PRELIMINARY DRAFT OF SODERSTROM AFFIDAVIT JUNE 27 2016

HRTO FILE 2013-16149-I

HUMAN RIGHTS TRIBUNAL OF ONTARIO

ASSOCIATION OF ONTARIO MIDWIVES

Applicants

v.

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

Respondent

AFFIDAVIT OF BOBBI SODERSTROM

I, Bobbi Soderstrom of the City of Ottawa in the Province of Ontario, MAKE OATH AND AFFIRM as follows:

1. I am an Associate Professor Emeritus at the Ryerson University Midwifery Education Program, one of the initial leaders of the development of community midwifery in Ontario and worked for many years as the AOM Director of Insurance and Risk Management. I am also a complainant in this proceeding.

2. This affidavit sets out my examination in chief in this matter, subject to further oral examination at the hearing in this matter. My background, knowledge and experience on which I rely to support my statements in this affidavit are set out in my Curriculum Vitae[1] and summarized in Part I below.

1 Curriculum Vitae of Bobbi Soderstrom, AOM0016607.

I. BACKGROUND

1. Education And Knowledge

3. My educational and knowledge background is multi-dimensional, spanning a Bachelor of Arts degree (1968 –University of British Columbia); Masters degree in Library Science, (1971- McGill University) a Bachelor of Science Degree in Nursing (1985 – University of Ottawa), an apprenticeship in midwifery (1983) and an accredited Pre-Registration Programme in Midwifery (1993- Michener Institute of Applied Science).

2. University Professor, Scholar and Researcher

4. I have been involved since the late 1980’s in the development of midwifery education in Ontario both in terms of choosing the consortium, helping to design the curriculum of the Midwifery Education Program (MEP), and in being a

member of the teaching faculty of Ryerson University's MEP since 1993. From 1993 to 2007 I was an Assistant and then Associate Professor, teaching midwifery specific courses in the program.

5. I also created and ran the clinical Placement Program for MEP students for the three sites of the MEP at Ryerson, McMaster and Laurentian Universities.

6. I co-authored with McMaster MEP faculty member Karyn Kaufman, a chapter "Midwifery Education in Ontario – Its Origins, Operations and Impact on the Professions" which was cited by MOHLTC expert Richard Chaykowski in this proceeding.[2]

7. I am also very familiar with the roles and responsibilities which midwives in Ontario must undertake as preceptors as I was the lead developer of the Preceptor Program for midwives. This program is designed to educate and support clinical preceptors through workshops, newsletters, and individualized advice. Together with teaching and supervision of direct client contact, it also provides access to high quality teaching models for education using simulation.

8. As a researcher for the Midwifery Education Program, in 2007 I made written recommendations to the University Consortium regarding the experience and use of preceptors. In order to develop these recommendations I used an in person structured survey with preceptors during site visits to all midwifery practice groups in Ontario and identified areas for quality improvement and support.

9. Since 2007 I continue to provide annual guest lectures on professional liability and insurance to midwifery students of all three sites, McMaster, Ryerson, and Laurentian.

10. I have published extensively on topics relating to maternal health as reflected in my curriculum vitae. From 2003 to 2008 I was a Peer Reviewer for the Canadian Journal of Midwifery Research and Practice. In 1988, I received the College of Family Physicians of Canada Research Award. In 1998 I received the YWCA Woman of Distinction Award for Science and Technology.

3. Practising Midwife

11. I practised midwifery in Ontario for nearly 25 years before my retirement from active practice in 2007. From 1984 to 2007 I provided midwifery services first privately and then as a member of the Midwifery Group of Ottawa practice group. I continued administrative work as a business partner in the Midwifery Group of Ottawa until 2013.

---

2 K. Kaufman and B. Soderstrom, "Midwifery Education in Ontario: Its Origins, Operation, and Impact on the Profession" in IL Bourgeault et al, "Reconceiving Midwifery" (January 4, 2004) AOM0000611.

12. From 1994 to 2007 I acted as a preceptor for midwifery students in the practice providing hands on clinical teaching and mentorship. Prior to that time I offered apprenticeship placements for aspiring midwives.

4. AOM/CAM Leadership Roles

13. As a pre-regulation practising midwife I was very involved in the campaign to obtain recognition and funding for midwifery which had long been excluded from the recognized health care system.

14. I was a key leader of the Association of Ontario Midwives during the pre-regulation years when the government was establishing and funding midwifery as a new female dominated profession and starting the Ontario Midwifery Program. I was President-Elect from 1988-1990 and President from 1990-1992. I was succeeded by Jane Kilthei.

15. During the 1980's, I was heavily involved in setting up the self-regulating policies, practices and processes which the AOM established to govern midwifery pre-regulation.

16. I was also active in the AOM's leadership group which engaged with the Task Force on the Implementation of Midwifery in Ontario (TFIMO). The paper I co-authored with Gerd Schneider, "Analysis of 275 Planned Births and 10 Unplanned Births,(Can.Fam.Physician 33:1163-1171) is cited in the Task Force Bibliography. During the regulation process I was a member of a number of key committees, including the AOM Liaison Committee to the Interim Regulatory Council for Midwifery in Ontario (IRCM), the AOM Legislation Committee, the AOM Funding Committee and the AOM *Public Hospitals Act* Committee. As part of the AOM Liaison Committee, I advised the IRCM about evidence-based content for the setting of standards, policies, and guidelines that would govern midwives as legislation was enacted.

17. I have also been involved at times over the years since the late 1980's in the development and implementation of midwifery compensation and funding. This included contributing to the AOM's thinking about pre-regulation recommendations to the MOH . As well, from 1994 to 1997 I was a member of the AOM Benefits Committee. From 1998 to 1999 I worked on the AOM committee as a funding contract negotiator as we moved to implement devolution and negotiated a contract based on an independent contractor status to protect the model of care.

5. Midwifery and Maternal Newborn Care Policy and Practices

18. In my career I have been active in a number of midwifery and maternity care policy areas including the following:

(a) Childbirth Education

19. I founded the International Childbirth Education Association chapter in Ottawa in 1976 and was instrumental in making the first natural childbirth education classes available in the area over the period up to 1983.

(b) Improving Quality of Maternal and Newborn Care

20. I have been active in efforts to generally improve the quality of maternal care in Ontario since the 1980's as reflected in my curriculum vitae which has included working with physicians. My most recent work includes the following:

(a) I was an initial contributing author of the MORE^{OB} program and then appointed to the Society of Obstetrician and Gynecologists of Canada's (SOCG) Obstetrics Review Committee (2001 – 2010). As an author and appointed member of these two SOGC groups, I critiqued relevant literature and made recommendations for clinical practice guidelines, evidence supported clinical management and inter professional communications. The MORE^{OB} program is a collaborative emergency skills hospital-based program for physicians, midwives and nurses that focuses on communication and uses a high reliability organization approach.

(b) I have been a Member of Quality Advisory Committee at the Ottawa Birth and Wellness Centre since 2013.

(c) I was a Member of the Professional Advisory Board of the Perinatal Partnership Program of Eastern and Southeastern Ontario (1999– 2011) and then of the professional Advisory Group/Network of the Champlain Maternal Newborn Regional Program, of the Champlain Local Health Integration Network (2011 – present). The Network provides direction for programming, oversight for the budget, and recommendations for improvement of clinical services in the region. Its members are representatives of all the health care institutions and programs providing maternal/newborn services in the area.

(d) I was a member of the Expert Review Panel for the Scarborough Hospital Maternal Newborn and Women's Health and Surgical Models (2013). On this panel I reviewed prior consultations and reports, delegation presentations and written submissions from previous consultants, staff and the public in order to make recommendations regarding efficiencies and possible integration of services across sites.

(c) Breastfeeding

21. I have been active in promoting, delivering and researching breastfeeding services for women. I was an International Board Certified Lactation Consultant through the International Board of Lactation Consultant Examiners from 1986 to

2006. From 2009 to 2010, I was co-chair of the Ontario Provincial Council for Maternal and Child Health (PCMCH) Breastfeeding Services and Supports Work Group (BBS-WG). I contributed to the Group's report to the MOH which made evidence-supported, cost-effective recommendations for delivery of breastfeeding services to improve breastfeeding rates and duration in Ontario.

(d) Evaluation and Cost Effectiveness Comparisons

22. Through various roles at the AOM I have developed capacities around outcome evaluation and cost effectiveness comparisons of midwifery and maternal newborn care.

23. I was a member of the original team developing the first Ontario database for collecting perinatal data from all obstetrics providers and interpreting outcomes for the Eastern Ontario region.

24. I contributed to the work of BORN Ontario as a member of the Evaluation Team for the birth centre Pilot Projects. I have been on the evaluation team since 2013. In this role I have contributed to the development of the parameters and the process for outcome evaluation and cost effectiveness of the birth centres at the request of the MOHLTC.

6. Hospital Leadership, Integration and Interprofessional Collaboration

25. Over the course of my career I have guided and worked to improve the integration of midwifery into three different hospitals, working with nursing and physician colleagues and hospital administrators. In doing so, I have worked to promote inter professional collaboration particularly between midwives, physicians and nurses.

