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 KELLY STADELBAUER

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

1. I am the Executive Director of the Association of Ontario Midwives (AOM) and have been in that position since 2006. I am also a Registered Nurse and began my career in clinical practice. The remainder of my career over the past three decades has been in education, administrative and policy roles in the health care sector, with the exception of 2001-2006 when I was the director of operations for a small business. My background, knowledge and experience that support the statements in this Affidavit are set out in my Curriculum Vitae and summarized in Part I below.[1] This affidavit constitutes the main section of my examination in chief in this proceeding.

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[1] *Curriculum Vitae* of Kelly Stadelbauer, CAV000005.

I. Background

a. Education

2. I graduated with a Bachelor of Science in Nursing in 1986. In 1999, I obtained my MBA, specializing in Not-For-Profit Leadership and Management, with a second specialization in Organizational Behaviour. I graduated with First Class Honours.

b. Nursing Practice and Education

3. I have spent my career working in and for female-dominated health professions. My work has always been grounded in a feminist perspective on health care.

4. I am a registered nurse with the College of Nurses of Ontario. I began my career as a public health nurse, creating community based health promotion and illness prevention programs, and providing individualized community-based nursing care in the home, predominantly in a case coordinator role. This work was strongly rooted in the social determinants of health.

5. As a public health nurse, I was a member of the executive of a local bargaining unit of the Ontario Nurses' Association. This was during the time when pay equity was introduced in Ontario and our public health unit was going through the exercise of establishing the workplace and comparators for public health nurses for the purposes of pay equity.

6. From 1990-1992, I was a nurse educator in a large tertiary care hospital, responsible for educational programs such as orientation of new nursing staff, a preceptorship program, and a stress management program for nursing staff.

7. From 1994-2001 I was the Director of Membership and Education at the Registered Nurses' Association of Ontario ("RNAO"). In that role, I was responsible for the development of nursing education policy, as well as the design, implementation and evaluation of cost-effective educational programs for registered nurses. I participated at the provincial level in policy development regarding a wide range of nursing education issues. I represented RNAO on key multi-stakeholder committees including the government mandated Joint Provincial Nursing Committee's Education Subcommittee, and the councils for both the university and the college based nursing programs.

8. In addition, I implemented and managed the Nurse Education Initiative, a Ministry-funded tuition reimbursement program. I managed all aspects of the Provincial Education Fund, an educational loans program for registered nurses. I provided support and guidance to 18 different specialty interest groups of the RNAO, including the Nurse Practitioners' Association of Ontario. I also acted as preceptor for numerous BScN, post-RN, and diploma nursing students.

c. Ontario Maternity Care System Roles

9. From 1992-1994, I was a community development worker in a women's health centre, designing, implementing and evaluating a broad range of women's health programming with a focus on violence against women programs. I secured a large federal grant to create a prenatal nutrition support program for women living in poverty.

d. Roles in the Midwifery Sector

10. In August 2006, I became the Executive Director of the Association of Ontario Midwives ("AOM"). Working with AOM leadership and staff, I have sought to address the issues of inequitable compensation, funding and bargaining structures that face Ontario midwives, as well as continued barriers, such as denial of hospital privileges and unjustified restrictions on midwives' scope of practice, that prevent midwives from being fully integrated into Ontario's maternity care system.

11. As Executive Director, and as a member of the AOM's Negotiations Committee, the Joint Midwifery Advisory Committee ("JMAC") and the joint Midwifery Contract and Funding Advisory Committee ("MCAFC"), I have played an instrumental role in the AOM's negotiations with the Ministry of Health and Long-Term Care ("MOHLTC" or "the Ministry"). I was on the compensation review Joint Steering Committee that resulted in the Courtyard Report.

12. I work closely with AOM's Director of Policy and Communications, Juana Berinstein, whom I hired into that position in January 2007. One of our co-

responsibilities is to support the AOM Board of Directors and key committees such as our Policy Committee and our Negotiations Committee and provide them with regular updates on emerging trends, political events, and stakeholder activities. This requires that I review and stay current on relevant research and developments, ranging from data on clinical outcomes of midwifery, to the economics of maternity care in Ontario, to laws and regulations governing various aspects of the health care system.

13. Working together with Berinstein, I have also played a key role in providing strategic and content support for AOM matters relating to the MOHLTC, and in maintaining communications with government policy and political actors. In order to do so effectively, I am continually scanning media reports, Ministry of Labour reports on collective bargaining and wage settlements, publications from other associations of health care professionals and other sources to ensure that I am aware of what has been negotiated and made available to other providers, as well as government policy more generally. Through my background in the health care system, I am generally aware of the health care providers that negotiate central contracts, and how to go about accessing those agreements. I also keep track of agreements negotiated by the Ontario government with other organizations such as the Ontario Provincial Police Association, AMAPCEO, and OPSEU.

14. Since 2006 I have also been a member of the multi-stakeholder Ontario Midwifery Reference Group, and the multi-stakeholder Joint Risk Management Working Group.

15. From 2006-2008, I provided staff support to the AOM Benefits Committee, the body initially responsible for administering a comprehensive benefits plan to all Ontario midwives using funding provided by the Ministry of Health and Long Term Care (MOHLTC).

16. In 2008, the AOM Benefits Committee was succeeded by the AOM Benefits Trust. I have been a Trustee of the Trust since its creation, served as Chair of the Finance Committee, and currently serve as a member of the Governance Committee.

e. Publications and Presentations

17. While at the RNAO, I authored the RNAO's submission to the Ministry of Health's Nursing Education Implementation Committee regarding the development of collaborative nursing education programs in Ontario. I was also the primary author of several RNAO position papers and policy statements, including "Prior Learning Assessment to Support Continuing Education in Nursing".

18. I have made numerous presentations over the course of my career. In my roles at the RNAO and AOM, I have frequently spoken on the role of a professional association in the health care environment.

II. CONTEXT FOR SEEKING EQUITY: MIDWIFERY AND THE ONTARIO MATERNITY CARE SYSTEM

19. By the time I took on the position of Executive Director of AOM in August 2006, midwifery was a well-established and vitally important part of Ontario's maternity care system. New research continued to demonstrate the benefits of midwifery care for women and babies. Ontario's 2006 Provincial Perinatal Report again detailed the excellent health outcomes that midwives were achieving for women and their newborns.[2] As well, during that year, the Ministry released data that showed midwives continued to produce excellent outcomes on a number of maternity care indicators.[3]

20. Over the period 2006-2008, the value of midwifery work continued to grow. As set out in detail below, the number of midwives and the percentage of midwife-attended births grew. Midwives' scope of practice and workload expanded, and midwifery education was significantly revised. There was also an increased emphasis on interprofessional and collaborative care. Yet midwives continued to face significant barriers to integration into the hospital system as well as ongoing attempts by physicians, and their representative organization, the OMA, to control and restrict the practice of midwifery.

21. By 2006, there was growing concern that Ontario was facing a shortage of maternity care providers. Indeed, shortages of maternity care professionals were well-document across Canada.[4] In May 2004, Health Canada established the Multidisciplinary Collaborative Primary Maternity Care Project (MCP^2) to identify ways to "reduce barriers and facilitate the implementation of national multidisciplinary collaborative strategies as a means of increasing the availability and quality of maternity services for all Canadian women." In June 2006, MCP^2 released its Final Report. The Report noted that fewer family physicians were choosing to provide maternity care, especially intrapartum care; that medical students were not choosing obstetrics as a specialty and a significant number of obstetricians/gynecologists were no longer providing maternity services.[5] It also noted that the impact of shortages was felt most acutely in rural and remote communities. The Report called for the development of regulations and legislation that allow collaborative maternal/newborn care practice to work effectively, and identified in particular the need for appropriate recognition, regulation and remuneration of midwives.

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2 Provincial Perinatal Surveillance System Committee, "Tailoring Services to Pregnant Women and their Babies in Ontario: 2006 Provincial Perinatal Report", 2006, AOM0000651.

3 Ontario, "Ontario Midwifery Program, Ministry of Health and Long-Term Care: Ontario Midwifery Clinical Database". APHEO Conference, October 16-17, 2006, AOM0000603.

4 MCP2 report at 8.

5 MCP2 at 8.

22. On September 6, 2006 the Ontario Maternity Care Expert Panel[6] (OMCEP) released its report entitled *Emerging Crisis, Emerging Solutions*. The OMCEP report noted not only the escalating crisis of shortages in maternity care providers but also rising intervention rates, and stressed the importance of valuing care providers as well as the need to expand the scope of practice of midwifery.[7] In particular, the OMCEP report noted a similar trend in maternity care in Ontario as the MCP2 had documented nation-wide. The number of family physicians providing maternity care had plummeted since 1981, while the number of obstetricians remained stagnant. Meanwhile, since becoming a regulated profession, midwifery had been growing nearly exponentially.[8]

23. The number of midwife-attended births had also increased. In 2006/07, 366 midwives attended eight percent of the 134,141 births in Ontario.[9] Yet this was only a fraction of the births for which midwifery services were sought. Although the number of midwives had grown dramatically since regulation, demand for midwifery services continued to outpace supply. In 2005/2006 midwives were still able to meet only 63% of the demand for their services.[10]

24. The OMCEP recommended expanding midwifery program entrant class sizes, noting that this would lead to an increase in the proportion of births attended by midwives in Ontario and thus address unmet demand for services.[11] The OMCEP also noted problems in the governance system to permit midwives to obtain admitting and discharge privileges in acute care hospitals, and recommended that hospital use the College of Midwives of Ontario (CMO) standard Indications for Mandatory Discussion, Consultation and Transfer of Care as the basis for local protocols.[12]

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6 The AOM's Vicki Van Wagner, Elana Johnson and Judy Rogers were members of this expert panel, and Van Wagner and Wendy Katherine of the Ontario Midwifery Program (OMP) were among the authors who prepared the report.

7 Ontario Women's Health Council, "Executive Report of the Ontario Maternity Care Expert Panel: Emerging Crisis, Emerging Solutions", September 6, 2006, AOM0005948.

8 Ontario Women's Health Council, "Executive Report of the Ontario Maternity Care Expert Panel: Emerging Crisis, Emerging Solutions", September 6, 2006, AOM0005948 at 17.

9 Interim Report to Minister of Health by HPRAC re: Mechanisms to Support Interprofessional Collaboration among Health Colleges and Regulated Health Professionals, (September, 2008), AOM0005928, at 82, note 14, citing Ontario Ministry of Health and Long-Term Care news release and Statistics Canada's summary table, generated from CANSIM's table 051-0004, on births and birth rate by province and territory. August 22, 2007.

10 Interim Report to Minister of Health by HPRAC re: Mechanisms to Support Interprofessional Collaboration among Health Colleges and Regulated Health Professionals, (September, 2008), AOM0005928, at 82.

11 Ontario Women's Health Council, "Executive Report of the Ontario Maternity Care Expert Panel: Emerging Crisis, Emerging Solutions", September 6, 2006, AOM0005948 at 17.

12 Ontario Women's Health Council, "Executive Report of the Ontario Maternity Care Expert Panel: Emerging Crisis, Emerging Solutions", September 6, 2006, AOM0005948 at 25.

II. 2008 NEGOTIATIONS

a. Framework and Preparation

25. In the 2005 contract, MOHLTC had committed to entering into negotiations by December 1, 2007 or earlier if there were significant changes to workload. The AOM began preparing for those negotiations well in advance, shortly after I assumed the role of Executive Director. In first preparing for and then undertaking these negotiations, I worked closely with Director of Policy and Communications Juana Berinstein, Elana Johnson, and Katrina Kilroy. Johnson was President of the AOM until May 2008, at which time Kilroy became President.

26. Since this was my first time engaging in negotiations on behalf of the AOM, I wanted to make sure I understood the issues from midwives' point of view. I also wanted to make sure that we were prepared and equipped to address the structural issues that had not been addressed in 2005.

27. It was my role to lead the staff team that provided information and analysis based on a range of sources, including research articles, newspaper articles, and government reports, to the negotiations committee and negotiations team. I was often directly involved in analyzing the information we gathered.

28. The AOM's focus in this round of negotiations was equity for midwives both in compensation and in access to programs and supports similar to those that were provided by the MOHLTC to other Ontario health care providers. Specifically, the AOM sought equitable compensation relative to CHC physicians, in line with the principles originally set out in the Morton report. The AOM also sought equity in programs that supported physicians and other front-line health professionals, such as parental leave, professional development, locum relief and IT infrastructure support.

(i) Compensation, Funding and Supports for CHC Physicians and Other Professionals

29. I was aware that midwives' compensation had originally been set in relation to two comparators: CHC physicians and nurse practitioners. That approach was affirmed in the 2004 Hay report, and provided the framework for our analysis of midwives' compensation. We consistently looked to the compensation – as well as the other funding and supports – provided to CHC physicians as a key point of reference in our negotiations.

30. In keeping with that approach, the AOM retained the Hay Group to provide an update to its earlier report to include consideration of market changes in compensation between 2005 and 2007. The Hay Group's report, entitled "Market

Changes in Compensation: 2005-2007" set out in detail the compensation increases provided to both CHC physicians and nurse practitioners.[13]

31. As part of this comparative exercise, as well as in response to concerns identified by midwives, I also researched the programs, grants and benefits available to other health care professionals to foster and support their practices in underserved communities, as well as the benefits and practice supports the MOHLTC provided to assist other professionals in managing their practices through various life events, such as pregnancy and parenting, and to assist in meeting administrative demands. This research revealed serious disparities between the programs available to midwives and those available to other health care professionals. The Ministry had never made the AOM aware of these programs, much less taken steps to ensure that midwives had access to the same kinds of supports as other health care providers to assist them in continued professional development and practice management throughout their careers.

32. Before coming to the AOM, I had worked for the Registered Nurses Association of Ontario. As the Director responsible for the Nurses Education Initiative for the RNAO, I was intimately familiar with the supports offered to nurses to continue their professional development and enhance their skills throughout their careers, and to serve as a recruitment and retention tool for the MOHLTC. When I arrived at the AOM, I was shocked to find that midwives did not have access to funding or support for professional development similar to what was available to all other publicly funded health care professionals, particularly in light of the significant concerns I was hearing about the pending obstetrical care provider crisis and the need for retention of intrapartum care providers. Through my broader research into the resources available to other health care providers – for example, under the Allied Health Professionals Fund - I became aware of how much midwives lagged behind in relation to a broad range of programs and benefits.

33. Finally, I also reviewed agreements entered into by the government with other organizations, as I do on an ongoing basis.

(ii) Midwifery Workload Analysis

34. At the time of regulation, the workload analysis relied upon by the AOM and the MOHLTC in their negotiations was the analysis set out in Van Wagner's pre-regulation 1991 thesis, *With Women: Community Midwifery in Ontario*. Van Wagner's analysis arrived at a figure of 48.25 hours per course of care. However, much had changed over the 16 years since her original calculations. In accordance with the AOM-MOHLTC 2005 agreement to re-open the Funding

[13] Report from Hay Group to AOM called "Market Changes in Compensation: 2005-2007", AOM0000566.

Agreement if there was a significant change in workload,[14] the AOM decided to carry out its own workload analysis.

35. In 2007, the AOM hired E. Dean and Associates to conduct a workload survey, supervised by the AOM's Juana Berinstein and working with AOM President Elana Johnson and Katrina Kilroy.

36. Through that analysis, the AOM arrived at a figure of 55.48 hours per course of care.[15] We also determined that the number of clinical hours per course of care had remained generally consistent since regulation, and the increase was driven by the greater number of hours required for practice support and administration in. This confirmed and provided clear evidence of what midwives had been reporting anecdotally – that the administrative demands of practice had increased dramatically since regulation.

(iii) Consultations with Members

37. We convened a number of meetings of our internal AOM negotiations committee – consisting of the President, board members, Berinstein and myself – and undertook general membership consultations through regional meetings. We also established a Remote Midwifery Committee and a Rural Midwifery Committee, to ensure that we heard and represented the perspectives and concerns of midwives working in these challenging areas.

38. In those consultations, midwives stressed the need for measures to support the growth and sustainability of the profession – in particular the recruitment and retention of midwives – and to ensure that midwifery care was accessible and available to women in rural and remote and Aboriginal communities. Midwives were also concerned that the Ministry already provided support to physicians who were working in rural and remote areas. Finally, midwives underlined the importance of addressing the significant barriers to full hospital integration.

39. The AOM entered into the 2008 negotiations very optimistic that with all of the evidence and information we had gathered, we would finally be able to address systemic compensation and other issues.

b. What the AOM Sought

(i) Compensation Increases

40. The AOM sought adjustments to bring midwives' earnings in line with those of CHC physicians and other health professionals. The AOM argued that through a

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14 Letter from S. Davey to E. Johnson re: conclusion of review of TPA-MPG funding agreement (June 28, 2005), AOM00025537.

15 Ontario Midwifery Workload, 1993 Historical Benchmark and 2007 Workload Analysis, AOM0001033.

combination of increase in workload per basic course of care (BCC) and significant increases in the compensation provided to CHC physicians and other health professionals, far in excess of the increases granted to midwives, midwives' compensation relative to CHC physicians had been significantly eroded.

41. In our Funding Agreement Proposals document, we noted that the 1993 compensation agreement provided for midwives at the top end to be compensated at a level equal to 90% of the lowest fee level for CHC physicians. In 2007, the lowest fee level for a CHC physician – not including on-call pay – was $155,613. A midwife at level 6 should therefore be earning at least $104,051 – rather than $84,000 (also not including on-call).[16]

(ii) On-Call Fee

42. A midwife is expected to be on call approximately 110 hours per course of care. For a full-time midwife – one who provides 40 primary courses of care per year – this means an annual on-call commitment of 4400 hours. For this, midwives were paid $12,000 – or $2.73 per hour on call. Midwives' on-call fee had not changed over the period 2005-2007. At the same time, on-call rates in the Ontario Public Service Employees Union (OPSEU) and Ontario Nurses' Association (ONA) collective agreements increased 9.1% and 10.1%, respectively. As of April 1, 2007, registered nurses were paid $3.30 per hour on standby, and $4.90 per hour for standby on holidays – significantly more than the $2.73 per hour paid to midwives. As another point of comparison, CHC physicians received an annual lump sum payment of $5353 in on-call fees.[17]

43. Our analysis found, and the AOM then argued, that not only were midwives paid less per on-call hour than other health care professionals, they faced far more onerous demands during their on-call time. Unlike on-call CHC physicians who are only required to provide medical advice over the phone, on-call midwives may be required at any moment to go and attend a birth or provide an assessment in the client's home. Other on-call professionals are responsible for defined, pre-scheduled shifts around which they can schedule other commitments, whereas midwives are on call 24/7. Moreover, the midwifery model of care, which is continuous and personalized, requires that the primary midwife who has provided prenatal care and assisted the pregnant woman in preparing for labour and delivery will be the midwife who actually attends the birth – absent exceptional circumstances such as her being at another birth or seriously ill.

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16 Funding Agreement Proposals from AOM to MOH (October 2008), AOM0000686, at 2. Note that in this document, we calculated midwives' effectively hourly wage for comparative purposes based on 54.25 hours per course of care. This was lower than the number we arrived at through the workload survey – namely 55.48 hours per course of care. For the purposes of negotiations, we decided to use a more conservative estimate that excluded "outliers" in the survey data.

17 Funding Agreement Proposals from AOM to MOH (October 2008), AOM0000686, at 3.

44. The AOM argued that fairness required that midwives receive increases in on-call fees comparable to those of their health professional colleagues, taking into account the much higher on-call demands placed on midwives. Specifically, the AOM sought an increase to $5.00 per hour, or $20,000 per year for a full caseload, to appropriately capture the difference in on-call expectation.[18]

(iii) Parental Leave Program

45. Midwives' status as independent contractors means that they are not eligible for a parental leave plan through an employer or through the federal EI program. In addition, unlike employees, midwives do not gain "seniority" during parental leave. This means that midwives on parental leave do not move up their compensation grid during their leave, nor are they credited by the Ministry for this time when they come back to practice. Moreover, unlike all other self-employed health care professionals, midwives cannot take on shift work to earn income while on parental leave, because the midwifery model of care and the requirement of continuity does not allow for "piece work". This is in contrast to physicians, for example, who can take on fee-for-service shifts on a part-time basis while on leave. As a result, midwives who sought to take a maternity or parental leave often faced serious financial hardship.

46. Many other publicly-funded health professionals, in contrast, are employees and therefore have access to the federal EI program – and generally also receive a healthy top-up from their employers, who receive funding from the Ministry to support this. For example, nurses who were members of ONA received a supplemental employment benefit equivalent to the difference between eighty-four percent (84%) of her regular weekly earnings and the sum of her weekly Employment Insurance benefits and any other earnings.

47. Physicians have benefits through the Pregnancy and Parental Leave Benefit Program (PPLBP), which was established under the 2004 Physician Services Framework Agreement, funded by the Ministry and administered by the OMA. The PPLBP provides eligible physicians with 9 weeks of pregnancy leave benefit and 8 weeks of parental leave benefit up to a maximum of $1000 per week - $17000 in total. In addition, physicians receiving benefits from the PPLBP can also have gross earnings up to $1000 per week without any deduction from their benefit entitlement.[19] Under the 2007 Reassessment, the PPLB eligibility requirements were expanded to allow physicians who received a similar benefit from their employers or through EI to receive a supplemental payment under the PPLBP equal to the difference between the amount they receive from their employer and/or EI and the amount payable under the PPLBP. This meant that CHC physicians who received pregnancy and/or parental benefits from the CHC

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[18] Funding Agreement Proposals from AOM to MOH (October 2008), AOM0000686, at 3.

[19] 2004 Physician Services Framework Agreement between MOHLTC and OMA, AOM0000635, at s. 15.2.

and/or EI of less than $1000 per week were eligible for a top-up under the PPLBP to bring their benefits up to that level.[20]

48. Again, I was surprised to learn in our preparations for negotiations that midwives had no access to a maternity/parental leave program, and that the Ministry had not informed that AOM that there was a ministry-supported program for physicians administered by the OMA, which applied to our comparator. The AOM sought to have a similar program funded for midwives. Specifically, we sought a program that allowed for up to one year pregnancy/parental leave.[21] This was in our view essential not only to achieving fair compensation but also to sustaining the profession as a whole. Midwives who have or who wish to have children face significant challenges in balancing the demands of practice with the demands of their families, and this in turn poses a significant challenge to the retention of midwives in practice. It was painfully ironic that midwives – almost entirely women professionals who devoted their work lives to supporting other women through pregnancy, labour, and the first weeks of caring for their new babies – received no support from the Ministry, their funder, to assist them in being able to experience the same profound life events without undue financial hardship.

