutor challenged this ruling by arguing that the unlawfulness of the reporting only protected the woman, but not other possible co-authors or intellectual authors.¹³¹

¹²⁸ Executive Decree 1089/2012, 5 July 2012, Regulation of Law No. 26.529 on the Rights of Patients in relation to Health Professionals and Health Institutions, article 1 (Argentina).

¹²⁹ Law 26.529, *supra* note 127, at art. 2(c). *See also*, Executive Decree 1089/2012, *Ibid.*, at article 2(c), determining that patient's data or personal information includes data on the patient's ethnic origin, political opinion, religious, philosophical or moral convictions, union affiliation or information regarding the patient's health or sexual life.

¹³⁰ Law 26.529, *supra* note 127, at art. 2(d). *See also*, Executive Decree 1089/2012, *Ibid.*, at article 2(d), which further establishes that in those situations where the health professional must reveal what has been entrusted by the patient, such decision must be documented in the patient's medical record. Moreover, the regulation on the right of confidentiality also determines that the health professional or any other person must inform the patient that the information entrusted will be disclosed.

¹³¹ Camara Federal de Casación Penal [National Criminal Cassation Tribunal], 13 July 2012, *A., G. Y. s/ cassation remedy*, (2012) Causa No. 10.193, Regitro No. 20.278 (Argentina), at para 2-3.

Responding to these facts, the National Criminal Cassation Tribunal decided that re-opening the criminal proceedings would re-victimize a woman whose actions were, in fact, protected by confidentiality, and thus the unlawful report meant that the criminal case could not be prosecuted.¹³² Further, the Cassation Tribunal specifically understood that permitting the re-victimization of the woman, as well as revisiting the physician's breach of the duty of confidentiality to the woman could entail obstetric violence. The disregard for the woman's right to privacy, protected by the duty of confidentiality, could constitute dehumanizing treatment by the health physician under the provisions established in the Statute on Violence against Women.¹³³ In this sense, it can be extrapolated from this criminal case that the physicians' duty to respect the confidentiality of women seeking post-abortion care takes precedence and overrides other considerations, such as an impulse to prosecute other possible agents involved in performing an unlawful abortion.

Regarding the patient's right of autonomy, the Statute defines it in terms of the patient's right to accept or refuse certain therapies or certain medical or biological procedures, with or without cause. It also establishes that a patient has a right to refuse treatment even after expressing the will to commit to a procedure or therapy.¹³⁴

Lastly, the national law also establishes the right of the patient to plan advance directives regarding her own health. This would entail the consent to or refusal of determined health treatments, preventive or palliative health care, and decisions relating to the patient's health that do not involve euthanasia.¹³⁵ This advance directive must be formalized through an affidavit or a judge and in presence of two witnesses. The patient can withdraw such directives at any time. Finally, the law establishes on this issue that health professionals are not liable under private, criminal, or administrative law for following the health directives set out by the patient.¹³⁶

¹³² Camara Federal de Casación Penal [National Criminal Cassation Tribunal], *supra* note 131, at para 9-11.

¹³³ *Ibid.* at para 11-12.

¹³⁴ Law 26.529, *supra* note 127, at art. 2(e).

¹³⁵ *Ibid.* at art. 11. *See also*, Executive Decree 1089/2012, *supra* note 128, at article 11, which further states that health institutions have the obligation to provide appropriate health sanitary services for guaranteeing the treatments demanded by the patient.

¹³⁶ Law 26742, 24 May 2012, Reform to the Law on the Right of the Patient, Clinical History, and Informed Consent Law, B.O. 23404, article 5 (Argentina).

In the context of maternal healthcare, the advance directives could be represented as a woman's birth plan designed by her and her family. For instance, a woman may lawfully decide in her birth plan not to undergo a cesarean section, or the administration of drugs for pain management. Likewise, the woman may also establish in her birth plan whom she wants allowed to accompany her during childbirth, a right established in Statute No. 25,929.