26. From 1994 to 1998 I was Head of the Division of Midwifery at the Riverside Hospital of Ottawa. This included advising the Hospital Board about the development of midwifery specific by-laws for the hospital. At the Riverside Hospital, I was responsible for credentialing the first midwifery staff in any Ottawa hospital. With positive leadership from the Physician Chief of Staff and the Chief of the Department of Obstetrics, midwifery was easily integrated as part of the professional team. For example, at a department meeting, one obstetrician was complaining that she did not like the way a midwife was doing something. The Chief of Obstetrics responded that midwives do things differently and as long as they are not unsafe, we need to respect that. At the Riverside Hospital I was also a member of the Quality Assurance Committee.

27. From 1998 to 2001 I was the Head of the Division of Midwifery at the Ottawa Hospital. I lead the integration of midwives into the Ottawa Hospital when the Riverside Hospital was forced to close as part of the provincial reorganization. I faced significant challenges with staff who were not yet receptive to having midwifery staff joining the professional staff ranks. At the Ottawa Hospital I was responsible for credentialing of midwifery staff, providing leadership to the team

of midwives, liaising with obstetrical nursing and physician staff, and responding to inter-professional as well as clinical problems within the unit relating to midwifery services.

28. As the head of the Montfort Hospital Division of Midwifery from 2005 – 2007 I again was called upon to provide leadership for midwifery integration. There I guided the midwives as we were moved for the third time. I continued to carry out the responsibilities, as noted above, of the Head Midwife.

7. Professional Liability Insurance and Risk Management

29. I have played a leading role for the AOM in securing and managing professional liability insurance and overseeing the handling of risk management issues for Ontario midwives.

30. As the AOM's lead insurance negotiator, I secured and negotiated the first professional liability insurance for non-regulated professional midwives in Canada (with Guarantee Company of Canada). I subsequently negotiated the professional liability insurance program for regulated midwives with ENCON which was arranged through Marsh and McLennan brokers. In 2001 I played an important role when insurance markets crashed to negotiate a professional insurance program for midwives in Canada with HIROC (Healthcare Insurance Reciprocal of Canada) and moved Ontario's midwifery insurance over to HIROC in 2003. I also facilitated the moving of insurance to HIROC in 2002 for the Alberta Association of Midwives.

31. From 1995 to 2007 I was the chair of the AOM's Insurance Committee and from 2002 to 2014 I was a member of the AOM/CMO/MEP Joint Risk Management Working Group. From 2007 to 2014 I was the AOM's Director of Insurance and Risk Management. Since 2014 I have worked as the AOM's Insurance and Claims Advisor. In these roles I have developed extensive knowledge concerning the scope of practice and work of Ontario's midwives and the risks issues that are faced by those doing maternal and newborn care in Ontario, including those faced by physician obstetrical providers. I have worked with professional staff at the Canadian Medical Protective Association to assist in the acceptance of midwifery staff by hospital obstetrical staff. I worked to develop the CMPA and HIROC Joint Statement on Liability Protection for Midwives and Physicians which clarified that each professional was liable only for their own professional care. [3]

32. At the national level, as Chair of the Canadian Association of Midwives' Insurance (Professional Liability) Committee (2003- 2009) I provided guidance to midwifery groups in varied jurisdictions. In this position I had a leadership role in helping other jurisdictions to determine their needs and facilitating them obtaining insurance. I drew on my experience with the AOM in brokering a relationship with

3 CMPA and HIROC on Joint Statement on Liability Protection for Midwives and Physicians.PDF (June 1, 2007) AOM0017399.

HIROC for CAM and a number of the provincial midwifery associations. During this time I provided access to risk management educational resources, presented at workshops and conferences about risk management and insurance programs for midwives and facilitated access for the midwives of one province to regularly obtain risk management advice, as well as assistance with the administration of their insurance policy. I am still an insurance and claims advisor from time to time to midwifery associations across Canada.

33. I have also delivered conference presentations internationally regarding insurance and risk management in midwifery and maternal and newborn-care practices.

34. In the course of my above-noted work, I have learned about the structure of physician insurance in Ontario and its development over the past thirty years. In the late 1980's I became aware of the responsibility of health care professionals to maintain fulsome malpractice insurance coverage in order to ensure adequate coverage for any client that may be injured during the course of care. I also learned of the necessity of all care providers to have malpractice coverage in order to reassure other professionals that they would not be carrying the financial burden should a midwife be negligent. Concern by physicians of their potential liability for midwives' actions was a potential impediment to integration of midwives. In 1986, I became aware of the insurance crisis that caused an increase in CMPA fees and the subsequent agreement of the Ministry to fund on an on-going basis physician insurance coverage to that level.

8. Feminist and Mother

35. My involvement in health care goes back to the 1970's when I became aware of the Boston Women's Health Collective and its efforts to assist women in our efforts to regain access to our own health care decision-making. I joined a women's group that met for self-study about our own bodies and to support each other in our efforts to return health decision-making to ourselves. I became an advocate in my own community for natural childbirth and home birth as being the best place for women to avoid the over-medicalization of childbirth and maintain choices in their childbearing. I was strongly influenced by Valmai Howe Elkins Rights of the Pregnant Parent, a Canadian classic.

36. As a new parent in 1973, I volunteered at a street clinic while breastfeeding my child. Pregnant women asked me how I prepared for natural birth and breastfeeding and this lead to my initiating the founding of the Ottawa Childbirth Education Association. Street clinics were a precursor to Ontario's Community Health Centres.

II. GENDERED DISADVANTAGES EXPERIENCED BY PRE-REGULATION ALMOST EXCLUSIVELY FEMALE MIDWIVES

1. The Role of Gender

37. In Ontario's 1980's health care system, I observed that physicians were predominantly male, particularly those who provided maternity, obstetrical and newborn care – namely obstetricians, family physicians, and pediatricians. When I had my children in 1973 and 1975, I was not aware of any female obstetricians and family physicians who attended births in Ottawa.

38. Community midwives were with one exception female and provided care for women for the experience of pregnancy and birth and advocate on their behalf and on behalf of the newborn child.I experienced the health care system as very hierarchical and authoritarian, particularly in hospitals where male dominated physicians had great power and influence.

2. Prejudices, Stereotypes and Barriers

39. For my own first birth, I was attended by an obstetrician who was British trained by midwives and did not object to my request for a natural birth. I had been unsuccessful in finding someone to attend at a home birth. I was required however to deliver on a delivery table and when it came time for birth, he told me I would do it on my side and he told me it had to be my left side. This was my first personal experience of the rigidity and authoritarianism of the medical approach to childbirth, even with a doctor who said he embraced natural birth.

40. After I became a midwife, I went to nursing school and discovered that there was prejudice amongst the nursing professors about my role as a midwife. I received no accommodation when I needed to miss a class to attend a birth. In my elective term I chose to go to the obstetrics department of a local hospital and I was told to avoid a certain hospital as the head nurse had complained about my work as a midwife there. I ended up doing my elective at another hospital obstetric department.

41. I took a nursing degree in part in order to be able to talk the same language as other health care providers.

42. During this time, I worked on developing skills of diplomacy in order to navigate the often negative views about midwives held by other health professionals.

III. DEVELOPMENT AND ENHANCEMENTS TO ONTARIO MIDWIFERY EDUCATION SYSTEM

1. Introduction

43. I was a key contributor to the development of this midwifery education system and continue to be a guest lecturer for the MEP regarding professional liability and insurance.

44. I co-authored a chapter, "Midwifery Education in Ontario: Its Origins, Operation, and Impact on the Profession" for the 2004 book "Reconceiving Midwifery" edited by Professor Ivy Bourgeault et al.[4] This Chapter reflects on the key events in the Ontario government and university policy-making process that led to Ontario's baccalaureate professional degree Midwifery Education Program, and describes the structure and curriculum of the program and analyzes the impact of the midwifery education system and considerations for its future development.

45. Developing an education system for new midwives and a credentialing system for existing midwives was one of the first tasks of the Ontario Ministry of Colleges and Universities, after the decision to regulate midwifery in 1986 and the issuance of the 1987 Task Force Report on the Implementation of Midwifery in Ontario (TFIMO).[5]

46. The 1987 Task Force's review of international midwifery education had concluded that key elements for a successful midwifery program included whether midwives had an integrated role in the health care system and financial support for the educational program.

2. The Curriculum Design Committee

47. In the 1980s the closest approximations to formal midwifery preparation were advanced obstetrical training courses in Alberta and the outpost nursing programs in Newfoundland and Nova Scotia. Yet many of the so-called "lay" midwives, such as myself, had extensive university backgrounds and had devised intensive self-study and skill development opportunities. For example, I had learned midwifery through studying extensive midwifery, scientific and obstetrical materials and through an informal apprenticeship to two local family physicians who were attending home births.

48. Within the Ministry of Health the Women's Health Bureau was tasked with creating an implementation strategy for integrating midwives into the health care system and that included working with the Ministry of Colleges and Universities

---

4 Book chapter by K. Kaufman and B. Soderstrom re. midwifery education in Ontario in book by I. Bourgeault (April 1, 2004) AOM0007189.

