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HUMAN RIGHTS TRIBUNAL OF ONTARIO

HRTO FILE: 2013-16149-I

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 JANE KILTHEI

I, Jane Kilthei, of the Town of Cowichan Bay in the Province of British Columbia, MAKE OATH AND AFFIRM as follows:

1. I am a former Ontario registered midwife, past president of the Association of Ontario Midwives and former Co-Registrar of the College of Midwives of Ontario and Registrar of the British Columbia College of Midwives of British Columbia and as such have knowledge of the matters set out in this affidavit.

2. This affidavit is made to constitute the main section of my examination in chief testimony in relation to the above-noted proceeding. Below is the table of contents to this affidavit. My background which informs the testimony set out in this Affidavit is set out below and detailed in my Curriculum Vitae.[1]

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1 Curriculum Vitae of Jane Kilthei (2015-09-17) AOM0016604.

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I. BACKGROUND

1. Education – Learning – Experience

3. After receiving a Bachelor of Arts at Carleton University in 1973 I worked subsequently as a writer and editor for the Federal Government, primarily at Agriculture Canada. In 1975 I moved to a cooperative farming community where I managed the dairy, coordinated the co-op's work scheduling, continued to write and to organize conferences related to community building, feminism and the emerging women's health movement.

4. After the birth of my first child in 1980, I trained and worked as a childbirth educator and as a gynaecological teaching assistant at Queen's University medical school and later at the University of Toronto medical school.

5. In 1982, I started a midwifery training and apprenticeship program in Toronto, Ontario under the supervision of a senior community midwife, Theo Dawson. Until 1983 when doctors were prohibited from attending home births, we worked as well with an experienced family physician, Dr. Carmen Price.

6. I subsequently graduated from the Midwifery Pre-Registration Program, Michener Institute of Applied Health Sciences, Toronto, Ontario, with a Certificate in Midwifery in 1993. As one of the "Michener" midwives, I qualified to become a

member of the College of Midwives of Ontario and to commence practising as a registered midwife in the first cohort of registered midwives as of January 1, 1994.

2. Work as Community and Registered Midwife

7. From 1983 to 1984, I practiced as a community midwife in Toronto and was mentored in practice as a new midwife during that period. From 1984 to 1985, I practiced midwifery in Easthampton, Massachusetts and from 1985 to 1986, I returned to practice midwifery in Locust Hill, Ontario with Ms. Dawson. In 1986 I started my own practice, Midwifery Services of York, with some midwifery colleagues, where I worked until 1997, including as a registered midwife from 1994 to 1997. We had our hospital privileges at Markham-Stouffville Hospital.

3. Association of Ontario Midwives Leader

8. From 1990 to 1992, I was President-Elect, Association of Ontario Midwives (AOM). As of 1992, I became President of the AOM and continued in that role until 1994.

9. Prior to that time, I was a member of the Board of the AOM from 1986 and active in the development of the AOM's voluntary practice standards and guidelines which formed the midwifery self-regulation system at that time. I was also involved in the creation of an AOM practice review process.

10. As an AOM leader, I learned about international midwifery through reading the international midwifery literature and being a delegated representative of the AOM to the International Confederation of Midwives Congresses in 1987 and 1993. After the 1987 Congress in the Hague, I also followed practising midwives as they provided care in Gouda and Utrecht, Netherlands to learn firsthand about Dutch midwifery practice.

4. Roles in Development of Regulatory and Funding Framework

11. As an active AOM member and leader, I was involved in the development of the midwifery regulatory and compensation/funding system. In particular

    (a) From 1989 to 1993, I was a Member of the Liaison Committee to the Interim Regulatory Council for Midwifery and the Council's Standards and Qualifications Committee.

    (b) From 1990 to 1991, I served as Member, Midwifery Integration Planning Project, Ontario Ministry of Health and Ministry of Education.

    (c) From 1992 to 1996, I was Chair of the AOM Funding Committee and lead negotiator for the first contract for funded midwifery services in Ontario.

(d) From 1994 to 1996, I was the AOM liaison to the Ontario Midwifery Program Quality Committee, the reference group for the provincial funding program for midwifery.

5. Midwifery Clinical Preceptor and Instructor

12. From 1993 to 1997, I was a Clinical Preceptor and Instructor with the Ontario Midwifery Education Programme (MEP), at Ryerson, McMaster and Laurentian Universities.

13. As a Clinical Preceptor, I worked with MEP students assigned to my midwifery practice in their clinical placements beginning in 1994.

6. Midwifery Representative

14. During the 1980's and 1990's, I was appointed by the Ministry of Health to various committees and projects

(a) From 1989 to 1992, I served as a Member, Ministry of Health Steering Committee reviewing Ontario's *Public Hospitals Act;*

(b) From 1993 to 1996, I was a member of the External Advisory Committee, Community Health Framework Project, Ontario Ministry of Health; and

15. From 1992 to 1994, I was appointed by the Chief of Staff of the Markham Stouffville Hospital as a member of the Hospital's Task Force on the Implementation of Midwifery and as a member of the Hospital's midwifery staff, I served as a member of the York Region District Health Council Acute Care Study group from 1994 to 1996.

7. Midwifery Regulator

16. From 1996 to 1997, I was the Co-Registrar of the College of Midwives of Ontario (CMO), sharing the job with Robin Kilpatrick, another practising midwife. This job-share arrangement was put in place to support the importance of midwifery organizational leaders continuing in clinical practice. In my work as Registrar I focused on the implementation and refinement of the College's standards of practice and on registration and active practice requirements and processes, as well as on the College's Prior Learning Assessment process to assess and orient internationally-educated midwives for registration.

17. From 1997 to 2014, I was the first Registrar and Executive Director of the College of Midwives of British Columbia until I retired from that position to work as an organizational consultant in May of 2014.

18. Relying on my experience with Ontario midwifery standards, regulations and registration processes:

(a) I led the process of getting the first B.C. midwives assessed, oriented and registered to practice in BC as of January 1, 1998.

(b) Thereafter, I was responsible for ensuring the BC midwifery registrants, including new university graduates and internationally educated midwives applying for registration, were knowledgeable and competent to practice, met continuing competency requirements and complied with the standards of practice and code of ethics set out in the B.C. regulatory framework.

(c) As BC midwives were being integrated into the health care system, I worked with the Ministry of Health and the College Board to take the Midwifery regulations under the Health Professions Act and create functional systems that would support midwives in practicing safely and effectively within the health care system.

(d) As well, I worked with Perinatal Services BC to ensure BC's perinatal data base system accurately captured outcomes for all births involving midwifery care in BC based on planned-place-of-birth, and I carried out the quality assurance, complaints and discipline aspects of the Registrar's position as described in the Health Professions Act.

8. Research Projects, Studies and Articles

19. I have participated in a number of midwifery related research projects including:

(a) From 1994 to 1997, I was a member of the Maternal Serum Screening Health Care Provider Survey Research Team; and

(b) From 1997-2000 I was a member of the British Columbia Ministry of Health Home Birth Demonstration Project Advisory Committee.

20. I have written, co-written and published a number of both peer-reviewed and general articles related to midwifery including the following:

(a) 1999: *Going the distance: the influence of practice location on the Ontario Maternal Serum Screening Program,* Canadian Medical Association Journal, August 24, 1999 (co-authored with Joanne Permaul-Woods BSc, June Carroll MD, Anthony Reid MD, Christel Woodward PhD, Greg Ryan MB, Sharon Domb MD, Stella Arbitman MD, Barb Fallis MD);

(b) 1997 *Maternity care and maternal serum screening. Do male and female family physicians care for women differently?* Can Fam Physician. 1997 Jun; 43: 1078–1084. (co-authored with C. A. Woodward PhD, G. Ryan MB, J. Carroll MD, A. Reid MD, J. Permaul-Woods BSc, S. Arbitman MD, S. Domb MD, B. Fallis MD);

(c) 1993 Access to Hospital Resources - Supporting Safe Midwifery Practice, Health Law in Canada Vol. 13, No 4, September 1993;

(d) 1993 *Negotiating a Funding Agreement for Midwives in Ontario,* Proceedings of the 23rd International Congress, International Confederation of Midwives, May 1993;

(e) 1993 *Cost Effectiveness of Midwifery Care,* a literature review to support funding negotiations with the Ontario Ministry of Health;

(f) 1992 *Home Birth Research: the Debate in Australia,* final paper for the Ontario Midwifery Pre-Registration Program, October 1992, a literature review and discussion paper co-authored with Vicki Van Wagner, Merryn Tate and B.A. Davis Putt; and

(g) 1987 *Home Birth in Ontario* and *Practicing Midwifery in a Hostile Environment,* two papers published in the Proceedings of the 21st International Congress, International Confederation of Midwives, August 1987.

9. Current Work

21. I am currently the Principal in Resilience Matters, a consulting firm which provides organizational consulting, facilitation and coaching services.

22. I am currently writing a discussion paper based on a literature review of the safety of the BC and Canadian model of midwifery using Canadian and international peer reviewed literature for the College of Midwives of BC.

10. Feminist and Mother

23. I came to the midwifery and health care world as a feminist, passionate about the importance of women being in charge of our own bodies – whether we are making a decision to be pregnant or not, or deciding how, where and with whom to give birth. This perspective was strengthened when I went through my own experience of pregnancy, childbirth and motherhood with my children.

II. ONTARIO MIDWIVES AND MIDWIFERY

24. Midwife means "with woman". Midwives are a 99.9% female profession in Ontario and provide care for women for the uniquely biologically female experience of pregnancy, birth and early mothering.

25. Midwives take supporting the autonomy of the woman as the core tenet of our model of care by emphasizing her informed choice, and choice of birth place in the context of building a mutual relationship of respect and trust through continuity of care. Midwives are not only closely connected to the women they provide care for - midwifery practice is about collaborating with women and supporting them in exercising agency in addressing their own health care and overall well-being. Midwifery care and support takes place in a context where women's health care needs have not been sufficiently addressed by the health

care system. This is what I understand “engendering” health care means in the context of midwifery.

26. Midwives provide high-quality and cost-effective primary care in the field of maternity care, a field that had been reserved in the funded health care system for physicians supported by nurses. Midwifery’s distinct maternity knowledge and care is on an equal footing with physicians in many respects and in a number of aspects has been shown to produce better outcomes. As well, some skills such as providing obstetrical care in a home setting are unique to midwives.

27. Drawing upon my extensive experience noted in Part II above, I have observed that the job content of midwifery work – health care for women and newborns, including vulnerable populations, involves complex, overlapping and multi-level diagnostic and technical medical, nursing and counselling skills integrated with continuous education, caring, and nurturing of women throughout their childbearing experience from conception to six-weeks postpartum. Such job content is mandated by legislation and by regulatory requirements. It is also my experience and observation that the full content, complexity and responsibility of midwifery work, and the education and training required to perform this work, is frequently invisible or undervalued by those not doing the work.

28. To midwives and their clients, pregnancy and birth are normal, healthy life events. At the same time, clients are undergoing a physically, socially and emotionally complex life transition which requires close attention, care and support. Midwives support normal childbirth and at the same time use their considerable assessment and diagnostic skills to help keep pregnancy and childbirth on a normal course by identifying concerns and potential health problems early, when changes in things such as diet, physical activity, sleep patterns, and other habits are more likely to be successful. Midwives also have the skill and ability to respond with timely and appropriate intervention when a woman’s health status or that of her newborn does deviate from normal and greater health care risks are identified. This requires the midwife to have the skills to handle emergencies and to identify when it is necessary to consult with or transfer care to a specialist. In 1994, midwifery became an integrated part of the Ontario healthcare system and is provided free of charge to residents of the province. Midwives provide care to women and their newborns in the hospital, birth centre and home setting.[2]

29. Ontario’s registered midwives are autonomous primary health care providers who are specialists in providing comprehensive around-the-clock, on-call, maternity care for women with low-risk pregnancies. This also includes transgender persons who are able to give birth. Along with family physicians and

2 Ministry of Health and Long-Term Care, "Midwifery in Ontario: What is a Midwife?", accessed at http://www.health.gov.on.ca/en/public/programs/midwife/; Ontario Hospital Association, College of Midwives of Ontario & Association of Midwives, “Resource Manual for Sustaining Quality Midwifery Services in Hospitals”, September, 2010. AOM0000607.

obstetricians, they provide primary maternity care in Ontario's health-care system. As well, along with paediatricians and family physicians, they provide health care to infants up to 6 weeks. The knowledge and skills of midwives cross a number of professional boundaries and include overlapping scopes of practice with family physicians, obstetricians, pediatricians, and nurses.

30. If a woman is in midwifery care she will not see a physician unless there are concerns or complications that fall outside the midwifery scope of practice. Midwives are the only regulated primary health care providers who attend at home births or birth centres in Ontario. Midwives are trained to manage both maternal and neonatal emergencies, including at out-of-hospital births.

31. Midwives, along with some family physicians, focus on low risk pregnancies and refer to or consult with an obstetrician, pediatrician or other physician specialist when needed. A consultation may or may not result in a transfer of care, depending on the circumstances. While obstetricians are trained to focus on high risk pregnancies, in Ontario a high percentage of the births they attend are for women with low risk pregnancies.[3]

32. It is generally accepted, using World Health Organization data, that approximately 70-80% of women giving birth in Ontario start out as low risk.[4] These women are eligible for care within the midwifery scope of practice.

III. MINISTRY OF HEALTH AND LONG TERM CARE (MOHLTC)

33. The Ministry of Health and Long Term Care (MOHLTC), known as the Ministry of Health (MOH) at the time of regulation, is the government entity responsible for the development and implementation of regulated midwifery in Ontario and the establishment effective January 1, 1994, of the Ontario Midwifery Program (OMP).

34. Beginning in 1993, before regulation, through my time in Ontario, the Community Health Branch (CHB), later renamed the Community Health and Promotion Branch (CHPB), was responsible for both the Ontario Midwifery Program (OMP) and the Community Health Centres program.

35. In the early 1990s, the MOH assigned leadership of the midwifery implementation and integration process to the Ministry's Women's Health Branch and created the position of Midwifery Implementation Coordinator. As the time for regulation drew near, the MOH assigned operational responsibility for the development and implementation of the program and the compensation system to the CHB, at the recommendation of and working with the Women's Health Branch.

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3 BORN data from 2013 to 2014, January 1, 2014. AOM0016157.

4 Executive Report of the Ontario Maternity Care Expert Panel "Emerging Crisis, Emerging Solutions, September 6, 2006. AOM0000650.

36. As noted in Part II above, in my roles with both the AOM and the CMO, I worked closely with the Ministry over the years to develop and implement the new midwifery system in Ontario.

37. During the pre-regulation and post regulation period of my involvement, the CHB was also responsible for the management of the Ministry's Community Health Centres and the setting of compensation of the salaried physicians and primary care nurses who work as employees in those Centres.

IV. PRIMARY HEALTH CARE REFORM AND HEALTH EQUITY

38. During the 1980's, the MOH was engaged in a number of policy initiatives which affected the regulation, design and compensation of the new midwifery services, along with the compensation of CHC staff.

1. Primary Health Care Reform

39. The MOH pursued primary health care reform since the 1970s. This was informed by the international movement for primary health care reform. This reform called for community-based, patient-focussed, holistic and equitable health care, an approach that was certainly consistent with the re-emergence of midwifery and with the Ontario midwifery model of care. Primary health care reform was also pursued as a way to manage rising health care costs while working to ensure better health outcomes, goals associated with more of a focus on prevention and continuity of care and a move away from acute and episodic fee-for-service driven models.

40. The Ministry's health care reform initiatives aimed to achieve an integrated patient-centred system that supported healthier patients, faster access and the right care at the right time at the right place.

41. Ontario's Community Health Centres, started in 1979, and the regulation and the funding of midwifery were major building blocks of that reform process. Health Gender Equity

42. The MOH also pursued providing more gender sensitive and effective health care services for women. The MOH Women's Health Branch was created to provide a focus on the need for equitable and appropriate health services for women.[5]

5 "Why Women's Health? Issues and Challenges for Women's Health Research in Canada in the 21st Century" paper prepared by K. Grant for the Women's Health Bureau (Health Canada) (December 06, 2002) AOM0000586.

2. Providing Appropriate and Safe Maternal Care for Ontario Women and Newborn Care

43. Given the connection of midwifery to women's health, the Women's Health Branch was given the lead in the implementation process.

3. Ensuring the Equitable Integration of the Previously Excluded Midwifery Profession into the Funded and Insured Health Care System

44. During this time, internationally there was growing evidence in support of the safety and cost-effectiveness of both midwife-led continuity of care and out-of-hospital birth in the context where well-trained midwives were integrated into health care systems that provided timely access to specialist consultation and transfer to hospital facilities when needed. This required removing barriers and facilitating the integration of primary care midwifery into Ontario's health care system, including proper positioning and compensation and managing costs while striving for better outcomes.

V. ONTARIO'S HEALTH CARE SYSTEM IN THE 1980'S

45. Ontario's funded health care system provided health care services in a variety of different ways through many different health care providers. Insured services were provided by "fee for service" physicians. They were also provided by salaried physicians in Community Health Centres and also by many other health care providers, like nurses working on teams in both community and acute care settings, and by senior primary care nurses trained as nurse practitioners taking on increasing primary care responsibility.

46. Primary care providers are those who provide first-contact assessment of a patient and continuing care for a wide range of health concerns. The scope of primary care includes the diagnosis, treatment and management of health problems; disease prevention and health promotion; and ongoing support, with family and community intervention where needed.[6]

VI. MATERNITY CARE SYSTEM IN ONTARIO IN 1980'S

1. Medical-Led Physician/Nurse/Hospital Model Only Funded Model of Care

47. Ontario in the 1980's had only one funded model of maternity care – the medical-led model where women gave birth in hospitals under the care of a funded family physician or obstetrician supported by nurses. Until 1983 a very small number of family physicians attended home births.

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6 Canadian Medical Association, 1994, cited in Information from University of Ottawa re: Primary Care Definitions and Historical Developments (August 25, 2014) AOM0000928.

48. The CPSO issued a notice to member in January 1982 which read in part "Some physicians have been urged by their patients to attend them at home when they go into .labour. The College would discourage this practice because it does not consider home births to be safe or in the patient's best interest."[7] In 1983 hospitals in the province developed policies that forbade physicians from attending out of hospital births or risk losing their privileges. Physicians who were known to be attending home births were sent letters advising them to stop. These rules served to reinforce the stereotype that home births were dangerous and that midwives were irresponsible for providing such care, despite the international evidence to the contrary. As a result of these policies, physicians no longer attended home births with midwives.

49. However, midwives continued to practice in Ontario and offer the choice of home birth. On regulation, midwives became the only regulated obstetrical care providers who offered the option of home and later also birth centre birth to Ontario women, as well as hospital birth. Doctors did not return to attending home births for a number of reasons, including that it was not practical for them to spend that amount of time outside their offices or to work without nursing support, and would need to invest in the emergency equipment which midwives carried.

50. As a young pregnant woman in 1979, I observed this physician-led model first hand. I was having difficulty finding maternity care that was congruent with my values – care that felt safe and sensible and human. I was strong and healthy and considered pregnancy and childbirth to be normal life events. When my rural family doctor, who didn't do obstetrics, referred me to an obstetrician I went to see him in the nearby city of Kingston. I'd been doing a lot of reading and talking to friends who'd had babies and I had some questions. When I took out my list he said something like, "Oh, you're one of those", like I was already a problem. Whenever I asked a "what would happen if..?" question, his answer was short, not very informative and invariably ended with, "Well, we would take you to the operating room, and your support person would wait in the waiting room."

51. I'd been working in grassroots feminist women's health and self-care for quite a few years at this point and I found this male doctor's lack of respect for me, my interest in being well informed, and my capacity to make decisions for myself, patronizing and dismissive. I asked about speaking to another obstetrician, thinking maybe they weren't all this bad, but he told me that they all shared call and worked in the same way. It was very discouraging. Then, on a tour of the hospital that was part of going to childbirth education classes, we went past this window where all these little newborns were wrapped up like sausages and lying in plexiglass bassinets, many of them screaming their heads off, and I had a

7 College Notices, January 1982 as cited in Book by Ivy Bourgeaut: "PUSH! The Struggle for Midwifery in Ontario" AOM0007185 at p 73.

visceral reaction, “Nobody is going to put my child in that place.” So I went looking for alternatives.

52. There were no midwives practicing in the area, but people gave me names of some family physicians who were supposedly more focussed on women-centred care. When I started calling around, I found out how truly restrictive the hospital policies at the Kingston General Hospital were, and the responses I got were not encouraging. Finally, when I was more than 7 months pregnant, a medical receptionist for a doctor who was not very supportive told me, almost in a whisper, about a local doctor who occasionally did home births. I called him, he agreed to see me and, after taking a history, doing an assessment and talking with me for a while, he agreed to attend my birth at home. We called him when I went into labour and he got there an hour or two before I gave birth to my son. This was in the spring of 1980.

53. I felt safely cared for. It was a powerful experience and I was grateful to be at home where I was comfortable and to not have to be separated from my son or my family either during labour or afterwards. It was profound for me, and I thought “It shouldn’t be so hard for women to access this kind of care if this is what they want.” The hospital is not that far away if it’s needed, and I believe the physiologic process of labour and birth is best facilitated by supporting the woman and providing her care in the place she feels most comfortable.

54. Over time my birth experience, and how hard it was to make it happen in a way that worked for me, led to my decision to become a midwife. The growth of midwifery in Ontario in the 1970's and 1980's came out of the similar concerns of many women that their health care needs were not being fully met through the physician-led model of maternity care.[8]

55. During my midwifery training, I studied both British and American midwifery textbooks, and also obstetrical textbooks like Williams Obstetrics to learn more about abnormal conditions that can arise during pregnancy and birth and how to recognize them. In the course of reading these medical textbooks I also got a better understanding of how deeply embedded the depersonalization and objectification of pregnant women, primarily as vessels carrying fetuses, and of women in general was in the medical-led model of care. I also read extensively about midwifery history and how childbirth had been taken over by the medical-led and controlled approach without any evidence that that approach was any safer for mothers or babies. Maternity care didn’t begin to become evidence-based until the Cochrane Collaboration began a systematic review of the evidence and established the *Oxford database of perinatal trials* in 1986.

8 Task Force on the Implementation of Midwifery, “Report of the Task Force on the Implementation of Midwifery in Ontario 1987 [Task Force Report], January 1, 1987. AOM0013549. MOHLTC Report "Echo: Improving Women's Health in Ontario - Sharing the Legacy - Supporting Future Action 2009-2012," January 1, 2013. AOM0000587.

56. Historically in Canada, the physician takeover of childbirth had a lot to do with general practitioners wanting to use maternity care as an opening to providing care for a whole family. Physician attacks on midwives in Ontario were most pronounced between 1871 and 1911 when an oversupply of physicians let to intense competition between the male-dominated medical profession and female midwives.[9] By the 1940s physicians' certificates said they were "licensed to practice medicine and midwifery" as they claimed sole responsibility for labour and delivery.

2. Hierarchical Structure of the Ontario Health Care System

57. Throughout my life and career, I have observed the hierarchical structure within the health care system with the profession of physicians at the top. It was apparent to me in observing and being a part of the day-to-day relationships between physicians and nurses and midwives on the hospital labour floor, both pre and post midwifery regulation. It was also apparent in multidisciplinary meetings, whether those were regulatory, hospital-based or government meetings. This doesn't mean that doctors aren't reasonable people, capable of being collaborative, but they generally see the world through the lens of being the ones in charge. That's what has been inculcated in their medical training, and everyone else in the system generally learns to cater to that view in order to get things done.

58. Nurses in hospitals, like midwives, are the ones with the most direct contact with patients. They are the ones at the bedside not just taking vital signs, but assessing skin color, timbre of voice, and change in behaviour from visit to visit, and taking the time to hear directly from patients about their concerns. They're the ones who decide when a doctor needs to be called and they usually have a good idea of what care, therapy or other action is needed, but this is something they would usually "ask" the physician about or at most "suggest" rather than "recommend". In meetings I noticed it was quite common for a nurse or midwife to share a thought or idea, get no response, and then hear a physician later state the same thing as if it had not already been put forward, at which point the medical people at the table would usually take up the idea as a good one. We generally came to think of this as a success in moving things forward, if one of the physicians embraced an idea of ours as his own. The goal was making positive change, not getting credit, but as a woman working in that kind of male-dominated hierarchy, it got really tiring to see such a waste of talent and ideas.