Moreover, the Statute on the Rights of Patients defines what is meant by informed consent. Informed consent is the "adequate declaration of will by the patient, or the patient's legal representatives if any, expressed once the health professional has informed her in a precise, clear and adequate way about: her health status; recommended a procedure and the objectives sought by using it; the expected benefits of the proposed procedure; the risks, issues, and foreseeable adverse effects; a specification of alternatives procedures, their risks, benefits, and harms in comparison to the recommended procedure; and the foreseeable consequences of not undergoing either the recommended procedure or the specified alternative procedures."¹³⁷

Further, the Statute regulates that informed consent is expressed verbally. However, the law further specifies that informed consent must be expressed in writing and confirmed by a health professional whenever the patient needs: in-patient care, surgical procedure, invasive therapies and diagnostic procedures, procedures that imply risks as determined by law, and refusal to receive treatment.¹³⁸ The law further imposes the obligation on health professionals to obtain informed consent from the patient in order to have permission to display the administration of treatment for academic purposes. The informed consent must be obtained prior to the display of the patient.¹³⁹

Applying these standards to situations of obstetric violence, as shown in Chapter 2, the NGO INSEGNAR in the City of Rosario gathered testimonies from mothers whose childbirth experience at medical school hospitals was displayed for academic purposes without informed consent.¹⁴⁰ The obligation on health professionals to obtain prior informed consent serves as a

¹³⁷ Law 26.529, *supra* note 127, at art. 5 (translation is my own).

¹³⁸ *Ibid.*

¹³⁹ *Ibid.* at art. 8.

¹⁴⁰ INSEGNAR, *supra* note 49, at 29.

legal tool for women refusing to publicize their childbirth experience for the purpose of academic teachings.

3.3 The Legal Effect of Medical Guidelines and Statutory Obligations in Tort Law: a Study on their Use and Enforcement by Judges

In addition to the statutory rights recognized for pregnant women requesting medical care, tort law establishing health professionals' negligence liability when failing to abide to the professional care standards also protects women. When determining a practitioner's negligence as a breach of standards, the practitioner may need to explain his awareness of medical practice guidelines. According to Dickens and Cook in such a scenario physicians should be able to account for compliance with, deviation from, or contradiction of medical guidelines during treatment.¹⁴¹ Thus, they explain, medical practice guidelines may serve health professionals as justifications of clinical practices and simultaneously enforce knowledge of standards on those who refuse evidence-based practice.¹⁴²

Judges may rely on these guidelines as persuasive sources for determining if a health professional's practice fulfills, is negligent, or knowingly contradicts the duty of professional standard of care.¹⁴³ Thus, in adjudication of tort liability, courts have given medical practice guidelines legitimacy and legal effects in determining legal standards of professional care. Have courts actually applied medical practice guidelines as persuasive sources for determining the legal standard of professional care in cases involving physician's infliction of obstetric violence against women?

Reliance on medical practice guidelines or general guidelines for ensuring safe and effective abortion healthcare in the adjudication of cases was established in Argentina in a landmark case on access to non-punishable abortion care; the Argentinean Supreme Court relied on recommendations from WHO guidelines for establishing health professionals' legal standard of

¹⁴¹ Bernard M. Dickens and Rebecca J. Cook, "The Legal Effects of Fetal Monitoring Guidelines" (2010) 108 Intl. J. of Gynecol. Obst. 170-173, at 171.

¹⁴² *Ibid.*

¹⁴³ Bernard M. Dickens and Rebecca J. Cook, *supra* note 141.

professional care.¹⁴⁴ In this case “F., A. L.” the Court determined the scope of the right to autonomy and personal integrity during medical care. In this case, the Court disentangled confusion between the criminal laws governing abortion treatments and the liability of health professionals in the context of the rights of women seeking abortions after their rapes resulted in pregnancy.¹⁴⁵ Two issues were addressed by the Court; the Court had to parse the language of the criminal law to determine the legality of abortions resulting from rape, the Court also had to clarify the status of the physician’s demand for proof of judicial authorization or police report from the rape victims requesting abortions.

