HRTO FILE 2013-16149-I

HUMAN RIGHTS TRIBUNAL OF ONTARIO

ASSOCIATION OF ONTARIO MIDWIVES

Applicants

v.

HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO AS REPRESENTED BY THE MINISTER OF HEALTH AND LONG-TERM CARE

Respondent

AFFIDAVIT OF CAROL CAMERON

I, Carol Cameron, of the City of Pickering in the Province of Ontario, MAKE OATH AND AFFIRM as follows:

1. I am a registered midwife in the Province of Ontario. I have been engaged in the clinical practice of midwifery for 28 years including as Clinical Manager of the Childbirth Centre in Markham Stouffville Hospital. I was also President of the AOM from May, 1996 until December 1997 and founding President of the Canadian Association of Midwives. I am also a complainant in this proceeding.

2. My background, knowledge and experience which support the statements in this Affidavit are set out in my Curriculum Vitae[1] and summarized in Part 1 below. This affidavit constitutes the main section of my examination in chief in this proceeding.

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I. BACKGROUND

1. Education and Apprenticeship

3. I completed a Midwifery Apprenticeship in 1989 in Ontario under midwife Peggy Cannon, now retired. The apprenticeship was as outlined at that time by the Association of Ontario Midwives and a direct entry Midwifery program in 1988 in Texas at Maternidad Zaragosa.

4. In 1993, I graduated from the Michener Institute of Applied Health Sciences Pre-Registration Program for midwives.

5. I also earned a Master's degree with Merit from Thames Valley University in 2005 on Midwifery. My thesis entitled "Why Do Midwives Leave ? the Experience of Becoming, Being and Loss of Self Among Recent Midwifery Graduates" addressed the issues of recruitment and retention of midwives in Ontario.

2. Practicing Midwife

6. After completing my apprenticeships, I starting practising midwifery in 1989 with Peggy Cannon.

7. On regulation, in 1994, I was one of 3 midwives who established Midwifery Services of Durham (MSD). I am a senior partner at MSD and our satellite site, Markham Stouffville Midwives. We have privileges at Markham Stouffville Hospital.

8. As the senior partner in a practice of 12 midwives I am responsible for managing the operations of a large midwifery practice group including administrative support staff, budgeting, policy and procedures, real estate holdings, strategic direction and leadership to the midwives.

9. I was the first midwife in Ontario to lead a birth unit, namely as Clinical Manager of the Childbirth Centre at Markham Stouffville Hospital from 2011-2014 (discussed further below).

10. At our hospital, we have a robust Division of Midwifery and good working relationship with the other parts of the Obstetrics and Gynaecology department. Midwives at Markham Stouffville Hospital work to their full scope of practice including managing oxytocin and monitoring epidurals.

11. I was the Head Midwife in the Division of Midwifery at our Hospital from 2006 to September of 2011. As the Division Head, I represented midwifery within the Obstetrics and Gynaecology department and other departments and disciplines within the Hospital. This involved developing unity protocol and policy, ensuring quality of care and evidence based maternity care practices and participating in various forward-looking task forces. I was also a co-investigator in current department midwifery research initiatives.

3. Academic and Clinical Teaching

12. I am currently an Assistant Clinical Professor, in the Department of Family Medicine, Midwifery at McMaster University and am a Tutor for Preparation of Advanced Practice and Clerkship courses.

13. I have also been a Clinical Preceptor in the Midwifery Education Program since 1994. As well, I was a Lead Instructor in the International Midwifery Education Pre-Registration Program.

14. As a former MOREob Trainer for Salus Global, I facilitated and trained hospital based maternal care teams in the MoreOB program – which is an interdisciplinary education program including doctors, midwives and nurses.

15. I also teach the AOM Emergency Skills Workshop.

4. AOM/CAM Roles

16. I was President of the AOM from May, 1996 until December 1997 during which time the AOM was preparing for the devolution process. I was also a Board member of the AOM prior to regulation and member of the AOM Funding Group at the time of the Joint Funding Work Group meetings and the development of September 1993 Ontario Midwifery Program Framework. As well, I was a member of the Program Quality Committee appointed pursuant to that Framework.

17. I was also the Founding President of the Canadian Association of Midwives for the period 2001 – 2003**.** As founding President I helped to establish the first board and bylaws as well as the first national conference and relationships with stakeholders. including physician organizations nationally. I established an active Society of Obstetricians and Gynaecologists relationship including membership for a midwife on the SOGC national council and formal relationship with SOGC.

5. Inter Professional Collaboration and Midwifery Integration

18. I have had a career long focus on professional integration. I was a founder of the interdisciplinary hospital integration committee at the Markham Stouffville Hospital two years before midwifery was regulated in Ontario. I was also a member of the Ontario Hospital Association Bylaws Working Group in the period 1993-1994 which established model bylaws for Hospitals to adopt in integrating midwives.

19. From 2011 to 2014, I was the clinical manager of the Markham Stouffville Hospital Childbirth Centre. This Childbirth Centre handles the births of all babies in the hospital regardless of the obstetrical provider. That is, midwives, obstetricians and family physicians all provide obstetrical care in this Centre and I am the clinical manager for that care.

20. In the Centre, my responsibilities include overseeing the day-to-day operations in order to facilitate and promote the best possible professional service to the users and employees of the center, organization and community. As the clinical manager, I also provided staff education, led policy initiatives, and was responsible for financial and human resource management and practice enhancement.

21. As a member of the Society of Obstetricians and Gynaecologists of Canada I have been very involved in inter professional education in maternity care.

22. As a SOGC ALARM instructor, I participated in creation of the ALARM syllabus and program as well as program delivery. ALARM teaches obstetrical emergency skills to both learners and practitioners. Learners include Family Practice and Obstetrician residents and midwifery students. Practitioners included Obstetricians, Family Physicians, Nurses and Midwives.

23. As an ALARM International Committee member, I was involved in writing course material and designing the ALARM program for developing countries and delivering it in Uganda.

6. Maternal and Newborn Health and Primary Care Reform

24. I have been actively involved in the initiatives to advance the quality of maternity care in Canada. This has included the following:

    (a) Member of the Working Group on The Future of Maternity Care in Canada

    (b) I was appointed by the MOH in March of 1995 as a member of the Provincial Coordinating Committee on Community and Academic Health Science Centre Relations, (PCCCAR) Subcommittee on Primary Care. I worked on preparing the AOM's submission to this Subcommittee which addressed the issues of midwifery's contributions to primary health care reform.[2] In this brief I advocated for the PCCCAR Sub-Committee to add primary reproductive care to the list of core services which must be delivered by a primary health care agency funded by the MOH. I also requested that the PCCCAR Sub-Committee recommend that the devolution to locally administered funding for midwifery practice groups demonstrate consistency with the work of the PCCCAR Sub-Committee on Primary Health. I felt that this request would be assist in ensuring that autonomous MPGs were fully integrated into the primary health care system.