49. Although there was at this time a parental leave "benefit" available to midwives through the AOM Benefits Committee, it was in fact nothing more than a self-loan: midwives could pay a portion of their earnings into it, and then draw from that self-funded pool while on leave. This was an attempt in the early years by a small, fledgling female-dominated profession to support midwives on maternity/parental leave in some way, even if it was just a forced savings program.

50. As set out above, midwifery was by this point a vitally important and growing part of Ontario's maternity care system. Yet despite the need for both fairness in compensation and the retention of midwives in practice, the Ministry did not proactively provide any dedicated funding for parental leave. In fact, not only had the Ministry failed to take any steps to provide pregnancy and parental leave benefits to midwives – the most female-dominated profession providing maternity care in Ontario's health care system – it did not even inform the AOM of the benefits it made available to other providers. This was especially troubling given that data compiled and analyzed by the MOHLTC and presented to the AOM underscored the importance of pregnancy and parental leave to the sustainability of the profession. According to the MOHLTC's own data, in 2006-2007, 66% of Ontario midwives were between the ages of 20 and 44 – and among new registrants, this figure rose to 96%. In other words, a significant majority of all midwives and an overwhelming majority of new midwives were in the age range

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20 Memo of agreement OMA-MOH re 2004 Physician services framework, AOM0006213 at s. 7.

21 Funding Agreement Proposals from AOM to MOH (October 2008), AOM0000686, at 8-9.

most commonly associated with pregnancy, adoption, and parenting of infants and small children. Not surprisingly, in 2006-2007, midwives between the ages of 25 and 44 who were on leave accounted for 65.12% of the total midwives on leave. That same year, more than one in five midwives aged 25-29, fully a quarter of the midwives aged 30-34, and just under 18% of midwives aged 35-39 were on leave.[22]

51. While the profession as a whole was growing, attrition was also a significant challenge – notably including among new registrants. In 2006-2007, again according to the MOHLTC's own data, just under half of all of the midwives who left practice had been registered for less than five years, and that trend had been evident for some time. In 2003-04, half of the midwives leaving the profession had been registered for less than five years; in 2004-2005 that number dropped slightly to 47.27%, but in 2005-2006 it rose again to 58.18%. In other words, it had been evident for some time that midwifery attrition rates were very high among relatively new registrants who, as noted above, were overwhelmingly in the 25-44 age range and thus most likely to be confronting the challenge of balancing their demands of practice and the demands of pregnancy and parenting young children. Relatively new registrants would also be more likely to be dealing with the financial pressures associated with paying off student loans and establishing themselves professionally – potentially including the cost of relocation. Pregnancy and parental leave benefits were therefore an important part of addressing midwifery attrition and the maternity care provider shortage.

(iv) Other Benefits

52. While the Ministry had increased midwifery benefits to 18% of salary in the 2005 round of negotiations, it still was not the 20% provided to CHC physicians. As well, because of the steady increase in the cost of maintaining the same benefit package over time, the package was eroding, particularly with respect to the group RSP component. As an AOMBT Trustee, I am aware that in 1993, funding allowed for a 75:25 insured-benefits-to-RSP allocation for each midwife. Over time, the group RSP component decreased in order to offset the increased cost of the benefits package (there had been no meaningful enhancement to benefits entitlements during this time).

53. Setting aside retirement income is critically important for midwives as independent contractors and as a female-dominated profession who statistically are likely to live a longer time in retirement than men. The AOM therefore sought an increase in benefits from 18% to 23% of salary.[23]

(v) Professional Development Program

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22 MOHLTC Presentation on Expansion and Contraction: Trends in Health Human Resources in Midwifery and Maternity Care in Ontario (May 16, 2007), MOH015003.

23 Funding Agreement Proposals from AOM to MOH (October 2008), AOM0000686, at 8.

54. Three professional development programs had been in existence for several years prior to 2008:

(a) The Continuing Medical Education Program provided physicians, including CHC physicians, with $100 per hour to attend continuing medical education conferences to a maximum of 24 hours per year (that is, up to $2400).[24] Physicians also had free online access to professional and practice related resources; e.g. OntarioMD.ca, an MOHLTC-funded subsidiary of the OMA.

(b) The Nurse Education Initiative provided eligible nurses with up to $1500 per year in tuition reimbursement.

(c) The Allied Health Fund also provided $1500 per year of tuition reimbursement to Audiologists, Dietitians, Medical Laboratory Technologists, Medical Radiation Technologists, Occupational Therapists, Pharmacists, Physiotherapists, Respiratory Therapists, and Speech-Language Pathologists.

68. The AOM sought a similar fund.[25] Again, the Ministry had not made any kind of professional development program available to midwives, and had not even taken steps to advise the AOM of the programs available to other health care providers. I believe that if it had not been for my previous experience at the RNAO administering a ministry-funded professional development program for nurses, the midwives would likely not have been aware at this time that other health care providers were receiving such ministry support.

(vi) Rural and Remote Incentives and Support

69. In recognition of the unique challenges in attracting and retaining health professionals to rural, Northern and remote communities in Ontario, the Ministry funded a range of incentives for physicians and other health care professionals to practice outside of urban centres, including locum tenens programs as well as additional remuneration and grants.

70. The MOHLTC funded a variety of locum programs – the Rural Family Medicine Locum Program, and both Urgent and Respite Northern Specialist Locum Programs – for physicians in rural, Northern and remote communities. Under these programs, a physician could choose to bill OHIP on a fee-for-service basis, or claim a daily stipend of $590 plus expenses including travel and accommodation.

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[24] Guide by MOH re: Family Health Team Guide to Physician Compensation (July 19, 2005), AOM0010087.

[25] Funding Agreement Proposals from AOM to MOH (October 2008), AOM0000686, at 28.

71. In addition, the $4 million, MOHLTC-funded Rural Medicine Investment Program, developed in partnership with the OMA, provides additional remuneration to physicians who provide full time, dedicated patient care in rural communities. This principle, of supporting care in underserviced communities, extends to CHC physicians working in underserviced areas, who earn on average 26.8% more than their CHC physician colleagues elsewhere in the province.[26]

72. The MOHLTC also provides other incentives, in the form of grants, to health care professionals including: a) up to $15,000, paid over four years, to family physicians who relocate to eligible designated southern communities; b) up to $15,000, paid over three years, to audiologists, chiropodists, occupational therapists, physiotherapists, and speech-language pathologists who relocate to fill positions in full-time MOHLTC-funded vacancies in Northern Ontario; c) up to $40,000, paid over four years, to family physicians and psychiatrists who relocate to designated northern communities; d) up to $20,000, paid over four years, to specialists who relocate to designated northern communities; c) $20,000, again paid over four years, under the Northern Medical Specialist Incentive Program, to northern specialists who provide a minimum of 12 days of outreach services per year.

73. Based on extensive and vigorous feedback from midwives who worked in challenging rural and remote areas of the province, and based on the AOM's analysis of comparative programs, the AOM argued that midwives are specialists in normal, low-risk birth and should be paid equitably in relation to physician specialists who locate in designated communities. The AOM requested that MOHLTC address the inter- and intraprofessional inequities facing rural and remote midwives by providing incentives comparable to those provided to other health care professionals. Again, our efforts in this regard reflected the need not only for fairness in compensation but also the retention of midwives in practice and the principles of women's choice in and meaningful access to high-quality maternity care. The AOM strongly supports keeping birth close to home. Its position is based on evidence demonstrating that requiring women to travel away from their communities to one centralized hospital for maternity care results in poorer outcomes for women and newborns, as well as the erosion of other aspects of women's health care in those communities. The principle of accessible maternity care close to where a woman lives is also supported by the 2006 OMCEP report, discussed in detail above, which describes its vision in the following terms: "Every women in Ontario has access to high quality, woman and family-centred maternity care as close to home as possible."[27]

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[26] Funding Agreement Proposals from AOM to MOH (October 2008), AOM0000686, at 12. See also Memorandum of Agreement Between the OMA and MOHLTC 2008, AOM0001948

[27] Ontario Women's Health Council, "Executive Report of the Ontario Maternity Care Expert Panel: Emerging Crisis, Emerging Solutions", September 6, 2006, AOM0005948 at 10.

74. As birthing units continued to close in rural and remote areas, the AOM argued that it was becoming increasingly imperative that midwives be available in these communities to ensure that birth can be maintained as close to home as possible. Providing care options to women living in these areas is an ethical issue, and the current funding agreement did not provide incentives for midwives to practice in such communities. Midwives also require these incentives to attract new practitioners to rural and remote areas, allowing midwifery clients to be served in their local communities.

75. Specifically, the AOM sought a funded locum program similar to the Urgent Locum Tenens Program for Specialist Physicians for rural and remote midwifery practices. This program would give rural and remote midwives the capacity to take holidays, sick leave, continuing education programs, and to attend to family and personal matters. That capacity is essential to the sustainability of a rural or remote practice. A locum program would also provide midwives an opportunity to explore practice in different parts of the province and encourage the development of rural and remote midwifery. Finally, a locum program would attract some experienced midwives who might not wish to continue in full-time practice, thus ensuring the retention of their expertise and their mentorship within the profession.

76. I was surprised to learn when I joined the AOM in 2006 that there had been no program put in place by the ministry to ensure the sustainability of midwifery in rural and remote communities. In our consultations with the Remote and Rural Midwifery Committees, we heard detailed first-hand accounts from the midwives how challenging it was to maintain a practice without appropriate time off for recovery from the challenging work of midwifery. I could not understand how the work of midwives in rural and remote communities could be so invisible and so unsupported when the Ministry was actively generating programs to recruit and retain other health professionals to these same types of communities.

77. The locum fund sought by the AOM would cover, at minimum, accommodation, living expenses, travel time, and mileage costs (including travel to and from the community where the locum takes place). As well, a mechanism for timely processing of the required liability insurance premium for the locum midwife would need to be ensured.

78. The AOM also sought additional funding for rural and remote practices similar to the Rural Medicine Investment Program. Specifically, the AOM asked the Ministry to replace the Remote grant with the establishment of a Rural and Remote Allowance program. This allowance would be provided to each rural and remote midwife who qualified, to address additional operating costs associated with rural and remote practice such as: increased time and maintenance requirements resulting from harsher road conditions; stress; satellite phone; higher commodity prices; weather-related expenses such as a backup generator; high costs of travel for continuing education; and, in remote areas, lower caseload availability and hence poorly remunerated on-call and operating costs.

79. We also requested an allowance that would contribute to recruitment and retention by acknowledging the more challenging aspects of working in isolated communities such as social and professional isolation, including lack of adequate call-sharing; earlier call-in times in rural areas for secondary midwives; a lack of easily accessible supporting health care resources; and in remote areas, lower caseloads resulting in midwives who were not able to attain a caseload equivalent to full time

80. This type of compensation and expense reimbursements would parallel the Rural Medicine Investment Program for physicians who provide full time, dedicated patient care in rural communities – including CHC physicians who were able to claim annual retention incentives under the Northern Physician Retention Initiative, established under the 2000 Ontario Medical Association Framework.[28]

81. The AOM argued during this negotiation that midwives are specialists in normal, low-risk birth and should be paid parallel to physician specialists who relocate to a designated community, and that providing incentives to join or open rural or remote practices will allow women across Ontario to have equity in their access to midwifery care.

(vii) Tuition Reimbursement in Exchange for a Return-of-Service

82. In addition to the locum relief, income supplements and/or grants for other health care professionals in rural and remote communities, the AOM staff learning in our research that the Ministry also offers a tuition reimbursement program for doctors, including CHC physicians, who practise in underserved areas. The Free Tuition Program for physicians provides up to $40,000 ($10,000 per year) in tuition rebates in exchange for a commitment to practise for three to four year in a community designated as underserviced or in an undersupplied speciality. Further, the local incentive fund could provide tuition grant candidates with additional financial incentives to relocate to designated communities if their tuition was less than $10,000 per year.

83. The AOM sought a similar tuition reimbursement program for midwives practising in designated rural and remote communities. Since midwifery tuition fees are less than the tuition fees for physicians, tuition reimbursement would cost less per midwife than the government was already paying per physician, and would make a significant contribution to the goal of ensuring equitable access to maternity care for all Ontario women.

(viii) IT Infrastructure Support and EMR

84. Like other health professionals, midwives were facing increased IT requirements – requirements that were expected to continue to grow as Health Canada pursued an initiative to accelerate the use of Electronic Medical Records (EMRs).

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[28] Agreement OMA-MOH 2000-2004, AOM0000634.

The goal was that by 2010, 50 per cent of Canadians and by 2016, 100 per cent of Canadians would have their electronic health records available to the authorized professionals who provide their health care services. Most hospitals provided on-line access for electronic strips, lab reports, physician documentation of care, etc., and midwives' access to these records was essential to facilitate interprofessional care.

85. Physicians had been well funded by the MOHLTC, through the OMA, to move towards an electronic medical record system. In our funding agreement proposal, we noted that MOHLTC-funded physician IT support included $150 million provided to the OMA for the Physician IT program, a program managed and delivered by the OMA with a focus on primary care physicians. Of this, $15 million was earmarked for 524 Family Health Group (FHG) physicians. Physicians could access a one-time site readiness grant of $4500 to prepare the office environment for the installation and use of a Clinical Management System (CMS); a funding subsidy of $600 per month for a period of 36 months for each participating physician for the acquisition, implementation and maintenance of a CMS; and a one-time performance recognition bonus of $2500 per participating physician for the establishment of EMRs for either 2/3 or 600, whichever was less, of their rostered patients. Physicians who did not wish to implement the entire CMS could access a smaller desk-top grant, a one-time grant of $2000 per participating physician.

86. Given the increased IT requirements placed on midwives, its importance to effective interprofessional care, and the need to ensure that client privacy was protected, the AOM sought funding from MOHLTC to support various IT initiatives. In particular, the AOM proposed that it be given financial support to undertake a variety of activities (e.g. workshops, conferences) to provide midwives with information regarding the benefits of EMRs and other available technologies (e.g. accessing lab reports online), and that funding also be provided to develop a Midwife IT program to support a move to EMRs. For each midwifery practice group, this would include:

- One-time funding for each current and new practice group for encryption software;
- Annual funding for anti-virus and firewall upgrades;
- Annual funding of $1500 to update existing software and hardware to ensure efficient, effective IT systems within the practice;
- Funding for hardware and software (including networking) on a ratio of one computer for every two midwives in a practice group, this ratio also to be reflected in the new practice equipment list.

(ix) Dispute Resolution and Amendments

87. In this round of negotiations, the AOM sought a dispute resolution process to deal with disagreements that might arise in the interpretation of the Funding

Agreement. We had observed how the OMA had further its interests through this route. We had also in the past faced situations in which midwives and their TPA disagreed about the interpretation or application of the Funding Agreement, and midwives had no forum in or defined process by which to discuss the matter, let alone resolve it. We wanted to avoid having to wait for each new round of negotiations to deal with issues that could and should be addressed in implementing the existing agreement. We saw developing a dispute resolution process as key to helping to lessen the significant power imbalance between a small MPG and the TPA (which could, for example, be a hospital) that administered its funds.

88. Based on our review of other agreements entered into by health care professionals, including directly with the Ministry, the AOM was aware that dispute resolution clauses were standard. The AOM sought to establish a dispute resolution process similar to that the OMA and the Ministry had agreed to in their Funding Agreement, which included:

(d) a joint committee to discuss the interpretation and application of the Funding Agreement and any issues of fair representation that might arise as a result of actions taken by the parties during its term;

(e) an appointed facilitator;

(f) funding of its own members by each party;

(g) ministry-funded administration costs for the committee and the facilitator;

(h) having the matter first referred to the joint committee if the Ministry and the OMA disagree regarding the interpretation or application of the Funding Agreement; and

(i) having the committee make recommendations to the parties regarding the resolution of the disagreement and potentially enlisting the support of an agreed-upon mediator to assist.

89. The AOM proposed jointly developing a mediation/arbitration clause, and creating a joint MOHLTC/AOM committee similar to the OMA joint committee to permit the parties to equitably and respectfully resolve disputes without unnecessary delay or escalation. In order to protect against unilateral changes to the agreement that would undermine the good faith between the parties, the AOM also sought a commitment from the Ministry not to amend the Funding Agreement without a negotiated process.

c. The Negotiation Process

90. By early 2008, the AOM was ready and eager to begin negotiations with the MOHLTC as agreed in the 2005 contract.

91. Having heard nothing from the Ministry, Johnson wrote to the OMP's Wendy Katherine on February 12, 2008, requesting that the parties begin reviewing the

funding agreement.[29] Katherine replied on February 21, 2008 advising that a meeting would be scheduled once they received the AOM's list of priorities.[30] We provided that list on April 30, 2008.[31]

92. On May 27, 2008, a "Funding Contract Review" meeting was held between the AOM and MOHLTC. At this meeting, we provided the Hay Group report entitled "Market Changes in Compensation, 2005-2007", which the Ministry agreed to review. The funding review process discussed at this meeting included four full days of in-person meetings in June 2008, for preliminary discussions to ensure that both parties fully understood the issues, followed by a period of Ministry staff research, and then a second round of in-person meetings, this time for six days in late July 2008, to determine what changes were needed to the funding agreement.[32]

93. In May 2008, however, the AOM was advised that as a result of a large-scale reorganization within the Ministry, Wendy Katherine had been seconded to the Strategy Division. Jody Hendry was hired as the Acting Coordinator for the OMP, and would be the lead negotiator on the new midwifery funding agreement. On June 19, 2008, I got a call from Hendry to say that the MOHLTC was cancelling our meeting scheduled for June 26, as she needed time to come up to speed and to confirm a process within the Ministry.[33] Although Kilroy, Berinstein and I met with Hendry and colleagues from the Ministry on July 24, 2008 concerning other matters, Hendry was at that time unable to provide any answers concerning how we could move forward with negotiations.[34] She indicated that negotiations might resume in September, but could not commit to that. By late August, the AOM still had not heard from the Ministry concerning negotiations.

94. Having experienced an 11 year period with no negotiations with the Ministry and no opportunity to address compensation issues, we were wary of a delay but also wanted to start this round of negotiations on the right note. I was careful in my communications with Hendry to be collaborative in my approach but also continue to be firm that we expected negotiations to start as quickly as possible. On August 28, 2008 I sent an email to Hendry asking whether I had missed any messages suggesting September negotiation dates, and if not whether she could propose

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29 Letter from Elana Johnson to Wendy Katherine, OMP re: Beginning Reviewing the Funding Agreement (February 12, 2008), MOH000428.

30 Letter from W Katherine to E Johnson re AOM request to review funding agreement (February 21, 2008), AOM0001422.

31 Meeting agenda and process outline re Funding Contract Review, Review Process Development (May 27, 2008), AOM0000685.

32 Meeting agenda and process outline re Funding Contract Review, Review Process Development (May 27, 2008), AOM0001434.

33 Email from Stadelbauer to AOM re call from J Henry, OMP cancelling meeting, identifying W Katherine not part of negotiations (June 19, 2008), AOM0001457.

34 Emails between Stadelbauer and J Hendry re. meeting plan (July 23, 2008), AOM0001462.

some. I noted my concern that everyone's schedule was filling up for the fall without us having set any time aside for negotiations. Hendry replied that although she was making progress in getting approvals on her side, she did not yet have any dates to propose.[35]

95. On September 9, 2008, we received a letter from Mary Fleming, Director of Primary Care, advising that the Ministry was now ready to commence discussions, and that Mary Catherine Lindberg, then the Executive Director of the Ontario Association of Teaching Hospitals, would be facilitating that process. Ultimately, it was not until October 28, 2008 that negotiations began. Lindberg, Hendry, Joan Mongeon and Samantha Ball represented the Ministry, while Elana Johnson, Katrina Kilroy, Juana Berinstein and I represented the AOM.

96. Throughout the summer of 2008, while the AOM was waiting for the Ministry to come to the table, we were also keeping a close eye on negotiations and settlements with other health care providers. In particular, we were aware that the OMA was in negotiations with the Ministry – negotiations the Ministry clearly had time and resources for, despite its internal reorganization – that we expected might well provide new benchmarks for compensation comparators.

97. In September 2008, MOHLTC entered into a new agreement with the OMA, which was ratified by OMA members in early October 2008. This new agreement increased CHC physicians' salaries from $155,399 in 2009 to $217,687 in 2011. This was on top of previous increases from the 2006 salary of $150,499. In addition, the new agreement provided that effective April 1, 2009, CHC physicians would receive "monthly incentives and bonus payments", and that a three percent General Fee Payment (3% GFP) would apply to "these eligible incentives and bonuses per the 2008 Physician Services Agreement negotiated between the Ontario Medical Association and the Ministry".[36]

98. As a result of these further compensation increases for CHC physicians, the pay equity gap for midwives grew even wider.

99. I recall being on vacation the week of October 8, 2008. Simultaneously, I was reading news reports of the OMA ratifying this very sweet deal with the Ministry and watching on TV the meltdown of the global markets.

100. Although we were of course aware of the global financial crisis and its increasingly significant effects on Ontario's economy, we were still hoping that MOHLTC would deal fairly with midwives and provide meaningful increases in compensation comparable to those it had just provided to physicians. We hoped that the budget cycles were such that our negotiations would have been factored into the midwifery budget prior to May 2008, just like the physicians' negotiations

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35 2008/09/01 MOH-AOM emails re rescheduling meetings (September 1, 2008), AOM0001453.

36 Ministry of Health and Long-Term Care, "Community Health Centre (CHC) Payment and Reporting Guide", April 1, 2009, AOM0000626.

would have been. We saw the physicians be provided significant increases in September as the financial crisis was unfolding. We were feeling confident that if the Ministry was holding to what it had budgeted for, and that if the physicians were able to achieve increases, then with our evidence in hand, so could we.

101. Instead, just one month after giving physicians a very substantial compensation increase, the Ministry advised the AOM that the economic difficulties required midwives to be subject to compensation restraint policies. These policies were not applied equally to other health care professionals, and were imposed on midwives despite the fact that MOHLTC was well aware that midwives had not received regular or equitable increases like other health care professionals.

102. The AOM's response was to highlight the increases provided to the physicians, along with the security of a four year agreement. The AOM reiterated the lack of process and compensation parity that midwives had relative to others who were funded by government, particularly the inequitable compensation relative to CHC physicians relative to the 1993 Morton benchmark of 90%.