From among different sources of law, the Supreme Court selected to rely on the WHO Technical and Policy Guidelines for Health Systems. These guidelines state that all requirements that are not medically necessary pose a significant barrier for women seeking abortions, increasing the probability that they will be discouraged from seeking safe abortion services. The Court held that health professionals, in accordance with law, must not require that women provide judicial authorizations or police reports proving the legality of non-punishable abortion services.¹⁴⁶

In relation to tort law liability under Argentinean law, tort liability and the elements for determining physicians’ civil liability of physicians for negligence is set out by the Civil Code: the existence of a wrongful act, the presence of fault or lack of due care because of negligence by the physician regarding to what is understood as reasonable *lex artis* in the exercise of medicine, a tort manifested as a physical, mental or moral impairment, and that the tort has been the result of the medical fault or negligence.¹⁴⁷ As regards the sources of evidence for proving medical negligence, Argentinean case law relies primarily on the patient’s medical records and expert reports on the provision of medical care, as well as the patient’s status.¹⁴⁸

¹⁴⁴ Corte Suprema de la Nación Argentina [Argentina’s Supreme Court], 13 March 2012, F., A. L. s/ medida autosatisfactiva (2012), Expediente Letra “F,” No. 259, Libro XLVI (Argentina), at para 27.

¹⁴⁵ *Ibid.*

¹⁴⁶ *Ibid.*

¹⁴⁷ Jorge Bustamante Alsina, *Teoría General de la Responsabilidad Civil* (Buenos Aires, Ed. Abeledo Perrot: 1997) at 539.

¹⁴⁸ Juan Manuel Prevot, “Responsabilidad Civil del Médico” (2009) I Jurisprudencia Argentina 1297, at 6.

In *G., M. C. Y. c/ Hospital Luis Lagomaggiore s/ daños y perjuicios*, the 3rd Appellate Chamber of Mendoza considered the tort suffered by a 23-year old woman, who received obstetric care in a public hospital for her first pregnancy.¹⁴⁹ During the patient’s examination, the obstetrics resident decided to perform a cesarean delivery on the woman despite the medical expert’s report showing that the woman was experiencing a normal pregnancy.¹⁵⁰ Further, the facts revealed that during the cesarean, the woman suffered a health complication, which, according to the obstetrics resident, required an episiotomy.¹⁵¹ Finally, the facts revealed that the episiotomy was “incorrectly performed” and the subsequent incorrect removal of the placenta led to a uterine infection and severe damage to the woman’s sphincter muscles.¹⁵²

The case resolution rested on assessing the adequate standard of care episiotomies and placenta removal. The judges established, firstly, that although universities still require residents to perform episiotomies as a medical school requirement, National Statute 17.132 and Provincial Statutes orders that episiotomies be practiced under the guidance of a senior obstetrician.¹⁵³ Because this legal requirement was not fulfilled, the judges found that the institution failed to comply duties to patient safety, since it did not provide healthcare staff capable of guaranteeing the safe provision of obstetric care.¹⁵⁴

Regarding the episiotomy, the Judges applied expert reports and Obstetric Manuals of Practice to determine that the episiotomy was incorrectly performed: the incision was long, sunken, and resulted in painful scarring, and ultimately the sphincter damage experienced by the woman.¹⁵⁵ Moreover, the judges determined that the evidence offered in expert reports showed

¹⁴⁹ Cámara 3ra de Apelaciones en lo Civil, Comercial, Minas, de Paz y Tributaria de Mendoza [Third Appellate Chamber on Civil, Commercial, Mining, Peace and Tax Law of the Province of Mendoza], 5 September 2014, *G., M. C. Y. c. Hospital Luis Lagomaggiore s/ d y p*, 2014, RCyS2015-III, 137, at 4-5 (Argentina). [*G., M. C. Y. c. Hospital Luis Lagomaggiore*] This 3rd Chamber presides over Civil, Commercial, Mining, Justice of the Peace and Tax cases.

¹⁵⁰ *Ibid.* at 5.