59. Physicians also exercise the most power and influence in the funded health care professional system in Ontario. I remember this as the dominant reality from the time public health care was being established in Canada. Then the physicians were the major group opposed to it and they exerted huge influence on how it was implemented and especially on how they would be paid. I experienced this

9 Beth Rushing. "Market Explanations for Occupational Power: The Decline of Midwifery in Canada." The American Review of Canadian Studies 21: 7-27, (1991-01-01) AOM0017412.

physician power very directly in my own work as a health care provider, not only as a pre-regulation midwife but also as a midwife practising post regulation and as a midwifery regulator.

60. By a hierarchical structure dominated by physicians, I mean the following:

(a) Due to the government's historical and ongoing laws, the profession of physicians (as well as dentists) had the exclusive right to hold admitting privileges to hospitals as provided by the *Public Hospitals Act* until the regulations to the *Act* were amended in 1993.[10]

(b) Physicians, through Hospital Medical Advisory Committees (MACs) are also the gatekeepers, deciding who gets hospital privileges. Many physicians opposed the broader changes recommended to the *Public Hospitals Act* in 1992 because they raised the potential for MACs to become more multidisciplinary decision-making bodies. I understood that this was one of the reasons the *Act* was never amended. In BC the hospital legislation was amended so that midwives who head departments of midwifery sit on their hospitals' MACs and a midwife is appointed to sit on the provincial hospital appeal board.

(c) An MAC not only controls whether a midwife is granted hospital privileges, but it can set limits on how much of her scope of practice a midwife can actually use and her conditions of work in hospital. These kinds of constraints have been placed on midwives in a number of Ontario hospitals, including imposing more restrictive requirements for when midwives have to transfer care and what choices women can make about their in-hospital care, e.g. if woman has had a prior caesarian, she may be required to have an IV in place immediately on admittance to hospital, restricting her mobility and medicalizing her birth in what is often referred to as a "trial of labour".

61. The medical profession's desire to have childbirth take place in hospital was a factor in the female-dominated nursing profession's initial support for physician-managed childbirth, because there was a clear existing role for nurses in supporting physicians in this model. The nursing profession also initially took the position that, if Ontario was going to include midwifery in the Ontario health care system, it should be a system of nurse-midwives working under physician supervision. From the nursing profession's perspective this was the system that they had been trained in and worked in and would potentially give them some additional recognition and autonomy. Yet this wasn't a unanimous view. About a third of Ontario's not-yet-regulated community midwives had nursing training, and we had a significant number of nurses coming to us for midwifery care and choosing home birth prior to midwifery regulation.

10 R.R.O.1990, Reg 965, s. 11(1)(c)

VII. THE GENDER OF THE HEALTH AND MATERNITY CARE SYSTEM AND MATERNITY CARE CLIENTS

1. Male Predominance of Physicians

62. During the 1980s, I observed that most family physicians and obstetricians were male. This male predominance was a generally accepted fact in the 1980s and was cited a number of times in the 1987 Task Force Report on the Implementation of Midwifery.[11]

2. Community Health Centres

63. During this period, I was also a patient at the Riverdale Community Health Centre from 1982 to 1984. My doctor was male and as far as I can recall I met him only once. All my patient interactions were with the senior primary care nurse or nurse practitioner.

64. Community Health Centres are inter-professional primary care non-profit organizations that combine health promotion and community development services with a focus on the social determinants of health combined with primary care services. They are governed by community-elected boards and funded by the Ministry.

65. The Centres were part of the Ontario Government's move to community-based and managed non-fee-for-service care.

66. Around the time of the negotiation of the September 1993 Ontario Midwifery Program Framework with which I was involved,[12] there were about 49 Community Health Centres located around the province. Most of these locations were situated in or near the same local areas as midwifery practice catchment areas.[13]

67. CHC staff included physicians, senior primary care nurses/nurse practitioners, registered nurses and large numbers of other clinical, health promotion, community development, administrative and management personnel. This range of staff is reflected in the MOH Approved Salary Schedule for CHCs which was in effect in 1993.[14]

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11 Task Force on the Implementation of Midwifery, “Report of the Task Force on the Implementation of Midwifery in Ontario 1987 [Task Force Report], pp. 29, 197, (January 1, 1987), AOM0013549.

12 Ontario Midwifery Program Framework Developed by the Midwifery Funding Working Group, September, 1993, September 1, 1993. AOM0007064.

13 "Community Health Centre Program: Proposed Specific Directions, March, 1992, p. 3 AOM0002741 "

14 MOH Community Health Centre Program Approved Salary Ranges 1994-1996 and portion of report from Hay Group CHC Report re salary and benefits, (January 1, 1996), AOM0001287.

68. Community Health Centres provided some degree of maternity care services to low risk women through a shared physician/nurse model. CHC family physicians, with some exceptions, did not typically provide intrapartum care, although a few, like the ones at the South East Ottawa Community Health Centre, did offer such care.[15] They referred patients with at risk pregnancies to obstetricians. Most CHC physicians either referred low risk women to obstetricians at 28 weeks of pregnancy or to midwives, family physicians who did obstetrics, or obstetricians at the time pregnancy was confirmed.

69. During the 1980s many senior primary care nurses in the CHCs were also known as nurse practitioners because of their education and the extended responsibilities of their practice, even though this was not yet a formal health professional designation in Ontario.

VIII. RE-EMERGENCE OF COMMUNITY MIDWIFERY AND MIDWIVES

1. Ontario's Community Midwives

70. My path to midwifery is set out in Part II above. I was part of a small number of midwives who started to practise in Ontario in the 1970's and 1980's without legal recognition. This was in response to a growing demand from childbearing women for alternative care that recognized pregnancy and birth as normal physiologic processes and respected women's choices. Our practice was precarious as a result of our uncertain legal status and the lack of recognition for our work by the health care system. Midwifery witnesses Vicki Van Wagner, Bobbi Soderstrom, Bridget Lynch, Elana Johnson, Katrina Kilroy and Carol Cameron all practised prior to regulation.

71. Generally, we worked in self-employed arrangements, often working within a group of midwives that provided backup for each other. Vicki Van Wagner's "With Women: Community Midwifery in Ontario" describes the practice and conditions of our community midwifery during this time including the prejudices and stereotypes we faced.[16] Such prejudices and stereotypes were reinforced by a health care system which was functioning to facilitate the medical-led model of maternity care which was being criticized for failing to consider properly the health care needs of women.

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15 Summary Report by Robert Morton for the Midwifery Funding Work Group titled "Compensation for Midwives in Ontario", (July 26, 1993) AOM0001278**.** Job Description Family Physician Position from South East Ottawa Community Services Health Services faxed July 15, 1993 (July 15 1993), AOM0009973.

16 Vicki Van Wagner, With Women: Community Midwifery in Ontario, M.A. Thesis, 1991. AOM0017358

2. Many Pathways to Knowledge - Apprenticeship, Nurse Midwives

72. Pre-regulation Ontario midwives, prior to being admitted to the Michener Institute program, gained their midwifery knowledge and skills through diverse paths, often including extensive apprenticeship to an experienced midwife, extensive reading and auditing medical classes and seminars. Quite a few had qualifications and experience as internationally-educated midwives and a number had nursing qualifications and experience. Most had pre-existing university degrees. [17]

73. As noted above, I came into my apprenticeship with a background in feminist women's health. My apprenticeship learning which took place over two years of training, a year of intensive apprenticeship during 1982 and into 1983, and a year of supervised or mentored practice in 1983 and into early 1984, where I had my own clients and was observed and support in practice by more experienced midwives.

(a) I started my apprenticeship by taking a ten-day intensive with the senior midwife with whom I would apprentice, which included learning both theory and hands–on skills, with a particular focus on evidence-based practice. We were given assignments to research in the medical school library at the University of Toronto, a good way to get us comfortable going back and researching issues that might arise with clients during the clinical side of learning throughout the year. This was before searching med-line or the Cochrane database on the internet was possible. We were given access to learning resources and expected to put together a course of ongoing theoretical study for ourselves that was approved by the midwife with whom we were working.

(b) I worked with senior midwife Theo Dawson during the year, attending and participating in clinic appointments, home visits and clients' labours and births with her, as well as doing some clinical training with the senior midwives at the Midwives Collective in Toronto. In what was an intense period of learning. I kept rough track of my time and spent about 3,000 hours gaining clinical experience under supervision over the course of a year, attending some 45-50 home births and 20-25 hospital births.

74. Clinical learning is central to the education of midwives, nurses and physicians. Apprenticeship is a form of clinical learning which various pre-regulation midwives like myself engaged in. During the Midwifery Pre-Registration Program at the Michener Institute in 1992 the international faculty observed and evaluated each of us attending births and working in our clinical practices.

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17 Profile of the 1996 Cohort of Applicants to the MEP and a Comparison of the 1993, 1994, 1995, and 1996 Cohorts of Applicants -Report by L.G. Houle and R.W. Pong (January 1997) AOM0009023.

3. Unique Model of Care

75. Ontario community midwives prior to regulation followed a model of care which focused on three principles: continuity of care, informed choice and choice of birthplace. At the centre of the model was the empowerment of each woman to make decisions about her pregnancy, labour and birth and how she is going to parent her newborn.

76. In order to support women to make informed decisions, midwives were committed to keeping up to date with evidence-based maternity care knowledge. Each woman in midwifery care had a midwife who she had the opportunity to get to know, to share her preferences and concerns with during her prenatal care, and who would attend her during her labour and birth. This was achieved by working in small teams of between two and four midwives to ensure backup. Midwives valued collaborative relationships with physicians who assisted us by being available to see women who were receiving midwifery care and arranging for lab work or other testing that midwives could not access prior to regulation.

4. Midwifery Work Pre-Regulation

77. The midwifery work I and other community midwives did pre-regulation is reflected to a large extent in the documentation which was prepared by the Interim Regulatory Council of Midwives as discussed below. The entry level competencies which were contained in the report of the Midwifery Implementation Planning Project, (MIPP) to the IRCM reflected the work midwives were already doing to a large extent.[18] It is also reflected in Van Wagner's thesis, "With Women: Community Midwifery in Ontario".[19]

78. Pre-regulation midwives practiced both full time and part time. Part time practice was a matter of managing caseload, working with how many primary courses of care were taken on. A lower caseload meant being called out less often even when the midwife was on-call all of the time. Having a shared care partner who could cover call was especially important if the reason for a part-time clinical load was because of other work commitments like teaching. A part-time midwife is still on call for all the women whose care she has undertaken, except for the times when she is specifically covered by another midwife who also has a relationship with the woman. If you wanted off call time, you needed to be working in a team of midwives.

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18 CMO Guideline on Core Competencies: A Foundation for Midwifery Education -- Recommendations of the MIPP to the IRCM, (January 1, 1994), AOM0016027.

19 Vicki Van Wagner's thesis 'With Women. Community Midwifery in Ontario'.pdf, (April 11, 1991), AOM0017358.

5. Comparison with International Situation

79. The main international model which Ontario midwives looked to at that time was midwifery in the Netherlands, where midwives, not physicians, cared for all women who were low risk, and most births took place at home. If a woman did not have a clinical indication, a risk factor, that required being in hospital, she had to pay additional fees to have her baby in hospital because the public health care system in the Netherlands didn't cover it.

80. Unlike Ontario, where the formal medical system disapproved of home birth, the system expectation in the Netherlands was that the majority of women had normal births at home attended by midwives. The outcomes were very good and the transfer rate to hospital for caesarean section was very low. Most European countries also had midwives in a primary care role for the majority of births. In countries like the United Kingdom, Denmark and Germany, midwives are the primary care providers for women at all levels of risk, consulting with physicians as required.[20]

81. In 1987 I presented two papers at the Congress of the International Confederation of Midwives in the Hague, "Practising Midwifery in a Hostile Environment"[21] and "Home Birth in Ontario, Canada".[22]

IX. STEREOTYPES, PREJUDICES, HOSTILITY AND DISADVANTAGES

1. Work of Midwives Misrepresented and Misunderstood

82. During my pre-regulation time as a community midwife in Ontario, I observed and experienced stereotypes, myths, prejudices and hostility related to my midwifery care and that of other Ontario midwives. The work of midwives like myself was misunderstood and often rendered invisible and devalued. Midwives like myself endured hostility, abuse and lack of recognition and respect for our skills, our effort, our responsibility and our working conditions.

83. This also often resulted in women who wanted midwifery care being denied access to that care as described below.

84. My above-noted paper "Practicing Midwifery in a Hostile Environment", detailed this negative environment for midwives and midwifery in Ontario at this time.[23] In

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20 Task Force on the Implementation of Midwifery, "Report of the Task Force on the Implementation of Midwifery in Ontario 1987 [Task Force Report], (January 1, 1987), pp. 37- 61. AOM0013549.

21 Jane Kilthei,"Practicing Midwifery in a Hostile Environment," presentation to the 1987 International Congress of the International Confederation of Midwives (1987-01-01) AOM0017409.

22 ICM Paper Funding - Funding of Midwifery Services in Ontario prepared by AOM (Draft with comments) (1993-02-14) AOM0002802.

this paper I addressed one of the harshest realities of midwife-attended home birth in the pre-regulation environment, when there was no regulatory college to which to refer practice concerns. If a baby died at home during this time a coroner's inquest almost certainly ensued, even if the management of care at home was identical to that which would have occurred in hospital. In the decade leading up to the decision to regulate midwifery in Ontario there were three such inquests concerning midwifery.

85. In each inquest the biases of the medical profession and others in the health care system against midwives were particularly evident. Yet, all of the inquest juries recommended the legalization of midwifery. The jury in a 1985 inquest, which ran for three and a half weeks and included testimony from international experts addressing parents' right to choose midwifery care, at home or in hospital, and the safety of home birth, urged that midwifery be legally recognized, regulated and integrated into the health care system. They recommended the profession be self-governing, that midwives be educated in a direct-entry program, have hospital privileges and access to appropriate emergency back-up, and that parents have the freedom to choose home birth. They urged that the legislation include the international definition of a midwife and that education standards endorsed by the International Confederation of Midwives be adopted. These recommendations were instrumental in establishing the need for midwifery to be a part of the regulated health care system, and it was truly unfortunate that something as economically and emotionally costly for midwives, parents and the public ended up being such an important part of defining and legitimizing midwifery practice.

86. In January 1986 the Ontario government committed to legally recognizing midwifery. The government's commitment lessened hostility in some quarters, while among some physicians antagonism toward midwives only increased, with the Ontario Medical Association arguing loudly that the role of the obstetrical nurse, still subordinate to the physician, should be enhanced rather than the midwife accepted as the specialist in normal childbirth.

2. Physician Role in Furthering Stereotypes and Prejudices

87. Beginning in the 1850's Canadian physicians spearheaded the "medicalizing" of childbirth and the notion that childbirth was dangerous and required their "superior scientific knowledge" through efforts to discredit midwives as incompetent and unsafe to provide maternity care. Working as a midwife I observed that physicians and their organized professional body, the Ontario Medical Association, were in a very powerful position in the health care system and used this power to dominate "legal" maternity care.

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23 Jane Kilthei,"Practicing Midwifery in a Hostile Environment," presentation to the 1987 International Congress of the International Confederation of Midwives (1987-01-01) AOM0017409.

88. I observed that many general practitioners believed and cultivated the reputation of being superior birth attendants to midwives, despite the fact that, at that time, general practitioners graduated from medical school and began practicing obstetrics with very minimal birth experience, and relied heavily on the nurses working in labour and delivery to teach them what they needed to know. Physicians would often rely on stereotypes and prejudices about midwifery that did not reflect the actual knowledge and skill of midwives in practice.

89. In the period leading up to and after midwifery regulation in 1994, a small, vocal group of doctors continued to speak about the "horrors" of midwife-attended childbirth.

90. Over the years I worked as a midwife prior to regulation I periodically read newspaper articles and letters to the editor which expressed prejudice and disdain for the work of midwives and its alleged dangers. Within the AOM, we would discuss whether a particular article should be responded to and task someone to write a response. Some examples of what appeared in the press at the time:

    (a) "Quebec MDs spurn legalizing midwifery", The Globe and Mail, (11 May 1989) which quotes the President of the Quebec Corporation of Physicians in response to a Government proposal to legalize midwifery "You might as well make prostitution legal. More people are asking for prostitutes than midwives" and the response of the President of the Quebec Federation of General Practitioners "It's like letting an apprentice pilot take charge of a Boeing 747 loaded with passengers."[24]

    (b) Rob McKenzie, “Sarnia Doctor Urges Midwifery Get Test Run Before Being OKed”, London Free Press (17 October 1986) In this Article Dr. Rob Brown, then president of the medical staff at St. Joseph's Hospital in Sarnia stated that home births conducted by midwives show "gross disregard " and "disdain for the baby". He then stated that he has disdain for midwives during a midwifery task force meeting presided over by Chairperson Mary Eberts;[25]

    (c) Lillian Newbery, "Specialists' group opposed to home births, probe told", Toronto Star (9 October 1986) [26]

24 Andre. Picard, "Quebec MDs spurn legalizing midwifery", The Globe and Mail, (May, 11 1989), AOM0000648.

25 Rob McKenzie, “Sarnia Doctor Urges Midwifery Get Test Run Before Being OKed”, London Free Press (October 17 1986), AOM0000647.

26 Lillian Newbery, "Specialists' group opposed to home births, probe told", Toronto Star (October 9, 1986), AOM0000645.

3. Opposition by Nurses

91. In addition to hostility from physicians, we also experienced hostility from some nurses. As noted above, the nursing profession initially favoured physician-managed childbirth and later supported the physicians' regulatory position favoring nurse-midwives working under physician supervision. The medical profession's desire to have childbirth only take place in hospital, where nursing support was required, guaranteed nurses a familiar role as well as the possibility of increased autonomy and recognition if that role was expanded. At the same time, there were nurses who were very supportive of our practice and quite a few registered nurses came to us for home births.

4. Managing the Hostile Environment

92. It was difficult for midwives including myself to practice in such a negative and prejudicial environment.

93. In light of the difficulties we faced as midwives, we needed to speak two languages: one - to de-medicalize obstetrical language and provide clear information to pregnant women, involving them as equal partners in decisions about their care, and; two - to speak the same medical and technical language as the medical profession in order to gain their respect and to communicate with them about a client's care.

94. At the same time it was necessary to be respectful and not to show off in any way. This meant that the midwives who were most successful in establishing collaborative relationships with doctors functioned like "high-level diplomats". Nurses often exercised similar diplomatic skills when working under physicians. Experienced obstetrical nurses are frequently a key source of knowledge and hands-on skill for medical students and new physicians and are strategically deferential in passing on their knowledge and skills.

5. Disadvantages Experienced

95. In contrast to the position of physicians,

(a) Midwives were excluded from the government's health care system and its funding for maternity care services until 1994. Until this was changed effective January 1, 1994, midwives were limited in their ability to provide the option of hospital birth to their clients, functioning as primary care providers outside the hospital and in an unrecognized support role within the hospital, and received no government funding for their services.

(b) Midwives were required to rely on private fee for service payments for their midwifery services, often on a sliding scale and sometimes they provided care at no cost for those unable to pay for their services, particularly immigrants, refugees, single mothers and uninsured women.

(c) While physicians were earning more than $100,000 annual incomes in the early 1990's, receiving public funds for their insured services, midwives were not publicly funded. The average earnings of a midwife in a very busy practice in the Toronto area were approximately $20,000 prior to regulation, while many other practices fared much worse.

(d) Lack of hospital privileges restricted our scope and ability to practice and to provide the best care for women. When coming into hospital with a woman who had been labouring at home under our care we would bring the records we kept of her care throughout pregnancy and early labour, prepared to provide that information to hospital staff. Because we had no formal role in hospital, we never knew whether the information we had would be heard and taken seriously or ignored or discounted. This was particularly troubling when we had specific clinical concerns needing timely medical attention and when a midwife's persistent diplomacy in communication was critical.

(e) Midwives also had no funding for their education, unlike the public funding provided for medical education.

(f) With no state sanctioned regulatory system, our state oversight was by prosecution, which was always a possibility but did not happen to midwives in Ontario, or by coroners' inquests as described above. Hostile physicians could deny midwives the ability to accompany women into hospital even as labour support. This led us to develop our own voluntary standards of practice and other self-governance measures through the Association of Ontario Midwives as reflected below in this affidavit.

(g) It was my experience that the exclusion of midwives from the regulated health care system and the often authoritarian nature of the physician-led model served to perpetuate stereotypes and prejudices about midwives, including myself. I believe that members of the medical profession often promoted the view that women were not competent to act as autonomous health-care providers outside of medicine, and that our clinical skills and knowledge as midwives were not as valuable, if valued at all, in comparison to those of physicians.

(h) I also believe that midwives' exclusion reinforced the often low value accorded to the wishes of women with respect to their maternity health-care needs. This was reflected in my own pregnancy experience set out above and in the experiences of women I supported and whose care I witnessed in hospital – experiences like:

    (i) a physician coming into a labour room, putting on a glove and doing a vaginal exam without explanation, without seeking the woman's consent, sometimes not even introducing himself or making eye contact with her.

(ii) I witnessed a forceps delivery carried out in the same manner without explanation.

(iii) Women would sometimes write birth plans, often at the invitation of the hospital, about care that really mattered to them - things like holding their newborn immediately after birth, delaying newborn antibiotic eye treatment and vitamin K injections so as not to disrupt that first hour of contact and the initiation of breastfeeding, only to have these things ignored for no good clinical reason, with their plan probably not even read by the attending staff.

(i) In my pre-regulation supportive role in hospital I could advocate for the woman, but I could only really be effective if I had or could build a relationship with the doctor and/or the nurse in attendance. Women generally had no control over who would attend then in hospital, as most physicians worked in call groups of six, eight or more, and the nurses all worked shifts, so a woman might get to know a nurse during her labour who would go off shift just before she gave birth. The lack of relationship and the almost assembly-line nature of hospital-based care meant that women's choices not only didn't matter, they were inconvenient to the functioning of the hospital system, and this furthered the stereotype that women were not competent to make many of their own decisions regarding their maternity care.

(j) As midwives were practising in an area of primary health care which had been exclusively reserved for physicians, and in a system that had largely been set up for physician's convenience, this caused a great deal of tension and competition, with physicians holding the most power.

6. Further Examples of Stereotypes, Prejudices and Hostility

96. Examples of the stereotypes, prejudices and hostility I observed or experienced included the following:

(a) I worked hard to develop relationships with physicians who respected both childbearing women and midwives, but we could never guarantee that one of those physicians would be taking call when the woman went into labour. Sometimes I would just be ignored by certain doctors in the hospital when I brought in a client in labour. These doctors were so opposed to midwives that they wouldn't acknowledge me even introducing myself. In those situations I would focus on quietly supporting my client, directly any questions or suggestions I might have through the nursing staff or the client herself.

(b) I frequently heard or overheard midwives referred to as:

(i) under-educated, out-dated and lacking in modern medical knowledge;

(ii) quacks or charlatans; and

(iii) dangerous to the health of women and their babies.

(c) The worst experience I had as a midwife was in 1987:

(i) I transported a client to hospital by ambulance after her home birth because she had a retained placenta and was bleeding. We did not delay transport, knowing that the procedure she needed to deliver the placenta was best carried out in a hospital operating room by an obstetrician with an anesthetist present. My client was stable when we left home and when we arrived in hospital, at most 10 minutes later. In calling the hospital I had clearly described the specifics of the retained placenta and blood loss, and the urgency of the situation.

(ii) When we arrived I asked the emergency room physician if the obstetrician was coming down to the ER or if my client would go straight up to the OR. I was stunned when he told me that the OB was refusing to see her because she had had a home birth. My client was left waiting in the emergency room with two IVs, one with oxytocin, in place. With a partially separated placenta, even with oxytocin her uterus could not clamp down adequately to stop her bleeding. I alternated between checking on my client and pleading with the emergency room staff to get the obstetrician to come and attend her.

(iii) After about half an hour, perhaps after speaking to the OB and reporting her continued blood loss, the ER physician had my client moved into an ER procedure room and attempted a manual removal of the placenta without anaesthetic. It was extremely painful for my client. I imagine the ER physician was acting on the obstetrician's instructions, but he was very rough with her during the procedure and it seemed he may have also disapproved of her choice of a home birth, or perhaps he was just unhappy to be put in the position of managing care when he knew as well as I did that she should be up in the OR. He would not say much to me.