103. Nevertheless, the compensation package the Ministry proposed in December 2008 provided only minimal increases: 2% over each of the three years covered by the agreement.

104. The Ministry was also initially resistant to many of the AOM's non-compensation proposals, including parental leave, a professional development program, tuition reimbursement, and meaningful IT infrastructure support. The Ministry also refused to agree to a dispute resolution process similar to that set out in the OMA's agreement.

105. We were very disappointed and dismayed by the Ministry's position. We could see no principled reason to treat midwives differently from other health care professionals, to whom the government was consistently providing increases, particularly since midwives provided such excellent outcomes for the Ministry. The AOM had provided detailed evidence to support our proposals, and had suggested various compensation mechanisms that would give midwives fair increases, in line with those being provided to other professionals, while also addressing the province's asserted need for fiscal restraint. Notably, these increases would not redress the midwives' historic underpayment, or bring them up to pay parity consistent with the Morton report. They would simply begin to provide midwives – in this round of negotiations – with some of the compensation, benefits and programs provided to other health care professionals.

106. I was continuing to scan media reports about other compensation settlements and agreements with the province, and on January 5, 2009, saw an announcement that the Ontario government had reached an agreement with the Ontario Provincial Police Association to pay the male-dominated OPP officers 2.34%, 2.25% and 2% along with pay equity adjustments for civilian employees.

Male-dominated corrections officers had also just received an offer from the government for 1.75%, 2.0%, 2.0% and 2.0%, as well as well two increases over 4 years in on-call pay as well as a special 6% adjustment if the government's proposal on sick time was accepted.[37]

107. It was increasingly difficult for the AOM to understand why the province was so resistant to agreeing to equitable funding for midwives, when it appeared to have resources available to increase compensation to other professions. It began to seem to us that resistance was coming from higher levels of government – who perhaps did not fully understand midwifery and its contribution to Ontario's maternity care system – and that in order to make progress we would have to speak to more senior staff.

108. I wondered whether senior MOHLTC officials might have seen the OMA's original 2007 Policy on Maternal and Newborn Care, which stated erroneously that midwives were compensated more generously than physicians for the same work, and whether that might be part of the basis for the government's intransigence. This was the same paper that Elana Johnson was able, in early 2008, to get the OMA to retract and correct. In January 2009, I called Vena Persaud, the MOHLTC's Program Manager for Primary Care, to advise her of the 2008 revisions by the OMA and to explain why the information in the original version was incorrect. I noted that in fact, midwives faced a significant and growing negative compensation gap. Persaud said that this was the first time she knew of such a large compensation gap between physicians and midwives and stated that she would get this information to the Strategy and Investment Prioritization Committee (SIPC), where midwifery compensation was being considered. She said she would bring the history of midwifery compensation and context to SIPC.[38]

109. On January 21, 2009, AOM President Katrina Kilroy wrote to Ron Sapsford, Deputy Minister of MOHLTC, requesting an urgent meeting to discuss the need to "fairly fund midwifery in Ontario." The letter noted that the Ministry's negotiation team had offered midwives a "compensation increase of half of what physicians and nurses settled for in the past year and no catch up for the lack of increases for 11 years from 1994 to 2005."[39]

110. Throughout our negotiations the Ministry kept telling us that they simply could not provide midwives the compensation increases we sought because of the

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37 OPPA Police salary negotiations update and other wage settlements, AOM0001486.

38 Transcribed telephone conversation between K. Stadelbauer and Vena Persaud (MOH) in January 2009 re compensation (January, 2009) AOM0001567; Email from Kelly Stadelbauer to Vena Persaud (MOH) on January 25, 2009 re OMA policy paper claiming that midwives make more than obstetricians. Jody Hendry (MOH) copied on email. (January 25, 2009), AOM0001512.

39 Letter dated January 21, 2009, from Katrina Kilroy, President of the Association of Ontario Midwives to wrote to Ron Sapsford, Deputy Minister of Health and Long-Term Care (January 21, 2009), AOM0000687 at p. 1.

economic downturn. We knew, however, that funding for midwifery – even with the increases the AOM was seeking – was effectively a drop in the Ministry's very large budgetary bucket. I did the math to show the relative impact on the Ministry's overall budget of an increase to midwives as compared to an increase to other health care providers. According to the 2008-09 Government Estimates, the Ministry's transfer payments to "physicians and practitioners" were $9,625,294,100, while transfer payments for midwifery care were only $88,534,900, or .92% of the payments made for care and services by physicians and practitioners. A 1% increase to physician compensation therefore has a much greater impact on the overall MOHLTC budget than a 1% increase to midwives. That is, a 1% increase in midwifery transfer payments (including both compensation and non-compensation expenditures) is equivalent to 0.0092% of an increase in the "physician and practitioner's" budget. [40] Yet the Ministry had sufficient funds for a large increase negotiated by the male-dominated OMA, but somehow not the much smaller amount needed to address the midwives' inequitable compensation in this round of negotiations.

111. We also did the math to show the overall budgetary impact of the AOM's compensation proposal as compared to the Ministry's. As of January 2009, the AOM was proposing what we considered to be a very modest increase in compensation: 3.5% for each of the three years covered by the agreement for each basic course of care, for midwives' on-call commitment, and for secondary course of care, as well as a 3.5% signing bonus. The difference between the AOM's proposal and the Ministry's proposal – 2% per year for each element of midwives' compensation, with no signing bonus – was as follows:[41]

Year	Base Fee Difference	On-Call Fee Difference	Secondary Care Fee Difference	Total
2008-09	$943,800	$181,500	$99,600	$1,224,900
2009-10	$623,929	$119,986	$42,498	$786,413
2010-11	$1,092,300	$197,404	$120,515	$1,410,219
Total	$2,660,028	$498,890	$262,613	**$3,421,532**

112. In other words, the Ministry was telling us that it could not afford total compensation increases of less than $3.5 million over three years – a small fraction of the deal it had just negotiated with the OMA, and an infinitesimally small percentage of the Ministry's overall budget.

113. On January 26, 2009, Kilroy, Johnson, Berinstein and I met with MOHLTC Minister David Caplan to discuss the AOM's concerns with the government's

40 Ministry of Finance, "Ministry of Health and Long-Term Care- The Estimates, 2008-09 Summary" (2008-2009), AOM0000655.

41 Cost comparison of AOM and MOH proposals (January 26, 2009) AOM0001476.

treatment and compensation of midwives.[42] We prepared a document showing graphically the gap that had developed in midwifery compensation since regulation.[43]

114. Minister Caplan informed us that he was firm in this offer and unwilling to address the pay gap.

115. Following this meeting, in our continued negotiations with the Ministry we were able to make some headway with respect to the non-compensation elements of our proposal, including benefits and supports for professional and practice development.

116. On February 23, 2009, the MOHLTC presented a proposal to the AOM. The proposal included an increase in benefits from 18% to 20% of salary, and provided funding for a new parental leave program for two years, administered by the AOM Benefits Trust in keeping with midwives' independent contractor status.[44] In addition, it provided for a new professional development program modelled after the professional development programs available to other health professionals, providing up to $1500 per midwife per year to be administered by the AOM; a $100,000 locum program for rural and remote midwives; a rural and remote compensation fees supplement and operational fee supplement for midwives working in such communities, also to be administered by the AOM; a $100,000 special populations grant to meet needs of specific groups of midwifery clients; a $100,000 interprofessional grant to assist the AOM in undertaking hospital integration work; and second attendant funding of $18,000 to support small rural and remote practices.[45]

117. With respect to compensation, the Ministry maintained its offer of a 2% increase per year. For operational expenses, the Ministry offered a 2% increase for 2008 and 1% for 2009-11. The offer did not acknowledge or include any pay equity adjustments.

118. This was far less than the AOM had been seeking, and far less than required to prevent further erosion in compensation relative to other providers – let alone to address the pay gap between midwives and our comparator, CHC physicians, that had developed since regulation. We were encouraged, however, by three non-monetary aspects of the MOHLTC's proposal.

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42 Kilroy and I memorialized our meeting in a follow-up letter to Minister Caplan – Letter from K. Kilroy and K. Stadelbauer to D. Caplan re: Midwifery Compensation (January 28, 2009), AOM0006232.

43 Midwifery 2007 Compensation Gap Graph Based on 1993 Job Evaluation Principles, January 26, 2009, AOM0002647.

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

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

119. First, although the Ministry refused to agree to a binding dispute resolution process, it did agree to AOM's request to form a joint advisory committee that would meet quarterly and discuss arising issues in relation to implementation of the funding agreement. Second, the Ministry said it would commit in writing to begin review of the funding agreement with the AOM no later than September 20, 2010. Third, and most significantly, the Ministry would commit to commissioning an independent compensation review. Our negotiations team pushed hard for this to be included in the offer; we knew that there was a risk our members would not accept the offer without some commitment to redressing the gender inequities in compensation experienced by midwives. Although this review would be non-binding, it was intended to inform the next negotiation.

120. While the monetary aspects of the Ministry's proposal were disappointing to say the least, the AOM and its membership understood, based on the non-monetary commitments the Ministry was prepared to make, that we would be back at the negotiating table in just over 18 months with a neutral, objective, evidence-based compensation report in hand – a report we were certain would conclude that midwives, an overwhelmingly female profession doing work for women, were seriously and inequitably undercompensated.

121. When we took the draft Memorandum of Understanding (MOU) to our membership in March 2009, we stressed these points as well as other "process" gains that had been made, including that the Ministry was recognizing the AOM as midwives' representative in negotiations, and that for the first time, our negotiations had included staff from the Ministry's "Negotiations Branch" in addition to staff from the OMP.

122. There were also other signs that negotiations with midwives were increasingly being treated in a similar manner to those with other professional bodies. In our communications with the Ministry about finalizing the MOU, Jody Hendry repeatedly stated the need to make sure that our process was consistent with "other negotiations" and advised that she had conferred with the Director of Negotiations on this point. In addition, the Ministry informally recognized the AOM's role in negotiations as similar to that played by the OMA in physician compensation negotiations. The Ministry stated that negotiations with the AOM would have to change to become more like those it undertook with other providers, and unilaterally announced that the Ministry's Negotiations Branch would now be the lead in negotiations instead of the Primary Care Branch. Communications from the Ministry described the 2008 amendments to the agreement as "new contract negotiation changes" and the process through which they were reached as the "contract negotiation process".[46]

[46] Letter to AOM from J Henry MOH re Billable course of care definition and various emails between AOM and MOH re implementation and communications (March 24, 2009), AOM0001473; Various emails between J. Mongeon (MOH), A. Simon and A. Ormiston re: draft communication to TPAs (July 17, 2009), AOM0001497.

123. The AOM and the MOHLTC entered into the MOU on May 7, 2009.[47] This was the first MOU the AOM had ever had with the Ministry. The MOU provided for the funding increases and new programs set out above. It also committed the Ministry to begin the next round of contract negotiations by September 30, 2010.

124. Article 4 of the MOU formally established the Joint Midwifery Advisory Committee (JMAC), consisting of five AOM representatives and five Ministry representatives. The MOU affirmed that JMAC would meet at least four times per year, and in addition would conduct an annual review of the Midwifery Practice Group – Transfer Payment Authority Funding Agreement and discuss any matters of concern in relation to that Agreement. This annual review by JMAC was explicitly intended to "supplement rather than to replace any other negotiations contemplated by the MOU." As set out in the JMAC Terms of Reference appended to the MOU, the purpose of JMAC is to "discuss issues and concerns of either party as they arise, be proactive in resolving issues and to build and maintain a productive working relationship." Disputes could be brought to JMAC for resolution with the option for a third-party facilitator if JMAC was unable to resolve with parties required to "use their best efforts to resolve issues and disputes in a collaborative manner."

125. The first meeting of JMAC took place on May 29, 2009. Kilroy, Berinstein and I attended on behalf of the AOM, and placed the compensation review for midwives on the agenda.

126. Article 7 of the MOU set out the agreement to jointly retain an objective, independent third party to conduct a compensation review of midwifery services. The primary goal of this review was to suggest an appropriate "total compensation" package for midwifery services based on available evidence, defined as including but not limited to:

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

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

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

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47 Report by Courtyard Group for MOHLTC Compensation Review of Midwifery (September 2010), AOM0007157 at 29.

Total compensation was defined by Article 7.3 as course of care fees, including operational on-call, secondary care, retention, experience fee and rural and remote supplements, along with all benefits or equivalent funding.[48]

127. Article 7.4 set out "best efforts" review process timelines that contemplated receipt of the final report by June 30, 2010 – in advance of the next scheduled round of negotiations.

III. JOINT COMPENSATION REVIEW – THE COURTYARD REPORT

a. Introduction, Scope of Review and Review Process

128. With the start of contract negotiations scheduled for the end of September 2010, we needed to get the compensation review underway and completed in order that it could inform our negotiations. In July 2009, AOM President Kilroy wrote to the MOHLTC to start the process.[49]

129. Pursuant to Article 7.1 of the 2009 MOU, a Joint Steering Committee was established in to conduct the compensation review process. The three Ministry representatives were Seetha Raja and Melanius Finney (a financial staff person from the OMP), and Arda Ilgazli from the MOHLTC Negotiations Branch; Katrina Kilroy, Juana Berinstein and I were the three AOM representatives. We first met on October 9, 2009 to discuss the terms of Request for Service and the scope and process of the review.[50]

130. The Ministry provided the initial draft of the Request for Service (RFS) and list of potential vendors. On January 29, 2010, I sent an email to Seetha Raja attaching a revised draft of the RFS and commenting on the initial vendor list. I noted AOM's concern that only one of the potential vendors had experience with compensation studies and asked what the process was for adding vendors to the list.[51] Raja responded that there was no process for adding vendors because all those on the list had been approved through a Ministry RFP process. Raja advised that a full, public RFP process would be time-consuming and likely result in the same potential vendors as those already on the Vendor of Record list.[52] On March 9, 2010, I received an email from Melanius Finney with an updated

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48 MOU between Her Majesty the Queen in Right of Ontario as represented by the Ministry of Health and Long Term Care and the Association of Ontario Miswives (May 7, 2009), AOM0001231.

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

50 Email from K. Stadelbauer to K. Kilroy re: Compensation Review Committee Meeting Planning, AOM0010107

51 Email from K. Stadelbauer to . M. Boyes forwarding email from M. Finney to K. Stadelbauer on March 9, 2010 re: Timelines for Compensation Review RFP. J. Berinstein and S. Raja were copied on the email., AOM0001588

52 Email from K. Stadelbauer to . M. Boyes forwarding email from M. Finney to K. Stadelbauer on March 9, 2010 re: Timelines for Compensation Review RFP. J. Berinstein and S. Raja were copied on the email., AOM0001588

timeline.[53] It was an incredibly tight schedule with most of the work to be completed over the summer, but the Ministry seemed committed to having a final report completed by September 30th. We agreed to the new timeline set out.

131. On June 8, 2010, the Ministry sent out the RFS to selected Vendors of Record. As per the MOU, the RFS sought

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

132. The Courtyard Group ("Courtyard") was the only responding vendor who provided a detailed submission, dated July 6, 2010.[54]

133. On July 14, 2010 the Joint Steering Committee met and reviewed Courtyard's proposal and on July 19, 2010 the Joint Steering Committee met with Courtyard consultants John Ronson and Gia Marasco to discuss various questions with respect to the review process. All of the members of the Joint Steering Committee expressed how impressed they were with Courtyard's presentation and that we were confident in their ability to carry out the review. On July 20, 2014, the Ministry approved Courtyard to undertake the compensation review.

134. The jurisdictional comparison was included in the RFS at the Ministry's insistence and pursuant to the MOU. The AOM negotiations team questioned the value of that comparison to a pay equity analysis. I had done some research on the Pay Equity Commission's website, and understood that a jurisdictional comparison was incompatible with a proper equity analysis as comparing underpaid women workers in one jurisdiction to underpaid women workers in another simply perpetuates and reinforces gender biases. At the July 28, 2010 Joint Steering Committee meeting, Kilroy and I (Berinstein was not present) pointed out that the government's own Pay Equity Commission website stated that an employer could not rely on external market information for valuing and comparing job classes. As well, we pointed out that some other provinces have employee models and these are not easily comparable with an independent contractor model with regard to scope, volume and complexity of work, including management HR responsibilities, business risk, and other such issues. At that meeting we came to a consensus that Courtyard would undertake a jurisdictional comparison in order to fulfill the MOU, but would only review Alberta and British Columbia.

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53 Email from K. Stadelbauer to . M. Boyes forwarding email from M. Finney to K. Stadelbauer on March 9, 2010 re: Timelines for Compensation Review RFP. J. Berinstein and S. Raja were copied on the email., AOM0001588

54 Proposal by Courtyard Group re: Compensation Review, AOM0010103.

More importantly, we came to a consensus that the comparison with other professions was more important than the jurisdictional one.

135. On August 8, 2010, the Joint Steering Committee met again with the Courtyard consultants, and the Joint Steering Committee developed and agreed on all of the evaluation questions that would guide their work.

136. The Courtyard consultants carried out their research throughout the remainder of August and early September, and worked closely with the Joint Steering Committee to identify interviewees and other sources of information. Both parties were provided with iterative drafts, and the opportunity to make corrections or add information as the report was developed, and I did provide significant feedback into this part of the process.

(i) Changes in CHC Physician Compensation

137. We wanted to make sure that the Courtyard report captured recent changes in CHC physician compensation. Under the 2008 Physician Services Agreement between the OMA and the Ministry, physicians were given increases in fees of 3%, 3%, 2% and 4.25% from 2008-2011, with a commitment to give "an equivalent adjustment" to non-fee for service physicians, including CHC doctors.[55] At some point after the 2008 negotiations between the OMA and the MOHLTC concluded, the Physician Services Agreement became public. In section 5.13 of the Agreement, the OMA and MOHLTC agreed to a compensation review to see if there was "alignment of CHC physician compensation with CHC service profile and accountability within their LHIN. Compensation models, including all fully salaried models, will be considered during the review….The review will be completed no later than October 1, 2009."[56]

138. From that review, as of April 1, 2010, CHC physicians received a sizeable compensation increase to give them parity with family physicians working in other models. There were 2 levels of compensation: Level I provided for $168,856 to $195,563, and Level II provided for $203,767 to $237,619.[57] The higher range was for physicians working in northern and "underserviced" rural and remote parts of the province. This increase was a significant jump in compensation for CHC physicians. According to the 2007 Hay Group report on market changes in compensation, the 2007 salary range for regular CHC physicians was $120,966

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

56 Memorandum of Agreement Between the OMA and MOHLTC 2008, AOM0016496

57 Letter from L. Pinkney, Manager, MOHLTC to Community Health Centre Executive Directors re CHC Physician Compensation, move to salaried model, MOH001176.

to $145,730 in 2007, while the range for CHC physicians in underserviced areas was $153,341 to $184,732.[58]

139. The Ministry was tasked by the Joint Steering Committee with providing the data regarding CHC physician compensation to Courtyard.

b. The Courtyard Report

140. On September 29, 2010, the Courtyard researchers presented the Joint Steering Committee with their findings. John Ronson provided a three-page summary with three recommendations:

(a) The Ministry should provide a one-time equity adjustment of 20% to the compensation of midwives effective April 1, 2011. Benefits allowances should remain at 20% of income, but increase in total dollar amount corresponding. Courtyard noted that this adjustment would restore midwives to their historic position of being compensated at a level between that of nurse practitioners and family physicians, and that while not completely consistent with the original Morton principles – which would push the upper limits of midwives' compensation even higher – it would be "fair in all the circumstances."

(b) Negotiations on other elements of compensation and annual changes in compensation should occur at regular intervals in order to avoid midwives falling behind once again in the future.

(c) The Ministry should provide for increased flexibility around payment for specialized clinical services.[59]

141. Hearing those recommendations was both a vindication and a relief. I and my colleagues at the AOM had spent years compiling the evidence to demonstrate both the value of midwifery and its serious under-compensation as a highly female profession. It was incredibly validating to hear an outside, independent and informed third party reach the same conclusions based on a comprehensive review of the evidence. This was exactly what we had hoped would happened – that we would be able to enter into the next round of negotiations with clear evidence in hand that what the AOM was asking for was only fair and equitable.

142. Moreover, we hoped that, although not strictly bound by the review, the Ministry would take very seriously Courtyard's conclusions. We were prepared for some tinkering at the margins – for example, we thought the Ministry might say that it could not provide the full 20% adjustment in one year but would instead have to distribute it over a few – but we expected that the recommendation would form

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58 Report from Hay Group to AOM called "Market Changes in Compensation: 2005-2007, AOM0000566

59 Courtyard Report, AOM0005893, at 43.

the basis of our upcoming negotiations. With the Ministry having been fully part of the process, and in fact having lead and sponsored this review, we believed that the Ministry would have confidence in Courtyard's findings.

143. The Ministry representatives at the September 29, 2010 meeting had clarification questions for Courtyard, but did not object to the findings or raise any issue with Courtyard's methodology. Courtyard solicited further feedback from the Joint Steering Committee, and on October 8, 2010, Gia Marasco sent out the final version of the report to the Joint Steering Committee members. I noted that the changes from the September 29th version were minor, and took this as tacit acceptance by the Ministry of the report.

144. The report said many of the things that we had been saying for years, including that: the expansion of midwives' scope of practice over the years reflected an increase in their responsibility and accountability; that the MEP had expanded to reflect the evolving role of midwives in maternity care and MEP students frequently had previous undergraduate or graduate degrees; that there had been a significant increase in midwives' non-clinical workload; that midwifery outcomes were excellent and the demand for midwifery services in Ontario was unmet; and that compensation increases for midwives had fallen well behind those of other professionals; and that compensation for midwives had strayed significantly from the Morton principles and the equity framework adopted at the time of regulation.

145. The report also concluded that the intermittent and irregular negotiations between the Ministry and the AOM, and the delays in the most recent round, hurt midwives' compensation.[60] Again, I felt vindicated as midwives had indeed experienced that Ministry-caused delays in negotiations had been quite prejudicial over the years since regulation.

146. Given these findings, we were hopeful about both the process and the outcome of our upcoming negotiations.

IV. POST-COURTYARD NEGOTIATIONS

147. In accordance with Article 9.6 of the May 2009 MOU, the Ministry and the AOM were to start those negotiations by September 30, 2010. The Ministry delayed, however, and our first meeting was not held until October 13, 2010.[61]

148. The lead negotiator assigned by the Ministry was Alex Lambert, who was then the Manager, Agreements & Negotiations, in the Negotiations Branch. In discussions leading up to our first meeting, Lambert had informed AOM negotiations consultant Neil Patton that the Ministry was centralizing negotiations with various groups such as the AOM and the OMA.