5 Report of the Task Force on the Implementation of Midwifery in Ontario (TFIMO) (1987) AOM0013549.

to develop an education system. There were conflicting opinions of midwives, consumers and government representatives about the TFIMO recommendation to have midwifery education at a baccalaureate level. The tension revolved around the need to provide a high level but accessible education system while also being accepted as well trained colleagues by other health professionals and ensuring the midwifery model was not unduly medicalized.

49. In order to make a decision the Women's Health Bureau appointed a Curriculum Design Committee in May 1989 with 12 members including consumers, midwives, physicians and nurses.

50. The Curriculum Committee's 1990 report recommended a baccalaureate Midwifery Education Program (MEP) but with the four year program compressed into three years.[6] The three year compressed model with no breaks in the summer was intended to provide students with a greater opportunity for clinical experience consistent with the continuity of care model of practice. As most MEP students would be women with young children, a shorter program was ideal. It later turned out that such a program was too intensive and stressful and it was changed to a four year program.

51. In 1991 a call for proposals was made by the Ontario Government to Ontario universities for the establishment of a baccalaureate program in midwifery.

3. The MEP University Consortium and Programme

52. I was on the external review panel appointed to make a recommendation regarding the program site for the MEP. We recommended that the Ryerson, McMaster and Laurentian consortium be awarded the program based on the ability of all three Universities to contribute to the MEP's objectives, including an interdisciplinary approach to health science education, a French language program, distance education, dedicated admission for Aboriginal students and a part-time option.

53. The MEP consortium has shared a curriculum and management structure since 1993 until present. Each of the three faculties admits its own students. But the faculty has worked together over the years to maintain a similar curriculum with the same core competencies. The biological and social science faculty of each University contribute to these foundation courses and the midwifery faculty organize and teach the applied midwifery courses.[7] There is some cross-over depending on the university. In the beginning, students from all 3 universities shared many of the courses and were in distance classes together. More recently there are fewer courses that are shared among the 3 sites.

---

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

7 Ryerson Website re: Midwifery Education Program (2016) AOM0005294.

54. Entrance to the MEP has always been very competitive. At the time of writing the Chapter in 2003, the ratio of applicants to available places has varied from 8:1 to 4:1 and on average about 20 per cent of the entrants have prior nursing preparation and about 50 per cent have a prior degree in arts or science.[8]

55. In late 1992, the consortium of these three universities was announced and the program started in August, 1993 with faculty hired earlier in 1993 to be ready for the start of the program. I was hired as a member of the MEP faculty at Ryerson.

4. MEP Curriculum

56. The MEP curriculum was designed to ensure that the established academic and experiential clinical knowledge of practising midwives was embedded into the academic coursework and clinical aspects of the MEP, as recommended by the IRCM Models of Practice and Payment Committee.[9] As a result, the faculty which taught the midwifery courses were required to be practising midwives to continue to embed this ongoing clinical knowledge in the MEP system. As almost every faculty member is a member of an Ontario practice group, faculty were grounded in the reality and practicality of midwifery practice and practitioners were able to benefit from the most current academic knowledge and research endeavours of faculty.

57. Once students were admitted and programs were underway, I assisted in creating and facilitating the clinical placement program for students from all three sites and a preceptor program for all clinical instructors. With midwifery faculty being practising midwives, the ongoing expansion and enhancement of academic and clinical knowledge of midwifery is embedded in the curriculum.

58. The MEP curriculum provides an appropriate balance of the sciences and social sciences, integrating both academic and clinical through the program. Approximately 70% of the program involves clinical placements, with about one half of those placements occurring in an inter professional, international, rural/remote, and/or research and policy context. [10]

59. The MEP program is a very challenging professional degree both in terms of the course work, fourth year independent study paper and extensive clinical placements.[11] Students spend six of nine academic terms in clinical placements,

---

8 K. Kaufman and B. Soderstrom, "Midwifery Education in Ontario: Its Origins, Operation, and Impact on the Profession" in IL Bourgeault et al, "Reconceiving Midwifery" (2004-04-01) AOM0000611 at page 195.

9 Report and Recommendations to the IRCM By The Models of Practice and Payment Committee (MOPP), June 19, 1992, AOM0006518, at recommendation 25.

10 For ex: Ryerson Website re: Midwifery Education Program AOM0005294; see also Ryerson MEP Course Calendar 2013-2014 (2014) AOM0001141.

11 For ex: Ryerson Website re: Midwifery Education Program AOM0005294; see also Ryerson MEP Course Calendar 2013-2014 (2014) AOM0001141.

and the other three terms have a heavy concentration of courses in sciences, social sciences, women's studies and research fundamentals. During clinical placements, the student must be available for all antenatal and postnatal visits and is on-call with the midwife preceptor for all labours.[12] At the same time, students on clinical placements continue to engage in academic coursework.

60. Students are assigned to a midwifery practice for the clinical component. Midwives across the province act as preceptors for the students in their clinical rotations. Students are also required to be on call at some other times during their studies.

61. There is a significant emotional and financial cost to the way clinical placements are arranged. Preceptors do not choose their students, nor do students choose their preceptors. Student placements are assigned through a lottery system that takes account of but cannot guarantee personal choice of geographic location. Students who must relocate to a community that is not of their choosing find this very stressful, particularly those who have young families.[13]

62. As midwifery has grown so rapidly there is an ever present demand for preceptors. Almost all practicing midwives throughout the province who have a minimum of one to two years of experience participate in the clinical teaching of students. The preceptor program provides training and support on how to be an effective teacher and supervisor. The demands of the preceptor role are quite extensive on midwives.

63. In light of the importance of the clinical aspect of the midwifery education, a New Registrant continuing education year was included in the year following the completion of the MEP. This year of “mentored” practice, is similar in many respects to the first year of family physician’s residency, happening within an established midwifery group practice where the New Registrant continues to consolidate her knowledge, skills, and confidence while being mentored by a practising midwife.[14] Both a New Registrant and Family Practice first year resident are registered professionals who work in an established practice under the mentorship of an experienced practitioner.

64. Mentoring New Registrants for a year is also demanding on the practising midwives who must carry out this role. My practice group had formal mentoring guidelines to ensure that the New Registrant always had a senior midwife

12 K. Kaufman and B. Soderstrom, "Midwifery Education in Ontario: Its Origins, Operation, and Impact on the Profession" in IL Bourgeault et al, "Reconceiving Midwifery" (2004-04-01) AOM0000611.

13 K. Kaufman and B. Soderstrom, "Midwifery Education in Ontario: Its Origins, Operation, and Impact on the Profession" in IL Bourgeault et al, "Reconceiving Midwifery" (2004-04-01) AOM0000611.

14 CMO Guidelines to the New Registrants Policy Revised November 2006 (December 1, 2006), AOM0015843.

available as needed. As well, every New Registrant was orientated to the practice and the Hospital. They were also observed concerning their appointments and births. In addition, there are requirements to meet set out by the College of Midwives of Ontario in the New Registrant year which must be met in order to continue to practice. For example all New Registrants must attend a minimum of a certain number of births as a primary midwife and a certain number as a second midwife. New Registrants who enter registration via the IMPP program (internationally trained midwives) must undergo a certain amount of special supervision and demonstration of skills under the mentorship of an experienced midwife and under a contract issued by the CMO before their New Registrant year is complete.

5. The Midwifery Integration Planning Project (MIPP)

65. The Ontario Government established the Midwifery Integration Planning Project (MIPP) to develop an integration process for existing midwives to become a part of the regulated midwifery system. The Project reported in 1991 and led to the below-noted development of the Michener Institute of Applied Health Science Pre-Registration program for eligible practicing midwives seeking registration under the new legislation.[15]

66. The Michener Institute of Applied Health Sciences Pre-Registration Program Curriculum was developed in 1991 and set out the extensive requirements of the Program.[16] 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, and other sciences. This one year Program began in the fall of 1992 with an extensive assessment done of applicants and an intense academic and clinical focus including an evaluation of each midwife's clinical practice by the international experts. I am a graduate of the Michener Institute for Applied Health Sciences Pre-Registration Program (1993).

6. Enhancements to the MEP

67. In 1996 following the external evaluation review by international midwifery experts, Lesley Page and Diony Young, which noted the intensity and financial burden of a program with no breaks, the MEP was restructured from three calendar years to four academic years.[17] The same review also resulted in an

---

15 Core Competencies: A Foundation for Midwifery Education - Recommendations of the MIPP to the IRCM, published by the Transitional Council of the College of Midwives (1993-03-01) AOM0009979.

16 The Michener Institute Pre-Registration Program for Midwifery - Course Outline. (1992/01/01.) AOM0014314.

17 External Review Report of the Midwifery Education Programme (MEP) by Diony Young (USA) and Lesley Page (UK) . 1996/07/15. AOM0001129.

increase in the biological science content and options in the social science and health science offerings.

68. There were further MEP evaluations (including in 2002, 2007 and 2012) which all confirmed the high quality of the program.[18]

69. Over the period from 1994 until now, I have observed the increasing demands of the MEP. The curriculum has been adjusted to include additional academic and clinical teachings as newer technologies and additional knowledge and skills are required by midwives, such as knowledge to prescribe additional pharmacologic agents and the skill of newborn intubation.