(iv) The placenta came out in pieces with significantly more blood loss and her blood pressure dropped during the procedure. She was put on a blood pressure monitor and continued on IV oxytocin. It was impossible to tell if the doctor had gotten all of the placenta out. It seemed unlikely to me. I asked the ER physician again when my client would be seen by the obstetrician. He said he was in phone contact with him and was unsure if he would come down.

(v) An hour later the ER physician took my client back into the procedure room and attempted to remove the rest of the placenta with ring

forceps, getting out more pieces with more gushes of blood. By my estimate she had lost at least 2 litres of blood since we had arrived at the hospital. A little more than half an hour after that, more than two hours after we had arrived at the hospital, they finally took her up to the OR, telling her the obstetrician was going to do a D&C.

(vi) I found out afterwards from the client that her blood pressure dropped again during the procedure and that she was resuscitated by the anesthetist. She was given six units of blood in the OR and in recovery. Then they told her she couldn't have her baby with her in the hospital because the baby was born outside the hospital and was "contaminated".

(vii) My client stayed in hospital for about 36 hours postpartum and continued to recover well, and I kept thinking about how much the obstetrician had put her life in danger to punish her for choosing a home birth. If she had been taken to the OR with an anesthetist and team and treated by the obstetrician as soon as we arrived, the placental removal and D & C would have been done at about the same time as if she had given birth in hospital and she almost certainly wouldn't have lost those extra two litres of blood, gone into shock, or needed that large blood transfusion. As I had no position or authority in the hospital, I was helpless to assist her in the face of the obstetrician's intransigence.

(viii) This occurred at a community hospital outside of Toronto and when the women from the local chapter of the Midwifery Task Force of Ontario heard about the incident they initiated a letter writing campaign to the hospital emphasizing that women in Canada were entitled to full and timely public health services from their local hospital regardless of their choice of birthplace and they expected better care in future.

(d) I also learned, after this experience, to be even clearer and more directive in emergency transport situations. Maybe a year or so later I had to manage a cord prolapse in early labour in the same community. My client, who was having her 6th baby, had the cord wash down in front of her baby's head when her water broke. This is a situation where you need to manually hold the baby's head up in the pelvis to keep it from putting pressure on the cord while moving directly to caesarian section. In this case when I called the hospital I again clearly described the situation, including the need for them to prep for an urgent caesarian while we were on our way in the ambulance, telling them how I was managing the emergency right up to her going through the doors of the OR where I would hand over care, and in this instance everyone from the ambulance team, through every doorway at the hospital was totally cooperative. It was a completely different experience from my earlier one, and the challenge working outside of the regulated

system is that you don't ever know how it will go. You have to be your best and clearest and you still don't know whether those working in the system will be your allies in an emergency or not.

7. Efforts to Build Collaborative Working Relationships

97. We continuously worked hard to build collaborative working relationships with family physicians in our communities, with obstetricians and pediatricians in our local hospitals, and with nursing staff on the labour floor. As a result, we developed some very rewarding collaborative relationships. There were doctors who recognized and acknowledged our assessment and diagnostic skills.

98. For example I worked, along with many of the other midwives, with a couple of obstetricians in the greater Toronto area who took most of their own call and were reliably available for us to call when we needed to transfer a client into hospital. I can remember calling to report a non-progressive second stage of labour with good fetal heart tones, a non-urgent transfer situation, and the obstetrician asking me whether, based on my assessment, I thought a vacuum or forceps would likely work or whether they should start prepping for a caesarean. It was so variable. Sometimes I was treated as a knowledgeable professional and sometimes I was persona non grata.

8. Female Midwives were Challenging the Medical System Designed for Physicians

99. In lobbying for the recognition of midwifery as set out below in this affidavit, the AOM challenged the male-dominated highly medicalized approach to women's health and childbirth, which did not appropriately take into account the cultural, social or emotional lives of women. We also put forward the growing body of evidence that supported midwifery approaches to care and the safety of low intervention practices used by midwives, including home birth.

100. The above noted the College of Physicians and Surgeons of Ontario and hospital rules which ended physicians attending home births served to reinforce the stereotype that home births were dangerous and that midwives were irresponsible for providing such care, and when midwives continued to provide care for women at home in a safe and responsible way, without a physician present, these rules also served to demonstrate that Ontario midwives were professionals capable of practicing in our own right.

101. In my experience, the marginalization and exclusion of midwifery from the health care system was also reinforced by the government's historical and ongoing decision to give the profession of physicians exclusive control over admitting

privileges to hospitals as provided by the *Public Hospitals Act* until the regulations to the Act were amended in 1993.[27]

102. Until the change in the regulations to the Act, effective January 1, 1994, midwives were unable to provide their clients with the choice of a hospital delivery in which they could receive primary care from a midwife. If a midwifery client wanted a hospital birth, the woman could have a midwife who attended her and monitored her early labour at home, but once in hospital the midwife could only continue in a supportive role, alongside the nurses monitoring the labour and a physician who would attend in the last hour in the role of primary caregiver to deliver the baby. The family would often request early discharge home three or four hours after the birth and the midwife would then be able to resume monitoring and support in a primary care role.

103. The history above led to 99% of Ontario births prior to 1994 being performed in hospitals under the control of a physician-dominated medical system.[28] While physicians gradually came to include substantially more women into their profession in the years since 1994, I observed that these female physicians were enculturated, worked within and benefited from the established attitudes and place of power and privilege of male physicians in the health care hierarchy.

104. As was detailed in the 1987 Task Force Report on the Implementation of Midwifery and particularly in its Appendix which detailed the history of midwifery in Canada, this hierarchy was developed and controlled by the male-dominated profession of physicians and in their interests for over a hundred years.[29]

X. THE ONTARIO ASSOCIATION OF MIDWIVES – COLLECTIVE REPRESENTATION OF MIDWIVES AND PRE- REGULATION REGULATOR

1. The AOM as Midwives' Collective Representative

105. The Association of Ontario Midwives (AOM) as the recognized representative of Ontario's registered midwives was established in 1984. It formed as a result of a merger of the Ontario Association of Midwives (established in 1979) and the Nurse Midwives Association (established in in 1982) to create the Association of Ontario Midwives.

106. The AOM represents the interests of midwives and the profession of midwifery regarding funding for midwifery services. During my period of involvement, it did that by negotiating with the MOHLTC concerning, amongst other matters, the

27 R.R.O.1990, Reg 965, s. 11(1)(c)

28 Task Force on the Implementation of Midwifery, "Report of the Task Force on the Implementation of Midwifery in Ontario 1987 [Task Force Report], (January 1, 1987), p. 10, AOM0013549.

29 Task Force on the Implementation of Midwifery, "Report of the Task Force on the Implementation of Midwifery in Ontario 1987 [Task Force Report], (January 1, 1987), AOM0013549.

funding the Ministry pays to midwives for their compensation and the provision of midwifery services.

2. Reliance of the Government on the AOM to Create Ontario Midwifery Program and System

107. As experienced practising midwives with extensive knowledge, AOM representatives brought to the system discussions about how to implement midwifery services within the Ontario health care system their in-depth understanding of midwifery and the commitment to adopting a best practices approach.

108. During the process leading up to regulation, the AOM was committed to the importance of evidence-based practice and this informed the development of both pre and post-regulation standards of practice, the MEP curriculum (and the one-time Pre-Registration Michener Program curriculum) and ultimately informed the process of setting the compensation and funding for the system.

109. The Ontario government relied extensively on the expertise and experience of existing midwives to assist in the creation of its Ontario Midwifery Program. In particular, such midwives and our organization, the AOM, and those working with it:

(a) worked with and made submissions to the Task Force on the Implementation of Midwifery in Ontario (TFIMO) chaired by Mary Eberts;

(b) were involved in the creation of the curriculum for the Midwifery Education Program and the one-time Michener Institute of Applied Health Sciences Pre-Registration Programme for ensuring the required knowledge and competence of pre-regulation midwives and their eligibility for registration;

(c) served as liaison members of Committees of the Interim Regulatory Council on Midwifery (IRCM) and Council and committee members of the subsequent College of Midwives of Ontario;

(d) helped to move the existing model of practice, practice standards and guidelines and entry-level competencies into the now legislated regulatory framework;

(e) acted as faculty at the three University sites (faculty had to be practising midwives as well as have appropriate Masters level or higher academic qualifications);

(f) assisted members to set up practice groups across the province which would deliver accessible midwifery services to Ontario; and

(g) worked with the Lebel Midwifery Care Organization (LMCO) and later the subsequent trustee, the Lawrence Heights Community Health Centre, to devolve the program to local Transfer Payment Agencies.

3. AOM is Not Certified as Bargaining Agent under Labour Relations Act

110. The AOM is not a certified bargaining agent under the Labour Relations Act as midwives have been designated as "independent contractors". As birth cannot be scheduled, and the Ontario midwifery model of care standard provides for continuity of care, informed choice and choice of birth place, midwives are on-call 24/7. The needs of women in midwifery care and the standards upheld by midwifery to respond to those needs did not permit midwives to be governed by Ontario's *Employment Standards Act.* As discussed further in Part ** below, we met with representatives of the Employment Standards Branch to see whether amendments to the Act or its regulations could be made to exempt midwives from certain provisions in order for them to fulfill the requirements of the midwifery model of practice, but there was no appetite on the part of the Ministry to consider such amendments. Ontario's *ESA* was not amended to provide an exemption for midwives' unique work profile.

XI. THE CAMPAIGN FOR INTEGRATION OF MIDWIFERY IN ONTARIO'S HEALTH CARE SYSTEM

1. Midwives Joined with Consumers of Midwifery Care

111. Both midwives and child bearing age women campaigned to integrate midwifery into Ontario's health-care system. Midwifery consumers formed their own organization, the Midwifery Task Force of Ontario (MTFO). After midwifery regulation this later became known as the Midwifery Consumer Network of Ontario. The MTFO was a major force during the TFIMO proceedings and also issued a1991 publication providing extensive information on the community midwifery profession in Ontario and its self-regulation. [30]

2. The Impact of Coroner's Inquests and Women's Activism

112. As previously noted, pre-regulation, the Ontario government exercised control over midwifery primarily through coroner's inquests and the potential of prosecutions. A high-profile inquest in 1985 involving Vicki Van Wagner as an attending midwife provided an opportunity for the AOM and the midwifery community to show the dangers of excluding midwives from the health-care

30 Midwifery Task Force of Ontario (MTFO) Issue: Information for New Members, (January 5, 1991), AOM0003237.

system and the need to address the medical profession's dominant control over maternity care.[31]

113. This 1985 inquest jury recommended that midwifery be legalized in Ontario and integrated as a funded and integral part of Ontario's health-care system. They recommended midwives having hospital admitting privileges, compulsory malpractice insurance and provide women with a choice of home or hospital births.

114. Following this inquest and women's community activism in support of midwifery and women-centred health care, the Ontario government started the process of recognizing midwifery.

XII. GOVERNMENT DECISION TO REGULATE MIDWIFERY

1. 1986 Government Decision to Regulate Midwifery

115. On January 23, 1986, the Minister of Health Murray J. Elston announced in the legislature the following:

(a) The government intended "to establish midwifery as a recognized part of Ontario's health care system" as a regulated health profession. The government was then engaged in a review of the health professions.

(b) While the development of midwifery had been hampered by its "uncertain legal status" in Ontario, midwifery is "viewed as a safe and integral element of health care" in many other jurisdictions, and demand was increasing in Ontario.

(c) A midwifery task force chaired by Mary Eberts would be established to recommend and report within one year on how midwifery should be integrated into the health-care system.[32]

116. At this time, Canada was the last Western industrialized country in the world which had no provision in law for midwifery.[33]

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31 Task Force on the Implementation of Midwifery, "Report of the Task Force on the Implementation of Midwifery in Ontario 1987 [Task Force Report], (January 1, 1987), AOM0013549.

32 Official Records of the Legislative Assembly of Ontario for 23 January 1986 re: Midwifery Regulation, 31st Parl, 1st Sess, (Hon. Murray Elston), AOM0002717.

33 Task Force on the Implementation of Midwifery, "Report of the Task Force on the Implementation of Midwifery in Ontario 1987 [Task Force Report], (January 1, 1987), p. 62, AOM0013549.

XIII. THE RELATIONSHIP BETWEEN CAMPAIGN FOR GENDER EQUALITY AND FUNDED AND REGULATED MIDWIFERY SERVICES

117. Advocates for respect for and integration of midwifery as a female dominated profession were also rooted in the women's movement in Ontario in the 1970's and 1980's. They were also influenced by the movement in Ontario to gain pay equity for women.

118. When the *Pay Equity Act* was being discussed in 1986, passed in 1987 and then the first cases started to be publicized, I, along with midwifery colleagues developed an even greater awareness of how important it would be for midwifery work to be appropriately analyzed and compared, particularly with the work of physicians, to ensure compensation was equitable and that the process for determining compensation recognized the value of midwives' work, especially in light of it having been subject to so many prejudices and stereotypes over the previous 140 years and into the present.

XIV. 1987 TASK FORCE ON IMPLEMENTATION OF MIDWIFERY IN ONTARIO (TFIMO)

119. Following on the Government's 1986 decision to regulate midwifery, the MOHLTC appointed the Task Force on Implementation of Midwifery in Ontario (TFIMO) chaired by Mary Eberts. Ms. Eberts later was appointed by the MOH to be the Chair of the Interim Regulatory Council of Midwives referred to below.

120. In my AOM capacity, I participated actively in the Task Force proceedings, attending hearings and presenting an oral submission in Kingston, Ontario.

121. In 1987, the Task Force issued its Report which recommended that Ontario enact a Midwives Act in which the midwife's scope of practice, whether in hospitals, clinics or homes, be defined consistently with the following International Definition of the Midwife:

> *[The midwife] must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the mother. This care includes preventive measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task in health counselling and education, not only for the patients but also within the family and community. The work should involve antenatal education and preparation*

for parenthood, and extends to certain areas of gynaecology, family planning and child care. [34]

122. The findings of the Task Force formed the foundation for the government's Ontario Midwifery Program and the discussions the AOM had with the MOHLTC. The Report's Chapters:

(a) Chapter 1 – Introduction

(b) Chapter 2 - Observations of Midwifery in Other Countries

(c) Chapter 3 – The Current System of Reproductive Care

(d) Chapter 4 – The Midwife's Scope of Practice

(e) Chapter 5- The Framework of Practice

(f) Chapter 6 – Qualifications for Practice

(g) Chapter 7 Regulation of the Midwifery Profession

(h) Chapter 8 – Integration of the Current Practitioners

(i) Chapter 9 – The Potential Requirements for Midwives

123. The Report reviewed the work and practice of midwives then practising in Ontario who worked in practice groups and relied on peer review and a collaborative team structure. Appendix 7 attached the existing Association of Ontario Midwives – Standards of Practice.

124. In reaching its conclusions, the Task Force relied on extensive research and consultation, including with many of the AOM witnesses who attended hearings and made submissions. The Task Force set out in its report findings the disadvantages and prejudices which midwifery had been subjected to in Ontario. These were also detailed extensively in Appendix 1 to the Report **–** "A History of Midwifery in Canada". [35]

125. The Task Force also recognized the male-dominated physician-led structure of maternity care in Ontario. The Task Force found that some women had "come to believe that maternity care was overly controlled by the predominantly male medical profession – obstetricians who regard every pregnancy and birth as a

34 Task Force on the Implementation of Midwifery, "Report of the Task Force on the Implementation of Midwifery in Ontario 1987 [Task Force Report], (January 1, 1987), p. 8, AOM0013549. Also aadopted by the International Confederation of Midwives, the International Federation of Gynaecologists and Obstetricians as well as the World Health Organization.

35 Vicki Van Wagner also made submissions for the Association of Midwives and was present at the Task Force Hearings in Toronto in October and November, 1987.

potentially pathological event".[36] Women "believed that midwives would provide more holistic care, in which pregnancy and birth would be regarded as healthy events, greater attention would be paid to their psychosocial and social needs, and resorting to such medical interventions as caesarean sections would be less frequent."[37]

126. The Task Force recognized that steps needed to be taken to overcome the "many years of isolation from the official health care system" midwives experienced and that the integration of midwifery required "government support."[38] It noted such support should include the following:

(a) "In order to obtain Ministry approval, proposed practices should be required to demonstrate that the midwives will be paid at a fair and reasonable level."[39]

(b) The "level of remuneration (for midwives) should take into account the level of midwives' responsibility, the demands on their time, and the difficulty of their work."[40]

(c) "The level of remuneration, which will constitute a significant component of the global operating budgets provided by the Ministry of Health, is likely to be established partly by comparing midwives with other health professionals".[41]

"Nursing salaries would be inappropriate for midwives because of the nature of the midwives' level of responsibility, the difficulty of their work and the greater (and less predictable) demands of her time."[42]

(d) That midwives carry professional liability insurance, "otherwise midwives cannot be fully responsible for their actions, physicians will be reluctant to cooperate with them, and hospitals will not grant them staff privileges."[43]

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36 Task Force on the Implementation of Midwifery, "Report of the Task Force on the Implementation of Midwifery in Ontario 1987 [Task Force Report], (January 1, 1987), p. 7, AOM0013549.

37 Task Force on the Implementation of Midwifery, "Report of the Task Force on the Implementation of Midwifery in Ontario 1987 [Task Force Report], (January 1, 1987), p. 11, AOM0013549.

38 Task Force on the Implementation of Midwifery, "Report of the Task Force on the Implementation of Midwifery in Ontario 1987 [Task Force Report], (January 1, 1987), p. 8, AOM0013549.

39 Task Force on the Implementation of Midwifery, "Report of the Task Force on the Implementation of Midwifery in Ontario 1987 [Task Force Report], (January 1, 1987), p. 166-167, AOM0013549.

40 Task Force on the Implementation of Midwifery, "Report of the Task Force on the Implementation of Midwifery in Ontario 1987 [Task Force Report], (January 1, 1987), p. 166-167, AOM0013549.

41 Task Force on the Implementation of Midwifery, "Report of the Task Force on the Implementation of Midwifery in Ontario 1987 [Task Force Report], (January 1, 1987), p. 166-167, AOM0013549.

42 Task Force on the Implementation of Midwifery, "Report of the Task Force on the Implementation of Midwifery in Ontario 1987 [Task Force Report], (January 1, 1987), p. 166-167, AOM0013549.

127. The Task Force report considered the issue of the appropriate employment model for midwives but did not recommend a particular model. [44]

128. The Task Force also referred to the OMA's submission which opposed the introduction of midwifery as a funded and autonomous profession as it felt that "the medical profession can meet the evolving needs in maternity care and that a more active role for nurses will solve any present problems by the extended role nurse performing the functions of the midwife."[45] The nursing organization opposed an autonomous midwifery profession and sought a hospital-based nurse-midwife model. The OMA lobbied to continue with a medical-led model with nurses supporting doctors in providing maternity care. Midwifery advocates observed this physician opposition to their autonomy.

XV. THE PASSAGE OF THE *MIDWIFERY ACT, 1991* AND *REGULATED HEALTH PROFESSIONS ACT, 1991*

129. The initial definition of the work of midwifery for the purpose of regulation started with the passage of the *Midwifery Act, 1991* in April, 1991 which came into force on January 1, 1994. That Act set out the following definition:

> *The assessment and monitoring of women during pregnancy, labour, and the post-partum period and of their newborn babies, the provisions of care during normal pregnancy, labour and post-partum period and the conducting of spontaneous normal vaginal deliveries.*

130. This definition was consistent with the International Definition of a Midwife with which the AOM and I were familiar from our work with the International Confederation of Midwives.

131. The *Regulated Health Professions Act, 1991* was also passed in April, 1991 and proclaimed January 1, 1994 and included midwifery as a regulated profession.

132. On May 29, 1991, Minister of Health Frances Lankin stated in the legislature that the *Midwifery Act:*

> *…gives legal recognition to midwives. This reversal in policy is largely due to the efforts of hundreds of individual women and a smaller number of practising midwives who through public education, lobbying and education of other health professionals demonstrated the need and the consumer demand for midwives.*

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43 Task Force on the Implementation of Midwifery, "Report of the Task Force on the Implementation of Midwifery in Ontario 1987 [Task Force Report], (January 1, 1987), p. 10, AOM0013549.

44 Task Force on the Implementation of Midwifery, "Report of the Task Force on the Implementation of Midwifery in Ontario 1987 [Task Force Report], (January 1, 1987), p. 30, AOM0013549.

45 Task Force on the Implementation of Midwifery, "Report of the Task Force on the Implementation of Midwifery in Ontario 1987 [Task Force Report], (January 1, 1987), p. 224, AOM0013549.

Thanks to them, women will soon have the choice of obtaining care from a midwife, a choice available to women virtually everywhere except Canada.[46]

133. I remember this as a critical victory for midwives as we were now assured that Ontario women would have access to funded midwifery services along with funded physician-led maternity care services.

XVI. DEVELOPMENT OF EDUCATION AND CREDENTIALING SYSTEM

1. 1987 Government Decision and Curriculum Design Committee

134. Following the Government's decision in 1986 to regulate midwifery and the Task Force Report's recommendations in 1987, it was decided by the Government to establish a midwifery education program and a system for credentialing the existing Ontario midwives. This led to the Government's announcement on June 30, 1989, of a Curriculum and Standards Development process, namely the Interim Regulatory Council on Midwifery and the Curriculum Development Committee. I participated as a member of the AOM's midwifery liaison committee to the IRCM.[47]

135. The Curriculum Design Committee was appointed by the MOH in 1989. This Committee issued its report in July, 1990.[48] The report recommended the development of a baccalaureate program and a system to qualify the existing midwives and internationally-trained midwives.[49] The Curriculum Development Report concurred with the TFIMO that a direct-entry midwifery education system was appropriate. The Report concluded that a nursing education was not the appropriate foundation for midwifery education.

2. October 15, 1991 Announcement of Education System and Baccalaureate Degree

136. The Ministers of Health and Colleges and University announced on October 15, 1991 the government's decision to move forward with a baccalaureate midwifery

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46 Reading of Bill 43 of the Ontario Legislative Assembly, An Act respecting the regulation of Health Professions and other matters concerning Health Professions, Ontario, Legislative Assembly, Official Report of the Debates (Hansard), 35th Parl, 1st Sess (May 29 1991) (Hon. Frances Lankin), AOM0000578.

47 MOHLTC News Release Minister Announces the Appointment of an Interim Regulatory Council on Midwifery Appointment of Interim Regulatory Council on Midwifery, (June 30, 1989), AOM0002333.

48 The Report of the Curriculum Design Committee on the Development of Midwifery Education in Ontario prepared for the MOH Minister Elinor Caplan, (May 30, 1990), AOM0014341.

49 The Report of the Curriculum Design Committee on the Development of Midwifery Education in Ontario (May 30, 1990) AOM0014341.

education.[50] Calls for proposals were made to Ontario educational institutions. The Joint Proposal from the McMaster University, Ryerson University and Laurentian University Consortium was accepted by the Government. [51]

3. Development of Education Program for Existing Midwives –The Michener Program

137. The Michener Institute of Applied Health Sciences' Pre-Registration Program Curriculum was developed in 1990 and 1991 to provide a program with extensive requirements to ensure pre-registration midwives were sufficiently educated and clinically competent to work safely as registered midwives. The Program aimed to ensure that the pre-registration midwife had the knowledge necessary to participate in the integration of the midwifery profession into the health care system, to meet both the ongoing needs of the community and the same standards as those who would complete the direct entry MEP. [52]

138. I was part of the advisory group which helped to develop this Curriculum, along with midwife Vicki Van Wagner, register nurse and IRCM member Ina Caissey, obstetrician Dr. Murray Enkin and family physician Dr. Anthony Reid. As such, we made sure that our work and recommendations were consistent with the recommendations of the Curriculum Design Committee's 1990 report.