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60 Courtyard Report, AOM0005893, at 42.

61 Summary of Meeting between AOM and MOH by A. Lopez and A. Ilgazli re: Negotiations (October 14, 2010), AOM0000755

149. We were initially pleased that the Negotiations Branch was involved, since we took this as a signal that the Ministry was taking these negotiations seriously and approaching them under the same negotiations framework that applied to other professionals. It quickly became apparent to us, however, that the Negotiations Branch was simply there to deliver a pre-determined position: that there would be no increases, and no adjustment to correct the longstanding inequity in midwives' compensation.

150. At our first meeting, AOM President Katrina Kilroy gave a presentation setting out various AOM proposals. Her presentation also provided a brief history of midwifery compensation, including both the 1993 Morton Report and the recently completed Courtyard Report. She explained that midwives were seeking fair and appropriate compensation.

151. The Ministry brought no proposals to the table. Instead, Lambert informed us that the government could not implement the Courtyard recommendations, stating that the Ministry had assigned the wrong staff to participate on the Joint Steering Committee and had issues with the report.

152. This was a complete shock to us. It was the first time we had heard that the Ministry had any issue with the Courtyard Report – a report it had been a full and active partner in producing. We were also angry. The AOM had ensured that we had the appropriate representatives at the table, given the importance of this project and the tight timelines in which to produce a quality report, and despite the difficulties of attending numerous meetings over the summer months. Midwives were now to be penalized for the Ministry's lack of proper attention to this review, reinforcing our perception that midwives were not valued by the Ministry.

153. Throughout our discussions in October and November, Lambert took the position that the Courtyard Report should be addressed through the Joint Midwifery Advisory Committee and should not feature in our negotiations. In one meeting, Lambert did suggest we discuss the Ministry's concerns with the report. We took this as the Ministry's way of "reopening" a report that in our view they had signed off on in early October. We said instead that we wanted to talk about implementing the report. We saw it as a tactic that the Ministry was using to avoid responsibility for the process and the content of the report, and, most importantly, the recommendations. We also thought this was a delay tactic by the Ministry: by prolonging discussions about the report, they could postpone dealing with implementing its recommendations.

154. Lambert displayed a serious lack of understanding of the midwifery model of care, how midwifery is funded, or the role it plays in Ontario's maternity care system. For example, he suggested that the difference between the number of courses of care provided annually by a full-time midwife and the number of patients on the roster of a family physicians should be taken into account when determining compensation, without any appreciation of the amount or scope of

work involved in a single course of care or the number of other professionals with whom physicians can and do rely in providing care to their patients. This focus on the number of clients as a determinant of compensation was dumbfounding to us. There was no understanding of the depth or breadth of work that a midwife typically performs in the course of care of one client.

155. The AOM felt that the positions the Ministry was taking were uninformed, and that Lambert's lack of knowledge about the practice of midwifery in Ontario was hindering our negotiations. Sometime in mid-November, I raised this concern with Susan Fitzpatrick, the ADM, and on December 6, 2010, the Ministry confirmed that they would replace Lambert with Mary Fleming, Director of Primary Care.[62] We knew that Fleming was much more familiar with midwifery in Ontario, and we were hopeful that with someone knowledgeable at the table we would be able to make more headway. We therefore welcomed her appointment, though it delayed our negotiations even further. Fleming needed time to come up to speed, as well as to deal with the Auditor General's report on Primary Care. As a result, our December meeting was cancelled and negotiations did not resume until January 2011. At our meeting on January 12, 2011, the AOM provided an additional document clarifying its original proposals.

156. On February 1, 2011, Kilroy, Lisa Weston, Madeleine Clin, Juana Berinstein and I met with Mary Fleming, Seetha Raja, Heather MacDermid, and Melanius Finney. A representative from the Labour Relations Secretariat attended and gave a PowerPoint presentation on government compensation restraint, which we were told the government had "forgotten" to give the AOM the previous summer, when they had provided it to public sector unions, in advance of their negotiations.

157. The presentation discussed the *Public Sector Compensation Restraint Act*, which had come into force in the spring of 2010 and covered only "employees". The Act prohibited increases to rates of pay, pay ranges, benefits and other payments in effect on March 24, 2010 unless as a result of an employee's length of time in employment or office; an assessment of performance; an employee's successful completion of a program or course of professional or technical education.[63] The AOM had reviewed the Act prior to entering negotiations. In addition, the AOM had received a memorandum dated April 22, 2010 from Saad Rafi, MOHLTC Deputy Minister, sent to all Chief Executive Officers/Senior Administrators (including me) advising that the "Government's fiscal plan provides no funding for compensation increases" and its purpose is to control "compensation of public sector employees."[64]

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62 Letter from S. Fitzpatrick to K. Stadelbauer dated December 6, 2010 re discussions about contract renewal, AOM0001600

63 Compensation Restraint to Protect Public Services Act, 2010, S.O. 2010, c. 1

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

158. Based on that memo and our own review, we did not think the *PSRCA* would have any bearing on our negotiations because midwives are independent contractors, not public sector employees – neither the Ministry nor the TPAs are their employers. On the contrary, the Funding Agreement expressly states that midwives are independent contractors and not employees.

159. We explained that the Act does not apply to the AOM or to midwives because the AOM's board, officers and directors are not elected or appointed by government; because the AOM is not an employer of public sector employees; and the AOM is not one of the listed entities to which the Act applies. We also noted that the collective bargaining exceptions in section 4(2) do not include the AOM because the AOM is not a trade union and does not represent Crown employees – or any employees for that matter. The AOM is not an "employee" organization.

160. Finally, we noted that the Act specifically provides that "nothing in this Act shall be interpreted or applied so as to reduce any right or entitlement under the *Human Rights Code* or the *Pay Equity Act.*"[65]

161. The Ministry representatives agreed that the letter of the *PSCRA* did not apply, but stated that the spirit of it did. We responded that if the spirit of the *PSCRA* applied to midwives, then the spirit of the *Pay Equity Act* should as well. In other contexts, the Ministry insisted that midwives' status as independent contractors meant that they were not covered by "employee protections" established by the *Labour Relations Act* or the *Pay Equity Act*. Yet here, the Ministry was suggesting that midwives should be treated in the same manner as government employees. In other words, the Ministry treated midwives as having all of the burdens of employees, but none of the benefits.

162. We again expressed our frustration and disappointment that the government was now refusing to implement the Courtyard report, which they had been instrumental in producing and paid for.

163. The Ministry then advised that it was postponing further meetings until May 2011 as it required additional time to review the Courtyard report.

164. It was sometime during these months after the Courtyard report was completed that the Ministry advised the AOM to stop using the term "negotiations" to describe our process. The Ministry was intent on calling the process a "discussion" or "review". We stated that our meeting and process had all the hallmarks of a negotiation, including the fact that they were taking place under the auspices of the Negotiations Branch. This refusal to recognize our process as a negotiation seemed to us not only Orwellian but also yet another way to devalue midwives.

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65 *PSCRA*, s.12(3).

165. On March 24, 2011, Fleming wrote to me to request an extension of the MOU as the contract was set to expire on March 31, 2011 and negotiations had not been completed.[66] On March 28, 2011, I wrote to Fleming and again raised concerns about delays and urged the timely resumption of negotiations.[67]

166. With no progress in sight, we requested a meeting with the Minister, Deb Matthews. At that meeting, on April 20, 2011, AOM President Kilroy and I urged the Minister to provide leadership on closing the pay gap. We recognized the fiscal constraints the government was facing, and advised that midwives were willing to accept a temporary freeze on normal compensation increases if the government would commit to addressing the substantial pay equity gap. In other words, midwives would comply with the "spirit" of compensation restraint, although it did not strictly apply to them, so long as the government committed to complying with its obligation to ensure that midwives were paid equitably. We recognized the government had a political problem, and were prepared to work with them to solve it, while also solving the urgent problems confronting midwives.

167. We prepared two possible scenarios that would set us on the right track, though we were not willing to state that either would be sufficient to entirely close the pay equity gap. The first alternative was a 16% equity adjustment in 2011/12 and a 0% regular increase in 2011-12 and 2012-13; the second alternative was a 0% increase in 2011-12 and 2012-13, followed by a 20% increase in 2013-14.[68]

168. Minister Matthews advised that the growth of the profession was her priority, not compensation for midwives. She cited issues with the Courtyard report, namely the lack of a jurisdictional review and the exclusion of liability insurance from compensation, and stated that she thought Ontario midwives were paid well compared to Alberta midwives and that their income was "pretty good for a four year degree." I was shocked at the time that a leader in government would make such a comment, showing a deep lack of understanding of how fair and equitable compensation is determined. Despite her comments, Minister Matthews did not seem to have read the Courtyard report nor did she respond to the AOM's concerns about the Ministry's complete disregard for its conclusions.

169. Minister Matthews' response would have been troubling in any event, but was especially so given the agreement the government had just reached with the male-dominated Ontario Provincial Police. As always, I had been paying close attention to government negotiations and settlements with other professionals, and so we were aware that the government had recently agreed to a 5.075%

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66 Letter from M. Fleming (MOHLTC Director) to K. Stadelbauer (AOM ED) re: MOHLTC & AOM MOU Extension, AOM0007016.

67 Letter from K. Stadelbauer (AOM ED) to M. Fleming (MOHLTC Director) re: MOHLTC & AOM MOU Extension, AOM0000694

68 AOM briefing note for meeting with Minister Matthews dated April 20, 2011, AOM0001650.

increase for the OPP in 2011, to bring them in line with other forces. This would be followed by a salary freeze in 2012 and 2013, in keeping with the government's compensation restraint policy, but then catch up in 2014 when they must be paid the same as the highest paid police in the province.[69] This was in fact the approach that we had modelled one of our own two scenarios on.

170. According to a newspaper article published on May 16, 2011, the projected salary increase for the OPP in 2014 was 8.5%. Even though the deal formally complied with the public sector wage freeze, it was so rich that the Chair of the Toronto Police Services Board criticized the Ontario government for driving up policing costs across the province by setting a new benchmark. [70] The article also reported that a first-class OPP constable would receive $87,240 in 2012 and $90,621 in 2015.[71] In light of Minister Matthews' comments, I was curious to know what the educational requirements were for becoming an OPP officer. According to the OPP's website, the minimum formal requirement is a high school diploma plus police college.

171. On May 5, 2011 it was disclosed that the government had a "secret deal" with OPSEU that was negotiated during the economic downturn in 2008 – when midwives were told that the government simply did not have the funds to give us the increases we sought. The government signed an agreement that provided 2% wage increases for four years and it also signed a separate, undisclosed agreement with OPSEU that provided for, granting them an extra percentage point — for a total of 3% — in 2012.[72]

172. On May 6, 2011, Susan Fitzpatrick, MOHLTC Assistant Deputy Minister called me to say that the Ministry was postponing the negotiations scheduled for the following week, and that the government was looking at a number of scenarios regarding the government's response to the Courtyard report, given the difficult environment.[73]

173. We were beginning to feel as though we had been hoodwinked. Midwives had ratified the 2009 MOU based largely on the promise of a joint, comprehensive, and independent compensation review. That review had reached the same conclusion we had long been urging: that midwives were profoundly undercompensated. And yet the Ministry was again refusing to address the need for compensation increases for midwives – let alone a pay equity adjustment –

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69 News article titled "OPP can't lose with new wage deal: McGuinty gang tries to sell bad agreement as a good one" (Randall Denley, Ottawa Citizen), AOM0000546.

70 Antonella Artuso, "OPP can expect hike in 2014", Sudbury Star (16 May 2011), CAV000002.

71 Antonella Artuso, "OPP can expect hike in 2014", Sudbury Star (16 May 2011), CAV000002.

72 "No excuse for secret OPSEU pay hike", National Post, May 5, 2011. See Article from Globe and Mail about secret OPSEU wage increase, AOM0000547 AOM0000540 AOM0000546

73 Email from K. Stadelbauer to K. Kilroy dated May 6, 2011 re: MOH postponing negotiations, AOM0001614.

while continuing to negotiate substantial increases for other, male-dominated professions.

174. On May 11, 2011, I called Mary Fleming, the Ministry's lead negotiator, to discuss the news of the OPSEU deal and the OPP deal. I also advised that the AOM leadership wanted to publicly release the Courtyard report, which – it now appeared – the government never intended to take seriously despite its considerable investment of time and resources. Although the Courtyard report was not confidential it had not so far been made public, because the AOM was trying to be collaborative and work together with the Ministry. It was increasingly clear, however, that the Ministry did not share that goal. Fleming's response was that she was getting some clear direction from within the Ministry regarding the Courtyard report in preparation for the next meeting.

175. While we were waiting for further information, I saw media reports providing newly-public details of the deal negotiated in June 2009 with male-dominated correctional officers, which gave them a 7.75% increase over four years, plus a 4% bonus intended to reduce very high rates of absenteeism.[74]

176. Further meetings were then scheduled for May 24-26, 2011. Although we did not expect it at the time, these turned out to be our last negotiation sessions until 2013.

177. At our May 2011 meetings, the AOM presented the Ministry with its summary of compensation increases that had been given to various public sector employees. The Ministry proposed increases of 0% in year one, 0% in year two, and up to 5% in year three, tied to meeting one or two specific clinical outcomes of 2-3% each.

178. ADM Susan Fitzpatrick acknowledged at the May 26, 2011 meeting that the proposal didn't "deal with the relativity issue" – the Ministry's term for the growing gap between midwives and other health care professionals – "in a substantial way." Nevertheless, the offer was a one-time deal, predicated on the understanding that we would drop the whole notion of pay equity. The potential 5% increase in year three would effectively be in lieu of the 20% adjustment recommended by the Courtyard report. The proposal was so bad our negotiations team believed it was not even worth taking to our members.

179. The government continued to refuse to address the issue of pay equity. Midwives refused to accept any agreement that did not address pay equity.

180. On June 1, 2011 more than 1,000 midwives and supporters rallied at Queen's Park and another 100 midwives and supporters rallied at Premier McGuinty's constituency office in Ottawa.

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[74] Article in Globe and Mail re prison guards raise, AOM0000550.

181. On June 30, 2011, Premier Dalton McGuinty wrote to Juana Berinstein, AOM Director of Policy and Communications, in response to communications from the AOM concerning the establishment of birth centres. Although the Premier did not address the issue of pay equity, he did state that the government was "committed to supporting midwives and to enabling them to provide the best possible midwifery service. We fully recognize the significant contribution that midwives make to the health care system and to the well-being of thousands of Ontario women and men."[75]

182. As of July 2011, the Ministry was still proposing a compensation freeze for two years followed by an increase of up to 5%, which was tied to meeting specific clinical outcomes. The Ministry then suspended negotiations until after the October 2011 provincial election.

183. During this period of continued delay, while midwives were working without a contract, I saw a news article quoting Dr. Michael C. Klein, a family physician doing maternity care, who stated that the "maternity care system is going to collapse in the next 10 years or so" since the average age of obstetricians in Canada is 58 and a mere 11% of family physicians attend births while demand outpaces supply.[76]

184. On October 24, 2011, after the election, I wrote to ADM Fitzpatrick to stress the need to return to the negotiations table immediately. By this point, midwives had been working without a contract for more than six months and away from the negotiations table for five months.[77] We did not receive any official response.

185. Although no negotiations meetings were occurring or scheduled, we did have several informal meetings with Ministry staff. The government maintained that the midwives had to abide by the spirit of the compensation restraint law. The Ministry would not apply any "pay equity" or "human rights" adjustment exemption even though the AOM stated that it was not asking for a regular compensation increase but for a pay equity adjustment to provide equity within Ontario's publicly-funded health care system.

186. On December 14, 2011, the AOM's Director of Policy and Communications, Juana Berinstein, met with the Minister's Director of Policy, Michelle Rossi. Afterward, Berinstein told me that Rossi advised that the Ministry was concerned that it needed to move forward first with the OMA negotiations, before it could resume negotiations with the AOM. Berinstein told Rossi that the AOM wanted a separate, binding pay equity review process, and could not settle without it. We

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75 Letter from Premier D. McGuinty to J. Berinstein (AOM Director of Policy and Communications) re: establishment of birth centres in Ontario, AOM0000697.

76 Toronto Star article: "Maternity care system on brink of collapse, warns physician", AOM0000551.

77 Letter from Kelly Stadelbauer AOM to Susan Fitzpatrick MOH re returning to negotiations and McGuinty's Sept letter, MOH004313.

were beyond frustrated that midwives again had to wait for the physicians to complete their process before we could resume ours, and we anticipated that this delay would again be prejudicial.

187. On January 19, 2012, I again wrote to ADM Fitzpatrick reiterating the AOM's unanswered request to return to the negotiation table. I highlighted the Courtyard report's finding that delays in negotiation exacerbated inequities, and advised that the AOM's members had been more than patient and were now at their wits' end.[78] As well, AOM President Kilroy sent a letter to Premier McGuinty dated January 19, 2012 asking for him to follow up on his campaign promise to provide equitable compensation to midwives.[79] Premier McGuinty responded by letter dated January 25, 2012 to AOM President Kilroy deferring to Minister Matthews to respond.[80]

188. The delay in negotiations was problematic not only because we were unable to move forward on a new contract but also because the government would not allow the Joint Midwifery Advisory Committee to be convened. The Ministry erroneously stated that JMAC's terms of reference provided it would not been convened during negotiations, and explained that the same was true of the Physician Services Committee, which was likewise prohibited from meeting during negotiations. What was most egregious about this statement was that over the many months since the tabling of the Courtyard report, the Ministry had told us we were not in a negotiation process because they did not "negotiate" with the AOM. And yet they were prepared to characterize our process as a negotiation when it suited their purposes, in order to suspend JMAC and avoid dealing with the issues we were trying to have addressed.

189. Simply suspending JMAC would have deprived us of one of the gains we had made in the 2009 MOU: a forum in which to address issues as they arose. In light of the fact that negotiations were in fact stalled, the government agreed to establish a new committee – the Midwifery Contracts and Funding Advisory Committee (MCFAC) – in January 2012.

190. The MCFAC Terms of Reference provided that the committee's purpose was to "to provide a forum for discussing issues and initiatives related to midwifery contracts and funding." It was chaired by the Director of Primary Health Care Branch – then Melissa Farrell – and was to meet four times per year.[81] Juana Berinstein and I represented the AOM on MCFAC, along with Lisa Weston and

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78 Letter from K. Stadelbauer to S. Fitzpatrick (MOHLTC Deputy Minister) re: return to negotiations, AOM0000701

79 Letter from K. Kilroy to Premier re Courtyard Report, AOM0000702.

80 Letter from Premier D. McGuinty to K. Kilroy (AOM President) re: compensation for midwives, AOM0000703.

81 Terms of Reference of the Joint Midwifery Committee and the Midwifery Contracts and Funding Advisory Committee, AOM0000620.

Elizabeth Brandeis, who became the AOM President and Vice President, respectively, in May 2012.

191. By letter dated February 13, 2012, ADM Fitzpatrick responded to my letter advising that the Ministry would need to extend the MOU "given that negotiations have not resumed."[82] By letter dated March 29, 2012, Mary Fleming, Director of Primary Health Care Branch, wrote further to Fitzpatrick's letter to confirm continuation of the MOU.[83]

192. On June 26, 2012, Minister Matthews wrote to AOM President Lisa Weston concerning the "contract negotiations" but did not address the compensation inequities.[84] There were still no negotiation meetings.

193. On August 6, 2012, Weston and I met with the Minister's Policy Director Michelle Rossi and Policy Analyst Brigid Buckingham. We stated that with a binding pay equity review, we could move forward on other issues. We emphasized the need for negotiations to resume immediately and continue regularly. The Ministry would not agree to a binding pay equity review and did not resume bargaining.

194. On September 26, 2012 the Ministry announced the government's plans to table legislation for a further mandatory two-year wage freeze. This freeze did not ever become law as the legislature was prorogued when the Premier resigned.

195. By letter dated September 27, 2012 to Premier McGuinty, Weston reiterated the AOM's strong objection to the two-year delay in negotiations and again asked for a return to negotiations to deal with all matters except wage parity. The AOM requested that the pay equity issue be dealt with by the creation of an objective and specific process to facilitate pay equity/wage parity. In doing so, it noted that "the midwifery profession, made up of female front line workers serving women clients, does not have access to labour legislation to mandate fairness, and therefore we rely on your government to negotiate fairly and in good faith with us, including negotiating in a timely manner." [85]

196. On October 4, 2012, Weston and Berinstein met with Michelle Rossi. Rossi advised that the Ministry's practice of directly negotiating with the midwives, which was unique, presented a significant obstacle as the government did not want to contradict its own directives. The AOM responded that midwives needed both to negotiate a contract and also to secure a process to address pay equity.

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82 Letter from S. Fitzpatrick (MOHLTC Assist. Deputy Minister) to K. Stadelbauer (AOM ED) re: negotiations and MOU extension, AOM0000704.

83 Letter from M. Fleming (MOHLTC Director) to K. Stadelbauer (AOM ED) re: MOHLTC & AOM MOU Extension, AOM0000706.

84 Letter from Minister D. Matthews (MOHLTC) to L. Weston (AOM President) re: negotiations, AOM0000707.

85 Letter from L.Weston (AOM President) to Premier D. McGuinty re: return to contract negotiations, AOM0000708.

Rossi said that the 5% increase based on meeting performance measures was off the table.

197. On October 18, 2012, Ministry policy analyst Brigid Buckingham sent an email to Berinstein. Her message did not address the request for increased compensation but instead set out the Ministry's "overview of our demonstrated commitment to the midwifery practice here in Ontario."

We recognize the significant contribution that midwives make to the well-being of thousands of Ontario women and newborns and we remain committed to supporting midwives in the provision of the highest standard of midwifery services. We continue to work not only in sustaining the practice of midwifery in Ontario but are committed to the growth of this valued service to women and their babies.

We are also proud of our record to date in support of midwives, including the fact that more than twice as many women have access to midwifery services since 2003, from about 8,000 to over 18,000 in 2010-11 and funding for the midwifery program has increased during this same period by 400%.

