**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 KATRINA KILROY

I, Katrina Kilroy of the City of Toronto in the Province of Ontario, MAKE OATH AND AFFIRM as follows:

1. I have been a practising midwife since pre-regulation starting in 1991, and I have been AOM Board Member at Large, Vice-President, President-Elect and finally President over the years 2004-2012. 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 Knowledge

3. I have an honours Bachelor's degree in Anthropology/Comparative Development from Trent University (1987). I completed one year of a Master's degree program at Carleton University in 1988.

4. I met several practicing midwives working at the abortion clinic where I was working as a counselor in the late 1980s. These midwives were working at the clinic as nurses or counselors to supplement their midwifery incomes, including one who had received some training from a program in El Paso, Texas. Aware that midwifery legislation was forthcoming in Ontario, I contemplated whether I should pursue midwifery training prior to legislative change or wait for the establishment of a formal midwifery education program.

5. I decided I could afford to attend an intensive training program to contemplate whether midwifery was a suitable career choice for me. I applied to a six-month program at an El Paso midwifery clinic.

6. I remember feeling motivated by the uncertainty of how midwifery's legal reform would unfold in Ontario. I hoped my experience would help to facilitate my acceptance to a formal midwifery education program that was being planned for Ontario, if I still felt committed to becoming a midwife after attending the intensive program.

7. I completed a midwifery apprenticeship in El Paso, Texas in 1991. I remember feeling "shocked and thrilled" when I was still in Texas, to be contacted by Ontario midwives Michelle Kryzanauskas and Heather Keffer with an offer to join their midwifery practice in 1991.

8. I subsequently gained entry to and graduated from the Michener Institute of Applied Health Sciences Pre-Registration Midwifery Programme in 1993. In my experience it is unusual to meet a midwife whose only university education is the MEP or the Michener Programme.

### 2. Practising Midwife

9. In May of 1991, I joined a midwifery practice in Simcoe-Grey counties, where I served primarily rural women.

10. Following legislation in 1994, I practiced for one year in Peterborough before beginning work with the Midwives Collective of Toronto in March 1995 where I continue to work.

11. I have been the Senior Midwife Manager there since 2010.

### 3. Teaching, Preceptoring and Mentoring

12. I have taught as a guest lecturer over the years since 1994 in the Midwifery Education Program at both McMaster and Ryerson on a variety of subjects, including "Surviving life as a Midwife", "Emergency Skills" and "Representing Midwifery in an Inter- Professional Context."

13. I have been an Instructor/Senior Instructor, for the AOM's Emergency Skills Workshop from 1996 to the present.

14. I have been the Midwifery Education Program Clinical Placement Liaison responsible for all clinical placements in the province from January 2013-August 2014.

15. I have also been a preceptor for many student midwives in training as well as the mentor for many New Registrant midwives.

### 4. Presentations and Publications

16. I have written and presented on numerous topics relating to midwifery skills and risks, hospital integration, inter professional collaboration and other issues including to multi-professional audiences as detailed in my CV. This includes the following:

(a) I have co-authored with 5 physicians and others, including obstetricians, family physicians and an epidemiologist, a peer reviewed journal article. Beyond Alcohol and Tobacco Smoke: Are We Doing Enough to Reduce Fetal Toxicant Exposure? Crighton E, Abelsohn A, Blake J, Enders J, Kilroy K, Lanphear B. Marshall L, Phipps E, Smith G Journal of Obstetrics and Gynecology Canada. J Obstet Gynaecol Can 2016;38(1):56-59

(b) Out of Hospital Birth: Choice, Risk, Decision. University of Toronto Refresher in Primary Maternity Care, May 2015

(c) Midwifery Care for Birth Outside of the Hospital: Facts Biases and Liabilities. Osgoode Certificate in Clinical Risk Syllabus. Osgoode Hall Law School, York, Feb 2014

(d) Midwifery in Canada and The CAM/TAMA Twinning Project. Ethiopian Midwives Association and Ethiopian Ministry of Health representatives, Addis Ababa, Dec 2014

(e) Home Birth: Facts, Biases and Liabilities. University of Toronto Obstetric Malpractice conference, Toronto 2009, Ontario Medical Association/Association of Ontario Midwives Liaison Committee, 2009, Collaborative Maternity Conference, Thunder Bay 2010, AWHONN Canada 21st National Conference, Montreal 2010, Clinical Leadership Day, Peterborough 2011, Ministry of Health Primary Health Care Branch, Toronto and Kingston 2011

(f) Reproductive Health Chapter Launch Panel POWER Study (Project for an Ontario Women's Health Evidence-Based Report). Feb 2011

(g) Do Midwives Do Things Differently? Mount Sinai Grand Rounds Presentation with V Van Wagner and E Brandeis, Feb 2011

(h) Bring your Challenging Cases and Situations. University of Toronto Refresher in Primary Maternity Care, May 2010

(i) Auscultation of the Fetal Heart Rate in Labour, and Fetal Heart Rate Monitoring in Labour - The Debate. University of Toronto Obstetrical Malpractice: A Survival Guide, 2013

(j) Talking About Home Birth In Hospitals-Canadian Association of Midwives conference. Nov 2010

(k) Maternal and Newborn Care: Meeting Community Needs and Integrating Midwives. Ontario Hospital Association, Sept 2010

(l) Optimizing the Use of Health Providers' Competencies in the Provision of Primary Care for Women and Newborns. Ontario Hospitals Association, Sept 2009

(m) Inter-Professional Collaboration in the Hospital. Ontario Hospital Association, Medical Staff Management Conference, June 2008

(n) Risk Management in Obstetrical Care-Inter professional teams. Ontario Hospital Association, Dec 2008

(o) Represented midwives at the Conference Board of Canada's 2014 conference on collaborative care.

**5. AOM/CAM Roles**

17. I was a Board member with the AOM from 1993 to 1995, during the time legislation and regulation was being developed. From 1996 to 2004, I was focused on my midwifery practice and participated in the AOM only as a member. However, the low compensation and stress of the job had profound personal impacts for me and compelled me to be very vocal in AOM compensation meetings and later to pursue an AOM leadership position.

18. I served as the Board Member at Large of the AOM from 2004-2005, Vice President from 2005 to 2007, President Elect from 2007 - 2008, and President from May, 2008 to May, 2012. These years were critical in terms of the AOM's negotiations with the MOHLTC. During that time I also sat on the OMA/AOM liaison committee.

19. I have also been on the board of the Canadian Association of Midwives (CAM) since 2006 and I am currently the President Elect.

### 6. International Midwifery and Maternal and Child Health

20. I am an active participant as a CAM representative in international midwifery and maternal and newborn health issues and conferences including the following:

(a) I have consulted with international midwifery organizations, NGOs and governments and attended many international midwifery conferences.

(b) I was an invited participant in the Global summit convened in May, 2014 by Prime Minister Stephen Harper of Canada and President Jakaya Kikwete of Tanzania. The "Saving Every Woman Every Child: Within Arm's Reach" Summit had the objective of shaping the future of Child and Maternal Health collaborations in Canada and around the world, bringing together Canadian and international leaders and experts, Canadian charities, businesses, scientists, developed and developing countries, international organizations and global foundations to ensure that maternal, newborn and child health remains a priority of the global development agenda. Toronto, May 2014.

(c) I was an invited participant to the Roundtable on Maternal and Child Health Chaired by Hon Rona Ambrose, the Federal Minister of Health and Dr. Margaret Chan, Director General, World Health Organization in May, 2014 in Toronto.

(d) I was an invited participant to the CAM –MNCH Symposium, Impact 2025: Working Together for Global Maternal, Newborn and Child Health, Ottawa, October, 2013.

(e) I attended the May, 2016 Woman Deliver Global Conference in Copenhagen as a representative of CAM. This conference was the largest gathering on girls' and women's health and rights in the last decade and one of the first major global conferences following the launch of the Sustainable Development Goals and included participants from 169 countries.

(f) I am a member of the steering committee for UMOJA, International Midwifery Association Twinning Project, Canada/Tanzania, 2011-present

### 7. Inter-professional Collaboration and Hospital Integration

21. Throughout my midwifery career I have been engaged in work to further inter-professional collaboration.

22. I was the AOM representative to the "Babies Can't Wait" Steering Committee, Primary Health Care Transition Fund Project, 2004-2007. This was an inter professional, primary health care research project funded by MOHLTC. The Committee examined issues related to the education, retention and inter professional collaboration of maternity care providers.

23. I was also a member of the Child Health Network of Greater Toronto, Maternal Newborn Taskforce, 2008-2010

24. I was a member of the MORE OB (Managing Obstetrical Risk Effectively in Obstetrics) Core Team, Mount Sinai Hospital, 2004-2008 – This team established the MORE OB program at Mount Sinai when it was still a pilot program and delivered the content to a very large group of staff made up of nurses, administrators, doctors and midwives. MORE OB was initially created by the Patient Safety Division of the Society of Obstetrics and Gynaecology of Canada (SOGC) in 2002 to address serious risk and patient safety issues in Birthing Units.

25. As a Board member of CAM, I participated in the development of the Joint Policy Statement on Normal Birth which was issued in December 2008 by the Society of Obstetricians and Gynaecologists of Canada ("SOGC"), the Association of Women's Health, Obstetric and Neonatal Nurses of Canada ("AWHONN Canada"*), the Canadian Association of Midwives ("CAM"), the College of Family Physicians of Canada ("CFPC") and the Society of Rural Physicians of Canada ("SRPC"). [2]

26. In 2010 I was hired as a consultant for a Health Force Ontario project funded by the Ministry of Health and Long Term Care (MOHLTC). In this role I worked with 8 different Ontario hospitals to improve the quality of care provided in birthing units by exploring problems and proposing resolutions to inter-professional issues. These birthing unit teams typically included obstetricians, nurses, a chief of staff, midwives and sometimes family physicians. The project goal was to create plans that could be applicable to other hospitals. [3]

27. Additionally, in 2012 I provided consultant services on inter professional issues to the Peterborough Regional Health Centre and Muskoka Algonquin Health Centre.

28. In addition to working at Mount Sinai Hospital, I have been in approximately 11 Ontario hospitals specifically addressing inter-professional relations, more than 10% of the Ontario hospitals that provide obstetrical care. Through this work I am very familiar with the barriers to midwifery integration in hospitals.

## 8. Feminist Perspective

29. My early learning encompassed not only women's health issues, but also feminist politics and international development, which helped prepare me for my entry into midwifery training and practice.

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2 The Society of Obstetricians and Gynaecologists of Canada, the Association of Women's Health, Obstetric and Neonatal Nurses of Canada, the Canadian Association of Midwives, the College of Family Physicians of Canada and the Society of Rural Physicians of Canada, "Joint Policy Statement on Normal Childbirth", December 2008 AOM0000831 at p. 1.

3 Final Report by AOM for HealthForceOntario re: Optimizing Use of Midwifery Competencies in the Provision of Primary Care for Women and Newborns (2009-09-30) AOM0005942.

30. I credit my interest in women's health and feminism to my mother's "early feminist" attitudes. She was a "natural birther" in the late fifties and early sixties and committed to the Lamaze method and partner accompaniment while birthing.

31. As an undergraduate student at Trent University in Peterborough, Ontario in the mid-1980s I went to a talk that was being given by a woman named Eleanor Barrington who had written a book called *Midwifery is Catching*. It was about how midwifery was being essentially reborn in Canada. She spoke about midwifery, which I had never really heard of before, and showed a film of a home birth. I was in second year university, I was studying international development, and I was sitting in the audience and I thought, "That is what I want to do. Yes, that is what I want to do."

32. I remember feeling an immediate resonance with midwifery's woman-centred philosophy of care. I envisioned its "perfect" fit with my feminist analysis of health care and women's control over their bodies and my interest in social justice. My interest in midwifery influenced my decision to seek volunteer work at a women's health centre. Through that I found paid work at a free standing abortion clinic in the 1980s.

### 9. Overview Perspective on the Changing practice of Midwifery

33. I view myself as most fundamentally, a clinically practicing midwife. I have practiced fulltime for almost my whole career with only a short break to carry a partial caseload in order to be president of the AOM and to work at the Midwifery Education Program.

34. Using my own experiences as an example, this section describes the work and life of a midwife both pre-regulation and in the years following 1994 and how that life and work has changed.

## II. PRE-REGULATION MIDWIFERY EXPERIENCES AND DISADVANTAGES

35. Prior to regulation, my workload as a full time midwife was already very heavy. I was on-call 24/7 for 10 months in a year with not a single day off. I covered a very large rural area where I had to drive large distances, at all hours, regardless of weather.

36. For example, there was a primiparous client who went into labour on Christmas Eve morning in a snowstorm. Even though the highway was soon to be closed, I made my way slowly and carefully to her home. After many hours of labour providing emotional support, physical support, helping her to the bathroom and cleaning up vomit and stool, and coaching her contraction by contraction through a fairly lengthy pushing stage, she gave birth. The second midwife and I monitored her closely for the next few hours. As returning to check on her would not be easy we both stayed for 6 hours post-partum. However by the time I was able to go, the road was completely closed so I just stayed there until the next day, which was of course Christmas Day

37. I also experienced the discrimination and inappropriate wielding of power against midwives and the women they cared for.

38. For example, a client hired me just before regulation because she knew her husband would not be able to be in the room with her or provide her with labour support. She laboured at home for some time then moved to the hospital for a planned hospital birth (she worked for the hospital). I provided labour support throughout the night for a difficult but progressing labour though I was not allowed to provide any other direct clinical care. When it became evident that she would need a forceps delivery, the OB on call came to the door of the room and told the nurse who was also caring for the patient that he refused to enter the room until “that woman leaves”, meaning me. I had never met that obstetrician before. I stood in the hallway listening to my client scream, “no, no, no” as he did an unmedicated forceps delivery. I was the one who cared for that woman’s physical, social and emotional needs and the sequelae of that traumatic delivery in the community for weeks after the birth. The client complained subsequently to the College of Physicians and Surgeons of Ontario (CPSO) about the treatment that she and her midwife received, including how traumatic it was to have her support withdrawn abruptly.

39. This kind of attitude was not uncommon. I recall clearly that at the time of legislation the President of the Quebec Corporation of Physicians said publically that "you might as well make prostitution legal. More people are asking for prostitutes than midwives." At the same time, the President of the Quebec Federation of General Practitioners said, “it’s like letting an apprentice pilot take charge of a Boeing 747 loaded with passengers.”[4].

## III. POST-REGULATION MIDWIFERY - LARGE URBAN PRACTICE GROUP

### 1. Midwifery Collective of Toronto

40. I began with my current practice group, the Midwives Collective of Toronto in March 1995. I am a partner and Senior Midwife Manager of the Midwives Collective. My experience as a practising midwife and Partner Manager at the Midwives Collective of Toronto informs my understanding of the MOHLTC midwifery funding practices and systems which have impacted on me and my practice group.

41. Established in 1983, the Midwives Collective of Toronto is the oldest group practice in Ontario (and probably Canada) and has provided care to thousands of families. We are currently a group of 18 midwives with a range of experience from one to thirty six years of practice. We attend births at home and also have admitting privileges at The Toronto Birth Centre and Mount Sinai Hospital.

42. Last year, we provided care to about 600 families and turned away approximately 1000. Our clients are very diverse and have a complex variety of needs. Our midwives are and always have been very involved in providing support to Ontario’s maternity care

4 Globe and Mail article by Andre. Picard "Quebec MDs spurn Legalizing Midwifery" (May 11, 1989) AOM0000648.

system as advisors, hospital and governmental committee members and advocates, usually on a volunteer basis.

43. The size of our practice is 18 midwives including 2 New Registrants that we are mentoring, 10-14 students per year and 4-6 staff. It is a very complex business to manage. I have been primarily responsible for its management in consultation with the other partners for 16 years.

### 2. Increasing Diversity, Complexity and Vulnerability of Clients

44. I have observed a significant increase in the complexity, diversity and vulnerability of clients served by midwives over the years since regulation. I believe this can be attributed to a number of factors including the following:

(a) Once midwifery was an insured service, it expanded the population of clients for midwives. Even though midwives pre-regulation had a sliding scale for those with financial issues, nevertheless midwifery often attracted the knowledgeable and privileged. The movement to an insured service with hospital admitting privileges meant that choosing a midwife was no longer an “outside the system” choice or one which required financial means.

(b) We have seen an increase in vulnerable clients including those affected by poverty, discrimination, unstable housing, immigration and refugee issues, and other social determinants of health.

(c) Increasing numbers of our clients are also uninsured. Ministry policy provides that midwives and Community Health Centres (CHCs) are the entities which can provide free care to the uninsured. Currently around 13% of the clients of our practice group are uninsured because they are immigrants, refugees, in a 3 month OHIP waiting period or have other impediments to access.

(d) As the population of those giving birth has aged, so too has the population being taken care of by midwives. Older clients may have complex, intersecting risk factors, such as age, weight, health status. Appropriately, none of these things would demand transfer to an OB but many of them increase the likelihood of pregnancy and birth complications.

## IV. THE LIFE OF A MIDWIFE

### 1. Introduction

45. The physical, emotional, sensory and intellectual demands and efforts of being a midwife have changed over the time I have been practicing. The demands and skills required of midwives are increasing, and include the expanding scope of practice, the changing demographic of the client base (including age and increasing diversity) and

the increasing demand for participation of midwives in various hospital and health system functions. Working conditions have also changed.

46. I feel that the only people who understand what midwifery is really like are midwives, their families and their therapists. The day to day is gruelling but rewarding. I have spent 25 years of 24/7 being on call with the exception of yearly holidays a brief period when I shared call with another midwife and a few short leaves to have babies of my own. In our practice, we work 5 months on call and one month of vacation (off call). So we are on call 10 months out of 12. Now, unlike the past, we have also setup a system that allows us to take a few days a month off call.

47. In addition to being physically exhausting, the job requires very intense emotional labour. Providing contraction by contraction support to someone experiencing what is likely the most painful and difficult experience of their lives, is very demanding and taxing work. Though the outcome often brings joy, it may also bring pain and complex emotions and physical impact.

48. Midwives do give devastating news. For example, I recently had to tell a woman that her babies would be born into palliative care. Midwives are often the ones who deliver the news that a pregnancy is not viable or that a baby has congenital anomalies. We may be informing a client who is just coming to the end of her first trimester that she has a sexually transmitted infection. These conversations are made all the more difficult by the fact that I build close relationships with every one of my clients. We manage the partners of midwifery clients in all kinds of emotional states from elation to aggression. We manage all kinds of families – extended, prying, abusive and supportive.

### 2. A Glimpse at the Life of a Midwife

49. There are many misconceptions and misunderstandings about what midwives do in Ontario in order to carry out the midwifery services required by the MOHLTC.

50. This description below is by no means complete but helps to provide a glimpse into what it is that midwives like myself do that we believe is inequitably compensated for by the MOHLTC relative to our comparator, the CHC physician.

#### (a) Clinical Work for Clients

51. Throughout any day, I will be answering unanticipated and unscheduled pages from clients. These pages could cover a myriad of topics and concerns and come in the day, evening or middle of the night. They include onset of labour, bleeding in early pregnancy, breastfeeding problems, and newborn issues such as crying babies. Clients page about everything so many different issues which might need to be addressed quickly: eg. yeast infections, questions about vaginal discharge, cramping, fetal movement, headaches, swelling, fever, viral or food borne illness, exposure to others who are ill, healing of the umbilical cord, colour of baby's stool, nipple pain, baby not nursing, baby hasn't stooled in a couple of days, concerns about milk supply, increase in postpartum bleeding and many, many other issues.

52. On average, I spend at least two and a half days per week at our clinic's offices. I schedule and attend appointments with clients at the office. I review lab results that have come. If there are any results which are not routine, we are paged so that we can review them, arrange for any follow up testing or consults required and then ensure documentation recorded and filed. With lab results, I may need to follow up with a client to give them difficult news, such as a result which discloses an issue such as Downs Syndrome or a fetus with other complications or which is not viable. This would lead to extensive and other emotional and difficult discussions with the client and family about options and necessary decisions to make moving forward.

53. I also do clinical prenatal visits and postpartum visits that are greater than one week postpartum. Clinic visits are one every one half hour to 45 minutes depending on the issues that need discussion. Up to one week postpartum, visits are done by attending at the client's home to see the client and the baby and address issues such as breastfeeding, postpartum sadness, healing and baby's weight gain.

54. Commonly after I finish my clinic and answer pages, I have one or more home visits to do. On average I do about 5-6 home visits per week. Some weeks I have 12 visits. I have to decide whether to go home and have dinner or do home visits first. This may depend on the client's availability. I can't commit to being home for dinner so have to have planned ahead if others are depending on me to prepare dinner or to be present.

55. Prenatal home visits are often in the evening so a partner can be at home and participate.

56. On average home visits take an hour plus travel time but if there are breastfeeding problems or significant issues of any kind, they can stretch to two hours.

(b) **Labour and Birth**

57. While birth attendance for a full time midwife averages out to one primary and one backup per week, in fact, it usually does not happen that way. I could easily have three primaries in a week, perhaps two of my own and one for another midwife who's call I am covering so she can have a few days off or because she is sleeping after a birth or has a family crisis.

58. Some births take 6 hours in total and some go on for three days.

59. As labour is unpredictable both in timing and duration, the number of births I am responsible for in a week cannot be predicted with certainty. I have to ensure that I am physically and emotionally alert so that I can act professionally in a labour and birth at all times when I am on call.

60. The primary labour would usually include answering one or two labour assessment pages which would take about a half hour each - which includes assessing the report from the client or her partner or family member, talking to her on the phone to assess the pattern of contractions, advising her about whether early labour and how to

manage it and reviewing appropriate care over next few hours and when to call next. At some point, I will go and do an in home assessment. With primips, (first babies) the women is often not in active labour but you still need to go and do physical assessment and spend some time with client teaching coping methods for early labour and reassuring them in order for them to feel safe and comfortable to stay at home and continue to allow the physiologic process to unfold. Most commonly, the next time I am called, I will stay with the woman throughout labour and birth. With multips, (second or more babies) in person early labour assessments are not universal but still happen regularly.

61. Once the client is in active labour, I remain in attendance at the home usually or at the birth centre. For planned hospital births, in our urban setting, we would stay in the client's home until relatively close to delivery. There are no breaks in this. I am alone or with a midwifery student. As we are often at a person's home for 4-8 or more hours and you have to eat – it's usually not possible to pack three lunches/dinners before leaving the house. So a midwife may often end up rummaging in other people's kitchens.

62. When it is close to time for delivery and planned hospital birth - I go in my own car or in their car to the hospital. There is a lot of physical support at this stage of labour – to help a laboring woman.