IV. DEVELOPMENT OF THE MIDWIFERY REGULATION SYSTEM

70. Following on the 1987 TFIMO Report, the Ministry of Health, under the leadership of its Women's Health Bureau moved to develop a regulatory and program system for integrating the profession of midwifery into the established health care system.

71. As a practising community midwife since 1983 and AOM leader, I played a key role in developing the regulated model of care and regulation system, drawing upon the established community midwifery model of care and peer review self-regulatory system.

1. The Model of Care and Interim Regulatory Council on Midwifery (IRCM)

72. A 13 member Interim Regulatory Council on Midwifery (IRCM) was appointed by Order in Council in June, 1989 to prepare this system and the future statutory College of Midwives.[19] I was an active member of the AOM's Liaison Committee to this Council. Working with the model of practice developed by pre-regulation midwives, including myself, the IRCM developed the midwifery philosophy of practice.[20] This model of practice focused on putting women and their needs at the centre of their health care in contrast to the traditional authoritarian medical-led model, which had pathologized birth.

---

18 Excerpts from 2012 MEP Program Review (2012), AOM0001131; Excerpts from 2007 MEP Program Review re: Ryerson MEP AOM0001130; Midwifery Education Programme, Report of the External Review, March, 2002, AOM0017422.

19 Interim Regulatory Council for Midwifery, Meeting Minutes, August 22, 1989, AOM0002334 at page 2.

20 IRCM Philosophy of care included in Preliminary Report by AOM re: Funding of Midwifery Services attaching Document by Interim Regulatory Council on Midwifery re: Philosophy of Midwfery Care in Ontario (1992) AOM0002336.

73. While the intended client of a midwife is a woman expecting a "normal" pregnancy and birth, "normal" does not mean "simple". Each individual presents a unique psycho-social profile that contributes to their health and maternity care needs and which must be addressed by the midwife. As well, midwives must respond to difficulties which may occur during care, such as a decline in maternal physical or mental health, increased risk for intimate partner abuse and violence, or an emergency during pregnancy or childbirth for the mother or newborn. Therefore, midwifery education needs to include material which prepares midwives to address these multiple circumstances. This includes the complexities of obstetrics in order to recognize when something falls outside of normal and be able to stabilize the client during an emergency.

V. ESTABLISHING THE FUNDING AND COMPENSATION OF MIDWIFERY

1. Approach to Midwifery Compensation and Funding

74. Starting in the 1980's with the TFIMO Report and the IRCM Models of Payment and Practice report referred to below, there was a recognition that:

(a) midwives were a vulnerable highly female profession that now needed to be integrated into the funded health care system after years of exclusion; and

(b) that this would require developing a process to place the compensation of midwives equitably in that system between nurses and doctors and

(c) providing options for full time and part time work.

75. In June, 1992, the IRCM provided its Report and Recommendations of the Models of Payment and Practice Committee[21]—to the MOH Women's Health Bureau. The report contained a series of recommendations and statements of principle that were aimed at ensuring the models of payment and practice were designed to support and enhance the midwifery model of practice and embody that model in regulatory form.[22]

76. In December, 1992, Minister of Health Frances Lankin announced that the Ontario government was committed to managing and funding midwifery services. The Ministry accepted the recommendation of the Task Force and the IRCM to reject the fee-for-service system used to compensate physicians in favour of a course-of-care fee that encouraged continuity of care and taking time with women during their pregnancy, birth and postpartum, so that women could make properly informed choices about that care.

---

21 Report and Recommendations to the IRCM By The Models of Practice and Payment Committee (MOPP) . (June 19, 1992) AOM0006518 at page14.

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

2. The 1993 Midwifery Funding Work Group and the Morton Report

77. I was a member of the AOM's Funding Committee along with Jane Kilthei, Vicki Van Wagner and Carol Cameron. As a result, I was involved in the AOM discussions which led to the MOH establishing a joint Midwifery Funding Work Group in April, 1993. The purpose of this Group was to work with the Government on creating a framework for the funding and compensation of midwifery services. This led ultimately to the issuance by the MOH of the September 1993 Ontario Midwifery Program Framework. [23]

78. I recall being interviewed regarding the appropriate level of compensation for midwives. I advised the interviewer, who I believe to have been Mr. Morton that an appropriate compensation for midwives would be between a senior nurse and a family physician, considering the work level that I and my partners worked at in our practice group.

79. I also understood that the Joint Funding Work Group was carrying out a pay equity exercise which we hoped would arrive at a determination of the equitable compensation for our newly regulated midwifery profession.

80. In the October 23, 1993 voting materials for AOM members developed by Jane Kilthei and Eileen Hutton to explain the process leading up to the development of the Program Framework and the setting of the funding and compensation terms they referred to the work with Mr. Morton as a "pay equity exercise." [24] The document stated:

> *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 working in the Community Health Centres in the areas of skill, effort, responsibility and working conditions."*[25]

81. This reflects my understanding and memory of the work of the Funding Work Group.

---

23 Ontario Midwifery Funding Framework (developed by the Midwifery Funding Work Group) (Sept 1993) AOM0000579.

24 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. 1993/10/23. AOM0001094.

25 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. 1993/10/23. AOM0001094. at page 3 of package.

VI. HOSPITAL INTEGRATION ISSUES

82. Throughout my career I have been deeply involved in the ongoing process of trying to integrate midwives into the health care system and particularly into Ontario's hospitals.

1. 1993 Amendments to the *Public Hospitals Act* regulations

83. A Steering Committee to carry out a *Public Hospital's Act ("PHA")* Review was struck in 1990. Among its various proposals, the Committee recommended granting midwives "clear privileges for normal labour admission."[26] The Steering Committee reviewing the *PHA* issued its final report in February 1992 broadly recommending "*The Public Hospitals Act* should provide 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.[27]

84. In 1993, the regulations of the *Public Hospitals Act ("PHA")* were amended to permit such privileges.[28] As a result, one of the significant discriminatory barriers facing midwives was removed: they were now allowed to independently admit, discharge and write orders in hospital both on an outpatient and inpatient basis. This opened up the way for midwives to be able to conduct hospital births in addition to home births. Facilitating hospital midwifery care allowed midwives to fully provide care within their scope of practice and facilitated independent admission of women who chose to give birth under midwifery care in a hospital setting.

2. Unsuccessful Proposals to amend the *Public Hospitals Act*

85. When attempts to amend the *PHA* failed, the Ontario Hospital Association, with input from the AOM and others, developed a set of draft by-laws that hospitals could use to amend their own by-laws in order to accommodate integration of midwives onto the medical staff.[29] But this set of by-laws could never substitute for a comprehensive revision of the hospital system as could be done by rewriting the *PHA*. With only the recommendations for possible adoption of the PHA by-laws, there remained an ongoing integration barrier for midwives. Since that time, the Ontario Hospital Association, with input from the AOM, developed a

---

26 IRCM Meeting Minutes, January 12, 1990 AOM0002354.

27 Into the 21st Century- Report of the Steering Committee, Public Hospitals Act Review.pdf Executive Summary, at page 20 (February, 1992) AOM0017406.

28 R.R.O. 1990, Reg. 965: HOSPITAL MANAGEMENT, AOM0015485.

29 Ontario Hospital Association, "Midwifery: the integration of midwifery services into hospitals" (1994) AOM0016578.

second, revised set of bylaws which various hospitals adopted to facilitate the further, better integration of midwifery.[30][31]

3. Other Integration Issues

86. Midwives are often excluded from decision-making relevant to their practice, including when they must consult or transfer care. Often a physician department (e.g. Department of Obstetrics) will rule that midwives must transfer client care to the physician when that care is clearly within the midwife's scope of practice. Like most hospitals, my three hospitals did have a Head Midwife (of a Division) but not a Chief of Midwifery (i.e. of a Department). This is in contrast to having a Physician Chief of Obstetrics or a Physician Chief of Family Medicine. In most hospitals, the Head Midwife is "under" the Chief of the department who is a physician.

87. While Chiefs are typically paid positions, most Midwifery Chiefs or Head Midwives are not paid by either the hospital or the OMP although it is possible to submit a Caseload Variable request for some of this work. I received a small honorarium at one of the hospitals and was able to submit a claim for caseload variables for a small portion of the work that was required. Adding to the feeling of discrimination, the hospitals were not consistent in offering an office or access to support staff services for the Head Midwife.

88. As Head Midwife I had significant responsibilities regarding quality midwifery care and inter-professional relations. Yet the position was not acknowledged in the same way as the position of the physician chiefs. Besides feeling discriminated against in regards to remuneration and hierarchical power, I felt further marginalized in not being provided with an office or access to support staff services.