As you know, the MOU between the Ministry of Health and Long-Term Care and the AOM that expired on March 31, 2011 is extended until a new agreement is reached. Since our government took office in 2003, midwives compensation is, on average, 38% higher (salary ranges have increased from $55-79K in 2003 to $95K-123K). This is the first increase in compensation for midwives since the profession was regulated in 1994.[86]

198. I was angered and dismayed by several aspects of this message. First, the reference to a midwifery compensation range of $95K-123K is inaccurate. There is no such range. Second, I was aware that the increases for physicians, including CHC physicians, during this same period were much greater – and were moreover increases to salaries that had not been frozen between 1994 and 2005. Third, the Ministry was responding to requests for increased compensation by referring to increased funding for the midwifery program. But funding for an increased number of midwives and practice groups, and for new infrastructure such as birth centres, should never be conflated with individual midwives' compensation. It was essentially the equivalent of responding to doctors' demands for increased compensation by pointing out that the Ministry had built additional hospitals. Physicians, including CHC physicians, are not required to accept spending on infrastructure or equipment as part of their total compensation. Similarly, government funding for medical education is not considered part of physician compensation. Yet when midwives raise concerns about compensation, they are frequently told to be grateful for increases in overall midwifery program funding.

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86 Email from B. Buckingham to J. Berinstein re: Support for Midwifery, AOM0005352.

199. I responded immediately to Buckingham's email on October 19, 2012, again strongly objecting to the delays and expressing the AOM's frustration with the lack of both negotiations and a pay equity review process. My message read in part:

Since the government took office in 2003, midwifery compensation has not kept pace with other public sector workers and, specifically, has fallen well behind comparable health professions. The 38% figure you cite is over an 8 year period, and includes a one-time increase to begin to rectify the 11 previous years of no increases each year since the inception of midwifery; that is, midwives have effectively had a 38% increase compensation in 17 years, which averages less than 2% per year. In June 2012, the Minister cited that the government provided an 85% increase in compensation for physicians over the same 8 year period. The government's consultant in 2010, based on the evidence they gathered for their report, stated that midwives were at least 20% behind where they should be in compensation. No doubt, the government's delays in addressing this wage parity issue for midwives, despite the Premier's promise in September 2011 to do so, has exacerbated the wage parity issue beyond what the Courtyard report identified.[87]

200. That same day, the AOM launched our "Born Without a Contract" campaign. Midwifery clients flooded Twitter with photographs of their babies and the message that they had been "born without a contract" for Ontario midwives.

201. As noted above, one of the Ministry's stated challenges in moving forward with our negotiations was the fact that it deals directly with midwives, and therefore has to be especially mindful of the optics of any settlement. While it is true that many other health care providers negotiate with a third party – for example, nurses negotiate their hospital contracts through negotiations facilitated by the Ontario Hospital Association – midwives are not the only professionals who negotiate with the Ministry directly. Physicians do too – and once again, the Ministry was able to reach an agreement with the OMA that provided increases to physicians, notwithstanding its fiscal constraints.

202. In fact, while the AOM could not even get the Ministry to engage in negotiations, the Ministry was able to conclude two agreements with the OMA: the Physician Service Agreement, and a Memorandum of Agreement concerning the OMA's Representation Rights.[88] [89] Both were announced on November 14, 2011. Minister Matthews said that the service agreement was worth $11.1 billion per year, adding $100 million to the total compensation package for doctors but

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87 Emails between B. Buckingham (MOH) and J. Berinstein, copying M. Rossi (MOH) and from K. Stadelbauer to. B. Buckingham (MOH), copying M. Rossi, L. Weston and J. Berinstein dated October 18, 2012 and October 19, 2012 re: compensation and negotiations, AOM0001672.

88 2012 Physician Services Agreement between the OMA and MOHLTC, AOM0001950

89 Agreement OMA-MOH representation rights agreement, AOM0007119.

included savings in other areas to offset the increase. “Yes, there is a little bit more in the physician services envelope, but every penny of that is offset by system savings that doctors control.”[90]

203. In the negotiations leading up to that agreement, the CHC physicians proposed that the MOHLTC collapse the two wage grids so that all CHC physicians would be paid on the basis of the higher grid. Family physicians in the Aboriginal Health Access Centres (“AHAC”) had already achieved that goal of having only one grid and moving all physicians to the higher grid. The Ministry did not agree to this request for the CHC physicians in these negotiations. The CHC physicians were the only physicians who took a direct decrease in salary compensation for the term of the agreement – namely 1.37% as of January 1, 2013 and 0.5% as of April 1, 2103. Other physicians had reductions in fees.

204. In addition to a service agreement that added $100 million to doctors’ total compensation, the OMA also secured a number of protections in future negotiations. The Memorandum of Agreement recognized that the Ontario government has historically “consulted and negotiated with the OMA as the representative of the medical profession in Ontario.” It formally recognizes the OMA as “exclusive representative of physicians practising in Ontario” including with respect to “the negotiation of physician compensation for physician services funded in whole in or in part directly or indirectly by the Minister.” It continued the Physicians Services Committee as a structured ongoing process for communications. The agreement also provided for key bargaining rights for the physicians that were not provided to the AOM. Specifically, the Ministry committed to the following:

- A facilitator can assist after a period of bilateral negotiations, and can make confidential recommendations to the parties.
- If no agreement is reached, a neutral conciliator can be called in to write a written report with non-binding public recommendations for resolving any outstanding issues.
- The Ministry will not advise the Government of Ontario to unilaterally implement proposals until after both the facilitation and conciliation phases have been concluded.
- The Ministry will negotiate with the OMA over all non-fee-for-service or blended compensation template agreements.
- The Ministry acknowledges the OMA's role in providing the government with advice about health-care policy and system issues affecting physicians.[91]

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90 Toronto Sun Article: OMA deal adds $100M to doctor compensation, AOM0016471

91 Agreement OMA-MOH representation rights agreement , AOM0007119

203. On December 4, 2012, following the "Born Without a Contract" actions, Minister Matthews met with AOM President Weston, Berinstein and me**.** Chris Carson, Ministers' Chief of Staff, Michelle Rossi, Minister's Director of Policy and Brigid Buckingham, Minister's Policy Advisor were also in attendance. The AOM raised three main issues: a) the need for a binding pay equity review distinct from contract negotiations so they did not have to negotiate for fairness; b) a process for negotiating a contract; and c) a mechanism to address midwifery infrastructure issues to enable the continued growth of the profession. The Minister stated there were issues with the Courtyard Report and that it needed "updating"; and that the Ministry would not deal with a 20% gap in compensation as the Courtyard Report recommended.[92]

204. The Minister did agree to a review of compensation (but not to a binding pay equity review) and a contract, as well as to support midwifery growth. She agreed that what the Ministry referred to as the "wage parity" issue should be considered separate from the contract issues. She also committed to the principle that midwives should be compensated fairly and that compensation discussions should take place at MCFAC. She directed the AOM to address these issues at MCFAC, with Melissa Farrell, Director of Primary Care, as the lead.[93]

205. MCFAC met on December 6, 2012. The AOM expected, as per the Minister's direction just two days prior, that a pay equity review, dates for negotiating a new contract, and issues relating to midwifery growth would be addressed. Instead, Farrell advised that did not share the AOM's understanding of the direction given by the Minister on December 4.[94] With great frustration and incredulity that yet another road block had been thrown in the path of fair and equitable compensation, we requested Farrell to have the Minister provide direction in writing.

206. In the meantime, on December 24, 2012, MOHLTC ADM Susan Fitzpatrick wrote to me to advise that there would be no funding for incremental compensation increases for new collective agreements.[95] She stated that while the government was keeping existing contracts intact out of respect for collective bargaining, Ontario was "expecting its bargaining partners to meet the following criteria for two years: no increases in compensation and no movement through the grid." Non-executives not governed by collective agreement "should live within fiscal restraints." Fitzpatrick noted that if agreement could not be reached, the government would impose administrative restraints.

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92 2012/12/04 - Meeting notes re: Meeting with Deb Matthews, AOM0006160

93 2012/12/04 - Meeting notes re: Meeting with Deb Matthews, AOM0006160

94 Midwifery Contracts and Funding Advisory Committee Minutes, MOH002253.

95 Letter from S. Fitzpatrick (MOHLTC Assist. Dep. Minister) to K. Stadelbauer (AOM ED) re: Funding for Insurance and Special Project, AOM0000709.

207. This was deeply troubling, coming as it did on the heels of agreements with the OMA not only to increase physician compensation but also to commit to a bargaining process in which government would refrain from unilaterally imposing measures until both facilitation and conciliation processes had been exhausted. Midwives, in contrast, were threatened with the imposition of administrative restraints if agreement could not be reached, at a point at which we had repeated asked to return to negotiations and been rebuffed. As we had feared, midwives were again being penalized for delays caused by the Ministry.

208. On January 24, 2013, Minister Matthews provided a letter, as requested, following up on the December 4 meeting. The letter was addressed to AOM President Weston and stated in part:

> *As discussed, the Ministry cannot commit to a binding compensation report. Rather, it would be more prudent to review and discuss the existing report completed in 2010. As you are aware, the Ministry has concerns regarding the report, but we strongly believe that midwives should be fairly compensated for the work they do. The Ministry has established the Midwifery Contracts and Funding Advisory Committee (MCFAC) where conversations regarding fair compensation will take place.* [96]

209. We were concerned that the MCFAC table was not the appropriate venue for discussions "regarding fair compensation" since the Director of Primary Care would not have authority to make decisions regarding equitable pay. This seemed to be a stalling tactic rather than a genuine gesture.

210. On March 1, 2013, Weston, Berinstein and I wrote to Premier Kathleen Wynne, reminding government that contract negotiations and wage equity commitments remain unaddressed.[97] We stated we were looking forward to working closely with the Premier to finalize the negotiations process and address wage parity.

211. On April 15, 2013, I sent an email to Seetha Kumaresh (née Raja), Midwifery Program coordinator, asking that she forward the Ministry's questions about the Courtryard report in advance of the next MCFAC meeting scheduled for April 18, 2013. Kumaresh responded on April 16 2013 via email and stated "Regarding the Courtyard report, the ministry has concerns about the report overall and will speak to them on Thursday".[98] Again, we were unable to get the Ministry's concerns about the Courtyard report in writing.

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96 Letter from D. Matthews (MOHLTC Minister) to L. Weston (AOM President) re: request for a binding compensation report, streamlined funding agreement and mechanism to discuss other issues, AOM0000710.

97 Letter from L. Weston (AOM President), K. Stadelbauer (AOM ED) and J. Berinstein (AOM Dir. of Policy) to K. Wynne re: Congratulations, AOM0000711.

98 Various emails between S. Kumaresh and K. Stadelbauer from April 15-16, 2013 re: Prep for meeting between AOM and MOH to discuss negotiations and Courtyard report, AOM0001712.

212. On April 17, 2013, I followed up with an email to Melissa Farrell, Director of Primary Care at the Ministry stating:

> *It's very disconcerting that there are no questions coming from the Ministry to form the basis of our discussion tomorrow (we've been hearing vague references to these concerns for 2 ½ years but yet to see specifics), but we're open to discussing why a jurisdictional review wasn't the focus on the compensation report. We'd also like to hear specifics about the methodology concerns that you mentioned. If you have further issues/questions about the report from others in the MOH, could you pass them along to meet this afternoon so we can be sure to bring the appropriate data/materials to help address those issues?*[99]

213. Farrell's reply email, sent April 17, 2013, did not respond to my request but simply said that she looked forward to a constructive discussion.[100]

214. At the AOM's request, one of the items on the agenda for the MCFAC meeting on April 18, 2013 was wage parity, including Courtyard report questions and a process and timeline for addressing the gap.[101] Farrell was absent from the meeting but we brought the issue forward to Seetha Kumaresh who led the Ministry representation. We highlighted our concern that the lack of regular good faith negotiations with set time frames had placed midwives at a serious disadvantage with respect to their compensation and left them feeling unvalued and unheard. We also indicated that the AOM needed a dispute resolution process similar to the process afforded to the OMA by government in order to have fair and effective negotiations.

215. At our meeting on April 19, 2013, I asked Farrell for clarification on the scope of MCFAC's decision-making authority and whether negotiations had been devolved to MCFAC. Farrell advised that the MCFAC table was not meant to replace negotiations; however, the Ministry was working with the AOM on its proposals and the TPA-MPG agreements in the same way that they work with other professionals.[102]

216. Farrell advised that the Ministry would "evergreen" the contract, and as a result, AOM members were not working "without a contract". AOM President Weston advised that the AOM did not consent to this unilateral action by the Ministry. Farrell also advised that the Ministry had concerns with Courtyard's jurisdictional review, and that the report was now outdated. The Ministry would not, however, set out its concerns in writing, nor would it be undertaking a new review. [103]

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[99] Various emails between K. Stadelbauer and M. Farrell re: Courtyard Report, AOM0001711.

[100] Various emails between K. Stadelbauer and M. Farrell re: Courtyard Report, AOM0001711.

[101] Agenda for Midwifery Contracts and Funding Model Advisory Committee Meeting, AOM0000712.

[102] MCFAC Meeting, MOH004867.

[103] MCFAC Meeting, MOH004867.

217. Farrell then suggested that the AOM consider aligning with other associations experiencing under-funding in their professions to strengthen the efforts to achieve appropriate compensation, which we thought was an odd suggestion for a negotiations process. There was a discussion about the appropriateness of CHC physicians and nurse practitioners as comparators for midwives. I reminded the Ministry representatives at this meeting that Ministry staff were consulted throughout the process of drafting the Courtyard report and assisted the consultants in coming to their conclusions. We asked if the Ministry believed that midwives were being compensated fairly, or if it acknowledged that there was a gap in pay equity for midwives and simply took the position that it could not be addressed at the time due to financial and economic constraints. Farrell responded that they did not have an answer at the time, but would bring the question forward.[104]

218. On April 23, 2013, AOM President Weston wrote to Farrell to follow up on the April 19, 2013 MCFAC meeting. Weston stated that midwives were not willing to accept the Ministry's position that there was simply no remedy for the pay equity gap. It was untenable for the Ministry to refuse to acknowledge or concretely plan to address the gender-based discrimination faced by midwives, which was prohibited under the *Human Rights Code*. Midwives needed both a concrete solution for addressing the existing wage parity gap, and a commitment to regular negotiations and access to an arbitration process if a decision could not be reached at the negotiations table. [105]

219. On the same day, Premier Wynne wrote to the AOM stating that a "fair and inclusive society is the foundation of a more prosperous Ontario" and that she "fully recognizes significant contributions" made by midwives. The letter did not address whether or how the government would address pay inequity.

220. On April 29, 2013, MCFAC met again. ADM Susan Fitzpatrick, Phil Graham and Fredrika Scarth attended to represent the Ministry, while Weston, Elizabeth Brandeis, Juana Berinstein and I represented the AOM. ADM Fitzpatrick circulated a letter at that meeting attaching a proposal, as Weston had requested in her April 23 letter.[106] The Ministry proposal to the AOM stated that the Ministry was unable to increase compensation because of restraints, and would engage in negotiation no later than October 31, 2013 for a contract to cover the next two years.

221. The letter also reviewed the Ministry's investment in health care infrastructure, including increasing the number of midwives and establishing "midwifery-led

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104 MCFAC Meeting, MOH004867.

105 Letter from L. Weston to M. Farrell (MOH Director of Primary Health Care) re: compensation and contractual issues, AOM0001707.

106 Letter from S. Fitzpatrick (MOHLTC) to AOM re: 2013 Contract Proposal, attaching Schedule A (MOHLTC's Proposal to the AOM), AOM0000713.

settings". Again, the Ministry was suggesting that these investments in the midwifery program were somehow relevant to compensation issues. While the Ministry stated that it continued to value midwives, who play an "integral role in the province's health care system," it was not prepared to attach any compensation increase value to that contribution.[107]

222. With respect to the Courtyard report, the letter stressed that it was not binding and indicated that the Ministry noted concerns regarding the authors' approach and methodology when the report was tabled, though it did not provide any detail regarding the nature of those concerns. Notably, it stated that the Ministry had never acknowledged the validity of the report, "particularly in light of the government's compensation restraint policy". We took this to mean that the Ministry's refusal to validate and implement the report's recommendations was largely driven by fiscal concerns rather than a principled pay equity or human rights analysis.

223. ADM Fitzpatrick told the meeting that the government was giving them no flexibility on negotiations, and that they had no ability to engage on the Courtyard report. There would be no budget growth relating to compensation. She again noted the (non-compensation) investments the Ministry had made in midwifery.

224. I asked if it was the Ministry's position that midwives were already paid fairly. Fitzpatrick replied that she did not think that was the Ministry's position, but that there was a need to get the budget under control before compensation could be addressed. Again, midwives were being told to be patient and wait their turn.[108]

225. On May 7, 2013, AOM President Weston and I wrote to Premier Wynne to advise that after years of proceeding without a clear commitment from government even simply to create a process to address the wage parity issue, the AOM Board saw no option but to recommend to our members to initiate a legal action.[109] Weston and I also wrote to Minister Matthews to set out the AOM's concerns and to alert her as well to the possibility of legal action.[110]

226. On May 10, 2013, Weston wrote to Fitzpatrick concerning the April 29, 2013 MCFAC meeting. She summarized what the AOM had heard from the Ministry at that time, including its position that the government was not "legally obligated to negotiate with us." Weston concluded by stating the AOM's understanding that the position taken on April 29 was the government's final word on compensation

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107 Letter from S. Fitzpatrick (MOHLTC) to AOM re: 2013 Contract Proposal, attaching Schedule A (MOHLTC's Proposal to the AOM), AOM0000713.

108 Notes from Important MCFAC Meeting with Susan Fitzpatrick, AOM0015520/

109 Letter from AOM Lisa Weston and K. Stadelbauer to Premier Wynne re: need to commence legal action as no government redress for pay inequity, AOM0006248.

110 Letter from AOM Lisa Weston and Kelly Stadelbauer to Minister Deb Matthews re: failure of government to address the wage gap and need to bring legal action, AOM0005761.

for midwives, and informing her that having been left with no other options, the AOM would take any and all additional steps necessary to address the discrimination midwives experienced.

227. I had been continuing to monitor the government's negotiations with other bodies, and was frustrated but by this point unsurprised to see that in late May 2013, shortly after advising the AOM that there could be no increases due to the compensation restraint policy, the government offered LCBO workers an $800 signing bonus , while the government's arm's length agency, Ontario Lottery and Gaming Corporation, made an offer to workers at the Woodbine Slots that included $600 lump-sum payments in each of the first two years and a 1.95% wage increase in the third year.[111]

228. At this time I took a short leave of absence until the beginning of August. During my leave, Juana Berinstein was the Acting Executive Director. I continued to be in touch with Berinstein after my departure, and received briefings from her both during my leave and following my return.

229. On May 27, 2013, Weston and Berinstein wrote to Premier Wynne. Their letter noted that, while the government acknowledged the gap, it refused to work constructively with the AOM to address it. The AOM stated it would welcome a commitment on the Ministry's part to redress the compensation gap and failing that, the AOM would proceed with litigation.[112]

230. That same day, Weston and Berinstein also wrote to Minister Matthews and advised of serious inconsistencies between the intentions expressed in her January 24, 2013 letter and what had actually transpired at the MCFAC meeting on April 29, 2013. In particular, they noted that while Minister Matthews had indicated it would be more prudent to "review and discuss" the Courtyard report rather than obtain a new one, such discussions had never taken place. Instead, the Ministry had refused to advise of the specifics of their concerns. They also noted that despite the Minister's statement that MCFAC was the forum in which conversations regarding fair compensation for midwives would take place, Ministry representatives at MCFAC had instead told the AOM that while the government acknowledge the compensation gap, it would not participate in or even provide a process to address it. They also affirmed that unless a process was established to rectify the compensation gap, midwives would proceed to litigation.[113]

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111 Article, Scott Stinson: Ontario developed workaround for wage freeze in apparent attempt to mend fences with big unions, appearing in National Post, AOM0001920.

112 Letter from L. Weston (AOM President) and J. Berinstein (AOM A/ED) to Premier K. Wynne re: intention to commence legal action, AOM0001705.

113 Letter from AOM Lisa Weston to Minister Deb Matthews re: Recent MCFAC Meetings, Systemic Gender Discrimination in Compensation and Recommendation for Legal Action, AOM0007296.

231. The AOM signed the funding agreement dated June 3, 2013,having advised the Ministry that we intended to seek a legal remedy for the pay inequity.

232. The Ministry cancelled the MCFAC meetings scheduled for June 12 and July 24, 2013.

233. On July 25, 2013, Premier Wynne responded to the AOM's letter requesting that she address the issue of midwifery inequitable compensation by referring the matter to Minister Matthews.[114] In a July 26, 2013, letter to the AOM, Minister of Labour Yasir Naqvi praised Ontario's *Pay Equity Act* as one of the most progressive statutes in the world but offered no pay equity redress mechanism for midwives. [115]

234. On September 9, 2013, the AOM met with Ministry representatives in a MCFAC meeting. The AOM requested dates for formal negotiations to recommence. In response, Melissa Farrell indicated that the AOM was not recognized as the bargaining agent for midwives and therefore there was no formal mechanism for compensation negotiation.[116] In other words, the Ministry would not "negotiate" with the AOM on the terms of the funding agreement, which governs the compensation, practice and work of Ontario midwives. We responded to this statement by expressing serious concern and requesting information about what would be required to become a recognized bargaining agent. The Ministry was not able to answer immediately but agreed to inquire and advise the AOM.

235. It was both surprising and deeply disappointing to hear the Ministry's new position on the AOM's status and the process by which funding agreements were to be developed, which went beyond the Ministry's recent reluctance to use the word "negotiations". As set out above, beginning in 2008 the Ministry explicitly treated the process of reaching agreements with the AOM as a negotiation. For the first time, a lead negotiator was appointed and staff from the Negotiations Branch as well as the OMP were involved.

236. This description of and approach to the AOM-MOHLTC process continued through the beginning of our meetings in 2010. As set out above, these again were described by the Ministry as "negotiations" and involved staff from the Ministry's Negotiations Branch.

237. Farrell's statement that the Ministry was no longer prepared to "negotiate" with midwives represented a serious step backward in our relationship and undermined much of the progress we had made. Notably, it occurred after the AOM had advised that midwives would seek a legal remedy for the wage

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114 Letter from Premier Wynne to AOM, AOM0000716

115 Letter from Minister of Labour to AOM re pay equity, AOM0000717

116 Minutes from MCFAC Meeting on September 9, 2013, MOH02279

discrimination they experienced, and after the Ministry had entered into a Memorandum of Agreement with the OMA that, as set out above, formally recognized the OMA as the "exclusive representative of physicians practising in Ontario" including with respect to the "negotiation of physician compensation".

