Regulation of Midwifery in Puerto Rico

by

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Abstract

Scholars and midwives agree that women’s autonomy over decisions related to birth is not being respected in a country where there is mainly one birth setting and one type of provider, in particular, when this setting and provider are often link to the use of unnecessary and excessive medical interventions. This is the case of Puerto Rico. I argue that midwifery could be an answer to this problem. Midwifery in Puerto Rico is not yet regulated, but I claim that in order to promote Puerto Rican women’s autonomy, midwifery regulation has to be well thought. This thesis includes an analysis of a bill proposed in Puerto Rico that pretended to regulate midwifery. Submissions presented to the legislature are also analyzed and criticized in this thesis. Some recommendations are provided on how Puerto Rico can enact a sensible scheme of midwifery regulation that would enhance midwives autonomy and therefore women’s autonomy.
Acknowledgments

Special thanks to my parents, for their ongoing support and unconditional love.

Thanks to my partner and best friend Alejandro, for his love, solidarity and support during this whole process. For being so patient, thoughtful and attentive, I cannot thank enough.

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Because I only hope that one Puerto Rican midwife will help me have my dreamed homebirth.
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Introduction

In Puerto Rico, obstetricians attend 99% of births either at public or private hospitals. Therefore, the physician attended childbirth at hospital is what most Puerto Ricans are familiar with. Being born in a hospital setting is a model that not many people question. Some do question the model however, including myself. My claim in this thesis is not to argue about what is the best way to give birth, because this decision should be left only to the prerogative of each woman, but about the right of women to decide how to proceed with birth. The critics, including scholars and midwives, agree that women’s autonomy over decisions related to birth is not being respected in a country where there is mainly one setting and one type of provider, in particular, when this setting (hospital) and provider (obstetrician) are often linked to the use of unnecessary and excessive medical interventions. These interventions are, in many cases, justified because the medical model sees birth as a pathologic process. As well, there is a cultural and medical over-confidence in the bio-medical model and in the use of new technology. The result of this approach towards birth is that many women feel that their rights are being violated: some experience traumas; and some feel that they did not consent to the treatments or that their decisions were not informed. The incorporation of midwives and their model of care into the birthing system in Puerto Rico could respond these issues. The Midwives Model of Care sees pregnancy and birth as a natural event. This model comprises: (i) monitoring the psychological and social well-being of the mother as well as her physical well-being; (ii) educating and counseling the mother individually; (iii) providing prenatal care and continuous attention and assistance during labor, delivery and post-partum: and avoiding technological interventions and referring women who are in need of obstetrical care. As

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1 Dalila Rodríguez Saavedra, “Parir en el hogar, mucho más que una alternativa”, 80 Grados (9 September 2011) online: 80 Grados <http://www.80grados.net/parir-en-el-hogar-mucho-mas-que-una-alternativa>.

well, there is evidence that a strong midwifery profession is an important counterweight to the obstetrical profession and its unnecessary interventions in normal births.\textsuperscript{3}

This said, there are different ways states and countries can incorporate the midwifery model of care. Regulation by legislation is one of them and it is what has been proposed in Puerto Rico. In this thesis I will argue that regulation of midwifery in Puerto Rico could be a step towards the recognition of women’s autonomy and women’s decisions regarding their health and bodies. Also, it would be a way of acknowledging birthing rights. Likewise, regulation and licensing could serve to legitimize the profession and to protect midwives’ autonomy. However, because it is well recognized that excessive regulation of midwifery could hinder the midwifery profession\textsuperscript{4} and in fact limit midwives’ autonomy, it is vital that the regulation is carefully designed and written in a way that would foster not only women’s autonomy but also the autonomy that midwives desire and need in order to practice their profession. More specifically, midwifery advocates and scholars indicate that elements like the composition of the regulatory board, supervision requirements, and the imposition of malpractice insurance are factors that could hinder or foster the midwifery profession. Therefore, it is pivotal to examine the different provisions contained in a bill that would regulate the midwifery profession because this would disclose what type of law it is. Based on these factors some scholars have characterized particular laws as either friendly or hostile towards midwives’ autonomy and therefore towards women’s autonomy.\textsuperscript{5}

Puerto Rico follows the American pattern of regulation, therefore I will start by discussing some issues related to the terminology and the different types of midwives that exist in the United States. An overview of the legal status of midwifery in the United States will follow, which will be Chapter 1. In order to fully understand the most

\textsuperscript{3} Suzzane Hope Suarez, “Midwifery is not the Practice of Medicine” (1993) 5 Yale JL & Feminism 315 at 324.

\textsuperscript{4} Raymond G. DeVries, Making Midwives Legal: Childbirth, Medicine, and the Law 2d ed, (Ohio: Ohio State University Press, 1996) at 46 [DeVries, Making Midwives Legal].

\textsuperscript{5} Raymond G. DeVries, Regulating Birth: Midwives, Medicine & the Law, (Philadelphia: Temple University Press, 1985) at 29 [DeVries, Midwives, Medicine & the Law].
important issues concerning regulation it is necessary to discuss the history of midwifery and the current maternity health care system in Puerto Rico; this will be Chapter 2. A general overview of what the different bills are trying to accomplish will be provided in Chapter 3 followed by an analysis of Bill 2873, which was a bill proposed at Puerto Rico’s Senate that, if approved, would have regulated the practice of midwifery. In this same chapter, I will analyze some selected submissions presented to the Legislature by three different stakeholders. Moreover, in this section I will use a comparative approach to discuss approaches that other states have adopted in order to regulate midwifery and that could be beneficial if implemented in Puerto Rico. Finally, in Chapter 4, I will provide a non–exhaustive set of recommendations on how Puerto Rico can enact an appropriate scheme of midwifery regulation that would enhance midwives’ autonomy and therefore women’s autonomy.

I would like to note two important starting points about my thesis. First, in the comparative section, I look to the United States both because our health care and maternal care systems are similar and because Puerto Rico’s political relationship with the United States makes American case law persuasive in Puerto Rico. This said, I recognize that the maternity system in the United States is far from perfect--in fact, it is failing women. It has been widely recognized that the United States has the lowest proportion of midwives to births (0.4 per 1,000 births) of any of the industrialized countries reporting these figures. Thus, it is only for practical reasons that I have used the United States in the comparative section. I honestly believe that a far more

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6 US, Bill HR 2873, Substitute for Bill 2873 of the House of Representatives “Law to Regulate the Midwifery Practice in Puerto Rico, create the Midwifery Examination and Regulation Board and Establish its Functions” (Sustitutivo del P. de la C. 2873, Ley para Regular la Práctica de la Partería en Puerto Rico, crear la Junta Examinadora y Reglamentadora de la Partería y establecer sus funciones), 16th Gen Assem, Reg Sess, PR, 2012 [Bill 2873].


9 Amnesty International, Ibid.
A comprehensive and radical approach is needed to change and improve Puerto Rico’s maternity care system. Taking into consideration the experiences of other countries is imperative to develop a progressive midwifery law, to improve our maternity health care system and moreover to revolutionize our health-care system. Because the United States has been criticized for the poor outcomes of their maternity system,\textsuperscript{10} we should look to countries or regions that have been applauded because of their birth models like Canada (the province of Ontario), New Zealand and The Netherlands\textsuperscript{11} if we want more concrete ideas on how to improve our maternity health care system. However, using their birth models as comparative frameworks is beyond the scope of this thesis because the health care systems in these countries are completely different from those in Puerto Rico and the United States.

The second starting point is related to my doubts and concerns about the effects of the regulation of midwifery. In the beginning of this research I was a little bit skeptical about midwifery being regulated in Puerto Rico. My skepticism originated in shared concerns between midwives and scholars who argue that midwifery regulation could bring institutional barriers that would hinder midwifery rather that fortify it.\textsuperscript{12} As well, others have argued that regulation has changed midwives’ practice and experience.\textsuperscript{13} In some cases, after a regulation has being enacted midwives have found themselves practicing their profession with less autonomy. However, after doing research, I have come to the conclusion that, although the mentioned concerns are valid and worth of study and concern, a carefully drafted regulation of the profession could bring many more benefits than disadvantages, at least in Puerto Rico.\textsuperscript{14} Legitimacy for the occupation and

\textsuperscript{10} Ibid.
\textsuperscript{12} DeVries, Making Midwives Legal, supra note 4 at 163.
\textsuperscript{13} Ibid at 177.
enhancement of midwives’ image is one of the benefits Raymond DeVries recognizes from regulating the profession.\(^\text{15}\)

Consequently, my point of departure is that the approval of a regulation would be a step forward to the recognition of women’s rights and a step towards the legitimation, protection and promotion of midwifery but only if it is the right kind of regulation and avoids some of the problems that I will discuss below.

\(^{15}\) DeVries, *Making Midwives Legal*, supra note 4 at 45.
Chapter 1

1. Midwifery in the United States

1.1 Types of Midwives in the United States

There are different types of midwives working in the United States and Puerto Rico. The main distinction between them is related to their education, in other words, it is due to the fact that there are various routes to become a midwife. Therefore, there are various terms used to describe them: lay midwives; traditional midwives; direct entry-midwives; certified professional midwives; certified nurse-midwives; and certified midwives. Even when there is a consensus on the meaning of some of these terms, many of these concepts are used by scholars, physicians and organizations in different contexts, which make the discussion about regulation very difficult.

First, “traditional midwives” or “traditional” birth attendants in the United States are those who learn or are trained based on the apprenticeship model.\(^\text{16}\) Therefore, direct experience is their principal form of training.\(^\text{17}\)

On the other hand, there is no consensus in the United States over the term “lay midwives”. It has been used indiscriminately to refer to formally or informally educated midwives.\(^\text{18}\) According to Raymond DeVries (1996), the term “lay midwives” was used by midwives who were not certified nurse-midwives.\(^\text{19}\) However, he mentions that many lay midwives thought that this term created an impression of incompetence.\(^\text{20}\) According to Marsden Wagner (2006), direct entry-midwives are called “lay” midwives when they

\(^{16}\) Suzzane Hope Suarez, “Midwifery is not the Practice of Medicine” (1993) 5 Yale JL & Feminism 315 at 332.

\(^{17}\) Ibid.

\(^{18}\) Ibid.

\(^{19}\) DeVries, Making Midwives Legal, supra note 4 at Preface xx.