2 Brief to PCCCAR Sub-Committee on Primary Health Care in Ontario (1996/03/01) AOM0010571.

7. Research on Midwifery Attrition

25. In 2011 I wrote an article drawing on my Master's research titled "Becoming and Being a Midwife: A Theoretical Analysis of Why Midwives Leave the Profession."[3] This study aimed to develop an understanding of the reasons why graduate midwives leave the profession, using a grounded theory study. My research focused on individual experiences rather than broader trends, although I did note that of the 518 midwives registered in Ontario between 1994 and 2008, 108 had left the profession (an attrition rate of 21%). The midwives I interviewed identified a range of complex reasons behind their decision to leave the profession including: lack of interprofessional respect from hospital staff, physical and emotional strain and difficulty balancing professional and personal lives.

II. 1992-1994: INVOLVEMENT IN REGULATION AND COMPENSATION SETTING PROCESS

26. I was involved in the process of establishing and developing the midwifery compensation and funding system in Ontario as an active member of the AOM's Funding Committee. As a result, I was involved in supporting the AOM members of the Joint Funding Work Group created in April, 1993 and the investigations and discussions leading up to the MOHLTC September, 1993 Ontario Midwifery Program Framework.[4]

27. The MOH established the Joint Funding Work Group in April of 1993. Its purpose was to work on creating a framework for the funding of midwifery services. The AOM worked diligently to prepare for the meetings of the Work Group throughout the summer and drew from its extensive knowledge base and experience.

28. During this time, I understood that the Joint Funding Work Group was conducting a pay equity exercise using the comparators of the CHC Physician and the senior primary care nurse, sometimes known as a nurse practitioner. After the Ministry announced the Ontario Midwifery Program Framework which had been reached by consensus with the AOM, the AOM moved to have it ratified by its members.

29. On October 23, 1993, the AOM Funding Committee sent a voting package to all members updating them on the negotiations with the MOH regarding the funding of midwifery services and asking members to vote on the ratification of the Ontario Midwifery Program Framework. This package referred to the fact that there had been a pay equity exercise conducted by the Joint Funding Work

3 Becoming and Being a Midwife: A Theoretical Analysis of Why Midwives Leave the Profession (2011) AOM0017383.

4 Ontario Midwifery Funding Framework (developed by the Midwifery Funding Work Group) (September 1993) AOM0000579.

Group and that a comparison had been made to the CHC physician and primary care nurse. [5]

30. I along with Jane Kilthei were members of the Program Quality Committee, a joint AOM/OMP Committee which was established by the September, 1993 Ontario Midwifery Program Framework. [6]

III. *SOCIAL CONTRACT ACT* FREEZE

31. The Ministry subjected the midwifery compensation set out in the September 1993 Ontario Midwifery Program Framework to deductions under the *Social Contract Act.* These deductions were reflected in the LMCO – AOM Contract. They continued after the March 31, 1996 expiry date in the *Social Contract Act.*

32. The AOM wrote to the LMCO by letters dated April 8, 1996 and April 29, 1996[7] requesting a stop to the social contract deductions as the statutory period had expired on March 31, 1996. By letter dated May 6, 1996 to AOM President Eileen Hutton, Bonnie Heath, OMP Co-ordinator advised that the social contract reduction to the transfer payment was permanent and the budget would not be increased to compensate for the social contract deduction. She wrote:

> *You are correct that the government's social contract expired on March 31, 1996. However, the reduction to transfer payments arising from the social contract is permanent. The LMCO's current budget reflects this permanent reduction. In other words, there will be no further social contract reductions nor will the budget be increased to compensate for the social contract. As you know, LMCO managed the social contract reduction through a 4.4% decrease in annual salaries over $30,000 as prescribed by the Funding Agreement. I suggest that the AOM contact LMCO to offer input as they develop their strategy for managing these permanent budget reductions in future.* [8]

33. It was not until September 29, 1996, after further requests by the AOM that the LMCO Board decided with the authorization of the OMP to return midwives' compensation to the original 1994 compensation levels for midwives ($55,000-$77,000) which was set out in Schedule C to the Funding Contract retroactive to

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5 Voting Package for AOM Members re Ontario Midwifery Program Framework - with attachments (1993-10-23) AOM0001275.

6 AOM Board Meeting Minutes, for Meeting on May 30, 1994 (1994-05-30) AOM0002373.

7 Letter from AOM President E. Hutton to MOH B. Heath re: compensation (1996-04-29) AOM0002381.

8 Letter from MOH B. Heath to AOM E. Hutton re: Social Contract deductions (May 6, 1996) AOM0002382.

April 1, 1996. The *Social Contract Act* reductions of 4.4% had reduced the compensation so that the range was $52,580 to $73,612.[9]

IV. 1995-1996: INITIAL DEVOLUTION DISCUSSIONS

1. Introduction

34. On regulation, the Lebel Midwifery Care Organization (LMCO) became the central transfer payment agency which entered into contracts with the Midwifery Practice Groups. However, the LMCO was never intended to be the permanent funding conduit for midwifery practice groups. The Ontario Midwifery Program Framework provided that there would be a devolution to local Transfer Payment Agencies (TPAs) by 1997.[10]

35. In 1994-1995, as midwives were implementing the new midwifery system and developing their practice group operations, the LMCO raised the issue of devolution.

36. In preparation for devolution, the AOM, led by Jane Kilthei, and the Community Health Branch, led by Bonnie Heath, began developing the Ontario Midwifery Program Submission Guidelines - Application to the Ontario Midwifery Program for potential local Transfer Payment Agencies. These Guidelines were intended to detail for transfer payment agencies the midwifery program and requirements, the model, hours and structure of care, employment status and the funding and budgeting process. After many drafts,[11] these Guidelines were in fact not finalized between the AOM and the OMP at the time the devolution process was put on hold in 1997 by the MOH and AOM.

2. Addressing the Employee Status Issue

37. The 1993 Ontario Midwifery Program Framework left open the option of employment by referring to either contract or employee status for midwifery.

38. When the LMCO and Community Health Branch, (CHB) wanted to move forward with devolution discussions and raised the issue of midwives being potentially employed by transfer payment agencies, this raised the issue of what the appropriate employment relationship for midwives should be and the implications

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9 LMCO template letter to Midwife attaching blank copy of the LMCO and MPG Template Funding Agreement AOM (1994-04-21) AOM0002744.

10 Ontario Midwifery Funding Framework (developed by the Midwifery Funding Work Group) (September 1993) AOM0000579 at p. 6.