238. On September 23, 2013 Farrell sent me an email suggesting that the AOM's legal counsel look at a government website that "provides information regarding union certification."[117]

239. By letter dated October 7, 2013, Weston and I communicated to ADM Susan Fitzpatrick the AOM's disappointment with the Ministry's position on negotiations. We noted that for many years, the AOM had been subjected to the government's on-again, off-again decisions with respect to whether it would "negotiate" with midwives, with the result that we had never had a stable process within which we could effectively negotiate equitable funding mechanisms. We also noted the contrast between the Ministry's approach to midwives and the much more favourable bargaining process afforded to the male-dominated medical profession, represented by the OMA, with which the Ministry had entered into an agreement that provided for an extensive bargaining protocol. We stated that the "unequal and discriminatory treatment of the representative of Ontario's almost exclusively female midwifery profession has contributed to the unequal treatment and compensation of midwives within Ontario's health care system." We asked that Fitzpatrick confirm that the Ministry would continue to meet with the AOM to address renewal of the funding agreement, and indicated our expectation that negotiation dates be confirmed no later than October 31, 2013 to ensure that meeting could take place and decision be implemented before April 1, 2014 – the date by which the existing one-year contract would expire. [118]

240. That confirmation was not provided.

241. On October 23, 2013, the Ministry sent out the Template Funding Agreement to the TPAs with a change to the termination clause that created an "evergreened" rather than a time limited contract. This change had not been discussed with, much less approved by, the AOM in advance.

242. On November 12, 2013, AOM President Weston wrote a letter to the Ministry's Melissa Farrell, expressing the AOM's shock that the template had been sent to the TPAs prior to finalization by both the AOM and the Ministry of this agreement. Weston characterized this as bad faith bargaining, and stated that it had undermined the negotiation process. Weston stated, "The AOM has a mandate from our members to act as their funding negotiators. We take this mandate very seriously and until the AOM has reviewed and approved the Funding Agreement template, it is not final and should not be disclosed." The AOM also noted that

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117 Email from M. Farrell to K. Stadelbauer re union certification, AOM0000718.

118 Letter from AOM to MOH (S. Fitzpatrick) re no recognition as bargaining agent, AOM0000719.

the Ministry's blatant move to make unilateral changes to the Funding Agreement occurred after it had given notice to the Ministry that it was in the process of preparing an application to the Ontario Human Rights Tribunal.[119]

243. Farrell responded on November 20 2013, apologizing for sending the template out prematurely and explaining that it was sent because all of the AOM's proposed changes had been made. Farrell also wrote:

Decisions with regard to the Province's financial and operational management of transfer payment programs are exclusively determined by the Government of Ontario. The Ministry's Financial Management Branch strongly recommends the use of "evergreen" transfer payment funding agreements for programs such as the midwifery program that are on-going without a program end date. This method of program financial management represents an operational stream-lining that frees up considerable Ministry resources from an unnecessary annual approval process which ultimately also serves the best interests of program funding recipients while maintaining their termination rights at all times.

Farrell concluded by saying the Ministry looked forward to "our upcoming discussions once dates are confirmed."[120]

244. Weston replied to Farrell by letter dated November 26, 2013, and stated that the AOM disagreed with the Ministry's description of what had occurred. Weston reminded Farrell that midwives are independent contractors and that the Ministry must therefore contract with midwives. Weston characterized as disingenuous the Ministry's suggestion that it felt free to unilaterally insert other clauses, which fundamentally changed the nature of the contract, simply because it also inserted changes the AOM had requested. Weston indicated that this violation of the negotiation process was a breach of good faith and unacceptable to the AOM.

245. On November 27, 2013 the AOM filed the within application with the Human Rights Tribunal of Ontario on behalf of hundreds of registered Ontario midwives. Additional complainants have since added their names to the application as new midwives join the profession and are subjected to discriminatory pay. A complete list of complainants, including their practice group affiliation and year of registration, is set out in Appendix "A".

246. The AOM continued to seek clarification regarding the process through which the terms of the next funding agreement would be decided.

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119 Letter from L. Weston and K. Stadelbauer to M. Farrell re: MOH Unilateral Changes to TPA-MPG Funding Agreement, AOM0000798.

120 Letter from M. Farrell to K. Stadelbauer and L. Weston re: Role of AOM in TPA-MPG Funding Agreement, AOM0000799.

247. At a December 4, 2013, meeting with Nadia Surani, Manager of Salaried Models and Programs, the AOM asked that the Ministry outline, in writing, the process through which midwifery funding discussions would proceed.

248. On December 11, 2013, Melissa Farrell wrote to Weston stating that the Ministry remained committed to the MCFAC being "the forum where midwifery funding and contract issues continue to be discussed."[121]

249. On December 18, 2013, AOM President Weston, AOM Vice President Brandeis, Director of Policy Berinstein and I wrote to Minister Matthews concerning both the Ministry's unilateral changes to the transfer agreement, and the continued need for an equitable and effective bargaining structure for the April 1, 2014 contract. We stressed that the MCFAC was established to *inform* the negotiations process, not to supplant it. We also noted that the Ministry provides a bargaining structure for the OMA, but asserted that midwives are limited to "discussions at MCFAC. We stated that this was untrue: there is no limitation on the bargaining process, and no law that says the Ministry can only "negotiate" with unions and the OMA. We noted that the Ministry had insisted for years that midwives are independent contractors and thus, by definition, in possession of a contract – in other words, of a negotiated agreement. We stated that "discussions" were not equivalent to negotiations and suggested a midwifery bargaining structure modeled on the agreement the Ministry had reached with the OMA. We reminded the Minister that midwives had mandated the AOM to be their bargaining representative for the purposes of negotiating their funding.[122]

250. Both ADM Fitzpatrick and Minister Matthews responded by letters dated January 28, 2014. Fitzpatrick's letter stated:

> *The Ministry understands that the AOM is the professional organization that represents its members' interests and treats the AOM as any other member association. The ministry provides support and funding to the AOM for the association's activities and for its members. The ministry and the AOM discuss issues of mutual concern and benefit.*
>
> *As with any other Transfer Payment program, the funding for the ministry's midwifery program is subject to the availability of funding as approved and allocated by the Treasury Board and levels of funding are not subject to negotiations.*[123]

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121 Letter from M. Farrell to L. Weston re: Funding Discussions Protocol, AOM0000800.

122 Letter from L. Weston, E. Brandeis, K. Stadelbauer, J. Berinstein to D. Matthews re: MOH Unilateral Changes to TPA-MPG Funding Agreement, AOM0000802.

123 Letter from ADM Susan Fitzpatrick to AOM Executive Director, Kelly Stadelbauer responding to various letters of the AOM and clarifying relationship between MOHLTC and AOM, AOM0002868.

251. Minister Matthews similarly affirmed that the ministry understanding that the AOM is the "professional organization that represents the interests of Ontario midwives" and that this "is why the ministry meets with the AOM regularly, including meetings with the Midwifery Contracts and Funding Advisory Committee (MCFAC), to discuss issues of mutual concern and benefit."[124]

252. I had entered into the 2008 negotiations – my first as Executive Director of the AOM – confident that with the evidence we had gathered we would finally be able to make meaningful progress in achieving fair compensation for midwives. Although I was somewhat disappointed in the increases we achieved then, I was encouraged by the gains we had made in establishing a fair and efficient process for negotiations. The Ministry took a number of steps to make what it then referred to as its negotiations with the AOM consistent with those it undertook with other professionals and their representatives. Now, not only had the Ministry refused to provide compensation increases or to implement – or even discuss – the Courtyard report recommendations, it had also stripped away the gains we had made in relation to the bargaining process.

253. Midwives were left doubly disadvantaged in relation to physicians. Not only did they experience a gendered pay gap – one which continued to grow as compensation increases to midwives were either denied or minimal when others saw significant gains – they also were denied a negotiation process, through their representative the AOM, like that afforded to physicians through the OMA.

254. The AOM leadership and staff who were actively engaged with the Ministry on these issues were all women. We were aware that the OMA leadership, in contrast, was predominantly male.[125] It was our impression that the differential treatment of the AOM as compared to the OMA was gendered not only because of the professionals we represented, but also because of who was at the table.

255. It was difficult not to conclude that despite everything – the wealth of evidence that continued to show that midwives provided excellent outcomes for women and babies, cost-effective services for the Ministry, and a vital contribution to Ontario's maternity care system; the promises that had been made to midwives and midwives' patience and good faith commitment to working together with government; all of our efforts, including our joint efforts with the Ministry in relation to the Courtyard report – midwives were in fact worse off, in relative terms, in 2013 than they were when I joined the AOM in 2006.

V. MISCONCEPTIONS CONCERNING MIDWIFERY CARE

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124 Letter From Minster Matthews to AOM Lisa Weston responding to AOM correspondence setting out Ministry position, denying any compensation gap acknowledged and stating Ministry is fully compliant with all legislation, AOM0002869.

125 AOM-prepared chart of OMA leadership showing breakdown by gender AOM0000628.

256. In my role as Executive Director of the AOM over the past ten years, I have met many people who have significant misconceptions of the midwives' role and skills, and of the value of midwifery in Ontario's health care system. Because I a not a midwife, I have experienced that individuals will openly share these misconceptions with me, and ask pointed questions about midwives and midwifery. I work hard to correct information wherever I can, as I have come to know that this biased view of midwifery is informed by fictional media portrayals such as *Call the Midwife*, and perpetuated by physicians and nurses who have skewed perspectives on midwifery work. For example, I've heard physicians say that midwives "send us their messes" when in fact, more accurately, physicians are only likely to see cases that have become high risk and developed complications, and therefore require an obstetrician for consultation or transfer. They don't see the smooth home birth delivery where that woman never enters the hospital, and this greatly skews their perception and understanding of what midwives actually do.

257. I have also experienced that those who do not work within the maternity care system have an even more difficult time imagining that a midwife will most likely have more in-depth knowledge and skills regarding pregnancy, labour, birth and the six week post-partum period than an Ontario family physician who does not practice obstetrics, which is most of them. I am constantly having to clarify the difference between a midwife and a doula, an unregulated care provider who gives emotional and practical support to maternity care clients. I often have to explain that the equipment a midwife brings to a home birth is equivalent to the equipment available in a Level I hospital. And the misconceptions go on and on. I've seen this lack of knowledge and understanding of the Ontario midwife countless times, including among Ministry bureaucratic and political staff. I recently heard a senior official equate their being on call and having to come in to the office during vacation to the on-call burden that midwives bear.

VI. THE MINISTRY'S CALCULATION OF MIDWIFERY COMPENSATION

258. Drawing on my knowledge of the administration of midwifery funding as well as my knowledge of and continued research concerning the funding and supports provided by the Ministry to other health providers, I clarify below some of the factual inaccuracies in the Ministry's calculation of midwifery compensation for the purpose of this proceeding.

259. The Ministry has included a number of non-compensatory elements of its contracts with midwives so as to magnify the total compensation – and compensation increases – provided to midwives. By including payments for things such as rent and equipment, the Ministry has artificially inflated the remuneration paid to midwives for their services in order to substantially but inaccurately narrow the gap between the midwives and male-dominated comparators.

260. The Ministry's characterization of midwives' total compensation is not consistent with the position it has taken over the years in midwifery contracts and negotiations, in which both parties have clearly and consistently distinguished been compensatory and non-compensatory elements. It is also not consistent with how it characterizes compensation for CHC physicians, other physicians, or other professions it funds in the public sector.

261. When the Ministry wanted to justify its decision to provide no increase in compensation to midwives, it asserted that midwifery "compensation" fell within the Government's compensation restraint laws which cover "employee" compensation not infrastructure investments. During that time, the Ministry did increase certain payments. It now states that these payments are part of midwifery compensation. In their negotiations, however, the Ministry was clear that the compensation that was frozen was strictly limited to Schedule C of the Funding Agreement, which lays out the Experience Fee, On-Call Fee, and Retention Incentive fees paid for each course of care.

262. More recent MOHTLC correspondence with the AOM also clearly distinguishes compensation from operating and project grants and education funding (controlled by Ministry of Colleges and Universities). Two recent letters demonstrate this:

(a) A letter sent to me by Susan Fitzpatrick, MOHLTC ADM Negotiations and Accountability Management Division, dated January 28, 2014 asserts that "funding for midwifery compensation remains frozen for the foreseeable future". The Government "continues to make substantial year to year investments in the provision of midwifery services". The letter then refers to increases in funding for "home birth kits, small practice administration and IT software" which were approved. These were not considered to be "compensation" which was frozen.[126]

(b) A letter dated January 28, 2014 from the MOHLTC Minister Deb Matthews to Lisa Weston, AOM President refers to "over the past decade, midwives' compensation has increased by approximately 33%." This figure does not include operating grants or other such matters which are referred to separately as the funding for the "program". Funding for midwifery education and new graduates is set out separately as well.[127]

263. As well, in contrast to the approach now taken by the Ministry for the purposes of this proceeding, MOHLTC does not include elements such as operating grants for rent and equipment, liability insurance premiums paid and other such elements in the compensation which it sets and funds for CHC physicians.[128] The

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126 Letter from Susan Fitzpatrick to Kelly Stadelbauer, January 28, 2014 AOM0002868.

127 Letter from Minister Deb Matthews to Lisa Weston, January 28, 2014, AOM0002869.

128 2008 Physician Services Agreement, Art. 5.13 covering CHC Physicians which refers to "physician compensation" and "fully salaried model". AOM0001948.

Ministry clearly delineates operating from salary/compensation expenses when it is dealing with CHC physicians. While the Ministry argues that credit for the operational, education and infrastructure expenses should be included when assessing the compensation of midwives, it fails to describe the very substantial investments which MOHLTC makes in relation to physicians more generally and to CHC physicians in particular.

264. The Ministry's calculation of midwives' total compensation relative to that of CHC physicians effectively compares "apples to oranges" by failing to take into account differences in workload and including a number of non-compensatory payments in midwives' total compensation that are excluded from the total compensation of CHC physicians.

a. Midwives' Workload

265. The Ministry refers to the 40 courses of care provided by midwives and 40 attendances at births as the required second midwife without reference to the number of hours spent for each course of care and secondary attendance. On average, each course of care is estimated as requiring 48.25 hours, although the AOM work load study showed this number was closer to 55 hours. This means that for 40 courses of care per year, a midwife would work between 1,930 and 2,200 hours per year. This does not include time midwives spend on-call to ensure women in midwifery care have 24/7 access to their midwives, in the event of clinical issues that arise between appointments and in the event of labour, which, of course, is generally spontaneous and not a scheduled event.

266. The Ministry also asserts that a CHC physician typically sees many more patients than does a midwife. While it is accurate that a CHC physician sees more patients, there is no systematic analysis provided by MOHLTC which compares the time spent with patients/clients, the nature of the medical care provided by midwives and CHC physicians and differences in the burden of time spent on call. A full-time CHC physician is expected to work 35 or 37.5 hours per week. Conservatively estimating three weeks' vacation, a full-time CHC physician works 1837.5 hours per year (37.5 hours x 49 weeks). Neither the Ministry nor its experts acknowledge this basic calculation.

b. Midwives' Compensation

202. As noted above, under the midwives' funding contracts the only payments referred to as compensation in Schedule C are the Experience Fee, On-Call Fee, Secondary Care Fee and Retention Incentive.

c. Non-Compensatory Payments

203. All of the funding provided for via Schedule D of the TPA/MPG funding agreement goes towards the costs of running a midwifery practice group, not towards compensation of the midwives who provide services in connection with that practice group. Similarly, all of the grants found under Schedule G are

directed towards the cost of running an MPG including the Office Equipment grant, New Registrant Equipment Grant, Leasehold Improvement Grant and Remote Practice Group Grant.

204. The details of these non-compensatory payments are set out below.

(i) Operation Fees/Overhead Expenses

205. Midwives do not receive overhead expenses as part of their compensation package. The "operational fee" is paid to the Midwifery Practice Group (MPG) which is a separate legal business entity from the midwives. It is paid to the MPG for its "overhead" and used to "defray the cost of rent, utilities, administrative support, etc." Practice group partners administer these funds, while associates and new registrant midwives neither control nor have access to them.

206. The tying of an operational fee (covering rent and other practice costs) to each course of care was and is a Ministry operational funding technique that was first implemented in the 2005 TPA/MPG agreement. The 1993 OMP Framework specifically separated compensation from operating expenses. At that point operating expenses had not been fully "worked out", but it was understood that they would be "similar to those details worked out in the Community Health Centre Program." Ministry funding of CHCs clearly separates general and operating expenses, rent and maintenance from salaries and benefits, including for CHC physicians. Treating the operational fee as a component of midwives' compensation is equivalent to including the cost of rent for a CHC facility in physician compensation.

(ii) Equipment Grant

202. With the exception of the new registrant birth bag, which the new registrant owns, equipment grants in are provided to MPGs, not midwives. The grant is equal to $1000.00 per year per midwife in the MPG. As with operating funds, associate and new registrant midwives have no control over the equipment grant, and no direct access to it. While MPG partners administer these funds, equipment grant money is reimbursed to the practice group only when a practice produces receipts for the approved equipment purchased.

203. Equipment grants are funded by MOHLTC in order to defray the operating expense of midwifery services. This funding is used by MPGs to purchase clinical and office equipment – chairs, fax machines, etc. – for the office space. The grant helps to ensure that midwives have safe and current working equipment as required by the College of Midwives of Ontario to provide clinical care.

204. To include equipment grants in midwives' "total compensation" is equivalent to including the cost of CHC waiting room chairs, examination tables, computers etc. in CHC physicians' salaries.

(iii) Benefits

205. CHC physician benefits include paid vacation and a pension plan. Midwives do not receive these benefits. CHC physicians also have a health insurance plan. Midwifery benefits funding is used to purchase a group insurance plan and a group RSP plan. The Ministry acknowledges that midwifery benefits are funded based on "20% of salary". That funding is not based on the "total compensation" figure the Ministry is now asserting, namely $192,264 per year for a level 6 midwife.

(iv) Travel Grant

206. Midwives receive a travel grant as part of the reimbursement of operating costs required to provide midwifery services, particularly where midwives work in a practice group that covers a very large catchment area. Unlike CHC physicians, midwives work in a variety of locales. Owning a car is a job requirement for midwives who must travel to clients' homes, clinics and hospitals – at all hours and often with little or no advance notice. It is simply not an option for midwives to rely on other transportation methods, such as public transit or bicycles. The costs of owning, maintaining, and operating a car are work expenses that CHC physicians do not have, and therefore do not require reimbursement for.

207. The travel grant was established in the 2005 funding agreement, and ranges from $80 per course of care in the urban core to $200 per course of care in a rural-dispersed population, where midwives may regularly have to drive hundreds of kilometers to provide midwifery care. The amount of the travel grant has not increased since 2005, despite dramatic increases in costs – especially gas and auto insurance. The grant therefore does not even provide full reimbursement for work-related travel expenses, despite requests from the AOM to do so.

(v) Professional Liability Insurance Premium

208. Midwives do not receive the professional liability insurance premium, at a current annual cost of $33,113, as part of their compensation package. It has always been treated by the Ministry as an operating expense and a necessary part of providing medical care and protecting patients, in the same way that the MOHLTC treats professional liability insurance for physicians. It is also not considered part of midwives' taxable income.

209. MOHLTC has not characterized this premium as "compensation" in its negotiations/discussions with the AOM surrounding funding contracts. As noted above, increased premiums have been paid during the "compensation restraint" years without any suggestion that such increases were not possible because such premium payments were considered "compensation". When premiums increased in earlier years due to difficult insurance markets, the Ministry did not characterize this as an increase in compensation. Equally, as premium costs have decreased as a result of midwives' excellent claims experience, the Ministry has not characterized this as a compensation decrease. The Courtyard Report

and the Morton and Hay reports also did not include the liability insurance premium as part of midwifery compensation.

210. CHC physicians and other physicians in Ontario also have their liability insurance reimbursed by the MOHLTC. The Ministry provides substantial reimbursement directly to the physician through the Medical Liability Protection Program.[129] It is not considered by the MOHLTC to be part of the physician's compensation package.

(vi) Second Attendant Disbursement

211. Small MPGs can seek approval from the College of Midwives of Ontario to have a non-midwife provide second attendant support. This is referred to as a Temporary Approved Practice Arrangement, or TAPA.

212. As detailed in Schedule D of the Funding Agreement, MPGs "with fewer than 160 Courses of Care per year may request funding each Contract Year to cover procurement costs for College approved Second Attendant services that are in addition to the labour, birth and early postpartum services covered by the Secondary Care Fee." In other words, this Second Attendant funding is available to small MPGs to cover the costs of having a non-midwife second attendant. Practice groups are required to keep a Second Attendant log, as per the Funding Agreement, "as documentation to support its invoices requesting reimbursement of these costs and shall record the MPG's utilization of Second Attendants at births."

213. This funding is properly considered overhead to the MPG rather than compensation. It is not paid to midwives but instead covers the cost of a non-midwife second attendant. It is the functional equivalent of funding received by a CHC to hire a nurse. Such funding is obviously not considered to be part of the compensation paid to a physician practising within that CHC and/or receiving support from that nurse in meeting the health care needs of patients of the CHC.

(vii) Remote or Small Rural Special Second Attendants Supplement

214. An alternative form of second attendant disbursement funding is available to qualifying remote or small rural practice groups. As outlined in Schedule D, "Qualifying Remote or Small Rural Practice Groups meeting all of the criteria set out below will receive up to $18,000 per year." The criteria include: proof of CMO Temporary Alternative Practice Arrangement approval, a budget, that the MPG have a maximum of 2 midwives and 95 BCCs per year, and that he MPG give up its eligibility for the regular Second Attendant Disbursement funding. In other words, the two sources of second attendant funding are mutually exclusive. Notably, the Ontario Midwifery Program does reserve the right to designate a

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129 See "OHIP for HC Professionals: Medical Liability Protection (MLP) Reimbursement Program" AOM0006304.

practice group as eligible for this supplement even if not all criteria have been met.[130]

(viii) Experience Fee Rural and Remote Practice Group Supplement

215. MOHLTC refers to a Rural and Remote Supplement as equivalent to up to an additional $7000 per year for a full-time midwife practising in a rural or remote practice group. The Supplement is not an annual payment but a payment per BCC. The amount of the supplement ranges from $125 per BCC to $175 per BCC depending on a midwife's experience level. A midwife working in a rural and remote area in her first year of practice can make earn a maximum supplement of $5,000 per year ($125 x 40BCCs) and a midwife in her second year can earn a maximum supplement of $6,000 ($150 x 40 BCCs). The supplement tops out at $175 after three years in practice – a maximum of $7000.