139. As pre-registration midwives had a diversity of backgrounds and a range of international and apprenticeship education and training, it was necessary to examine and identify any gaps which might exist between the required competencies for Ontario practice, based on these diverse backgrounds, and ensure they were addressed and included in the curriculum. Among other things, upon completion of the program the midwife had to have the necessary professional competencies to be:

(a) knowledgeable, skilled and competent to carry out midwifery care during normal pregnancy, birth, and the postpartum period, and to provide care to the normal newborn child;

(b) able to recognize when a pregnancy, birth, postpartum period or a newborn child is no longer within the midwife's scope of practice, and

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50 Joint News Release from Ministry of Colleges and Universities and Ministry of Health re: Establishment of MEP, (October 15, 1991), AOM0001140.

51 Joint Proposal from McMaster University, Laurentian University and Ryerson University re: Baccalaureate Program in Midwifery, (September 9, 1992), AOM0001128.

52 The Michener Institute Pre-Registration Program for Midwifery - Course Outline (January 1, 1992), p. 2, AOM0014314.

(c) to consult and transfer according to the standards set out by the IRCM/College of Midwives.[53]

140. The Program began in the fall of 1992 with an extensive assessment done of applicants and an intense academic and clinical focus during the program which lasted over a year. Experienced midwifery faculty were recruited from Denmark, New Zealand, the United Kingdom and the Netherlands to teach the Michener program, along with guest lecturers in pharmacology, hematology, etc. I graduated from the Program along with AOM Witnesses Van Wagner, Lynch, Soderstrom, Johnson, and Kilroy.

141. The course consisted of three components:

(a) a didactic component consisting of a four-week intense theoretical review and a series of written and oral examinations, as well as regional seminars and individualized study according to needs as assessed; topics covered include history taking and physical assessment, embryology and fetal development, midwifery and obstetrics skills and knowledge, critical appraisal of research, women's health, pain management, pharmacology, transfusion and haematology, and history of midwifery in Ontario;

(b) a clinical assessment period, consisting of direct observation of the midwife's full range of practice by faculty including observing midwifery care provided during labour and birth, complemented by an extensive chart review and oral examination of case management; and

(c) upon passing the first two components with a grade of at least 80%, the midwife proceeded to the health care system period, a four- to five-week period during which the midwife will observe the work of different health care providers in hospital and community settings. [54]

XVII. DEVELOPMENT OF REGULATORY SYSTEM AND MODEL OF PRACTICE

1. The Interim Regulatory Council of Midwives (IRCM)

142. The Interim Regulatory Council of Midwives (IRCM) was appointed by the MOH in June, 1989 to prepare for the future statutory College of Midwives.[55] The IRCM was a 13 member arms-length multi-disciplinary body. It also included a member chosen from the The Midwifery Task Force of Ontario (the consumer

53 The Michener Institute Pre-Registration Program for Midwifery - Course Outline (January 1, 1992), p. 2, AOM0014314.

54 The Michener Institute Pre-Registration Program for Midwifery - Course Outline (January 1, 1992), p. 3, AOM0014314.

55 Cite to June 1989 Announcement of Interim Regulatory Council IRCM Committee Membership, (January 1, 1989 est), AOM0002335.

organization) as well as an obstetrician, a family physician who provided maternity care and a nurse with experience in maternity care.

143. Along with myself, AOM witnesses Vicki Van Wagner, Bobbi Soderstrom, and Elana Johnson and five other practicing midwives were on the Association's Midwifery Liaison Committee to the Interim Regulatory Council on Midwifery and served on the Council's committees.

144. Reporting to the Women's Health Branch, the IRCM developed the Model of Practice, basing it substantially on the pre-regulation Model of Midwifery developed by the AOM. That model drew heavily from both the Model of Midwifery in the Netherlands (which had some of the best outcomes and lowest intervention rates globally) and extensive input from Ontario childbearing women.

2. Development of Model of Care - Standards and Qualifications

145. The IRCM developed the Midwives' Code of Ethics, the Standards of Practice, including the indications for consultation and transfer of care and schedules for prescribing, ordering and administering drugs and for ordering and interpreting screening and diagnostic tests. Based on this work, the IRCM further developed the model of practice, including the Philosophy of Midwifery Care in Ontario, specific standards for home birth practice such as the essential equipment midwives must carry, and the standard for two midwives at all births, all working with the AOM Liaison Committee. These IRCM standards and policies were subsequently adopted by the Transitional Council of the College of Midwives and then the College of Midwives of Ontario in 1994 at the start of regulation.[56] This model guided the integration of midwifery into Ontario's health-care system and the compensation for such work.

146. The scope of midwifery practice was defined within both the legislation and the IRCM's Standards of Practice, with the boundaries of the midwife's scope most clearly described in the IRCM's Mandatory Indications for Discussion, Consultation and Transfer of Care.[57] The work of the IRCM's Standards and Qualifications Committee and the Midwifery Implementation Planning Project at the Michener Institute defining the entry-level competences for registered midwives was adopted by the Transitional Council of the College of Midwives in March of 1993 and was also relied on by the Joint Funding Working Group during its 1993 discussions as detailed below.[58]

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56 The original Standards and Guidelines are included in an appendix to Vicki Van Wagner, With Women: Community Midwifery in Ontario, M.A. Thesis (1991) AOM0017358.

57 CMO - Indications for Mandatory Discussion, Consultation and Transfer of Care, approved December 18, 1995 - effective February 28, 1997 (February 28, 1997), AOM0001162.

58 Summary Report by Robert Morton for the Midwifery Funding Work Group titled "Compensation for Midwives in Ontario", (July 26, 1993) AOM0001278.

147. The Transitional Council of the CMO's Core Competencies: A Foundation for Midwifery Education, along with its numerous standards, guidelines and policies to regulate the work of midwives, set out the skill, responsibility, effort and working conditions (SERW) required for Ontario midwives effective in 1994.

148. The IRCM commissioned the preparation of a report by Doris Floding dated April 23, 1990, "Midwifery Cost Effectiveness and Safety", which detailed many different ways that the midwifery model of practice was cost effective and safe.[59] This report was relied upon by the MOH and the IRCM. In 1993, during the funding negotiations. I did an updated literature review on the Cost Effectiveness of Midwifery Care which I provided to the Joint Funding Work Group as noted below. I updated this literature review again in May 1994.

149. The IRCM issued on June 21, 1990, the Philosophy of Midwifery Care in Ontario. The CMO Philosophy of Midwifery Care in Ontario states that midwifery health care "is continuous, personalized and non-authoritarian. It responds to a woman's social, emotional and cultural, as well as physical needs".[60]

…Midwives respect the woman's right to choice of caregiver and place of birth in accordance with the Standards of Practice of the College of Midwives…The mother is recognized as the primary decision maker. Fundamental to midwifery care is the understanding that a woman's caregivers respect and support her so that she may give birth safely, with power and dignity.

150. The three principles of midwifery – continuity of care, informed choice and choice of birthplace were essential for facilitating the most effective health care for women and their babies and also served to substantially lower health-care costs from the physician-led model. As stated by the IRCM:

Midwifery care is based on a respect for pregnancy as a state of health and childbirth as a normal physiological process and for women's autonomy and right to be the primary decision-makers in their own care. Midwives are committed to providing personalized and non-authoritarian care, with the woman and her values and choices at the centre. This means being confident and competent to follow each woman and safely care for her in her chosen place of birth.[61]

151. As noted above, the midwifery model of practice aims to engender health care by putting women and their values and needs at the centre of their health care in contrast to the traditional authoritarian medical-led model, which pathologized birth. In fact, we would often hear physicians say that childbirth could only be judged as normal in retrospect.

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59 Midwifery: Cost Effectiveness and Safety- Report by Doris Floding, (April 23, 1990), AOM0002814.

60 CMO - "Philosophy of Midwifery Care in Ontario", (January 1, 1994), AOM0000597.

61 CMO - "Philosophy of Midwifery Care in Ontario", (January 1, 1994), AOM0000597.

3. Scope of Practice

152. As noted above the Transitional Council of the College of Midwives adopted the March 1993 "Core Competencies: A Foundation for Midwifery Education - Recommendations of the MIPP to the IRCM." These Core Competencies informed the development of the Midwifery Pre-Registration Program for currently practicing midwives at the Michener Institute for Health Sciences, the Midwifery Education Program (MEP) and also CMO standards. This nine page list of core competencies was used to guide midwifery education and evaluation, describing the skills and knowledge required by the new graduate or entry-level midwife.

153. These Core Competencies were organized by the following categories: general competencies; education and counselling; collaboration with other caregivers; antepartum care; intrapartum care; postpartum care of the newborn; postpartum care of the mother; sexuality and gynecology; professional, legal and other aspects.[62] These competencies were provided to the Ministry's pay equity consultant Robert Morton to be used as a part of his analysis.

154. These Core Competencies were formally adopted by the College of Midwives in 1994 at the start of regulation.[63] They were subsequently updated when the Canadian Midwifery Regulators Consortium issued the "Canadian Competencies for Midwives" in 2005 and then updated in 2008. These national competencies were adopted by the CMO.[64]

155. As a member of the IRCM's Standards and Qualifications Committee, I participated in the development of the IRCM Indications for Discussion, Consultation and Transfer of Care.[65] On this committee was also obstetrician, Dr. Murray Enkin, Professor in the Department of Clinical Epidemiology & Biostatistics and Department of Obstetrics and Gynecology at McMaster University' School of Medicine and an international expert in evidence-based maternity care.

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62 Core Competencies: A Foundation for Midwifery Education - Recommendations of the MIPP to the IRCM, published by the Transitional Council of the College of Midwives, (March 1, 1993), AOM0009979.

63 Core Competencies: A Foundation for Midwifery Education - Recommendations of the MIPP to the IRCM, published by the Transitional Council of the College of Midwives, (March 1, 1993), AOM0009979. CMO Core Competencies for Midwives, (January 1, 1994), AOM0001154.

64 Canadian Competencies for Midwives (Canadian Midwifery Regulators Consortium) Re Entry Level Competencies,(November 10, 2008), AOM0000606.

65 Draft Transitional Council of Midwives Guideline re: Mandatory Discussion, Consultation and Transfer of Care, (February 15,1994), AOM0001202, AOM0001203, AOM0001204, AOM0001205, AOM0001206.

4. Models of Practice and Payment Report

156. In June, 1992, the IRCM provided its Report and Recommendations of the Models of Practice and Payment Committee to the MOH Women's Health Bureau. [66] The report contained a series of recommendations and statements of principle that aimed to ensure that the funded midwifery model of care is based on an "Equitable Formula" which reflected and supported the philosophy, scope of practice and standards of practice formally approved by the IRCM.

157. The Report states:

> *We recognize the importance of ensuring that midwives are paid equitably among the health care professions. Rather than suggest a dollar value, the IRCM's role is to ensure that funding supports an acceptable quality of care where the midwife is able to act as a primary care practitioner, providing her clients with continuity of care in a variety of settings. It is important that midwives be fairly paid in keeping with their role as primary care providers.*
>
> *The fundamental measurements used to determine dollar equity are:*
>
> - *skill*
> - *education*
> - *working conditions*
> - *degree of responsibility*
>
> *The idea that the level of (midwives) remuneration is likely to be established by comparing midwives with other professionals is widely accepted. It has been suggested that remuneration fall between that of a senior salaried nurse and a family physician."*
>
> *It is very difficult to make direct comparisons between midwives and either doctors or nurses: their job descriptions and scopes of practice and methods of funding are dissimilar.*[67]

158. Accordingly the Report recommended that:

> *Payment: Equitable Formula*

66 Report and Recommendations to the IRCM By The Models of Practice and Payment Committee (MOPP), (June 19, 1992), AOM0006518.

67 Report and Recommendations to the IRCM By The Models of Practice and Payment Committee (MOPP), (June 19, 1992), AOM0006518. p. 10.

12. The Ministry of Health ensure that an equitable formula for the funding of midwifery be structured to fully support our recommended model of practice:

Level of Payment

13. Funding must reflect midwives' level of skill and responsibility as a primary care giver, education at a baccalaureate level, the realities of working on call and the time intensive nature of midwifery care. This equitable formula must take into consideration the different costs of providing care in a varying settings, geographic locations and populations. It must also take into account overhead costs, costs of setting up a new practice, travel, part time practice and professional activities[68]*.*

159. The Report also rejected "fee for service" as a model because the "fee for service" model provides more incentives for increasing the volume of care rather than the quality of care.

XVIII. ADDRESSING BARRIERS AND DEVELOPMENT OF EQUITABLE INTEGRATION MEASURES

160. As the TFIMO Report had recognized, it was necessary to develop measures which would ensure the equitable integration of midwifery into the health care system. [69]

1. Addressing Choice of Birth Place

161. In order to provide women with a choice of birth place, it was necessary to work to eliminate the existing barriers which prevented midwives from practising in hospitals or in birth centres, assuming the development of these centres continued to be pursued by the Ministry of Health, and to better integrate home birth practice into the health care system.

2. Obtaining Hospital Privileges

162. As noted above, according to the *Public Hospitals Act* originally only doctors and dentists could apply for privileges. Each hospital's Medical Advisory Committee determines which applicant gets hospital privileges. This Committee is controlled by physicians. Unless midwives were able to get privileges with their local hospitals, Ontario's midwifery services would be restricted to women who chose home birth and, even with these women, midwives would not be able to continue providing direct primary care if there was a need to transfer in to hospital, which would be a concern for continuity of care and safety.

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68 Report and Recommendations to the IRCM By The Models of Practice and Payment Committee (MOPP), (June 19, 1992), AOM0006518. p.17

69 Task Force on the Implementation of Midwifery, "Report of the Task Force on the Implementation of Midwifery in Ontario 1987 [Task Force Report], (January 1, 1987), p. 8, AOM0013549.

163. In order to ensure women had a choice of birth place, it was necessary to make changes to the *Public Hospitals Act* to provide midwives with access to hospital admitting privileges.

164. A Steering Committee to carry out a *Public Hospitals Act (PHA)* [70] review was struck late in 1989 or early in 1990. I was an appointed as the midwife member of this Steering Committee which addressed the issue of hospital privileges as well as many other aspects of modernizing this legislation. There were only two women on this Committee including myself and the Registrar of the College of Nurses of Ontario. The rest of the members of 24 person committee were men. Most of them were hospital administrators, trustees or health care providers from within the existing health care system, primarily physicians. Among its various proposals, the Steering Committee's Report recommended granting midwives "clear privileges" for labour admission, care and discharge.[71]

165. The Steering Committee issued its final report in February 1992 broadly recommending the *PHA* be amended so that midwives and other "regulated health professionals not employed by a hospital have the right to apply for access to the hospital's resources appropriate to their scope of practice". This included registering and treating outpatients, and admitting and discharging inpatients.[72] There was opposition from within the medical and hospital community to widening the privileges to this extent and to the more multidisciplinary and patient-centred focus of the report's recommendations. As a result, only the *PHA* Regulations 518/88 and 965 were amended to include "midwifery staff" and provide for access of midwives to hospital privileges.

166. As a result, one of the significant barriers facing myself and other midwives was removed: we were now allowed to apply to independently admit, discharge and write orders in hospital both on an outpatient and inpatient basis. Since 99% of Ontario births at that time occurred in the hospital setting, the absence of hospital privileges would have marginalized the midwifery profession. Hospital privileges enabled midwives to fully function within our scope of practice by facilitating our independent admission of women who chose to give birth under midwifery care in a hospital setting. Ensuring this was key to integrating midwives like myself into the Ontario health care system.

167. The Steering Committee's recommendations to amend the *PHA* itself were never acted on which has caused an ongoing integration barrier for midwives. As a result, midwives are not included in the definition of "medical staff" in the *PHA.* This definition only referenced physicians, and therefore midwives were excluded from participating in decision-making by hospital Medical Advisory Committees

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70 *Public Hospitals Act*, R.S.O. 1990, Chapter P.40

71 IRCM Meeting Minutes, (January 12, 1990), AOM0002354.

72 Into the 21st Century- Report of the Steering Committee, Public Hospitals Act Review.pdf (February 1992) AOM0017406 p.20

(MACs) on applications for privileges as MAC membership only included "medical staff".[73] As well, amongst other rights denied to midwives, they do not have the same right to appeal a refusal of hospital privileges as physicians do under the *PHA*. Amendments to the Act which were recommended as stated above would have put midwives on a more equitable and level playing field with physicians and given midwives who headed midwifery departments access to sit on a hospital MAC and all midwives access to appeal a privileging decision to the provincial Hospital Appeal Board (recommendation 7.20).

168. However, the Ontario Hospital Association did include the AOM in the process of establishing model bylaws for midwifery privileging, work to assist hospitals in updating their bylaws to including privileges for midwives and support them in integrating midwives into hospital practice.[74]

XIX. DEVELOPMENT OF FUNDING SYSTEM

1. Principles of Funding

169. Throughout 1992, in a timeframe that paralleled the work of the IRCM's Ad Hoc Committee on Models of Practice and Payment, the AOM developed its Principles of Funding in order to help guide our negotiations with and the decision-making of the Ontario government with respect to midwifery funding and compensation. A draft of these Principles of Funding was included in an abstract submitted in February 1993 to the International Confederation of Midwives for presentation at the 1993 International Congress to be held in Vancouver in May of that year and the Women's Health Bureau was updated on the AOM's progress in developing funding principles at around this same time .[75]

170. The main focus of the AOM was to ensure that the government's funding model worked to secure the midwifery model of care - ie. a model where all midwives provided continuity of care, including 24 hours on-call access to a midwife known to the woman, and choice of birth place – both were considered fundamental.

171. The Women's Health Bureau created the January 1992 Funding Services Report to provide the MOH with a rationale for the necessity of public midwifery funding using a model which supports the model of care.[76] This report accurately reflected that the AOM supported the Government position that a fee for service model should be avoided and that the AOM believed that either a capitation or

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73 R.R.O. 1990, Reg. 965, s. 11(1)(c)

74 Ontario Hospital Association, "The Integration of Midwifery Services in Hospitals", (January 1, 1994), AOM0016578.

75 ICM Paper Funding - Funding of Midwifery Services in Ontario prepared by AOM (Draft with comments) (1993-02-14) AOM0002802

76 Issue: Principles of funding midwifery in Ontario prepared by MOH Women's Health Bureau, January 1, 1992, AOM0011433.

salary approach could support the model. At that point in time, the MOH Alternative Funding Payment Plan was being considered as a possible funding mechanism to direct funds to midwifery practices for services.

172. Early in the 1993 negotiations, the AOM provided the MOH with its updated April, 1993 Principles of Funding.[77]

2. Securing Government Funding in Late 1992

173. As noted above, in December 1992, Minister of Health Frances Lankin announced that the Ontario government was committed to managing and funding midwifery services. The MOH decided that the program would be housed in the Ministry's Community Health Branch.

174. The Community Health Branch was responsible for community-based managed health care, including CHCs. This was consistent with the focus of the new midwifery program. The Government had accepted that the midwifery program should remain community-based, following on the model of the existing community midwifery system in Ontario which had been established by the pre-regulation midwives.

175. Jim O'Shea was appointed Program Team Leader – Community Health Branch and Sue Davey was appointed Program Associate – Midwifery Community Health Branch.

176. The Ministry also accepted the recommendation of the Task Force and the IRCM to reject the fee-for-service system used to compensate physicians.

3. Relationship to Pay Equity

177. At this time, pay equity for women was very much on the radar in the health care and women's rights movement with media coverage of the nurses fighting for equal pay for work of equal value in their workplaces in hospitals and in community health settings.

178. At the AOM we were encouraged because we were aware that Minister Lankin had an understanding of pay equity and gender equality matters as she had been an active member of the Ontario Equal Pay Coalition and active in the implementation of Ontario's *Pay Equity Act* as an Ontario Public Service Employee Union representative up to the time of her election as a M.P.P. in 1990.

179. The setting of compensation for midwives came as women were struggling to enforce their rights to be free from pay discrimination and prejudice. At the time that the AOM and the Ministry were starting to address the issue of the

77 AOM Memo Principles of Funding, (April 1, 1993), AOM0002830.

appropriate employment status for midwives and their compensation, the health-care sector was working on implementing its obligations under the *Pay Equity Act* and determining what adjustments if any were necessary to achieve pay equity under the *Pay Equity Act.*[78]

180. I was aware that the whole health care sector, including Community Health Centres, had to do pay equity plans to comply with the *Pay Equity Act* and that there was government funding for pay equity adjustments. At the time of the funding discussions, we understood that pay equity was a part of the whole process of pegging where the midwife would be placed in the health care pay hierarchy and that the process would be ongoing.

181. The Government had still not decided whether some or all midwives would be employed within the CHCs or any other health organization. As a result we were not certain how midwives would continue to be assessed for pay equity. At this time, there were a lot of unknowns. However, we understood that, as women in a predominantly female profession working within the Ontario health care system, there would need to be a process to address pay equity for midwives in an ongoing way.

XX. THE ROLE OF THE WOMEN'S HEALTH BUREAU AND COMMUNITY HEALTH BRANCH

182. Margaret Ann McHugh, Midwifery Implementation Coordinator, advised me that she believed that the Community Health Branch (CHB) was the best place for the OMP to be situated as they would be in the best position to understand midwifery, given their community-based approach and patient-centred focus.

183. The CHB was also separated from the dynamics of Insured Health Services which dealt with physicians and their fees. The CHB was also responsible for Community Health Centres, where refugees and uninsured persons could access health care. Because these were women midwives were already caring for, we very much wanted those disadvantaged and vulnerable women to continue to have access to midwifery care. As well, there were already discussions about devolving midwifery to local transfer payment agencies.

XXI. PREPARATION FOR FUNDING NEGOTIATIONS BY AOM AND MOHLTC

1. Introduction

184. In the fall of 1992, the AOM saw that the Ministry was moving forward with a government-managed, community-based midwifery model which appeared to reflect and have the potential to be supportive of the midwifery model of care and

78 *ONA v. Haldimand Norfolk (No.6),* and *Women's College Hospital*, (No.4), Pay Equity Hearings Tribunal decisions.

community midwifery system in Ontario which had been established by pre-regulation midwives.

185. The AOM began to prepare to engage with the MOH about the funding and compensation model.

2. AOM Preparations Ensure Funding Followed Model of Care and Equity

186. Our negotiating team was myself, Eileen Hutton and Rick Salter, the AOM's lawyer, supported by the AOM's Funding Committee which included Bobbi Soderstrom, Vicki Van Wagner, Carol Cameron, Robin Kilpatrick and Larry Lenske. We started working in the fall of 1992 to prepare for talks with the MOH concerning the funding and governance of midwifery services.

187. As a small group of midwives, 99% of whom were female, who had no funding status in the health care system and who had struggled against opposition to our existence as autonomous health care providers, we knew we did not have a great deal of bargaining power. We decided to rely on a principled and values-based approach to funding issues, anchored in the evidence supporting the safety and effectiveness of our model of care.

188. We sought to establish the place of a newly funded, almost exclusively female profession in the health care hierarchy. The AOM acted from the position there was a need to redress a sexist wrong which had excluded midwifery from the funded health system.

3. Discussion of Employment Model – Contract or Employment

189. As noted above, the question of an employment model for midwives was considered but not resolved in the 1987 Task Force Report.[79] Regardless of the model, there was a need to ensure the professional autonomy of midwives in order to secure the philosophy and model of care and support the empowerment of women as the primary decision-makers throughout their childbearing experience.

190. Vicki Van Wagner's "With Women: Community Midwifery in Ontario" addressed this issue in the context of midwives integrating into a health care system where physicians exercised considerable historical, cultural and legal authority.[80] This led to questions about whether and how midwives would work with health care institutions. In particular, this included the issue of working in local hospitals and also in local Community Health Centres.

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79 Task Force on the Implementation of Midwifery, "Report of the Task Force on the Implementation of Midwifery in Ontario 1987, (January 1, 1987), p. 9, AOM0013549.

80 Vicki Van Wagner's thesis 'With Women. Community Midwifery in Ontario'.pdf, (April 11, 1991), AOM0017358.

4. Establishing Equitable Compensation or "Pay Equity"

191. A key component of the equitable integration of midwifery into Ontario's health-care system was the setting of an equitable compensation for midwifery services. The need for such equitable compensation was called for in the 1987 Task Force report [81] as well as in the IRCM Models of Practice and Payment Committee report.[82]

192. In the AOM's view, compensation reflected the value accorded to the profession in the health care system and would set the basis for the position of the profession within the health profession funded compensation hierarchy. It was very important to get this positioning right and equitable, particularly when the profession is so highly female. We believed this was part of the redress needed to end the discrimination we had faced, as well as the historical gender-based discrimination against our profession that came before us.