11 Development Of Ontario Midwifery Program Submission Guidelines – Various Drafts (1994 - 1995) AOM0009251 and AOM0009256.

of a standard "employee" relationship for the continuity model of care provided by midwives in accordance with the College of Midwives of Ontario's requirements.

39. During the period 1995 – 1997, the AOM, the LMCO and the CHB continued to meet and have discussions concerning whether an appropriate employment model could be established and whether the model as it stood could be characterized as an "employee" model.[12]

40. Midwives were initially characterized as "dependent contractors" as they are dependent on one source for funding of their midwifery activities (i.e., the Ontario Midwifery Program) and are therefore dependent economically.[13]

41. On April 20, 1995, Betty Dondertman, the Executive Director of the LMCO, solicited the opinion of the AOM Funding Committee on the issue of the employment model for midwives. She requested that we prepare a statement for a Program Quality Committee meeting that was to occur on May 17, 1995. In the fax, Dondertman states "While we can see possible pros and cons to the employment model, generally we are not in favour of it."[14]

42. At our 1995 Annual General Meeting, our membership passed a resolution demonstrating overwhelming support against an employee model and in favor of a contract model.[15] Midwives did not believe that the employee model in the circumstances could meet the interests of their clients to have continuity of care.

3. 1995- Employment Model Working Group

43. During 1995, the OMP and AOM created the Employment Model Working Group to address the issue of the employment status of midwives on devolution to TPAs. The Group, led on the AOM side by Jane Kilthei, worked on producing a prototype agreement that could be used by TPAs that would be consistent with the model of care. Given the difficulties encountered as set out below, the agreement was not completed.

44. The Working Group discussed the impact of the *Employment Standards Act* on midwives if they were designated as “employees” due to the unique and onerous working conditions of midwives required by their model of practice.

45. The AOM was very concerned to ensure that any new TPA model and employment status was consistent with the needs of the model of practice, the

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12 Development Of Ontario Midwifery Program Submission Guidelines – Various Drafts (1994 - 1995) AOM0009251 and AOM0009256.

13 Midwifery Practice Financial & Business Manual (March 1, 1995) AOM0008080.

14 Fax from Betty Dondertman to AOM Funding Group re: Employment Model (April 20, 1995) AOM0009192.

15 Minutes from AOM Board Meeting October 19, 1995 (1995-10-19) AOM0003831.

autonomy of midwives and the extraordinary working conditions of midwives, which requires 24/7 on-call work and continuity of care. Such conditions required much longer than the prescribed hours under the *Employment Standards Act* and did not fit easily within a standard "employee" relationship. The new model needed to reflect the system of mutual support on which midwifery is based with the TPA relating to midwives within the context of their practice groups and the midwives relating to one another within the group for their day to day professional accountabilities.

46. In an LMCO meeting on August 20, 1995, the AOM and the MOH lawyers were tasked with investigating the possibility of an exemption from the *Employment Standards Act*. [16]

47. With the support of our legal counsel, we drafted a letter seeking exemptions for midwives related to employment matters like overtime and consecutive work day. In particular, we were hoping to acquire for midwives formal exemptions from ESA requirements such as those related to maximum hours worked, overtime pay and on-call. [17]

48. In doing this, we hoped that we could protect the model of practice should a midwife ever be in an "employee" situation, while at the same time reiterating that the AOM supported a dependent contractor relationship.

4. AOM Devolution Strategy Group

49. The AOM created in 1995 an internal Devolution Strategy Group which included Jane Kilthei and Elana Johnson. After Jane Kilthei left the AOM to become of the Co-Registrar of the Ontario College of Midwives in April 1996, this process on the part of the AOM was taken over by, Vice President Remi Ejiwunmi, me as the AOM President, and later by my successor, Bridget Lynch.

50. I worked with the AOM Devolution Strategy Group and the LMCO and MOH as the LMCO pressed the AOM and MPGs to enter into contractual relationship with local transfer payment agencies.

5. Primary Care Subcommittee of the Provincial Coordinating Committee on Community and Academic Health Sciences Centre Relations (PCCCAR)

51. During this time, I was also active in my work as an MOHLTC appointed member of the Primary Care Subcommittee of the Provincial Coordinating Committee on Community and Academic Health Sciences Centre Relations (PCCCAR),

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16 Minutes of LMCO In Camera Board Meeting on August 19 and 20, 1995 (1995-08-20) AOM0012744.

17 Letter from Jane Kilthei, Chair, Funding Committee, AOM to Bonnie Heath, OMP (1996-01-15) MOH003888.

52. On March 4, 1996, on behalf of the AOM I provided a brief to the PCCCAR Sub-Committee on Primary Health Care, dated March 1, 1996 regarding the state of Midwifery Practice in Toronto, the state of negotiations with the MOH and our goals for midwifery and its place in Ontario's primary health care system. [18] In the submission I advocated for the PCCCAR Sub-Committee to:

    (a) Add primary reproductive care to the list of core services which must be delivered by a primary health care agency funded by the Ministry of Health and,

    (b) Recommend that the devolution to locally administered funding for midwifery practice groups currently being undertaken by the Ministry of Health demonstrate consistency with the work of the PCCCAR Sub-Committee on Primary Health Care.

53. On March 19, 1996, the AOM sent a copy of this brief to Bonnie Heath, along with a letter advising her of the meeting with the PCCCAR Sub-Committee on Primary Health Care.

V. MAY, 1996 – DECEMBER, 1996: ONGOING DEVOLUTION AND EMPLOYMENT MODEL ISSUES

1. Introduction

54. During the period from May to December, 1996, we continued to wrestle with the problem of how to address devolution in the current environment. The devolution process (which ultimately moved forward to implementation with the 2000 devolved contract between MPGs and Local TPAs) created the independent contractor status contract framework which we still have today.

55. In May of 1996, the leadership of the LMCO changed dramatically. Kelly Wharton replaced Kathy Thompson as the President of the LMCO, and Hal De Lair became the Executive Director of the organization, replacing Betty Dondertman.

56. The LMCO advised us by letter dated May 31, 1996, that they were recommitting to moving forward with the devolution process.[19] We wanted to put on hold the devolution discussions with the LMCO and CHB in order to give us time to assess the implications for midwifery of the devolution process, given the

18 Brief to PCCCAR Sub-Committee on Primary Health Care in Ontario (March 1, 1996) AOM0010571.

19 Letter from K. Thompson/LMCO to Midwives re: Devolution (May 31, 1996) AOM0003976.

uncertainty surrounding the employment status issue and protecting our model of care.[20]

2. Assumption of AOM Presidency and Devolution Resolutions

57. In June, 1996, I assumed the Presidency of the AOM at end of our annual AGM. I had also replaced Jane Kilthei on the Program Quality Committee as the AOM representative as she had left to be the Co-Registrar of the College of Midwives in April, 1996.