\(^{20}\) Ibid.
are being criticized; for him, this is a pejorative label that suggests that they are not trained.\footnote{Marsden Wagner, \textit{Born in the USA: How a Broken Maternity System Must be Fixed to Put Women and Children First}, (California: University of California Press, 2006) at 117.} Over the years, the term began to be replaced by other names: midwife, direct entry midwife, practical midwife, traditional midwife or empirical midwife.\footnote{DeVries, \textit{Making Midwives Legal}, supra note 4 at Preface xx.}

Direct-entry midwives (DEMs) are midwives who enter directly into midwifery education and practice rather than entering through the discipline of nursing\footnote{Sarah Ann Stover, “Born by the Woman, Caught by the Midwife: The Case for Legalizing Direct-entry Midwifery in All 50 States” (Winter 2011) 2.1 Health Matrix 307 at 309. As cited in Liani Cabán, \textit{An Opportunity to Regulate the Midwifery Profession in Puerto Rico} (2013) [unpublished].} \footnote{Reed & Roberts, supra note 14 at 133.}. However, this term has also been used to refer to midwives that don’t have any formal schooling.\footnote{North American Registry of Midwives, “What is a CPM”, online: North American Registry of Midwives <http://www.narm.org> [NARM, “What is a CPM”].} In this thesis, the term traditional midwife will be used specifically for midwives who do not have formal training.

Certified professional midwives (CPMs), are one type of DEM who have met the standards for certification set by the North American Registry of Midwives (NARM).\footnote{Reed & Roberts, supra note 14 at 134.} DEMs who have been certified by NARM use also the CPM designation.\footnote{NARM, “What is a CPM”, supra note 25.} They are qualified to provide the Midwives Model of Care.\footnote{Ibid.} The CPM credential is the only midwifery credential that requires knowledge about and experience in out-of-hospital settings.\footnote{Ibid.}

On the other hand, certified nurse-midwives (CNMs) are:

> [R]egistered nurses who have graduated from a nurse-midwifery education program accredited by the Accreditation Commission for Midwifery Education (ACME)
(formerly the American College of Nurse-Midwives (ACNM) Division of Accreditation (DOA)) and have passed a national certification examination to receive the professional designation of certified nurse-midwife.29

The certified nurse-midwife originated in the United States during the 1920’s.30 In fact, it has been said that midwifery experienced a revival when it joined its forces with nursing during the 20th century.31 Currently, in the United States, the combination of nursing and midwifery qualifications possessed by certified nurse-midwives is the most common route to midwifery.32

Certified Midwives are DEMs certified by the American Midwifery Certification Board (AMCB). The AMCB is a national certifying body for certified midwives who have received their graduate level education in programs accredited by the Accreditation Commission for Midwifery Education (ACME).33 This type of midwife emerged because the ACNM was asked to explore the creation of the accreditation of a new education program for non-nurse midwives.34 They are identified as CMs once they pass the same certification given to certified nurse-midwives by the ACNM accreditation council.35

One of the most noticeable distinctions between certified nurse-midwives and direct entry midwives is that the former tend to work in a hospital setting and direct entry midwives are mostly found attending home births.36 Even when certified nurse-midwives are

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30 Stover, supra note 23 at 317.
31 Davis-Floyd et al, supra note 11 at 417.
32 Ibid.
34 Reed & Roberts, supra note 14 at 134.
35 Ibid.
36 Davis-Floyd et al, supra note 11 at 417.
allowed to attend home births by the ACNM, the majority of these professionals work in hospital settings.\textsuperscript{37} As will be shown below, regulation of certified nurse-midwives in the United States has not been easy and they are still struggling with the effects of regulation.\textsuperscript{38}

Although it has been said that the existence of different kinds of midwives could be confusing for consumers, it has also been recognized that several routes of entry to the profession are necessary to increase the numbers of professional midwives.\textsuperscript{39} This factor is particularly important in states or countries where the numbers of practicing midwives are very low, as is the case in Puerto Rico. Before moving to the practice of midwifery in Puerto Rico, however, it is necessary to provide an overview of the regulation of midwifery in the United States given its significant influence on Puerto Rico.

1.2 Police Power and Public Health

In the United States, midwives are regulated at the state level. States have a police power to enact regulations by the legislative branch to protect public health and public safety.\textsuperscript{40} This police power extends to issues related to childbirth.\textsuperscript{41} As a result, the authority exercised by the state also covers the persons that can assist or intervene in births.\textsuperscript{42} Therefore, midwives, and the work that they do have been subject of regulation by the state.

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\textsuperscript{38} Reed & Roberts, \textit{supra} note 14 at 146.

\textsuperscript{39} Hope, \textit{supra} note 16 at 331.

\textsuperscript{40} \textit{Jacobsen v. Massachusetts}, 197 US 11 (1904).


\textsuperscript{42} \textit{Ibid.}
Each state is allowed to regulate health professions in the way it deems appropriate. Consequently, in the United States there are as many laws and frameworks that regulate the different midwives as there are states. For example, even though CNMs have been legalized in all 50 states of the United States, each state has a different framework. As a result, they way CNMs are regulated, the regulatory requirements imposed on these professionals and their scope of practice might vary from state to state. For example, there is a wide variation amongst states regarding the regulation of CNMs prescriptive authority. There are also inconsistencies between states concerning the requirements of CNMs to have malpractice insurance.43 The same happens with CPMs, although these professional have been licensed or legally recognized in only 28 states.44 Such is the variation of CPM’s legal status and regulation, that there are 9 states and the District of Columbia, which expressly criminalize their practice.45 On the other hand, CM’s are relatively new and originally only practiced legally in New York.46 Rhode Island followed New York and recently permitted their practice. Their legal status is very unclear in the rest of the states.

I have explained that the motivations for state regulation of midwives are public health and safety. However, it is surprising to see that even when regulation sometimes imposes a burden upon midwives, these professionals have been trying to organize themselves in order to advance some pieces of legislation throughout the United States. Midwives want to be regulated because, according to them, it is a way of getting legitimization and also of being in a more secure position. In states where midwifery is not prohibited but is not


46 Reed & Roberts, supra note 14 at 135.
regulated, midwives often practice knowing that if while attending a birth something goes wrong they could be prosecuted for the practice of medicine without a license. It has been said that normally prosecutions against midwives occur in those states, which either leave their status undetermined or prohibit lay midwifery. Therefore, being regulated gives midwives some kind of protection. It also increases their visibility and accessibility.

Thus in many circumstances both the state and the midwives want this profession to be regulated. However, these two stakeholders have different reasons for why they want midwives to become regulated. On one hand, the state wants to regulate the profession because it has a duty to protect the public health and safety of its citizens. On the other hand, midwives want some kind of regulation enacted because they need to protect themselves and because regulation gives them legitimacy. This tension is apparent when it comes to determining what type of legislation is suggested, the definition of a midwife, how collaboration is defined, supervision requirements, the board composition, the imposition of a malpractice insurance, etc.

In terms of the regulatory framework, this could be put forward by the state or pushed by midwifery advocates; in any case, there are different ways of regulating the profession. Midwifery can be legalized by the delegation of the regulation to a specific agency. It can also be regulated by judicial interpretation of statutes or by legislation. Regulating the profession by passing a law and creating a regulatory board is what has been proposed in Puerto Rico, but regulation of midwives through legislation is not the only pathway that has been used by midwives and mothers in pursuing other alternatives to the

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48 Ibid at 236.


bio-medical model of birth. Litigation is another strategy that has been used in the past in many American states to vindicate some rights regarding the midwifery profession, although, in the majority of the cases, the outcomes have not been positive. Specifically, midwives have attempted to test the constitutionality of the regulations inflicted upon them, \(^5\) trying to overturn statutes that they consider restrictive or to clarify what they consider to be ambiguities in the law. \(^6\) Since it is likely that this could also happen in Puerto Rico if a law is eventually approved, it is important to review some of these constitutional challenges.

Feminist scholars and midwifery advocates, with whom I agree, have argued that women’s decisions concerning pregnancy, prenatal care and childbirth are fundamental elements of their autonomy. \(^7\) Having alternatives available for prenatal care and childbirth, different from those provided by obstetricians and hospitals, is necessary to respect women’s autonomy and women’s capacity to make decisions regarding their health and bodies. The Supreme Court of the United States has not yet decided on a woman’s privacy interest in making decisions concerning the approach of childbirth. \(^8\) Midwives have relied upon constitutional rights like the right to due process, the right to privacy and the doctrine of vagueness in the cases they have brought in state courts. \(^9\) However, courts all across the United States have failed over and over to recognize these rights in the context of midwifery, a result denounced by midwifery advocates.

One of the most troubling aspects is that judges have constantly used jurisprudence related to abortion in the United States to resolve the birthing rights of women. Judges have decided, using Roe v. Wade’s viability argument, that, since birthing rights are exercised during the third trimester, states have an interest in the health of the fetus,

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51 Rausch, supra note 47 at 238.
52 Ibid at 239.
53 Rebecca A. Spence, “Abandoning Women to Their Rights: What Happens When Feminist Jurisprudence Ignores Birthing Rights” (Fall 2012) 19 Cardozo JL & Gender 75 at 4.
54 Reilley, supra note 50 at 1140.
55 Ibid at 1131-1142.
which permits intervention. Thus, with this argument, women’s right to privacy, when not permitted to select the birthing attendant of their choice, is denied. The first time a court attended a privacy argument was in the case of *Bowland v. Santa Cruz*.  

This case decided “that at the point of fetal viability, the state has an interest ‘in the life of the unborn child that supersedes the woman’s privacy right’.” Choosing an abortion and choosing a direct entry midwife are decisions equated by *Bowland’s rationale*. About this particular result, it has been said that women seeking alternative birth practices should not be compared or classified with women who are seeking an abortion. In this context, the words of Rebecca A. Spence are accurate and revealing:

> If birthing women are to prevail against courts seeking to substitute their judgment for women’s constitutional rights, feminist jurisprudence must build to teach students a nuanced analysis of how birthing rights can be distinguished from abortion. Without serious attention to this question in feminist jurisprudence courses, casebooks, and elsewhere, women will continue to be abandoned to exercise their rights in extremely hostile environments.

Although it could be a difficult task, various constitutional rights guaranteed by Puerto Rico’s Constitution could be invoked in Puerto Rico in order to protect reproductive rights. Specifically, the right to privacy, the right to dignity, equality and non-discrimination and the right to be free from torture or other cruel, inhuman, or degrading treatment or punishment could be invoked to defend birthing rights. Unfortunately, Puerto Rico could go on the same direction as the American courts.