63. The driving requirements of being a midwife are onerous and sometimes dangerous. Of course one should obey all traffic rules all the time but the reality of midwifery is that we must balance the potential impact of our arrival time on the well-being of our clients with the conditions we are driving in. We have to balance speed, weather conditions, and the safety of our clients and those on the road with us. We don't want to risk an accident or traffic ticket or the well-being of our clients. We don't have the option to not drive in bad weather conditions.

64. When we get to the hospital, it is often when the woman is in transition. I will need to get her admitted at the exact same time she needs the most intensive labour support from me and clinically a lot can be going on which needs my attention. I am trying to determine the appropriate time for the second midwife to be called, I am reporting in to the Team Leader in the hospital and I may also be advocating for something the family wants that may be different from the hospital routines.

65. Advocating for choices which are different than routine protocol, for example the family are refusing antibiotics for Group B strep prophylaxis, requires a very particular skill set and can create stress between a midwife and the other members of the health care team. I am negotiating all of this at the exact time that my client needs me the most and when I have the most demanding charting requirements due to the hospital's cumbersome electronic medical record. I will have to spend some time re-entering all of the data that I have already entered in my own records from the labour at home.

66. She is primip, so when pushing with descent (perhaps one half hour into pushing – encouraging her to push, cleaning feces and vomit, monitoring the heart rate

every 5 minutes, helping her to change positions) I call the backup midwife to come. As this is in an urban context, the backup midwife will likely arrive in 20 -30 minutes. During this time, as the baby is crowning and being born, there is an incredible amount of intensity - it is the most challenging at this point to assess the fetal heart rate due to the positioning of the baby low in the pelvis, trying to do everything possible to reduce the risk of tearing. The client is usually expressing intense pain and there are heightened emotions as the head is showing. I am also dealing with any family member or support person present including sometimes a sibling.

67. As a midwife I am on the alert for any signs of potential complications eg. shoulder dystocia. I am constantly doing assessments – is it safe to wait for the baby to just rotate or do I need to do maneuvers. I am also doing cord management if necessary to ensure the cord is not in a problematic position.

68. The baby is born with just two midwives in the room. We are each responsible for one patient and have unique tasks. This could range from normal care to managing a life threatening emergency.

69. If the baby is born not breathing, the secondary midwife will resuscitate the baby and ensure the baby's transition to extra uterine life is proceeding as safely as possible, while calling for assistance as necessary.

70. 10% of babies in Canada need some form of resuscitation. This often requires use of special equipment and requires special training. As midwives we are recertified annually in Neonatal Resuscitation including intubation and umbilical vein catheterization. This recertification and biannual recertification in emergency skills and CPR along with multiple other quality assurance requirements for registration also have to be fit into our work lives on a regular basis.

71. The primary midwife is responsible for the mother's physical and emotional well-being, including assessing bleeding and other issues, and managing the delivery of the placenta which is the third stage of labour.

72. The baby is put skin to skin with the mother and then our tasks continue. We stay in the hospital until she is ready for discharge, doing a newborn exam, clinical care, teaching, repair, breastfeeding teaching, newborn care teaching, helping her to bathroom, cleaning up blood, changing underpads, assessing both mother and baby for stability and extensive charting. At Mt. Sinai Hospital for example, the new electronic record system has added significant time to the birth work of a midwife at the hospital.

73. We get the woman ready for discharge, into a wheelchair and at this point the backup midwife goes home. The primary midwife assists the woman to her car and often spends a half hour talking to the student afterwards about what happened at the birth. Then, if I don't have any urgent home visits that I have been putting off during the time of the labour, I will go home. Otherwise, I may go do a home visit for another client. During this entire time, I answer pages with respect to matters for other clients and likely

also from my family asking when I am going to be home or about other family matters requiring my attention.

74. If this is in the morning, I have probably spent 20 minutes phoning my teenage daughter trying, usually unsuccessfully, to get her out of bed in the morning for school (much less effective over the phone).

75. It is very common also that I may call for relief at 8 a.m. in the morning (once I am up for more than 24 hours) if the baby is not born yet. I will call the second midwife to take over as primary. If the baby comes while I am off sleeping, eating, bathing, for 6-8 hours, a third midwife will have to be called to attend in the second midwife role. Before I can go to sleep I have to think about all the things in that day, that I have to rearrange, post-partum visits, emails to be answered, are there follow ups that require my immediate attention.

76. When I get up, if the baby is not born yet, I go back to the birth. If the baby has been born I need to get full report from the midwife who covered for me. I have to do the day one visit which is likely early the next day so I won't be able to sleep in the next morning to try to catch up on the sleep missed the previous day.

77. Whatever I was supposed to be doing that day while I was sleeping, has to be attended to now. If I had clinic it has probably been rebooked. If there are home visits, consult letters, care management tasks to be attended to, I have to get up and do them, usually immediately as it is likely late in the business day.

78. I may have inductions to book, complicated by the fact that at my hospital all spaces are usually taken 10-14 days in advance. Someone may need follow up for a probable first trimester loss or bladder infection. I may have a baby whose weight gain I am concerned about who needs an extra home visit. I also could get called to a new birth.

### (c) **Teaching and Mentoring**

79. During my work, I am also teaching students which is done in a variety of ways depending on the learning stage of the student. Teaching inevitably makes every appointment longer as students have to practice their skills.

80. At the end of the day, there is usually a review with the student - one half hour to an hour of learning with the student. The student may draft a consult letter which briefs a physician on a consult need and history, which I review, edit and explain to the student. There are evaluations conducted with the student's tutor approximately every 6 weeks.

81. As well, during a day, I may also have responsibility for a New Registrant. All of this also requires me to be observing students and New Registrants so that I can provide assessments of their work and any necessary guidance.

### (d) **Administrative Tasks**

82. As a midwife I have many administrative tasks and responsibilities which take up a lot of time. These are much greater for me as I also lead the management of a large midwifery practice group. Also, during my lunch and at the end of the clinic day I usually do something administrative, for example, birth distribution, which involves deciding which of the requests for care can be accepted and which will be referred. Since we have more requests for care than can be accommodated, only 1 out of 3 women who make requests get care in our practice. Birth distribution is a very detailed process. We must prioritize “out of hospital” births (due to caseload restrictions in the hospital), and also prioritize special needs populations, people planning a natural birth, repeat clients and then fit it all into a calendar with planned holidays, students and midwives schedules and who can work with New Registrants. This takes hours every week. Of course we could choose to fire 2 or 3 midwives and care for 100 less people per year and take all clients on a first come first served basis but we do not feel that would prioritize the health care needs of the population we serve.

83. Since it is a greater workload for a midwife to be assigned to work with New Registrants, we try to balance out assignments. Students also have dates which need to be accommodated, to ensure babies are born before a student’s term is over to facilitate their experience of continuity of care and ensure they have sufficient quantity of experience.

84. We also need some balance of primips and multips as primips are significantly more time intensive for a course of care.

85. It is very complicated to do practice planning for a practice like ours of 18 midwives, 12 partners, 2 new registrants and 4 associates, in addition to 4 or 5 staff and 10-14 students per year.

86. Additionally, I need to prepare the budget requests, include any possible growth, and make requests for all caseload variables and for new registrant spots. We still have to present the same business case every year and often mid-year for the above.

87. We have to create our internal operating budget and budget for equipment, apply for leasehold improvements, liability insurance. We may have significantly greater equipment needs than $1000 allotment for each midwife per year and have to figure out how we will manage that. Will we defer some necessary purchase or try to find economies elsewhere in our operating budget.

88. We have relatively high turnover of staff as our budget does not allow us to pay a sufficient wage to all of our staff to make the positions attractive to people over the long term. This turnover creates more stress. Information technology is a particular problem and has been for many years, as it is not resourced properly by the Ministry. Unlike physicians who have received some funding, the MOHLTC has not provide us with adequate funding for creating electronic medical records, updating our outdated technology equipment or an appropriate secure email system. We may have no access

to databases of updated clinical research, such as UptoDate so we may need to rely on our student's university access to those materials. All of these issues make our practice life more difficult and stressful.

89. Other administrative tasks come along on an ad hoc basis. I may get a phone call at 3am from the alarm company telling me that the alarm is going off at the clinic. There may be a flood in the basement that I have to deal with, contacting the landlord and managing the clinic space while repairs are done. We will have a researcher coming to talk to the practice about a research study they are engaged in that requires us to recruit participants, obtain consent, fill out forms, provide treatments and gather follow up information to be forwarded to the researcher. All midwives will likely participate in this and one midwife will be the contact person for the practice. All of this work is not remunerated.

### (e) **Hospital and Maternity Care Administrative Work**

90. There is also hospital administrative work to fit in, such as in-services, training and many inter professional committees where I and other midwives participate and discuss hospital practices, protocols and other issues.

91. As well, we receive requests from the local community to participate in work that supports the maternity care system. These can include: a consultation about how to provide better care to community members who are marginalized and pregnant; a request to come and speak at the local high school about midwifery It may be a request to participate in larger discussions around collaborative care, the development of quality assurance programs for maternity care providers or planning some educational or professional development opportunities for caregivers in the community. We get regular requests from Nurse Practitioner students, Family Medicine residents and others seeking placements in our practice to learn about midwifery.

### (f) **Some Weekly Tasks**

92. Some of my weekly tasks include weekly practice meetings that, in our practice, last for about 4 ½ hours. These practice meetings give us a chance to engage in practice planning, human resources management, caseload management, clinical review, protocol development, crisis management and problem solving.

93. I dedicate 4 hours a week on a non-clinic day to perform my practice management duties. This will include practice planning, student planning, budget preparation or assessment, communication with the TPA, and human resource management. Also, I have to prepare all of the contracts for NRs, associates, and partners.

94. Many midwives attend rounds weekly in their hospital, not only to keep up on clinical knowledge but to maintain good relations in their hospital.

### (g) **Some Monthly Tasks**

95. We are required to prepare and enter data about all outcomes for our clients in order to get paid for the care. We then oversee monthly invoicing to the TPA. We have to submit any relevant expenses to the practice for reimbursement. We attend monthly peer review sessions as required by our College.

### (h) **Impact of Practice Demands on Family/Vacations/Health**

96. Midwifery is not simply a job. It is a lifestyle and a constant demanding presence for a midwife and her entire family. Some midwives don't go to movies or stay up late reading or socializing because they are afraid that they may have to work in a couple of hours. It is a constant negotiation with yourself as you are always aware that you could be called out at any moment.

97. The pager interferes with family, bathing, intimacy, dental work, fitness, cooking and time for friends. You name any routine human activity and I will have an experience where my pager has gone off during such an activity. Midwives who are on call cannot drink alcohol as even small amounts while socializing may be problematic for driving or providing clinical care.

98. Making routine health care or specialist appointments is particularly challenging and I have had to pay significant fees in the past for missing an appointment due to a birth. Even family counselling appointments are challenging when you work on-call. The family gets tired of hearing that your clients' priorities come before their needs. For example, I have had to call my ex-partner while he is in the middle of a team sports activity and tell him, "You have to come home right this minute" to take care of our children. I am now separated and I know that the stresses of living with a working midwife contributed significantly to the separation.

99. We miss our kid's concerts that they have been preparing for weeks. We are reading bedtime stories and the pager goes off and you have to leave immediately. This is very disruptive for small children, in fact I think this was the worst thing for my kids. It has a significant impact on kids because it's hard for them to understand when everything shifts so quickly and where client demands come before their needs. They are in a paddling pool with me and then they need to get to the person who cares for them while I go to a client who needs me. They are told to get out immediately and get in the car but kids are naturally resistant in this type of situation and this adds conflict for a family. On another occasion, we might be all packed up and 10 minutes into a drive over to grandma's house when the pager goes off. It adds stress and disappointment to normal everyday activities on a regular basis. When my kids were little, they sometimes used to break into tears when my pager went off.

100. As a midwife, I have had to balance the needs of my elderly mother, my sister in palliative care, parental duties at my kids' schools, being with my kids as a family pet was dying. While I understand that all working people have these challenges, the nature of on-call, 24 hour work is very different. It is difficult to make any kind of commitment

to your family and know that you may or may not be able to keep that commitment. If you ask your practice partners to cover you for any extended period of time, you have a keen awareness of how much stress this will be adding to their lives as they are dealing with all of this and now your workload as well.

101. These sacrifices and demands are part of the nature of our work but they need to get compensated fairly. I do not believe the sacrifices we make and the demands on us which produce excellent outcomes for women and the health care system are understood or properly valued by the rest of the system.

102. Given the increased professional demands on midwives and the diverse circumstances of midwives, there is a desperate need for both full-time and part-time employment options. The on-call nature of midwifery work means that it can be very difficult for midwives to accommodate our own childcare, elder care and other family needs. It can also be difficult to manage illness or take any kind of break from the intensity and stress of midwifery practice. Part time practice is also necessary to accommodate the midwifery MEP faculty who are required to be practising midwives and midwives who have a disability that makes full time work impossible.

103. The midwifery model demands that midwives provide intrapartum care. For a midwife like myself, (who after decades of practice is suffering an injury that makes intrapartum care impossible, i.e. no lifting, bending, twisting, squatting, standing for extended periods) there is no midwifery employment option at all. As the sole income earner in my family, I had to push myself, continuing to provide intrapartum care, until I was no longer able to work at all as a result of my injury which is my current situation since June of this year.

104. On the other hand, MOHLTC funding practices make it difficult for midwives to control their ability to earn income when they do have the personal capacity to increase caseloads or for practices to expand when there is demand.

### 3. Comparison to Physicians and Nurses

105. Through my inter-professional work I have observed that the working life of a midwife is extremely demanding relative to the life of a physician or nurse or nurse practitioner given the on call demands and continuity of care required of midwives.

106. I have been frequently told by hospital nurses that they would never do what midwives have to do for their money, especially given that midwives do not receive a HOOP pension, overtime pay, have little control over their schedule and have to work in other people's homes. My own family doctor on a recent visit about my current health disability related to my work, said to me that my job was more demanding and difficult than his.

107. Our comparator, the CHC physicians have described in their statements in these proceedings their regular work day. Job postings/descriptions for such positions note that the positions have regular hours as an attractive feature of the work allowing work/life balance. Such balance does not happen for a midwife. Physicians are very

aware of how hard they worked to become physicians but there seems to be very little awareness of the commitment, hard work and sacrifice involved in the life of a midwife.

## V. LABOUR SHORTAGE OF MIDWIVES AND ONGOING RECRUITMENT AND RETENTION ISSUES

### 1. Labour Shortage of Midwives Ongoing

108. In my experience, ever since pre-regulation there have been many more women wanting midwives and, despite increasing numbers of new midwives each year coming into the system, there is a chronic labour shortage of midwives.

109. At our practice group over the last few years we have turned away upwards of 1000 clients each year. Turning away substantial numbers of clients each year has been a feature of our practice group since regulation.

110. Over the last 20 years of maternity care meetings and working groups I have participated in, a frequent theme is the decreasing numbers of family physicians who are willing to provide obstetrical care (in large part because of the work demands of providing intrapartum care even with nursing support). At the same time, we have seen that more and more women want the particular model of care which midwives provide.

111. I was the AOM representative to the "Babies Can't Wait" Steering Committee, an interprofessional, Primary Health Care Transition Fund project funded by MOHLTC, 2004-2006. This project and the report examined the depth of the maternity care health human resource crisis in Ontario and identified multiple barriers related to the education, retention and inter professional collaboration of maternity care providers. [5]

112. As well, I have also observed midwives in our practice who found ongoing practice requirements extremely demanding with insufficient reward and respect for such demands. I have seen midwives leave the field for this reason.

## VI. SIMILARITY OF SCOPE OF MIDWIFERY AND PHYSICIAN MATERNITY AND NEWBORN CARE

113. Through my work in providing intrapartum care in hospitals and participating in studies of hospital intrapartum care, I have observed that the scope of intrapartum work of family physicians, obstetricians and nurses in hospitals is often very similar to that of a midwife when dealing with clients who are considered "low risk".

114. Family doctors in particular have very similar scope to midwives in the hospital I work in and I observe that they consult and transfer care to obstetricians for essentially

5 Babies Cant Wait Final Report, Part 1.pdf, (July 31, 2006), AOM0017397.

the same matters that midwives do. However, they do not attend throughout the labour - that work is done by nurses.

115. Family doctors and midwives are both primary care providers in maternity care – family doctors as generalists and midwives as specialists in such care. Midwives and family physicians generally order the same tests and diagnostic procedures for low risk pregnancies.

116. Our comparator, CHC family doctors do not generally provide intrapartum care. They generally refer to obstetricians at approximately 28 weeks gestation during the client's pregnancy.

117. The above-noted similarities reinforced for me that I and my fellow midwives were being discriminated against in relation to our remuneration. How could our work be similar in so many respects and yet our pay be so fundamentally out of proportion? While I have never thought midwives should be paid the same as the CHC doctors and recognized differences in our work and education, the lack of proportionality seemed very inequitable. As did the fact that we fell so far behind over time.

## VII. CONTINUING PREJUDICES, HOSTILITY AND INVISIBILITY

### 1. Prejudices, Stereotypes and Hostility

118. Since regulation, I have continued to face from time to time dismissive and negative comments and prejudices during conferences, in hospital rounds and more generally about my work as a midwife and about midwifery more generally

119. Examples of this include the following:

(a) Even something simple, like hearing somebody in rounds say about a complex case, "well, at least she wasn't a midwife client".

(b) Having a nurse say during a newborn resuscitation, "that's why we don't do births at home."

(c) Even things as simple as anaesthetists stating that midwives don't' have the skills to assist with and monitor epidurals. These are skills that midwives exercise daily in their work but they are still often seen as unskilled by some physicians in some hospitals.

(d) I recall presenting on home birth to a group of physician leaders and made a joke about how midwives bring a kettle, bulb syringe and pair of scissors to a home birth and when they did not laugh, I realized that they thought I was serious. Fifteen years after regulation and they were astonished that we took a complete set of modern equipment with us to home births.

120. These kinds of attitudes, stereotypes and prejudices continue to impact the ability of midwives to practice in many communities.

### 2. Invisibility of Profession and Work

121. Apart from comments, I also experience the fact that professionally, midwives are often rendered "invisible." Examples of this are the following:

(a) On lab forms there is often no provision for ordering by a midwife, only a physician.

(b) Hospital staff relentlessly asking patients, “Who’s your doctor?”

(c) New systems or technologies are rolled out at the hospital and you show up there for a birth and there’s a piece of equipment you’ve never seen and someone says, “Oh, we forgot to tell you…”

(d) Instructions to pregnant women by others in the health care system often include “ask your doctor…”

(e) Politicians making promises about access to health care usually promise more doctors and nurses, in spite of the ongoing shortage of midwives.

(f) The *Ambulance Act* was changed in 2005 which had major impact on midwifery clients being transferred to hospital which could have been avoided if the AOM and midwives had been consulted.

## VIII. BARRIERS TO PROFESSIONAL INTEGRATION AND DISADVANTAGES EXPERIENCED

### 1. Introduction

122. The September, 1993 Ontario Midwifery Program Framework recognized that the equitable integration of midwives into the health care system was an essential requirement for the sustainability of midwifery and the equitable treatment of midwives, a highly female predominant profession.[6] It recognized a role for the Ontario Midwifery Program in providing stewardship for the program to ensure these goals.

123. As an AOM member, as the years went by after that Framework was agreed to, I increasingly felt that the Ministry was not paying attention to our requests or concerns. As midwives we experienced that the Ministry claimed all the power and, particularly over the last 16 years, didn't consistently exercise effective leadership to address our concerns and ensure the equitable integration of midwifery. That integration was an

6 Ontario Midwifery Program Framework Developed by the Midwifery Funding Working Group, September, 1993 (September, 1993) AOM0007064.

articulated objective of the Ontario Midwifery Program Framework we had worked with the MOH to create in 1993.

124. Prior to the regulation of midwifery, both family doctors, and specialists (i.e., obstetricians) provided low-risk primary care. When midwives – experts in low-risk birth – were regulated, there was no system-level analysis of how the introduction of this new profession would impact obstetricians, who would now be expected to move their focus from providing low-risk care, to high-risk care. This lack of analysis meant that no system-level mechanism was put into place that would appropriately support obstetricians moving into a specialist, consultative relationship with midwives.

125. Across the province many hospitals have caps on the number of midwives given privileges, caps on the number of midwifery clients and medically unnecessary restrictions on scope of practice. This means that there are many competent, well trained and ready to work midwives who are unable to do so.

### 2. Hospital/Physician Caps on Hospital Privileges for Midwives

126. My understanding is that in most hospitals, the Medical Advisory Committee takes recommendations on credentialing from department heads. This process is mostly not transparent and a midwife, unlike a physician, generally has no statutory right to appeal the decision. A midwife may be turned down for privileges for the simple reason that the OB group wants to maintain or increase its size so that the volume of deliveries they are managing in each shift remains the same (or grows), without regard to the demand for midwifery in their community. Thus the OBs can maintain their income without having to work more call shifts. As AOM President, I saw a letter from a physician group at an Ontario hospital outlining this rationale for restricting further growth of midwifery within the community despite the fact that women in the community wanted midwifery care.

127. In our practice at Mount Sinai Hospital we have been capped at 3-4.5% of all hospital births since we joined the hospital in 2000. There is no support within the hospital for growing the midwifery program. This has always puzzled us as midwifery births reduce the demand for resources on the hospital (do not use nursing resources, shorter length of stay, early discharge and in home follow up). We have heard recently that part of this is because the Ministry actually pays the hospital less for a midwifery managed birth because they are less resource intensive and not high risk. As a result of these restrictions we have been forced to turn away thousands of clients and not renew the contracts of many midwives.

128. We did grow our practice to support the establishment of the Toronto Birth Centre and we do more births there than any other practice. Given the current crackdown on numbers at Mount Sinai Hospital, we have been forced to turn away most people who call our practice requesting a hospital birth. We know that a certain proportion of those planning out of hospital births will require in hospital care. These women take up the vast majority of our quota at Mount Sinai Hospital. We don't feel that

this appropriately supports a woman's right to choose her birth place but we do not have the power to fix this problem.

### 3. Hospital/Physician Restrictions on Scope of Midwifery Practice

129. Obstetricians, family physicians and anaesthetists have, in more than half of Ontario hospitals, succeeded in placing medically unnecessary scope of practice restrictions on midwives. This effectively results in low-risk women coming under the care of physicians specializing in high-risk care or a transfer of care to a parallel provider in the case of family physicians. For example, midwives may work in hospitals where they are required to transfer care to a physician because the physician is unwilling to consult to provide an order for oxytocin for the induction or augmentation of labour. This happens even though the College of Midwives considers this within the midwifery scope of practice and midwives are trained to provide this type of care.