¹⁵¹ *Ibid.* at 7.

¹⁵² *Ibid.*

¹⁵³ Law No. 17.132, 31 January 1967, Rules for the Art of Healing for the exercise of Medicine, Odontology, and other Activities, B. O. 21119, article 50 (Argentina).

¹⁵⁴ *G., M. C. Y. c. Hospital Luis Lagomaggiore*, *supra* note 149, at 8.

¹⁵⁵ *Ibid.* at 9.

incomplete removal of the placenta, triggering an infection, which required subsequent hospitalization and curettage.¹⁵⁶

The Judges considered this “incorrectly performed” episiotomy and removal of the placenta negligent practice according to the duty to ensure patient security. Accordingly, practitioners must provide medical assistance that guarantees that the patient will not suffer health complications as a result of the intervention.¹⁵⁷ The judges further determined that the duty of security owed the woman by the practitioner shall be interpreted as an *obligation of results*, by applying the Statute on the Rights of Women in Health Facilities, which recognized a woman’s right be considered healthy during childbirth.¹⁵⁸ In the interpretation of the Judges, given that the medical records and medical expert report showed a normal pregnancy, and additionally the woman’s right is to be considered healthy at the moment of childbirth, appropriate care by the obstetrics resident should not have resulted in damages.¹⁵⁹ Hence, the judges awarded the petitioner judicial relief and declared the obstetrician’s practice to have been negligent.

As noted above, as expressed by her testimony, the woman was subjected to the cesarean delivery and episiotomy without her consent.¹⁶⁰ The judges did not analyze the obstetrician’s liability for performing invasive interventions on the woman’s body without her consent, which is especially alarming considering that the judges mention and enumerate the rights of the woman under Statute on the Rights of Women in Health Facilities and the legal proscription of obstetric violence.¹⁶¹ Proper judicial reasoning should have identified that unconsented practices of episiotomy and cesarean delivery fail to respect women’s right to participate in the decision-making process and/or constitute abusive medicalization.¹⁶² Insofar as the woman was not previously informed about the perils or benefits of cesarean delivery or the episiotomy, basic

¹⁵⁶ G., M. C. Y c. Hospital Luis Lagomaggiore, *supra* note 149, at 7.

¹⁵⁷ *Ibid.* at 3.

¹⁵⁸ *Ibid.* at 5. *See also*, Law No. 25.929, *supra* note 119, at article 2(c).

¹⁵⁹ *Ibid.* at 5-6.

¹⁶⁰ *Ibid.* at 5, 8.

¹⁶¹ *Ibid.* at 4.

¹⁶² Law No. 25.929, *supra* note 119, at article 2(a); Law 26.485, *supra* note 15, at 6(e).

respect for women's right to autonomy and self-determination as highlighted in the Statute on the Rights of the Patient is absent from the judges' reasoning.¹⁶³

The Court's failure to analyze health professionals' legal obligations to provide humanized obstetric care, including obtaining informed consent, impact women's decision-making autonomy. This failure itself is sufficient to condemn the obstetrician's performance, even if the procedures had not resulted in actual bodily injury. Dickens and Cook explain that a medical professional may inflict assault on an individual if the practitioner provided reproductive health treatment without her consent or reasonably should have known that the provision of such reproductive health treatment could bring about a tort on the individual. Such situation can be framed as an assault without (simple) consent.¹⁶⁴ Hence, the obstetric resident ought to have provided information on the treatment he chose to provide, as well as suggest possible alternative treatments and obtain the woman's consent for the procedure. The lack of information for providing consent takes away the woman's decision-making freedom about accepting or rejecting treatments.