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56 *Bowland v Santa Cruz*, 556 P (2d) 1081 (Cal 1976).
59 Stover, *supra* note 23 at 331.
60 Spence, *supra* note 53 at 89.
Chapter 2:

2. Midwifery in Puerto Rico

2.1 Brief History of Midwifery in Puerto Rico

Although the practice of midwifery in Puerto Rico is currently limited, throughout the history of childbirth, there have been other options than that of giving birth in hospitals with obstetricians. Even though Spanish chroniclers made few observations regarding the way native Indians gave birth, it is certain that midwives have been present in the history of Puerto Rico since the Spaniards colonized the Island and Africans were brought to work as slaves. Spanish and African midwives were present in Puerto Rico since the Island was colonized by Spain. Shortly after Puerto Rico became a territory of the United States, a Board of Medical Examiners was created. This board was later in charge of administrating the tests that midwives were given. In 1903, the Medical Association of Puerto Rico published a bulletin in which physicians commented that there was a lower death rate because of puerperal sepsis among women assisted by midwives than those who were attended by physicians in the United States and England.

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63 *Ibid* at 67.

64 *Comadronas: Arte y Oficio de Mujer*. 2001, DVD: (San Juan, Prohibido Olvidar, Corporación de Puerto Rico para la Difusión Pública) [*Comadronas: Arte y Oficio de Mujer*].
In 1931, Law 22 of April 22 of 1931, was enacted to, among other things, regulate the practice of midwifery. This law introduced the term “auxiliary midwives” (comadronas auxiliares) to Puerto Rican legislation. This term was used for midwives to identify those who were registered and already practicing at that time. The law also supported the creation of the “Midwives Club” (Club de Comadronas), which had the purpose of supervising practicing midwives and training them under the Puerto Rico Department of Health. As stated by Córdova (2008), this club “was supervised by nine nurse-midwives who met every month with all the licensed midwives in the different municipalities across the island.” The licensed midwives were auxiliary midwives that had met state requirements, amongst which was a written examination. Their education was mainly based on empirical experience. During the 1950s, the Health Department reported that there were over 1,500 auxiliary midwives working on the Island. However, Córdova (2008) affirms the following: “Because the comadrona auxiliar was not professionally organized nor prepared to defend her professional autonomy, her practice and social standing weakened. She did not adapt her profession to the changing demands of the population and the shifts that the new urban-industrial presence dictated on the island.”

During the 1940s, approximately 85% of births were home births attended by midwives. In 1949, the first four-year medical school was founded in Puerto Rico.

65 Ley Núm. 22 de 22 de abril de 1931, “Ley del Tribunal Examinador de Médicos de Puerto Rico.
67 Ibid at 38.
68 Ibid at 42-43.
69 Ibid at 43.
70 Ibid.
71 Ibid at 52.
72 Ibid at 41.
73 Ibid at 52.
74 Comadronas: Arte y Oficio de Mujer, supra note 64.
Some scholars have said that this was a foreshadowing of future changes related to health and medical practice. Childbirth practices were already being influenced by licensure regulations. Midwifery practice diminished drastically in Puerto Rico when the Medicine School of Puerto Rico was opened. At that time, physicians were required to attend births in order to be able to graduate. Between 1950 and 1954, recently graduated doctors did not have the opportunity to learn and be trained by local midwives, although this practice did exist in other countries. During this period there were many maternal deaths. Consequently, due to the high number of deaths, the Department of Health implemented a propaganda campaign in which it exposed maternity and birth as a pathologic event. Nevertheless, Debbie Díaz (1999), a certified professional midwife in Puerto Rico, argues that others factors that could have influenced this high number of deaths were not considered. During the 1950s, the percentage of home births attended by midwives was reduced to 60%. When midwifery was being marginalized, there was no valid scientific reason that could justify it, explained Díaz (1999). In 1962-63, the Department of Health announced a tendency towards birth hospitals. Ten years later, the Department of Health did not include midwives’ work in their annual report. At this point, the decrease of the midwifery profession was evident.

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75 Córdova, supra note 66 at 39.
76 Ibid.
77 Ibid.
78 Comadronas: Arte y Oficio de Mujer, supra note 64.
79 Ibid.
80 Ibid.
81 Ibid.
82 Ibid.
83 Ibid.
84 Ibid.
85 Diaz & Cabrera, supra note 61 at 79.
86 Ibid.
In her dissertation, Córdova (2008) claims that the changes and transformations in birthing practices were the outcome of political, social and cultural underlying forces that were also responding to leading power structures. She also states that legislation and “legal-medical campaigns” sped this process of transformation that was also linked to the disappearance of midwives and home births.

Midwifery reemerged in Puerto Rico during the late 1970s thanks to a new group of midwives. Two women started attending homebirths in 1978. One of these women was a North American midwife who worked in Rincón (a municipality located in the western part of the Island) and the other was Rully Delgado, a Puerto Rican traditional midwife who worked in Luquillo (a municipality located in the eastern part of the Island), and who later served as a colleague and teacher for a new group of midwives who started their practice soon after. Delgado was special because she was considered to be the link between traditional midwifery and midwives that have an academic formation. She also completed many courses in different areas in order to refine her practice. Some DEMs who practice today had the opportunity to learn from her practice. According to Diaz (1999), out of the 4 midwives who were practicing in Puerto Rico in 2001, Delgado had the best statistics. She achieved 98% of her births without the mother having to be transported to a hospital.

The new group of midwives who followed her contacted other midwives within the international midwifery network. This type of networking had been nonexistent for

87 Córdova, supra note 66 at 3.
88 Ibid at 58.
89 Ibid at 251.
90 Comadronas: Arte y Oficio de Mujer, supra note 64.
91 Ibid.
92 Ibid.
93 Ibid.
94 Córdova, supra note 66 at 250.
their predecessors. Even though they had been relegated for so many years, this group of midwives attended the home births of over 1000 women during the 1980s and 1990s. Paradoxically, at the same time, with the approval of a law in 1980, midwifery became deregulated. Law 112 of June 4th of 1980 had the effect of derogating Law 22 of April 22 of 1931, which regulated birth attendant licenses and midwifery. On one hand, midwives would have greater autonomy while practicing; but on the other, they would face sidelining. According to Córdova (2008): “With this law, midwifery became deregulated, opening the path, ironically, to greater independence, yet pushing them into anonymity. The midwife was not recognized legally just as she was not specifically marked as illegal.”

On the other hand, nurse-midwives have also struggled to be recognized and to gain professional autonomy on the Island. These professionals have been present in Puerto Rico since late in the decade of the 1920’s. In fact, by the year 1950, The Department of Health established an initiative with the goal of creating a training center of obstetric nurses on the Island. In order to have academically prepared personnel to staff the program, a group of nurses, selected by the Department of Health, was sent to the US to be trained in obstetric nursing. However, after a couple of years, the program failed to reach its purpose. As a result, other initiatives were attempted to establish a local nurse-midwifery program.

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95 Ibid.
96 Ibid at 265.
97 Ley Núm. 112 de 4 de junio de 1980, cited in Córdova, supra note 66 at 232.
98 Ibid.
99 Ibid at 113.
100 Ibid.
101 Ibid.
102 Ibid at 113-114.
Decades later, in the year 1998, the first program of nurse midwifery was created at postgraduate level in Puerto Rico.\textsuperscript{103} It was attached to the Public Health School of the Medical Sciences Campus of the University of Puerto Rico and accredited by the ACME.\textsuperscript{104} Currently, this program still exists and continues graduating nurse-midwives, thus, increasing the options of birth attendants in the Island.

2.2 Midwifery and the Current Birthing System in Puerto Rico

In 2010, there were 42,203 births reported on the Island of Puerto Rico.\textsuperscript{105} The same report that offers this number also presents statistics regarding births per municipality, the mothers’ age, birth defects, babies’ sex, cesareans, vaginal births, and many other relevant factors that reflect the demographic scenario in Puerto Rico. Nevertheless, this annual report does not contain statistics associated with the number of births assisted either by obstetricians or by midwives in the Island. Also, it does not contain information about the birth setting (home birth or hospital). In fact, official statistics are non-existent during this period of time. This detail, \textit{per se}, is revealing. The reason for this silence can be explained by the fact that Puerto Rico’s maternity health care system is mostly in the hands of obstetricians and hospitals. It was only recently that the document (form) that is supposed to be presented at the Demographic Registry of the Department of Health (Registro Demográfico del Departamento de Salud) was amended. It now requires information on whether the birth took place at a hospital or at a home, and if this was the case, whether it was planned in advance.


\textsuperscript{104} Ibid.

\textsuperscript{105} Puerto Rican Health Department, \textit{Informe anual de estadísticas vitales: 2009 y 2010, Nacimientos, matrimonios y divorcios} by Mariluz Bezares & Marianne Cartagena (San Juan: Departamento de Salud de Puerto Rico, 2012) at 9.
Puerto Rico’s current maternity system recognizes the hospital, under the supervision of obstetricians, as the main setting and provider for birth. Therefore, as noted, Puerto Ricans are mostly familiar with the bio-medical model of birth. Conversely, alternative birth attendants (like midwives); and different birth settings (like home births or freestanding birth centers); are unfamiliar to many Puerto Ricans. This leads us to examine what the reasons behind this are. The absence of midwifery regulation and the anonymity that comes with this practice could be one of the factors for why alternative birth settings are so unknown to Puerto Ricans. Moreover, the low number of midwives practicing in Puerto Rico does not contribute to change the described scenario. By 2010, there were 35 certified nurse-midwives, but only 6 were working as midwives. Most of them work in hospitals and therefore follow hospital protocols and are under the supervision of physicians. There are no birth centers on the Island and home births are mainly performed by the 5 existing DEMs in Puerto Rico. There are no traditional midwives and Dr. Ramón Pérez is the only obstetrician who is known for attending home births.

According to Rita Aparicio (2001), a Puerto Rican CPM, the health system in Puerto Rico does not take into consideration or validate women’s feelings while pregnant and while giving birth. She emphasizes that from the first moment a woman in labor goes to the hospital and through the emergency room, she is considered a patient. Women are seated down in a wheel chair, separated from their partners and changed into a hospital gown. In addition, intravenous therapy (IV) is also administered to pregnant women.

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106 Supra note 103.
107 Ibid.
108 “Prepárate para la llegada de tu bebé”, Primera Hora, (22 August 2011) online: <http://www.primerahora.com/estilos-devida/madres/nota/preparateparalallegadadetubebe-540606/>; See also Rodríguez supra note 1.
110 Comadronas: Arte y Oficio de Mujer, supra note 64.
111 Ibid.
women at hospitals.\textsuperscript{112} This type of practice is so systematic and institutionalized that women perceive that when they go to the hospital while in labor, everything that takes place there is inevitable and necessary.\textsuperscript{113} Therefore, Aparicio argues that, to a certain extent, an institutionalized violence against women is present when the system encourages these sorts of procedures.\textsuperscript{114}

There is an absence of regulation and therefore a failure of insurance companies to cover midwifery services, a lack of access to information, and a strong opposition of obstetricians, hospitals and insurance companies on the Island to midwifery. These are among the multiple reasons that can be mentioned when trying to explain why midwives are not a part of our maternity healthcare system and hence, why this alternative is practically not available and not considered by the majority of women in Puerto Rico.