130. These scope-of-practice restrictions force medically unnecessary transfers of care from the midwife as the primary care provider to the obstetrician and result in the double billing of the health-care system. They also demean and undervalue midwives by implying that they are not competent to provide this type of care in spite of it being within their scope of practice. In fact, according to data from the government's own survey of midwifery practice groups on the matter of hospital integration, 52% of midwifery practice groups have medically unnecessary restrictions placed on their college-regulated scope of practice.[7]

### 4. Hospital/Physician Caps on Midwifery Courses of Care

131. As described above, a hospital or obstetrics department within a hospital may simply say to a midwifery practice, "you may not exceed xx number of births per year in this hospital." The midwifery group is powerless to do anything about it. Obviously, this is a multifaceted issue but in many cases it comes down to competition for clients and income. Physicians end up controlling access to midwifery care in this way and the system does not effectively prevent them from doing this in order to increase their income or for any other reason.

## IX. INEQUITABLE COMPENSATION AND FUNDING PRACTICES

### 1. Introduction

132. As our pay continued to be frozen over the years since regulation, and our system contributions continued to be showing excellent outcomes, I increasingly became frustrated with how badly we were being treated by the MOHLTC when it came to setting our compensation and providing us with appropriate funding.

133. As early as the late 1990s, I was asking questions about how the compensation grid would be reviewed and increased to keep pace with inflation. – A very small group

7 OMP Hospital Integration Survey of MPGs 2011 (April, 2011) AOM0005933.

of midwives were working hard at establishing a small profession by, helping to establish and run the College of Midwives of Ontario, a professional association and 3 university programs. Like many female dominated caregiving professions, we put the needs of others ahead of our own needs and those of our families.

134. The Ministry seemed focused on expanding the program through creating more midwives to meet the ever increasing demand for midwives and ongoing attrition issues. That was done while freezing our compensation and ignoring our requests for equitable compensation. It seemed to me that after the first decade the Ministry focused on managing its increasing budget based on increasing demands for midwives while relying on the fact that midwives would accept frozen compensation to deliver those increasing services

135. The low compensation for our work, given its value combined with the stresses of the work finally impelled me to become directly involved with the AOM in trying to address the unfair compensation we faced. My efforts are set out in this affidavit below.

## 2. Compensation Setting

136. Unlike at the time of regulation, during the post-regulation period, I observed that the MOHLTC did not have any systems in place to determine whether we were being paid equitably. Instead it appeared that the Ministry's budgeting policies and practices were being applied without any regard to the need to ensure equitable compensation. What I heard from the Ministry was repeated claims that they couldn't afford to pay us more, or they would get to us after they finished negotiating with the doctors, or after this election or that, or after reorganization of the Ministry, or after some growth or change in the midwifery program.

137. My particular experience with the Ministry's practices are set out later in this affidavit.

## 3. Overview of Impact of MOHLTC Funding Practices on Midwives, Practice Groups and Clients

### (a) Infrastructure and IT Support

138. I have observed increasing number of hours spent by midwives in practice management and related matters. The increasing demands of practice management have happened as a result of devolution, the 1999 changes to the funding agreement and the fast pace of expansion of Midwifery and growth in the size and complexity of practice groups. Midwives have agreed to the organization systems mandated by the Ministry but without the incentives that have gone to physicians. An example is the $25 000 incentive to physicians for IT support (including electronic charting). Despite requests by the AOM in our 2008 negotiations onwards, the Ministry will not offer any incentives to the midwives, who are in group practices.

### (b) Data Collection for MOHLTC

139. Further, midwives are asked to do uncompensated data collection. Collecting for the Ministry's BORN data base takes about 30 minutes per course of care. This task was imposed on midwives without the provision of any infrastructural support in recognition of the additional hours added to midwives' workload. Midwives' compensation is withheld if they do not perform this task. This is one more way that midwives have supported improvements in the health care system without reciprocated support and value for that work by the Ministry.

### (c) Hospital Integration Work

140. We also take on unpaid work to facilitate hospital integration and inter-professional collaboration. Head midwives are rarely paid by the hospital with whom the practice group has privileges so the practice group absorbs the costs. Although some allowance is made for this work by the provision of caseload variables (CV2) for hospital, local and provincial committees and, inter professional work, in my practice the caseload variables (CV2) which we qualified for under contract rules only provide compensation for a small portion of the work. Last year for our practice, the hours that would qualify for CV2 were 520. We are allowed to bill a maximum amount of 240 hours under CV2.

141. In a large, complex hospital like Mount Sinai Hospital in Toronto, hospital committee work takes hours every week and we as a practice have decided to take money from our operating budget to pay the midwife who does this work. I take from the fact that this work is not considered worthy of compensation or staff support by the hospitals, that the value of midwives is not recognized appropriately within the health care system.

## X. 2003-2005 AOM MOHLTC COMPENSATION NEGOTIATIONS

### 1. Seeking Equitable Compensation

142. In 2004, I decided to become an AOM Board member for the second time in my midwifery career. My primary motivation was to provide leadership to help combat what I saw as discrimination against midwives within the Ministry of Health. It seemed that the Ministry was not addressing the fact that midwives were being paid unfairly and that our real earnings were deteriorating significantly given the cost of living over the years since 1994. I felt that this problem should become a major focus of advocacy for our professional association. I recall speaking up at a regional meeting of the AOM to voice my concern that we as midwives were an undervalued female profession that was being taken advantage of.

143. While midwives were so busy just building a profession and providing care, I knew we needed to take time to advocate strongly for ourselves because it was clear the Ministry would not act unless there was strong pressure on it. As well, the Ministry had structured the program and compensation setting so that midwives did not have an effective bargaining system to address our concerns, as the physicians had.

144. In 2005, as Vice President, it was clear to me that the MOHLTC valued the excellent outcomes of midwifery but wanted to continue to rely on midwives as relatively "cheap labour" to produce those outcomes. The MOHLTC, despite our 2000-2001 requests for equitable compensation and our hiring the Hay Healthcare Group to prepare a report which we forwarded and discussed with the MOHLTC, remained unwilling to actually increase our compensation.

145. I was present during the May, 2004 AOM annual conference when then MOHLTC Minister George Smitherman stated that the Ministry was planning for a significant expansion of midwifery services but avoided committing on the question of a compensation increase.[8]

146. That Conference also heard a MOHLTC presentation on the 2004 “Ontario Midwifery Program Evaluation,” which found that midwives were achieving better health outcomes than family physicians on five different measures: the rate of C-sections, operative vaginal deliveries, episiotomies, discharge from hospital within 48 hours and breastfeeding at six weeks.[9] The Evaluation did not address the issue of the adequacy or equity of the midwives' compensation even though the equitable integration and funding of midwifery was a central tenet of the OMP.[10]

147. During this period AOM President Elana Johnson wrote to the Ministry repeatedly in an effort to confirm that we would be able to discuss compensation at the upcoming negotiations, and I supported her efforts.

### 2. The 2003 – 2004 Hay Reports

148. When I joined the AOM as Member at Large in 2004 the Hay Health Care Consulting Group ("Hay Group") led by Moshe Greengarten had already produced for the AOM the June 2003 "Compensation Review” report.[11]

149. In February, 2004 this report was updated by the Hay Group to reflect updated salary data, including the significant compensation increase provided by the MOHLTC to CHC Physicians.

150. As a Board member of the AOM I was frustrated when the Ministry’s response to our advocacy was that they were engaged in OMA negotiations and midwives would need to wait for that outcome.[12] We were very concerned about the future recruitment

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8 Draft Notes for Remarks by the Honourable George Smitherman (MOHLTC Minister) for Announcement re: Midwifery Funding, (August 19, 2004), AOM0000678.

9 MOHLTC Presentation at the AOM Conference of Ontario Midwifery Program Evaluation (May 13, 2004) AOM0000602.

10 MOHLTC Presentation at the AOM Conference of Ontario Midwifery Program Evaluation (May 13, 2004) AOM0000602.

11 Report by Hay Group for AOM re: Compensation Review, (June 2003), AOM0000827.

12 Email from Leonard Domino to President Elana Johnson and AOM Alison Dantas, November 19, 2004 (November 19, 2004) AOM0005699.

and retention of midwives if they continued to be inappropriately compensated for the value they provide.

### 3. "Because Storks Don't Deliver Babies" Campaign

151. In the face of the Ministry delays, inequitable compensation and concerns about attrition, the AOM launched its "Because Storks Don't Deliver Babies" public campaign. This campaign included the practice of midwives calling their MPP offices each time they were paged by their clients, even if it was in the middle of the night. Midwives left messages saying that they were going to attend a birth or attend to any kind of urgent clinical work and that they were not being properly compensated for that work. Midwifery consumers were also engaged in this campaign and provided communications supporting the AOM request. 13

152. I was involved in planning the December 14 2004 AOM Campaign Rally and in communicating with the Ministry during that time.

153. Immediately before the campaign rally and press conference that was to be covered by the CBC, OMP Program Coordinator Wendy Katherine called Elana Johnson and advised that the government was prepared (if the rally was cancelled) to put the following money on the table, but that the amount was not negotiable: increase in total midwifery program budget of $5.3 million in 2005-06; $8.0 million in 2006-07; and $9.0 million in 2007-08.

154. This included money for the expansion of midwifery positions and, increased compensation. Most of the money in years 2 and 3 went to program expansion rather than increased compensation.14 I recall the AOM board meeting where we decided, in the face of this non-negotiable position by the Government, that we would cancel the rally and press conference. We did this when we received the offer in writing from the Ministry.15

### 4. 2005 AOM-MOHTLC Negotiations

155. I was not one of the AOM negotiation representatives for the 2005 bargaining although I was briefed on the discussions.

156. I was very frustrated when the Ministry made its offer in March, 2005 and did not provide any justification as to why it chose $92,600 as the job rate for midwives or why it offered an on-call rate of $300 per course of care to the midwives and 18% for benefits. The Hay report, while not a pay equity analysis, had advised that this job rate should be

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13 Bulletin by AOM to AOM Supporters re: Storks Don't Deliver Babies Campaign (December 1, 2004) AOM0006280.

14 Key Components of Compensation Discussed at Feb. 8, 2005 Meeting of the OMP and AOM Negotiating Teams, (February 8, 2005), AOM0002563.

15 Fax from Elana Johnson to all AOM members re: Press Conference Cancelled, (Dec. 13, 2004) AOM0006273.

$108,000, the on-call figure should be $330 and benefits at 20%. We understood that the Ministry was under pressure to put a significant amount of the budgeted increase into expansion of the program rather than to a compensation adjustment for midwives.[16] I was also frustrated that the Ministry enforced a subdivision of the course of care, carving out the secondary care fee and changing the criteria under which it was paid to midwives.

157. We were aware that this amount of money only went part way to close the pay gap. Despite our frustration we felt that there was no alternative at that time but to stop further disputing the Ministry's position, given Minister Smitherman's promise that further progress to close the gap would be made in the next round of negotiations.

## XI. 2006 TO 2008 WORK:

### 1. Work with OMA

158. I continued to be active in addressing compensation issues as AOM Vice President and President Elect from 2006- 2008. During this time I supported Elana Johnson in her attempts to foster a positive relationship with the Ontario Medical Association. We re-established an AOM/OMA Liaison Committee and met regularly to discuss a variety of issues. These issues included: how the Ministry interest in inter professional care models would impact our professions; how respect for midwives could be fostered; and how OBs could be paid fairly for work they did with midwifery clients.

## XII. THE MIDWIFERY WORKLOAD STUDY

159. I also supported the AOM's efforts to conduct a workload analysis study which was finalized in 2007. [17] I was an active member of the Steering Committee for this project. Midwives were consulted regarding workload in different regions of Ontario and provided detailed data which they were asked to collect about their work which they logged daily over a period of time.[18] I gathered data as a working midwife and as a managing partner of a large midwifery group.

160. This was the profession's first workload study since 1993, prior to regulation. Our project aims were to: Document a baseline to define the course of care upon which the payment to our members from the Province of Ontario is based; document what has changed since the original standards/benchmarks were put in place; and, based on

16 Fax from Elana Johnson to all AOM members re: Press Conference Cancelled, (Dec. 13, 2004) AOM0006273.

17 Workload Analysis (Batch)\E-mails & attachments\Email to WASC re workload survey user manual - Jul 3 07, (July 3, 2007), AOM0005806. AOM Participant Instructions re: Workload Analysis Pilot, (July 1, 2007), AOM0005525.

18 Proposal by E. Dean & Associates re: Phase 2 Workload Analysis - to Undertake a Work Analysis and Establish a Benchmark for the Association of Ontario Midwives (October 5, 2010) AOM0005682.

above evidence, determine and/or demonstrate that the current benchmark or scope of care has changed.

161. AOM Executive Director, Kelly Stadelbauer, sent a communication to midwives describing the project as

> *"Our aim with the current survey is to show whether and how much things have changed since 1993. The survey is designed to track the amount of time and scope of activities involved in a course of care, as well as the time and scope of non-clinical activities that midwives perform. It should give a comprehensive picture of the work of Ontario midwives in 2007."*[19]

162. We encouraged midwives to give us an accurate picture of what they do in their work.[20] We wanted to measure similar aspects of midwifery work as the 1993 study e.g., how much time is spent in prenatal care, how much in intrapartum care, how much in postpartum care, and how much on administrative work. One of the complexities of this study is that no one day in the life of a midwife is like another, and so we had midwives track their time over a series of weeks. It was an onerous but important undertaking for midwives and the AOM. This project was entirely funded by midwives through their membership dues to the AOM.

163. This was a very complex project. One of the roles of the Steering Committee was to assist the consultants to deeply understand the complexity of midwifery work and therefore capture the data in a way that would accurately reflect the work. At one point in the project, we wanted to assure ourselves that the consultants were taking a valid approach to the data collection, and that we were using a tool that would ensure maximum participation by Ontario midwives. We requested the assistance of Dr. Jacquelyn Burkell of the University of Western Ontario, currently the Assistant Dean or Research in the Faculty of Information and Media Studies, who we knew had skills in survey design. Dr. Burkell reviewed the process and the tools designed for the data collection and provided us with insights and feedback that helped to strengthen the project deliverables.

164. We paid close attention to issues of Data Validity and Reliability. The sample of midwives and clients was found to be comprehensive and the number of records more than adequate to reflect patterns in the population.

165. The study also identified significant changes in midwives' work that were not originally included or contemplated in midwives' work in the 1993 study. These changes include :

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19 Template Invitation by AOM ED Kelly Stadelbauer to Members to participate in Workload Survey, (January 1, 2007), AOM0005591.

20 Workload Analysis (Batch)\E-mails & attachments\Email to WASC re workload survey user manual - Jul 3 07, (July 3, 2007), AOM0005806. AOM Participant Instructions re: Workload Analysis Pilot, (July 1, 2007), AOM0005525.

(a) Changes to requirements and Scope in the BCC

(i) Infant hearing test

(ii) Increased standards for infection control

(iii) Client Tracking sheet completion

(iv) Early entry into care (<8 weeks)

(v) Arranging FTS/IPS Genetic Screening

(vi) More initial blood work, PAP smears

(vii) More informed choice regarding GBS, Glucose screening, VBAC and Vitamin K

(viii) Increased Epidural and Oxytocin management

(ix) Group B Strep management

(x) Assisting in placement of epidurals and vacuums and forceps

(xi) Increases in client special populations for which CV's do not apply, resulting in increased time

(b) Changes to Administration

(i) Increased time requirements for intake and waiting list (documentation)

(ii) Documenting unbilled courses of care projections

(iii) Administering home births infant health cards

(iv) Provincial Privacy requirements

(v) Integration, including minimizing unnecessary consults, etc

(vi) Increased hospital documentation requirements

(vii) Increased documentation databases (NIDAY, PPESO)

(viii) Increased requirements for invoicing

(ix) Increased data review

(c) Changes to Requirements for Partners

(i) More administrative work associated with larger practices

(ii) Budget prep and submission

(iii) Internal Practice budget management

(iv) Payroll and Supervising employees

(v) Negotiating and managing contracts

(vi) Office Management

(vii) Support for obtaining hospital privileges for practice members

(d) Changes to Accountability Requirements from the Province

(i) Quarterly reports

(ii) Caseload variables mid and end of year reports

(e) Changes to Responsibilities of Head Midwives

(i) Head midwife administration, monitoring and securing of infant health cards

(ii) Advocating for hospital privileges

(iii) Changes to Professional Requirements

(iv) Increased time and efforts to obtain hospital privileges

(v) Increased mandatory requirements (ESW, MOREOB)

(vi) Increased supervision of MEP/IMPP, PLEA or new registrants

(vii) CMO quality assurance audits

(viii) Increased personal research requirements

(ix) Increased participation in hospital, regional committees

(x) Increased engagement with risk management.

166. Through a comprehensive workload survey, the AOM determined that the total average number of hours spent providing a course of care increased from 48.5 in 1993

to 55.48 in 2007.[21] Our study also found that although the average amount of time midwives spent on clinical work had barely changed since 1993, the average time spent on non-clinical work had more than doubled. [22]

167. This came as no surprise to me. I was already aware that the administrative burden was increasing on midwives. The initial course of care hours were based on the work of midwives pre-legislation. But as outlined above many things had changed since then which impacted on workload.

## XIII. 2008 – 2009 NEGOTIATIONS WITH THE MINISTRY

### 1. Delays Getting to the Negotiation Table

168. In spite of a written commitment to start negotiations for the next contract by December 1, 2007, and a follow up letter by the AOM to the Ministry, [23] it was not until February of 2008 that the OMP's Wendy Katherine asked the AOM to forward its "list of priorities" for negotiations.[24] We provided these priorities by letter dated April 30, 2008 from Elana Johnson to Katherine with the subject heading: "Creating Equity for Midwives in Ontario's Health Care System."[25] This letter was presented at the first negotiations meeting on April 30 2008, attended by myself along with the AOM's Johnson, Juana Berinstein, Kelly Stadelbauer and Alice Ormiston and the OMP's Wendy Katherine, Samantha Ball, Joan Mongeon and Rena Porteous (OMP).

169. In this process we identified the need for substantial compensation and funding increases to achieve equitable compensation as a key priority along with a parallel process for regular negotiations and a dispute resolution process similar to those available to physicians and nurses. In this document we framed our requests as necessary to put midwives on an equal professional plane with physicians as well as other health care professionals. We also identified the need for midwives to get equitable treatment with respect to a number of issues such as professional development, clinical educators, maternity and parental leave, and rural and remote practice provisions such as an in return for service tuition program.

170. In May, 2008, I took over as the AOM President and continued in that position until May, 2012.

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21 Chart: Ontario Midwifery Workload, 1993 Historical Benchmark and 2007 Workload Analysis AOM0001033.

22 Workload Analysis (Batch)\E-mails & attachments\Email to WASC re workload survey user manual - Jul 3 07, (July 3, 2007), AOM0005806.

23 Letter dated February 12, 2008 from Elana Johnson, President of the Association of Ontario Midwives to Wendy Katherine, Coordinator of Ontario Midwifery Program. MOH000428.

24 Letter dated February 12, 2008 from Elana Johnson, President of the Association of Ontario Midwives to Wendy Katherine, Coordinator of Ontario Midwifery Program. MOH000428.

25 Letter dated April 30, 2008 from Elana Johnson, President of the Association of Ontario Midwives to Wendy Katherine, Coordinator of Ontario Midwifery Program. AOM0000685.

171. In the "Funding Contract Review" meeting on May 27, 2008 with the Ministry, the AOM provided the Ministry with a document, “Market Changes in Compensation, 2005-2007, Hay report, January 2008” which the Ministry agreed to review.26

172. At that time, the Ministry was undertaking a large reorganization under Deputy Minister Ron Sapsford whereby "stewardship" became the new mission and mandate. The Ministry would "provide overall direction and leadership for the system, focusing on planning, and on guiding resources to bring value to the health system".27 We had a meeting scheduled with Sapsford on June 27, 2008 but he did not attend. We met with ADM Josh Tepper instead and discussed the Ministry's stewardship of the OMP and the strong unmet demand for midwifery services.[28]

173. As a result of this re-organization, we were informed that Wendy Katherine had been seconded to the Strategy Division of the MOH. We were told that Jody Hendry was hired as the Acting Coordinator for the OMP and would be the main negotiator with the AOM for the new funding agreement. This was the first time that someone with no background or knowledge of midwifery was hired for this position and, to me, signalled a change in the way the OMP was seen in the Ministry. Prior to that OMP staff had midwifery knowledge and involvement. To me, it indicated less concern about stewardship of a still vulnerable program.

174. The MOHLTC subsequently advised the AOM that it needed to delay the funding agreement review meetings due to this major organizational change in the Ministry. In late June 2008, Hendry advised us that negotiations may resume in September, pending approval by her superiors. [29]

175. While we were being told that negotiations were not possible due to Sapsford's reorganization, the MOHLTC prioritized its negotiations with the OMA. The OMA informed its members on September 15 2008 that the MOHLTC came to an agreement with the OMA which provided for substantial increases in compensation for physicians including CHC physicians30, despite the growing world financial crisis. The OMA-Ministry agreement running from April 1, 2008 to March 31, 2012 provided for a 12.25%

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26 Meeting agenda and process outline re Funding Contract Review, Review Process Development (2008-05-27) AOM0001434; Hay Group Health Care Consulting, “Market Changes in Compensation, 2005-2007”, (January 2008) MOH003862.

27 MOHLTC presentation re: Health Care Professionals, A New Direction (June 11, 2008) AOM0016151.

28 Letter from K Kilroy to Ron Sapsford, MOH Deputy Minister Enclosing "Midwives and Interprofessional Care" policy position statement on IPC in maternity care settings, (June 27, 2008), AOM0010256.

29 Letter from K Kilroy to Josh Tepper. MOH Asst Deputy Minister, enclosing "Midwives and Interprofessional Care" policy position statement on IPC in maternity care settings, (June 27, 2008), AOM0010258.

30 Update from K. Arnold (OMA President) to OMA Members re: tentative agreement between MOHLTC and OMA, attaching Q&A and MOHLTC Press Release (September 15, 2008) AOM0000639.

fee for service component increase as follows: October 1, 2008, 3%; October 1, 2009, 2%; October 1, 2010, 3%; and September 1, 2011, 4.25%.[31]

176. On September 9, 2008, I received a letter from Mary Fleming, MOHLTC Director of Primary Care, informing me that the MOHLTC was "prepared to commence discussions with the Association of Midwives (AOM) regarding compensation for midwifery services and support to assist the growth and sustainability of the sector." [32] Fleming asked us to present the AOM's priorities and informed us that Mary Catherine Lindberg had been assigned to lead this process. The letter also informed us that "Unfortunately, due to scheduling restrictions we are unable to meet with you and your AOM representatives prior to" the end of October.

177. Prior to beginning negotiations we provided the Ministry with a document setting out funding agreement proposals. We asked for adjustments to the course of care payments and referenced the 2007 Workload Study and the Morton Report. We further requested an increase in the operational fee and for travel disbursements.