193. Fair compensation was also necessary to support the demanding on-call primary care work required to provide effective care for women and their newborns within the midwifery model of practice. We focused on the importance of having funding follow and support the model of care to provide safe and effective care while serving and empowering Ontario women. To do this we needed to make sure that midwifery work, which had for so long been subject to so many stereotypes and prejudices, was understood and valued appropriately, particularly in relation to physicians.

5. Positioning the Midwife between the Senior CHC Primary Care Nurse/Nurse Practitioner and the CHC Physician.

194. During the period prior to regulation, as discussion turned to the need to come up with fair compensation for the female-dominated midwifery profession, frequently the measure that was used was positioning the midwife between the senior nurse or nurse practitioner and the physician.[83] This was raised in presentations to the Task Force and was also discussed as a measure in the Task Force Report as noted above. As well, it was referenced in the IRCM Models of Payment and Practice Committee Report.[84]

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81 Task Force on the Implementation of Midwifery, "Report of the Task Force on the Implementation of Midwifery in Ontario 1987, (January 1, 1987), p. 153, AOM0013549.

82 Recommendations to the IRCM By The Models of Practice and Payment Committee (MOPP), June 19, 2016, AOM0006518.

83 Task Force on the Implementation of Midwifery, Report of the Task Force on the Implementation of Midwifery in Ontario 1987, (January 1, 1987), p. 153, AOM0013549.

84 Recommendations to the IRCM By The Models of Practice and Payment Committee (MOPP), June 19, 1992, AOM0006518.

195. At this time, the senior primary care nurse or Nurse II was sometimes referred to as a nurse practitioner, although the formal “Nurse Practitioner” term was not recognized formally until 1998. This position was also discussed in Van Wagner’s 1991 thesis.[85]

196. When the time came to address the issue of compensation, the Ministry had decided on a community-based system managed out of the Community Health Branch which also managed the Community Health Centres. This close connection between midwifery and the CHCs and the shared primary health care reform and patient-centred approach between the two led to the focus in the Joint Working Group discussions on the CHC Physician and CHC Nurse Practitioner as the primary comparators.

197. The Joint Funding Work Group meetings were mostly at the Anne Johnston Health Station, a Community Health Centre in Toronto. Connection with the Community Health Centres

198. Various Community Health Centres were interested in integrating midwives into the primary care services offered by such Centres in the province, although many of them had a limited understanding of the midwifery model of care or the midwife’s scope of practice.

199. Jim Shea, the lead CHB funding negotiator, also had a background in community health and was interested in integrating midwives into the system of CHCs. Sue Davey, the other CHB negotiator on the Funding Work Group had been an Executive Director at the Lawrence Heights Community Health Centre.

200. In September 1993, I received a letter written by David Hole, the Chairman of the Network of Executive Directors, Eastern Ontario CHCs and Executive Director at the South East Ottawa Community Services to myself, the Community Health Branch, the Women’s Health Bureau and others enclosing a proposal for such integration.[86]

201. I later learned that the CHB’s Jim Shea had met with CHCs in the spring of 1993 prior to our funding negotiations to discuss the possible employment of midwives upon their regulation in Community Health Centres.

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85 Vicki Van Wagner's thesis 'With Women. Community Midwifery in Ontario'.pdf, (April 11, 1991), AOM0017358.

86 Undated Letter from David Hole, Chairman, Network of Executive Directors, Eastern Ontario CHCs to S. Arrojo, Association of Ontario Health Centres, J. Kilthei, AOM and Executive Directors of Community Health Centres in Ontario Re: Integration of Midwifery into Community Health Centres, (September 1, 1993), AOM0002732.; A Proposal Relating to the Integration of Midwifery made by Eastern Ontario CHCs, Executive Directors Network (1993) AOM0002733.

XXII. NEED FOR NEGOTIATIONS FRAMEWORK

1. Vulnerability of the Midwifery Profession

202. The AOM recognized that, as a small and potentially vulnerable female profession, it did not have the same bargaining power as the OMA.

203. The AOM worked diligently to prepare for the meetings of the Joint Funding Work Group and drew from its extensive knowledge base and experience. Vicki Van Wagner, Larry Lenske, Carol Cameron, Robin Kilpatrick and Bobbi Soderstrom, all members of the AOM Funding Committee, worked to get the necessary information to support the funding discussions.

204. At that point, the only health care professional association which I was aware of that the Government directly negotiated with was the OMA. At that time, the OMA was very powerful and the AOM did not even have an office. Yet we believed that direct negotiations with the MOH based on a principled framework were needed to address the systemic gender bias against midwives, who were 99% women and providing health care to women. We wanted to make sure that the Government did not underfund or under resource another female-dominant health profession. We were acutely aware that inadequate or inequitable funding would increase midwives' work stress and put their ability to deliver safe and effective care at risk.

2. AOM "Principles of Funding" April 1993

205. The AOM"s Funding Committee worked on principles of funding to guide the funding negotiations with the MOH. Our document, "Principles of Funding" dated April, 1993 [87] was provided to the MOH at a meeting on May 5, 1993, of the reference group, as discussed below, that was convened to support the funding discussions prior to the first meeting of the Joint Funding Work Group on May 19, 1993.

206. These AOM "Principles of Funding" are as follows:

(a) *1. Upon Proclamation of the Midwifery Act, midwifery services in Ontario should be publicly funded.*

(b) *2. The funding arrangement must support the Ontario Model of Midwifery Care which includes continuity of care, informed choice and choice of birth place. Because we believe that it is critical that all midwives provide continuity of care and choice of birth place, it is essential that there be one payment method" which will ensure that all midwives are able to provide care in accordance with this model, no matter where their practice is based.*

87 AOM Principles of Funding and attached AOM document' How Much Should Midwives Be Paid? The Issue of Equity, (April, 1993), AOM0001281.

Midwifery funding must be independent of any institution which may attempt to place restrictions on continuity of care or choice of birth place. All midwifery services, whether or not they are associated with an existing institution, must be funded in the same basic manner.

(c) *3. The funding arrangement must acknowledge midwives as autonomous practitioners. It must reflect midwives' level of skill and responsibility in the provision of primary care, her education at a baccalaureate level, the realities of working on call and the time intensive nature of midwifery care. In addition it must deal with the costs of running a practice. These aspects have been identified by the Task Force on Implementation of Midwifery in Ontario (1987)*

(d) *4. Funding should allow for two midwives at all births except in cases of transfer of care to a physician (where one midwife should attend with a physician). That two midwives be in attendance at all births is a recommendation of the Interim Regulatory Council for Midwifery (IRCM) that has been adopted by the Transitional Council of the College of Midwives. This is consistent with the standard of care in Ontario of having two skilled attendants at every birth and also strives to protect the model of midwifery care.*

(e) *5. Funding should permit midwives to work with other health care providers. For example: clients of midwives should be able to access the services of physiotherapy or dieticians on referral from the midwife; midwives must be able to access services of physicians consistent with the IRCM <u>Indications for Mandatory Consultation and Transfer of Care.</u>*

(f) *6. Funding should allow access to or working relationships with existing health care facilities including Community Health Centres (CHC's), hospitals, community health units, and birthing centres. It might be appropriate, for example, for a midwife's clinical practice to be located in a CHC and the funding should allow for this type of arrangement to occur. In addition, midwives will have hospital admission and discharge privileges, and funding must not interfere with the midwife's access to institutions such as a hospital or birthing centre when a woman chooses to birth there or circumstances dictate that she should be there.*

(g) *7. The funding arrangement should be flexible enough to accommodate payment variables as follows:*

(i) *Specific client populations: Some identifiable populations of women are known to require more hours of care, for example teens and low income women.*

(ii) *Cost of practice: Some provision will need to be made for costs as they vary among practices.*

(iii) *New practices: New practices which start with a lower volume of births will need to be supported particularly when the practice is in areas where midwifery is not yet well known.*

(iv) *Travel time: Regardless of the place of birth, midwifery care involves home visits, therefore travel time must be considered. Travel time may vary considerably in different practice locations.*

(v) *Part time: Allowance must be made for part-time as well as full time practice.*

(vi) *Professional activities: Consideration must be given to midwives' involvement in such professional activities as continuing education, clinical teaching, evaluation, inter-professional community programs e.g. Best Start, Birth Centre boards, District Health Councils.*

(vii) *Geographic characteristics: Practices in certain rural, isolated or sparsely populated areas with lower volume may need special compensations.*

(h) *8. Registrants of the College of Midwives must have access to public funding. Currently practicing midwives who meet Pre-Registration Program requirements and who become registered with the College of Midwives must be grandmothered into the funding system.*

(i) *9. There should be 'one central negotiation process' in which the AOM has a direct relationship with the government. The goal of such negotiation would be to produce a province wide contract for midwifery services which would apply to all midwives. This principle is particularly important because midwives comprise such a small group and are unlikely to have other practice options outside of the arrangement established with the Ministry of Health.*

(j) *1O.Professional association dues and fees should be deducted by the funding agency and remitted to the AOM. The Association will be required to negotiate the funding agreement which will benefit all practising midwives. Therefore although a midwife may choose not to join the AOM, provision will be made for the financial support of the negotiation procedure through payment of the equivalent to dues and fees from all practising midwives.*

(k) *11.The funding arrangement should acknowledge the existing partnership between midwives and the women to whom they provide care, as well as the new partnership with government. An effective mechanism for community input, which involves both midwives and consumers of midwifery care, such as a community board or boards should be established to deal with the channelling of midwifery funds as well as accountability for those funds.*

207. The AOM saw our task as getting the model of care properly funded - ie. continuity of care, including 24 hours on-call access to a midwife known to the woman, and choice of birth place. These requirements were fundamental. As was our equitable compensation and funding.

XXIII. THE MOH AND AOM FUNDING WORK GROUP NEGOTIATIONS

1. Preliminary Communications and MOHLTC Invitation

208. On December 15, 1992, Eileen Hutton, Robin Kilpatrick and I met with Margaret Anne McHugh, Midwifery Implementation Coordinator within the Women's Health Branch of the Ministry. At that meeting we discussed how midwifery might fit within the Community Health Branch, including the CHB's support for community-based practice as well as care for refugees and vulnerable populations. The support for these matters was consistent with midwifery principles of care.

209. On December 17, 1992, McHugh met with representatives of the Community Heath Branch to discuss the implementation of regulated midwifery services in Ontario. I spoke with McHugh after that meeting and McHugh indicated that there was some interest expressed in the potential for midwifery working within CHCs.

210. By letter dated February 26, 1993, I wrote to Margaret Anne McHugh of the Women's Health Bureau requesting a meeting with the Minister to address funding.[88] That meeting did not take place.

211. By letter dated March 26, 1993, Dorothy Loranger, Director of the Community Health Branch, wrote to me as AOM President to advise that the CHB had been asked to develop, in association with relevant partners, the funding arrangements for midwives in Ontario and asking the AOM to participate in that project. She noted that Jim Shea, CHB Senior Policy and Planning Analyst, had been asked to take the lead in the process. She stated that "as there are many funding-related issues that will need to be discussed in order to facilitate the implementation of midwifery in Ontario, Jim will be calling you shortly to set up a meeting to discuss the process and begin the necessary planning."[89]

212. On March 29, 1993, the Ministry issued a Midwifery News Release and attached Backgrounder: Notes on Midwifery. The Release stated: "Modern community-based midwives have been practising in Ontario for more than a decade, but outside the regulated health care system. Consumer demand for improved access to midwives and for standards of practice led to the establishment of the Task Force on the Implementation of Midwifery in Ontario in 1987."[90] The

88 Letter from Jane Kilthei, AOM President to Margaret McHugh, Women's Health Bureau re: discussions concerning funding mechanism,(February 26, 1993), AOM0002789.

89 1993/03/26 - Letter to Jane Kilthi, AOM from Dorothy Loranger, Director, Community Health Branch, (March 26, 1993), AOM0009756.

90 MOH Backgrounder - Notes on Midwifery, (March 29, 1993), AOM0009210.

Release reviewed the well-established international practice of midwifery and highlighted the steps which were being taken to establish a regulated midwifery system in Ontario, including establishing a College of Midwives and standards of practice.

213. On April 5, 1993, I was first briefly introduced to MOH Lead, Jim Shea at the Women's Health Bureau.

214. I replied to Ms. Loranger by letter dated April 12, 1993 advising that the AOM was ready and willing to participate in the process, saying that the AOM was anxious:

"to establish with your government a co-operative process to negotiate a funding arrangement that will provide a solid base for midwifery services to the women of Ontario. One of our primary objectives is creating an arrangement that supports the Ontario model of midwifery practice. We will work closely with Mr. Shea to discuss principles and establish the process and time lines to ensure funding arrangements are in place as soon as possible." [91]

215. I next met with Mr. Shea for lunch on April 21, 1993, to discuss the mandate of the Joint Funding Work Group and the broad context of the funding negotiation process. During that lunch, Mr. Shea and I agreed that a pay equity focus would be important to our funding discussions to ensure that a new female dominant profession was properly placed into the funded health care system from the beginning. He spoke with me frankly about the challenges of working in the current fiscal climate while still striving for a fair and equitable result. I left the meeting feeling that Mr. Shea and I shared a set of values around equity and fairness which would be of great assistance to us in having productive funding discussions.

2. Background - Government Negotiation Team

216. Jim Shea brought to the negotiations his background working in the community health sector and with Community Health Centres as well as his experience as a facilitator and an activist seeking justice and compassionate care within the health care system for those suffering with HIV/AIDS. Working with June Callwood and others, he had a significant role in the establishment of Casey House, Canada's first HIV/AIDS hospice.

217. Sue Davey brought to the Work Group her work up to 1992 as the Executive Director of the Lawrence Heights Community Health Centre (LHCHC) and her training as an Occupational Therapist. Davey also had pay equity experience as a result of her responsibility to implement the *Pay Equity Act* for the female job

91 Letter from AOM President Jane Kilthei AOM to Dorothy Loranger Director CHB re: accepting invite to participate in working out the funding arrangements for Midwifery Funding, (April 12, 1993), AOM0009757.

classes in the LHCHC and also her CHB role to assist in funding identified LHCHC pay equity adjustments.

218. Margaret Anne McHugh, the Midwifery Implementation Coordinator at the Women's Health Branch, while not on the Joint Funding Work Group remained involved and tracked the process of the negotiations. I remained in communication with her. She had been instrumental in the choice of the Community Health Branch as the place in which midwifery funding would be situated because she advised me it was the most compatible with the midwifery model of care. In her conversations with me prior to the start of the negotiations McHugh had been clear about the importance of ensuring pay equity for midwives was addressed in the negotiations as this was a government priority for all female dominant positions.

3. International Confederation of Midwives Conference in Vancouver

219. As well, May 9-14, 1993, the International Confederation of Midwives' conference was held in Vancouver, hosted by the Midwives Association of British Columbia. Eileen Hutton and I presented a paper "Funding of Midwifery Services in Ontario" we co-authored on the ongoing process of legislating, integrating and funding Ontario midwives which focused on the importance of ensuring an equitable funding mechanism was put in place that supported midwives and the midwifery model of practice. This paper also informed our AOM Funding Committee and Work Group discussions.[92]

4. Funding Work Group Meeting Dates

220. On May 5, 1993 a high level meeting to discuss the Principles for Funding took place prior to the first meeting of the Work Group. The AOM's April, 1993 Principles of Funding were shared at this meeting and broadly supported as a principled basis for guiding the negotiations. This meeting included Midwifery Implementation Coordinator Margaret Anne McHugh, policy staff from the Minister's office, Community Health Branch Director Loranger and Policy Director Shea, as well as Ministry representatives from Birth Centres, Institution Planning and Health Strategies, IRCM Chair Mary Eberts, Dianne Pudas, the MTFO representative on the IRCM, and Carol Cameron and myself along with our legal counsel Rick Salter and MOH lawyer David Bernstein. This group was established as a reference group for the negotiations should there be difficulties, but it was not convened again.[93]

221. Starting in May and through the balance of 1993, the Joint Funding Work Group met frequently (mostly at the Health Station CHC) to work out the details of

92 "Jane Kilthei and Eileen Hutton, Funding of Midwifery Services in Ontario, Presentation to the International Confederation of Midwives Conference, (May, 1993), AOM0017339.

93 Agenda - Midwifery Funding Development Project Reference Group Meeting - May 5, 1993 with J. Kilthei Notes, (May 5, 1993), AOM0002833.

funding implementation with a target date of starting regulated funded practice on January 1, 1994.

222. The Joint Work Group met on May 19, May 31, June 1,[94] June 15, June 21, June 24, June 29, July 6 July 8, July 12, July 19, July 20, July 22, July 22, July 23 and July 26. All of those meetings were at the Health Station CHC except for the July 26 which was at the CHB office.

223. There were further discussions with Jim Shea and Sue Davey on October 7, 1993 and October 18, 1993. Those discussions were about transition issues. Further meetings with Jim Shea and Sue Davey took place on November 18, 23, 26, and December 1, 9, 20, 1993, concerning finalizing the LMCO funding contract and other details to permit the regulated midwifery system to start on January 1, 1993.

5. Government Retainer of Management Consultant Robert Morton

224. Based on my April 21st meeting with Jim Shea, I was aware that we were going to be looking at pay equity issues at some point in the negotiations. Jim Shea called me on June 28, 1993, to let me know that he was going to bring Robert Morton, a human resources consultant and compensation expert, into the Work Group meetings to take us through a pay equity exercise working with the physician and primary care nurse/ nurse practitioner as the key comparators in the CHC. I understood this to be a courtesy call before he firmed up arrangements with Morton and brought this formally to the Work Group. It is my recollection that it was Jim Shea who used the term "pay equity exercise".

225. I asked Jim Shea to tell me more about Morton so that I could discuss his involvement with our negotiating team. Jim Shea explained that he had had prior experience working with Morton and that, in addition to working on compensation and pay equity analyses, Robert Morton was also doing some outplacement counselling, given the current challenging economic environment, and had been initially trained as a psychologist. The Joint Funding Work Group agreed to work with Robert Morton at our meeting on July 6, 1993, and our meetings with Robert Morton took place on July 8, 19, 20, 21, and 22. We were introduced to Mr. Morton by way of a conference call into our Work Group meeting on June 29th. During our meetings with Robert Morton, Morton referenced that the work was an analysis based on skill, effort, responsibility and working conditions. I do not recall whether or not Morton specifically used the term “pay equity exercise”.

XXIV. CHOICE OF CHC PHYSICIAN AND SENIOR PRIMARY CARE NURSE

226. The CHC Physician and CHC Primary Care Nurse (focusing on Senior Primary Care/ Nurse Practitioner) were the comparators which were used for the SERW

94 Minutes from Midwifery Funding Group Meeting on May 31 and June 1, 1993 (1993-06-01) AOM0009793.

analysis. This analysis included scope of practice, competencies and primary care and on-call responsibilities. It was relatively straightforward to consider comparisons in addressing prenatal and postpartum care.

227. The Nurse II designation was also sometimes used for the Senior Primary Care Nurse. The term “Nurse Practitioner” was also used, although the formal standard for the Nurse Practitioner was not put in place until 1998 when the Expanded Nursing Services for Patients Act was passed.“[95]

228. When we talked about intrapartum care, we had to apply SERW comparisons to senior salaried obstetrical nurses and physicians who had full obstetrical practices because NPs did not generally work in hospital and many CHC physicians only did prenatal care up to 28 weeks and then postpartum care starting about two weeks after birth. This intrapartum comparison was necessary to cover midwives’ full scope responsibility and make sure people clearly understood that on-call intrapartum care was a significant part of our workload and responsibility throughout the childbearing cycle. Using both senior salaried obstetrical nurses and on-call physicians as comparators was important because midwives’ intrapartum work and workload includes the work done by both these professions.

229. Midwives, CHC physicians and CHC nurse practitioners do share a number of key factors – providing community based health care, working full time and part time and servicing vulnerable populations of Ontario residents and those without OHIP coverage such as refugees.

230. At the same time, there were other differences in addition to those related to intrapartum care as noted above. Midwives, unlike CHC physicians and nurse practitioners, are also responsible for the management of their own clinics whereas the Ministry provides separate funds and resources to the CHC to carry out that function. Yet the purpose of a pay equity analysis is to compare different jobs based on SERW to see how they compare.

XXV. PAY EQUITY EXERCISE

231. Throughout our discussions, our Work Group used a "pay equity lens". By that I mean the analysis of skill, effort, responsibility and working conditions ("SERW), the approach taken by Morton and the Work Group, was the same approach I was aware was used under the *Pay Equity Act*. Morton also had us looking at education, and considering breadth and/or depth of knowledge/skill as a part of the skill analysis. This approach helped us to look consistently and accurately at

95 This legislation gave NPs registered in the extended class with the College of Nurses of Ontario (initially primary health care NPs) the authority to practice within a broader scope of practice which included three additional controlled acts: communicating a diagnosis, prescribing a limited range of drugs, and ordering certain tests, x-rays and ultrasound” However, the use of the name was not a protected title until 2008".

the work of midwives side by side with the work of the key comparators, the male predominant CHC physician and CHC senior primary care nurse.

232. The concept of pay equity was foundational to the negotiations. We had prepared for the negotiations by creating a number of background documents, both to support discussions with the AOM membership and to offer as background resources to the Joint Work Group.

233. Pay equity was as important and constant a theme in this work as was the model of practice, although the model of practice often required more discussion because Jim Shea and Sue Davey were less familiar with the midwifery model than they were with pay equity. We worked with our legal counsel Rick Salter who had expertise in negotiating with governments on behalf of First Nations and was also familiar with the acceptable approaches used to assess pay equity both generally and under the *Pay Equity Act*.

234. The term "pay equity exercise" is the wording we also used to describe the process to the AOM's members in documentation Eileen Hutton and I prepared and sent to them in October 1993 when the members were asked to ratify the results of the Joint Funding Work Group.[96] In the Questions and Answers About Midwifery Funding and Related Issues we stated that:

"*The negotiations were long and intensive but proceeded with a spirit of cooperation that allowed for flexibility and creativity on all sides. The AOM used the Funding Committee of the Legislation Committee for guidance throughout the process and relied on the AOM position papers prepared prior to the negotiations. The result is a Framework Agreement that:*

a. strongly supports the Ontario Model of Practice

b. that involves consumers from the Midwifery Task Force directly in funding implementation and

c. acknowledges the value of the work midwives do by establishing a professional wage.

To determine the salary scale, outside consultants were brought into the process to survey midwives and other health professionals and to take the working group through a pay equity exercise that evaluated midwives in comparison to primary care nurses and to physicians in Community Health Centres in the areas of skill, effort, responsibility and working conditions."

96 Letter from AOM Funding Committee to AOM Voting Members re: Funding of Midwifery Services in Ontario attaching Ontario Midwifery Program Framework, Q&A about Midwifery Funding and Note re: Caseload and Working Conditions AOM0001094.

235. The NDP government's language at this time was very focused on labour and pay equity justice so it was an important time for us to be negotiating. The other language of the NDP during this period was "social contract" as the *Social Contract Act* was passed in early 1993.

236. We understood that all of the players in the health care system and the public were part of the social contract and that one of the social contract's intentions was to address the period of fiscal restraint in a "fair and equitable manner" without penalizing one group of workers over another. We took this to mean that it would not include penalizing a new female-dominant profession entering the funded health care system for the first time. As well, the *Social Contract Act* explicitly provided that pay equity or human rights entitlements were not affected.[97]

237. At this point, we did not know what the actual funding mechanism or employment status of midwives would be - but we did know that, regardless of that mechanism or status, a pay equity process needed to be in place. We also understood comparing jobs using skill, effort, responsibility and working conditions was the accepted pay equity process to compare male- and female-dominated work to ensure compensation was free of systemic gender discrimination.[98]

238. During our meetings, the Joint Funding Work Group, supported by the work of Robert Morton, considered the skill, effort, responsibility and working conditions of the entry-level midwife relative to the Community Health Centre ("CHC") salaried physician. We also compared the midwifery work to the work and pay of the CHC "senior primary care nurse/nurse practitioner". The pay for these two CHC positions, which is reflected in the report produced by Robert Morton, were taken from the Ministry's provincial approved salary ranges for these CHC positions.