VII. CHANGES TO MIDWIFERY WORK SINCE 1994

1. Increased Skill Effort Responsibility and Working Conditions

89. Over the period since 1994, the College of Midwives of Ontario has expanded the scope of practice and requirements for midwives. Further, the MOH imposed additional requirements. Other changes drove increases in work during this period, including certain advanced technologies which became the norm in maternity and newborn care. Some examples of changes added to midwives'

30 Resource Manual for Sustaining Quality Midwifery Services in Hospitals (September 28, 2010) MOH022414.

31 Ontario Hospital Association, Hospital Prototype Corporate By-law (February 2010) AOM0017403.

work include: routine hearing testing of newborns, use of CPAP equipment, vacuum delivery (even if only assisting), increased administrative reporting. .

90. As part of the inter-disciplinary care team, midwives play an important part when an emergency occurs. Midwives need to play an even stronger role in more rural and remote communities where resources are slim. So midwives are called upon to do surgical assist which requires special training and regular experience. And in some remote communities midwives must be part of a call group together with physicians, to be on call to care for both physicians' and midwives' clients.

91. These changes resulted in requirements for increased skill, responsibility, as well as more effort and more time. I experienced this personally in my own practice and also observed it as the head midwife in various Ottawa Hospitals, in my capacity as university midwifery professor and also as a partner in my midwifery practice group.

2. Increased Pharmacopeia

92. In 2003, midwives were now authorized to prescribe the medication Carboprost for the treatment of post partum hemorrhage.

93. Further medication additions were added in February of 2010, when I was the AOM Director of Insurance and Risk Management. To add new medications to our practice, midwives were required by the CMO to complete a learning module and to pass an exam prior to being able to prescribe and use these drugs. New drugs added were: Intravenous antibiotics for intrapartum prophylaxis for clients screening positive for vaginal/rectal Group B Streptococcus, oral antibiotics for the treatment of Urinary Tract Infections (UTIs) and asymptomatic bacteriuria, Mastitis and Bacterial Vaginosis; Non-steroidal anti-inflammatory (NSAIDs) drugs for the treatment of post partum pain (Diclofenac, Naproxen); 2 additional antihemorrhagic and oxytocic drugs (Carbetocin, Misoprostol); two additional local anesthetics for perineal infiltration and repair (Bupivacaine, Chloroprocaine); Domperidone for milk supply issues; certain vaccines (Measles/Mumps/Rubella and Varicella Zoster Immune Globulin).[32]

94. While these changes are a welcome addition to the role of midwives as they contribute to better client care, they do add to the work and must be considered in the equitable compensation of midwives as midwives are providing more services for their clients.

3. Additional CMO Practice Guidelines

95. The CMO requirements for six different practice protocols (care during pregnancy, care during labour and birth, care during postpartum, emergency

32 CMO Guidelines; 2010-02-10 - CMO Guidelines - Standard on Certification for Prescribing and or Administering Drugs Designated in the Regulation.pdf (February 10, 2010) AOM0015406.

situations, death and bereavement, conditions for safe practice) (2006)[33] The requirement for these practice protocols and the necessity to complete the very detailed CMO's Practice Assessment Workbook are examples of the added burden of professional work required by the CMO for continued registration.

4. First Assist at Caesarean Sections

96. In 2007, midwives were authorized to obtain certification allowing them to act in the role of surgical first assist at caesarean section. Studying and confirming the knowledge and additional skills takes time. Midwives are happy to contribute in their communities by taking the place of a second physician at cesarean deliveries both of their own clients and of physician clients as they do in some communities but the time and skill needed should be considered in compensation. Currently, most midwives provide this service for free.

5. Taking blood samples from fathers or donors

97. In 2009, midwives were authorized to take blood samples from fathers or donors for the purpose of tests that might impact the pregnancy. Again the time needed to counsel and perform these tests should be acknowledged.

6. Communicating a Diagnosis

98. In 2009, the Midwifery Act was amended to reflect that midwives needed to be authorized to not only assess but also communicate a diagnosis identifying, as the cause of a woman's or newborn's symptoms, a disease or disorder that may be identified from the results of a laboratory or other test or investigation that a member is authorized to order or perform on a woman or a newborn during pregnancy, labour and delivery and for up to six weeks post-partum.

7. Putting an instrument, hand or finger beyond the anal verge (2009)

99. This additional authorized act was required because midwives may need to assess whether or not a fourth degree tear has occurred during birth. It also allows the midwife to administer suppository drugs as appropriate beyond the anal verge.[34]

8. Revised CMO Consultation and Transfer of Care Standard

100. In 2015, an updated "Consultation and Transfer of Care" replaced the 1999 CMO Standard.[35] In keeping with the midwifery scope of knowledge and care, midwives were no longer required to transfer care or perform a consultation with

---

33 CMO Policy on Practice Protocols Revised October 2006 (October 13, 2006) AOM0015798.

34 Midwifery Act, 1991, S.O. 1991, c. 31 (prior to amendment on August 31, 2011) (December 15, 2009) AOM0017408.

35 CMO Standard: Consultation and Transfer of Care (May 28, 2014) AOM0015947.

a physician for certain conditions and circumstances such as maternal age less than 14, pregnancy beyond 42 completed weeks' gestation, cephalhematoma in a newborn or a newborn with greater than 10% weight loss. These changes enable midwives to use their clinical judgment to determine when to consult or transfer care when a condition has not responded to midwifery intervention or therapy, increasing the responsibility of the midwife and reducing the workload of consultants.

9. Quality Assurance Program Practice Assessment Workbook

101. In 2015, the CMO introduced a new Quality Assurance Program Practice Assessment (PAW) Workbook and process.

102. Midwives also have an ongoing obligation to ensure their midwifery practice is assessed and kept up to date as per the PAW.[36] This takes considerable administrative and communication time.

10. Intubation of Newborns

103. In 2015, midwives were now authorized to intubate newborns beyond the larynx and to perform umbilical vein catheterization of the newborn when required for a neonatal resuscitation. Midwives must add the time it takes to learn and practice in order to stay current with these skills to their regular emergency skills practice since the actual skill is, thankfully, not frequently required, but is somewhat complex.

11. Requirement for Providing Electronic Data

104. The requirement for midwives to provide the Ministry with detailed course of care data added to the work of midwives. Particularly with the introduction of BORN data requirements in 2012, midwives are required to input substantial data about the client's health, pregnancy, labour and birth, postpartum and newborn before they are paid for each course of care. Increasing Needs of Clients

105. Similar to the witness statements CHC physicians filed by the MOHLTC in this proceeding, midwifery clients also come from complex populations, including refugees, those in poverty or with different religious perspectives, or clients who are LGBTQ, racialized or with disabilities.

---

36 CMO Quality Assurance Program 2015 Practice Assessment Workbook Policies, Procedures and Guidelines (2015) AOM0015943; CMO Practice Assessment Workbook (2014) AOM0015944, CMO Record-keeping Checklist and Chart Audit Tool (2015) AOM0015492; CMO Guidelines; 2014-07-01 - CMO Guidelines - Essential Equipment, Supplies and Medications.pdf (July 1, 2014) AOM0015446.

12. Increased Complexity and Responsibility of Running a Practice

106. Over time, the responsibilities of running a business have escalated considerably from the time of the Morton report when a question mark (?) was put under administrative responsibilities for midwives. While midwives had in fact run practice groups before regulation, the MOHLTC and regulation requirements since that time substantially increased the work of midwives. This increased work included supervising non midwifery staff members, complying with workplace and municipal legislation requirements, and administrative responsibilities in relation to the TPA and MOHLTC, including the requirements and stresses of budget submissions and tracking complex finances.

13. Preceptoring and Mentoring

107. Preceptoring and mentoring were not included in the Entry Based Competencies which were the foundation of the Morton report.

108. Midwives must take the work of precepting students or mentoring new registrants very seriously. These emerging and new practitioners must have the time they need to be supervised by experienced practitioners in order to become competent and confident members of the health care team. Preceptors and mentors must take the time to plan instruction and/or interaction, supervision and feedback and evaluation in order to do a credible job. Some caseload variables are available for mentoring and some remuneration is provided for precepting students but the reality of time and stress surpasses the compensation provided to date. This compensation has not changed since the beginning of the MEP.

VIII. PROFESSIONAL LIABILITY INSURANCE AND RISK MANAGEMENT

1. Introduction

109. As set out in Part I above, I have extensive knowledge of insurance management in midwifery since prior to regulation.

110. I have acted in a variety of professional roles through which I have become very familiar with the structure and operation of professional liability insurance and risk management for not only midwives but also for physicians. In my time working with the Association of Ontario Midwives, I have served as the Director, Insurance and Risk Management, Insurance and Claims Advisor, a Member of the Ontario Midwifery Joint Risk Management Working Group, a Funding Contract Negotiator, and an insurance negotiator. I acted as the Chair of the Insurance (Professional Liability) Committee for the Canadian Association of Midwives, and I still act as an advisor to other provinces and I presently sit on the Obstetrics Project Advisory Group of the CMPA.

2. Obtaining Liability Insurance For Midwives

111. I worked on locating and securing professional liability insurance for Ontario midwives both pre-regulation and post regulation.