178. It was not until late October 2008 that the Ministry met with the AOM. By then midwives had been substantially prejudiced as a result of the global recession, which had started to gain momentum in August 2008, and was repeatedly referred to by the Ministry as the reason why midwives could not get similar compensation increases given to doctors and nurses.

179. Our first meeting on October 28, 2008 was led by Mary Catherine Lindberg for the MOHLTC and myself for the AOM, and included MOHLTC staff Jody Hendry, Rena Porteus, Joan Mongeon and Samantha Ball; and AOM representatives Elana Johnson, Kelly Stadelbauer, Juana Berinstein and AOM negotiations consultant Neil Patton. At this meeting:

(a) Johnson and I co-presented on the history of midwifery compensation and funding[33].

(b) We provided a history of the current funding models and the principles that informed it; and how the Morton report led to the Ministry's recognition that midwifery compensation should fall in between an advanced practice nurse and a family practice physician.

(c) We ensured in our presentation that the MOHLTC representatives knew about the two key parameters for funding: "Appropriate" fee which is the compensation range that reflected skill, effort, responsibility, and working

31 Ontario Medical Association, "Tentative Agreement Reached!", Vol. 13, No. 24, September 15, 2008 AOM0000639

32 Letter from M. Fleming to K. Kilroy re: Beginning Compensation Discussions, (September 9, 2008), AOM0006173.

33 Creating Equity for Midwives in Ontario's Health Case System - AOM Slide Deck, (October 28, 2008), AOM0006458.

conditions when compared with other health professionals; and a "Fair" fee, which is the compensation range that considers the above factors plus the general context in relation to others in the same economic market.

(d) We explained that the Morton report provided rating scales and charts for skills, responsibility, working condition comparisons; and that it included consideration of: education, breadth of knowledge, responsibility in decision-making, comparison of authorized acts, comparison of job requirements, and comparison of core competencies.

(e) We explained the Morton principle, in which Morton had recommended in 1993 (and the Ministry had accepted), based on his analysis of the above factors and based on his recommendation that the CHC physician and CHC Primary Care Nurse/NP were the most appropriate comparators, that a top level midwife would be paid 90% of the lowest level of a CHC physician, and that the lowest level midwife would be paid slightly more than the highest earning CHC Primary Car Nurse/Nurse Practitioner.

(f) We also explained the 11 “lost years” and how over this time, this principle had been badly eroded, and that now it was necessary to provide equity for midwives by returning midwives to their placement between CHC physicians and CHC Nurse Practitioners.

(g) We presented on our concerns that a “pink collar ghetto” was being created for this highly female dominated profession. We presented on the very strong clinical outcomes of Ontario midwives, their cost-effectiveness to the system and that midwives were necessary to help resolve the obstetrical provider shortage.

(h) There were other discussions at this meeting besides compensation. We were very concerned in this initial meeting that the MOHLTC raised concerns that midwives “only” provided care to 40 clients.

(i) We were able to explain that the comprehensive nature of midwifery care cannot be compared to physician care and therefore a small number of clients is appropriate for the type of care that women want and need for excellent clinical maternal newborn outcomes and the extraordinary satisfaction rates of midwifery care.

(j) We also explained that in a physician led model, the care required for one obstetrical clients requires the work of both physicians, nurses, and lactation consultants; whereas in the midwifery model, all of that care is provided by one health care professional, the midwife. This means the midwife spends many more hours with a client than other health care providers would in the physician-led model of care. We seemed to be

successful in our explanation, as this issue was not raised again during our negotiations.

180. We met with the Ministry again in November and December but were met with the Ministry's constant concern about the need for fiscal restraint.

181. To me, I found it very disturbing that the most vulnerable of the primary health care professions, (one that was overall in proportion a drop in the health budget bucket) was somehow going to have to bear a disproportionate impact for the global economic crisis. I believed that our right to fair compensation had been jeopardized by the MOH decision to delay our negotiations while they bargained with the OMA and other parties. I was very concerned that the Ministry had failed to prioritize our compensation needs during good times was now going to use the "bad times" as a reason to justify no action on equity for us. I realized that the Ministry, despite its ability to plan and budget for its own priorities was not setting aside adequate money to fund our compensation requirements.

### 2. Negotiations in the Winter of 2009

182. On January 5, 2009, I saw the Government announcement that the Ontario government had reached an agreement with the Ontario Provincial Police Association to pay the male-dominated OPP officers 2.34%, 2.25% and 2% along with pay equity adjustments for civilian employees. Corrections officers had also just received an offer from the government for 1.75%, 2.0%, 2.0% and 2.0%, as well as well two increases over four years in on-call pay as well as a special 6% adjustment if the government's proposal on sick time was accepted.

183. As the AOM President, I wrote to Ron Sapsford, Deputy Minister of MOHLTC on January 21, 2009 requesting an urgent meeting to discuss the need to "fairly fund midwifery in Ontario." In this letter I noted that the Ministry's negotiation team had offered midwives a "compensation increase of half of what physicians and nurses settled for in the past year and no catch up for the lack of increases for 11 years from 1994 to 2005."[34]

184. On January 26, 2009, the AOM including Executive Director Kelly Stadelbauer and myself as well as Elana Johnson, and Director of Policy and Communications Juana Berinstein met with the MOHLTC Minister David Caplan to discuss the AOM's serious concerns with respect to the Ministry's stewardship of midwifery. In particular at that meeting:

(a) The AOM provided to him a document dated January 26, 2009 requesting equitable compensation for midwives.[35] In addition to discussing high

34 Letter from President of the Association of Ontario Midwives to Ron Sapsford, Deputy Minister of Health and Long-Term Care (January 21, 2009), AOM0000687, at page 1.

35 Association of Ontario Midwives, "Agenda: Association of Ontario Midwives Meeting with Hon. David Caplan, Minister of Health and Long-Term Care", (January 26, 2009) AOM0000689;

value of midwifery and needed input for the AOM into Ministry decision-making regarding maternal child issues, the AOM focused on the need for equitable treatment in the compensation of midwives, the impact on recruitment and retention and the need for a process to address the erosion and inequity in midwifery compensation.

(b) The AOM provided a document "Comparative Compensation + Benefits Document: Midwifery and Other Health Care Providers".[36] I informed the Minister that unlike other health care professionals, midwives did not receive increases during better economic times, therefore, compensation relative to other providers and relative to midwives themselves since 1994 had eroded.

(c) While the AOM acknowledged in the above meeting that there were difficult economic times, it pointed out that midwifery compensation had been frozen by the MOHLTC during times when other professionals received substantial increases. I stated that midwives have lost their parity with other healthcare professionals over the last 15 years, and the compensation offer provided an increase that was less than equitable when compared with other healthcare colleagues. MOHLTC Minister Caplan informed us that he was firm in this offer and unwilling to address the gap.

(d) We followed up from this meeting with a letter to Minister Caplan. We stated:

*"Unfortunately while midwifery is a tremendous success story for this government there has been significant erosion to our compensation over the past fifteen years. While we recognize that we are in the midst of difficult economic times ending the pay inequities between midwives and other health care professionals is critical to ensure the sustainability of the profession. Midwives need an equitable pay increase to stop further erosion of compensation, to ensure that midwives are treated equitably to our other health care colleagues, and to appropriately recognize the value of the profession to Ontario's health care system. In addition, it is critical that midwives not be penalized for their willingness to accommodate the Ministry's request to wait for the reorganization of the Ministry of Health before beginning the negotiations process which had been scheduled for April 2008."*

(e) On February 17, 2009, AOM Executive Director Kelly Stadelbauer, AOM policy analyst Alisa Simon and I met with ADM Susan Fitzpatrick to

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Association of Ontario Midwives, "Comparative Compensation + Benefits Document : Midwifery and Other Health Care Providers" (2007) AOM0002655.

36 AOM document "Comparative Compensation + Benefits Document: Midwifery and Other Health Care Providers, (January 2007), AOM0002655.

> discuss Minister Caplan's message of no pay equity compensation and 2% annual increases only[37]. We shared with her our frustration, and midwives' need for a process that fairly determines their compensation. We pressed the question of how compensation should be determined for midwives if not through an evaluation of skills, education, responsibility and working conditions, but she had no answers for us.

185. The MOHLTC made a presentation to the AOM dated February 23, 2009 and proposed 2% for base fees, 2% for operational expenses for 2008 and 2% in 2009-11 with increase in benefits from 18% to 20%.[38] The offer did not include any pay equity adjustments and did not address the outstanding disparity in any way.

186. The proposal also provided for a new parental leave program, administered by the AOM in order to protect midwives' independent contractor status; a new professional development program modelled after the long standing professional development programs that other health professionals can access providing up to $1500 per midwife per year; a $100,000 Locum program to support the sustainability of rural and remote midwifery practices; a rural and remote compensation fees supplement and operational fee supplement for midwives working in such communities; a $100,000 special populations grant to meet needs of specific groups of midwifery clients; and a $100,000 inter-professional grant to assist with hospital integration work; and second attendant funding of $18,000 for small rural and remote practices.

### 3. Compromise and Commitment for Compensation Review

187. During the meetings in the winter of 2009, I was part of many internal discussions about how patience, collaboration and consensus-building, the very foundations of midwifery care, were not helping us at all in this process of achieving recognition for the inequities in our pay. We resolved that the issue of compensation inequity had to make some movement forward in this round of negotiations.

188. We again argued in our meetings with the Ministry that compensation restraint had not applied equally to other health professionals, and that we had made the Ministry aware for years that midwives had not received regular or equitable increases like other professionals.

189. It appeared to me that the gender of our profession and the nature of our intensive work for women and commitment to them was leading the MOHLTC to take us for granted and not be concerned about prioritizing our compensation. They knew we were committed to expanding midwifery services for women and it appears hoped we would accept funding for that expansion as the measure of our "valued work".

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37 Internal AOM email re meeting with MOH - Neil Patton, (February 18, 2009), AOM0001500.

38 Ministry of Health and Long Term Care, "Presentation to the Association of Ontario Midwives", (February 23, 2009), AOM0000690.

190. In these negotiation meetings, given the ultimate power of the Ministry over funding, we felt compelled to consider the things on offer as they were important in bringing our members some equity with other comparable players in the health care system such as physicians and nurses. Midwives appeared to be alone amongst those major comparators in not having access to professional development resources or parental leave. Our benefits program was severely underfunded and our rural and remote midwives desperately needed support.

191. In particular, I felt compelled to recommend we accept the offer which provided for badly needed support for midwives, such as a parental leave program and a rural and remote locum program. However, it felt as though we were being coerced because we would only get it if we accepted a very substandard compensation increase. We worked hard to ensure that the agreement included a commitment to a joint compensation review by an independent entity and were explicit that the review was to inform the next negotiations which were to start by the end of September, 2010. The Ministry agreed to this although they insisted the report would not be binding.

192. Yet we still had some faith that if we could get the Ministry to turn its attention towards the inequity in midwives' compensation and truly understand the depth and breadth and validity of our concerns that they would, in good faith, address it. In short, we trusted that the compensation review would have meaning and be a legitimate process whereas in reality it turned out to be a travesty. In fact, I personally recommended to midwives that they vote yes on this deal because the compensation review meant that the Ministry was willing to engage with us on that question. `

193. As a result, the AOM and the MOHLTC entered into a new Memorandum of Understanding (MOU) signed May 7, 2009[39] which was to be effective until March 31, 2011. It provided for

(a) an increase in the course of care fees of 2% annually as of April 1 of 2008, 2009 and 1% in 2010;

(b) introduced the experience fee for rural/remote supplements and operational fee supplements for small rural or remote practices;

(c) increased the benefits from 18% to 20% of salary;

(d) introduced a professional development program similar to those long standing programs provided to physicians ("the CME program") nurses (the "Nurse Education Initiative") and to other health professionals ("the Allied Health Fund"); and

39 Memorandum of Understanding between Her Majesty the Queen in Right of Ontario as represented by the Ministry of Health and Long Term Care and the Association of Ontario Midwives, May 7, 2009 AOM0007010.

(e) Included a parental leave program, a program already funded for several years by the Ministry for other health-care professionals.[40]

194. As a result of the persistence of the AOM, the Ministry agreed in Article 7 of the Memorandum of Understanding to jointly retain an objective independent third party to conduct a compensation review of midwifery services – to be completed by September 2010.

195. The primary goal of this compensation review was to suggest an appropriate "total compensation" package for midwifery services based on available evidence, including but not limited to:

(a) comparable relevant and historical compensation levels and factors of nurses, doctors and other relevant health care providers;

(b) comparable and relevant midwifery compensation models in other jurisdictions and;

(c) the initial Morton compensation report and the February 2004 Hay Compensation review report".

(d) Total compensation was defined by Article 7 as: "course of care fees (includes operational, on-call, secondary care, retention, experience fee and rural and remote supplements, and all benefits or equivalent funding"

196. The Ministry insisted on including that "neither party shall be bound to implement or support the findings of the third party consultant." [41]

197. We made sure that there was a reference in the MOU to the Hay and Morton reports and the comparison to the nurses and doctors which were the models in those reports. We did object at the time to the jurisdictional comparisons as it could incorporate the undervaluation of midwifery across Canada. However, we ended up agreeing to its inclusion, while reserving our concerns about what consideration should be given to it in an equity analysis.

### 4. Joint Midwifery Advisory Committee

198. Since there was no process in place to discuss matters of mutual concern between the AOM and the MOHLTC, at the request of the AOM, the Ministry agreed in the 2009 MOU to the creation of the Joint Midwifery Advisory Committee ("JMAC") with

40 Report by Courtyard Group for MOH re Compensation Review of Midwifery (September, 2010), AOM0000567, at page 29.

41 MOU between Her Majesty the Queen in Right of Ontario as represented by the Ministry of Health and Long Term Care and the Association of Ontario Midwives, (May 7, 2009), AOM0000617.

five AOM representatives and five Ministry representatives, with meetings four times per year.

199. The JMAC Terms of Reference provide that[42]:

(a) The purpose of the JMAC is to "discuss issues and concerns of either party as they arise, be proactive in resolving issues and to build and maintain a productive working relationship."

(b) The JMAC is "intended to supplement major negotiations between the parties – it is not intended to replace those negotiations."[43]

(c) Disputes could be brought to JMAC for resolution with the option for a third-party facilitator if JMAC was unable to resolve with parties required to "use their best efforts to resolve issues and disputes in a collaborative manner."

200. The first meeting of JMAC took place on May 29, 2009 attended by Jody Hendry, Rena Porteous and Joan Mongeon from the Ministry of Health, and myself, Kelly Stadelbauer, and Alisa Simon from the AOM; the AOM placed the compensation review for midwives on the agenda.[44] The minutes of this meeting refer to the 2008-09 "negotiations."

201. The MOU committed the Ministry to begin the next round of contract negotiations by September 30, 2010. During these discussions the Ministry informally recognized the AOM as being similar to the OMA in their role in negotiations. The Ministry representatives stated that negotiations would need to change to become similar to other negotiations undertaken by the Ministry, and unilaterally announced that the Ministry's Negotiations Branch would now lead the negotiations rather than just the Primary Care Branch. Communications from the Ministry explicitly referred to the "new contract negotiation changes."[45]

### 5. Encouraged midwives to ratify the MOU covering 2008-2011, based on the compensation review

202. Although we were disappointed by the delays and differential treatment I did feel that the commitment to undertake a compensation review signalled the MOHLTC's willingness to address our equity concerns. For that reason and the reasons mentioned

42 Terms of Reference of the Joint Midwifery Committee and the Midwifery Contracts and Funding Advisory Committee (2013-11-27) AOM0000620.

43 Terms of Reference of the Joint Midwifery Committee and the Midwifery Contracts and Funding Advisory Committee,(November 27, 2013), AOM0000620.

44 JMAC Minutes, (May 29, 2009), MOH020190.

45 "Contract negotiation process" is mentioned in AOM0001473, AOM0001497, MOH003370.

above I took a leadership role in encouraging the Board to recommend to the AOM membership to ratify the 2009 MOU.

203. The compensation review proposal made by the AOM was integrated into negotiations in an effort to work with the real financial constraints that the MOHLTC had raised with us. Even though it was non-binding, we trusted that this opportunity would be taken seriously by the Ministry. Initially members did not want to approve the offer because they felt they were accepting another pay decrease. As AOM president I advocated with members to accept it. I argued first that the commitment to a neutral third party compensation review signalled that we were getting recognition and moving towards being treated with respect akin to other health professions. Secondly, I emphasized to our membership the value of gaining some small measure of equity with other health care professionals, through new provisions for parental leave, rural and remote support and professional development funds.

204. It was a major disappointment when I later found that the compensation review process was not dealt with by the MOHLTC in good faith for the reasons set out below.

### 6. Compensation Restraints

205. On March 25, 2010, just prior to the commencement of the compensation review, the Ontario government introduced the *Compensation Restraint to Protect Public Services Act, 2010.* This act received Royal Assent on May 18, 2010, and was effective March 25, 2010. The law froze compensation structures for non-bargaining employees of the broader public sector and the Ontario public sector for two years. Specifically, the Act prohibits increases to rates of pay, pay ranges, benefits and other payments in effect on March 24, 2010 unless as a result of an employee's length of time in employment or office; an assessment of performance; an employee's successful completion of a program or course of professional or technical education.[46] The Act specifically provides in s.12(3) that "nothing in this Act shall be interpreted or applied so as to reduce any right or entitlement under the *Human Rights Code* or the *Pay Equity Act.*

206. On April 22, 2010, Saad Rafi, MOHLTC Deputy Minister wrote a memorandum to Chief Executive Officers/Senior Administrators (including the AOM) advising that the "Government's fiscal plan provides no funding for compensation increases" and its purpose is to control "compensation of public sector employees."[47]

207. , The government took the position in its discussions with us that the midwives could not have their compensation increased because of this *Act.* The Ministry in other contexts insisted that midwives were independent contractors and not "employees" and therefore were not covered by "employee protections" like the *Labour Relations Act* or

46 Compensation Restraint to Protect Public Services Act, 2010, S.O. 2010, C. 1 AOM0015199.

47 Memorandum dated April 22, 2010, from Saad Rafi, Deputy Minister of Health and Long-Term Care to Chief Executive Officers/Senior Administrators, Transfer Payment Agencies regarding compensation restraints, (April; 22, 2010), AOM0000691.

the *Pay Equity Act.* Yet here they were to be covered by compensation restraints which by law only applied to "employees."

208. It was particularly difficult to accept the MOHLTC's position that economic difficulties required midwives to be part of compensation restraint policies given that Ontario physicians, including CHC physicians, had recently received a very substantial compensation increase and that midwives were likely to be asked for additional years of zero increase after so many years of being subjected to them already.

209. The AOM's response was to highlight the increases provided to the physicians, along with the security of their four year agreement. The AOM reiterated the lack of process and compensation parity that midwives had relative to others who were funded by government, particularly the inequitable compensation relative to CHC physicians relative to the 1993 Morton benchmark of 90%. We also highlighted inequities for midwives in other program areas to which, for some time, the government had given other health care professions access.

## XIV. INVOLVEMENT IN THE COURTYARD COMPENSATION REVIEW

### 1. Selecting the Courtyard Group

210. With the start of contract negotiations scheduled for end of September, 2010, there was a need to finalize the compensation review in order that it could inform that upcoming contract negotiations. I wrote to the MOHLTC in July of 2009 to start the process.[48]

211. The Ministry began getting the internal budgetary and policy approval for a review in late 2009 and only sent out an RFP to selected Vendors of Record on June 8, 2010. The Ministry Request for Proposal detailed the requirements as:

> *"the development of a report that suggests the appropriate "total compensation" for midwifery based on evidence which will include but not be limited to comparable, relevant and both current and historical compensation levels and factors of nurses, doctors and other relevant health care providers; comparable and relevant midwifery compensation models in other jurisdictions; and the initial 1993 Morton compensation report and the February 2004 Hay compensation review report."* [49]

212. A Joint Steering Committee process was set up in June 2010, to conduct the compensation review process with three Ministry and three AOM representatives. The Ministry representatives were OMP Manager Seetha Raja and OMP Policy Analyst, Melanius Finney, and Arda Ilgazli from the MOHLTC Negotiations Branch. We were pleased to have Ilgazli, an economist from the Negotiation Branch so that Branch would

48 July 2009: AOM letter to Raja (OMP) re TOR for comp review (2009-07-31) AOM0001492.

49 Report by Courtyard Group for MOH re Compensation Review of Midwifery, (September 2010) AOM0000567, at page 3.

be better informed about midwifery issues once we began the negotiation process in the fall. AOM representatives were AOM Executive Director, Kelly Stadelbauer and AOM Director of Policy and Communications Juana Berinstein and me. [50]

213. The Courtyard Group was chosen from a Ministry-approved list of consultants who were vendors of record.[51] The AOM was not allowed to propose any additions to that list. The MOHLTC funded the Courtyard Group for its work.

214. Courtyard was the only responding Vendor who provided a detailed submission about their proposal for carrying out the project. Their proposal was dated July 6, 2010, and included details of their experience and profiles of their proposed consultants. Courtyard had experience in the analysis of compensation of health care providers in Ontario as well as understanding of the Ontario health care environment including community and primary care.

215. On July 14, 2010 the Joint Steering Committee met and reviewed the proposal that Courtyard conduct the review. We had a discussion again as a group to make sure that Courtyard was able to appropriately take on the work the parties had agreed should be done in the 2009 MOU. The AOM representatives were a little suspicious at the beginning because Courtyard was the only vendor who responded with a serious submission and there had been recent coverage in the press of Courtyard's close ties with the Liberal government. We were worried we wouldn't get a fair hearing. It didn't turn out that way. Courtyard was very engaged and the consultants from my observations were quite determined to thoroughly understand the issues surrounding midwifery compensation.

216. The Ministry selected Courtyard as meeting the RFP's requirements. This approval took place on July 20, 2010 with a project start date of July 27, 2010 and end date of September 20, 2010. [52] The Courtyard consultants were well aware that the review was to inform the negotiations which under the 2009 MOU were to start by September 30, 2010.

### 2. The Courtyard Compensation Review Process

217. The Joint Working Group was formed to work with the Courtyard consultants, John Ronson and Gia Marasco.

218. On July 19, 2010, the Joint Working Group met with the Courtyard consultants. We reviewed questions with respect to the review process.

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50 Summary of Meeting between AOM and MOH by A. Lopez and A. Ilgazli re: Negotiations, (October 2010), AOM0000755.

51 Email from M. Finney (MOH) to K. Stadelbauer (AOM), copying J. Berinstein (AOM) and S. Raja (MOH) re: Compensation Review RFP, (February 25, 2010), AOM0000797.