239. The choice of these comparators and positioning the midwife between the nurse and the physician was also consistent with the original recommendations of the 1987 Task Force Report on the Implementation of Midwifery in Ontario. As noted above, the responsibilities of the midwife include both the primary care responsibilities of the physician and nurse practitioner and also those of the obstetrical nurse. At the same time, we were aware that neither the senior primary care nurse/nurse practitioner in Ontario's CHCs nor the Ontario obstetrical nurse had themselves yet had a full pay equity assessment done with pay equity adjustments made and were thus likely to be underpaid as compared to male dominated work. In terms of pay equity, the main comparator for us was the then male-dominant job class of the CHC salaried physician.

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97 Social Contract Act, S.O. 1993, c. 5

98 Pay Equity Act, R.S.O. 1990, c. P.7

240. I have reviewed the document "MOHLTC - Preliminary Draft Re Primary Position Comparisons between Midwives and Nurses and Physicians: Summary of Data from Interviews." which was produced to the AOM by the MOHLTC.[99] I had not previously seen this document.

241. However, this document does accurately reflect that as it states:

"the primary comparisons were with registered nurses and physicians (i.e.. general practitioners) These are the comparisons which are foremost in the minds of the members of the Work Group as well as of the midwives and other health care professionals who were interviewed.

The general factors used for analysis are those specified in legislation (i.e. the Pay Equity Act); that is, skill, effort, responsibility and working conditions. They are considered as industry standard in many countries and were recently used by the Ontario Government to determine pay equity across all job classes in the Ontario Public Service. A general description and examples of the major elements of the four factors are as follows:

skill – the experience, training, education, and ability required to perform a job under consideration;

effort – the measurement of the physical or mental exertion needed for performance of a job

responsibility – the extent to which an employer depends on the employee to perform the job as expected, with emphasis on the importance of job obligation; and

working conditions- the physical surroundings, and hazards of a job including dimensions such as inside versus outside work, excessive heat or cold fumes and other factors relating to poor ventilation." [100]

242. In working with Mr. Morton we did work on some similar charts as set out in this document which compared midwives to nurses and general practitioners on the basis of the SERW factors. This document covers much of the topic areas of the discussions we had with Robert Morton and Ministry negotiators, Jim Shea and

99 MOH Document - Preliminary Draft: For Discussion Purposes Only- re: Primary Position Comparisons between Midwives and Nurses & Physicians attaching Table 1 Midwives Compared To Nurses - Skill Effort Responsibility and Working Conditions and Table 2 Midwives Compared To General Practitioners - Skill Effort Responsibility and Working Conditions, (January 1, 1993 - undated), AOM0009962.

100 MOH Document - Preliminary Draft: For Discussion Purposes Only- re: Primary Position Comparisons between Midwives and Nurses & Physicians attaching Table 1 Midwives Compared To Nurses - Skill Effort Responsibility and Working Conditions and Table 2 Midwives Compared To General Practitioners - Skill Effort Responsibility and Working Conditions, (January 1, 1993), AOM0009962. p. 1

Sue Davey about pay equity and particularly the: skill (breadth and depth), effort, responsibility and working conditions of the positions. However, this document does not include some key aspects of our discussions such as:

(a) Interventions – we would never have agreed to either the statement "there are few occasions when midwives are called on to make life or death decisions" or "physicians are better able to recognize risk and intervene sooner". Part of what makes midwifery safe is our training in assessment and ability to recognize early signs of deviation from normal and our emergency management skills and training.

(b) Caseload of 50 – I am unaware of where this number came from but it was not from our Work Group discussions where we worked with midwives having an annual caseload of 80 - roughly 40 as a primary midwife and 40 as secondary midwife. The number 50 was never on the table. A team of 4 midwives would together carry a caseload of 160.

243. Based on our discussions with Margaret Anne McHugh at the Women's Health Bureau it was clear that the Ministry recognized the importance of assessing pay equity as midwives were brought into the Health Care system, and the Ministry representatives and Morton recognized in the Joint Work Group process the need to do a systematic analysis of the SERW of the midwifery work when setting the compensation structure for midwives. I have reviewed the MOHLTC witness statements of Sue Davey and Robert Morton.

244. Sue Davey states in paragraph 3 as follows:

The 1993 Midwifery Funding Work Group was an exercise in setting compensation for a newly-regulated health profession with reference to agreed-upon available comparators, given that Ontario was the first province in Canada to regulate midwifery. It was not a pay equity exercise. Nor did any member of the Work Group request that a pay equity analysis be undertaken.

245. For the reasons set out above, I disagree with her statement that the Work Group process was "not a pay equity exercise". In my discussions with Margaret Anne McHugh and at my lunch meeting with Jim Shea on April 21, 1993, prior to the beginning of the Work Group process, I heard from both of them that a pay equity analysis would be a part of our work together and thus I assumed there was no need for us to formally request "a pay equity analysis" be done.

246. The AOM had very clearly provided to the CHB its March, 1993 Funding Principles which required the development of equitable compensation and funding for midwives. As well, Jim Shea and I had discussed and agreed on the need for an equity analysis before the negotiations even began.

247. In any event, we believed it was the obligation of the government to ensure such an analysis was done when it was setting the compensation and funding of a highly female predominant profession which had been subject to so much

prejudice and disadvantage. I thought the CHB understood that it needed to make the compensation funding it was setting compliant with pay equity whether midwives were on contract or employees, potentially within CHCs.

248. When Jim Shea told me that Robert Morton had been engaged to do the work on CHC job comparators, specifically referring to it as a pay equity exercise, I assumed that Jim, as the lead on the Ministry side would be bringing in someone suitably qualified to do this work, and the use of the SERW analysis approach and terminology reinforced this belief.

249. I was given no reason to doubt that the process was a legitimate pay equity exercise. I also assumed that this was a familiar process for Sue Davey, who I also assumed had experience dealing with pay equity as an Executive Director of a CHC.

250. However, I did find it disconcerting when we finally saw Robert Morton's comparison charts that he left areas such as supervision and administration blank under midwifery. Eileen Hutton and I had both described the work we did in administering our practices, the many meetings we were already having with hospitals in preparation for midwives having hospital privileges and sitting on hospital committees, and the work we were doing to prepare for having midwifery students in clinical placements with us. I also thought it was strange that Morton did his analysis but did not provide a recommended compensation range. This may have been because Jim Shea was dealing with a global budget that had already been set and had specifically asked him not to do this.

XXVI. REVIEW OF JOINT FUNDING WORK GROUP MEETINGS

1. June 21, 24, 1993 Meetings

251. At the meetings of the Joint Funding Work Group on June 21 and 24th, 1993**,** topics included budgetary funding and the development of an initial central transfer payment agency (MCO) before devolution to local transfer payment agencies such as CHCs.

252. At the June 24, 1993, meeting, Jim Shea gave the Work Group an overview of the budget allocation that he had just received, which he stated was preliminary and also subject to *Social Contract Act* deductions. He stated that the 93-94 allocation was up to $2.3 million and the 94-95 allocation was $6.2 million.[101]

101 Minutes from Midwifery Funding Group re: CTPA and Compensation, (June 24, 1993), AOM0009747.

2. June 29, 1993 Meeting - Caseload and Working Conditions and Morton

253. At the June 29, 1993, meeting the Group discussed the "Caseload and Working Conditions" document prepared by the AOM.[102] This extensive document relied, amongst other reference sources, on:

(a) the IRCM's above-noted Models of Payment and Practice Committee report; and

(b) the information in Vicki Van Wagner's 1991 work, With Women: Community Midwifery, which included her survey of 30 midwives about their caseload, conditions and hours of work.

254. While Van Wagner had arrived at a figure of 45 hours per course of care, the AOM proposed 48.25 hours based on an updated detailed calculation of time given the midwifery model had developed by 1993, including a better understanding of some of the additional work that integration into the health care system would entail. The AOM also recommended a full time caseload of 40 primary births and 40 secondary births. The AOM also had an internal group working on the costs of practice.

255. This was also the meeting where the AOM was formally advised that the Ministry had contracted with Robert Morton. At the next meeting on July 6, 1993, having considered the matter, the AOM agreed to work with Morton to carry out a compensation analysis and pay equity exercise. The AOM provided contact information for midwives in different regions of the province so that Morton could carry out interviews.

The AOM also produced for the Group at that time the document "Cost Effectiveness of Midwifery Care";[103]

3. Cost Effectiveness of Midwifery Care

256. The "Cost Effectiveness" paper, for which I did an international literature review, showed that:

(a) while midwifery care was more labour and time intensive than the doctor/nurse/hospital model, it saved health care system costs, including the costs of routine hospital care because of shorter stays, or in the case of home birth, fewer hospital stays, and reduced costs related to reduced rates of intervention.

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102 Caseload and Working Conditions, (June 29, 1993), AOM0009734.

103 "Cost Effectiveness of Midwifery Care" prepared by AOM President Jane Kilthei, (March 14, 1993), AOM0010020.

(b) midwifery care, delivered in a continuity model with choice of birthplace, resulted in lower rates of episiotomies, instrumental deliveries, and reduced use of analgesia and anaesthesia, while maintaining good birth outcomes, including lower rates of premature birth and neonatal intensive care costs associated with prematurity.

(c) the projected cost of the 4-year baccalaureate program, at this point planned to be delivered in three calendar years with no summers off, and found was also projected to result in a very cost effective and specialized obstetric education.

These findings are consistent with the current research literature on midwifery care delivered in a continuity of care model and offering choice of birth place that I have recently reviewed for a paper I am in the process of completing for the College of Midwives of British Columbia.

4. July 1993 Work Group Meetings with Robert Morton

257. At the July meetings noted above Mr. Morton took the Work Group through a "pay equity exercise". This process included reviewing the job descriptions and information for the:

(a) Family Physician – South East Ottawa CHC Physician Description - This description was provided by the CHB.[104]

(b) Primary Care Nurse – basic to enhanced - [105]- Primary care nurses at this time were employed in the CHCs - This job description was also provided by the CHB.

(c) Midwife – Core Competencies: A Foundation for Midwifery Education[106] – a document created by the IRCM's Standards and Qualifications Committee and the Midwifery Implementation Planning Project at the Michener Institute and adopted by the Transitional Council of the CMO describing the entry level competencies required of graduates to apply for registration, provided by AOM.

258. I recall being surprised that the job description for the Family Physician included obstetrical care, because in my experience of contact with the CHC physicians in Toronto intrapartum care was rarely provided. I had quite a bit of exposure to Community Health Centres through my participation of the External Advisory

104 Job Description Family Physician Position from South East Ottawa Community Services Health Services faxed July 15, 1993 (July 15 1993), AOM0009973.

105 Generic Job Description for a Primary Care Nurse in a Primary Care Facility, (May 6, 1991), AOM0009977.

106 Appendix B Summary Report by Robert Morton for the Midwifery Funding Work Group titled "Compensation for Midwives in Ontario", (July 26, 1993) AOM0001278.

Committee of the Ministry of Health's Community Health Framework Project, as well as my experience of receiving care at the Riverdale CHC. The only CHC physician I knew personally who did primary care obstetrics at that time was Dr. Catherine Oliver who sat on the IRCM and who I believe was chosen for that role because of her maternity care experience.

259. I learned that the South East Ottawa CHC physicians did do full obstetrical care, and this is probably why the CHB provided that particular job description, but given that offering full obstetrical coverage was rare for CHC physicians, using this as the sole job description for comparison purposes struck me as somewhat misleading.

5. How Much Should Midwives Be Paid – the Issue of Equity

260. In addition to the pay equity exercise carried out by Robert Morton and the Funding Work Group, the AOM carried out its own study and wrote an internal working paper "How Much Should Midwives Be Paid: The Issue of Equity" (July 13, 1993) to support us both in the Funding Work Group discussions and in discussions with the AOM membership.[107] Based on our own study the AOM concluded that a salary range of $55,000 to $85,000 for midwives with annual increases of $2,000 per year of active practice over 15 years would be equitable and appropriate. Using $85,000 as the top end of the scale at that time reflected the CHC physician rate at entry of $80,000 plus the $5,000 on call fee.

261. Based on a pay equity assessment, and the overlapping SERW, I believe we could have legitimately asked for an overlap into the physician range. However, since we were only beginning the process of integration into the health care system, even more of midwives' work as primary care providers was invisible than it is today.

262. Our experience was that many physicians and their representative organizations considered it nothing short of heresy for any other care provider to say they were doing work that physicians do and should be compensated for it. It seemed to be quite shocking to them that anyone would even ask to be paid close to a physician.

263. The Task Force Report on the Implementation of Midwifery recommended a salary range between a senior salaried nurse and a physician, and our belief was that both the analysis we had done and the one that Morton had done backed that up.

264. Accordingly, we decided that we should proceed with getting an agreement on as fair and equitable compensation as we could and then address the equity issue again after midwives were registered and working in the health care system

107 AOM Principles of Funding and attached AOM document' How Much Should Midwives Be Paid? The Issue of Equity, (July 13, 1993), AOM0001281.

when midwives would be working to their full scope of practice and everyone would have a better understanding of what midwifery work involved.

6. "Two Midwives at Each Birth"

265. The AOM also developed two other internal working papers "Midwives Compensation: Comparing Midwives with CHC Primary Care Nurses and Physicians" and "Two Midwives at Each Birth" which detailed the need to have two midwives at the time of the birth itself for safety reasons, as required by the College of Midwives,[108] to support us in our Funding Work Group discussions throughout July 1993.

266. The issue of funding two midwives to be in attendance at each birth was a bottom line for us as it was a College of Midwives standard of practice. Midwives are required to be re-certified each year in neonatal resuscitation (NRP) as a safety standard. In 1993, neither nurses nor doctors were consistently required to be trained in neonatal resuscitation. Standards were hospital-based and quite variable. The College of Midwives required that there be two NRP certified midwives in attendance at each birth because there are two persons to care for directly at the time of birth, the mother and the infant. The primary midwife generally cares for the mother and the second midwife for the baby, but both midwives need to be skilled in all emergency measures and flexible to do whatever is needed. This is particularly important as there could potentially be an emergency involving the mother and the baby at the same time. The second midwife usually comes just prior to the birth itself rather than at the start of labour where the primary midwife is the person responsible and monitoring the progress of labour. Two midwives ensure safer births, build skill and experience, and ensure that the woman receives continuity of care as required by the CMO standards.

7. Building In Part Time Midwifery Work

267. Part of the discussions of the Work Group also included the need to have an employment and compensation system which was structured to permit midwives to carry a partial caseload as many midwives were also working in other parts of the midwifery system such as being MEP faculty, working with the AOM or with the College of Midwives. MEP faculty were required to be practising midwives.

268. As well, many midwives, as women, required maternity leaves and had family, child and elder care responsibilities which at times required them to work part time. Due to these and other circumstances, some midwives found the 24/7 on-call schedule too onerous and needed to have a less than full-time caseload. As previously noted, a full-time caseload was considered 40 courses of care as a

108 AOM Documents "Two Midwives at Each Birth" and "Midwives Compensation: Comparing Midwives with CHC Primary Care Nurses and Physicians" - Updated July 22, 1993, (July 22, 1993), AOM0001283.

primary caregiver and 40 courses in the role of second midwife. Accordingly, many midwives remain active in the midwifery system carrying a three-quarter or half-time caseload at different points of time in their lives.

8. July 23, 1993 Meeting – Reaching Consensus on Compensation Range

269. Relying upon the extensive knowledge of the AOM representatives with respect to midwifery and the knowledge of Sue Davey and Jim Shea particularly with respect to the CHC positions, along with other interviews and documentation referred to in the Morton report, the parties came to a consensus which is reflected in the Morton report.

270. On July 23, 1993 Sue Davey arrived at the Work Group meeting and said she had been up all night and she could not in good conscience justify paying midwives $85,000; that even $70,000 at the upper end of the range was a stretch for her. I responded by saying that I could not in good conscience justify taking an upper limit of $70,000 back to the membership of the AOM. We agreed to a compromise which was a range of $55,000 to $77,000 with 11 annual $2,000 increments not 15. We also agreed that the second midwife, as required by the CMO, would be paid a second attendant fee.

271. The purpose at that time of the lengthy set of steps was to recognize the extensive experience of the existing practising midwives and that they were coming into public funding with knowledge, skills and experience beyond the entry-level competencies.

272. The above-noted compensation grid meant that midwives would be paid approximately 90% of the lowest step of the CHC Physician non-underserviced grid and approximately 63% of the maximum rate of that grid.

273. Based on these above discussions and agreement, the Morton report dated July 26, 1993 reported under “Recommendations” that “The Work Group recommended that the salary range for midwives be set at $55,000 to $77,000, and that progression through this range be based on $2,000 annual increments.”[109]

274. As Morton noted in his report, his purpose was to assist the Working Group to arrive at its own conclusions.

275. Sue Davey states in para. 4 of her witness statement that "the Morton Report did not recommend salaries for midwives. Instead, the members of the Work Group came to a consensus on midwives’ compensation."

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109 Summary Report by Robert Morton for the Midwifery Funding Work Group titled "Compensation for Midwives in Ontario", (July 26, 1993) AOM0001278.

276. I agree that the AOM and the MOHLTC did finally reach an agreed upon compromise as to the compensation. However, we did this in the context that we were well aware that it was the MOHLTC who had the ultimate power to set the compensation. Our analysis of the SERW and comparator information had lead us to propose a salary of $55,000 to $85,000 and 15 steps based on $2000 increments as was described in our July 13, 1993 document “How Much Should Midwives be Paid? – The Issue of Equity”.

277. The Morton report summarized the "method to establish the compensation level " as follows:

An endeavour such as setting a salary range for a new profession is a matter of informed judgement. The Consultants sought to inform the judgements to be made through systematic and careful research into how the profession of midwifery compared to related health professions with respect to the dimensions of skill, effort, responsibility and working conditions. Toward this end, they surveyed approximately 25 consumers, midwives, nurses, physicians and educators, by telephone, to establish perceived similarities and differences between related jobs and that of Midwifery. Information regarding the relative skill, effort, responsibility and working conditions gained from this research, as well as a proposed framework for comparing jobs, was brought to the Work Group for review, discussion and confirmation in an initial working session. General agreement was reached, by the Work Group, that the system would provide a sound method for examining the relationship between the job of the midwife and those of comparator professions. In order to further assess the comparison method, the consultants sought the perspectives of people in other health professions to confirm its validity. This resulted in what the consultants considered to be a fair and objective outcome in terms of the process and content of the exercise.

During a second working session, the consultants presented a refined set of rating scales which emerged from discussions in the first session. The process included defining the essential elements of each of the key factors such as education, breadth of knowledge and responsibility in decision-making. In addition, the consultants presented a comparison of "Authorized Acts" (Appendix A), a comparison of job requirements (Appendix C) based on job descriptions for a primary care nurse and a family physician in a Community Health Clinic and a list of core competencies for midwives (Appendix B). These comparisons were further informed by considering relevant dimensions of other related professions such as psychology and social work. The outcome of this session was agreement on the relative positioning of midwifery in relation to primary care nurses and family practitioners in a Community Health Clinic.

A third working session aimed at deriving a salary range for midwives was then undertaken. The consultants presented current salary data (Appendix D) which they had collected in relation to professions in the health and social service fields. This enabled the Work Group to consider the "market value" of the various

professions. Again, the primary comparisons were with primary care nurses and family physicians in a Community Health Clinic, but others, such as psychology, dentistry and pharmacy were considered. The group then worked toward a preliminary decision on a salary range for midwives in Ontario.

At a fourth and final working session, the Work Group revisited issues and reached agreement on the above noted salary range.[110]

278. There was discussion in the Work Group concerning the market levels of compensation of other health care professions. These are reflected in Appendix *D* of the Morton Report. I recall commenting on the generally superficial nature of the addition of market levels of compensation and questioning its relevance as there was no SERW analysis done and market forces often reinforce systemic inequities. However, I did also note that only the most male-dominant profession of those chosen by Morton, dentistry, crossed over into the compensation range of general practitioners.

279. The Morton report text was provided to the Work Group after we had reached a compromise with the MOH representatives that the midwifery compensation would range from $55,000 to $77,000. This compromise is reflected in the Report itself.

280. With respect to the report:

(a) While midwives serviced all of the areas covered by the CHCs, the report did not address the issue of whether midwives should be paid more for working in the “underserviced” areas although this warranted more pay for the CHC physicians. The Morton report set out in Appendix D the pay grid of $80,000 to $118,000 CHC physicians. It did not include the on call payment CHC physicians received of $5453. I learned through this proceeding that there was a higher CHC pay grid at the time for underserviced areas which ranged from $117,766 to $135,830. In recognition of the need to recruit physicians to underserviced areas, the CHC provincial salary schedule provided for a separate higher grid for underserviced areas which were all the areas other than the GTA, Hamilton, London and Windsor. Some centres with a satellite location designated as “underserviced” will have physicians on two separate grids.[111] As noted in the September, 1993 Ontario Midwifery Program Framework set out below many of the midwifery practice groups were located in these underserviced areas. However, midwives did not earn more compensation for working in these underserviced areas. While Jim Shea and Sue Davey were aware of both this higher pay grid and that midwives

110 Summary Report by Robert Morton for the Midwifery Funding Work Group titled "Compensation for Midwives in Ontario", p. 2-3, (July 26, 1993) AOM0001278.

111 Summary Report by Robert Morton for the Midwifery Funding Work Group titled "Compensation for Midwives in Ontario", (July 26, 1993) AOM0001278.

worked in these underserviced areas, they did not bring this information forward at any time in our funding discussions.

(b) I also later learned that there was a practice within the CHB that CHC physicians were paid at the maximum of the salary grid regardless of their experience or seniority whereas the MOHLTC only provides compensation for midwives based on their experience level.[112] We were not provided with this information at the time of the funding negotiations.

(c) The Morton report also did not address the issue of benefits. This entitlement was later set at 16% of the salary in below-noted discussions that took place between the CHB and AOM in the fall of 1993. Once we had arrived at the compensation range, we raised the issue that benefits had to be addressed. In the CHC context, the Ministry provided a percentage amount for benefits based on the salary. Given the time pressures to get the Framework completed and sent on to higher level government approval process, it was decided to leave the issue of benefit percentage to be addressed in the Fall with the other issues such as funding for the costs of practice and the contract arrangements.

(d) As noted above, the Morton job comparison analysis left a "?" for what midwives' responsibilities were for "supervision" and "administration" while providing credit for those job features to the CHC physician and CHC primary care nurse.[113]

(e) The report also did not state what consideration was given to the fact that the midwives worked for approximately 44 hours per week and the CHC nurse and physician had a 35-hour work week.[114] 44 hours is 22% longer than a CHC workweek of 36 hours. 44 hours was actually a low estimate, focusing primarily on the time required to provide direct client care, but we decided to go with it at the time in large part because there were many unknowns related to the additional hours that working within the regulated health care system would require and our discussions on this topic within the Work Group had not been very fruitful.

XXVII. EMPLOYMENT STATUS OF MIDWIVES

281. During this process there continued to be discussions about the proper employment status for the midwives. It was finally decided that the midwives

112 Handbook by Association of Ontario Health Centres on developing a CHC - Phase II: Needs Assessment and Proposal Development, (September 1, 2000), AOM0000623.

113 Summary Report by Robert Morton for the Midwifery Funding Work Group titled "Compensation for Midwives in Ontario", p. 28, (July 26, 1993) AOM0001278.

114 Report by Hay Health Care Consulting Group to AOM re Compensation Review of Midwives in Ontario, (February, 2004), p. 8, AOM0000565.

should at least initially be in a contract relationship rather than a traditional employee model. This model was consistent with the principles that the funding should be driven by the model of care and would best meet the needs of women by providing continuity, informed choice and choice of birthplace. The AOM understood that "employee" arrangements might still be considered on devolution and we continued to explore what that would mean in terms of providing continuity of care within the model of care under the Employment Standards Act.

282. The employment and compensation system for midwives was structured to permit midwives to carry a part time caseload as many were also working in other parts of the midwifery system such as being MEP faculty, and with the AOM or with the College of Midwives.

283. There was a discussion about compensation based on numbers of courses of care. The AOM team did not equate compensation with being a direct salaried employee only. It had still not been decided exactly how the compensation arrangement would be constructed. Our team thought of midwives as "dependent contractors, not “employees", because midwives would be dependent on one funding source through an agreement with the only transfer payment agency being established to provide health care funding to midwives in the province. We remained open to considering an employee model so long as it did not compromise the model of midwifery care.