58. On June 10, 1996, at the AOM's Annual AGM, the membership passed two resolutions relating to the devolution process. I wrote a letter recording these resolutions to the membership in a memo dated July 3, 1996:[21]

    (a) the first is that any move of midwifery practices to local transfer payment agencies be consistent with the model of practice. Further, that agencies created through primary care reform be considered potential transfer payment agencies and that midwifery funds be devolved only to those agencies providing health care services. in addition, the resolution provided that where no appropriate agencies providing health care services exists in a community, that a central transfer agency be retained for those practices.

    (b) The second resolution that members supported was that the AOM support devolution to local transfer payment agencies that have effective mechanisms for community involvement but that these agencies must not be restricted to a community board governance structure.

59. Following the AGM, I met with Charles Bigenwald, the Assistant Deputy Minister of Health Human Resources Planning in the MOH. We discussed the two AGM resolutions. Mr. Bigenwald reiterated the government's commitment to devolution and that they were open to non-community board governance structures for TPAs. However he also informed us that health care in Ontario was at that time in a state of flux and that there were many unknowns that would potentially impact the devolution process.[22]

60. On July 2, 1996, the new LMCO Executive Director, Hal De Lair, published a memorandum that was sent to the AOM that was in response to the resolution

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20 Memo from AOM President Carol Cameron to AOM Board re: Provincial Coordinating Committee on Community and Academic Health Sciences Centre Relations (PCCCAR) responsible for providing advice to Minister of Health Jim Wilson re: future directions and human resources planning for primary health care. (February 12, 1996) AOM0002396.

21 Memo from AOM President Carol Cameron to AOM Representative re: Devolution (July 3, 1996) AOM0003827.

22 Memo from AOM President Carol Cameron to AOM Representative re: Devolution (July 3, 1996) AOM0003827.

about the employee model versus the contract model that our membership had passed in 1995 at the AGM. In his letter, he stated his opinion that midwives are "employees" of the LMCO. He supported his contention by quoting a conversation he had with Suzanne Silk Klein of the Ministry of Labour.

61. On July 4, 1996, I wrote to De Lair the following:

I am writing in response to your memo dated July 2, 1996 with regard to a resolution that was passed by the AOM membership on the employee model versus the contract model. For the record, this resolution was passed at our AGM and Conference in 1995.

Answering some of the questions that you raise in your memo will require feedback and direction from the Funding Committee of the AOM. Indeed there is a history with regard to this particular issue. The AOM file on this matter includes legal interpretation of the implications of an employee model for midwives and also includes points of reference to current Employment Standards Act law and interpretation. I am forwarding your memo to the Funding Committee so that it may be raised at their next meeting in August 1996. I expect that there are several documents which the committee will want to make available to you at that time.

I think it is important to note that the consideration of midwives as "employees" and support staff as "employees" of local transfer payment agencies are two separate issues. It may indeed be possible for a person providing administrative support to a midwifery practice to be employed by the local transfer payment agency and, in fact, to have other job functions outside of this role. When contemplating the impact that an employee/employer model would have on the function of midwifery practice groups, however, many issues arise that need to be addressed. [23]

62. On July 8, Mr. De Lair wrote a memorandum to the Midwifery Practice Groups of Ontario expressing a desire to resume conversations about devolution and announcing that he would be visiting the midwifery practice groups to get information from them regarding their needs in the devolution process.[24]

63. Over July and August, Mr. De Lair visited almost all the Midwifery Practice Groups. I attended many of these meetings. On July 22, he sent a second letter

23 Letter from AOM President Carol Cameron to LMCO Director Hal De Lair re: issue of employee model v. contract model responding to De Lair's July 2, 1996 Memo (July 4, 1996) AOM0010126.

24 Letter from LMCO ED H. De Lair introducing self to MPGs re: devolution process (July 8, 1996) AOM0003965.

to the Midwifery Practice Groups with updated information about his work to connect with potential TPAs. [25]

64. During this period, it was extremely difficult for midwifery practices to plan their caseloads, given the unknowns about funding allocations for new registrants on the horizon. On August 6, 1996, I drafted a memo to all practice groups outlining various options for how to move forward in the uncertain times, and sketching out the costs and benefits to each option.[26]

65. On August 23, 1996, Mr. De Lair drafted a third memorandum to the Midwifery Practice Groups regarding the role of consumers in future TPA governance.[27]

66. Around this time, the LMCO was actively seeking opinions from Revenue Canada and the Ministry of Labour about the "dependent contractor" status of employees and the implications of this position for the LMCO regarding taxation and employment standards.

67. In letter to Revenue Canada by Mr. De Lair dated August 28, 1998, he takes the position that midwives are dependent contractors.[28]

68. On August 29, 1996, the LMCO sent a letter to all the practice groups advising them that any non-recurring expenditures (like office equipment) would have to be approved by the MOH, because the LMCO was entering the final year of its mandate, and there was an expectation that devolution to TPAs would soon be underway.[29]

3. September - November, 1996: Membership Survey and Consensus Building Meeting

69. The AOM took steps to seek input from the membership on devolution in the fall of 1996. Issues surrounding devolution were slated to be discussed at the regional meetings throughout the fall.[30] In August and September, 1996, Remi Ejiwunmi and Eileen Hutton conducted a survey of all the Midwifery Practice

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25 Letter #2 from LMCO ED H. De Lair to MPGs re: Devolution and finding new TPAs (July 22, 1996) AOM0003963.

26 Memo from C. Cameron to practice groups re: Caseload Planning and New Registrants (August 6, 1996) AOM0002397.

27 Letter #3 from H. De Lair to MPGs re: Consumer Involvement in Devolution (August 23, 1996) AOM0003961.

28 Letter from Hal De Lair to Revenue Canada (August 28, 1998) AOM0013121.

29 Letter from H. De Lair/LMCO to MPGs re: Non-recurring Expenses (August 29, 1996) AOM0003953.

30 List by AOM re: Items to Include in Regional Meetings (September 1, 1996) AOM0008135.

Groups on where their practice groups were in the devolution process, and of their positions on exploring employer-employee relationships with TPAs.[31] [32]

70. At that time, the survey found that MPGs were in various stages of dealing with trying to identify local transfer payment agencies.