52 Statement of Work for General Management Consulting Services, (July 27, 2010), AOM0004685.

219. On July 28, 2010, the Joint Working Group had a further meeting with the Courtyard consultants to kick off the review.[53] John Ronson from Courtyard led this meeting. He spent a great deal of time determining the parameters of the project from all members of the Joint Steering Committee. In my mind, he asked very appropriate and insightful questions about, for example, who was the project sponsor, what aspects of the compensation models of other jurisdictions are of particular interest, what were other relevant documents besides the Morton and Hay reports, and what activity does the MOH want to incent? What policy imperatives need to be considered?[54]

220. On August 8, 2010, the Joint Working Group had a further meeting with the Courtyard consultants. At that meeting I delivered a powerpoint presentation on the history of midwifery compensation and there was a discussion of the timeline and tasks to meet the project deadline of late September. This meeting also included a discussion of the AOM's Workload Analysis, the interviews to be conducted by Courtyard and the evaluation questions.

221. There was a very important discussion at this meeting, raised by Courtyard, as to the evaluation framework that we were going to use for this project. [55] the Committee agreed to the following framework questions:

(a) Does the current compensation model recognize adherence to best practice guidelines and the achievement of the Ministry's policy objectives?

(b) Does the current compensation model reflect the current scope of work performed?

(c) Does the current compensation model reflect the volume/complexity of work performed?

(d) Does the current compensation model reflect the costs of doing work?

(e) What is the value of benefits, or equivalent funding received by midwives?

(f) Does the current compensation model reflect the experience and training of midwives?

(g) Is the current compensation model comparable to other professions performing similar work? What market trends should be taken into

53 Presentation from Courtyard Review kick-off meeting on July 28, 2010, (June 28, 2010), AOM0001579.

54 Presentation from Courtyard Review kick-off meeting on July 28, 2010, (June 28, 2010), AOM0001579.

55 Compensation Review of Midwifery - Steering Committee Meeting - Kick Off(part 2) Agenda**,** August 6, 2010), AOM0004894.

consideration? Have compensation increases remained aligned with economic growth in Ontario?"[56]

222. The consultants also developed a strong rubric that tied the evaluation questions to specific research/interview questions and information sources that could be sought.[57]

223. Throughout the remainder of August and early September, the Courtyard consultants carried out their research and worked with the Joint Working Group with respect to obtaining all appropriate information.

224. The Courtyard consultants were very thorough in their work and in their reporting. All members of the Joint Steering Committee received written weekly status updates from Gia Marasco, as well as updates within the Joint Steering Committee meetings. [58] Courtyard exercised great diligence in keeping all members of the committee informed on every aspect of the project's progress. Both the AOM and the MOHLTC provided data to the consultants. The Ministry took the lead in providing information regarding physician payment and CHC information.

225. Ronson and Marasco communicated both separately with the Ministry and AOM representatives as well as jointly through communications and meetings. Each of the parties requested that the Courtyard representatives follow up on issues which they regarded as relevant to the review process. **[59]**

### 3. Courtyard Findings and Report

226. Throughout September, Courtyard sent the Joint Steering Committee members a number of iterative drafts of the report for comment. Courtyard was very transparent with its calculations throughout this process by providing the Excel spreadsheets where

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56 Compensation Review of Midwifery: Version Final (Courtyard Group)**,** (September 29, 2010), AOM0004571, at page 4.

57 Evaluation Questions used by Courtyard Group, (August 1, 2010), AOM0004898.

58 Email from G Marasco to OMP & AOM, (August 5, 2010), AOM0004893. 2010/08/06-2010/09/24 Est. Progress Reports by Courtyard Group (August 6, 2010), AOM0004704. 2010/08/06 Status Reports from Courtyard to MOH, (August 6, 2010), AOM0004818. Compensation Review of Midwifery - Steering Committee Meeting - Kick Off(part 2) Agenda, (August 9, 2010), AOM0004894. Email from G. Marasco to OMP & AOM re: Aug 6th Meeting - Summary of Actions, (August 9, 2010), AOM0004903. Report by Courtyard re: Summary of Progress and Activity (August 13, 2010), AOM0005894. Email from G. Marasco to S. Raja, M. Finney, A. Ilgazli, J. Berinstein, K. Kilroy, M. Boyes, J. Ronson, K. Stadelbauer re: compensation review status report, (August 21, 2010), AOM0004909. Report by Courtyard Group re: Status of Compensation Review of Midwifery (August 21, 2010), AOM0010161. Status Report of Compensation Review of Midwifery, (September 11, 2010), AOM0010165. Status Report re: Compensation Review of Midwifery (September 13, 2010), AOM0010154. Report by Courtyard Group re: Status of Compensation Review of Midwifery (September 19, 2010), AOM0010167. Report by Courtyard Group re: Status of Compensation Review of Midwifery, (September 27, 2010), AOM0010169.

59 Variety of Correspondence and documents re: Midwifery Compensation and Courtyard report (28/10/2010) MOH022429.

the calculations were made. The AOM responded by providing corrections, comments and analysis where we thought necessary[60], and we understood the Ministry was doing the same.

227. At the September 2, 2010 of the Joint Steering Committee, Courtyard gave an update on research findings to date[61]. There was significant progress in the project. Along with the findings, Courtyard provided further discussion questions and information gaps for the Steering Committee to address together.

228. At the September 29, 2010 meeting, Courtyard provided the Joint Committee with a draft three-page summary of its findings.[62] I had no input into this summary document prior to the presentation at this meeting by Courtyard. None of the other AOM representatives had input into this document. I can remember feeling unsure about what Courtyard's conclusions would be.

229. Courtyard's John Ronson presented the three-page summary to the whole group together, with both the AOM and the MOHLTC representatives present.

230. The AOM representatives had an emotional response to the presentation by Courtyard, particularly me. I was overcome with tears when they began their presentation by saying that midwives provided high value to the health care system. It quickly became apparent that they had determined that we were not being paid equitably and were recommending an immediate "equity" adjustment.

231. It felt good that someone who had no prior knowledge of midwifery compensation issues, reviewed the facts and after examining the matter had objectively recognized our work. Even though it was not a full pay equity analysis, the report had gone a long way to address the issue of inequitable compensation and acknowledged the impact of the Ministry's handling of our compensation over the years. I think the Courtyard consultants recognized the serious pay equity issue, and were trying to put something in the report that they thought we could actually get. In fact, Ronson said at that meeting that their recommendation did not necessarily fully address the deficit in what midwives were paid but they were trying to balance the inequity with the government's financial strain.

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60 Various Emails Between K. Stadelbauer and G. Marasco replying to email from G. Marasco to K. Kilroy, S. Raja, M. Finney, A. Ilgazli, K. Stadelbauer, J. Berinstein, M. Boyes re: Courtyard Report Feedback, (September 14, 2010), AOM0010222. Various Emails btw K. Stadelbauer, G. Marasco, K. Kilroy, M. Boyes, J. Berinstein, S. Raja, M. Finney, A. Ilgazli dated September 22, 2010 to September 23, 2010 re: Draft Courtyard Report, (September 22, 2010), AOM0010223. Feedback, (September 14, 2010), AOM0010222. Various Emails btw K. Stadelbauer, G. Marasco, K. Kilroy, M. Boyes, J. Berinstein, S. Raja, M. Finney, A. Ilgazli dated September 22, 2010 to September 23, 2010 re: Draft Courtyard Report, (September 22, 2010), AOM0010223.

61 Compensation Review of Midwifery, Steering Committee meeting, (September 2, 2010), AOM0010180.

62 Findings and Recommendations - DRAFT from Courtyard, (September 30, 2010), AOM0005121.

232. Further feedback was solicited by Courtyard from the Steering Committee which the AOM provided. I understood the MOHLTC was also providing feedback before Courtyard finalized its report and findings. On October 8, 2010, Gia Marasco sent out a final version of the report to committee members which recommended in part a 20% equity adjustment.[63]

233. Courtyard was paid by the Ministry in full for their work. The Joint Committee did not meet again after the September 29, 2010 meeting. .

## XV. POST-COURTYARD NEGOTIATIONS

### 1. Initial contact with Ministry appointed negotiator

234. After the release of the Courtyard report, the Ministry and the AOM were to start negotiations by September 30, 2010 in accordance with Article 9.6 the May 2009 MOU. The Ministry delayed the start of those negotiations until October 28, 2010, having cancelled the scheduled October 13, 2010 meeting.

235. On October 28, 2010 the AOM met with MOHLTC representatives including the Negotiations Branch lead negotiator Alex Lambert.

(a) The AOM representatives in this negotiations were Elana Johnson, Lisa Weston, Madeleine Clin, Kelly Stadelbauer, Juana Berinstein, Neil Patton and me.

(b) The Ministry representatives were Alex Lambert, Andreas Lopez (also from the Negotiations Branch), Arda Ilgazli (from the Negotiations Branch), Seetha Raja, (OMP coordinator), Melanius Finney and Laura Pinkney.

236. Even before our first meeting we had been informed that that the Negotiations Branch would now be involved in the negotiations with the AOM; and that the Ministry was centralizing negotiations with various groups such as the OMA and the AOM. We had also been informed that there was now a "compensation freeze" imposed due to fiscal restraints. We were deeply concerned that midwives would once again have their pay frozen and equity concerns not addressed.[64]

237. As AOM President, I provided a presentation at our first meeting on October 28, 2010 that laid out various proposals from the AOM, with the theme of Growing & Maintaining the profession of midwifery; Innovation; Compensation; and, Excellent Care for All. [65]

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63 Report by Courtyard Group for MOH re Compensation Review of Midwifery (September 2010) AOM0000567 ; Email from G. Marasco to S. Raja, M. Finney, A. Ilgazli, J. Berinstein, K. Kilroy, M. Boyes, J. Ronson, K. Stadelbauer re: final Courtyard report (October 8, 2010) AOM0005209.

64 Email from N. Patton to K. Stadelbauer, K. Kilroy, L. Weston, M. Clin and J. Berinstein re: Agenda for Meeting with MOH (October 19, 2010) AOM0005991.

65 Agenda for MOH AOM Negotiation, October 28, 2010 AOM0006186 and MOH000975.

238. Specifically, the AOM proposals focused on: support for home births; hospital privileges / scope of practice; transfer of care issues; new clinicians / clinical specialists; IT systems and tech support; online access to health care info/data; A Midwifery Secretariat (like the existing nursing secretariat); multi-year budgeting; birthing centres; and supporting interprofessional care.[66]

239. At that meeting I also provided an overview of the data that shows a declining number of family physicians doing intrapartum care and the unmet demand for midwifery care, despite its rapid growth. I emphasized the value that midwives bring to clients and the health care system. I also provided a brief history of midwifery compensation, including information about the 1993 Morton Report and about the commitment to a pay equity approach at that time, and the Courtyard Report.

240. After reviewing the 2005 negotiations I told the meeting that the 2005 increases had not fully or systematically addressed compensation inequities or the issue of what the benchmark should be for midwifery compensation. I made it clear that midwives were seeking “appropriate” and “fair” compensation. By “appropriate” I meant the "fee range that reflected skill, effort, responsibility, and working conditions when compared with other health professionals”, and “fair” meant a “fee range that considers above factors plus the general context in relation to others in the same economic market.”[67] In our context here, this meant positioning the midwife as the Courtyard and Morton reports had done between the CHC senior primary care nurse/nurse practitioner and the family physician in the Ontario health care system.

241. At that meeting I also reviewed the high level findings of the Courtyard Report, specifically that: midwives provide excellent care and produce excellent outcomes; midwives in Alberta are paid more than Ontario midwives; intermittent negotiations hurt midwives compensation; and the growing profession places demands on midwives; there have been greater administrative demands from Ministry; and, there were additional responsibilities added to midwives’ scope of practice in 2009.

242. During that first October 28, 2010 meeting, MOHLTC Negotiator Alex Lambert displayed very little understanding of midwifery issues. For example, he did not understand the midwifery model of care; how midwives were funded (by course of care), or the principles of the funding model (for example, midwives provide comprehensive care to a small volume of clients; whereas physicians rely on other professionals to provide some care, such as nurses and pediatricians, and therefore do not spend as much time per client over the course of a woman’s pregnancy intrapartum or post-partum periods.)

243. In the above meeting, Lambert stated that the government could not implement the Courtyard recommendations. He was dismissive and disrespectful to us. I recall that

66 Report by AOM re: AOM-MOH Negotiations Priorities (October 28, 2010) AOM0006134.

67 Powerpoint presentation by the Association of Ontario Midwives “Midwives in Ontario’s Health Care System”, October 28, 2010. AOM0006458.

without understanding basic concepts around the midwifery model of care, Lambert brought an adversarial attitude and was preoccupied with the idea of midwife accountability, in spite of the fact that midwives were the only practitioners in the maternal health system at that time who were required to report in great detail the outcomes for every client in order to get paid and had other extensive reporting requirements.

244. During the meetings in October and November, Lambert tried to move the discussion about the Courtyard report out of the negotiations process and to the Joint Midwifery Advisory Committee. He also dismissed the findings out of hand and told the AOM representatives that no pay equity adjustment was possible. Lambert stated that the Ministry could not negotiate any compensation increase, at least in part, because the Public Restraint Compensation Act[68] prohibits such increases and that this legislation applies to the AOM and the midwives of Ontario.

### 2. Further Delays and Change in Negotiator

245. The AOM raised concerns to the ADM Susan Fitzpatrick that Lambert was not knowledgeable and was hindering rather than facilitating effective negotiations. Subsequently, the Ministry replaced Lambert with Mary Fleming, Director of Primary Care, on November 25, 2010 as the lead negotiator, who then needed time to come up to speed, as well as time to deal with the Auditor General's report on primary care. This delayed the negotiations even further and the December 2010 meeting was cancelled. Meetings resumed in January, 2011. The AOM provided a further document at the negotiations meeting on January 12, 2011, providing clarification on its original proposals.[69]

### 3. Continued Disagreement over the Applicability of Compensation Restraint

246. By email dated January 28, 2011, Fleming advised AOM negotiator Neil Patton that the Ministry of Finance had requested that the Labour Relations Secretariat meet with the AOM.

247. A meeting took place with Secretariat representatives on February 1, 2011. I was at that meeting along with Lisa Weston, Madeleine Clin, Kelly Stadelbauer and Juana Berinstein. Together we met with Ministry representatives Mary Fleming, Seetha Raja, Heather MacDermid and Melanius Finney and a representative from the Labour Secretariat. The representative from the Labour Secretariat attended and gave a powerpoint presentation on government compensation restraint and informed us that

68 Public Sector Compensation Restraint to Protect Public Services Act, 2010, S.O. 2010, CH. 1 Sched. 24, AOM0015199.

69 Clarifying Proposals - Supporting the Growth of the Profession. Summary of AOM-OMP Negotiations Proposals (January 11, 2011) AOM0002680.

the government had “forgotten” to give a presentation to the AOM that they had provided to public sector unions the previous summer.[70]

248. At that meeting I pointed out that the *Public Sector Compensation Restraint Act* (PSCRA) does not apply to the midwives for the simple reason that midwives are not employees; the Ministry does not hold itself out as the employer, the TPAs are not employers and the AOM is a professional association, not an employer of midwife employees. The Funding Agreement expressly states that midwives are independent contractors and not employees.

249. Ministry representatives agreed that specifically the Act did not apply, but the spirit of it did. We argued that if the spirit of this legislation should apply to midwives, then why not the spirit of the Pay Equity Act? The same legislation, the PSCRA says that adjustments required by the Human Rights Code or Pay Equity Act are not covered by the restraint law. The Ministry replied that the Pay Equity Act did not apply to midwives as they were not employees. It appeared to us that the Ministry was not playing fair with us by applying at times the strict wording of a law or else the "spirit" depending on which interpretation worked to their advantage. Again we raised the Courtyard report and our frustration and disappointment that the government was trying to back track on a process that they fully participated in.

250. The Ministry then cancelled further meetings as they told us they required additional time to review the Courtyard report.[71]. By letter dated March 24, 2011**,** Fleming requested an extension of the MOU from April 1, 2011 as negotiations had not been completed and the contract expired on March 31, 2011.[72]

251. By letter dated March 28, 2011 from the AOM's Executive Director Kelly Stadelbauer to Fleming, we again raised concerns about the Ministry's negotiation delays and urged the timely resumption of negotiations.[73]

### 4. Return to Negotiations in Spring 2011

252. As a result of various calls, we were able to secure a meeting with the Minister of Health and Long Term Care. Deb Matthews on April 20, 2011. At this meeting,

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70 Powerpoint presentation by the Association of Ontario Midwives “Midwives in Ontario’s Health Care System”, October 28, 2010. AOM0006458.

71 Various Emails between N. Patton and K. Stadelbauer from March 24, 2011 re: Negotiations (March 24, 2011) AOM0005717; Email from N. Patton to K. Stadelbauer and M. Clin copying K. Kilroy, L. Weston and J. Berinstein re: Notes from Meeting with M. Fleming (March 26, 2011) AOM0006015.

72 Letter dated March 24, 2011, from Mary Fleming, Director, Primary Health Care Branch, Ministry of Health and Long-Term Care to Kelly Stadelabauer, Executive Director of Association of Ontario Midwives (March 24, 2011) AOM0001648.

73 Letter dated March 28, 2011 from Kelly Stadelbauer, Executive Director of Association of Ontario Midwives to Mary Fleming, Director, Primary Health Care Branch, Ministry of Health and Long-Term Care (March 28, 2011) AOM0001648.

(a) Kelly Stadelbauer and I advised the Minister that it was critical that the serious pay equity issue had to be resolved along with the unnecessary hospital and physician restrictions on privileges and scope which were a serious barrier to women accessing care. We pointed out that we had evidence to support our pay equity claim.

(b) Minister Matthews stated in the meeting that she thought midwives were pretty well paid and that their salary was “pretty good for a four year undergraduate degree”, and that compensation issues for midwives were not a priority for the government. Minister Matthews stated that she was interested in delivering better health care.

(c) I was completely flabbergasted by this comment, at first taken aback and later very angry. My immediate thought was that she would never say that to a room full of predominantly male engineers. I thought it was uniformed. I also thought it was sexist since our compensation was being evaluated, not by an assessment of our skills, efforts and working conditions but by what the Minister of Health thought was “pretty good” on the basis of her view of one feature of our work, the length of our educational program. I found it quite demoralizing as well, as a front line care provider who was working hard to produce the excellent health outcomes for women which the Ministry said was its high priority. I think it was at that moment that I realized the government was not taking us seriously, they weren’t properly concerned about us as public sector professionals and they appeared to have no intention of seriously looking at the issues that we were raising. It felt like we were just being strung along.

(d) I advised Minister Matthews that we were willing to accept a compensation increase of 0% in 2010/11 and 0% in 2011/12 if the government would address the substantial pay equity gaps. I stated it was unacceptable that a small group of professional women in a caregiving health profession with relatively little power in the system was being told again and again to be good and wait their turn, particularly after so many years without increases while others received substantial increases.

(e) We also pointed out to Minister Matthews that:

(i) ongoing unnecessary restrictions on scope of practice and inappropriate delays in getting hospital privileges were constant barriers faced by the midwives, which also affected how their work was viewed and compensated and the working conditions in their day to day lives; and

(ii) leadership was needed from the Minister to close the pay gap. While not stating that this would close the pay equity gap, the AOM proposed two options: a 16% equity adjustment in 2011/12 and 0%

regular increase in 2011/12 and 12/13 or two 0% years and then 20% in 2012/13.

253. On April 28, 2011 I co-authored a letter with Kelly Stadelbauer as a follow up to our meeting with Minister Matthews[74]. In it we reiterated:

*"We remain concerned with the serious pay equity issue that exists for midwives in Ontario. We urge you to review the Courtyard report commissioned by the Ministry of Health and Long-term Care. The report reviewed various factors that determine appropriate compensation and concluded that a comparison to other health care providers in the same jurisdiction (namely nurse practitioners and CHC family physicians in Ontario), based on an analysis of education, scope of practice and level of responsibility, was the best method to measure compensation. These are the same measures the government requires in the pay equity legislation. When our members agreed to the terms negotiated in 2008, they believed that the Liberal government would undertake a compensation review in good faith. Therefore, our members will want to know if all of the conclusions and recommendations of this report will be rejected out of hand by the government, or if it will be given serious and due consideration. The Courtyard report is a comprehensive analysis of the historical factors that led to the current inequities and provides an equally comprehensive analysis of current conditions and how to proceed into the future.*

*We are struggling to understand how the government can ignore the numerous, factual, evidence-based conclusions of this report, including:*

> 'The 1994 Morton report found that the income of a midwife should be somewhere above that of a primary care nurse and below that of a Community Health Centre family doctor, taking into account a variety of factors, including training, scope of practice, responsibility, overtime and other requirements .... We see no reason to change this positioning, and believe it has only been reinforced given the history and development of both the profession and maternal care in the province over the past 16 years.'

*We understand the constraints of the Public Sector Compensation Restraint Act. This legislation does not apply to midwives because the Act applies to employers and employees, and midwives are not employees. However, we believe that we can convince our members to abide by the spirit of the legislation, and accept zero increases for two years, if the Ministry also abides by the spirit of the Act, the Compensation Report and Pay Equity legislation and recognizes that there is a pay equity issue that exists in the midwifery profession that needs to be addressed, as the wage restraint legislation provides for. We urge you to work*

74 Letter from K.Kilroy, President and K.Stadelbauer, Executive Director, AOM to D.Matthews, Minister of Health and Long-Term Care. Re: Failure to negotiate, act on Courtyard Report findings and pay equity (April 26, 2011) MOH002770.

*with us on addressing this serious concern. This is an issue that has the potential to impact on recruitment, morale and retention in the profession. It needs to be addressed as we move forward together to support the expansion of midwifery services in order to serve more Ontario women. Midwives will be very disappointed and further frustrated if our decade long campaign to achieve pay equity is not achieved in this round of bargaining. Most certainly, a systemic undervaluing of a female-dominated occupation working in a care-giving profession will have a negative impact on the sustainability of a profession that is greatly valued by a growing number of women and families in Ontario."*

254. On May 9, 2011 we released the Courtyard Report to our members.

255. During the AOM's annual general meeting on May 18, 2011, members overwhelmingly passed a resolution to express their great disappointment and frustration with government's unwillingness to acknowledge or address pay equity; its unwillingness to fairly compensate midwives based on a comparator of similar health care professionals, using criteria that includes scope of practice, education, on-call requirements, and responsibility for quality of client care and agreed to pursue various actions to protest and fight for pay equity. Health Minister Deb Matthews sent written "Minister's Greetings" to the AOM praising the role of midwifery in the health-care system.[75]

256. The Ministry then set up new AOM negotiation dates for May 24-26 2011. These turned out to be the last negotiation dates until 2013, although we were not aware of this at the time. At that time, the AOM presented the Ministry with its summary of compensation increases that had been given to other public sector employees.