XXVIII. DEVELOPMENT OF THE ONTARIO MIDWIFERY PROGRAM FRAMEWORK

1. Drafting the Ontario Midwifery Program Framework

284. As a Work Group, we developed drafts of the Ontario Midwifery Program Framework as we worked through the funding issues. The first drafts were created in July and the final form of the document is the September 1993 document version which was adopted by the Government and announced at the end of September 1993.[115] While the AOM was not in an equal bargaining position with the MOH, we did come to reach the compromise agreement that is reflected in the Framework.

2. September 1993 Ontario Midwifery Program Framework

285. The September 1993 Ontario Midwifery Program Framework formed the basis of the government’s “Ontario Midwifery Program” announced along with public funding on October 1, 1993. The Framework was recommended by the AOM and approved formally by the AOM after being ratified by its members in October, 1993.

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

286. This resulted in the Ministry setting the compensation for midwifery provided in its Ontario Midwifery Program at a salary scale that was more than the female-dominated senior primary care nurse/nurse practitioner and less than the CHC physician. The top range of midwifery salary was set at approximately 63% of the maximum pay of the CHC physician for non-underserviced areas ($118,000 plus on-call fee of $5323) and 82% of the lowest paid CHC physician ($80,000 plus on-call fee of $5323).[116]

287. This salary scale represented a good start towards pay equity. It resulted in midwives receiving a significant pay equity adjustment from their pre-regulation private sector compensation.

288. For ease of reference, key text from the Ontario Midwifery Program Framework which has been relied upon by the AOM and the Government in subsequent funding discussions, is reproduced below:

Consumers of midwifery services in Ontario have had a major role in ensuring that regulation and funding become a reality. In addition, they have been instrumental in the development of the model of practice in Ontario.

The funding program for midwifery services (Ontario Midwifery Program) was developed by a working group formed by the Community Health Branch and the Association of Ontario Midwives. This document outlines the proposed structure and functioning of the program as developed through this working group process.

Model of Practice

A model of practice for midwifery in Ontario, developed by the Association of Ontario Midwives (AOM) and the Midwifery Task Force of Ontario (the consumer organization), has been endorsed by the Transitional Council of the College of Midwives (College) and has guided the integration of midwifery into the Ontario health system.

The main features of the Ontario midwifery model of practice, which involves providing primary care maternity services in the community, (see Appendix I - The Midwifery Model of Practice) are as follows:

Continuity of Care
Informed Choice
Choice of Birth Place

116 Report by Hay Health Care Consulting Group to AOM re Compensation Review of Midwives in Ontario, (February, 2004), p. 8, AOM0000565.The higher grid for the CHC physician in 1993 who worked in underserviced areas was $117,766 to $135,830 on top of which is added the on-call allowance. The lower grid was $80,295 to $117,766 before adding in the on-call allowance. See also A Strategic Review of the Community Health Centre Program, Report prepared for the Community Health and Promotion Branch, MOHLTC, (May, 2001), AOM0000625.

The Ontario Midwifery Program is designed to be supportive of this model of practice and to be consistent with the standards of practice as developed by the College.

Health Reform in Ontario

The Ontario health reform objectives have also influenced the development of this program. The Ministry's efforts to introduce greater accountability and local decision-making to the health system and ensure more significant consumer participation in the management and direction of programs is well supported by the directions proposed for the Ontario Midwifery Program.

During the 1980's, large numbers of both family physicians and obstetrician / gynaecologists stopped practising obstetrics. A survey of family medicine residents at McMaster University in 1988 showed only 20% of newly graduated family physicians starting practices which included obstetrics. With fewer family practitioners providing obstetrical services for low-risk pregnancies, higher cost specialists are being used more often and pregnancy and birth have become increasingly illness and intervention oriented. The introduction of midwifery funding in Ontario will help to reorient care for low-risk pregnancy and birth by supporting a community-based approach which supports greater consumer involvement.

Research has shown that midwifery care achieves improved health outcomes for both the child and the mother (e.g. fewer low-birthweight babies, lower C-section rate). Midwives "also have lower associated costs (e.g. lab tests, bed-day costs) as a result of a lower intervention rate and a de-emphasis of the high-tech approach. There is also a lower rate of pharmaceutical use.

As the health system attempts to emphasize wellness and health maintenance, midwifery services are well positioned to support these efforts in the area of maternal and child health.

Consumers have been at the forefront of the definition of the model of practice and have been instrumental in urging government action in the areas of regulation and funding. This consumer involvement fits well with the health reform concept of continuous quality improvement. Quality of service, in this concept, is defined not simply by the profession delivering the service, but more importantly by the consumers of the service.

Current Midwifery Practice in Ontario

Midwives in Ontario are organized in practice groups and provide their services in a group practice model with a variety of shared-care arrangements. The only exceptions to the practice group organization is in a few isolated areas where midwives are working alone.

The group practice model is seen as one which works well for midwives and their clients. It helps to ensure that the model of practice is realized and assists the individual midwives in providing the highest quality of care. This is achieved through peer review, peer consultation and the shared-care approach.

While it is expected that a few midwives will be moving their practices from one city to another in the near future, most midwifery practices will remain in their current geographical location when the funding program begins (see Appendix II for a chart of the current location of midwifery practices in Ontario).

A Pre-Registration Program for currently practising midwives began in October, 1992 at the Michener Institute for Applied Health Sciences. Successful participation in this program is a requirement to be part of the initial group of registrants with the College. There are 76 midwives enrolled in the Michener Institute program who may become eligible for registration as soon as Bill 56 is proclaimed into law. It is projected that with some midwives working part-time and involvement in the university program and integration activities, this represents approximately 60 full time equivalents (FTEs).

THE ORGANIZATION OF MIDWIFERY SERVICES

The View Five Years From Now

Midwifery programs in Ontario will be provided by local non-profit transfer payment agencies (TPA or agency). This form of community-based management will support and enhance the group practice model and help to ensure access for women who may not have had access to midwifery services in the past.

A variety of existing TPAs (e.g. community health centres, birthing centres) may become providers of midwifery services in their area, through an application and approval process. In areas of the province where there is not an appropriate existing agency, a new agency may be created for the sole purpose of providing a local midwifery program. All efforts will be made to find an existing agency before this option is exercised.

TPAs will either contract for services with midwifery practice groups or employ midwives to provide services within a practice group. The arrangements will depend on local conditions and the desires of the TP A and the midwives wishing to practice in the area. Local arrangements will have to conform with established requirements of the Ontario Midwifery Program, such as the levels of compensation for the midwives, appropriate expenses and the model of practice. In addition, the arrangements will have to ensure that the essential local management functions are in place (e.g. monitoring of service levels and access).

Each TPA will enter into a funding contract with the Community Health Branch. The contract will be consistent with the framework as outlined in this report and will stipulate the service delivery expectations, financial requirements and level of

funding. While funding is expected to continue from year-to-year, the contracts will be annual.

This form of local management will allow for the greatest amount of local control to ensure access, service quality and prudent management of public funds while maintaining the existing approach of care provision through group practice.

In the longer term, district health councils will be involved in planning for new programs and will review proposals from local TPAs to provide midwifery programs. The catchment area for the local midwifery programs will be defined by the local agency, in consultation with the district health council(s) and approved by the Ministry. As with all health planning efforts today, it is expected that both consumers and providers would have a role in planning new programs.

How We Plan to Get There

The Ontario Midwifery Program will develop a network of locally-responsive community-based midwifery programs. At this time there are not a sufficient number of local transfer payment agencies who understand and support the model of practice and are ready to provide midwifery services. There is a general expectation that midwifery services will be funded upon proclamation of the new law. Therefore, a solution was developed to ensure that midwifery services could be provided in the short term and that implementation at the local level could be supported as quickly as possible.

A non-profit organization will be established to be the interim central provider of midwifery programs in Ontario for the next four years. During this interim period the organization will carry out these functions everywhere in the province where there is no local TPA arrangement in place. This central organization will contract with existing midwifery practice groups and assist them in linking up with local transfer payment agencies which may be interested in providing midwifery programs. The central organization will also assist in the development of an active network of local TP As with midwifery programs (see Appendix m for draft terms of reference).

There are many advantages to this interim approach to the development of this newly funded program:

provides time to select and orient appropriate local transfer payment agencies;

ensures consistency in application of the new funding across the province;

provides midwives with assistance in the initial stages of integration at the local level;

provides time to implement local management in a well-planned and staged process to ensure lower risk of problems;

easier to build in a consistent level of accountability.

The Midwifery Task Force of Ontario, a strong consumer organization which has been very active in helping to establish midwifery as a regulated and funded profession in Ontario, has agreed to take on the task of establishing this new organization. This will help to ensure a solid consumer orientation to the program from the beginning.

The Ministry will fund the central organization to provide midwifery programs. The central organization will, in co-operation with district health councils and the Ministry of Health, identify appropriate TPAs who may be interested in providing a midwifery program for their area. It will then assist a midwifery practice group in making arrangements (service contract or employment) with the local TPA and when everything is in place (including Ministry approval) the Ministry will redirect funding for that midwifery program from the central organization directly to the local TPA.

Since the initial set of programs will involve existing practice groups in contract with the central organization, district health councils will be informed of the location and catchment areas for these midwifery programs. District health councils will get involved in the process as local TPAs are being identified.

By the end of 1996 the central organization will review its progress and report to the Ministry on whether it will have completed its tasks and will be ready to dismantle by the end of 1997. It is anticipated that as new midwifery practice groups enter the system they will develop local arrangements from the start rather than arrangements with the central organization. This will help to ensure that the central organization does not become a permanent provincial structure.

HUMAN RESOURCES AND FUNDING

Projection of Number and Distribution of Midwives

<u>Initial Registrants</u>

Eighty people were accepted into the Pre-Registration Program at the Michener Institute. It is known that 76 candidates completed the first phase. Two of these midwives are currently living out of province and unless their plans change would not be applying for funding. A survey of the remaining midwives in the Michener Program conducted on July 20, 1993 indicated that a number of midwives intend to practice to a part-time capacity, because of involvement in the education program, professional association commitments or other personal considerations. The survey indicated that funding would need to be available for 60 full time equivalent (FTE) midwife positions.

<u>Future Registrants</u>

The midwifery baccalaureate program will have its first intake of students in September of 1993. Thirty-three candidates have been offered placement in the program. Students have been accepted into the program on both a full and part-time basis, which will result in somewhat staggered completion dates.

Persons from other jurisdictions seeking registration as midwives in Ontario will be required to apply to the College of Midwives. The Transitional Council of the College of Midwives has developed a process for establishing equivalency of training and experience to the Ontario baccalaureate degree in midwifery.

Table 1 (on the next page) illustrates the projected number of midwives who will be eligible for registration and funding from 1993/94 to 1998/99.

TABLE 1
Projection of Number of Midwives in Practice in Ontario

Fiscal Year	*Initial Registrants*	*Baccalaureate Program*	*Equivalency Granted*	*Cumulative Total*
1993/94	*60*		*0*	*60*
1994/95			*20*	*80**
1995/96			*20*	*100**
1996/97		*27*	*20*	*147**
1997/98		*29*	*20*	*196**
1998/99		*54*	*20*	*270**

* *It is impossible to predict the number of people who will enter the system through the granting of equivalency. This process is dependent on people making application and then proceeding through a number of steps which will determine their status and action steps required in order to bring them to the level of equivalency. Therefore, the numbers in Table 1 must be interpreted as conservative.*

<u>Current Distribution of Practices</u>

A review of the existing practices of midwives in the province demonstrated that several distinctive characteristics can be used to classify practices into four types as follows:

Type A: Midwives working in these practice groups are themselves separated by distance, and provide care for clients in a large geographic area.

The distances separating midwives in these practices range from 19 to 65 km. There is considerable variance in the distance travelled to clients but most midwives agreed that the usual distance limit was about one hour driving time, although some exceptions of clients living up to 1-1/2 hour away existed in most of these practices. In this category there are a total of 9 practices with between 2 and 5 midwives in each practice for a total of 26 midwives.

Type B: Midwives in these practice groups live close to each other, but provide care to clients in a larger geographic area. These practices are centred in urban centres. In this category there are a total of 6 practices with between 2 and 3 midwives per practice for a total of 14 midwives.

Type C: These practices serve the communities where the midwives live and are located in major urban centres. There are a total of 6 practices in this category with between 2 and 8 midwives per practice for a total of 30 midwives.

Type D: This category is comprised of three midwives who are solo practitioners, usually separated by geography from other practising midwives.

(See Appendix N for chart of the Distribution of Midwifery Practice Groups by Type of Practice.)

Practice Caseload Expectations

A transfer payment agency with responsibility to deliver a midwifery program will employ midwives or enter into a contract with a practice group to provide midwifery services to women and their families. This contractual or employment arrangement will include caseload expectations which will take into consideration the particular circumstances related to providing midwifery services in that area.

In a typical practice group each midwife working full time will provide care, either as primary or secondary care-giver, for 80 pregnant women and their newborn infants. Since midwives generally work within a shared-care approach, each midwife will act as the primary care-giver, providing a complete course of care throughout pregnancy, labour and birth, to 6 week postpartum for 40 women and their newborns. Additionally, each midwife will be the secondary care-giver to another 40 women and their new born infants. Transfer payment agencies will be able to use these figures to plan for the number of women and their families to whom it can make the midwifery program available.

Not all midwifery practices, however, will be typical. There are a variety of factors which could have an impact on the precise number of courses of care which could be provided in a particular year. Special consideration of these factors will be required in planning programs and developing contractual and employment arrangements. The factors which have been identified may increase or decrease the number of courses of care from the number provided in the typical practice as noted above.

Those identified factors related to the client population which may have an impact on caseload are as follows:

age, previous caesarean section, disability, socioeconomic status, language and culture, and geography.

Other factors which may have an impact on practice caseloads are catchment area and participation in related activities (e.g. requirements for integration into the health system).

Accommodating and planning for these factors can best be worked out at the local level between the appropriate transfer payment agency and the midwives involved. However all local variations in arrangements throughout Ontario should be based on the factors described above and further set out in any guidelines developed jointly by the Ministry of Health and the Association of Ontario Midwives and not as a result of redefinition of the model of practice.

a. Compensation of Midwives

Midwives will be compensated on a salary basis. This approach to compensation is best able to support the model of practice and is most compatible with the community health approach to program and service delivery.

The salary range will be $55,000 to $77,000, subject to cost-of-living adjustments as determined from time to time by the Ministry of Health. All transfer payment agencies receiving funds from the Ontario Midwifery Program will be required to contract or employ midwives in accordance with this salary range and the following terms for its application:

- *The range will have 12 steps and each step will represent an equal fixed dollar increment. (i.e. The range of $55,000 to $77,000 will have eleven $2,000 increments.)*

- *The first step is considered to be the entry level for a newly registered midwife with experience of less than one year's active practice.*

- *Progress through the range will occur with the Increase in the number of years of active practice. Each step represents one year of active practice.*

- *The Initial group of registrants will be placed on the range according to their level of experience. This will be determined in accordance with the definition of active practice used by the Michener Institute in determining the level of experience for the Pre-registration Program.*

- *Midwives entering the Ontario health system from other jurisdictions will be placed on the range In accordance with a determination of their years of active practice (or its equivalency) In a model of practice similar to that of Ontario*

b. Operating Expenses

Midwifery Services Expenses

Operating expenses of the midwifery practice group related to the provision of midwifery services determined to be acceptable for funding will be Included in the funding arrangements. Although specific details regarding which expenses will be included have still to be worked out, it is assumed that they will be similar to those details worked out in the Community Health Centre Program. For example, expenses related to premises, equipment, supplies, communications and travel are regarded as acceptable expenses. There may be some variation from other programs in the Ministry to accommodate the uniqueness of the Ontario Midwifery Program.

Program Administration Expenses

Transfer payment agencies with midwifery programs may require some funding of expenses related to program administration (e.g. support for a midwifery program advisory committee). It is assumed, however, that in most cases a midwifery program's association with an existing transfer payment agency will provide opportunities for financial efficiencies.

During the interim period the central organization will require a budget to carry out its activities. This budget will be negotiated annually and will represent funding which will, after the completion of its mandate, be available to fund local TPA program administration expenses.

Part II Program Management

Ministry of Health Roles

The Ministry of Health, through the Community Health Branch, will fund and manage the Ontario Midwifery Program.

Other parts of the Ministry will also have an on-going interest and role in midwifery:

- *The Health Human Resources Policy Unit will be active in the human resource planning aspects of midwifery.*

- *The Women's Health Bureau will continue, during the integration period, to take the lead on implementation issues. In the longer term, the Women's Health Bureau will continue its advocacy role*

and will assist the Community Health Branch in the development of program policy.

- *The Professional Relations Branch will continue to be the primary contact for issues related to the College of Midwives.*

- *The Clinical Education Program will be involved in the preceptor funding related to the university program.*

- *The Alternative Funding Unit, as funders and regulators of birthing centres, will also be involved in midwifery issues.*

- *The Information, Planning and Evaluation Branch may be involved in the evaluation of the Program and will have a role in relation to the district health councils' involvement in planning for midwifery services.*

As is illustrated above, midwifery issues reside in a number of areas around the ministry. The Community Health Branch will have responsibility to ensure that there is a coordinated provincial approach.

c. Ontario Midwifery Program Quality Committee

The Ministry of Health defines quality as "Doing the Right Things Right All the Time." In an effort to ensure the highest quality midwifery funding program, and in order to continue the collaborative approach which has characterized the development of the funding program, the quality committee will be constituted by the Community Health Branch. The quality committee will monitor program implementation and provide advice to the Community Health Branch.

The specific mandate of the quality committee will be to monitor program implementation, ensure communication among identified stakeholders and provide advice to the Community Health Branch on program improvements. (see Appendix V for draft terms of reference)

The committee will have representation from the Association of Ontario Midwives, Midwifery Task Force of Ontario, midwifery transfer payment agencies and the Ministry of Health and will meet twice each year (more often if necessary). Sub-committees may be established to deal with specific areas which require improvement. The committee will be supported by the Community Health Branch.

Members of the program quality committee will also be available to the Community Health Branch as individual advisors as the need arises.

289. At the end of September, the Government announced the Framework after obtaining Cabinet approval.[117]

XXIX. RATIFICATION BY AOM MEMBERS AND AGREEMENT TO WORK IN FUNDED SYSTEM

290. Subsequent to the Government announcing its agreement to the Ontario Midwifery Program Framework, I then arranged to have AOM members vote on the package. By communication dated October 23, 1993, I forwarded a package of documents to the AOM members to brief them with respect to the vote to be held. As set out above, this package included a reference to the "pay equity exercise" we had engaged in order to arrive at an equitable compensation for midwives. [118]

291. The AOM membership ratified the Ontario Midwifery Program Framework. Meanwhile, throughout September and into October the AOM Funding Committee had continued its ongoing work on the costs of practice and other matters related to the implementation of the Framework in anticipation of the Ministry announcement on October 1, 1993.[119]

292. MOHLTC Witness Sue Davey states in her witness statement that there has "never been a requirement for midwives to accept public funds. However, midwives who choose to accept public funds must comply with the terms of the funding agreements."

293. While there may not be a legal requirement to accept public funds, midwives cannot practice midwifery without the required professional liability insurance which is arranged by the AOM and covered by the MOH as part of its funding of practice expenses.

As well, Article 6 of the LMCO contract provided that midwives were not able to accept money for midwifery services.[120] CHC physicians were able to bill OHIP for insured services provided outside the CHC – such as in a walk in clinic or an emergency room. Midwives did not have these kinds of options. It would be extremely difficult, if not impossible, for a midwife to meet College of Midwives standards of practice and insurance requirements and practice outside of the publicly funded health care system.

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117 Ontario Midwifery Funding Framework (developed by the Midwifery Funding Work Group), (September 1, 1993), AOM0000579.

118 Voting Package for AOM Members re Ontario Midwifery Program Framework - with attachments, (October 23, 1993), AOM0001275.

119 MOH News Release: "Milestone Reached for Ontario Women" (1993-10-01) AOM0010710

120 Midwives were permitted to charge for teaching childbirth education classes.

XXX. TRANSITION TO REGULATION AND FUNDING – FALL, 1993

1. Introduction

294. Throughout the fall of 1993 I continued as the AOM lead in the ongoing negotiations with the MOH concerning operationalizing the Program Framework, developing the benefits amount and supporting AOM midwife and Funding Committee member Larry Lenske in developing the program to administer midwives' benefits which would be managed by the AOM as of January 1, 1994, as well as working with the Midwifery Care Organization, which came to be called the Lebel Midwifery Care Organization, on implementation issues.

2. LMCO – Lebel Midwifery Care Organization

295. The Lebel Midwifery Care Organization (LMCO) (named after the midwife who attended the birth of the Dionne Quintuplets), was established in October, 1993 as the interim central transfer payment organization with funding provided directly from the Community Health Branch of the Ministry of Health.[121] The LMCO was to act as the central transfer payment agency until the program could be devolved to community-based TPAs which was targeted to happen by the September, 1993 Program Framework for 1997.

3. Ongoing Meetings with the MOH

296. During this time I continued to work closely with AOM President-Elect Eileen Hutton. Eileen and I met with Sue Davey and Jim Shea on a number of occasions, including over lunch on October 7, 1993, at Ministry offices at Overlea Blvd on October 18, 1993, again back at Health Station on November 3, 1993, and again on November 18, 1993. In these meetings we continued the work of operationalizing the Program Framework, including outlining what would need to be addressed in the Ontario Midwifery Program Guidelines and working on the first drafts of this document.[122]This required, among other things, looking at costs of practice and other compensation variables, matters referenced in the Program Framework and that the AOM had continued to research in detail since September 1993.

297. I also attended a MOH meeting on October 26, 1993 regarding the communication plan for midwifery implementation.

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121 LMCO Factsheet re: Background Information on Midwifery Funding, (January 1, 1994), AOM0000580.

122 Draft #2 OMP Program Guidelines, (November 9, 1993), AOM0002864. OMP Program Guidelines, Draft #3 with handwritten notes on document by Jane Kilthei, (January 13, 1993), AOM0002860. OMP Program Guidelines, Draft #4, (July 21, 1994), AOM0002859. OMP Program Guidelines, Draft #5, (September 7, 199), AOM0002855. OMP Program Guidelines, Draft #6 forwarded to Jane Kilthei from OMP Bonnie Heath, (November 17, 1994), AOM0002854. Draft 8 of OMP Guidelines - Draft #8, (November 1, 1995), AOM0001285.

298. On November 23 and 26, 1993, Eileen Hutton and I, along with our legal counsel Rick Salter, met with Jim Shea, Sue Davey and the Ministry lawyer back at Health Station to work on the language of the contact template for midwifery practices with the LMCO.

299. On December 1, 1993, Eileen and I had a full day meeting with Jim Shea and Sue Davey to work further on contract language and on the Ontario Midwifery Program Guidelines.

300. We met again at Lawrence Heights CHC on December 9, 1993, including with both AOM and Ministry legal counsel, and at Ministry offices on December 13, 1993, to finalize contract language.

301. On December 15, 1993, we met with Jim Shea, Sue Davey and LMCO representatives at Lawrence Heights CHC to work on budget.

302. Eileen Hutton and I had a meeting to finalize funding implementation issues with Jim Shea and Sue Davey on December 20th at Health Station.

303. I also attended a number of meetings with the Ontario Hospital Association from October into early December as we worked on finalizing model hospital bylaws for midwifery privileging in the hope that midwives could have their hospital privileges in place by January 1, 1994.

4. Funding, Expenses and Developing the Contract

304. As stated in the Program Framework, the OMP and the AOM were using the model of expenses used by the Community Health Centres.

305. Subsequent to the finalization of the September, 1993 Framework, the AOM was advised that the funding available for the new midwifery system was less than the figure which the MOH representatives had advised in the Funding Work Group discussions leading up to the Program Framework. [123] This made our work on costs of practice additionally challenging.

306. The basic structure for the delivery of midwifery services was to be carried out by midwives in practice groups. Each practice group was to enter into a contract with the LMCO. This contract sets out the compensation to be paid to midwives as directed by the MOH in its contract with the LMCO. The Ministry funds the compensation and operating expenses of midwives through the LMCO.

307. I met with the LMCO Board at Lawrence Heights CHC on October 27, 1993, again on November 14, 1993, and for a full day meeting on December 7, 1993, with a focus on coordinating the implementation of regulated, funded midwifery in Ontario as on January 1, 1994.