Nevertheless, in this scenario, more and more Puerto Rican women are choosing to give birth either with the aid of other providers or at a different birth setting. Some other obstetricians are also being recognized for their different approach and because they have been open to collaboration with midwives. Dr. Edgardo Rivera Rosa, Director of the Residency in Obstetrics of the Municipal Hospital in San Juan, is one of those obstetricians who has recognized the range of different sectors in Puerto Rico comprised of doulas (a woman who is trained to assist another woman during childbirth), midwives and obstetricians who are trying to keep the birth process in the control of the parturient.\textsuperscript{115}

Another obstetrician who has been recognized for being critical of the maternity health system in Puerto Rico is Dr. Ramón Pérez. Pérez has affirmed that what physicians do at

\textsuperscript{112} Ibid.
\textsuperscript{113} Ibid.
\textsuperscript{114} Ibid.
\textsuperscript{115} “Ganan los terrenos por un parto humanizado”, Primera Hora (15 February 2013) online: <http://translate.google.ca/translate?hl=en&sl=es&u=http://www.primerahora.com/gananterrenosreclamosporunpartohumanizadovideo-789499.html&prev=/search?q=Fq%3DHospital%2BMunicipal%2BSan%2BJuan%2Bparteras%2Bbirth%2Bparteras%26client%3Dbsafari%26rls%3Dden>. 
hospitals could be considered torture.\textsuperscript{116} He is convinced that the vast majority of women, those that are low-risk, do not need the interventions usually performed at hospitals.\textsuperscript{117} He has specified that high-risk women are those who suffer from hypertension, diabetes, morbid obesity, hypotiroidism or are prone to a complicated birth.\textsuperscript{118} He is certain that physicians have been using c-sections as a way of controlling births for their convenience and not to save the life or health of women and babies,\textsuperscript{119} the reason being that a c-section could last up to three hours. Conversely, the process of a natural birth could last up to 48 hours.\textsuperscript{120} This explains one of the approaches taken by obstetricians and how it differs from the methods practiced by midwives. For midwives, there is not one rule or norm concerning the duration of labor-- it could last hours or even days. That is why Aparicio mentions that when a woman goes into labor, her whole house and family is transformed; the schedules become altered and no one knows when she is going to return home.\textsuperscript{121} She even mentions that it is not only her family that undergoes this transformation, but also she, herself.\textsuperscript{122} Therefore, the contrasts between these two approaches are drastic.

During the last few years, different individuals, groups, organizations and a few obstetricians have been trying to make their voices heard in favor of a respected and humanized birth and the promotion of other birthing alternatives. Local grassroots organizations have emerged for the purpose of educating the general public, specifically mothers to-be, by informing them of the available birthing options. Women Helping Mothers (Mujeres Ayudando Madres), for example, has been helping hundreds of


\textsuperscript{117} \textit{Ibid.}

\textsuperscript{118} \textit{Ibid.}

\textsuperscript{119} \textit{Ibid.}

\textsuperscript{120} \textit{Comadronas: Arte y Oficio de Mujer, supra} note 64.

\textsuperscript{121} \textit{Ibid.}

\textsuperscript{122} \textit{Ibid.}
women; by educating, supporting and empowering this population with regards to their birth processes. Doula Caribe has trained hundreds of doulas who work in and out of hospitals. Another group called In-necesaria (this phrase refers to unnecessary caesarean sections) was also founded to create awareness of the high number of caesarean sections performed in Puerto Rico. Clearly, the resurgence of these organizations speaks about the need to change our maternity health care system and the way pregnancy and childbirth is viewed in our country. For Teresa Canino, a Puerto Rican photojournalist who has been covering the midwifery movement in Puerto Rico for more than a decade and who has recently presented a documentary about midwives in Puerto Rico as part of her Masters’ thesis, photography helps to view birth from a natural perspective. She understands that photographs of natural births and home births are absent from the imagination of Puerto Ricans and that documenting this process visually through images is a powerful tool that could promote social change.

In summary, midwives and midwifery practices are gaining more attention from women and men, and as a result diverse organizations are taking steps to promote the recognition of other birth alternatives and providers and the importance of a respected and humanized birth. However, at the present moment there is no regulation of the midwifery profession on the Island. These professionals have been working outside of the legal framework for decades. Although non-regulation has permitted midwives to work in an autonomous manner, they continue to face many difficulties. One of these obstacles, shared with other American states, is that midwives and the type of work that they do, their knowledge and

128 Díaz & Cabrera, supra note 61 at 97.
experience are considered a myth. Stereotypes sometimes portray midwives as lay women or hippies who assist birth without any formal training, or witches who use magical potions. There is a great deal of misinformation regarding the type of work a midwife does, her training and the differences between the various kinds of midwives. Some people even confuse the role of a doula for that of a midwife, using these terms indistinctively. Thus, lack of access to information is one of the biggest challenges that Puerto Rico faces with regards to the establishment of the midwifery profession.

However, it is my claim that unless midwives are recognized as health care providers and covered by health insurance companies under Puerto Rico’s health system, Puerto Rican women who are interested in receiving the services of a midwife will remain unable to access them because of economic barriers. Amnesty International has recognized this issue of cost as a barrier to obtaining care by midwives in the context of the United States. In order for midwives to be considered health professionals and therefore to be covered by public and private insurance companies, it is necessary that the profession be regulated. This will allow women to access their services, although it will not guarantee the autonomy of either midwives or women. Even though I favor the enactment of a law that would regulate the midwifery profession on the Island, Puerto Rico’s lack of regulation, when compared to an inadequate and inefficient legal framework, might not be the worst scenario. The reasons sustaining this argument will become apparent in the next chapter where I analyze two recent attempts to regulate the midwifery profession in Puerto Rico.

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129 Wagner, supra note 21 at 102-103.

130 Ibid at 103.

131 Amnesty International, supra note 8 at 81.
Chapter 3:

3. Puerto Rico Recent Attempts at Midwifery Legislation: Bill 2873 and Bill 309

3.1 Overview

During recent years, there have been two attempts to pass a law that would regulate the midwifery profession in Puerto Rico. In 2010, a group of certified nurse-midwives submitted what was later named Bill 2873 to the House of Representatives of Puerto Rico. This bill was titled: “Law to Regulate the Midwifery Practice in Puerto Rico, Create the Midwifery Examination and Regulation Board and Establish its Functions” (Ley para Regular la Práctica de la Partería en Puerto Rico, Crear la Junta Examinadora y Reglamentadora de la Partería y Establecer sus Funciones). The purpose of this Bill was to establish a board that would examine and regulate midwifery in Puerto Rico, including the certification and licensing of midwives. The intention of this Bill was also to incorporate midwives as health professionals and to establish the standards for the practice of midwifery as well as their scope of practice. It is significant that this proposed law was submitted to the legislature of Puerto Rico by a group of certified nurse-midwives. As a result, it can be inferred that the legislation being proposed met the expectations and interests of certified nurse-midwives. Conversely, the interests of direct entry midwives who also work in Puerto Rico were not necessarily taken into consideration or reflected in the drafting of this Bill.

In 2012, after receiving and analyzing submissions presented by stakeholders who both promoted and opposed the measure, the House of Representatives and the Senate evaluated and approved Bill 2873. However, the Governor of the Island at the time, Luis Fortuño Burset, did not sign the Bill. According to Puerto Rico’s Constitution, the governor had 30 days to sign the Bill, and he did not sign the Bill within this period.\(^{132}\)

\(^{132}\) PR Const. Art. III, Sec. 19
This provided another opportunity for opponents of the Bill to come up with a proposal that would correct the flaws of the Bill 2873. Simultaneously, in November of 2012, Puerto Rico underwent national elections in which the past administration was defeated and lost their legislative majority. Shortly after, in January 2013, certified nurse-midwives presented the same Bill again, although this time to the Senate and under another number (Bill 309).\textsuperscript{133} It is expected that Bill 309 is going to be evaluated at some point this year. Because these Bills are identical, I will focus on the original Bill, Bill 2873.

Because midwives, midwives scholars, organizations and individuals have recognized that laws of this nature can hinder the profession, it is necessary to analyze the different provisions contained in the Bill being proposed. Even though it is my opinion that the proposed Bill contains some positive provisions, if it had been approved, it could have had some counterproductive effects. Put simply, I am suggesting that no law could sometimes be more desirable than a bad law. An inadequate legal framework regulating midwifery, as such, could do more damage to midwife’s autonomy than a non-existent legal framework.\textsuperscript{134} The next section will explore the effects of Bill 2873.

### 3.2 Analysis of Bill 2873

As was noted above, in 2012, Luis Fortuño Burset, the former Governor of Puerto Rico, considered signing the proposal to regulate the midwifery profession, although he never did and the reasons behind this decision were never publicly revealed.\textsuperscript{135} It was clear, however, as will be explored in more detail below, that physicians, hospitals and insurance companies were against the approval of the Bill. Ironically, DEMs also

\textsuperscript{133} US, Bill S 309, Law to Regulate the Midwifery Practice in Puerto Rico, create the Midwifery Examination and Regulation Board and Establish its Functions (Ley para Regular la Práctica de la Partería en Puerto Rico, crear la Junta Examinadora y Reglamentadora de la Partería y establecer sus funciones, 17th Gen Assem, Reg Sess, PR, 2013.

\textsuperscript{134} DeVries, Making Midwives Legal, supra note 4.

opposed the Bill. It is my claim that if this Bill were to be approved, instead of increasing women’s options to decide where and how to give birth, if approved, it would cause a practice that is presently struggling in the Island to disappear entirely. As a result, this would also constitute an infringement to women’s autonomy.

3.2.1 Drafting Problems

First of all, the Bill’s poor drafting makes it unclear. The Bill has writing problems that deserve to be studied carefully. As an example, the Bill has numbering problems. There are two sets of articles, each numbered 13 through 16. One article numbered 13 deals with midwives’ obligation to inform and another article also numbered 13 is a transitional provision that would apply to midwives who are already practicing in Puerto Rico. The first article 14 imposes a *sine qua non* requisite of malpractice insurance and the second article 14 establishes that the interpretation of the law should be in accordance with the rights that midwives (that are already practicing in Puerto Rico) have. The first article 15 deals with the information that the midwife needs to provide for the birth certificate whereas the second article 15 establishes the independence of the Bill’s provisions (this means that even if a provision of this Bill is consider invalid, the rest of the provisions will still be valid and therefore enforceable). The first article 16 relates to the amendments this Bill makes to other laws that are already in place and the second article 16 establishes the date of the Bill. To avoid confusion I will refer to each of these articles not only by its number but also by its subject. As well, a copy of the Bill is annexed to this thesis for reference.