The judges' reasoning also fails to apply and legitimize international and national clinical practice guidelines and ethical protocols. The sources they have employed for assessing the negligence in practicing the episiotomy and the removal of the placenta focused primarily on the patient's medical record and medical expert reports. The application of international and national clinical practice guidelines on the "incorrect practice" of the episiotomy and removal of the placenta could have served as persuasive source for determining negligent practice. For instance, the WHO guidelines on *Care in Normal Birth* provide information on the contentiousness around routine practice of episiotomies as ineffective; they are considered a highly invasive practice, requiring justified medical indication and women's informed consent.¹⁶⁵ Similarly, the Ministry of Health *Guidelines for Healthcare of Normal Childbirth in Family-Centered Maternity Wards* recommends that episiotomies shall be performed by trained attendants, in situations where they are "necessary."¹⁶⁶

¹⁶³ Law 26529, *supra* note 127, at art. 5.

¹⁶⁴ Bernard M. Dickens & Rebecca J. Cook, "Types of Consent in Reproductive Health Care" (2015) 128:2 *International Journal of Gynecology and Obstetrics* 181, at 181.

¹⁶⁵ *Care in Normal Birth*, *supra* note 27, at 16.

¹⁶⁶ *Guideline for Healthcare of Normal Childbirth*, *supra* note 57 at 34.

By utilizing the protocols fostering more humanized treatment by health professionals, the judges' reasoning could have applied medical standards of professional care guaranteeing women's participation in maternal healthcare. In this sense, the judges could have required the obstetric resident to show that his practice reflected the patient's choices and preferences when he did not obtain informed consent, as recommended in *Family-Centered Safe Maternity Wards* guideline.¹⁶⁷ Additionally, since the medical record showed a normal pregnancy, the judges could have demanded that the obstetric resident explain his decision to practice cesarean delivery and the medical it awarded to the patient; the judges could also have applied and legitimized FIGO's *Guidelines on Ethical aspects of Cesarean Delivery*.¹⁶⁸

This analysis reveals how the judges resolved this tort case on obstetric violence by applying legal remedies that rely on evaluating the practitioner's compliance with the legal standard of clinical practice. However, the judges' reasoning, firstly, fails to identify the practitioner's obligations in providing humanized treatment during childbirth, recognized as of the 2004 National Statutes, and secondly, fails to enforce the practitioner's duty to practice according to the legal standard of humanized treatment for women. This shows that the judicial reasoning in this case focused on awarding relief for the physiological malpractice during childbirth, but failed to recognize the damages to women's emotional, and psychosocial needs, or consider their choices and preferences. Lastly, this judgment serves to observe the lack of legal effects granted by courts to medical guidelines on clinical practice and humanized treatment sources for assessing medical legal liability.

This chapter has shown that the 2003 publication of the *Guidelines for Healthcare of Normal Childbirth in Family-Centered Maternity Wards* by the Ministry of Health had the positive effect of impelling the enactment of the 2004 Statute on the Rights of Women in Health

¹⁶⁷ Fondo de las Naciones Unidas para la Infancia et al., *Maternidad Segura Centrada en la Familia (MSCF) con Enfoque Intercultural*, 2nd ed (Buenos Aires: UNICEF; 2011) (Argentina.) [UNICEF]

¹⁶⁸ FIGO, Committee for the Study of Ethical Aspects of Human Reproduction and Women's Health, *Ethical Issues in Obstetrics and Gynecology* (London: FIGO, 2012), at 88-89. Online: FIGO <<http://www.figo.org/sites/default/files/uploads/wg-publications/ethics/English%20Ethical%20Issues%20in%20Obstetrics%20and%20Gynecology.pdf>>. [Ethical Aspects Regarding Cesarean Delivery for Non-medical Reasons]

Facilities during Pregnancy. Further, it discussed how the Statute serves as a legal tool recognizing women's right to receive humanized treatment from health professionals during their reproductive processes.

This Chapter also explained that the legal proscription of obstetric violence resulted in better quality maternal care, setting new obligations for practitioners and prohibiting certain behaviors when providing maternal healthcare. Similarly, this Chapter showed how the enactment of a framework legislation recognizing the Rights of Patients also favors the development of the legal standard of medical care for more safe and humanized provision of maternal care.