71. However, as Midwifery Practice Groups were meeting with prospective TPAs, there remained confusion regarding the exact nature of the relationship between them. In a memorandum to the LMCO Board on September 29, 1996, Mr. De Lair identifies an issue that has arisen between the Midwifery Practice Groups and the TPAs in their early negotiations:

> *Before two parties can negotiate, they have to define who they are in relationship to what is being negotiated. To take a trite example, but it illustrates the point, labour and management could not negotiate if they were unclear about who owns the plant and who provides the labour. The framework document says the TPA will provide and manage midwifery services. Midwives would say they provide and manage their own services. So, what's it going to be?*[33]

72. This was reflected in the AOM's survey of the membership. Notably, the summary of findings from the surveys yielded that 95% of those surveyed disagreed with exploring employer-employee relationships with TPAs and 91% agreed with maintaining a contract relationship.[34]

4. Consensus Building Session and Report

73. Following the survey, I arranged for the AOM to conduct a consensus building session with our members on October 24, 1996 which I participated in. The purpose of the session was to relay information to members from the survey and other background information on the devolution process, and to obtain broad consultation from members regarding the next steps.[35] We hired Veritas Communications to assist us with this process. The session was facilitated by Deborah Bonsor.

74. The purpose of this session was to relay information to members from the survey and other background information on the devolution process and to obtain broad

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31 Funding Committee Meeting Agenda and attachments for Sept. 18, 1996, AOM0002394.

32 AOM Survey on Devolution Summary Results (September 20, 1996) AOM0008048.

33 Memorandum to the LMCO Board by Hal De Lair dated September 29, 1996, AOM0003912.

34 AOM Survey on Devolution -Summary of Results - prepared for the AOM Funding Committee by R. Ejiwunmi and E. Hutton (October 1996) AOM0001123 at p. 4.

35 1996 Draft Report on Consensus Building Session on Devolution (November, 1996) AOM0002841.

consultation from members regarding the next steps.[36] Participants gathered for the session at ten teleconferencing sites around Ontario and Toronto was the host site. We asked each midwifery practice to send one midwife and one consumer and over 80% of the practices were represented.

75. As AOM president I gave the opening remarks along with Jackie Scott, the President of the Ontario Consumer Midwifery Network (OCMN) (formerly the MTFO. At the opening of the consensus building session we presented a summary of the results of the devolution survey, which allowed us to review the issues and focus the discussion. We then sought consensus among participants on the principles the AOM should be protecting through the devolution process. We then asked the participating consumers and members for their suggestions as well as perceived benefits and concerns about devolution going forward.

76. At this meeting we identified a number of benefits that midwives and consumer saw in a devolved funding system. We also identified some questions and concerns about devolution. The major themes across the concerns were regarding:

- Process and transition to a devolved system of funding (for example: that proposed TPAs did not fit with the model, the need to ensure MOH and midwives have shared understanding of the status of midwives, consistency of the quality of TPAs);

- Access to Midwifery Care (for example: that the increased workload caused by devolution may cause midwives to decrease caseloads, role of the TPA in determining clientele);

- Impact of the Midwifery Model of Care (that the model of care is protected as a "first principle");

- Timeframe (that the timeline was unrealistic and midwives felt devolution was happening too quickly);

- Unresolved Legal Issues (the need for legal mechanisms to protect the autonomy of the Midwifery Practice Group);

- Governance and Provincial Overview of TPAs (the need for a mechanism for TPA accountability, including essential criteria to measure the TPAs ability to support midwifery principles);

- Impact on Consumers (the need to reimburse consumers for their work contributing to devolution and keeping consumers involved) and,

36 1996 Draft Report on Consensus Building Session on Devolution (November, 1996) AOM0002841.

- Autonomy of Practice (not control but rather the protection of the ability of midwives to serve communities according to the principles of midwifery practice).

77. At the meeting, the AOM members reached a consensus on a list of principles which they felt must be protected as devolution proceeds. Midwives were very clear that they were worried about preserving the autonomy of the profession, and about protecting the midwifery model of care.

78. During the meeting we decided the steps that would be necessary to move forward with devolution planning and implementation. We agreed to first report on the consensus meeting to the AOM Board members and for the Board to develop a position on devolution to be ratified by the members. We further agreed to continue to meet with midwife members and request additional meetings with senior government officials as needed.

79. The results of this consensus building session were reflected in the AOM's November 1996 Draft Report on Consensus Building Session on Devolution.[37] This Report was provided to the LMCO and OMP. The Report reflected the considerable anxiety from the membership about the devolution process that was created by "tight timelines, uncertainty about the process, and no clear direction about the process when serious questions are raised".[38]

80. In particular, meetings with members had revealed concerned that devolving the management of midwifery practice groups to local agencies would erode the client-centered model of care. We were concerned that this erosion would be especially problematic if we became employees of the agency and therefore required to work under the control of an employer. We were also concerned that there had been very little consultation with practice groups. The Program Quality Committee had been meeting bi-monthly with stakeholders but was disbanded by the Ministry following the first year of the program. We did not feel that the devolution plan, which emphasized the control of TPAs over practice groups, would allow midwives to practice our unique model of care.

81. On October 29, 1996, the OMP's Bonnie Heath drafted a letter to me, advising that the OMP had hoped to have a final draft of the Program Guidelines by the end of October, but that given the state of the LMCO's process with devolution, it may take longer.[39]

82. After the meeting with the membership on October 24, 1996, the AOM drafted a document entitled "AOM Principles to Protect in Devolution" and another entitled

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37 1996 Draft Report on Consensus Building Session on Devolution (November, 1996) AOM0002841.

38 Report from AOM to LMCO Board (November 2, 1996) AOM0013114.

39 Letter from the OMP's Bonnie Heath to AOM's Carol Cameron (October 29, 1996) AOM0002399.

"Midwives in the Ontario Healthcare System: A Vision Statement."[40] The "AOM Principles to Protect in Devolution" are found on page 8 of the Report on the Consensus Building Session on Devolution (October 1996). These principles had been unanimously supported by members in the AOM's Survey on Devolution and were approved by the Board.[41]

5. Midwifery Liaison Committee

83. There was a workshop meeting held October 18, 1995 which was attended by delegates from the OMCN, CMO, AOM, MOH and the Education Programme. The meeting was facilitated by Michael Rachlis and we attempted to determine the roles and responsibilities of each of the stakeholders. The final decision of the meeting was to establish the Midwifery Liaison Committee as the forum for deciding questions around data collection, management, analysis and distribution. It is recognized that while each of the stakeholders has different data requirements there is also much overlap. I was a member of this Liaison Committee.