112. The TFIMO Report recommended that all midwives must have professional liability insurance. Such a requirement subsequently became part of the College of Midwives' requirements. The Task Force Report provided the following rationale for requiring all midwives to carry liability insurance:

> *Professional liability insurance is necessary to protect midwives and their clients against the consequences of mistakes made in the provision of care. Unfortunately, the integration of midwifery into the health care system comes at a time when the availability of professional liability insurance is restricted and premiums are high. The Task Force nevertheless believes that liability insurance should be mandatory for practising midwives; without it, midwives cannot be fully responsible for their actions, physicians will be reluctant to cooperate with them, and hospitals will not grant them staff privileges. Midwives employed by hospitals and other institutions will be covered by their employers' insurance, but those in private practice will have to purchase individual policies. Midwives should take steps through their professional association to develop a self-financed insurance program.*[37]

113. The AOM was well aware of the need for liability insurance and had made a submission to the TFIMO on the need for such insurance in order to help integrate midwives into the health care system.

114. Subsequent to the TFIMO report, I took the lead in securing liability insurance for practising midwives in 1990 through Guarantee Company of Canada. To start we secured one million dollars of coverage per occurrence. A different policy was then created to cover midwives upon regulation.

115. The issue of professional liability insurance for midwives once regulation occurred was addressed by the Interim Regulatory Council of Midwives. The IRCM recognized the importance of sufficient insurance coverage and the need for sustained commitment to covering the costs on the part of the Ministry. Having insurance removed a significant barrier that midwives had faced in the integration process. This was also recommended by Models of Practice and Payment Committee, Interim Regulatory council on Midwifery in June 1992: (the following is from their report):[38]

---

37 Task Force Report on the Implementation of Midwifery in Ontario, 1987, AOM0013549 at pg 14.

38 Report and Recommendations to the IRCM By The Models of Practice and Payment Committee (MOPP) . (June 19, 1992) AOM0006518 at page13.

It is important for both the consumer and the midwife that all midwives be covered by liability insurance for all settings and that the midwife should be named as the insured.

Liability, perceived or real, will influence the granting of admitting privileges to hospitals and birth centres and may influence the relationship that CHC's or any prospective employer may wish to have with midwives.

A strong system of individual liability insurance is the best answer to any concerns hospitals may have about their indirect liability for actions taken by midwives who hold privileges in their institutions.

We recommend that all midwives be covered by liability insurance for all settings and the midwife should be named as the insured. (Rec. #21)

116. The first insurer as of January 1, 1994 was ENCON with Marsh & McLennan, later Marsh Canada, as the broker.

117. As a result of many years providing insurance advice to the AOM I have a thorough understanding on how insurance works for midwives.

(a) The professional liability insurance for midwives is managed through the AOM with funding for the insurance premium provided by the Ministry.

(b) The AOM provides to the Ontario Midwifery Program (OMP) a count of the number of midwives expected to be practicing in the following insurance year and the cost per midwife for budgeting purposes. The OMP reports back to the AOM once the funds have been approved within the Ministry.

(c) At renewal time and for each new midwife, the premium invoice for the individual midwife is sent by the insurer to the AOM. The AOM forwards these invoices to the Midwifery Practice groups who then forward the invoices to the TPA with a request for the funds to be deposited into the practice group's account. The practice group sends the amount to the AOM who collects all the remittances and forwards at annual premium renewal time a single payment to the insurer.

118. As of 1994, the Association of Ontario Midwives has administered a midwifery professional liability insurance policy. Each midwife has a certificate under the AOM's policy. Until 2003 this policy was brokered by Marsh Canada and underwritten by ENCON Insurance Managers Ltd.

119. Liability insurance is not a benefit (part of a compensation package) paid to midwives, but it is a benefit to clients and a benefit to the system. Furthermore, the Ministry started characterizing the Ministry's payment of midwives' liability insurance premiums as part of compensation only when they saw the conclusions of the Courtyard report; up until then, it was characterized (accurately) by the Ministry as a disbursement to reimburse an expense.

120. At all times during the process of establishing the funding for midwifery services on regulation and since that time, the premium for liability insurance has been treated by the parties as an operational expense and this is reflected explicitly in the TPA-MPG funding contracts, including the present funding contracts, which set out the obligation of the MOHLTC to pay for such insurance as a "disbursement" expense. The 2010 Template MPG-TPA agreement lists insurance under the definition of "Disbursements", where it states: "Disbursements means:. (c) malpractice liability insurance premium expense reimbursement;"[39]

121. Article 7.9 on page 19 says:

> ***Insurance Related Disbursements**. Despite section 7.1, and subject to the limits and conditions set out in Schedule "F", the TPA shall pay to the Practice Group the amounts listed in the Annual Budget for Disbursements in respect of malpractice liability insurance premium expense reimbursements*

122. Schedule "D" Disbursements says:

> ***"**The Practice Group may request funding each Contract Year to cover the actual costs of malpractice liability insurance required for each Member of the Practice Group in order to be able to practise midwifery in the Province of Ontario. The Practice Group shall make its requests for malpractice liability insurance allowances in the manner set out using the form of budget contained in Schedule "E"."*

123. Further, Schedule D contains other expenses to be reimbursed: travel, home birth kit, "other expenses", second attendant, and admin support for small practices. Clearly the Agreement from the beginning intended liability insurance to be an expense reimbursement and not compensation.

124. This is consistent with the 1999 AOM's Practice Guide, which states that:

> *"Disbursements: Includes costs, expenses and amounts for travel, second attendants, malpractice insurance and benefits. At the beginning of April in each year of the agreement the transfer payment agency will pay a percentage of the disbursements as an "advance" to the practice group. This has been provided because insurance payments are required at this time. The practice group can invoice for disbursements again only when the advance has been used up."*[40]

---

39 Template Agreement between TPA and MPG (October 2009) MOH028422 page 6

40 Association of Ontario Midwives 1999 Practice Guide (1999) AOM0008085 at page 5.

125. I am aware that the AOM's 1999 Practice Guide was sent to Wendy Katherine at the OMP on April 17, 2003 by AOM staff member Michael Heitshu. I do not believe the Ministry has ever refuted what was in this document when they received it. [41]

3. Midwifery and Physician Professional Liability Insurance As an Operational Expense of Ontario's Health Care System

126. Liability insurance allows practitioners to practice to their full scope and to their full capability without fear of litigation hanging over their heads – this is good for clients and the health care system. Without it, there would be very few midwives and other clinicians who would be willing to be involved with obstetrics even if legislation allowed it. It ensures that clients who are injured in the course of care are able to seek support for managing any disability or injury resulting from the care provider's actions.

127. The MOHLTC INFO Bulletin # 4575 dated October 29, 2012 Re: 2013 Medical Liability Protection (MLP) Reimbursement Program Announcement, provides that:

(a) "CMPA membership fees for Ontario physicians are calculated based on medico-legal risk in the province."

(b) The Ministry "will continue to subsidize physician medical liability protection costs by reimbursing approximately $145 million to physicians for the 2013 fees". Those fees were $181 million.

(c) "… as a result of the current tripartite agreement between the Ministry, the CMPA and the Ontario Medical Association, (OMA) the Ministry will reimburse physicians for any fees paid over and above the established 1986 base rate under the Medical Liability Protection Reimbursement Program". [42]

128. The Ministry provides the following rationale for the Medical Liability Protection Reimbursement Program [43]

> *The Government of Ontario understands that professional liability protection is a necessary part of practicing medicine. Enabling physicians*

---

41 2003/04/07 Email from M Heitshu to W Katherine & S Knox re: Program Evaluation Information (April 17, 2003) AOM0006383.

42 Information Bulletin #4575 by the Claims Services Branch to Physicians - 2013 Medical Liability Protection (MLP) Reimbursement Program Announcement (October 29, 2012) AOM0017405.

43 Website by MOH re: Medical Liability Protection Reimbursement Program (accessed October 13, 2013) AOM0006304, See also: Website – MOHLTC - Medical Liability Protection reimbursement program, 2013-11-27, AOM0000631; MOHLTC website re: Medical liability protection reimbursement program FAQs, 2013-11-27, AOM0000632.

> *to access adequate medical liability protection allows Ontario to remain competitive in recruiting and retaining physicians in Ontario. Ensuring that physicians have access to a medical liability protection program also means that there is adequate compensation available to patients who are harmed by medical negligence. Furthermore, the College of Physician and Surgeons of Ontario (CPSO) mandates medical liability protection as a condition of licensing physicians. Representatives from the Ministry of Health and Long-Term Care (MOHLTC), the Canadian Medical Protective Association (CMPA) and the Ontario Medical Association (OMA) work together to assure continued availability of professional liability protection for Ontario physicians at a reasonable cost.*

129. Like physicians, midwives must have liability insurance as a regulatory prerequisite to practice and like physicians, midwives receive reimbursement from the MOHLTC for insurance premium costs as described above.

130. Midwifery professional liability insurance premiums are not treated by the MOHLTC as a benefit to midwives. As well, the Courtyard and Hay reports reflect the treatment by the parties of professional liability insurance as an operational expense which is treated separate from the quantum of compensation.

131. Bass says in his rebuttal report:[44]

> *An item that is required to do one's job would not be regarded as a benefit and would not be included in the total compensation of an employee. These are the responsibilities of the Employer.*

132. I agree. Liability insurance, for example, is required by legislation for a midwife to practice, and therefore it is not a benefit.