Lastly, this Chapter analyzed the legal effects of medical practice guidelines as a persuasive source for judicial assessment in determining practitioner's legal liability in tort cases, as well as professional application of the legal standards of care prescribed in the Statutes. An analysis of the case *G., M. C. Y. c/ Hospital Luis Lagomaggiore s/ daños y perjuicios* involving obstetric violence during childbirth failed to identify practitioner's obligations to provide humanized maternal healthcare. Additionally, the judges reasoning showed that, in tort law cases, medical practice guidelines are not being utilized when measuring medical legal liability.

4 Conclusion

This thesis has showed that Argentina has largely internalized the global initiative for shifting the existing standards of protection in maternal health through raising awareness, advocacy, and enforcement of reproductive rights. The development of clinical practice guidelines by the Ministry of Health for all medical practice in maternal health has accelerated. This thesis has examined the effectiveness of this spurt of clinical practice guidelines and determined that the State has misleadingly reported on the monitoring of their implementation. Additionally, this thesis has shown that Obstetric Medical Societies and Associations have barely adopted the National medical guidelines through their own clinical practice guidelines and codes of professional ethics.

Equally important was the analysis of the legal effects of such clinical practice guidelines. As shown in Chapter 3, medical guidelines offer physicians evidence-based standards of medical care; consequently, physicians are expected to provide healthcare with attention to these

guidelines, as well as judge their merits in consideration of the patient's interest. As regards their legal effects, medical professional guidelines may serve to determine the health professional's duty under the standard of care set by tort law.

However, a review of the scant tort case law assessing responsibility for obstetric violence claims revealed that judges ignore the clinical practice guidelines set by the Ministry of Health and/or the Global Safe Motherhood Initiative. Therefore, clinical practice guidelines still hold little weight in affecting the determination of the legal standard of medical care in maternal health. But most importantly, analysis of this scant tort case law shows that judges fail to identify and enforce legal obligations for practitioners established in the Statutes governing the provision of maternal healthcare. In this sense, the Chapter illustrated the court's failure to enforce statutory obligations for adequate and safe quality of maternal healthcare, contributing to women's inability to perceive judicial relief for rights violations. Similarly, the court fails to convey the meaning of adequate and humanized practice in maternal healthcare respectful of women's choices, preferences, and social needs, beyond their physiological need at childbirth, to medical practitioners.

The perverse phenomenon framed as "Obstetric Violence" in Argentina has also been recognized and garnered legal legislative responses elsewhere in Latin America, Venezuela and Mexico, e.g. The progress and challenges of Argentinean policies for preventing and eliminating obstetric violence through better quality care shown in this thesis may be useful for broadly identifying and addressing structural problems in maternal healthcare. At the same time, hopefully, the findings and conclusions of this thesis will raise legal consciousness on possible legal instruments and policy strategies for contributing to increased litigation and more sophisticated monitoring and implementation policies for defending the rights of pregnant women.

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Appendices

Appendix A. List of Statutes on Maternal Healthcare and Related Statutes

Statutes	Description
Law No. 17.132 (1967)	Rules for the Art of Healing for the exercise of Medicine, Odontology, and other Activities. Article 50 regulates the exercise of Obstetricians.
Law No. 25.929 (2004)	Rights of Women in Health Facilities during Pregnancy, Labor, Childbirth, and Post-Partum.
Law No. 26.485 (2009)	Integral Law for the Sanction, Prevention, and Eradication of Violence against Women. Article 6(e) prescribes a legal definition of obstetric violence.
Law No. 26.529 (2009)	Right of the Patient, Clinical History, and Informed Consent Law.
Law No. 26.742	Reform to the Law on the Right of the Patient, Clinical History, and Informed Consent Law

Appendix B List of Executive Decrees related to the Scope of Legal Standard of Care in Maternal Health

Executive Decree	Description
Executive Decree No. 1011/2010	Regulation of Law No. 26.485 for the Sanction, Prevention, and Eradication of Violence against Women
Executive Decree 1089/2012	Regulation of Law No. 26.529 on the Rights of Patients in relation to Health Professionals and Health Institutions.