257. The MOHLTC Assistant Deputy Minister Susan Fitzpatrick attended the negotiations meeting on May 26, 2011.

(a) Ms. Fitzpatrick advised at this meeting that the reason that compensation could not be addressed was due to fiscal constraints caused by a rapidly growing health care budget. She acknowledged that midwives were valued and midwifery care provided good outcomes at a lower cost. The Ministry proposed 0%, 0% and up to 5% in year 3 tied to meeting one or two specific clinical outcomes of 2 – 3% each.

(b) Fitzpatrick acknowledged at the meeting that it "doesn't deal with the relativity issue in a substantial way". When asked about the Ministry response to the Courtyard Report, she stated that the "Ministry still has questions but acknowledges that there is a relativity issue".

(c) When asked about the "intention" of the Pay Equity Act and why this wasn't being considered in the treatment of midwives, the most female

75 Letter from MOHLTC Minister Deb Matthews to AOM members re: Greetings for AGM (May 2011) AOM0005379.

dominated profession in the province (at that time 100%), Fitzpatrick stated, “you don’t have the same rights as those people” referring to employees. This statement made a great impression on me as it reinforced for me the conclusion I had reached in my meetings with the Government, that I had no rights. It also made me feel that the Government was unconcerned about my human rights to be paid fairly as a member of a female dominated profession. We had the compensation restraint law applied to us even though we were not employees but when it came to the *Pay Equity Act*, different rules applied. Either way, we had no right to access to a fair compensation process according to the Government.

(d) Fitzpatrick acknowledged that other public sector workers were getting increases despite the restraint law but that was because they had different processes.

## XVI. AOM’S ONGOING CAMPAIGN FOR PAY EQUITY

### 1. June, 2011 Rally at Queen’s Park

258. After it became clear to us that the MOHLTC was not willing to engage with the compensation review or our claim for pay equity I was heavily involved in leading midwives through discussions of job action possibilities. These discussions and the routes we did take were greatly impacted by our "caring dilemma" where we often did not think it appropriate or "ethical" to do anything to further our financial interests which would impact the health care interests of our clients. Midwives quite simply stated that they couldn’t leave their clients to be cared for by others such as obstetricians who might not understand or respect their birth plans since those planning home births would be forced to go to hospital. I and other midwives believe that the quality of care that they provide is valuable and that asking their clients to give this up in order for midwives to be paid fairly would be too much.

259. On June 1, 2011 more than 1,000 midwives and supporters rallied at Queen’s Park and another 100 midwives and supporters also rallied at Premier McGuinty’s constituency office in Ottawa later that week. As the AOM President I made a speech entitled-“You cannot separate the worth of women from the worth of midwives.” That speech was posted on the AOM website – “Rally for Pay Equity: Speech.[76] I stated:

> *Though the midwifery system has at times received support from all three political parties, midwives as workers have not. When this profession was created in 1994, the Ministry of Health commissioned a report that looked at the training, scope and responsibilities of midwives to determine, using an evidence based approach, how much this new female-dominated profession should be paid - to determine what midwives were worth to the Ministry and to the people of Ontario.*

76 Speech given by K. Kilroy at pay equity rally on June 2, 2011 (June 2, 2011) AOM0001621.

*At that time in history pay equity was very much on policy makers' minds and a conscious attempt was made to ensure that we did not underfund this new profession simply because it was staffed almost entirely by women. If only these original policy makers had had the foresight to include a process for that pay scale to be regularly reviewed and updated, we would likely not be here today. Unfortunately, in the time since that decision the commitment to pay equity has been lost.*

*Midwives have spent the intervening years dedicating themselves completely to the creation of an outstanding midwifery system in this province. Indeed, we've not only created excellent midwifery care in Ontario, we've championed a model of care that is the envy of the world. As midwives, we committed ourselves to the exceptional care of women and babies in this province, we created a midwifery education system that has set the world standard for direct entry midwifery, we got effective self-regulation up and running, we spent hours ensuring that midwifery was properly integrated into our hospitals.*

*Typical of care giving professions and women's work historically we did not successfully put our own needs or the needs of our own families on the government agenda. Midwives went 11 years without any pay increase at all. Let me be clear – while others were receiving 2, 3 and 4 per cent increases, midwives received, zero, and zero, and zero, and zero, and zero, and zero, and zero, and zero, and zero, and zero.*

*Even after one partial adjustment in 2005 midwives have in every other instance had increases that are less than other comparable health care workers. What possible reason can be given for this? How can any government construe this as anything other than paying midwives as little as they can get away with? Where was the stewardship that was promised for the midwifery program?*

*Some might say that the partial adjustment we received in 2005, after 11 years with no increase, was good enough and that we should be satisfied with what we are compensated. In reality, midwives in this province have not been paid fairly since 1995. We want an explanation from this government about why other professions are more highly valued than midwives. Why is it that year over year, doctors, teachers, police officers, crown attorneys, nurses, professors, not to mention, MPPs all receive compensation increases – but not midwives.*

*It isn't good enough for women or for midwives to earn less than other comparable professions. A recent independent third party report factored in the 2005 increase, and even with this increase, midwives are still working at 20% below our health care colleagues.*

*It's just not good enough...it's just something governments have been able to get away with. Is it because midwives are a small, powerless profession made up of women? Is this government content to pay midwives as little as they can get*

*away with? Midwives are subsidizing the health care system to the tune of 20% of what they should be paid – what other profession has been asked to do this?*

*Year after year, contract after contract midwives have been given reasons why the government couldn't come to the table right now, why, once they did finally sit down they just couldn't afford to pay midwives as fairly as they committed to in 1994.*

*Midwives deliver excellent results. We provide 24 hour coverage, care in the home and a reduction in visits to the ER. We support normal birth. Women in midwifery care have a c-section rate approximately half of the rate for the rest of the province, our induction rates are lower, our epidural rates are lower, our instrumental delivery rates are lower and our hospital length of stays are much shorter. We work incredibly hard to allow women and babies to spend as little time as they need to in expensive hospital care and instead we provide care to them in their communities and in their homes.*

*While we have seen some commitment to the growth of the midwifery program, we have not seen the same level of commitment to the front line workers who are providing the care. How can we expect the profession to grow and thrive if we are not properly valuing the people who are doing the work?*

*If midwives are told that they are not worth as much to this government as the colleagues they work next to, what message does that give to our young people who are considering a midwifery career? How do we attract the best and brightest to the profession of midwifery and how do we retain graduates in the province of Ontario? Women want midwifery care – 40% of women in this province who want a midwife, can't get access to one. There is only one way to solve this access issue – build a solid foundation for the profession that includes paying midwives fairly.*

*We want an explanation from this government about why police and prison guards are more highly valued than midwives. Why Premier McGuinty and Finance Minister Duncan are willing to give 9.75% to prison guards including a 4% bonus to reduce absenteeism rates, and 13.5% to the OPP to address a pre-existing shortfall and a commitment to, not pay equity, but pay superiority by 2014. All this for men with guns and nothing to the women who deliver our babies.*

*For 11 years, midwives had no increase. And now we have fallen behind. We're staring at a pay equity gap and we need government action now. The families of this province have clearly stated that they want midwifery care and that they value that care highly when they receive it.*

*We need a government that respects and values midwives and the results, excellence and cost saving that we bring to each and every one of you and to all Ontarians.*

> *You cannot separate the worth of women from the worth of midwives. Women grew midwifery in Ontario, it belongs to us. Women are worth it. Midwives are worth it. The people of this province who value midwives want to know who to vote for.*[77]

260. In July 2011, the Ministry was still proposing a deal of 0% in 2009/10 and 2010/11 and up to 5% in 2011/12 with significant part of the 5% tied to meeting specific clinical outcomes. During July and August, it was very challenging to get the Ministry's attention. The negotiations were then suspended by the Ministry until after the October, 2011 provincial election.

261. In September 2011, the government was in full election mode. Premier McGuinty, in reply to a questionnaire sent to all three parties about their position on a variety of issues, including equitable pay for midwives, responded on September 2, 2011[78]. He stated "We believe that midwives should be able to work in accordance with the full scope of their practice in all environments, including hospitals. We also believe that midwives should be fairly compensated for the important work they do. We support recognizing midwives and their compensation relative to other health care professionals."

## XVII. 2012 NEGOTIATIONS

262. The AOM's Executive Director Stadelbauer again wrote to ADM Fitzpatrick by letter dated January 19, 2012 and asked to return to the negotiation table.[79] Through this letter we highlighted the Courtyard report's finding that delays in negotiation exacerbated inequities and that our members were frustrated and at their wits' end. We also wrote to Premier McGuinty by letter dated January 19, 2012 asking for him to follow up on his campaign promise to provide equitable compensation to midwives.[80] Premier McGuinty responded by letter dated January 25, 2012 to me deferring to Minister Matthews to respond.[81]

263. With negotiations stalled, the government would not allow JMAC to be convened The Ministry explained that JMAC could not meet during negotiations in the same way that the Physician Services Committee ("PSC") could not meet during OMA/MOHLTC

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77 Catherine Porter, "Ontario midwives rally for a raise they deserve", Toronto Star (2 June 2011) AOM0000552.

78 Letter from Premier D. McGuinty to K. Kilroy (AOM President) and J. Berinstein (AOM Director of Policy and Communications) re: support for midwives and their fair compensation (September 2, 2011) AOM0000699.

79 Letter dated January 19, 2012, from Kelly Stadelbauer, Executive Director of Association of Ontario Midwives to Susan Fitzpatrick, Assistant Deputy Minister- Negotiations and Accountability Management Division (January 19, 2012) AOM0000701.

80 Letter from Katrina Kilroy, President of Association of Ontario Midwives to Premier Dalton McGuinty.(January 19, 2012) AOM0000702.

81 Letter from Premier Dalton McGuinty to Katrina Kilroy, President of Association of Ontario Midwives Kilroy (January 25, 2012) AOM0001677.

negotiations. This was very frustrating to me. On the one hand, the Ministry chided us for using "negotiations" language, ever since the Courtyard report. We were not being afforded the processes of the OMA when it came to negotiations, and yet, here was the Ministry now insisting that we had to follow a process because “we were in negotiations”. I found this a highly dysfunctional method of trying to resolve systems issues for the midwifery sector. It seemed wherever we turned the Ministry was denying us our right to a process for and entitlement to equitable pay.

264. However, since negotiations were not in fact occurring and major midwifery issues needed to be addressed, the parties agreed to set up a new committee in January 2012, the Midwifery Contracts and Funding Advisory Committee (“MCFAC”).

265. The MCFAC Terms of Reference provided that the committee's purpose was to "to provide a forum for discussing issues and initiatives related to midwifery contracts and funding." As the AOM's president it felt unreasonable to me that we were not allowed to access any forum to discuss the urgent compensation and stewardship issues.

266. At the time that my AOM presidency ended we had still not returned to the negotiations table. By letter dated March 29, 2012, Mary Fleming, Director of Primary Health Care Branch stated to ED Stadelbauer that further to Fitzpatrick’s letter dated February 13, 2012, the Ministry confirmed the continuation of the MOU.[82]

267. Throughout my time as president at the AOM I was constantly struck by the contradiction of seeing midwives being in very high demand and achieving excellent outcomes but being told fair compensation was not possible. At the same time the MOHLTC were taking the position that it was necessary to pay physicians more because they are in high demand by Ontarians. This inequity has harmed both the profession of midwifery generally and the lives of individual midwives who have endured financial and personal stress in order to stay in the profession.

## XVIII. PERSONAL IMPACT OF INEQUITABLE PAY

268. As I set out above in the section which described a glimpse at my life as a midwife, I have experienced the impact of the lack of equitable compensation on my family life and retirement income. For me this has included the high cost of having my former spouse stay home to care for our children (which impacts on family earnings and continues to impact my current earnings and retirement income). As well, there is the great impact of missing important child and family events. My purchasing power to buy food for my family, pay down my mortgage and keep up with the ever increasing cost of living in Toronto has been significantly degraded. I was forced to work a greater than full time caseload just to make ends meet and am currently paying the price for that with significant health care issues that are currently preventing me from working. I am behind my peers in terms of personal savings for retirement and in spite of dedicating my entire

82 Letter from Mary Fleming, Director of Primary Health Care Branch to Kelly Stadelbauer, Executive Director of Association of Ontario Midwives (March 29, 2012) AOM0000706.

adult life to serving the people of Ontario, I don't see any financially feasible path to retirement at the same age that my peers in other comparable professions are planning to retire.

269. Having practiced as a midwife since 1991, I am in my fifties and am facing a solo retirement with almost no pension.

## XIX. OBSERVATIONS REGARDING FACTUAL INACCURACIES IN MOHLTC EXPERT EVIDENCE

### 1. Introduction

270. Drawing on my knowledge and experiences, I would like to comment on the factual accuracy of statements in the expert reports of Robert Bass, Dr. Richard Chaykowski, Mr. John Kervin, Dr. David Price, Dr. Candace Johnson and Dr. Lisa Graves

271. Drawing on my professional midwifery experience and experience as a senior managing partner of a midwifery practice group and addressing some but not all matters in the reports, I will clarify below factual inaccuracies or omissions in the MOHLTC expert reports.

272. Overall, as reflected below in my specific statements, I found that the authors of the reports did not have a good factual understanding of the work and compensation arrangements for midwives and tended to overstate the work of physicians. As I read these reports it struck me that the sexism I believe pervades the way midwifery is treated in the health care system and by the Ministry is also present in these reports.

273. For example, I was astonished that one of the MOHLTC experts would use the example of performing prostate exams as justification for the more challenging working conditions of CHC physicians. This person didn't even stop to consider what it might be like to perform a vaginal exam on a client who is engaged in what is likely the most painful and difficult experience of her life. Let alone if this woman was a sexual assault survivor or a non-English speaker. It seemed to me from reading these expert reports that these experts did not know what the working conditions of midwives were like and had not taken steps to find out. In my experience, this lack of investigation and evidence based analysis is often how women's work gets undervalued

274. For example, one expert referred to birth as a "happy" event which is celebrated at birthdays, when midwifery "birthing" work is in fact primarily very gruelling, difficult work. Women are engaged in a physically, emotionally and socially demanding and intensely painful task that leads in most cases to a joyful but complex and demanding conclusion. This expert's statement trivializes and simplifies the work that midwives do.

275. The idea that being with these women and caring for their life and well-being and bearing witness to their suffering for hours and hours and hours on end is so simple because babies are welcomed and mostly born alive and healthy is itself a sexist statement. To dismiss or not even consider the difficult and life changing news that

midwives must sometimes give their clients aligns with my personal experience of the way that traditionally women's work is not given appropriate status and compensation or even considered in any depth. This is why I understood pay equity required a proper analysis of work of women and their comparators.

### 2. Chayowski Report November, 2014

#### (a) Page 9 - Physicians Cannot Substitute for Midwives

276. Dr. Chaykowski writes on page 9 of his report that:

> *1. There are five key characteristics of Ontario of the health services industry that are directly relevant to the determination of the earnings of midwives and family physicians and that differentiate midwives and CHC family physicians:*
>
> *(i) While both physician and midwives services are considered essential to the health and well-being of the public, the key difference is that family physicians are trained and are licensed to perform the authorized acts of a midwife, but a midwife cannot provide the full range of medical services of a family physician, so that physicians can fully substitute for midwives whereas midwives cannot fully substitute for physicians.*

277. Dr. Chaykowski writes in his initial and response reports that doctors can substitute for midwives and therefore doctors have greater bargaining power than midwives and this contributes to justifying their substantially greater compensation.

278. First of all, if midwives were directly substitutable in a way that was acceptable to the public (who are paying for the health care system) then midwifery would not have been created in the first place. This clearly was not an acceptable substitution for the people who demand, and pay for health care services in this province.

279. As well, for a number of reasons it is not true that family practitioners could substitute for the care that midwives provide:

(a) Family physicians are not authorized, educated or competent to perform "midwifery" care which is a model of care expected and valued by women which can only be practiced by those educated and registered as midwives. "Midwifery" is a protected name and cannot be used by other health care providers. [83]

(b) In particular, CHC physicians could not substitute for midwives for many reasons over and above the model of care issue. They work in the employee model which would constrain them and make them unable to be true substitutes. With some exceptions, they don't have hospital privileges. They aren't insured to do obstetrical care and it is not generally part of

83 Midwifery Act, 1991, S.O. 1991, c. 31.doc, AOM0015476.

their job description. They work on a 35 hour per week schedule. They would not be able practice continuity of care, nor be on call 24/7, nor work on statutory holidays, nor work overtime without overtime pay, and yet comply with ESA standards.

(c) In accordance with College of Physician and Surgeons of Ontario policies, family physicians who do not currently provide obstetrical care would not be competent to perform that care without adequate training and experience. [84]

(d) Family physicians could not provide obstetrical care without hospital privileges to provide that care. Hospitals have their own rules as to admitting privileges and the necessary competence to obtain privileges for obstetrical care.

(e) Even if family physicians were to provide obstetrical care using the physician/nurse/medical model of obstetrical care, there are not enough family physicians willing to provide the care that would be required to replace the woman power that midwives provide each year to carry out approximately 18,000 midwifery births in Ontario across the province. This is especially true in underserviced communities.

(f) Physicians do not do labour support. They do not attend home births. Part of the reason that midwives were regulated in the first place was to make sure that competent safe care was available to women giving birth outside the hospital. This was seen as a need within the health care system and no other providers are trained to provide care to that population.

280. Chaykowski is incorrect to say

*"In fact, CHC physicians are licenced to carry out the range of activities that midwives undertake (subject, of course, to having recent experience and training), just as they did prior to the establishment of the midwifery profession in Ontario; the fact is that they have the discretion to do so; and many are simply observed to opt not to; in contrast, there is a full array of procedures/acts that CHC physicians perform that midwives can under no circumstances undertake."*

281. In Ontario, health care professionals have "registration" with their regulatory body. Once they are registered, they must comply with College standards of practice and College policies. Medicine is similar to nursing in that someone who is registered is unlikely to be able to practice to the full scope of that registration depending on whether or not they have the competency to do so. It would be professional misconduct to do otherwise. The CPSO is very clear that physicians do not have a broad mandate or

84 College of Physicians and Surgeons Feature Story re: Defining Scope of Practice: College explores possible solution to practice drift (2012) AOM0016509.

scope of practice. For example, the public can access from their website this information on scope of practice[85]:

*"'Our mandate is to regulate in the public interest,' said Dr. Rocco Gerace, College Registrar, 'and that starts with registration. We know that appropriate training leads to practice competency and that those without appropriate current training are more likely to have trouble maintaining an appropriate standard of care'"[86].*

*"We introduced the Changing Scope of Practice policy in 2000. It created an obligation to report significant changes or intended changes of scope and indicates that physicians changing their scope are required to participate in a process, including training, supervision and assessment, to ensure that they have the necessary competence to practise in the intended area"*

282. The CPSO has a very clear policy on changing scope of practice:[87]

*"Principles*

1. *The public is entitled to be treated by physicians who are competent to practise.*
2. *The College recognizes that, over time, physicians may change the focus of their practice.*
3. *Physicians are responsible for being appropriately trained to practise competently.*
4. *The College is charged with the responsibility of ensuring that physicians practise competently to meet the standard of practice for their chosen area of practice.*

283. Dr. Chaykowski gives significant weight in his initial report to the interests of Ontarians in having access to a family physician yet he does not set out the high demand for midwives in his report. His facts do not include that Ontarians have most definitely demonstrated (literally and figuratively) their deep interest in having access to midwifery care. In addition to flocking to midwives in numbers that cannot be accommodated by the current cohort of midwives, Thousands of Ontarians have demonstrated in the streets for increased access to midwifery care. Tens of thousands

85 College of Physcians and Surgeons: Changing Scope of Practice- A Physician's Guide (August 26, 2015) AOM0016422.

86 College of Physicians and Surgeons Feature Story re: Defining Scope of Practice: College explores possible solution to practice drift (2012) AOM0016509.

87 Changing Scope of Practice, Policy Number:1-08, (September 1, 2008) AOM0016421.

have sent postcards to the government requesting more access to midwives in birth centres.

### (b) **Page 9 and 38 MOHLTC Control of Remuneration of Midwives**

284. Dr. Chaykowski further writes on page 9, and again on page 38 of his report that:

> *2. Taken together, the funding framework under which the Ontario government sets the remuneration of midwives does not include agreements that:*
>
> *i. Specify the number of midwives in a practice group;*
>
> *ii. Specify the number of primary or secondary courses of care to be undertaken per midwife;*
>
> *iii. Require certain levels of work effort per course of care;*
>
> *iv. Require a set number of hours per course of care; or*
>
> *v. Set a total salary or the earnings of a midwife.*

285. However, this representation misapprehends how funding agreements work for midwifery practice groups (MPG). There is a funding agreement that specifies terms of payment including the level of work required and which sets the earnings per midwife per unit of work (course of care); as well as the budgets submitted which form part of the agreement and which specify caseloads. The below comments relate to the above roman numerals.

### (c) **Subheading i - Control of Number of Midwives**

286. With respect to subheading i, the funding framework does not "specify" the number of midwives in a practice group. While a specific number is not specified, the TPA and MOHLTC are to be made aware of the addition and termination of each midwife in the MPG (see 14.3 and 14.4 of the funding agreement). Of course, by approving a certain caseload, the Ministry controls the number of full time equivalent midwives that could practice within an MPG.

### (d) **Subheading ii - Specification of Courses of Care**

287. Subheading ii is incorrect. The MOH does specify the number of courses of care in its budget approval.

### (e) **Subheading iii - Definition of Course of Care**

288. Subheading iii is incorrect. There is an expectation of what a course of care will entail. The definition of Course of Care from the Funding Agreement states:

> *"Course of Care" means the provision of Midwifery Services to a female person for a period of 12 or more weeks during the female person's pregnancy, during*

*labour and birth, and for up to six weeks post-partum in accordance with College Rules, which course of care involves, on average, 48 hours of Midwifery Services and includes, but is not limited to, the following:*

*(a) approximately 12 prenatal visits, including one home visit;*
*(b) attendance at labour and birth;*
*(c) three to five postpartum home or hospital visits;*
*(d) one to three postpartum clinic visits;*
*(e) 24-hour access to Midwifery Services; and*
*(f) practice administration.*

### (f) Subheading iv - Expectation of 48 Hours of Care on Average

289. Subheading iv is incorrect. There is an expectation that on average there will be 48 hours of care; See Schedule C of the Funding Agreement that says "A "unit" of Non-Clinical Services means 48 hours of work in Non-Clinical Services and a "unit" of Clinical Services means a Course of Care."

### (g) Subheading v – Payment Per Course of Care Specified

290. Subheading v is incorrect. The Funding Agreement clearly specifies the payment per course of care, accordingly to the experience level of the billing midwife (See Schedule C of the funding agreement). It clearly states that a midwife cannot bill a woman separately (see 5.1 (l) of the funding agreement "ensure that no Woman is charged any fee or pays any Monies for Midwifery Services"); and constrains the number of courses of care that the practice group can bill (See 4.2 of the funding agreement "The Practice Group shall provide, in each Contract Year, up to that number of Billable Courses of Care indicated in the Annual Budget for such Contract Year.") This constraint is set by the Ministry.