6. LMCO Insistence that an Employee Relationship Existed

84. On November 21, 1996, Revenue Canada responds to Mr. Delair finding that there is no employee-employer relationship between midwives and the LMCO for Revenue Canada purposes.[42]

85. Mr. De Lair wrote to me on November 25, 1996 advising that the AOM could not have a member on the LMCO Board of Directors because "the LMCO represents the role of employer and to have employees as voting members is viewed as a conflict of interest".[43]

86. The Ministry's positions raised concerns for the AOM. Members were concerned that devolving the management of midwifery practice groups to local transfer payment agencies would erode the client-centered autonomous model of care. We were concerned that this erosion would be especially problematic if midwives became employees of the agency and therefore were required to work under the control of an employer and/or a physician. We were also concerned that there had been very little consultation with practice groups. We did not feel that the devolution plan being pursued by the LMCO, which emphasized the control of TPAs over practice groups, would allow midwives to practice our unique model of

40 Draft AOM Document re: A Vision Statement for Midwives in the Ontario Health Care System (1996/11/11) AOM0003866.

41 Memo from C. Cameron to AOM Members re: Principles to Protect in Devolution (November 11, 1996) AOM0003862.

42 Revenue Canada letter to Hal Delair at the LMCO (November 21, 1996) AOM0013123.

43 Letter from H. De Lair, Executive Director LMCO to Carol Cameron. President AOM. Re: various issues (November 25, 1996) AOM0002393.002.

care as required by the College of Midwives of Ontario standards and practices. (i.e. continuity of care, informed choice, choice of birthplace).

VI. DEVOLUTION PROCESS PUT ON HOLD BY AOM AND MOH

87. In the first week of January 1997, the AOM Board met to discuss our next steps. We were very concerned that the LMCO wanted the MPGs to move into the TPAs as employees.

88. On January 9, 1997, I met with Tariq Asmi, Special Assistant to the Minister of Health to discuss devolution. At that meeting, we found that the AOM and the MOH shared many priorities regarding the devolution of the administration of midwifery services. A large part of the problem at this time was that there was a lack of legitimate healthcare agencies who could ensure the delivery of midwifery services. We remained extremely worried that a hasty devolution plan would compromise the ability of midwives to work under the midwifery model of care.

89. In a follow up letter dated January 14, 1997, I explained to Special Assistant Tariq Asmi that:

> *I want to be clear that while the AOM has taken a very significant step in recommending to its members not to proceed with devolution at this time, we are not saying that devolution should not or will not happen. Rather we are halting the process to allow the AOM the opportunity to raise its concerns and to have these concerns addressed by the MOH (which until our meeting last week had not happened).*[44]

90. The process was put on hold while the MOH reviewed policies on appropriate agencies with the AOM involved in consultations.[45]

91. On January 13, 1997 the AOM executive wrote to all members confirming that a membership survey had indicated a strong mandate from the AOM membership to halt the devolution process. We notified members that we had conveyed the AOM's position on devolution and were "very encouraged that the Ministry of Health and the AOM share similar views were regard to the problems associated with the devolution policy." We further noted that at that time the AOM's position was that midwives were funded through a dependent contractor model (i.e. not employees) and that "it is important that members are aware that despite the LMCO's statements to the contrary, the AOM Board of Directors does not agree with the position that midwives are or should be employees."[46]

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44 Letter from AOM President Carol Cameron to Office of the MOH Special Assistant - Policy - Tariq Asmi re: various issues (January 14, 1997) AOM0001122.

45 Memo from Carol Cameron to all MPGs re: Devolution (1997-02-19) AOM0003817.

46 Memo from AOM Board of Directors to All Midwives (1997-01-13) MOH003946.

92. On January 20, 1997, we had a "Town Hall" members meeting to share information with the members and decide upon next steps for the AOM in the devolution negotiation process.

93. On January 24, 1997, Kelly Wharton, the LMCO President wrote to the Midwifery Practice groups to ask them directly whether they endorse the AOM's decision to halt devolution discussions and reminding them of their obligation under Article 7.3 of the Funding Agreement to cooperate with identifying local TPAs. [47]

94. On January 24, 1997, I wrote to Wharton to advise her of the rationale of the AOM membership for suspending devolution discussions pending a review of the rationale, goals and timeline of the policy. [48]

95. On January 31, 1997, Jacqueline Scott of the Ontario Midwifery Consumers Network (OMCN) wrote a letter to the OMP echoing the concerns of the AOM and supporting the resolution to halt devolution discussions "pending the review of the policy to devolve the administration of midwifery funding, its rationale goals and timelines equally by all stakeholders." [49]

96. On February 14, 1997, Geoffrey Quirt, the ADM of Population Health and Community Services Systems Group at the MOH wrote to me and agreed that "criteria for selecting the agencies will be reviewed with the AOM and LMCO and will benefit from expert input on health systems integration. The planned transfer of the management of midwifery services is therefore on hold pending completion of a review of current ministry policy on appropriate agencies".[50]

97. Upon receipt of this confirmation, I sent a letter dated February 19, 1997, to the membership advising them of the development and that the AOM would be responding that the AOM "looks forward to participating in this very specific review of appropriate transfer agencies, but that the AOM is also interested in having the Ministry review the larger devolution policy issue, specifically the rationale for devolution."[51]

98. On March 10, 1997, I wrote the Minister of Health, Jim Wilson, to express that the AOM was looking forward to participating in the review and requesting terms

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47 Memo from K. Wharton (President, LMCO) to Midwifery Practice Groups re: Devolution and Funding Agreement (January 24, 1997) AOM0008059.

48 Memo from C. Cameron to K. Wharton (President, LMCO) re: Devolution and Funding Agreement Memo (January 24, 1997) AOM0008058.

49 Letter from J. Scott (OMCN) to B. Heath (MOH) re: Devolution concerns (January 31, 1997) AOM0003290.

50 Letter from Geoffrey Quirt (MOH ADM of Population Health and Community Services Systems Group) to LMCO President Kelly Wharton and Carol Cameron Re: Devolution (February 14, 1997) AOM0008024.

51 Memo from Carol Cameron to all MPGs re: Devolution (February 19, 1997) AOM0003817.

of reference. [52] I also expressed the AOM's concern that the review as written in Quirt's letter was too narrow to address our broader concerns, namely the "appropriateness of the original devolution policy itself," especially in light of provincial changes to primary care more generally. I wanted to ensure that the future of the midwifery program ensured that it was integrated in the larger health care delivery system. Finally, we requested a meeting with the Minister to discuss solutions to the narrow scope of the review.

99. In April of 2004, the LMCO began directly contacting the Midwifery Practice Groups to express their displeasure at the AOM's halting of the devolution process and to solicit a "clear and unequivocal response as to whether the practice was halting its cooperation with devolution".[53] The letter also warns the practice groups that they will have less control over the process after its review.[54] Finally, Mr. De Lair's letter addresses the question of whether midwives are employees as follows:

> *I don't know how to make the employee issue any clearer. We just don't get to choose to break the law. All indications are that the Funding Agreement describes an employment relationship. All the Lawyers and accountants we [sic?] spoken to give us the same opinion; under the current funding arrangement with the TPA, midwives are employees.*[55]

100. On April 15, 1997, Jacqueline Scott of the OMCN wrote a letter to Minister Wilson seeking a response to their January 31, 1997 letter to the OMP.[56] Scott reiterated that like the AOM, the OMCN is not opposed to devolution, but believes that a review of the policy, its rationale, goals and timelines, is necessary to ensure that the midwifery funding framework in Ontario is the strongest one possible.