216. While this amount could properly be included as part of compensation, the analysis in the AOM Application did not include this supplement. Similarly the Application did not assert a comparison to the higher underserviced areas salary grid which is provided by MOHLTC to CHC physicians. Unlike the small rural and remote supplement provided to midwives, CHC physicians entitled to the higher "underserviced" grid earn at the top level more than $35,000 than the top level of the non-underserviced salary grid. If this midwifery rural and remote supplement is included then a true comparison would require that the higher underserviced CHC salary grid be factored in.

217. CHC physicians also receive further compensation through MOHLTC funded programs such as the Rural Family Medicine Locum Program; Northern Physician Retention Initiative (NPRI) & NPRI CME; Northern and Rural Recruitment and Retention Initiative and the Postgraduate Return of Service Program (Formerly UAP); Northern Specialist Locum Programs; Rural Medicine Investment Program; Rural Northern Physician Group Arrangement (RNPGA) hospitals with 2 physicians and 24-hour emergency coverage.

(ix) Birth Kits and Birth Bags

218. Approximately 20% of midwife-led births occur at home. The Ministry has an interest in incentivizing home births because they are much more cost-effective for the health care system than hospital births, without sacrificing excellent outcomes for women and their newborns. Until March 31, 2013, women wishing to deliver at home were required to personally cover the cost of supplies they and their newborns required, ranging from pads to some medications. Women delivering in hospital, in contrast, are not required to pay out-of-pocket for these supplies. As of April 1, 2013, the Ministry provides funding for home birth kits. These kits effectively pass the cost of supplies from the woman to the Ministry, facilitated by the MPG, thus removing a financial barrier to choosing home birth.

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130 Schedule D, page 51, October 2009 Funding Agreement.

219. An MPG uses the birth kit funding to purchase and bundle the supplies required for a home birth. These kits do not form part of midwifery compensation. Similarly, “birth bags” provided to new registrant midwives do not form part of their compensation but rather are the equipment that a midwife requires to provide clinical care.

(x) Small Practice Group Administrative Support Grant

220. MPG overhead costs are paid per course of care. In small practice groups with relatively few courses of care this overhead funding is insufficient to support the administrative demands of running a practice. Midwives themselves were having to devote much of their time to meeting administrative needs, which removed them from clinical care. The AOM and MOLTC negotiated this additional overhead payment to ensure that small MPGs, particularly in rural and remote areas, could hire administrative support, thus allowing midwives to focus on providing care. The Small Midwife Practice Group Administrative Support Grant to MPGs with 120 or fewer approved courses of care was first included in the new 2013 – 2014 funding contract.

(xi) Small MPGs Funding

221. The Ministry also provides additional funding to MPGs with seven or fewer midwives to defray the cost of more expensive equipment (e.g. sterilizer, examination table, birthing pool) that would be difficult to afford based on the operational fees collected by a small practice. This again is not compensation for midwives but rather about ensuring that small MPGs are appropriately equipped to provide safe, quality care.

(xii) Grant Funding Paid to AOM

222. The following are MOHLTC grants provided to AOM to help manage the midwifery system in Ontario:

(a) $2,950,000 sustainability investment to provide parental leave, including $202,000 for AOM administrative overhead

223. The MOHLTC provides a similar program to all Ontario physicians through a program administered by the Ministry, previously administered by the OMA. This is not considered part of physicians’ compensation.

224. With the exception of the first two years when this program was funded under a multiyear MOU, there have been varying degrees of uncertainty about its continuation. Each year, the AOM is required to submit a proposal for funding and have often had to wait 9 to 11 months into the fiscal year to hear if our proposal has been funded. This has created significant anxiety for pregnant midwives and new parents who are uncertain if the program will be there when they need it. If this were indeed part of midwives’ compensation, we would not

expect that it would have to be reapplied for annually, with no guarantee that it will in fact be provided.

(b) $1,046,760 for professional development

225. The total funding for this program is determined by a formula equivalent to about $1500/year per midwife, which is intended to mirror the Allied Health Professional Development Fund and the Nurse Education Initiative. The funding is used to provide midwifery-specific educational programs and to provide a tuition reimbursement program. Tuition reimbursement can only be accessed by a midwife for an approved professional development course or activity for which certification or proof of completion is provided and receipts are submitted.

226. Physicians have historically had similar continuing education support through the Continuing Medical Education (CME) Program described above. Despite the discontinuation of that program, many physicians continue to access Ministry support for continuing education through OHIP billings or through their employer. None of this is described by MOHLTC as compensation for the CHC physicians.

227. In any event, the Professional Development Fund, which was negotiated between the AOM and the MOHLTC in 2008 as set out in detail above, has never been referred to or considered part of midwives' "compensation" by either party.

- *$198,342 for special projects*

228. Funding for "special projects" supports activities that advance the integration of midwives into the health care system, foster inter-professional collaboration and enhance the provision of care to marginalized or high-needs populations. Projects are carried out by the AOM and do not provide any direct compensation to individual midwives for the provision of midwifery work. These activities are ones that the Ministry would otherwise have to do to appropriately "steward" the midwifery program and increase health care access to marginalized people, but has instead delegated to the AOM. The special projects grant therefore substitutes for a cost that would otherwise be borne by the Ministry internally.

- *$148,357 for midwifery locums in rural and remote settings*

229. This program provides compensation to a midwife who provides locum relief for a rural or remote provider. To characterize this as part of the overall compensation of every midwife entirely misconstrues this funding, and effectively double counts the compensation paid to the midwife providing locum relief.

230. Notably, physicians have a similar program administered by the MOHLTC, previously administered by the OMA, which is not considered to form part of their compensation.

- *$250,000 to address barriers to hospital integration*

231. These funds support projects that address issues of scope of practice restrictions in hospital settings and/or restrictions on the number of midwives or midwifery attended births in hospitals. Projects include educational rounds at hospitals and the production of educational materials for health professionals and hospital administrators including risk managers. This funding to the AOM is to replace work that the Ministry should be doing to appropriately "steward" the midwifery program, but has delegated to the AOM to do on behalf of the Ministry.

232. Projects are carried out by the AOM and do not provide any direct compensation to individual midwives for the provision of midwifery work.

- *$63,500 for an IT Needs Assessment*

233. This one-time funding was provided to the AOM to undertake a needs assessment on the state of readiness for the adoption of electronic medical records (EMRs). It does not provide a benefit to midwives and does not form part of their compensation.

- *$40,952 for a Risk Management advice service*

234. The AOM manages a 24/7 on call telephone advice service to assist in managing obstetrical risk for Ontario midwives. It is a proactive and early intervention approach to real and potential risk management issues that arise. This service mitigates the future costs of liability insurance for practicing midwives and the costs of claims by providing immediate support and expert guidance to each midwife who calls this service. Therefore, although the midwife is the direct recipient of this service, the service is a benefit to women who receive midwifery services as well as the Ministry who funds liability insurance for midwives and should not be considered compensation.

- *$195,529 to administer professional liability insurance*

235. The AOM manages the administration and risk management issues around the professional liability insurance policy funded by MOHLTC and held by the AOM as the policyholder. Originally ENCON was the insurer and Marsh Canada provided administrative services for the insurance policy. These administrative services were paid for by MOHLTC and were paid to Marsh Canada. When HIROC became the insurer for midwives in Ontario, the Ministry agreed that the AOM was better suited for this administrative role and provided funding to the AOM to take on this work. Work in this program includes negotiating insurance renewal, including undertaking claims analysis and marketplace monitoring, so that all practicing midwives are provided with sufficient liability coverage necessary to ensure public protection in as cost effective a manner as possible; Ensuring that all registered midwives are able to practice by ensuring that they are able to be insured in a timely manner and have appropriate coverage that meets College of Midwives of Ontario requirements to practice; and that new and returning midwives are integrated seamlessly into the program throughout the

year; and providing support to midwives on all insurance related issues and inquiries regarding coverage.

236. At no time in the history of the insurance program has MOHLTC considered this program to be part of the compensation provided to midwives. The Ministry has supported the AOM to take on this role, and associated risk reduction and mitigation programs, such as the Risk Management advice service, to best provide value for money to the Ministry and to provide the best risk management support to practicing midwives. However, this is not compensation, as the main beneficiary of these services are women who receive care from midwives well educated in risk management and patient safety practices as a result of the AOM's work – as well as MOHLTC, which has excellent claims experience and therefore lower costs in the future as a result of this well-managed policy and insurance program.

VI. COMMENTS ON THE MINISTRY'S EXPERT REPORTS

237. Drawing on my knowledge and experience as Executive Director of the AOM, as well as the knowledge and experience I gained through other educational, administrative and policy work in the Ontario health care system including at the Registered Nurses' Association of Ontario, I address below some of the factual inaccuracies and omissions in the Ministry's expert reports.

a. Negotiations

238. One of the suggested causes of the pay gap between midwives and CHC physicians is the fact that midwives have not engaged in collective bargaining and do not have the same bargaining strength.

239. Midwives have experienced the government's refusal to engage with them in a remotely comparable manner – indeed, its refusal to negotiate at all – as yet another effect of gender discrimination in their work. In other words, the absence of a collective bargaining process for midwives is not an alternative explanation for the compensation gap, but rather a manifestation of the same inequity.

240. Midwifery was shut out of the Ontario health care system for a century due to gendered stereotypes and discrimination. Midwifery as a regulated profession is therefore smaller, newer, and has less bargaining strength because of historic gender discrimination.

241. Since becoming regulated, midwives have sought to engage with the Ministry in negotiations processes, with the AOM as their representative. As set out at length above, the AOM has consistently and repeatedly sought a mechanism through which timely and regular meaningful negotiations can be undertaken with the Ministry, and for compensation to be the subject of meaningful discussion and agreement, rather than simply imposed. Specifically, the AOM has sought the same representation and bargaining protections afforded to the OMA is its negotiations on behalf of physicians.

b. Compensation of Midwives and Hospital Registered Nurses

242. On pages 128-133 of Mr. Bass' expert report he sets out a "total compensation model" for midwives relative to hospital nurses. He concludes, "There can be no question that the total compensation premiums enjoyed by these Ontario midwives far exceed the total compensation adjustment that Hospital Registered Nurses receive as a part of their employment relationship."

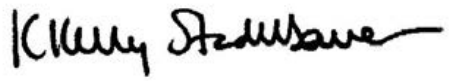
243. However, Mr. Bass' analysis does not include a number of aspects of hospital nurses' compensation that would have to be included in order to provide a true "apples to apples" comparison. In other words, his calculation of midwives' total compensation includes various items the equivalents to which are excluded from his calculation of hospital nurses' compensation, namely:

- Professional development (neither the RNAO Nurse Education Initiative tuition reimbursement program administered program funded by the MOH, nor any "free" professional development activities offered in hospital such as MORE-OB)
- Other RNAO grants
- Locum programs
- Vacation and statutory holiday pay
- Paid sick leave
- Shift premiums
- Weekend premiums
- Access to employment insurance

244. With respect to parental leave, the ONA chart shows only the "top-up" funding provided by the employer, and does not include the base amount received from EI. The midwifery benefit number, in contrast, shows the entire parental leave benefit. As noted above, midwives are generally not eligible for EI due to their status as independent contractors.

245. Mr. Bass also does not include in his calculation of hospital nurses' compensation the cost of equipment, facilities, IT infrastructure, liability insurance paid by hospitals to cover nurses, or the cost of nursing compensation paid to educational institutions. In the previous pages of his report, however, he argued that the equivalent amounts – which are properly categorized as overhead or operating costs – should be included in the calculation of midwives' compensation.

AFFIRMED this 29th day of July, 2016.



A Commissioner for Taking Affidavits

Kelly Stadelbauer

APPENDIX "A": LIST OF COMPLAINANTS

Midwife Applicant	Practice Group	Year of Registration
Eileen L. Abbey RM	Maternity Care Midwives - Thunder Bay	2000
Mona Abdel-Fattah RM	The Hamilton Midwives	2013
Stephanie Anne Aghajani RM	Midwives of Headwater Hills	2007
Shirin Aghili RM	The Hamilton Midwives	1997
Esra Agtas RM	Not Currently Affiliated with a Practice	2013
Martha Smith Aitkin RM	Family Midwifery Care of Guelph	1996
Farhana Disha Alam RM	New Life Midwives	2014
Valerie J Albrecht RM	Ottawa South Midwives	2013
Kimberly Ann Alderdice RM	Midwifery Care of Peel and Halton Hills	2015
Krystine Alexander RM	Sages-Femmes Renaissance Midwifery	1999
Annie J. Allard RM	Sages-Femmes Renaissance Midwifery	2002
Christine Macrae Allen RM	The Midwives' Clinic of East York-Don Mills	2003
Catherine Cora Alstrup RM	Community Care Midwives	2015
Dione Althea Amsterdam RM	Community Midwives of Toronto	2007
Sarah Anne Elizabeth Anderson RM		2015
Carolyn Elizabeth Archbold RM	Kawartha Community Midwives	1997
Basak Ardalani RM	Guelph Midwives	2000
Kelly Anne Collins Armstrong RM	Orillia Midwives	2008
Tuesday Arnew-Austin RM	Cambridge Midwives	2013
Stephanie M. Arsenault RM	Midwifery Collective of Ottawa	2004
Feben Aseffa RM	Association of Ontario Midwives	2009
Amanda Ashe RM	New Life Midwives	2007
Sarah Eileen Atkinson RM	Midwives of Sudbury / Sages-femmes de Sudbury	2011
Jennifer Marie Aylward RM	Community Midwives of Halton	2010
Kathleen Babe RM	Seventh Generation Midwives Toronto	2010
Kiran Baboolal RM	Community Midwives of Halton	2011
Myriam Ruth Badger RM	Cambridge Midwives	2009
Houleymatou Bah RM	Kensington Midwives	2004
Charlotte Baici RM	Stratford Midwives	2005
Deborah Baker RM	Midwifery Care-North Don River Valley	2010
Gyulane Balazs RM	Kawartha Community Midwives	2010
Nasrin Bandari Vali RM	Kitchener-Waterloo Midwifery Associates	2005
Teresa Bandrowska RM	Midwifery Group of Ottawa	1994
Elyse Emma Bronwen Banham	Midwifery Group of Ottawa	2014
Elodie Barbut RM	Midwifery Group of Ottawa	2012
Sarah Jane Barillaro RM	Burlington and Area Midwives	2005
Ana Maria Barillas RM	Cambridge Midwives	2009
Terri Lee Barlow RM	Not Currently Affiliated with a Practice	2010
Karen Elizabeth Barrett	West End Midwives	2006
Janette Audrey Batacharya RM	Midwives of Sudbury / Sages-femmes de	2002

	Sudbury	
Shawn Renée Bawden RM	Thames Valley Midwives	2002
Terry Beale RM	Midwives of Algoma	1999
Diane Beard RM	Burlington and Area Midwives	2009
Natalie Evelyn Beauchamp	Not Currently Affiliated with a Practice	2007
Melanie Beauchamp-Grandmaitre RM	East Ottawa Midwives	2015
Melanie Claire Beaudoin RM		2012
Sylvie Beaudry RM	East Ottawa Midwives	2014
Melissa Anne Beaver RM	Caring Hands Midwifery Services	2009
Kerry Bebee RM	Midwives of Lindsay and the Lakes	2005
Lana Elaine Becker RM	St. Jacobs Midwives	2006
Erin Kathleen Beckett RM	Midwives Collective of Toronto	2012
Carolyn Begg-Reid RM	Sages-Femmes Rouge Valley Midwives	2013
Alison Klasina Diane Bekendam RM	Community Midwives of Hamilton	2015
Nadia Bellio RM	Seventh Generation Midwives Toronto	2007
Christine Jeannette Marie Benard RM	Midwifery Services of Lambton-Kent	2011
Amélie Marie-Pierre Bender RM	Ottawa Valley Midwives	2011
Carol Bennett RM	Family Midwifery Care of Guelph	2005
Nicole Bennett RM	West End Midwives	2003
Christina Heike Berger RM	Family Midwifery Care of Guelph	2010
Lara Elaine Bernstein RM	Burlington and Area Midwives	2015
Joanna Louise Besana RM	Community Midwives of Halton	2013
Zuzana Betkova RM	Midwives Collective of Toronto	2011
Melissa Bevan RM	Midwives of Muskoka	2009
Stephanie Elizabeth Biswell RM	Burlington and Area Midwives	2012
Shana Blackburn RM	Guelph Midwives	2003
Megan Siobhan Catherine Bobier RM	Kensington Midwives	2011
Helen Margaret Bone RM		2012
Lesley Janet Bonell RM	Community Care Midwives	2008
Mary Whitney Elizabeth Bonnett RM	Midwives Grey Bruce	2008
Deborah Bonser RM	The Midwives' Clinic of East York-Don Mills	1999
Allyson Y. Booth RM	Association of Ontario Midwives	2003
Sara Elizabeth Booth RM	Seventh Generation Midwives Toronto	2002
Mehran Bordbar Haghighi Sabet RM	The Midwives' Clinic of East York-Don Mills	2004
Barbara-Ann Borland RM	Midwives of Muskoka	1999
Nicole Boudreault RM	Midwives of Sudbury / Sages-femmes de Sudbury	2015
Khadija Boulaftali RM	Midwifery Collective of Ottawa	2012
Elisabeth Boulanger RM	Community Midwives of Hamilton	2009
Chantal Rhéa Bourbonnais RM	Midwifery Group of Ottawa	2005
Cheryllee M. Bourgeois RM	Association of Ontario Midwives	2007
Kirsty Marie Bourret	Community Midwives of Thunder Bay	2006
Alison Bowen RM	Midwives of Lindsay and the Lakes	1997
Jennifer Boylan RM	St. Jacobs Midwives	2007
Anna Jean Bradley RM	Guelph Midwives	2005
Sarah Elizabeth Bradley RM	Community Midwives of Hamilton	2008

Rebekah A.S. Bradshaw RM	Stratford Midwives	2003
Elizabeth Dawn Brandeis RM	Midwives Collective of Toronto	2003
Judith Brandson RM	Community Care Midwives	2001
Angel Brazeau-Taylor RM	Markham-Stouffville Midwives	2005
Heather Laura Brechin RM	Community Midwives of Kingston	2000
Jennifer Brewer RM	Kensington Midwives	2013
Anita Bright RM	Midwife Alliance	1998
Valérie Diane Brisson RM	Not Currently Affiliated with a Practice	2007
Ashley Lynn Broadbent RM	Gentle Beginnings Midwifery/Sages-femmes premières tendresses	2008
Kara Rebecca Brockington RM	Midwives of York Region	2004
Naomi Sara Brooks RM	Barrie Midwives	2004
Jesse Morgan Brown RM	Community Care Midwives	2015
Sarahanna Yvonne Brown RM	Cambridge Midwives	2011
Barbara Bryja RM	Midwives Grey Bruce	2003
Jessica Buckingham	Not Currently Affiliated with a Practice	2013
Catharine Jane Bulstrode RM	Midwifery Care of Peel and Halton Hills - Georgetown Site	2002
Babette Beverly Burrell	Not Currently Affiliated with a Practice	2008
Catherine Lee Bush RM	Community Midwives of Hamilton	2015
Alyssa Shelley Byers-Heinlein RM	Community Midwives of Kingston	2014
Erin Jean Calder RM	Midwifery Care of Peel and Halton Hills	2011
Jane Elizabeth Calhoun RM	Midwives Grey Bruce	2008
Amy Callahan RM	Midwifery Services of Lambton-Kent	2015
Carol A. Cameron RM	Midwifery Services of Durham	1994
Shannon Alyssa Cameron RM	Midwifery Care of Peel and Halton Hills - Brampton Site	2014
Andrea Campbell RM	New Life Midwives	2007
Kristen Ann Campbell RM	The Midwives' Clinic of East York-Don Mills	2013
Carron Lynda Canning RM	Midwifery Care-North Don River Valley	1999
Stella Capisciolto RM	The Midwives' Clinic of East York-Don Mills	2009
Aimée Danielle Carbonneau RM	Seventh Generation Midwives Toronto	2005
Sarah Carey RM	Family Midwifery Care of Guelph	2006
E. Rebecca C. Carson RM	Family Midwifery Care of Guelph	2005
Anne-Marie Carter-McAuslan	Ottawa Valley Midwives	1996
Andrea L. Cassidy RM	Midwifery Collective of Essex County - Leamington Satellite	2005
Elizabeth Cates RM	Midwifery Care-North Don River Valley	2015
Brianna Cavan RM	Midwives Grey Bruce	2014
Aoife Clare Chamberlaine RM	West End Midwives	2012
Sara Chambers RM	Kensington Midwives	2008
Pilar Chapman RM	Lincoln Community Midwives	1999
Savannah Chapman	Kensington Midwives	2013
Lisa Chappell RM	Kawartha Community Midwives	2004
Erin Mary Chartrand RM	Ottawa South Midwives	2012
Jasmine Chatelain RM	Midwifery Group of Ottawa	2010
Shâdé Olubukunola Folasade Chatrath RM	West End Midwives	2010
Sindy Cheung RM	Markham-Stouffville Midwives	2007