### (h) Page 10 - Main Factors Determining Midwifery Compensation

291. On page 10, Dr. Chaykowski writes:

*The main factors that determine individual midwives' annual earnings are, in fact: 1st: Midwives' choice of on-going active work versus part-year work status; and 2nd: Midwives' choice of the number of primary and secondary courses of care.*

*3. Therefore, individual midwife earnings increases directly in relation to the number of cases that the individual decides to undertake, which is a function of their active status and individual choice of number of courses of care.*

292. These characterizations are not accurate. The main factor which determines midwives' compensation and funding for their services are the terms set out in the MOHLTC funding agreements. Dr. Chaykowski's statement also fails to consider the following details:

- Midwives' Practice Group budgets are approved by the TPA and Ministry

- The MOHLTC controls the timing of when budgets are approved. (this will impact the earnings of a new registrant who may not be able to start work months after she graduates; or a midwife who is moving from one practice to another but has to wait for budget approvals to do so; or a new general registrant who needs to wait for budget approval because her position may be a newly added position).

- The rate is set by the government per course of care.

- midwifery compensation is also a function of decisions made within the practice to allocate caseload to individual midwives.

- As with CHC physicians, there are many other life factors such as pregnancy, illness, need for family leave, availability of childcare that also impact midwives' annual compensation and whether they work full time or part time or take leaves.

- It is, and has historically been, understood by the entire midwifery sector, including midwives, TPAs, the OMP, the CMO and the MEP that a full time midwife would provide 40 courses of care in one year. To imply otherwise is disingenuous and/or demonstrates a complete lack of understanding of the history and structure of midwifery in Ontario.

### (i) Page 21 - Employment Characteristics of Midwives

293. On page 21, section 2.4 (i), Dr. Chaykowski writes of the "General Employment Characteristics of Ontario Midwives"

> *There are five key characteristics of employment and work in Ontario midwifery:*
>
> *(i) Midwifery is characterized as a "profession" in the legislation governing the activity, which determines their professional requirements, authorized acts, and responsibilities; and is considered an occupation and midwives do not hold a job.31 Midwives are certified on the basis of an expectation of :*
>
> - *professional conduct;*
> - *competency in specific skills areas;*
> - *specific skill and educational requirements; and*
> - *clinical experience.*
>
> *The requirements, authorized acts, and responsibilities of a registered midwife are not affected by individual caseload, case procedure requirements, or the location of the services provided.*

294. This is not accurate. As with any regulated profession in Ontario, the midwives are bound by their regulatory act and College requirements, regardless of their work setting. This is also true for the CHC physician. At the same time, the work of midwives providing services to the OMP is also governed by the requirements of the MOHLTC contracts, policies and practices, just as the CHC physician is bound by their employment contract with their CHC and its specific rules. As well, a midwife may take on additional competencies to work in rural and remote areas and a midwife must take on a certain number of cases and home births per year in order to maintain her active registration with the College of Midwives.

### (j) P. 22 Section 2.4 (iv) - Sites where Midwives Work

295. On page 22, section 2.4 (iv), Dr. Chaykowski writes:

> *(iv) Midwives are independent contractors; where: "Midwives are independent practitioners who work in a number of sites – in their clinics, in clients' homes and in hospital.*

296. This statement is incomplete. Midwives also work in birth centres. As well, while midwives are independent contractors in order to protect their model of care, they are also dependent on the MOHLTC who exercise significant control over their work and also sets their compensation. The Ministry also to some degree controls where midwives set up their clinics and how those clinic spaces can be configured, both directly through approving or withholding leasehold improvement grants (very few spaces available on the open market would be in "move in" condition for a midwifery practice) that allow such spaces to be workable and by the TPA approving where midwifery practices will be located. Unlike family physicians who can decide where to practice, midwives cannot practice in an area without approval by the MOHLTC.

### (k) P. 25 – Section 3.2(ii) Midwifery Practice Groups

297. On page 25, section 3.2 (ii), Dr. Chaykowski writes:

> *Midwives provide services as a part of a "Practice Group" which typically consists of either: one midwife (i.e., sole proprietorship); or two or more Midwives who have voluntarily formed a partnership, and which provides midwifery services; or as a part of a Midwife Practice Group (MPG), in which individual midwives provide midwifery services and receive payments from the MPG for the quantity of services they have chosen to provide.*

298. This statement "two or more midwives who have voluntarily formed a partnership." does not reflect the reality of operation of MPGs under the Ontario Midwifery Program. For a new practice, this will not be voluntary -- that is, the MOHLTC would require a group of midwives to enter into a partnership agreement before a new MPG was approved, unless the community could only support one midwife (eg a remote community). Further, individual midwives are constrained by budget approvals and by the distribution of caseloads within the group.

### (l) Page 36 – Section 3.2 (ii) -Estimated and Actual MPG Budgets

299. On page 36, section 3.2 (ii), Dr. Chaykowski writes:

> *The MPG estimated projected budget assumes a total number of courses of care to be delivered by the total estimated number of midwives in the MPG with certain experience levels;*
>
> *But the actual realized budget expenditures may deviate from the projected budget because of variations from the original estimates, in the actual billable courses of care, the number and experience levels of attendants who actually undertook to provide the courses of care and, therefore, in the actual caseloads across midwives.*

300. This statement does not reflect a full understanding of how MPG and OMP budgeting works in practice. MPG budgets are submitted to the OMP far ahead of when clients are finally discharged and that course of care is billed. Therefore deviations from the original proposed MPG budget can be caused by the large difference in time between projection in a budget, the timing of budget approval and the actual billing for service. The projected date of delivery (and therefore the invoice date) deviate significantly.

301. In fact, for much of the work that midwives provide, they have no idea what their approved budget will be. Women book for care 9-10 months before the practice can invoice for them and so approval may not come until well into their pregnancies. In fact, in the case of women giving birth between February and August/September, they will be discharged before the budget is even approved.

### 302. Page 36 – Section 3.2 (ii) –Variance between Proposed MPG Budget and MOHLTC Funding Received

303. On Page 36, section 3.2 (ii) Dr. Chaykowski writes:

> *Each Midwife Practice Group receives annual funding from a Transfer Payment Agency based upon their estimated annual budget.*

304. The annual funding received by an MPG is contingent on the estimated proposed budget of the MPG being approved by the TPA and MOHLTC. Final approved budgets are frequently different than requested budgets.

### (m) Page 39 – Section 4.1(iii) - page 40, section 4.1( iv ) Other Fees and Incentives

305. On page 39, section 4.1(iii), Dr. Chaykowski writes:

> *"Other Fees and Incentives (e.g., on-call fees; retention Incentives; remote/rural supplements); and which are disbursed directly to the individual."*

Later, on page 40, section 4.1( iv )

*"Travel payments (on the basis of a travel rate per course of care); and disbursed directly to the individual."*

306. This is not accurate. These fees and incentives are actually disbursed directly to the MPG, and the MPG then disburses them to the midwife.

(n) **Page 40 & Page 44 – section b (ii) Factors Constraining Size of Caseload**

Page 40

307. Dr. Chaykowski writes: "Individual midwife earnings are a function of a midwife's choice of caseload." (Page 40) He goes on to write:

*Given a midwife's decision to provide work during a given year, the subsequent decision is whether or not to work over the period of the full year (i.e., be continuously active), or to be on a short-term leave for a part of the year.*

…

*Taken together, the actual observed variation in caseload (courses of care) across midwives who decide to work, in a given fiscal year, is a function of:*

*The proportion of midwives who are on short-term leave;*

*Among those midwives on short-term leave, the duration of the short-term term leave; and Individual choice of caseload (at page 42).*

On page 44, section b(ii), Dr. Chaykowski writes:

*Figure 6a and Figure 6b display the actual distribution of midwives by number of primary and secondary caseloads, respectively, for midwives who are active over the period of the full fiscal year in Ontario for 2012-13. These data and figures:*

*(ii) Are entirely consistent with the fact that midwives, as independent contractors, determine their annual level of caseload.*

308. Clarification: First of all, we do not determine our annual caseload freely. I do not understand why this is relevant to how fairly we are paid, that some midwives work part time. Midwives are entitled to be paid fairly for each course of care, whether they are full time or part time. As well, midwifery was established on the basis of it being structured to permit full and part time practice.

309. The assumption that caseload size is always a midwife's choice is incorrect. There are many factors that can shape caseload size that are unrelated to a midwife's choice. Many of these factors reflect the fact that midwifery is a highly female

dominated profession where women have extensive family care obligations. It was anticipated right from the start and reflected in the 1987 Task Force report and 1993 Ontario Midwifery Program Framework that midwives would be working both full time and part time. Plus this assumption that midwives could just earn more equitably if they worked greater than full time is preposterous.

310. Factors which can affect caseload size for a midwife can depend on:

- sick or disability leave,
- leave to care for a sick family member,
- parental leave,
- difficulties accessing childcare that can be responsive to 24/7 call schedules.
- stress leave,
- physical challenges for older midwives providing 24/7 care who may need to reduce caseload in order to feel that they are providing safe care;
- caseload that was actually approved for an MPG is smaller than planned/requested; (Note: This is a decision of the Ministry and is a frequent case of partial caseload; that is, the Ministry restricts the growth of a practice because of the timing of MPG budget approvals and the approval of requested caseload might be smaller than what was requested. The MPG has no option but to give midwives partial caseload. This is a Ministry imposed condition that then forces midwives to take on a partial caseload.
- difficulties getting hospital privileges approved;
- restrictions imposed by a hospital on a number of midwives or number of midwifery births or number of births of all providers. This has certainly happened in my practice where we have had to decide whether to disperse cuts in caseload across the practice in order to not exceed a restrictive hospital quota or to fire one midwife to allow the others to maintain their caseload.
- A pair or team of midwives sharing call and the actual birth attendance not being equally distributed between the call periods, so some midwives are billing at less than full time and some at more than full time.
- doing work in other areas of the maternal/newborn care sector- paid and unpaid, including teaching in the MEP, research, working in the MOHLTC; and

- Some MPGs have experienced a reduction in approved cases over requested every year for the past few years. However, annual midwife caseloads are all subject to MOH approval. For the last two years, in my practice, we have not been initially approved for our proposed annual caseload in spite of our clear history of stability, our desire to support the Ministry funded birth centre and to meet our substantial unmet demand. Our request for additional caseload to meet our needs was met in both of those years a few weeks before the end of the fiscal year. In 2014, this happened after we notified the Ministry of a planned press conference to announce the firing of 2 midwives while we had 1000 people on our waiting list.

(o) **Page 58 – para.7 -Factors Affecting Relative Pay of Midwives and CHC Physicians**

311. On page 58, at paragraph 7, Dr. Chaykowski writes:

*Major factors that I expect to determine the relative pay of midwives and CHC physicians include:*

(a) *Education requirements, investment and attainment;*

(b) *Scope of practice;*

(c) *Required core competencies in the occupation;*

(d) *Responsibility for risk;*

(e) *Collective bargaining strength; and*

(f) *Market conditions.*

312. Apart from the above mentioned comment about education requirements by Minister Matthews, the Ministry and its representatives have not made comments to me about how they have determined the appropriate pay level for midwives. In fact, they have been unwilling to engage in such a conversation or provide rationale with the exception of some comments that it's all they can afford to pay us (sometimes political pressures were referred to, i.e., if we give you a significant increase to address past deficits we will have to give it to others, even when the implied others, doctors and nurses, received regular increases when we did not, and sometimes financial pressures).

313. In any event, the list of Dr. Chaykowski set out above, does not include several key factors which have been recognized by the MOHLTC to affect the pay of health care providers:

(a) hours of work

(b) onerous on call demands of midwives,

(c) health and safety;

(d) responsibility, accountability and risks undertaken;

(e) contribution to the Patients First agenda and health care reform;

314. For example, the first paragraph of Schedule C of the Funding Agreement:

*"This Fee Schedule recognizes the on-call demands, responsibility and accountability placed on Midwives and Practice Groups by College Rules, Applicable Law and Ministry policies in the provision of Primary Midwifery Care to Women during pregnancy, labour and birth and to Women and newborns for six-weeks postpartum. The multiple pay rates in the Fee Schedule acknowledge the experience that Midwives obtain by providing services."*

(p) **Page 74-75 Nature of Responsibility for Health Care and Financial Risks**

315. On pages 74-75, in the section entitled "Nature of the Responsibility for Risk," Dr. Chaykowski argues that:

*the scope of practice of physicians is greater than that of midwives; but, even in the area of practice related to childbirth, the nature of the services that midwives can provide is more restricted than the services that physicians can provide. One key factor defining the differences is the level of health risk associated with the childbirth case, where:*

….

**(ii) Midwives currently can only take on low-risk cases**:

*"The scope of practice of physicians is delineated in the Medicine Act, 1991. The scope of practice of midwives is delineated in the Midwifery Act, 1991. For both professions, authorized acts are specified in the respective Acts. For midwives, the drugs that can be administered or prescribed are contained in the regulations. Although there is overlap, physicians have a much greater scope of practice for maternal and newborn care, and midwives may take on only low-risk cases."*

316. While this appears to be relevant on the surface, it is actually not that relevant in practice in many settings. At Mount Sinai Hospital, for example, family doctors have essentially the same scope as midwives. That is, although many things may technically be within their scope according to the *Medicine Act*, hospital protocol requires family physicians to consult with a specialist physician.

317. One example of this is prescribing oxytocin for the induction or augmentation of labour. The protocol at Mount Sinai Hospital is that family physicians will always consult with the OB on call in such a case but continue to be the most responsible provider, as do midwives. In some other locations family physicians may have a larger scope of practice but so too, can midwives (e.g., midwives at Markham Stouffville Hospital prescribe and administer oxytocin).

> *"Midwives are experts in normal birth, and neither the College nor its members support any move toward midwives providing care for high risk pregnancies."*

318. The Canadian Association of Midwives, in fact, states in their mission statement that every pregnant person in Canada should have access to a midwife for them and their newborn

> *"… midwives handle few complex cases – this is owing to their practice philosophy and scope of practice. This scenario results in midwives having limited ongoing exposure to higher-risk pregnancies…"*

319. This is completely untrue. This statement perhaps more than any other shows that Chaykowski did not bother to determine the reality of midwifery practice beyond perhaps reading some written material published by the CMO. It is evident to me that he has not spoken to any midwife who works within her full scope unrestricted by her hospital.

320. Midwives in my practice often are managing complex patients, for example someone may come in to care with the pre-existing risks of advanced maternal age, obesity and history of a deep vein thrombosis. In pregnancy this woman may have abnormal bio chemistry markers in the first trimester but further testing shows no chromosomal abnormality (a marker for increased risk of a poor outcome). She may be diagnosed with gestational diabetes in her pregnancy and have ongoing surveillance to assess if fetal growth is appropriate. All of this is managed by the midwife, consulting with specialists as appropriate.

321. Thirty seven percent of our clients in the last 2 years were over the age of 35, 22 percent of them were overweight or obese at the beginning of pregnancy, 12.5 percent had had a previous caesarean section, 13% did not have OHIP, which can be seen as one type of proxy for the social determinants of health. All of these impact the complexity of a case. Not to mention the complexities added to a course of care by precarious housing, food insecurity, violence, etc. These factors are not included in Chaykowski's facts.

> *(iv) I expect the level of risk associated with a healthcare case, including cases of childbirth, to be a proxy for the level of effort, skill, and competency required to successfully provide the care required.*

322. No evidence for this statement and assumes all complex cases can be screened out before hand, also patently untrue. A midwife may have to simultaneously manage a

life threatening post-partum hemorrhage and determine if the second midwife needs any assistance with a neo natal resuscitation, all in an out of hospital setting.

> *Only physicians are expected to handle high-risk cases associated childcare; and they are also expected to handle high risk cases in all other areas within their scope of practice.*

323. This is not relevant to family physicians, only OBs. Furthermore, CHC physicians do not even do intrapartum care.

> *Therefore, I expect that the greater professional capacity that physicians must have in order to treat high risk cases, including high risk childbirth cases (and which reflects the higher level of effort, skill and competency required by physicians) to explain a part of the differences in earnings between midwives and physicians.*
>
> *Therefore, with respect to the nature of the health cases,*
>
> *Even in the provision of health services related to childbirth, midwives are restricted to normal, low-risk cases whereas physicians are not limited whatsoever.*
>
> *I expect the significant differences in the nature of the health cases treated by CHC family physicians and midwives to be a factor explaining the observed differences in the earnings of CHC family physicians and midwives.*

324. There is no evidence of this provided and it is not factually true in the field of maternity care.

325. Mr. Chaykowski's statements do not reflect an accurate understanding of the health care risks undertaken by midwives nor do they account for the financial risks of those owning/running a midwifery practice which are omitted entirely and made invisible.

**Financial Risks:**

326. For example the Funding agreement requires the practice to take on $10 M in general commercial liability insurance (see 17.1 – 17.3 of the Funding agreement). There are many risks built into the Funding agreement where the MPG is responsible for the funds provided by the MOH and will have to pay these back under certain circumstances. MPGs are responsible for:

- paying all members
- statutory deductions for any employees
- complying with all laws related to running a small business eg. OHSA, ESA, and AODA..

- assuming all legal risks associated with the practice.

- carry the financial costs of each course of care until approximately 1 month after discharging the client from care.

327. Partners are required to take out loans, lines of credit to finance their practices while waiting for payment from the Ministry, especially during periods of growth. Partners are legally and financially liable for all of the above. MPGs are vulnerable to legal actions from new registrants and associates regarding payment status, leave obligations etc.

328. These financial risks are not present for CHC physicians.

### (q) Page 84 - Comparison of Scopes of Practice of Midwives and Physicians

329. On page 84, Dr. Chaykowski writes

> *"Comparing the respective scopes of practices of midwives and physicians makes clear that…"*
>
> > *i. The scope of practice of midwives is a relatively small subset of the scope of practice of CHC physicians; and that*
> >
> > *ii. The scope of practice of physicians and midwives is asymmetrical, because a physician can perform the authorized acts contained in the midwife scope of practice, but a midwife can only perform a very limited number of acts included in the physician scope of practice.*

330. First of all, this statement, like much of Dr. Chaykowski's report is very physician-centric and assumes the dominant position of physicians and their physician/nurse/hospital model of maternity and newborn care. In fact, it is midwives who are the experts in normal and low risk maternal and newborn care.

331. CHC family physicians are not experts in maternity and newborn care. With few exceptions, they do not provide obstetrical care, do not have hospital privileges and do not wish to do obstetrical care. In some centres, such as Queen Street West CHC they do not even provide prenatal and post-partum care as that is provided by Nurse Practitioners.

332. Dr. Chaykowski's statements above fail to reflect the fact that physicians are not authorized, trained, competent or registered to perform the scope of practice of midwifery as set out in the *Midwifery Act* and the standards and guidelines of the College of Midwives. This model of midwifery care which is highly valued by women and produces better outcomes than the physician/nurse/hospital model and is outside the scope of practice of any kind of physician in Ontario, including family physicians.

### 3. John Kervin Report, November 2014

#### (a) p. 23 Problem Solving Skills of Midwives

333. In Kervin's comments on Paul Durber's report, he writes that Durber's assessment of the problem-solving skills of midwives relative to doctors and nurse practitioners:

> *Durber rates nurse practitioners lower than midwives. [This is ] Unexpected since diagnosis is largely a problem-solving skill, and since nurse practitioners and family physicians likely diagnose a much broader range of conditions than midwives…As well, since midwives work in pairs at the time of delivery, the onus of any problem-solving is shared (at page 23).*

334. However, part of midwifery practice includes identifying and addressing many complex diagnoses. This includes for example, urinary tract infections, (UTI), post-partum depression or psychosis, gestational diabetes, life threatening hemorrhage, mastitis, newborn heart murmur, newborn hypoglycemia, shock and anaphylaxis.

335. Further, Kervin's statement appears to be based on the inaccurate assumption that all problem-solving would occur at the time of delivery and would involve 2 midwives which in my experience is not the case. Out of a 48 hour course of care, I have found that only about 2-4 hours would be with 2 midwives in attendance and even in labour and the immediate postpartum, the most acute phase, is only 2-4 hours out of the midwife's continuous care during labour which could be up to 24 hours in length.

#### (b) Kervin p. 23 Interpersonal Skills

336. Kervin takes issue with Durber's rating of midwives and family physicians at the same level for "interpersonal skills" because "family physicians deal with more traumatic situations" (at page 23).

337. However, midwives spend a significant amount of time with people experiencing one of the most challenging and painful experiences of their lifetime.

338. I can testify to my own experiences delivering bad news on a regular basis including miscarriages, fetal anomalies, sexually transmitted infections (STIs,) still births and life threatening conditions.

339. Within the last two years, I have informed people they have an STD or that their pregnancy is non-viable. I have told women many times that their fetus has no heartbeat or that their baby will be born too early to survive, sometime this was in the second trimester. I have told people that there is a high likelihood that their baby has Down Syndrome and helped them decide whether or not to terminate the pregnancy.

340. I have attended more than one stillbirth including a set of 21 week twins. I have cared for multiple families choosing to have a genetic termination of wanted babies,

including providing most of the bedside care, catching the babies and helping the families through the ensuing weeks.

341. In my work as a midwife, I have told a woman who was 41 and a half weeks pregnant that her baby has a terminal brain tumour. I worked with this woman and her family for the 11 days that the baby lived and for several months afterwards. I have told someone holding their new baby in their arms that the baby appears to have a significant birth defect.

### (c) **Kervin p. 23 Responsibility for Services to People.**

342. Kervin takes issue with Durber rating midwives and nurse practitioners at the same level for "Responsibility for services to people" because "most births (about 80%) occur in hospital settings, where the availability of medical assistance is much greater and thus the onus of responsibility on the midwife is much less."

343. This shows a lack of understanding of how care is provided by midwives both inside and outside the hospital.

(a) In my practice for example 40% of births occur outside the hospital. An additional 10% have a planned for out of hospital birth that transfers into hospital at some point in the labour.

(b) In a rural setting, a midwife and her client may be in a hospital but the available medical assistance is often not within the hospital outside business hours and must be called in from home (sometimes with weather or other things happening inside the hospital impacting response times). Midwives must and do remain in charge and providing primary care during these times.

(c) And furthermore, in many planned for hospital births, the client is attended at home in labour, sometimes for many hours.

(d) And of course generally all the care provided prenatally and post-partum is in an autonomous clinic setting outside of the hospital.

344. To claim that a midwife is not responsible for care because a doctor may or may not be in the hospital promotes the biased assumption that midwives are somehow a “lesser than” provider and not the most responsible care provider with all the responsibility for service that implies.

345. Again, this reflects a misunderstanding of how midwifery practice operates and also that family physicians, like midwives, would also have access in hospitals to specialists.