4. MOHLTC Payment of Physician Professional Liability Insurance

133. In his expert report, Chaykowski states that there should be a relationship between "risk, competency and earnings". I agree, however, clearly this has not been a factor considered or accepted by the MOHLTC, since they determine that the cost of this risk should be borne by midwives and the costs of liability insurance counted as compensation.[45]

134. Until 2014, The Ministry's Medical Liability Protection ("MLP") Reimbursement Program covers the cost of physician's insurance premiums over and above the 1986 base fees, which results in the physicians paying a low fee for liability insurance. In 2015, obstetricians paid an annual insurance premium of $74,928. However they were reimbursed for $68,823 of these fees through the MLP, and

44 Bass Rebuttal Report (2015) at page 38, paragraph 116.

45 Chaykowski Expert Report at page 86 #13.

only paid the difference of $6,105. Similarly family physicians with an obstetrics practice paid $12,852 in fees, were reimbursed for $11,357 of these fees, and effectively paid $1,495. Family physicians without an obstetrics practice (but including anaesthesia and general surgery) paid $12,852 in fees, were reimbursed for $11,357 in fees and effectively paid $1,495.[46] Since 2014, the contribution paid by physicians has included a small increase relative to the 1986 rates. It is my understanding that the professional liability insurance for CHC physicians is fully reimbursed by the CHC as an operating expense, rather than as compensation.[47]

135. As WDS Thomas explains in his article, Physician's Foresight, A Profession's Pride: A History of the Canadian Medical Protective Association,1901 – 2001, "The fee for service paid to doctors, including a portion of their liability protection fees, is negotiated by provincial medical associations with the provincial and territorial governments." [48]Although physicians pay high fees to CMPA for liability protection, the Ministry's Medical Liability Protection ("MLP") Reimbursement Program mostly covers the cost of physician's CMPA fees above the 1986 fees, which results in the physicians consistently paying a low fee.[49]

5. Insurance Challenges Over the Years

136. The annual insurance premium for each midwife at the time of regulation was $4,374 (including tax). As of 2015-16 it is $32,603 (including provincial sales tax). These increases generally reflect the significant increases in court awards and settlements for catastrophic injury (not only in obstetrics) in the intervening years, and the necessity for the coverage of the midwifery insurance limits to increase concurrently to ensure appropriate coverage is in place.

137. , Midwives were affected by the insurance crisis precipitated by the catastrophe of September 11, 2001, when many insurance companies went bankrupt and others, including ENCON and its related insurance providers, declared their intention to reduce their business risk by not insuring against health care adverse events. As a result, there have been issues over the years with increasing premiums for insurance, especially in obstetrics.

138. In February 2001 the insurer for Ontario midwives, ENCON, informed the AOM that due to the significant decrease in the availability and increase in cost of

---

46 MOHLTC Medical Liability Reimbursement Program Schedule 2015 (2015) AOM0016573.

47 Website by MOH re: Medical Liability Protection Reimbursement Program (accessed October 13, 2013) AOM0006304 . See also the The Canadian Medical Protective Association Fee Schedule, 2015-01-01, AOM0006289.

48 Report by WDS. Thomas re: Physician's Foresight, A Profession's Pride: A History of the Canadian Medical Protective Association,1901 – 2001 (August, 2001) AOM0016483

49 Information Bulletin #4575 by the Claims Services Branch to Physicians - 2013 Medical Liability Protection (MLP) Reimbursement Program Announcement (October 29, 2012) AOM0017405.

insurance across North America (as a result of an insurance crisis following 9/11), they planned to increase annual midwifery insurance premiums for each midwife from $6,100 to $15,000. With that amount, they would be providing less coverage per occurrence. ENCON made it clear to the AOM that they intended to get out of the business of covering maternity care and that providing insurance, albeit at increased cost and for less coverage, would be a stop gap measure. The AOM immediately notified both midwives and the Ministry regarding the urgent new developments.[50] We were reassured by the Ministry that funding would continue despite the increased cost.[51]

139. Despite this initial assurance from the MOH, we were forced to make repeated requests of the Ministry to ensure that sufficient funding was provided in time for the increased premiums in order to not jeopardize the ability of midwives to provide midwifery care which was in high demand. [52] By the summer of 2001 we had still not received approval and midwives had to negotiate a multi-installment payment plan without the guarantee of funding from the MOH. The AOM paid Marsh Canada $1.2M on May 31, 2001 as a first installment on the total premium pending the Ministry's consideration of the funding issue, with the remainder ($3.3M) due by July 20, 2001[53]

140. I had discussions with Ministry representatives concerning the increasing operating expense costs of insurance coverage. The Ministry advised me that it did not have sufficient funds in its current OMP budget to pay for that increased premium. This was a very stressful period: if the Ministry did not fund the expense of the higher premium, the midwives would be unable to pay it which would mean that they would be unable to practice, since the College regulations require midwives to be covered for liability insurance in order to maintain their registration. **[54]** [55] Not only is it required by regulation, but coverage must be in

---

50 Memo on March 2 2001 alerting MPG to increased insurance premium estimates states "at this time we have notified the OMP staff [Wendy Katherine and Sue Davey] of this development and they have stated that the Ministry will continue to uphold its current funding commitment of liability insurance premiums" Memo from AOM Executive to Members re: Professional Liability Insurance (2001-03-02) AOM0003128.

51 Memo from AOM Executive to Members re: Professional Liability Insurance (2001-03-02) AOM0003128.

52 For example: Letter from Remi Ejiwunmi, President, AOM to Tony Clement, Minister of Health re comp and other issues (2001-06-19) AOM0010399 and Letter from Karen MacLeod, Vice-President, AOM to Tony Clement, Minister of Health and Long-Term Care re response refunding increase professional liability insurance premiums (2001-07-09) AOM0010398.

53 Midwifery Program, Community and Health Promotion Branch - Briefing of Minister's Office (2001-05-30) AOM0012282 at slide 12.

54 O. Reg. 168/11: REGISTRATION filed May 18, 2011 under Midwifery Act, 1991, S.O. 1991, c. 31, AOM0015477 at 11.

55 Midwifery Program, Community and Health Promotion Branch - Briefing of Minister's Office (2001-05-30) AOM0012282 at slide 15.

place in order to protect clients, midwives, and the other professionals with which midwives collaborate.

141. With no response by July of 2001 the AOM again wrote to the Ministry stating "we urgently request that you meet with us so that the solution you spoke of can be reached before midwives in Ontario are unable to practice because they do not have liability insurance."[56]

142. The Ministry finally sought Cabinet approval for increased funding and Cabinet agreed to increase the operating funding to cover the cost of the increased premium.

143. At no point at this time or at any time in my dealings with the Ministry since the early 1990's has any Ministry or government representative communicated to me that such payments were to be considered part of midwifery compensation. Professional liability insurance for midwives has always been treated as an operational expense and rightly so, when considering the rationales for coverage stated by the TFIMO and the MOH, as noted previously.

144. In the meantime, I began looking at alternatives as ENCON made it clear that we would not be able to continue coverage with them indefinitely. I began discussions with HIROC CEO Peter Flattery who indicated that Healthcare Insurance Reciprocal of Canada (HIROC) would be a very suitable insurance partner and wished to provide a solution for midwives. HIROC's Board met and decided to change its by-laws to accommodate midwifery. In the meantime, a comprehensive survey of the marketplace by insurance broker Marsh yielded no other market insurers willing to underwrite the policy.

145. As of the 2003 renewal, the AOM professional liability insurance policy has been provided via HIROC. [57]

146. In 2004, because HIROC was not sufficiently resourced to administer the program, the AOM was required to take over this responsibility. The AOM submitted to the Ministry a grant proposal for funding of in-house administration for the professional liability insurance program.

147. In 2004-05 the Ministry provided a grant to the AOM to administer the professional liability insurance policy for all midwives in the province of Ontario and to administer specified risk management activities.

---

56 Letter from Karen MacLeod, Vice-President, AOM to Tony Clement, Minister of Health and Long-Term Care re response re funding increase professional liability insurance premiums (2001-07-090) AOM0010398.

57 MOHLTC memorandum to TPAs re: Midwifery Liability Insurance Refunds (2003-11-24) MOH020688.

148. In 2016, the cost per midwife including foreign coverage and GFD is $32,834.49 [58] The coverage per occurrence was $15 million in 2001, increased to $25 million in 2003 and to $35 million by 2016.

IX. RISKS MANAGED BY MIDWIVES

1. Introduction

149. I have extensive knowledge of the scope of responsibilities of midwives and their exposure to risk in relation of the care of their maternal clients and newborns. This knowledge arises because of my various AOM roles in relation to risk management and insurance claims. As of June 2014, I became the Insurance and Claims Advisor for the AOM. In this position I take the lead on decisions relating to insurance for midwives and high cost claims, including providing advice and guidance to midwife legal counsel and HIROC. Prior to June of 2014, I was the AOM's Director of Insurance and Risk Management. In that role I was responsible for decision-making for the on-going professional liability insurance program for midwives as well as the risk management program. I also created educational materials and workshops, and other presentations for continued learning for midwives and provided direct support and guidance for midwives on risk management and claims matters. I created a 24/7 hotline for midwives to call in for staff and peer advice when facing high risk events or adverse outcomes. I also liaised with HIROC as the insurance provider and partner in insurance affairs.