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I argue that there are also other problematic issues. For example, the sentence in Article 2(d), which defines the licensed midwife, has 10 lines, making it very difficult to interpret. The Bill, designed to regulate the midwifery profession, uses five different terms to refer to what could be interpreted as the same profession making the Bill very confusing. Why the legislator uses different terms to refer to the same profession is a question that needs to be asked. Are there any differences between these terms? If the answer is yes, then the Bill should provide definitions for each of these terms to facilitate the interpretation. In other words, the mentioned project makes reference in its different articles to: “the nurse-midwife”; “the midwife”; “the professional midwife”; the “licensed specialist midwife”; and the “licensed midwife”. Yet, the only term that is defined in the proposal is the “licensed midwife”. This type of inadvertence will confuse both judges, who might later be required to interpret this law, and regular citizens, who will be affected by it. These types of mistakes suggest that there could be more problematic issues of substantive. And there are. In the next section I will proceed to discuss some of the main substantive problems with the proposal.

3.2.2 Significant Dilemmas

(a) Failure to Protect Women’s Rights

By reading only the Bill’s title one is able to notice that its objective is to examine midwives and regulate the practice of midwifery. Even though the explanatory memorandum seems to indicate that this Bill acknowledges women’s rights and the importance and excellence of Puerto Rican midwives, I question whether its articles actually recognize these rights. Quite to the contrary, some of its provisions, like the imposition of malpractice insurance, which could be financially unrealistic, and the transitional provision, serve to threaten the practice of an already weakened profession.

142 Ibid, art 2(d).
143 Ibid. In its Article 2(d) it defines “el/la partero/a licenciado/a”. In its Article 2(g) it mentions “el partero/a” and “enfermeras parteras”; In its first Article 15 it mentions “el/la profesional de la partería”. In its Article 3 (c) mentions “la/el especialista en partería licenciada/o”.
For this reason, the Bill will have a direct effect on available birthing alternatives for women. In addition, some of its principal articles are too vague, while others involve serious substantive contradictions. Even though it could seem that regulating the profession would implicate an automatic concession of rights to women, a careful reading of the different articles of this proposal does not support this hypothesis.

The title of the project itself states that the Patient’s Bill of Rights and Responsibilities (Carta de Derechos y Responsabilidades del Paciente) will be amended to “guarantee in accordance with the right of freedom of choice, the option of primary services concerning the selection of healthcare plans and providers of medical/hospital services offered by a properly licensed midwifery professional.”

The Statement of Motives reads as follows:

This is necessary in order to guarantee by right of law the true option for a natural birth without interventions, assisted by a midwifery professional to every woman who desires and chooses this option.

Yet, the Article 16 that relates to the amendments this Bill makes to other laws that are already in place establishes the following:

(c) As amended, a new sub-point (f) is added to Article 6 of Law 194-2000, known as the Patient Bill of Rights and Responsibilities (Carta de Derechos y Responsabilidades del Paciente) and reads as follows:

Article 6.-Rights related to the selection of plans and health providers.

Concerning the selection of health plans, hospitals, services and providers; every patient, user, or consumer of such plans and services in Puerto Rico has the right to:

(a) ... ...

(e) Every public or private facility of medical or hospital health, will allow their patients to have access to health services, as a primary provider, of a midwifery professional properly licensed to practice the functions stipulated by law, after being evaluated by the committee of credentials of

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145 Bill 2873, supra note 6, Statement of Motives.
146 Ibid, [emphasis added].
such hospital.\footnote{Ibid, art 16 [emphasis added].}

The use of the verb phrase “will permit” in this sub-point (e) is problematic because the writing seems to indicate that this is not the woman’s right, and that the access to this service will be a prerogative of the public or private hospital or medical facility. Even though the proposal recognizes midwives’ autonomy and creates a regulatory committee comprised by midwives, if a midwife decides to work in a hospital setting, the credential committee of the hospital will subsequently have to evaluate these. The criteria that the credential committee of the hospital will use with regards to these health professionals is unknown. However, we do know what has happened in other states in this same situation. Lynee Loeffler, from the American College of Nurse Midwives, testified in a hearing in front of the Department of Justice and the Federal Trade Comission about practices that have occurred in some hospitals and strategies that some physicians have employed to restrain the practice of midwives. For example, she testified that several hospital boards of directors delegated the responsibility for establishing the credentials of midwives to the staff doctors. She argued that doctors have no reason to do so because midwives are their competition. I argue that the drafting of this sub-point (f) is a mistake if the true intention of this sub-point, as expressed in the explanatory memorandum, is to recognize the rights of women.

(b) Lack of Clarity About Standards for Certification

Article 6, which deals with the creation of the regulatory board, referred to as the Committee, establishes that the Committee will be in charge of certifications, issuances and revocation of licenses:

[T]o practice the profession of midwifery in Puerto Rico according to what is established in this \textit{Bill, its regulations and related laws}.\footnote{Ibid, art 6 [emphasis added].}

At the same time, the Article 13 that deals with the transitional provisions that would apply to midwives who are already practicing in Puerto Rico declares the following:
The persons that, at the date when this law comes into force, can prove that they have practiced the midwifery profession for more than two (2) years previous to the date of validity should apply for an evaluation of their credentials by the Committee created by this law. The Committee will determine if the applicant fulfills the equivalency requirements stipulated by this law or its regulations for the issuance of the license. This period will initiate when the regulations come into force and will end one year after.\textsuperscript{149}

It is troubling that the mentioned Article 13 allows the Committee to evaluate the equivalency requisites stipulated by this law or its regulations. This suggests that the requirements can be stipulated in the regulation, yet are not contained in the law. This is very troubling when one considers that the Committee will create this regulation. Therefore, until a regulation is conceived, no one will know what requirements will be imposed and whether midwives actually practicing the profession will be able to comply with them.

Likewise, Articles 6 and 13 of the legislative measure contradict each other. Article 6 states that the midwifery certification will be in accordance and compliance to what is established in “this Bill, its regulations and related laws.”\textsuperscript{150} On the other hand, Article 13 establishes the following:

\textit{[C]ommittee will determine if the midwife complies with the equivalency requisites stipulated by this bill or its regulations for the granting of the license.}\textsuperscript{151}

The second article numbered 14 provides that the interpretation of the law should be in accordance with the rights of midwives who are already practicing in Puerto Rico:

\textit{Nothing stated in this law can be interpreted in a way that would lessen or limit the rights of midwives who have served the women who have solicited their services; with excellence, humane and professional responsibility, and have educated themselves and transformed their profession into a vocation.}\textsuperscript{152}

\textsuperscript{149}\textit{Ibid}, art 13 [emphasis added].
\textsuperscript{150}\textit{Ibid}, art 6 [emphasis added].
\textsuperscript{151}\textit{Ibid}, art 13 [emphasis added].
\textsuperscript{152}\textit{Ibid}, art 14.
I would argue that this provision has no legal effect whatsoever, nor does it confer any rights at all to midwives. The drafting of this article is extremely poor and even though it makes reference to the rights of midwives, it remains unclear what these rights are. Nor is it clear what is meant by “humane responsibility”.

(c) Unitary Framework for All Midwives

The Bill is confusing because it licenses and regulates what have been previously considered to be two different professions: CNMs and midwives who do not have a background in nursing, such as DEMs. The proposed unified framework has been adopted in New York but deviates from the standard approach taken in the United States and could present some problems that need to be taken into consideration. The differences with respect to scope of practice between DEMs and CNMs are widely recognized. In addition, as was discussed earlier, each of these professions is certified by a different organization. In fact, an examination of the history and development of both professions in the United States is quite revealing. As previously discussed, the crucial difference between the organization that certifies the CNMs, which is the American College of Nurse Midwives (ACNM) and the organization that certifies the CPMs, which is the North American Registry of Midwives (NARM) credentialing unit associated with the Midwife Alliance of North America (MANA) is the route to credentialing, in other words, the training and education as a midwife. The effects of this proposed unified framework are not clear, therefore it would be necessary to study them before enacting such a framework.

(d) Malpractice Insurance

Article 14 of Bill 2873 imposes the “sine qua non” requirement of malpractice insurance upon midwives. Yet, taking into consideration that midwives have a significantly lower number of malpractice lawsuits than physicians, this imposition seems

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153 Reed & Roberts, supra note 14 at 134.
154 Ibid at 143.
155 Bill 2873, supra note 6 art 14.
unnecessary. There are various factors that contribute to this low number of lawsuits, including the following: midwives are known to have a cautious attitude towards medical technology; they only work with low-risk women; and they create a special personalized relationship with the women with whom they work. Furthermore, the fact that malpractice insurance has been widely discussed as problematic even for physicians should be taken into account. Finally, it has also been suggested that the requirement of malpractice insurance upon midwives could produce another negative effect by reducing the number of midwives and thus reducing job opportunities for women and also diminishing women’s birthing options.

If malpractice insurance is imposed upon midwives, the quality of their services and their model of care approach could suffer in order for them to be able to cover the high costs attributed to this insurance. This requirement could result in a scenario where midwives would need to attend more pregnant women to generate enough income in order to meet the burden of the malpractice insurance cost. This could produce a decrease in the number of midwives, since many would opt to stop providing these services rather than having to care for an overwhelmingly high number of pregnant women in order to meet the malpractice insurance costs. As a consequence, many women who are seeking home births would be left without this possibility. As a matter of fact, following this line of thought, Midwives Sisterhood of Puerto Rico (La Hermandad de Parteras de Puerto Rico) has voiced its concern about the requirement of malpractice

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157 Ibid at 1016.
159 Slessor, supra note 57 at 517.
160 Mamie Guidera et al, “Midwives and Liability: Results from the 2009 Nationwide Survey of Certified Nurse-Midwives and Certified Midwives in the United States” (July/August 2012) 57:4 Journal of Midwifery & Women’s Health 345. (“[b]irth centers, staffed almost exclusively by midwives, saw a 189% rise in the cost of their malpractice insurance premiums between 2006 and 2007, largely related to insurance company investment losses on the stock market. The rise in malpractice premiums, coupled with a plateau in health care insurance reimbursements, has contributed to the closure of birth centers and maternity services nationally.” at 346).
insurance by expressing its fear that their services could be affected as a result.\footnote{161}{“Parteras llevan sus reclamos a La Fortaleza” Primera Hora (27 January 2012), online: Primera Hora <http://www.primerahora.com/noticias/gobiernopolitica/nota/parterasllevansusreclamosalafortaleza-663565/>.}

Furthermore, it is relevant to bring into this discussion the fact that “[v]ery few states require physicians to carry insurance as a condition of licensing, although insurance is often a precondition to obtaining hospital privileges, or employment in a medical group practice”.\footnote{162}{Fisch, supra note 45 at 108.}

The requirement of malpractice insurance could be more understandable if midwives want to work at a hospital or for CNMs who are likely to work in a hospital setting. In these cases malpractice insurance is imperative as a requisite to obtaining hospital privileges. However; one can question whether it is necessary to require midwives to have malpractice insurance if they are not interested in obtaining hospital privileges. In this context, it may be necessary to differentiate between midwives based on their scope of practice and to create specific regulations for each. In the United States, few states with licensed CPMs require them to carry liability insurance.”\footnote{163}{Ibid.}

Yet, some states require uninsured providers to disclose that they are uninsured in order for women to be able to make an informed decision.\footnote{164}{Ibid at 109.} In Wisconsin, for example, CPMs can get licensed and become Licensed Midwives (LM’s) without the requirement of obtaining malpractice liability insurance.\footnote{165}{Ibid at 113.}

The fact that obstetricians serving as back-up doctors for midwives could have trouble finding malpractice insurance companies who will cover them does have to be taken into consideration. Fisch has suggested one solution to this problem: “State insurance regulators can play an important role in ensuring that insurance products offered within
the state do not discriminate based on arbitrary decisions that have nothing to do with statistical evidence.”  