123 AOM Document, Ontario Midwifery Program Budget, (October 1, 1993), AOM0001286.

5. Dependent Contractors and Salary

308. Midwifery compensation was described in the LMCO contract as a "salary". One of the early tasks of the LMCO was to carry out an assessment of the clinical experience of the midwives who had passed the Michener Midwifery Pre-Registration Program and were eligible for registration to determine where each midwife would be placed on the salary scale. This assessment included the auditing of midwives clinical records.

309. Midwives were characterized at this time as "dependent contractors:"[124] The Program Framework provided that transfer payment agencies would "contract or employ" midwives in their practice groups based on the designated salary. The AOM's 1994 Guide states:

> *"Midwives are dependent contractors. They are contractors for service in terms of controlling their own business but they are dependent on one source for funding of their midwifery activities (i.e., the Ontario Midwifery Program) and are therefore dependent economically."*[125]

6. Developing the Benefits Package

310. As a result of our ongoing discussions with Jim Shea and Sue Davey, the MOH agreed to provide midwives with benefits in the amount of 16% of their salary. This too was a compromise that was driven by the limitations of the global budget, as we were aware that CHCs provided their staff with 23% benefits plus relief. [126] At the time it seemed important to establish that midwives were entitled to benefits at the point of funding implementation on January 1, 1994, even if the amount was not yet equitable.

311. The AOM developed a benefits package plan and program for midwives that recognized the unique elements of the Ontario Midwifery Program, including the unique demands of on-call midwifery work in relation to the assessment of short and long term disability. It was approved by the AOM on December 29, 1993. [127]As they were "dependent contractors" midwives were not covered by Unemployment Insurance Benefits or the Employer Health Tax.

312. The AOM established the AOM Benefits Program, with a Benefits Committee and Trust Fund that was at arms-length from the AOM Board and which included elected regional representatives in the Program's governance, in late 1993. All

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124 Midwifery Practice Financial & Business Manual: Introduction, (March 1, 1995), AOM0000599.

125 Midwifery Practice Financial & Business Manual: Introduction, (March 1, 1995), AOM0000599.

126 AOM Document, Ontario Midwifery Program Budget, (October 1, 1993), p. 6, AOM0001286.

127 Midwifery Services of York Draft Plan re: The AOM Benefits Package December 28, 1993 Approved by the AOM Executive, (December 28, 1993), MOH003739.

benefits were then disbursed from the Program's Trust Fund. The LMCO then disburses to the Trust Fund the 16% of midwives' salaries budgeted for benefits.

313. Initially, effective January 1, 1994, the benefits were a group health plan, group RRSP, a maternity/short term disability self-insurance plan, and a long-term disability plan.[128]

XXXI. MIDWIFERY AT REGULATION

314. As of January 1, 1994, midwifery became a fully regulated profession and a government-controlled and funded service for Ontario women.

315. As of January 1, 1994, the regulation and funding of midwifery offered Ontario women a choice about how their prenatal care and childbirth would be conducted so that those who wish to be cared for by midwives during pregnancy, labour and delivery had this option. Midwives now shared with doctors the provision of autonomous maternal and newborn health care as well as the public funding of such services.

316. The College of Midwives of Ontario became the body responsible for regulating the midwifery profession as of January 1, 1994. This included its registration and quality assurance requirements, standards of practice, policies and guidelines.

317. The AOM undertook to provide midwives with evidence-based clinical practice guidelines and model practice protocols to support midwives in their practices, including developing model practice agreements for members of midwifery practice groups. The AOM issued a Practice Guide for its members in 1994.

318. During the first years of regulation, the AOM, practising midwives, those at the CMO and those in the MEP were extremely busy carrying out the many different roles they needed to play to make the newly regulated midwifery system work. Practising midwives were involved in all these organizations and institutions as well as involved in collaborating with health care institutions, obtaining hospital privileges and developing working relationships with hospitals, physicians and nurses, and other organizations providing local community health care and resources.

319. The LMCO's summary of the status of midwifery at the time of regulation is as follows:

(a) The College of Midwives' standards require two midwives at a birth, and most midwives organize their work in a shared care arrangement within a practice group. Funding for midwifery services is flowed to the practice group, not to individual midwives.

128 Midwifery Services of York Draft Plan re: The AOM Benefits Package December 28, 1993 Approved by the AOM Executive, (December 28, 1993), MOH003739.

(b) Funding to a midwifery practice group begins when the practice enters into a contract with LMCO (or, in the future, another agency) to provide midwifery services in a Ministry-approved catchment area. The practice group is funded for the set-up costs, operating expenses (rent, travel, etc.) and individual compensation (not salary, as midwives are not employees).

(c) The compensation level of a midwife is between that of a senior salaried nurse and a family physician and reflects the level of responsibility as a primary care provider and the demanding nature of a midwife's work.

(d) Pregnant women can book directly with a midwife; a physician's referral is not required. A woman who chooses midwifery care for her pregnancy, delivery and postpartum care will not normally see a physician; the midwife is the primary care provider.

(e) In line with the Ontario model of midwifery practice, midwives are required to be on call 24 hours a day, seven days a week. Usually a client will be cared for by two midwives in a shared-care arrangement and in no situation will a client see more than four midwives during her course of care. A great deal of information-sharing takes place during clinical appointments, which last approximately 45 minutes.

(f) Midwives provide comprehensive postpartum care to women and their newborns; they make several home visits in the days and weeks following the birth.[129]

(g) As of proclamation, there were 68 midwives in 21 practice groups serving Ontario women in specific government-designated catchment areas from Kingston to Niagara, as well as the communities of the Grey-Simcoe area, Guelph, Huntsville and the surrounding area, Kitchener-Waterloo, London, North Bay and the surrounding area, Ottawa, Peterborough, Sarnia, Sudbury and Thunder Bay. Each midwife working full time provides care in a shared-care arrangement to 80 women and their newborns throughout pregnancy, birth and the postpartum period on an annual basis. A midwifery practice made up of four midwives provides care to 160 women each year.[130]

129 Communique from LMCO re: General Information on Midwifery Funding, Background AOM0009207. Description of AOM, AOM0009209. MOH Backgrounder - Notes on Midwifery, (January 1, 1993), AOM0009210.

130 Communique from LMCO re: General Information on Midwifery Funding, Background AOM0009207. Description of AOM, AOM0009209. MOH Backgrounder - Notes on Midwifery, (January 1, 1993), AOM0009210.

(h) For many years to come, the demand for midwifery services will far exceed the availability.[131]

XXXII. INITIAL AOM – LMCO FUNDING CONTRACT

320. The AOM, MOH and LMCO worked on creating the initial LMCO funding contract. As AOM President, I worked with the LMCO's initial Executive Director, Betty Dondertman in early 1994 on budgeting and operational issues.[132]

321. The 1994 LMCO Funding contract between the LMCO and the Ministry set out the compensation to be paid to midwives, which was then reflected in the funding agreement between the LMCO and the "practice group". That agreement continued in place until a new contract was implemented in 2000 when devolution to local transfer payment agencies actually took place.

322. The LMCO/Midwifery Practice Group agreement[133] provided that:

(a) The LMCO will pay to the practice group as funding compensation for midwifery services during each fiscal period a range of remuneration that is a salary starting at $55,000 with a maximum rate of $77,000.

(b) "The rate of compensation shall increase by a fixed amount ($2,000) after each year of full time service completed by the midwife, to the maximum rate in the Table."

(c) "In keeping with the principles of the social contract, if the amount payable for a midwife in 1994/1995 is projected to be greater than $30,000 the amount payable in that fiscal year will be reduced by 4.4%; but if the reduction results in the amount payable for that midwife in that fiscal year being less than $30,000, the amount payable will be $30,000."

(d) Funding to the midwifery program is divided into "compensation," "operating," "special operating" and "non-recurring." Compensation is only paid to practice groups for approved Ministry midwifery positions. Professional liability insurance was set out as an operating expense. The only matter covered by "compensation" was the salary.

(e) The LMCO will also pay an amount equal to 16% of the amounts paid for "compensation" for the cost of a benefit package. (Article 3.10)

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131 Communique from LMCO re: General Information on Midwifery Funding, Background AOM0009207. Description of AOM, AOM0009209. MOH Backgrounder - Notes on Midwifery, (January 1, 1993), AOM0009210.

132 AOM Document How Much Should Midwives Be Paid - the issue of equity, (July 13, 1993), AOM0001276.

133 Funding Agreement between Lebel Midwifery Care Organization of Ontario and Midwifery Practice Group, (January 1, 1994), AOM0001288.

(f) Payment was made for compensation based on the percentage working full time.

323. As noted above, the LMCO was responsible for deciding, with the support of the AOM and the practice groups, where each of the midwives were placed on the compensation range based on their experience level based on years of active practice as assessed by the LMCO, and whether they were currently full time or part time.

324. At the time of regulation, the LMCO contract did not have specific provisions to address the unique concerns of rural and remote midwives, with the exception of the caseload variable for travel. I understand that provisions for rural and remote practice were not enacted until the 2008 contract.

XXXIII. ONGOING MEETINGS AND CONTROL BYTHE MOH

325. Our meetings with MOH representatives Jim Shea and Sue Davey also continued into the new year. Early in 1994 Bonnie Heath was appointed as Midwifery Coordinator within CHB and given responsibility for moving the development of the Ontario Midwifery Program Guidelines forward starting with Draft 3.[134]

326. By the spring most of our meetings were with Heath who ended up as chair of the Ontario Midwifery Program Quality Committee which included representatives of both the AOM and the LMCO.

327. The OMP was working with a current budget shortfall of $5,835.93 in the 1994-1995 fiscal year.

328. The Ministry exercises considerable control over the size of the midwifery profession, including where midwives practise throughout the province, the size of their practices and their lack of ability to withdraw their services as a result of their professional obligations of care and the exigencies of caring for women during pregnancy and childbirth. Midwives are not able to withdraw services without breaching CMO standards and jeopardizing the care of women and their newborns.

329. The midwifery practice group is constrained in the number of clients that the midwives can take on, since caseload is preapproved by the MOHLTC. In contrast, a fee-for-service physician is not constrained in the number of patients they can take on, nor the kinds of service they can bill for so long as the service billed for is on the OHIP schedule of funded services.

134 Memo from AOM J. Kilthei to OMP Midwifery Coordinator Bonnie Heath re: OMP Program Guidelines - Draft 3 AOM0002856.

330. The availability and number of placements within a given practice group is controlled by the Ministry, who can approve or disapprove new placements. Practices must justify any increased demand for midwifery services in their community. Midwives cannot create a new practice group without TPA and Ministry approval with regards to where that new practice group will be located, its catchment area and its caseload.

331. Midwifery practice groups take on the risk of a small business, but unlike other small businesses including physician-based practices, their ability to increase income with effort is constrained by the managed care system embraced by the CHB (Ontario midwives do not have access to a commensurate reward for additional effort that Ontario physicians do); their practices cannot grow or expand without MOHLTC approval nor can their practices, or individual midwives within those practices, bill for additional services.

XXXIV. INITIAL DEVOLUTION DISCUSSIONS AND EMPLOYMENT STATUS ISSUES

1. Introduction

332. In 1995, as midwives were implementing care within the new midwifery system and developing their practice group operations, the LMCO raised the issue of devolution which led to the discussion of the employment status of midwives. While midwives did not fit the definition of employees, neither were they the same as independent contractors like the medical profession who offer their services in a fee-for-service basis and have a range of options for offering and billing for care.

333. The AOM created an internal Devolution Strategy Group which initially included myself and Elana Johnson and included other AOM representatives after I left the AOM to become the Co-Registrar of the College of Midwives of Ontario in April 1996.

334. In preparation for devolution, the AOM and the Community Health Branch lead by Bonnie Heath at CHB continued developing the Ontario Midwifery Program Guidelines, including Submission Guidelines for Application to the Ontario Midwifery Program for potential local Transfer Payment Agencies. These Guidelines detailed the joint understanding of the AOM and the CHB concerning midwifery program and requirements, the model, work hours and structure of care, and the funding and budgeting process. Despite many drafts[135], I

135 Development of Ontario Midwifery Program Submission Guidelines – various drafts 1994 -1995 – Minutes for OMP Program Quality Committee, (April 4, 1995), AOM0009251. 1995/05/17 - Agenda for Program Quality Committee,(May 17, 1995), AOM0009255. Minutes from OMP's Program Quality Committee Meeting re Employment Model for Midwives, Partial Courses of Care, Funding Details, (May 17, 1995), AOM0009256.

understand that these Guidelines were in fact not finalized between the AOM and OMP until May, 1999 when the devolution process finally was implemented. [136]

335. Subsequently this process was put on hold as a result of the uncertainty with respect to the employment status of midwives and the issues with respect to TPA structures and the *Employment Standards Act.*

2. Employment Model Working Group

336. During 1995, the OMP and the AOM created the Employment Model Working Group to address the issue of the employment status of midwives on devolution to TPAs. The Group, led by myself for the AOM worked on producing a prototype agreement that could be used by TPAs that would be consistent with the model of care. The Group discussed the issue of addressing of the employment status of the midwives and the impact of the *Employment Standards Act* on midwives if considered to be employees due to the unique and onerous working conditions of midwives required by their model of practice.

337. The AOM was very concerned that any new TPA model and employment status be consistent with the model of practice including the need for professional autonomy and continuity of care.

338. We believed that it was necessary to find an employment status which best reflected the requirements of the model of practice, the autonomy of midwives and the needs of both midwives and their clients within the extraordinary working conditions required of midwives, including 24/7 on-call availability and the provision of continuity of care. Midwives work hours were much longer than the prescribed hours under the Employment Standards Act and did not fit within a standard employment relationship. Any employment model also needed to reflect the system of mutual support on which midwifery is based, with the TPA relating to midwives within the context of their practice groups and the midwives relating to one another within the group for their day to day professional accountabilities. [137]

339. As chair of the AOM Funding Committee, I met with Suzanne Klein, Manager of the Employment Conditions and Practices Unit of the Employment Standards Branch and representatives of the LMCO and OMP on December 8, 1995 in order to discuss the application of the *Employment Standards Act* to midwives. It became clear at this meeting that for midwives to continue to provide care within the model of practice as regulated by the College of Midwives a formal exemption of ESA requirements such as those related to maximum hours worked, overtime pay and on-call would need to be obtained and obtaining that

136 Guidelines by OMP re: Transfer Payment Agency Submission Guidelines, (May 26, 1999), AOM0008027.

137 AOM's 1999 Practice Guide, (January 1, 1999), AOM0000600.

exemption was considered unlikely as there seemed to be no appetite within the Branch to consider such exemptions.[138]

340. During the period 1995 – 1997, the AOM, the LMCO and the CHB continued to meet and have discussions concerning whether an appropriate employment model could be established and whether the model as it stood could be characterized as an "employee" model. I was no longer involved in these discussions as of the spring of 1996.

XXXV. MONITORING IMPLEMENTATION OF FRAMEWORK – THE PROGRAM QUALITY COMMITTEE

341. The Ontario Midwifery Program Quality Committee was established in the early summer of 1994 and met numerous times after regulation to continue to work on the Ontario Midwifery Program Guidelines and monitor the implementation of the OMP to ensure it was being carried out in accordance with the principles set out in the 1993 Program Framework. The CHB's Bonnie Heath chaired the Committee and Eileen Hutton and I were both AOM members of the Committee. LMCO Executive Director Betty Dondertman attended on behalf of the LMCO. Sue Davey may have also attended on occasion. I also continued to be chair of the AOM Funding Committee.

342. The Quality Committee was tasked with addressing issues such as setting up evaluation systems to evaluate the Ontario Midwifery Program, instituting a hospital integration survey and moving forward the issue of devolution and the transferring of the LMCO funding agreement to devolved TPAs and MPGs.

343. At the November 22, 1994 meeting of the Committee, there was a discussion of implementation issues, including program evaluation and the ongoing process of drafting of Program Guidelines and Submission Guidelines for devolved TPAs. This was a very challenging time for us as Eileen Hutton and I both frequently found that our input on issues related to midwifery practice and the impact of funding policies and procedures on midwives' ability to safely and cost effectively deliver care within the model of practice was often neither appropriately respected, given our experience and knowledge, nor welcome.

344. I wrote a letter dated January 15, 1996 letter to Bonnie Heath at the OMP concerning amendments to ESA.[139] In this letter I reiterated the AOM position that the AOM did not support a move to the employment model unless an ESA exemption could be granted due to the extraordinary working conditions required of the midwifery model of practice. I expressed concern that an employment model could erode the midwifery model.

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138 Handwritten Notes of Meeting with Suzanne Klein, (December 8, 1995), AOM0011388.

139 Letter from Jane Kilthei, Chair, Funding Committee, AOM to Bonnie Heath, OMP, (January 15, 1996), MOH003888.

345. An April 4, 1995 meeting discussed developing a prototype employment contract based on the funding agreement to see what was possible.[140] At that time Bonnie Health informed us that she had spoken with Sue Davey about the AOM proposing a prototype employment contract that would parallel the Funding agreement.

346. The AOM obtained a legal opinion from Rick Salter and by letter dated May 15, 1995, I provided that opinion to Bonnie Heath which set out legal concerns about the employee model for midwifery. [141]

347. At the May 17, 1995 meeting of the Quality Committee, we continued to discuss the possibility of a prototype employment contract and what would happen if there was a transfer of the funding agreement to a local TPA. We were also concerned about having a process to address changes in the level of compensation of midwives and a process to address changes to the agreement. We discussed the pros and cons of an employee model for midwifery and our concerns about the implications of the Employment Standards Act provisions on the ability to carry out the model of care. Funding issues in Northern communities were also addressed. [142] [143]

348. Bonnie Health forwarded a letter dated July 11, 1995 from her to me and others re: an Employment Model Working Group meeting. The letter attached draft Terms of Reference for Employment Model Working Group to produce prototype employment agreement for TPAs to use.[144]

349. On July 19, 1995, the Employment Model Working Group met and discussed the AOM requirements for such a model and "List of Essentials" for protecting the model of care if midwives became employees. The list included issues such as a midwife's ability to choose her practice partners and manage her caseload including on-call schedule and client selection, length of visits, clinical protocols and her relationship with the Midwifery Education- Program in collaboration with those practice partners rather than those being dictated by an employer. Our

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140 Minutes for OMP Program Quality Committee, (April 4, 1995), AOM0009251.

141 Letter from Eileen Hutton and Jane Kilthei to Bonnie Heath OMP re: Concerns re: Potential Employment Model, (May 15, 1995), AOM0009302.

142 Minutes from OMP's Program Quality Committee Meeting re Employment Model for Midwives, Partial Courses of Care, Funding Details, (May 17, 1995), AOM0009256.

143 Minutes from Program Quality Committee Meeting, (November 22, 1994), AOM0009243; and Ontario Midwifery Program Program Quality Committee Agenda, for Wed. March 27, 1996 meeting, with notes from Jane Kilthei, (March 27, 1996), AOM0002848.

144 Draft Terms of Reference of OMP Employment Model Working Group, (July 6, 1995), AOM0009267.

concerns centered around maintaining the professional autonomy of midwives to carry out the model of care.[145]

350. I understand that in early 1997 the LMCO obtained a legal opinion from Filion Wakely. This opinion included liabilities under Ontario employment-related legislation including the Human Rights Code and the Pay Equity Act and an offer to prepare a Pay Equity Plan.

XXXVI. CHANGES IN MIDWIFERY WORK – 1994-1996

351. During this period, midwives as a group were establishing the infrastructure of a self-regulated profession despite insufficient support from the MOHLTC. Many midwives, in addition to doing all the listed tasks in their own practices, were deeply involved with the establishment of the education program, the self-regulating college that governed the profession and was tasked with protecting the public, and with the professional association as it developed new systems and tools to support the profession within the regulated health care system.

352. Midwives were also occupied with many different new responsibilities in their practices, hospitals and communities, many of which were not considered in the original Morton analysis. This included:

(a) setting up their group practices and administering them, both as businesses and as health care services that involved meeting together to coordinate care, ordering and following up on lab work and diagnostic testing, arranging and following up on medical consultations, ensuring clinic schedules were rebooked when they needed to be cancelled because of labours and births, etc.;

(b) learning and implementing the detailed CMO standards of practice, policies and guidelines;

(c) meeting continuing education requirements to ensure ongoing competency, including neonatal resuscitation and emergency skills courses; and

(d) preceptoring the students who were being educated as midwives in the new baccalaureate program and then mentoring the new graduates for one year post-graduation; and

(e) integrating into hospital practice, including meeting their obligations as hospital midwifery staff, and taking on administration and committee work in hospitals, at local District Health Councils, as well as in their professional association and regulatory college.

145 Minutes from OMP Program Quality Committee, Employment Model Working Group Meeting (July 19, 1995) AOM0009268.

353. By 1996, the new system was generally implemented. Ontario midwives were now carrying out their additional administrative and financial responsibilities required by regulation as well as their various practice and other supervisory responsibilities and were following CMO Standards, Policies and Guidelines as required.

354. The Ministry did not carry out any further pay equity evaluation of midwifery work either on its own or in relation to its CHC comparators, the Family Physician and Senior Primary Care Nurse/Nurse Practitioner, despite the fact that by 1996 much more was known about the actual skill, effort, responsibility and working conditions required of midwives to work effectively within the Ontario health care system.

355. Instead of considering whether an increase in compensation was required, the Ministry continued to deduct 4.4% from their pay past the Social Contract expiry date of March 31, 1996.

356. During the period 1994 to 1997, midwives continued their significant contributions to the development of midwifery services and primary health care in Ontario. The Durber report Annex 7 refers to the increasing value of their work, including their increasing supervisory and non-clinical responsibilities.

XXXVII. ONGOING EQUITY ISSUES IN THE 1990'S

1. Barriers, Prejudice and Stereotypes

357. Despite some progress, midwives continued to struggle, facing challenges such as:

(a) ongoing difficulties gaining access to hospital privileges in many communities with no recourse to appeal processes because the Ontario Hospitals Act had not been amended;

(b) Hospital Medical Advisory Committees limiting midwives' ability to work within their full scope of practice as provided for in legislation, regulation and standards of practice of the College of Midwives; and

(c) enduring marginalization, stereotyping and prejudice concerning the value of their work.

358. As an example of the prejudices at the start of regulation, was the common complaint by physicians that their compensation was lower than the midwives. This resulted from a fundamental misunderstanding and undervaluing of midwives work. Physicians would commonly equate what they were paid to deliver the baby, once they had been called by the nurse to attend when a labouring woman was ready to give birth and after the nurse had assessed, monitored and cared for the woman on the physician's behalf throughout her labour, and compare that to the entire course of care fee paid to midwives for

carrying out their responsibilities that included fulfilling both the role of the nurse and the physician in a more time-intensive model of care throughout a woman's entire pregnancy, during her labour and birth, and up to 6 weeks postpartum, including being on call 24/7 and caring for the newborn.

359. In the September 1994 issue of the Canadian Medical Journal a physician writing a letter to the editor, went so far as to claim for physicians: "if ever there was a claim for pay equity, this one fits the bill". I responded to this letter clarifying the responsibilities and compensation structure for midwives; the fact their work week was really 50-60 hours with being on call 24/7; referencing midwifery's excellent outcomes and indicating that midwives were looking to work collaboratively with the physicians in the new system. [146]

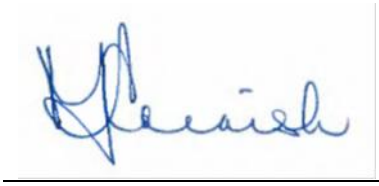
360. It was the responsibility of the OMP's Program Quality Committee to monitor and address these equity-related integration issues in addition to other matters such as compensation provided for in the Framework. Unfortunately under the leadership of Bonnie Heath the Committee did not take up this responsibility.

146 Letters to the Editor by Dr E. Dobkin and J. Kilthei in Canadian Medical Association Journal re: Cost of Midwifery:151(3), (September 1994), AOM0001769.

XXXVIII. APPOINTMENT AS CO-REGISTRAR, ONTARIO COLLEGE OF MIDWIVES – APRIL, 1996

361. In April 1996, I was appointed as Co-Registrar of the College of Midwives of Ontario.

SWORN this 28th day of July 2016.



A Commissioner for taking Affidavits.

Jane Kilthei