101. In the meantime, midwives were still having difficulty obtaining hospital privileges. While this was not a problem in my situation, as noted below, midwives were still beholden to the processes at individual hospitals in the process to obtain privileges. This caused many midwives considerable frustration and hardship.[57]

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52 Letter from C. Cameron to J. Wilson (Minister of Health) re: Devolution of Midwifery Funding to Local TPAs (March 10, 1997) AOM0008061.

53 Letter from LMCO to St. Jacobs Midwives re devolution from LMCO to local TPAs (April 2, 1997) AOM0013270 at p. 1.

54 Letter from LMCO to St. Jacobs Midwives re devolution from LMCO to local TPAs (April 2, 1997) AOM0013270 at p. 2.

55 Letter from LMCO to St. Jacobs Midwives re devolution from LMCO to local TPAs (April 2, 1997) AOM0013270 at p. 2.

56 Letter from J. Scott (OMCN) to Minister J. Wilson re: concerns regarding LMCO Devolution (April 15, 2007) AOM0003288.

57 Letter from S. Columbia to C. Cameron regarding hospital privileges (May 28, 1997) AOM0001970.

Further, midwives were spending considerable time meeting with potential TPAs and the LMCO was refusing to fund the work. [58]

102. With the 1997 deadline approaching, the LMCO obtained a legal opinion from the Filion Wakley law firm that the midwives were likely best categorized under the current funding and management structure as LMCO employees and not as independent contractors and therefore would fall under employee legal protections (which included the *Pay Equity Act*).

103. On May 6, 1997, at the Midwifery Liaison Committee Meeting:

> *Bonnie Heath reported that the Community Health Branch of the MOH has received a legal opinion that the current funding agreement could be interpreted as an employee contract. The implication of this is that the LMCO will need to meet obligations as an employer, e.g., employer deductions. An exemption from the employee standards act will also be sought. Bonnie and the LMCO will work together to draft a second model which would allow midwives to operate as contractors rather than as employees, based on the past understanding that this option should be available. This model will be reviewed by the AOM. Some discussion of the implications of having the two models took place and was earmarked for further discussion at a future meeting.*[59]

VII. AUGUST 1997: "TOWARDS MORE INTEGRATED AND COST EFFECTIVE MIDWIFERY CARE"

104. In the summer of 1997 the MOH worked on a review of the TPA criteria while the AOM used the time in the Spring and Summer of 1997 to consider the feedback it had received from its member on the devolution process. We also engaged with the concerned and issues raised by the MOH, OMP and LMCO. This resulted in the preparation of our discussion paper "Towards More Integrated Cost-Effective Midwifery Care in Ontario" which identified a proposed model for going forward for the process of devolution and contractual relationships for midwives.[60]

105. In August, 1997, Bridget Lynch assumed my role as AOM President and Remi Ejiwunmi became the Vice President. The incoming AOM executive and I recognized the urgency of finding a solution given that the interim funding structure, the Lebel Midwifery Care Organization, was set to expire in December, 1997.

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58 Draft Minutes from AOM Funding Committee of April 9, 1997 (May 1, 1997) AOM0002390 at pp. 6-8.

59 Minutes of May 6, 1997 Midwifery Liaison Committee Meeting (May 1997) AOM0010252.

60 Letter from Carol Cameron, President, AOM to Bonnie Heath, Coordinator, OMP enclosing Towards More Integrated, Cost-Effective Midwifery Care in Ontario (1997-08-29) MOH003939.

106. In one of my last acts as President of the AOM, I provided the Ministry of Health with the AOM's above-noted solution's paper "Towards More Integrated Cost-Effective Midwifery Care in Ontario." By letter dated August 29, 1997, I forwarded to the OMP's Bonnie Heath the document to help move forward the discussions.[61]

107. In this letter I wrote that this proposed model "while maintaining many components of the current "devolution" strategy, better promotes and protected essential aspects of the midwifery model of care and provides the midwifery profession more flexibility to move with the developing trends towards Primary Health Care Reform."[62]

108. Our proposal, "Towards More Integrated Cost-Effective Midwifery Care in Ontario" begins by acknowledging that the devolution plan by 1997 outlined in the 1993 OMP Framework document had proven to be unworkable and that a new extended time line approach was necessary. We recognized that the original plan to devolve the administration of midwifery to local TPAs had incorporated a number of assumptions that were not valid by 1996. The key assumption was that Community Health Centres and birthing centres would act as TPAs, which would have allowed for a uniform infrastructure. By 1996 CHCs had not expanded as planned and free standing birthing centres had not been developed. We noted that shifting management and supervision of midwifery to diverse, local, non-health care agencies would resulted in a fragmented model of midwifery care. We also raised concerns that management of midwives by TPAs would undermine the inter-professional dynamics between physicians, nurses and midwives.

109. Key considerations in the paper were as follows:

    (a) We recognized that the original plan to devolve the administration of midwifery to local TPAs had incorporated a number of assumptions that were not valid by 1996. The key assumption was that Community Health Centres and birthing centres would act as TPAs, which would have allowed for a uniform infrastructure. By 1996 CHCs had not expanded as planned and free standing birthing centres had not been developed.

    (b) We noted that shifting management and supervision of midwifery to diverse, local, non-health care agencies would result in a fragmented model of midwifery care.

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61 Letter from Carol Cameron, President, AOM to Bonnie Heath, Coordinator, OMP enclosing Towards More Integrated, Cost-Effective Midwifery Care in Ontario (1997-08-29) MOH003939.

62 Letter from Carol Cameron, President, AOM to Bonnie Heath, Coordinator, OMP enclosing Towards More Integrated, Cost-Effective Midwifery Care in Ontario (August 29, 1997) MOH003939.

(c) We also raised concerns that management of midwives by TPAs would undermine the inter-professional dynamics between physicians, nurses and midwives.

(d) As well we were concerned about the lack of direct consultation with the AOM about devolution as the "the AOM has had little formal input into devolution specifically. This has led to a real, legitimate concern among practicing midwives as to their future status."