346. However, the roles and responsibilities of midwives in hospitals are more complex than Kervin indicates, particularly as midwives must often navigate barriers placed on their work in hospitals. These barriers are sometimes the very physicians

(obstetricians) which Mr. Kervin assumes are always being of assistance to the midwife. Instead such obstetricians may be putting up resistance to the midwife's care of her client. For example, obstetricians and family physicians have admitted to me as part of my consultancy work on interprofessional relations in hospitals, that once a midwife requested a consultation for a minor matter (e.g., a prescription for GBS prophylactic antibiotics) or oxytocin for augmentation, they would require a transfer of care for financial reasons or because they did not trust the midwife's training or skills.

347. In Level 2 or 3 hospitals, obstetricians, anaesthetists and pediatricians, may be on site. They may or may not be immediately available (in the OR, emergency, their office, sleep room, etc.). In most, if not all, level 1 hospitals there is no specialist physician on site. A physician may be able to respond in a few minutes or may take 30 or more minutes to respond. Further, midwives may need to transfer from a level 1 site to a site with a higher level of care. Midwives in all settings need to be able to manage emergencies until a higher level of care is available.

### (d) p. 24 Emotional Demands

348. Kervin takes issue with Durber rating midwives higher than the CHC family physicians for "emotional demands" because:

> *[P]hysicians bear the burden of informing patients of life-threatening or life-ending conditions, and are required to deal with patients' denial, resistance, and grief… [and because] working in pairs at the critical time of birth may lower the emotional stress on an individual midwife (at page 24).*

349. However, Kervin fails to appreciate that midwives also do this work and deal with people in acute pain and distress a very high proportion of time. For example, genetic terminations, intrauterine fetal death, fetal anomoloies and perinatal mortality are a regular part of a midwife's job. Many midwives attend and conduct deliveries during genetic terminations. In cases where the baby is born alive, the midwife will care for that baby with respect until it dies. She hands the baby to the grieving parents. She is with that family for hours and days through the process.

350. Midwives also provide continuity of care for families experiencing a stillbirth, which can mean delivering a baby that has perhaps been dead for many hours or days. Even something as simple as supporting a family through days in the NICU for a baby born with Meconium Aspiration Syndrome is difficult. Though midwives know the outcome will likely be good, those parents are distressed and suffering for days until their baby is breathing normally on its own. Continuity of care adds emotional stress for the midwife in these situations because she knows the family well and is with them throughout.

351. Kervin's remarks about the reduction of emotional stress because midwives work in pairs mischaracterize the situations in which two midwives are in attendance. This is like saying that MDs work in pairs because there is an obstetrician and an anesthetist present at a caesarean delivery. Each midwife has a specific job to do and a patient she

is responsible for (i.e., primary midwife responsible for mom and second midwife responsible for baby).

352. Emotional demands on midwives are very significant and include spending many hours each week alone with labouring women. Only a small proportion of the time at a labour is actually spent with two midwives in attendance and usually all or most of the first stage of labour the midwife is alone.

### (e) p. 24 Sensory Demands

353. Kervin takes issue with Durber rating midwives higher than family physicians for

> *"sensory demands" because: "physical touching and manipulation is part of the physicians' routine for diagnosing (e.g., prostate examinations)" (at page 24).*

354. However, Kervin fails to appreciate that midwives regular routine includes physical touching and manipulation including: vaginal exam in labour, perineal suturing, manual extraction of clots from a post-partum uterus. Midwives also participate in routine and frequent cleaning up of human vomit, feces and blood, and routine performance of invasive procedures (sometimes for women with a history of sexual assault and often for someone who is already in pain).

### (f) p.26 Interpersonal Skills

355. Regarding Durber's rating of midwives as "level 4" on interpersonal skills, Kervin writes that:

> *Durber provides no evidence that midwives influence their clients to change their behaviours or decisions (an element found in level 5). Durber provides no evidence that midwives resolve major issues (another element of level 5) (at page 26).*

356. These statements reflect a fundamental misunderstanding of midwifery work and fail to take into account the important roles that counseling and informed choice play in midwifery care. Midwives routinely counsel women to change behaviours around smoking, other substance use, or diet. Midwives are the caregivers sought out by those who are most resistant to medical intervention. This means that midwives are regularly in situations where they are influencing clients to accept medical tests or interventions that they are ideologically resistant to embrace (for example, Vaginal Birth After Caesarean (VBAC) in hospital, ultrasound technology, transfer of care or use of interventions in a labour that is not progressing normally).

357. Regarding Durber's rating of midwives as "level 4" on interpersonal skills, Kervin writes that:

> *Durber does not mention in his analysis that, if a pregnancy encounters serious problems, midwives call on physicians to deal with the difficulty. Having such a "back-up" limits the stress midwives encounter, and thus eliminates the need for*

> *exceptional human relations skills to deal with the stress (another element in level 5) (at page 26).*

358. However, Kervin fails to mention that one of the most challenging parts of a midwife's job is caring for clients who refuse all or specific interventions and advice. For example, the client with platelets of 50, or VBAC or meconium and late sounding decelerations on auscultation who refuses transfer to hospital from a planned home birth. In some cases midwives have to manage births of breech babies or twins when clients refuse to birth in hospital. Some clients with a clear indication of a serious complication refuse consultation with a non-midwife practitioner. These situations require exceptional human relations skills.

359. Additionally, because of the partnership approach to care and the continuity of care, midwives may be quite involved in resolving disputes, assisting those in emotional distress (such as postpartum depression or bereavement), or assisting other family members, especially partners. Again, I don't know where Kervin got his information about how midwives provide care but it is inaccurate.

360. Kervin writes that:

> *Midwives demonstrate very good responsiveness skills, using discretion in dealing with their clients in situations of some stress or concern, and in emotionally charged situations." [which the author asserts is a class 4, rather than a class 5 characteristic] (at page 26).*

361. However, in my experience the Level 5 description does best describe the work that midwives do in inter professional relations within their hospitals:

> *The job requires influencing others to accept a point of view or convincing people to take a different course of action willingly. The jobholder may negotiate with or influence others to promote significant ideas or resolve major issues or demonstrate leadership with a high level of communication, where the outcome depends on diplomacy and professional counselling skills.*[88]

362. In his reflections on why family physicians are deserving of the level 5 designation for "interpersonal skills", Kervin writes:

> *One may think of family physicians in two considerably less happy, but not uncommon, circumstances: (1) convincing a patient to lose weight or stop smoking in order to improve the quantity and quality of the patient's life… (at page 26).*

363. Kervin does not mention that midwives also do this exact work whenever it is relevant. As well it is my understanding that this work in a CHC, is frequently done by Nurse Practitioners rather than by family physicians.

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88 New Zealand Department of Labour Equitable Job Evaluation Factor Plan (2007) AOM0006834.

### 4. David Price November 2014 Report

364. At pages 7 and 8 of his report, Dr. Price outlines the skills, efforts, responsibility and working conditions of family physicians (and CHC physicians in particular). His descriptions are remarkably similar to the descriptions of these categories in midwifery practice, with the following exceptions:

365. *Resource responsibility*: Midwives who are associates also often provide advice and guidance on efficiencies and practice management but midwives who are partners/owners must do this. Partners/owners bear the financial and legal risks and responsibilities of this through contracts with the TPA, contracts with associate midwives, partnership agreements, and employment contracts with administrators, lease agreements, etc.

366. *Outcome responsibilities*. Price says of physicians that "in some cases reporting is required for billing," however, extensive reporting is required of midwives for all cases, and if it is not submitted the practice does not get paid.

367. *Physical demands:* Physical requirements for midwives during labour and birth are extremely onerous (including staying up through the night; ability to turn clients, conduct emergency manoeuvres, constant bending, twisting, kneeling, squatting, on our feet for long periods of time, driving in the middle of the night).

368. On page 9, Dr. Price discusses the potential earnings of a family physician working outside a CHC setting where they physician provides primary care to 40 women per year during pregnancy, labour and birth, including conducting normal vaginal deliveries and providing care to mothers and babies during the first 6 weeks postpartum.

369. However, Price's analysis makes a number of unrealistic assumptions, including:

- that the time spent in prenatal and postpartum visits is the same
- the time spent with women during labour is the same
- that the number of visits prenatally and post-natally is the same
- that no travel is involved

370. He also omits the fundamental reality that much of the work that midwives do in labour and post-partum is in fact done by nurses for women under physician care. Also not included is the work that may be done by lactation consultants, social workers, administrators and housekeeping. He also omits the fact that in addition to being primary attendants, midwives are also second attendants for another 40 deliveries per year

### 5. Robert Bass November 2014 Report

371. In his critique of Durber's report, Robert Bass states that:

> *Since job evaluation is an art and not a science, there is a wide range of potential results that could be defended. It is not unreasonable to assume that an expert retained by a party which desires a particular result might retain an expert from whom they might expect a result at one end of the spectrum (at page 25).*

372. Bass does not mention that the MOHLTC was involved both with the Courtyard and the Morton reports.

373. I have a number of concerns with Bass' discussion of midwifery financing on page 116-117.

374. On page 116, he writes:

> 3. …Approval is not capped at 40 courses of care per midwife per year in all cases; if circumstances warrant, approval for more than 40 courses of care per midwife per year may be (and has been) granted (at page 116).

375. This statement excludes many of the years when funding was capped at 42 courses of care per midwife. It is also misleading in that it implies that midwives in the province could just choose to work greater than full time caseload (if they could somehow find the time) when this is absolutely not the case.

376. In my practice for example, last year we had 16 general registrant midwives working in our practice. We requested 550 courses of care for those midwives and were approved for 445 (43 courses of care less than we had utilized in the previous year). On March 22 of the fiscal year ending March 31,2015 this approval was increased to 553. All this to say, that, though we greatly appreciate being funded to provide the midwifery services that families were demanding and we were capable of providing, it is a vast oversimplification to say that midwives can get approval for more than 40 courses of care.

377. The OMP is not transparent about when and how they would approve more than 40 courses of care per midwife. Nor are they transparent about other funding decisions. I do not believe many Ontario practices are funded for more than 40 times the number of midwives in the practice.

378. Bass alleges that "Each midwife also receives a travel grant averaging $133 per course of care, or $5,320 per year."

379. However, the amount for travel grant in urban areas (where a significant proportion of midwives practice) is $80, totalling $3200 per year (at page 117).

380. Bass characterizes the supplement received by rural or remote midwives as follows:

> 14. Midwives practicing in rural or remote practice groups receive a supplement for every rural or remote client. The amount is based on the number of years practising in rural or remote practice group. The value of the supplement is $125 per course of care in the first year, $150 per course of care in the second year, and $175 per course of care in the third and subsequent years. This supplement is equivalent to up to an additional $7000 per year for a full-time midwife practising in a rural or remote practice group. In 2012-2013, total MOHLTC expenditure on this supplement was $196,475. (at page 117-118).

381. To clarify, the $7000 per year amount assumes that all cases meet the eligibility requirements of the remote and rural fee. It could be that a midwife receives supplements for 1 – 40 cases. Also, this supplement recognizes the unique hardship of practice in remote and rural areas. This operational fee recognizes that the cost of providing care in remote and rural areas is higher, it supports infrastructure for practice. This is not compensation, but reimbursement for expenses.

382. Further, MPGs carry the financial costs of each course of care until up to 7 weeks after discharging the client from care. Bass does not account for this unique financial risk anywhere in his analysis of midwifery financing.

### 6. Candace Johnson August 2015 Report

383. Johnson in her report makes connections between lay or traditional midwifery in other countries and professional midwifery in Ontario.

384. For example, Johnson writes:

> In the area of maternal health, for instance, there is overwhelming evidence (more on this below) that access to medical care (and not lay or traditional midwifery care) is the key to reducing maternal deaths around the globe (at page 4, paragraph 6).

385. Licensed Midwives in Ontario do not practice lay midwifery. They practice professional and regulated midwifery with proven excellent outcomes.

386. Johnson cites the findings of the Safe Motherhood Demonstration Project, an initiative of the Ministry of Health, the University of Nairobi and the Population Council (2003), which found that training Traditional Birth Attendants (TBA) did not reduce maternal mortality in places where they were used (at page 6, paragraph 13).

387. Professional, regulated midwives and Traditional Birth Attendants do not have similar practices. There is well established evidence in Ontario that Ontario midwives produce excellent health outcomes.

388. Johnson also writes:

> *The global health consensus, reflected in (and generated by) World Health Organization policy, indicates that the best way, in effect the only way, to reduce*

> *maternal mortality ratios is to facilitate access to skilled providers and institutions at time of birth. To be clear, this definition of skilled providers does include trained, licensed midwives and nurses, but does not include traditional or lay midwives. In other words, what the World Health Organization has concluded is that maternal mortality is reduced only by improved access to medical doctors and facilities at time of birth. (At page 6, paragraph 14).*

389. Johnson does not accurately refer to the global health consensus. – paras. 12-13.

390. The contributions of professional midwifery to reducing maternal and infant mortality are extensively detailed in world reports. "The State of the World's Midwifery 2014 Report, A Universal Pathway: A Women's Right to Health" produced by UNFPA, the International Confederation of Midwives (ICM), and the World Health Organization (WHO) and several other partners, "shows the progress and trends that have taken place since the inaugural 2011 edition, and also identifies the barriers and challenges to future progress. The report focuses on the urgent need to improve the availability, accessibility, acceptability and quality of midwifery services".[89]

391. In her critique of Bourgeault's expert report, and in support of a general warning about inappropriate "romanticization" of traditional midwifery, Johnson writes:

> Ontario's population is incredibly diverse and any assumptions about cultural dispositions toward normal/ natural births and scientific cultures/ literacy and medical authority need to be examined very carefully (at page 7, paragraph 15).

392. As I have highlighted in this affidavit, as a midwife serving a diverse downtown Toronto population for over 20 years, I can speak from direct experience of how natural birth and medicalization matters to diverse populations of Ontarians.

393. In our practice, where demand for midwifery far outstrips supply, we prioritize those clients that are planning a natural birth as we feel that we have a unique skill set in that regard that may be challenging to match in medical care. We ask this question on intake and screen clients accordingly so by definition, the vast majority of our clients are seeking a natural birth.

394. Our client population reflects the diversity of Toronto. Though BORN does not collect detailed demographic data, the Toronto Birth Centre does collect data about what proportion of clients admitted there are from priority populations ( on the basis of income, racial identity, sexual orientation, language, country of origin, etc.). We do know that in the vast majority of months we reach and often exceed the target of 50% for priority populations.

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89 The State of the Worlds Midwifery - UN Report (C1657259xA0E3A) (May 29, 2014) AOM0017372.

395. Johnson is critical of Bourgeault's connection between increased rates of medical intervention in birth and the growing privileging of the medical model of maternity care. She writes:

> We can also posit that the increases identified above can be attributed to the rise in other complicating factors, such as more births to mothers of advanced maternal age, increased rates of hypertension, diabetes and other non-*communicable diseases, more assisted conceptions, and so on (See Lisonkova et al 2011) (page 8 at paragraph 20).*

396. Drawing on my extensive clinical knowledge and experience, I observe that demographic factors affect the midwifery client base. In my experience, the average age of midwifery clients in Ontario has been older than the general birthing population. Midwives are trained to work with clients that have the above complicating factors.

397. With the exception of pre-existing diabetes, these things listed above do not require transfer of care to medicine though they may increase the complexity of the work that midwives do. We do take care of people with pre-existing hypertension, advanced maternal age, many non-communicable diseases (e.g., thyroid disease, some cardiac conditions, gestational diabetes) and all types of assisted conception.

398. Johnson does not distinquish between family doctors and obstetricians when, she states:

> It is assumed in the Bourgeault report but never demonstrated that midwives provide services that are equivalent to the services provided by medical doctors. It is difficult to understand how this could be the case when a key component of midwifery professional practice is the transfer of maternal patients from midwives to medical doctors when indicated. The logic of the transfer of care seems to be that more complicated cases require a different and more sophisticated set of skills (at page 11, paragraph 31).

399. Johnson states that Bourgeault's report oversimplifies the relationship of medical science to midwifery and their gendered aspects. She writes

> "Rejection of medical science is not a reflection of diverse women’s wants and needs, rather it is a political move that seeks to reconfigure power distributions" (at page 13, paragraph 36).

400. It is my professional experience as set out in this affidavit that professional midwifery in Ontario is not a rejection of medical science. That is a myth and stereotype. Professional midwives in Ontario are rigorously trained according to feminist and scientific principles.

401. Johnson refers in para. 9 to the “romanticized character” of natural childbirth which is “foundational to midwifery.” I find this quite patronizing both towards women who choose midwifery and to midwives. There is much research which supports the

importance and excellent health outcomes of “natural” childbirth and the commitment to such a birth process is the foundation of Ontario’s OMP.

### 7. Robert Bass August 2015 Rebuttal Report

402. In his Rebuttal of Mackenzie and Durber's Reports, Dr. Bass states that:

> An individual is regarded as a midwife, both in title and in compensation, upon completion of the 4 year MEP and registration with the College. The level experience attributed to this job class is a level one which represents a minimum of 0-6 month’s post-degree experience to become a midwife (at page 16, paragraph 53).

403. To clarify this point, midwives are required to complete a year as a New Registrant during which they are mentored and, at times, supervised. They cannot practice independently without this experience.

404. In his discussion of midwifery finances Dr. Bass writes "purchases attributable to overhead are the property of the contractor, as distinct from similar employer expenses, which are not the property of the employee" (at paragraph 207).

405. In fact, these assets, in the case of midwifery, are the property of the practice group not the individual midwife (with the exception of the midwifery bag which includes the basic, “essential equipment” that she must have with her at all time).

406. Our funding agreement clarifies the relationship of midwives to assets:

> ***“11.1 Ownership of Assets.*** *Subject to section 11.3, if the Practice Group is a partnership, both during the Term, and after the termination of this Agreement, each of the Partners of the Practice Group shall own jointly in accordance with their respective interests in the Practice Group, any assets the Practice Group purchased with Grant funds in order to provide Midwifery Services pursuant to this Agreement.*
>
> *11.2* ***Corporation to Own.*** *Subject to section 11.3, if the Practice Group is a corporation, the corporation shall own any assets the Practice Group purchased with Grant funds in order to provide Midwifery Services pursuant to this Agreement.*
>
> *11.3* ***New Registrants to Own.*** *Notwithstanding sections 11.1 and 11.2, both during the Term and after the termination of this Agreement, if the Practice Group purchased any assets listed in Schedule “G” in the column titled “New Registrant Equipment” for a New Registrant, the New Registrant Equipment shall be owned by the New Registrant shall be deemed to be the owner of such New Registrant Equipment immediately upon receipt of the equipment."*

### 8. Lisa Graves August 2015 Expert ReportIn

407. In her expert report, Dr. Lisa Graves writes that:

> *Family physicians care for [a] broad diversity of patient practice in practices that can be large and complex. Some of these group practices cover wide geographic areas and entire communities. There is no typical patient roster, but the range covers 900-2500 patients. Roster sizes reflect complexity of patients within the catchment as well as community needs (at page 5, paragraph 20).*

408. To respond to Dr. Graves, in my experience, midwifery practices can also be large and complex. Additionally, there are midwifery practices which cover large geographic areas and may encompass several communities. The range for family physicians is different than midwives because the model of care is different.

409. Dr. Graves writes that *"the role of the family physician is to consult other specialists outside of family medicine to address medical conditions, coordinate these referrals and ensure appropriate follow-up for their patient" (at page 6, paragraph 23).*

410. However midwives work with specialists in this way as well.

411. Dr. Graves writes that "*There are also new conditions that emerge or advances in medicine that are incorporated by the family physician in his or her practice as the primary care provider" (at page 6, paragraph 26).*

412. However, midwives, too, regularly adjust to ongoing medical advances.

413. Dr. Graves writes that:

> T*he management of normal pregnancy, labour and postpartum periods and the conduct of spontaneous normal vaginal deliveries is considered a competency to be acquired during residency. Other skills in maternity care are expected beyond this. Currently, 22 priority topics are listed. (at page 7, paragraph 29).*

414. However, the vast majority of these 22 competencies are common to both physicians and midwives.

### 9. Chaykowski August 2105 Response Report

415. Dr. Chaykowski writes that

> *The Durber and Mackenzie reports fail to acknowledge that the work of CHC physicians is, fundamentally, competency-based and not job-based; and that a pay equity analysis based upon job evaluation is not suited to a comparison of the pay of midwives and CHC physicians.*

416. In fact, the work of physicians includes:

- "… professional competence
- is about decision-making and acting within complex environments.
- is context-dependent.
- involves high-order problem-solving and decision-making skills.
- requires integration of many personal resources, such as knowledge, skills, judgment, and attitudes, based on experience and reflection on practice.
- includes the ability to select relevant external resources adequately.
- Competence implies critical analysis, creativity, and autonomy. It is intertwined with the progressive development of professional identity. It is a dynamic process, always evolving and dependent on the adoption of a reflective stance during one's practice and after specific practice events, accompanied by an engagement in lifelong learning." (at page 20 paragraph 39)

417. However, all of these conditions also apply to the work of midwives.

418. Dr. Chaykowski writes that *"emotional effort in cases related to terminal illness applies to CHC physicians but not to midwives (page 22, paragraph 42).*

419. Dr. Chaykowski fails to acknowledge that midwives give terminal diagnoses to parents throughout their career.

## XX. PRECEPTOR COMPENSATION

420. Through my inter-professional work I am aware that physicians have received an increase for such teaching but midwives remain frozen for over 20 years at the rate of $500 per month for full time precepting. I have found precepting to be rewarding but extremely intense work. A midwife may spend 200 hours precepting while she is performing the duties of her work. This adds complexity and risk and additional hours of work each week for an additional $500 per month.[90] When interviewing hundreds of midwives about teaching as part of my job at Ryerson, a significant number of them mentioned this lack of increase or recognition as a reason that they had stopped teaching or were disincented to teach.

## XXI. INTERVIEW WITH PAUL DURBER

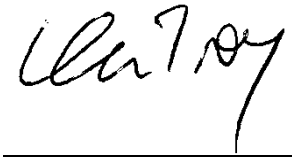
421. In the fall of 2013 I was interviewed by Paul Durber for his report. Our conversation focused primarily on my experiences as a practicing midwife.

90 Notes of Durber from telephone interviews (2013-09-16) AOM0007022.

422. I discussed with Mr. Durber the difficulties I have experienced as a registered midwife including the lack of infrastructural support, such as unions or clinical educators. We also discussed the inadequate funding for preceptors. I also described to Mr. Durber the increases in work load since 1994. Further, we discussed the inherent in the midwifery model of care. I also told him that in my consulting with hospitals I have found that the staff still often have biases against midwifery competence

**SWORN** this 28th day of July 2016.

A Commissioner for taking Affidavits



Katrina Kilroy