Although currently there are no official statistics regarding the work done by Puerto Rican DEMs, a thesis has been produced that includes statistics and an analysis of midwives’ services by examining the level of satisfaction of the mothers attended by the midwives during pregnancy, birth and post-natal periods from 1980-1990. The information gathered in this thesis could provide congressmen an insight into the practice of midwifery in Puerto Rico, the positive perception of the quality of their services and the low risk of liability that these professionals confront. Any decision imposing malpractice insurance would be arbitrary and irresponsible if taken before analyzing this information and taking into account the statistical evidence that would justify it.

(e) Elimination of Traditional Midwives

It is important to recognize that an inevitable result of Bill 2873 would be the elimination of traditional midwives from Puerto Rico’s history. Although the last known traditional midwife on the Island, Rully Delgado, passed away in 2011, the definition of “licensed midwife” incorporated into this Bill implies that there is no way that Puerto Rico will have traditional midwives in the near future. This is because Article 2(d), which provides the definition of “licensed midwife” in this Bill, requires that midwives have some kind of academic education or training.

(f) Positive Provisions: Composition of the Board

One of the most positive aspects about Bill 2873 is the way in which it places oversight of the profession into the hands of midwives. With respect to the composition of the

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166 Reed & Roberts, supra note 14 at 146.
167 Díaz & Cabrera, supra note 61 at 95.
168 Alfonso A. Román Ortiz, Cristina Rehbein y Gisela Jung Seifert, eds, “Una Gran Partera”, Madre 6:12 (Spring 2011) 3. (Rully Delgado worked as a lay midwife since 1978 until 2011. In 1997, served as the co-founder of the Midwives Sisterhood of Puerto Rico (Hermandad de Parteras de Puerto Rico) and was the firs Vice-President, and held the first Honorary Chair) at 3.
169 Bill 2873, supra note 6, art 2(d).
board, only midwives are part of it, which is to say that physicians, nurses or other professionals are not part of it. It has been recognized that when midwives are part of their regulatory bodies there is a particular interest in the success of the profession and in the pursuit of high quality services.\footnote{Reilley, \textit{supra} note 50 at 1144.} The structure proposed by Bill 2873 would definitely respect midwives’ scopes of practices. Conversely, it has been shown that when midwifery regulatory boards are composed exclusively of physicians or when physicians are the majority, this institutional barrier has affected the midwifery profession.\footnote{Ibid.} This has been the case in the United States. In fact, commentators have emphasized that placing supervision of the profession in the hands of medical and nursing boards has weakened midwifery as a profession.\footnote{Rausch, \textit{supra} note 47 at 252.} Unfortunately, this is one of the recommendations made by the Hospital Association of Puerto Rico.\footnote{US, Hospital Association of Puerto Rico, \textit{Proyecto de la Cámara de Representantes 2873} (2012) at 5 online: Oficina de Servicios Legislativos de Puerto Rico <http://www.oslpr.org/2009-2012/ponencias/A2SRRVTR.pdf> [Hospital Association of Puerto Rico].} It is not necessary that regulatory boards be comprised only of midwives. However, the experience from other jurisdictions shows that midwives should, at least, comprise a substantial proportion of the members of these boards.

\section*{3.2.3 Conclusions re Bill 2873}

Even though Bill 2873 was written to regulate the midwifery profession, the flaws that have been discussed reveal that it contravenes the principles enshrined in its own explanatory statement. At first glance, the Bill seems to be a step forward. Certainly, there is an urgent need to examine the actual birth conditions and options in Puerto Rico’s hospitals and to listen to women and their experiences. I have the conviction that Puerto Rican women deserve to have birth alternatives different from those offered by obstetricians in local hospitals. The actual maternity system in Puerto Rico has been the target of many criticisms. However, I have no doubt that the proposed Bill does not further such causes. Although the provisions with respect to the composition of the board
are positive, for the most part the proposed Bill does not recognize the rights of either women or midwives. However, there is also no doubt that a good law could serve to legitimize the profession of midwifery and recognize rights to women and also to midwives.

3.3 Rhetorical analysis of the submissions presented by doctors, hospitals’ associations and insurers’ associations regarding Bill 2873

When Bill 2873 was proposed there were 11 submissions presented by various stakeholders. In this next section I will examine the submissions of two stakeholders who were against the approval of this Bill, the Hospital Association of Puerto Rico and the Association of Medical Insurers. As well, I will discuss a letter published by the president of the College of Surgeons of Puerto Rico (Colegio de Médicos Cirujanos de Puerto Rico), Doctor Eduardo Ibarra. I will argue that these submissions, which are very disapproving and critical of the profession of midwifery lack analysis, do not present any evidence or statistics to support the statements being made, and fail drastically in presenting a critical and exhaustive report of the issues. However, they do illustrate the very powerful stakeholders who are opposed to the legal recognition that would come from regulation of midwifery and who would continue to resist an expanded role for midwives even if legislation regulating the profession was adopted.

3.3.1 Hospital Association of Puerto Rico

The Hospital Association of Puerto Rico, an organization that represents the majority of public and private hospitals in the Island, with a total of 63 hospitals, presented a submission stating that it does not endorse Bill 2873. This submission contains

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175 Hospital Association of Puerto Rico, supra note 173 at 1.
numerous problematic premises and grounds. It seems that the principal reason why the Hospital Association opposed the Bill is because it (the Bill) represents an increase in the daily risk hospitals take on as a consequence of the different situations that could occur in the birthing rooms at hospitals.\(^{176}\) However, they do not mention any statistics to support this premise. Their primary interest is not women, their rights or their alternatives, but other economic priorities. As well, they state that professionals who attend birth at hospitals in Puerto Rico are “capable experimented professionals”. What does this mean? CPMs, DEMs and CNMs in Puerto Rico are capable and experimented professionals. There is statistical evidence showing the high levels of satisfaction expressed by women who have received their services from CPMs and DEMs.\(^{177}\) Furthermore, one of the most problematic aspects of the Hospital Association’s submission is that it reveals that their foundation sees midwives as practicing medicine with lower standards than doctors. Not only is this statement completely inaccurate, but also it is imperative to clarify that midwifery is not equivalent to the practice of medicine.\(^{178}\) The midwifery model offers an alternative to the medical model of childbirth.\(^{179}\) Therefore, it is erroneous to impose on midwives the standards and educational requirements that pertain to the medical profession.

Reinforcing the bio-medical model of birth, the Hospital Association also indicated that even when physicians manage situations adequately, they do not receive the expected results.\(^{180}\) There is much literature that discusses why the outcomes of the maternity system are not that efficient in the United States. Morbidity, mortality and rates of caesarean sections in the United States are among the highest of all industrialized countries in the world.\(^{181}\) In fact, in jurisdictions where midwifery services have been

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\(^{176}\) Ibid at 3.

\(^{177}\) Díaz & Cabrera, supra note 61 at 197.

\(^{178}\) Hope, supra note 16 at 315.

\(^{179}\) Kleinhaus, supra note 2 at 34.

\(^{180}\) Hospital Association of Puerto Rico, supra note 173 at 3.

\(^{181}\) Hope, supra note 16 at 337-345.
included either in outside of the hospital setting, the number of interventions tends to be much lower.\footnote{182}

The care options available to pregnant women in the USA are more limited than in many other industrialized countries with better maternal and infant health outcomes. In many countries midwives or family practitioners are the usual maternal care providers for low-risk pregnancies, and specialist doctors – obstetricians – are asked to step in only in high-risk cases and in cases where complications develop unexpectedly. In contrast, in the USA, although 83 percent of women have low-risk pregnancies, the vast majority receives care from obstetricians and only 8 percent are attended in childbirth by a midwife. One of the factors contributing to the limited nature of the options available is the failure to include community members and advocacy groups in the decision-making process regarding what constitutes appropriate, quality maternal care. An individual woman’s ability to actively participate in her care is hampered by a lack of information about care options and the failure to involve women in decision-making regarding their own health care.\footnote{183}

The Hospital Association of Puerto Rico also alleged that letting midwives work in a hospital increases the risk of claims to the hospital due to their lack of formal education.\footnote{184} First, the emphasis on formal education has to be questioned because its starting point is that a person who lacks formal training is not capable of providing a reliable and efficient service to the community. Yet trained physicians and obstetricians are failing over and over to decrease the number of cesarean sections and numbers of mortality and morbidity cases in the United States. Moreover, although presently there are no traditional midwives in Puerto Rico, in various American states, Mexico and many countries of South and Central America; lay or traditional midwives are gaining increased respect and popularity because of their knowledge and outcomes.

The Hospital Association of Puerto Rico’s point of departure has to be questioned because it suggests that midwifery is the practice of medicine, and therefore since midwives do not have the same academic formation as doctors, the quality of their services is poor and not equivalent to the standards of medicine. Once again, this

\footnote{182} Hope, \textit{supra} note 16 at 324
\footnote{183} Amnesty International, \textit{supra} note 8 at 80.
\footnote{184} Hospital Association of Puerto Rico, \textit{supra} note 173 at 3.
premise is faulty. Even though midwifery has been regarded by many courts in the United States as the practice of medicine, other states have ruled differently.