(e) We proposed new policy goals for developing a devolution process which would address 8 key issues:

(i) a new program consultation mechanism (a provincial midwifery committee with representatives from the AOM, OMCN and the MOH);

(ii) alternative funding approach for TPAs (discussed below);

(iii) financial accountability (by maintaining a provincial funding agreement and financial accountability procedures);

(iv) protecting the model of midwifery care (through the CMO and through Midwifery Practice Groups where midwives would have a non-employee status allowing them to provide 24 hour on-call service);

(v) preserved and enhanced consumer partnerships (continued consultation with the OMCN, including a seat on the propose Provincial Midwifery Committee);

(vi) evidence-based policies (the proposed Provincial Midwifery Committee would ensure that evidence-based policies and practices are incorporated into midwifery);

(vii) supporting midwifery practice groups (by funding the AOM to hire staff to assist Practice Groups with managing business aspects of the practice) and,

(viii) clear roles and responsibilities (including the proposed Provincial Midwifery Committee).

(f) Under the heading "alternative funding approach for TPAs" we set out two possible approaches. Each approach was designed to ensure an appropriate funding relationship, effective monitoring and reporting mechanisms and clear accountability. The approaches differed only in the mechanism used for flowing funds between the MOH and practice groups.

(i) The first approach envisioned using an intermediary transfer who could function as a funds administrator for the follow of funds. We proposed using health care agencies to which the MOH normally transfers funds (likely a CHC or Hospital where midwives have privileges). The agency would not have any governance relationship with the midwifery group, it would serve a "banking function" of administering funding and ensuring appropriate financial accountability practices were upheld.

(ii) The Second approach was a "Direct Transfer" option where the MOH would flow funds directly to each midwifery practice group. The amount of funding would be determined in part by the provincial agreement negotiated between the AOM and the MOH. [63]

110. The "AOM Principles to Protect in Devolution" from the Report on the Consensus Building Session on Devolution (October 1996) were attached to the above-noted August, 1997 paper as Appendix One. These principles had been unanimously supported by members in the AOM's Survey on Devolution.

111. In September of 1997, I received a response to my letter from MOH ADM Ron Sapsford. Sapsford took the position that that midwives would be working as employees and that "the ministry expects that midwives will be able to practice the Ontario model of midwifery care as employees once the necessary regulation changes to the Employment Standard Act have been made." He further stated that direct negotiations with the profession are inconsistent with a managed program. In this letter Sapsford pointed out the CHB's experience with managing CHC's.

112. AOM President Bridget Lynch, AOM Vice President Remi Ejiwunmi and AOMs Wendy Katherine and Elana Johnson engaged in these discussions as the AOM's ongoing Devolution Strategy Team with the LMCO and the Ministry.

VIII. INTER PROFESSIONAL AND HOSPITAL INTEGRATION

1. OHIP Fee Code for Midwifery Referrals to Specialists

113. During the 1990's, I was involved in the attempts to get the OHIP fee codes amended so that specialists did not receive less money for accepting a referral from a midwife than from a family physician. In May of 1997 I met with the Ontario Society of Obstetricians and Gynaecologists (OSOG at the Ministry to discuss the issue. Dr. Richard Johnson, the Char of the OSOG, followed up with

63 Letter from Carol Cameron, President, AOM to Bonnie Heath, Coordinator, OMP enclosing Towards More Integrated, Cost-Effective Midwifery Care in Ontario (1997-08-29) MOH003939.

me by letter to reiterate the OSOG's opinion that midwifery consultations were essentially an uninsured service.[64] This was an issue that spanned years.

2. Importance of Positive Hospital Integration Process

114. My career has had a long focus on inter professional and hospital integration.

115. As a founder of the interdisciplinary hospital integration committee at the Markham Stouffville Hospital two years before midwifery was regulated in Ontario, I had firsthand knowledge of the role which a positive hospital integration process can play in helping midwives to integrate into the health care system.

116. Hospitals have a tremendous amount of control regarding the level of integration of midwives in the hospital. Each hospital writes its own by-laws, which determine divisions and departments within the hospital.

117. I was involved in working with the OHA around regulation to develop bylaws for hospital to integrate midwifery into their practices. The OHA recommends that hospitals have midwifery departments. In London, for example there is a midwifery department whose head is paid the same as a head of obstetrics, but elsewhere, as in Markham Stouffville Hospital where I work, there is just a division, which means the head is not paid as much.

118. At Markham Stouffville Hospital, we have a "Maternal Child Program" and a Division Head for midwifery within the Obstetrics and Gynaecology department. That person addresses quality of care issues, deals with polices, and is the main contact with other stakeholders in the Hospital. I was the head midwife from 2006 to September of 2011.

IX. LIABILITY INSURANCE

119. In 2001, there was a crisis with respect to our liability insurance premiums increasing dramatically as a result of 9/11 and its impact on the insurance industry. The crisis was coming to a head in June, 2001.

120. On June 4-6, 2001, a Symposium organized by the AOM, CMO and MEP took place on the Model of Midwifery Care in Ontario. The Minister of Health and Long Term Care Tony Clement spoke at that conference. During the conference I questioned the Minister about the expiry of the current premium policy on July 31, 2001 and the need for Government to address the issue of the higher premium. My conversation was transcribed as follows[65]:

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64 Letter from R. Johnston (OSOG) to C. Cameron re: midwifery consultations for OB-GYNS (1997-05-30) AOM0002055.

65 AOM Document - Text of Question and Answers with MOH Minister Clement at AOM Symposium on Model of Midwifery Care in Ontario (2001-06-06) AOM0002158.

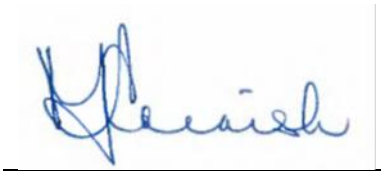
Good evening I'm Carol Cameron, I am a practicing midwife for over 13 years in the Durham Region and I am also the president of the Canadian Association of Midwives. You did address most of my question which was about liability insurance premiums but I would like to press you a little further and let you know that our premium policy does expire in less than 2 months on July 31st, so when will the midwives hear that the government is committed to continuing to fund these premiums.

Minister: Obviously I want to get to this as soon as possible, what I want to do is look at some of the alternatives – we are in a situation now as I understand it where we've got a monopoly provider, which really holds us over the barrel a little bit so I think there are other approaches used by other provinces that I'd like to pursue, as potentially models for us so that we aren't beholden to a monopoly provider, I am kind of against monopolies, they tend not to deliver the best service at the best rate so let's see if we can explore some other alternatives. I will have to talk to some of my cabinet colleagues because some of the models involve the province taking a more active role but I am committed to raising that issue and I am aware of the time sensitivity, so I can't commit to an exact date right now but you have my commitment that I want to move this forward and try to get some other options on the table for us.

Ms. Cameron: If you want some information on the BC model I can give it to you.

Minister: That would be great, thank you.

SWORN this 24th day of July 2016.



A Commissioner for taking Affidavits.

Carol Cameron

Carol Cameron