2. Understanding “Normal” and “Risk” in Midwifery

150. In his report Dr. Chaykowski states that: "in the provision of health services related to childbirth, midwives are restricted to normal, low-risk cases whereas physicians are not limited whatsoever."[59] This statement is not fully accurate for a number of reasons:

(a) Family physicians who do obstetrics (which are in the minority) handle low risk cases as well. Family physicians who are not competent in obstetrics are not permitted to do it by the College of Physicians and Surgeons of Ontario without sufficient training and experience as described in the next section. [60]

58 Letter from HIROC to OMP-Insurance Renewal 2016-2017; sent March 7, 2016, CAV000003.

59 Chaykowski Expert Report at page 86, #12.

60 College of Physicians and Surgeons: Changing Scope of Practice- A Physician's Guide, AOM0016422.

(b) Further, while family physicians may not be restricted by their hospital in the clients they can take on, they are often required or strongly encouraged to consult and/or transfer primary care for the clients who are high risk, including many of the same types of clients for which midwives would need to transfer. Unless the physician is doing a high volume of obstetrics, they will tend to refer their higher risk clients to obstetricians during the pregnancy because of lack of confidence in their own competency regarding those at risk.

(c) Midwives, even though they attend mostly to clients considered at outset of their pregnancy to be "low risk", in fact still provide care which falls into the highest level of insurance risk. The health status of a client, even one at low risk, can change at any time. Furthermore, midwives do accept clients who are at increased risk but want midwifery care even if that care has to be shared with a specialist.

(d) Obstetrics, due to the risks involved in the birth process and the fact there are two patients and a potential for life-long injuries, is considered to carry the highest risk of claims in medical malpractice. Costs provided for may include future care costs as well as lost earnings, which in the case of an infant with non-life threatening catastrophic injuries can mean multimillion dollars settlements or court awards.

(e) Doctors have short encounters with individuals whereas a midwife is with the person in labour for many hours. That exposure increases the likelihood of being present and involved when an adverse event occurs. Unlike a nurse, where a doctor would be supervising care, midwives have the sole responsibility for care unless they have consulted or transferred care.

(f) The responsibilities that midwives take on in their care provision are in fact considered riskier than the work of the CHC physician who does not do obstetrics as reflected by the fact that such physicians are assigned amongst the lowest liability protection costs by the CMPA.

Chaykowski also states regarding risk:

The nature of the risk associated with the healthcare cases handled by physicians and midwives is fundamentally different. …

[and that the Durber report fails] to account for the fact that family physicians also attend complex, high risk cases, as well as low risk cases, related to areas of their scope of practice that are unrelated to childbirth; [61]

61 Chaykowski expert report, p. 86 #13.

He appears to be making an assumption which, as indicated above, is incorrect regarding the nature and risks relating to midwifery work.

151. Professional liability insurance premiums reflect the insurance industry's calculation of the risk of claims arising from the professional work as well as the extent of coverage.

152. While one cannot make direct comparisons, because the CMPA does not specify what the limit of coverage is for its members, in 2015, the CMPA costs for medical protection (insurance) for obstetricians in Ontario was $74,928, the highest of all specialities. The next highest specialty was neurosurgery and the cost of the premium was $46,260. This contrasts significantly to cardiology with a premium of $4,620. Medical legal costs also tend to be higher in Ontario than other regions of Canada and are reflected, for example, in regional differences in fees that physicians of the same specialty will pay. Ontario is the most litigious region in Canada and this is reflected in insurance fees for medical practitioners.

153. For reference, the CMPA and HIROC Liability protection/insurance fees for 2015[62] were:

OBs	$74,928
Family Physicians doing obstetrics	$12,852
OBs NOT doing labour and delivery	$7,944
Family Practitioners NOT doing obstetrics	$4,620
Midwives	$32,603.29[63]

154. I agree with Chaykowski's statement on Page 86, #3 of his report when he says that there should be a relationship between "risk, competency and earnings."[64]

3. Change in Scope of Practice of Physicians

155. The College of Physicians and Surgeons of Ontario has specific requirements which would apply to a family physician who intends to change the scope of his practice from what he is normally doing.

156. The CPSO document, Changing the Scope of Practice states as follows:

---

62 The Canadian Medical Protective Association Fee Schedule (2015) AOM0006289.

63 Letter Dated March 25, 2015 to Bobbi Soderstrom from Richard Yampolsky re 2015 insurance costs (March 25, 2015) CAV000004.

64 Chaykowski expert report, p. 86 #13.

In accordance with the annual renewal form, physicians must report to the College when they have changed their scope of practice or intend to change their scope of practice. The College's Changing Scope of Practice policy outlines the College's expectations of physicians who have changed or will be changing their scope of practice and who do not have the necessary training and/or experience to practise competently in the new area of practice.

FAQs

How does the College define scope of practice?

The definition of scope of practice:

1. Every physician's scope of practice is unique.

2. A physician's scope of practice is determined by the patients the physician cares for, the procedures performed, the treatments provided, and the practice environment.

3. A physicians ability to perform competently in his or her scope of practice is determined by the physician's knowledge, skills and judgment, which are developed through training and experience in that scope of practice.

What does the College consider a change in scope of practice?

A change of scope of practice occurs when there have been significant changes to any of the elements set out in part 2 of the definition. If the patient population you care for, the procedures that you perform, the treatments you provide, or the environment in which you see patients has changed in a significant way, the College may find that you have changed your scope of practice.

Key to this concept is what the College considers "significant," In general, if you have changed your practice such that you are practising outside of what would be considered the usual scope of practice for your discipline, then your scope of practice may have changed significantly.

How do I know if a potential change is significant or if it is simply a normal evolution of my practice?

In general, a change is significant if:

I. You are completely changing your type of practice (For example you are a surgeon who wants to go into general practice)

OR

2. You are adding something in to your practice that you have not done before AND

ii. it is not something that is considered a usual part of your discipline AND

iii. Most physicians in your discipline are not changing their practice in this way. (For example you are a pediatrician who wants to start working in an Emergency Department caring for adult patients)

OR

3. You are focusing your practice in an area in which you have not been active for at least three years. (For example you are a GP who was previously trained in sigmoidoscopy, but have not done any for the past five years and want to start doing it again.)

157. This CPSO rule would prevent a family physician who has not done intrapartum care from providing such medical care without following the above requirements.[65]

4. Discussion with Paul Durber

158. In September of 2013 I was interviewed by Paul Durber as part of his investigation for the preparation of his pay equity/human rights analysis report for the AOM.[66]

159. I discussed with Mr. Durber the increasing competencies of midwives, including diagnosis, ordering newly authorized medications and lab work. I also told him that the business aspects of MPGs are far more complex than anyone anticipated.

160. I also highlighted for him some elements of a day in the life of a midwife.

161. We also discussed barriers to the effective integration of midwifery into Hospitals. Specifically I told Mr. Durber that without legislative change, most midwives have no representation on medical advisory boards in hospitals.

162. I drew on my decades of experience as a practicing midwife to give Mr. Durber insights about the unique structures of midwifery practice groups. For example, we discussed the collaboration between midwives in creating care plans and the importance of peer review.

---

65 College of Physicians and Surgeons: Changing Scope of Practice- A Physician's Guide, AOM0016422.

66 Notes of Paul Durber's Interview with Bobbi Soderstrom. (September 16, 2013) AOM0017401.

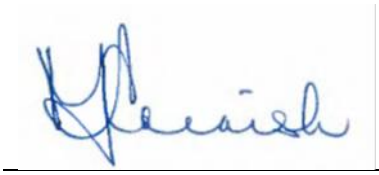
X. IMPACT OF STRUGGLE FOR PAY EQUITY

163. As a business partner in a practice group, I felt the pressure year after year to submit a budget that would adequately take care of the midwifery business. The whole process of budget submission is complex and it was very difficult each year to conduct a business while not knowing what the approved budget would be until well into the new budget year. It was very stressful and challenging to try to plan for the number of clients to take into care when we did not know whether course of care fees would be approved for those clients.

164. Over time, I felt the emotional strain of being treated so differently from physician colleagues who regularly received compensation and funding increases. This strain was exacerbated by the fact that I felt our midwifery work was not being properly respected by many physician specialists or for that matter by the MOHLTC who set our compensation. We were working so hard to comply with the Ministry's health care objectives and to produce excellent outcomes for our clients and yet our compensation did not adequately reflect those efforts or contributions. Instead, we had to constantly struggle for respect and to be allowed to practice to full scope. It has been more than 30 years since I started to practise as a midwife in Ontario and seek equitable integration for midwifery. While I had hoped these issues could be resolved without litigation , I signed on to be a complainant in this proceeding as the Ministry refused to properly address our equity claims.

SWORN this ► day of July 2016.

Bobbi Soderstrom



A Commissioner for taking Affidavits.

165.