In any case, we have to question the knowledge this Association has regarding the actual training and education of midwives in the United States and Puerto Rico. The different routes to becoming a midwife have already been discussed in this thesis and should be thoughtfully discussed in the legislature before it approves any law to regulate the profession.

Moreover, this Association thinks that letting a midwife work in a hospital increases the risk of claims against the hospital. This should be examined since it is a very powerful statement and, as far as their submission paper goes, no statistics are presented to support this conclusion.

It is revealing when the Hospital Association of Puerto Rico mentions that they are worried women would not receive adequate treatment because the quality of midwives’ services are below the standards of the medical profession. This statement is shocking because it shows the shared confusion that many stakeholders and people have. A certain academic formation does not necessarily guarantee quality services. As well, the fact that midwives do not use the latest technology, as doctors do, do not necessarily makes them less competent. And again, midwifery is not the practice of medical profession. Therefore, medical standards cannot be imposed upon midwives. Both professions have different scopes of practice, thus different standards and diverse philosophies regarding the process of childbirth.

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185 Ibid.


187 Hope, supra note 16 at 315.

188 Slessor, supra note 57 at 516.
intervention in order to be successful.\(^{189}\) Midwives, as explained earlier, have a different perspective on childbirth.

The Hospital Association also argued that in the United States midwives practice primarily in rural areas and because Puerto Rico does not have the same geographic characteristics we should not let midwives attend births. The argument is that we have highly capable professionals available to attend births.\(^{190}\) The Association is correct in stating the practice of midwifery has historically been focused in the rural areas of the United States. But the remainder of their analysis reveals their lack of knowledge regarding the actual status of midwifery in the United States. The Association concludes that women select this type of birth setting because of their rural location, ignoring that it is more than that—that women are exercising autonomy in choosing the birth setting that they prefer.

The Hospital Association of Puerto Rico went further by declaring that midwives would put the health and the life of mothers and newborns in danger.\(^{191}\) Again, this flat rejection of midwifery was not supported by evidence, statistics or science. In fact, in many cases, it is exactly because women understand the risks and the implications for their safety and their babies that they choose to give birth outside of a hospital setting or with a midwife rather than with an obstetrician. Sheila Kitzinger, a renowned writer and anthropologist, writes about pregnancy and birth from a humanist perspective, discussing the many reasons for why low risk women should not go to a hospital to give birth.\(^{192}\) To support this point, Kitzinger mentions the following reasons: induction, active direction, electronic monitoring of the fetus, intermittent vigilance, analgesics, epidurals, acceleration of the expulsive period and episiotomies.\(^{193}\)

\(^{189}\) Ibid.

\(^{190}\) Hospital Association of Puerto Rico, supra note 173 at 4.

\(^{191}\) Ibid at 3.

\(^{192}\) Sheila Kitzinger, Nacer en Casa. (Barcelona: RBA Libros 2002) at 12-39.

\(^{193}\) Ibid, at 22-34.
Additionally, the Hospital Association of Puerto Rico argued that midwives do not meet the quality and educational standards that hospitals require in order to accept health professionals, and that they are not willing to adjust their standards to accommodate midwives because midwifery standards are below the norms that hospitals require.\textsuperscript{194} I would like to suggest exactly the opposite: those who are not willing to change certain bio-medical paradigms that they support in order to provide better outcomes regarding the maternity health system, are precisely hospitals, physicians and courts.

The most problematic aspect of the Association’s submission is their argument that if the legislature ends up approving Bill 2873 then the Physicians Examiners Board should regulate the midwifery profession. The reason given is this measure would entail less bureaucracy. The suspected reason, however, is that it will allow physicians to assume control over the midwifery profession. As was discussed earlier, historically boards comprised of physicians have served as institutional barriers. Article 7 of Bill 2873 establishes and describes the composition of midwives’ regulatory board.\textsuperscript{195} As discussed earlier, the arrangement of the board proposed by this Bill reflects what I understand, is a “friendly” approach in the regulation of midwifery; for it is composed only of midwives.

A positive aspect of the Hospital Association of Puerto Rico’s submission is that it mentions that this issue deserves a serious, complete and comprehensive discussion regarding the different aspects of midwifery regulations.\textsuperscript{196} Thus, it solicits the legislature to undergo research with respect to midwifery services in the United States.

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\item \footnotesize Hospital Association of Puerto Rico, supra note 173 at 5.\textsuperscript{194} \item \footnotesize Bill 2873, supra note 6 art 7.\textsuperscript{195} \item \footnotesize Hospital Association of Puerto Rico, supra note 173 at 4.\textsuperscript{196}
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Likewise, the Puerto Rico Insurers Association Inc. presented a submission disapproving of the Bill.\(^{197}\) Even though the Puerto Rico Insurers Association Inc. acknowledged that the World Health Organization and the ACNM both recognize (in the first case) and certify (in the second case) midwives, it expressed disapproval of the recognition of midwives as an autonomous and independent profession.\(^{198}\) Furthermore, this Association recommended that the legislators consult different medical professions (obstetricians, pediatricians and specialists in neonatology) as well as other medical organizations and medical scholars. The reasoning behind this recommendation appears to be that these groups and individuals with expertise in the field should be the ones who define midwives’ scope of practice.\(^{199}\)

Anyone who knows a little bit about the history of midwifery would argue that these mechanisms have only served to reduce the independence of midwives and to place them under the authority of physicians.\(^{200}\) These types of approaches have marked the history of midwifery in the United States with the effect of diminishing it, and in some cases eradicating it completely. Secondly, organizations like NARM and ACNM are the main bodies in the United States in charge of defining the scopes of midwives. As well, “[t]he core competencies for any health care profession are not generally established through a legislative process. Competencies are developed and continually evaluated by the experts in the profession itself, not by licensing bodies.”\(^{201}\) Asking obstetricians, pediatricians,


\(^{198}\) Ibid at 2.

\(^{199}\) Ibid at 3-4.

\(^{200}\) DeVries, *Making Midwives Legal*, supra note 4 at 46.

\(^{201}\) “NARM Position Statement”, supra note 49 at 4.
neonatology specialists as well as other medical organizations to define midwives’ scope of practice is absurd, especially in Puerto Rico, where midwives have encountered blatant opposition from physicians. Legislators cannot expect anything different from physicians than a narrower definition of midwives’ scope of practice than that provided by the above mentioned organizations. In this sense, not only would midwives’ profession suffer, but also the alternatives provided to women. Consequently, if my initial argument is that a “friendly” law is needed in order to promote midwives’ autonomy and therefore women’s autonomy, then this mechanism represents a barrier due to the fact that it limits the independence midwives need.

Allowing physicians to define midwives’ scope of practice would make this Bill a “hostile licensure” as considered by DeVries (1996).\(^\text{202}\) He explains that mechanisms like the one proposed by the Puerto Rico Insurers Association Inc. has been used as a strategy of dominance in licensure attempts in Arizona, California and Texas.\(^\text{203}\) As well, “[o]ther laws create a dependence on physicians for such things as education or certification of physical and mental health. These allow disapproving physicians to prevent midwifery practice by withholding cooperation.”\(^\text{204}\) Conversely, “[w]hereas midwives are required under certain circumstances to consult with and/or transfer care to physicians there is no such a requirement for physicians to consult with and/or transfer care to midwives.”\(^\text{205}\) There are other examples of the outcomes of these types of mechanisms suggested by physicians. Until recently, the New York Professional Midwifery Practice Act, included a provision that required midwives to have an agreement signed by a physician.\(^\text{206}\) This provision was removed in 2010 precisely

\(\text{\(^{202}\) DeVries, Midwives, Medicine & the Law, supra note 5.}\)
\(\text{\(^{203}\) DeVries, Making Midwives Legal, supra note 4 at 83.}\)
\(\text{\(^{204}\) Ibid.}\)
\(\text{\(^{205}\) Ibid at 84.}\)
\(\text{\(^{206}\) Stephanie Paterson, “Feminizing Obstetrics or Medicalizing Midwifery? The Discursive Constitution of Midwifery in Ontario, Canada” (July 2010) 4:2 Critical Policy Studies 127 at 139.}\)
\(\text{\(^{207}\) Laura Andre, “New York Midwives Celebrate the Passage of Bill” (Nov/December 2010) 163 Mothering 32,}\)
because it was working as a barrier against midwives. Although scholars have celebrated Washington State as a *progressive*\(^{208}\) leader in midwifery regulation, other scholars like DeVries (1996) have stated that Washington, as well as New York, had legislation that operated against the interests of the midwives.\(^{209}\) Even in cases where states permit lay midwives and CNMs to work, there are institutional barriers that suppress their practice.\(^{210}\) In Washington State, for example, even though there was a law that regulated the midwifery profession, the medical community was unwilling to fully incorporate them into the system.\(^{211}\)

From this Raymond Devries concludes that there is a need for a more credible and uniform licensing legislation.\(^{212}\) In my opinion, however, this situation reveals a broader issue that is not necessarily a legislative matter, although it is closely related. The underlying issue here is that the fact that the legislature creates a law that would regulate the profession, even if this law is progressive, does not mean that the system and the scenario are ready for it. By this, I mean that a type of collaborative relationship is crucial to the success and establishment of the midwifery profession. I have many concerns in this regard. First, it seems to me that what is happening is that a law will regulate the profession although there are many powerful stakeholders against it. Puerto Rico is not ready for this type of law. There is too little information about midwives available with regards to their services, the benefits and their scope of practice. Moreover, there is a lot of tension between midwives and physicians, insurance companies and hospitals. Currently, it is difficult to visualize midwives working in a hospital setting or even working in a home birth setting with the collaboration of physicians. I suspect that even if a similar Bill were approved and signed, Puerto Rico could succumb to the same fate as Washington State.

\(^{208}\) Stover, *supra* note 23 at 331.

\(^{209}\) DeVries, *Making Midwives Legal*, *supra* note 4 at 171.

\(^{210}\) Reiley, *supra* note 50 at 1126.

\(^{211}\) DeVries, *Making Midwives Legal*, *supra* note 4 at 173.

\(^{212}\) *Ibid*. 
3.3.3 Published Letter from the President of the College of Surgeons of Puerto Rico (Colegio de Médicos Cirujanos de Puerto Rico), Doctor Eduardo Ibarra

The president of the College of Surgeons of Puerto Rico, Doctor Eduardo Ibarra, also expressed his opposition to Bill 2873 mainly because, according to him, midwives (as compared to obstetricians) do not possess vast knowledge, a medical background or academic experience.\(^{213}\) Once again, medical academic experience and medical knowledge are being expected from midwives. However, Dr. Ibarra’s rhetoric appears to be different from that employed by the Hospital Association of Puerto Rico. The Association was mainly concerned with claims that could hold hospitals responsible because of midwives’ lack of academic training. On the other hand, Dr. Ibarra constructed his argument around women’s health and lives. He claimed that this Bill could put women’s and babies’ lives and health at risk without providing any statistics or evidence to support his argument. Ironically, states that have already regulated the midwifery profession have done it precisely due to the fact that it is a measure to protect public health.

In his letter, Dr. Ibarra favors scientific knowledge and rules out midwifery as a profession of the last century. Reflecting this line of thought, DeVries (1997) describes the tension that exists between the natural and non-interventionist traditional approach employed by midwives and the technology used by obstetricians. He asks: “Can midwifery, with its low-technology, non-interventive tradition, find a place in an environment where competence is equated with the use of the latest, high-technology devices?”\(^{214}\)

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\(^{214}\) DeVries & Barroso, “Midwives Among the Machines”, supra note 186.
In the context of this discussion, and because Dr. Ibarra represents one of the most important stakeholders against the approval of this Bill, we reproduce part of his statement:

Our voice and advice were left unheard and a project, which could potentially put in risk the lives and health of many Puerto Rican women and their soon to be born children, was approved.

There is no doubt that these women hold an incalculable value for assisting and helping millions of our mothers, grandmothers, great-grandmothers, and other countless women throughout history during the process of pregnancy and child labor. However, in spite of their help, dedication and sacrifice, the description of terrible deaths and suffering that some women underwent before our day and age as an unavoidable consequence of their biological function in the reproduction of our species, have reached great depths. This said, it would be irrational to incorporate these practices into our present communication. Nowadays, and thanks to scientific advances, these deaths are almost entirely preventable and avoidable.

The role of midwifery in our present world should represent a valuable contribution when applied to our mothers in the understanding that humanity, with regards to pregnancy and child labor, has accumulated. However, it should not replace or substitute the security, encouragement, and scientific knowledge now available for the care and wellbeing of both mothers and their newborns…\textsuperscript{215}

Ibarra, like as other physicians in Puerto Rico and in the United States, strategically appeals to the public interest in order to advance professional concerns. This has been seen in the rhetoric of many groups in other countries, specifically physicians from different states across the United States as well as from Canada. The Canadian example given by Philippa Spoel and Susan James (2006) is the role played by the Ontario Medical Association (OMA) during the process that led to enactment of the Midwifery Act in the province of Ontario in 1980s.\textsuperscript{216} Although the OMA acknowledged that the

\textsuperscript{215} Ibarra Asks Fortuño not to Sign the Bill that Regulates Midwifery, supra note 213.

\textsuperscript{216} Philippa Spoel & Susan James, “Negotiating the Public and Professional Interests: A Rhetorical Analysis of the Debate Concerning the Regulation of Midwifery in Ontario, Canada” (2006) 27 J. Med Humanit 167 at 176
maternity system in Canada was not meeting the needs of women, throughout their discourse they favored the current players, the physicians over the midwives.\textsuperscript{217}

3.3.4 General Reflections

It is important to involve the Hospital Association of Puerto Rico, the Puerto Rico Insurers Association Inc. and Dr. Eduardo Ibarra in this discussion due to the fact that they, as well as others, are key stakeholders in this dialogue. However, it is clear that the interests defended by hospitals, insurance companies and physicians are very different from the ones defended by women, women’s organizations, midwives and midwifery advocates. In fact, it is quite revealing that women in general did not have the opportunity to participate in the discussion of Bill 2873. Pregnant women, the principal subject affected by these provisions, ought to be consulted and their voices need to be heard. In a discussion of reproductive rights as an important element of human rights, the following has been said about the participation of key stakeholders:

\begin{quote}
The voices of key stakeholders must contribute to all stages of decision making, from development and implementation of policies and programs to monitoring and evaluation. Participation of key stakeholders—particularly marginalized populations who face significant barriers to accessing reproductive health services—ensures that the needs and priorities of those who are most affected by reproductive health policies inform the delivery of such services.\textsuperscript{218}
\end{quote}

The regulation of midwifery in any state or country requires not only submissions that are thoughtful and carefully written, but also public hearings in which all sectors can participate to ensure that the Bill would be discussed thoroughly. In this context, while doing my research, I was impressed to learn about the process to regulate midwifery in Ontario, Canada. The process took years and involved laborious lobbying and countless consultations and reports.\textsuperscript{219} The Task Force on the Implementation of Midwifery in

\textsuperscript{217} Ibid.

Ontario was created for the purpose of making recommendations to the Minister of Health.\textsuperscript{220} This Task Force consulted numerous organizations and received submissions from more than 500 women’s groups, consumer organizations and individuals.\textsuperscript{221} They also traveled to Europe and the United States to visit midwifery schools and regulatory bodies.\textsuperscript{222} During this process they chose to visit places where midwifery was autonomous, as well as places where midwives had difficulty “functioning to their full potential”.\textsuperscript{223} They were guided by what had and had not worked in other countries.\textsuperscript{224} In the end, they incorporated midwives’ services into the health system in the province, a model that has already been praised. It would be desirable that some of these described steps that were taken in Ontario in order to implement midwifery in a health system be considered in Puerto Rico before enacting a law to regulate the profession.

\textsuperscript{221} Ibid.
\textsuperscript{222} Ibid.
\textsuperscript{223} Ibid.
\textsuperscript{224} Ibid.
Chapter 4

4. Recommendations on how Puerto Rico can Enact a Sensible Scheme of Midwifery Regulation

After reading many books about midwifery and dozens of legal articles about the experience of midwifery regulation in different states of the United States, I realized that there are certain widely recognized on common denominators with respect to how a jurisdiction, in this case Puerto Rico, can implement a scheme of midwifery regulation that would promote the profession and respect women’s rights. Here I present a non-exhaustive set of recommendations.

(a) Broader Consultation

First, because CNMs were the ones who drafted the proposed bill I would encourage the legislature to give DEMs a say in how the profession should be regulated. Different women’s organizations and women in general should also be asked for submissions and there should be an open process of public hearings held about this issue. Furthermore, the legislature should create a task force to carry out research about the maternity health care system in Puerto Rico. This could be done with the help of the Department of Health and different schools of public health in Puerto Rico. As well, it would be very helpful to know women’s perceptions of the maternity health care system in Puerto Rico. The information gathered could shed some light on aspects that should be improved. As well, lawmakers should not ignore the research and statistics that validates the safety and importance of the midwifery model. In fact, it is pivotal to “continue to conduct scientifically rigorous studies, educate about the findings, and enact legislation that reflects the acceptance of alternatives” in order to change the inaccurate social understandings about midwifery and the safety of childbirth at home.

225 Storck, supra note 7.
226 Hope, supra note 16 at 364.
227 Hafner-Eaton & Pearce, supra note 41 at 831.
(b) Clearer Drafting

The writing of the Bill should be revised so its interpretation could be clearer for judges in future litigation. The elimination of long sentences, consistent use of terminology and the avoiding of vague provisions are required in order to have a good piece of law.

(c) Composition of the Regulatory Board

In terms of the provisions included in Bill 2873, the legislature should keep Article 7, which establishes a regulatory board composed only of midwives. By doing this, legislators would make sure that midwives’ voices are heard. They would also be ensuring that “the profession remains tailored to the ‘naturalistic, noninterventionalist’ principles upon which it is based.” Likewise, I would encourage midwifery advocates to keep supporting and defending this provision in its original form.

(d) Malpractice Insurance

The legislature of Puerto Rico should study alternatives to the requirement of malpractice insurance. As noted, in Puerto Rico, malpractice insurance is a requirement for health professionals. However, the midwifery profession is already weak in Puerto Rico and the economic burden that malpractice insurance would impose on midwives could have counterproductive effects because it could reduce the already low number of practicing CNMs and DEMs. If elimination of this requirement is non-negotiable, I would advise the legislature to examine this issue closely to ensure that affordable and cost effective malpractice insurance premiums are made available to midwives.

(e) Unified Framework for All Midwives

The possible effects of regulating CNMs and DEMs under the same law should be seriously studied. As has been discussed, this type of unified framework is an exception rather than the norm and it would be very helpful to understand the possible effects of

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228 Bill 2873, supra note 6 art 7.
229 Rausch, supra note 47 at 253.
using this type of framework to regulate midwifery in Puerto Rico. It is important make representatives and senators aware that although both CNMs and DEMs are midwives, they have different academic formations and scopes of practice and have therefore been considered as different professions. It is also important that they understand that in order to respect women’s autonomy and rights, different birth providers and birth settings should be available. This variety also helps to strengthen midwifery in general.

(f) Other Strategies

In terms of the maternity health care system in Puerto Rico, there are also other strategies suggested by some experts in the field that could be considered in order to improve this system. Marsden Wagner, a recognized physician and former Director of the Women’s and Children Health at the World Health Organization (WHO), mentions some of these strategies.\textsuperscript{230} These vary from “educating the public, revising education for maternity care providers, regulation by litigation, taking political action for humanized birth, strengthening the monitoring and regulation of obstetrics practices; and forming coalitions among others”.\textsuperscript{231}

\textsuperscript{230} Wagner, supra note 21 at.219-249.

\textsuperscript{231} Ibid.
Conclusion

Puerto Rico’s actual legal framework impedes women who are exploring, studying and considering different childbirth alternatives from the mainstream setting offered by obstetricians at hospitals to select such alternatives. Since midwives are not considered as health professionals by the state, health insurance companies do not cover their services. Therefore, women who might be interested in using their services are forced to pay with money out of their own pockets. As a result, there is a restriction on women’s autonomy about how to proceed with birth.

At the moment of the writing of this thesis, Bill 309 is being analyzed and studied by the Senate’s Health Commission. Therefore, by the time the Bill goes to the Senate floor it could undergo some changes that for obvious reasons have not been evaluated in this thesis. However, Bill 309, as originally presented, suffers from the same problematic provisions of Bill 2873 because, as noted, both Bills are identical.

Although the recent attempts suggest that midwifery regulation in Puerto Rico will be a reality in a matter of months, as this thesis has shown, some provisions, are problematic and could do more harm than good. If Bill 309 is approved, there could be a setback in terms of the availability of midwives and therefore of women’s and midwives’ autonomy, despite the fact that some of the Bill’s provisions are certainly positive. If Bill 309 is approved by the legislature as written and is signed by the Governor, in my opinion it should be either abrogated or amended, through legislative lobbying, so that its provisions are in accordance with the aspirations set out in its explanatory memorandum.

Puerto Rico needs a real cultural change in the way its women, people and institutions view childbirth and midwifery. Law by itself is not going to create the social change that is necessary, although this step could certainly be a point of departure.
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