Julie Mae Chipman RM	Riverdale Community Midwives	2005
Hedrey Chu RM	Midwives Collective of Toronto	2008
Jennifer Clare-McCutcheon RM	Midwives of Middlesex and Area	2011
Janet Nicola Clarke RM	Talbot Creek Midwives	1998
Teresa Clarke RM	Community Midwives of Kingston	2005
Shelley-Ann Clarke-Dolby RM	Sudbury Community Midwives	2005
Kimberley Dawn Cleland RM	Norfolk Roots Midwives	2008
Lois Madeleine Clin RM	Countryside Midwifery Services - Milverton Clinic	1997
Heather Clinch RM	Grand Valley Midwives	2006
Kim Annie Cloutier Holtz RM	Sages-Femmes Temiskaming Midwives	2005
Elaine Ann Coffin RM	Community Care Midwives	2013
Mhairi Sian Colgate RM	Countryside Midwifery Services - Palmerston Clinic	2010
Lauren Emily Columbus RM	Access Midwives	2013
Sabrina Jennifer Elaine Connor RM	Countryside Midwifery Services - Palmerston Clinic	2011
Nicole Conway RM	Sudbury Community Midwives	2007
Laura Elizabeth Coombs RM	West End Midwives	2011
Dana Shaylyn Cooper RM	Midwives of Sudbury / Sages-femmes de Sudbury	2012
Annabel Cope RM		2009
Jeannine Marlys Corbiere RM		2011
Abigail Deborah Corbin RM	Community Midwives of Halton	2006
Susan Jean Corchis RM	Midwifery Services of Lambton-Kent	2006
Amanda Cordocedo RM	Midwives Collective of Toronto	2015
Jessica Marie Core RM	Midwives Grey Bruce	2015
Julie Anne Corey RM	St. Jacobs Midwives	1997
Paule Nora Carole Marie Corneil RM	Sages-Femmes Temiskaming Midwives	2013
Heather D. Corscadden RM	Family Midwifery Care of Guelph	2005
Melissa Lynn Coubrough RM	Womancare Midwives	2012
Carol Mercedes Couchie RM	K'Tigaaning Midwives	1997
Moya Victoria Crangle RM	Society of Obstetricians and Gynaecologists of Canada	1999
Colleen Janis Crawford RM	Niagara Midwives	2011
Leah Meredith Crawford RM	Seventh Generation Midwives Toronto	2015
Sarah R. Cressman RM	Guelph Midwives	2005
Elizabeth Ruth Cripps RM	Guelph Midwives	2013
Lisa Cristini RM	East Mississauga Midwives	2013
Sheryl Lee Cronk RM	Genesis Midwives	2003
Sarah Cross RM	Burlington and Area Midwives	2011
Tama Elise Cross RM	Diversity Midwives	1999
Erin Croteau RM	New Life Midwives	2008
Stephanie Marie Crouch RM	East Mississauga Midwives	2004
Meredith Joy Crowder RM	Sudbury Community Midwives	1999
Debra Anne Crumb RM	Community Midwives of Halton	2015
Jacqueline Kerry Curran RM	Family Care Midwives	2010
Lucia D'Amore RM	Burlington and Area Midwives	2002
Céline D'Arcy RM	Gentle Beginnings Midwifery - Embrun Site	2001

Janis Dalacker RM	Uxbridge Stouffville Midwives	2009
Kristen Michelle Dalton RM	Access Midwives	2012
Annita J. Damsma-Young RM	Burlington and Area Midwives	2000
Elizabeth Kathleen Darling RM	Midwifery Group of Ottawa	1997
Kathryn Anne Darling RM	East Mississauga Midwives	2015
Sky River Dasey RM	Genesis Midwives	2003
Jeannette Aileen Davies RM	Quinte Midwives	2002
Margaret Davies RM	Midwifery Care of Peel and Halton Hills	1999
Sarah Bronwen Davies RM	The Midwives' Clinic of East York-Don Mills	2013
Yvonne Davis RM		2010
Betty-Anne Daviss RM	East Ottawa Midwives	1995
Sharon Rose Dean RM	Ottawa South Midwives	1998
Alexandra Dee-Bradley RM		2011
Jennifer Deguire RM	Lincoln Community Midwives	2011
Nicole Del Vecchio RM	New Life Midwives	2012
Kate Demers RM	Community Midwives of Hamilton	2009
Kristen Dennis RM	Community Midwives of Toronto	2009
Rachel Elizabeth Dennis RM	K'Tigaaning Midwives	2012
Suzanne Desaulniers RM	Midwifery Group of Ottawa	2007
Trina Lynn Desjardins RM	Sudbury Community Midwives	2011
Sylviane Devos RM	Community Midwives of Kingston	2007
Nimerta Kaur Dhami RM	Midwives Collective of Toronto	2014
Iryna Didyk RM	Community Midwives of Kingston	2009
Courtney Dini RM	Midwives of Sudbury / Sages-femmes de Sudbury	2012
Claire Grace Dion Fletcher RM	Seventh Generation Midwives Toronto	2013
Vanessa Dixon RM	The Midwives' Clinic of East York-Don Mills	2015
Diana Lynn McPherson Doe RM	Born Midwives	2007
Deborah Doiron RM	New Life Midwives	2006
Julie Doldersum RM	Midwives Nottawasaga	2011
Sarah Donnelly-Hyde RM	Access Midwives	2012
Caroline Josephine Dönni RM	Midwife Alliance	2013
Laura Aynsley Donohue RM	Midwifery Care-North Don River Valley	2006
Mahnaz Donyadideh-Torei RM	Midwife Alliance	1998
Melissa Emily Dorsay RM	Midwifery Collective of Ottawa	2009
Mojgan Dostar RM	Maternity Care Midwives - Thunder Bay	2009
Yvette Valerie Downer RM	Diversity Midwives	1998
Sarah Doyle RM	Ottawa South Midwives	2002
Suzanne Draper RM	Ottawa Valley Midwives	2013
Christy-Lynn Marie Drimmel		2013
Amelia C. Drydyn RM	Community Midwives of Kingston	2008
Nicole Drysdale RM	Blue Heron Midwives	2007
Michelle Duff-McCracken RM	Blue Heron Midwives	2004
Nadine Duhil-Enns RM	Family Midwifery Care of Guelph	1998
Laura Susanne Duivesteyn RM	Midwifery Care of Peel and Halton Hills - Georgetown Site	2013
Lillian Alexandria Dunn RM	Community Midwives of Thunder Bay	1995
Diane Dunwoody		2013
Sharon Ruth Dyck RM	Sages-Femmes Renaissance Midwifery	2005

Amy Victoria Eagle RM	Community Midwives of Halton	2011
Emily Elizabeth Eby	Midwives Nottawasaga	2012
Sarah Marie Eelman RM		2012
Aderemi Ejiwunmi RM	Midwifery Care of Peel and Halton Hills	1996
B. Jane Erdman RM	Womancare Midwives	1996
Mehrnaz Eshghi Azad RM	Diversity Midwives	2002
Natalie Espinet RM	Stratford Midwives	2009
Jenna Falk RM	Midwives of Headwater Hills	2015
Aimee P. Fehlner RM	Womancare Midwives	2007
Carmen Gloria Felix RM	Midwives Collective of Toronto	2007
Sabine Gudrun Fella RM	Riverdale Community Midwives	2010
Harriet Ann Molloy Ferrant RM	Ottawa Valley Midwives	2015
Elaina Ferrari RM	Community Care Midwives	2004
Jacqueline Ferreira RM	Womancare Midwives	2013
Hardeep Fervaha RM	Burlington and Area Midwives	2013
Connie Fetterly RM	Access Midwives	2004
Sandra Louise Fincham RM	Midwives Nottawasaga	2009
Mary M. Fish RM	Community Midwives of Toronto	1999
Katelyn Ordeen Fisher RM	Talbot Creek Midwives	2012
Agnes FitzGerald RM	Midwifery Collective of Ottawa	1998
Linda Fleming RM	Community Care Midwives	2009
Jane Emily Flindall RM		2007
Anne-Christine Foisy RM		2015
Adriana Fontaine RM	Kitchener-Waterloo Midwifery Associates	2012
Elise Simone Ford RM	Access Midwives	2010
Anne Fortin RM	Midwife Alliance	2003
Rebecca A. Foster RM	Burlington and Area Midwives	2003
Erin Faith Frank RM	Burlington and Area Midwives	2013
Tracy Franklin RM	Midwives Collective of Toronto	2002
Elizabeth Louise Markman Fraser RM	Midwifery Collective of Ottawa	2014
Angela R. Freeman RM	Midwives Grey Bruce	2006
Denise Fuller RM	Not Currently Affiliated with a Practice	2007
Elizabeth Anne Fulton-Breathat RM	Sudbury Community Midwives	1996
Tiffany Fung RM	Riverdale Community Midwives	2011
Sherene Furnell RM	Markham-Stouffville Midwives	2008
Meagan Furnivall RM	Talbot Creek Midwives	2011
Genevieve Gagnon RM	East Ottawa Midwives	2008
Yanxiang Gao RM	AMMA Midwives	2006
Jennifer L. Gardiner RM	The Midwives' Clinic of East York-Don Mills	2006
Kelly Jane Gascoigne RM	Community Midwives of Brantford	2002
Jennifer Louise Gasparotto RM	Niagara Midwives	2011
Jacqueline Anne Gaudette RM	Talbot Creek Midwives	2015
Emily Anne Marie Gaudreau RM	New Life Midwives	2015
Monique Gauthier		2015
Christine Alice Geiger RM	Midwifery Care of Peel and Halton Hills - Brampton Site	2015
Isabelle Gelineau	Family Midwifery Care of Guelph	2008
Karen Marie George RM	Family Midwifery Care of Guelph	2015

Tracy Alison Gerster RM	The Midwives' Clinic of East York-Don Mills	2001
Sylvie Kelly Gervais RM	Gentle Beginnings Midwifery/Sages-femmes premières tendresses	2014
Rebekah Leigh Ghent RM		2014
Terri A. Gil RM	Not Currently Affiliated with a Practice	2007
Fariba Gilanpour RM	AMMA Midwives	2008
Erin Marie Giles RM		2014
Emily M. Gillard RM	Community Midwives of Hamilton	2005
Stephanie Gingerich RM	St. Jacobs Midwives	2008
Ginger Girard Fram RM	Midwives of Windsor	2009
Anita Grace Given RM	Community Midwives of Kingston	1999
Hava Alissa Glick RM	Community Midwives of Toronto	2015
Karey Lynn Goheen RM	Barrie Midwives	2012
Jennifer Melanie Goldberg RM	Community Midwives of Toronto	2001
Sarah Golledge RM	Barrie Midwives	2009
Céline L.S. Goodrich RM	Midwifery Group of Ottawa	2000
Alison Gorringe	Community Midwives of Kingston	2011
Catherine Goudy RM	Countryside Midwifery Services - Milverton Clinic	2007
Kelly Erin Graff RM	Kenora Midwives	2010
Courtney Jane Graham RM	Riverdale Community Midwives	2014
Jasmine Katrina Smith Graham RM	Huron Community Midwifery Services	2013
Catherine Grant RM	Cambridge Midwives	2006
Gemma Rachel Greenberg RM	Midwifery Care-North Don River Valley	2012
Nancy Greenwood	Midwifery Group of Ottawa	2008
Noelia Greizerstein RM	Kensington Midwives	2014
Carly Renaud Griffith RM	Womancare Midwives	2008
Simone Griffith RM	Access Midwives	2004
Shirley Anne Grove RM	Blue Heron Midwives	2010
Helena Janzen Guenther RM	Ottawa South Midwives	2015
Mélanie Guérin RM	Pratique de Sages-Femmes de Hearst Midwifery Practice	2003
Jerrylyn Guevarra RM	West End Midwives	2013
Kanmani Grazia Guruswami RM	Kensington Midwives	1996
Leah Joan Colden Hackett RM	Generations Midwifery Care	2010
Rebecca Ann Hagman RM	Niagara Midwives	2014
Tiffany Anne Haidon RM	Uxbridge Stouffville Midwives	2002
Rae Ann Haley		2013
Crystal Jean Hall RM	Midwives of Windsor	1997
Shannon-Lynn Arlene Halvorsen RM	Community Midwives of Thunder Bay	2015
Lorelei Gaye Hammond RM	Sages-Femmes Rouge Valley Midwives	2012
Gabrielle Hammond-Kannegieter RM	Guelph Midwives	1997
Manavi Handa RM	West End Midwives	2000
Stephanie Roxanne Hanley RM	Sages-Femmes Renaissance Midwifery	2015
Ayeshah Haque RM	Midwives of Chatham-Kent	2015
Suki Hardesty RM	Madawaska Valley Midwives	2011
Lise Kathleen Hart RM	Cambridge Midwives	2009
Sepideh Hashemitari RM	Midwife Alliance	2011
Katrin Hassanzadeh RM	Sages-Femmes Rouge Valley Midwives - Ajax	2013

	Clinic	
Marie Hatherall		2000
Rebecca J. Hautala RM	Community Midwives of Thunder Bay	2007
Barbara Heathcote RM	East Mississauga Midwives	2006
Corinne Hebden RM	Kensington Midwives	2008
Kerstin Helen RM	Barrie Midwives	1997
Jerren Hazlett Helwig RM	Family Midwifery Care of Guelph	2011
Lynn Hendrick RM	Midwifery Care of Peel and Halton Hills	2013
Janis Marie Herold RM	Blue Heron Midwives	2011
Kilmeny H. Heron RM	Madawaska Valley Midwives	2004
Tenisha Hibbert RM	Diversity Midwives	2013
Allison Hines RM	Grand Valley Midwives	2009
Laurie-Ann Hintzen RM	Diversity Midwives	1999
Elaine E. Ho RM	West End Midwives	2005
Tarah Hoag RM	Midwives Collective of Toronto	2015
Abir Hoblos RM	Midwife Alliance	2006
Elleana Jacoba Hoekstra RM	Talbot Creek Midwives	2009
Tiffany Holdsworth-Taylor RM	Midwifery Services of Haliburton-Bancroft	2015
Janet Holtham RM	Midwife Alliance	2000
Sarah Hook RM	Community Midwives of Hamilton	2014
Leslie A. Howarth RM	Guelph Midwives	1997
Susan Howlett RM	Kawartha Community Midwives	1994
April Hoyt RM	Midwives of Headwater Hills	2013
Susan L. Hubbard RM	Community Midwives of Kingston	2005
Christina Jane Hull RM	Caring Hands Midwifery Services	2014
Mary C. Hunking RM	West End Midwives	1994
Kristina Marie Hunter RM	Caring Hands Midwifery Services	2016
Elena Monika Ikonomou RM	Community Midwives of Toronto	2006
Barbara Inthavixay RM	Not Currently Affiliated with a Practice	2014
Bounmy Inthavong RM	Midwifery Collective of Essex County	2015
Amy Jackson RM	Community Midwives of Thunder Bay	2011
Alison Michelle James RM	Markham-Stouffville Midwives	2014
Michelle Susan Janutka RM	Midwifery Care-North Don River Valley	2001
Diane Marie Jaworiwsky RM	Midwifery Collective of Essex County	2014
Brittany Jewell		2011
Dora Melida Jimenez RM	Riverdale Community Midwives	1997
Elana E. Johnson RM		1994
Christine May Johnston RM	Midwifery Care-North Don River Valley	2007
Heidi-Anne Johnston RM	Kitchener-Waterloo Midwifery Associates	2011
Rebecca Anne Johnston RM	Midwifery Care of Peel and Halton Hills - Brampton Site	2012
Althea Jones RM	Midwifery Care-North Don River Valley	2013
Jessica Mhari Jones RM	Community Midwives of Hamilton	2011
Buhay S. Juniosa RM	Family Care Midwives	2005
Sanaz Kama RM	Diversity Midwives	2014
Nabal Kanaan RM	The Midwives' Clinic of East York-Don Mills	2014
Masoudeh Kazemiashtiani RM	The Hamilton Midwives	2010
Caitlin Keelan RM	Stratford Midwives	2011
Ashley Esther Keen RM	Access Midwives	2013

Laura A. Keere RM	Sages-Femmes Rouge Valley Midwives	2006
Heather Keffer RM	Midwives Grey Bruce	1994
Fatemeh Keivan-Far RM	Midwives of East Erie	2015
Lesley Kelly RM	Quinte Midwives	2012
Kristi Dawn Kemp RM	Access Midwives	2011
Iwona Kempa RM	Guelph Midwives	2000
Katherine Kennedy RM	Cambridge Midwives	2009
Andrea Kenny RM	Midwives of Middlesex and Area	2010
Diane Kent RM	Community Midwives of Halton	1996
Rosalind Heidi Kern RM	West End Midwives	2013
Rezvan Khaleghi RM	Markham-Stouffville Midwives	2003
Alanna Gail Kibbe RM	Seventh Generation Midwives Toronto	2006
Katrina Helen Kilroy RM	Midwives Collective of Toronto	1994
Sarah Louise King RM	Community Care Midwives	2002
Catherine Kipp RM	Countryside Midwifery Services - Palmerston Clinic	2001
Natalie Kirby RM	Midwives Nottawasaga	2009
Jewell Marie Kirkopoulos RM	Access Midwives	2015
Sara Rachael Klaiman RM	Family Care Midwives	2011
Jacquie Marie Klan RM	Midwifery Care of Peel and Halton Hills	2010
Tiffany Sue Klassen RM	Midwives of Chatham-Kent	2010
Leah Beth Klein RM	Midwives Collective of Toronto	2012
Sandra René Knight RM	Niagara Midwives	1997
Evelyn Kobayashi RM	Stratford Midwives	2011
Amanda Nell Kocheff RM		2009
Kaelyn Nicole Koepke RM	Burlington and Area Midwives	2010
Jillian Fae Korolnek RM		2012
Minke Kraak RM	Genesis Midwives	2004
Jessica Kraitberg RM	Caring Hands Midwifery Services	2010
Devi Joy Krieger RM	Midwives Collective of Toronto	2009
Alfonse Otis Kryzanauskas RM	Community Midwives of Hamilton	2012
Michelle Kryzanauskas RM	Midwives Grey Bruce	1994
Susana Elsa Ku Carbonell RM	Midwifery Services of Lambton-Kent	2014
Karolina Kullerstrand RM	Midwifery Care of Peel and Halton Hills	2015
Pooja N. Kurban RM	St. Jacobs Midwives	2007
Katherine Sabrena Kwietniowski RM	Community Care Midwives	2011
Sushma Lachmansingh RM	Midwifery Services of Durham	2000
Alison Clare Lally RM	Midwives of Chatham-Kent	2000
Dawn Elizabeth Lambert RM	Midwives of Chatham-Kent	1998
Mianh Jessica Lettieri Tran Lamson RM	Countryside Midwifery Services - Milverton Clinic	2012
Beverly Ann Langlois RM	Born Midwives	2010
Leslee Ann Larsen RM	Not Currently Affiliated with a Practice	2008
Amy Nicole Larson RM	Community Midwives of Thunder Bay	2007
Elizabeth Margaret Constance Larsson RM	Kitchener-Waterloo Midwifery Associates	2013
Patrice Gabriela Latka RM		2000
Erin Marion Laver RM	Talbot Creek Midwives	2014
Julie Laverdière		2011

Melanie Gabrielle Lavers RM	Cambridge Midwives	2005
Claudette Leduc RM	Sages-Femmes Rouge Valley Midwives	2004
Natalie Lucienne Leduc RM	Midwives of Sudbury / Sages-femmes de Sudbury	2012
Megan Anne Lehman RM	Family Midwifery Care of Guelph	2012
Sylvie B. Lemay RM	Midwifery Group of Ottawa	1998
Meghann Jessica Leonard RM	Boreal Midwifery Practice	2009
Mary Ann Leslie RM	Midwifery Care-North Don River Valley	1994
Sarah Elizabeth Campbell Leslie RM	The Midwives' Clinic of East York-Don Mills	2003
Amanda Gayle Levencrown RM	Countryside Midwifery Services - Milverton Clinic	2010
Nellie Grace Lévesque RM	East Ottawa Midwives	2011
Olga Levitin RM	Midwifery Collective of Ottawa	2011
Andrea Levy RM	Midwifery Care-North Don River Valley	2005
Melinda Levy RM	The Midwives' Clinic of East York-Don Mills	2007
Xia Li RM	Kitchener-Waterloo Midwifery Associates	2008
Navjot Gill Lidder RM, CRM	West End Midwives	2006
Ann E. Liebau RM	Blue Heron Midwives	2005
Andrea Lindenbach RM	Midwives of Algoma	2015
Erin Little RM	Community Midwives of Brantford	2010
Min Liu RM	Kitchener-Waterloo Midwifery Associates	2010
Yuefang Liu RM	Thames Valley Midwives	2009
Christie E. Lockhart RM	The Midwives' Clinic of East York-Don Mills	2007
Catherine Matania Lombardo RM	Midwifery Group of Ottawa	2015
Danielle Helen Longfield RM	Womancare Midwives	2014
Suzan Michele Lorenz RM	Midwife Alliance	2012
Leanne Lubberts RM	Womancare Midwives	2010
Andrea M. Luciuk RM	Riverdale Community Midwives	1998
Jessica May Ludgate-Yee RM	Midwifery Group of Ottawa	2008
Mei Rong Luo RM	Family Care Midwives	2008
Daya Kiara Sunflower Lye RM	Not Currently Affiliated with a Practice	2011
Bridget G. Lynch RM	Community Midwives of Toronto	1994
Beth Lynes RM	Stratford Midwives	1999
Krista Lysenko RM	Maternity Care Midwives - Thunder Bay	2014
Stacey Adele Lytle RM	Quinte Midwives	2006
Tasha MacDonald RM	Seventh Generation Midwives Toronto	2001
Tonya Ann MacDonald RM	The Hamilton Midwives	2004
Lindsay MacDougall RM	Community Midwives of Kingston	2006
Kathleen Anne Macerollo RM	Riverdale Community Midwives	2015
S. Jay MacGillivray RM	P3 (Special Bun in the Oven)	1994
Pamela MacInnis RM	West End Midwives	2004
Laura MacIntosh RM	Burlington and Area Midwives	2013
Arlaine Seta MacLennan RM	Access Midwives	2014
Caitlin Jane MacLennan Penman RM	Access Midwives	2014
Natalie Louise MacLeod RM	Sudbury Community Midwives	2013
Sandra Maju RM		1999
Victoria Malamant RM	Midwives of York Region	2016
D. Anne Margaret Malott RM		1997

Tylee Elizabeth Maracle RM	Midwifery Collective of Ottawa	2015
Melissa Noelle Marchand RM	Access Midwives	2013
Anya Marion RM		2014
Bianca Christina Marlatt RM	Bloom Midwives	2012
Alexandra Katherine Marshall RM	Caring Hands Midwifery Services	2013
Emily Rose Martel RM	Midwives Grey Bruce	2014
Jennifer Martin RM	Not Currently Affiliated with a Practice	2014
Lilly Lisanne Martin RM	Midwives Nottawasaga	2006
Susan Martin RM	The Hamilton Midwives	2004
Heather Adrienne Mason RM	Generations Midwifery Care	2011
Brigid Grace Astle Matheson RM	Grand Valley Midwives	2015
Sarah Maylin RM	Sages-Femmes Renaissance Midwifery	2014
Heidi Leanne Mayr RM		2012
Allison Joanna McCallum RM	Midwives Nottawasaga	2008
Megan Victoria Rekai McCarrell RM		2011
Nicole Joelle McCloud RM	Midwifery Care of Peel and Halton Hills	2012
Natalie McClure RM	Seventh Generation Midwives Toronto	2013
Chantal Yvonne McCullagh RM		2014
Helen C. McDonald RM	The Hamilton Midwives	1994
Lauren McEachern RM	Community Midwives of Toronto	2014
Amy Elizabeth Campbell McGee RM	Midwifery Collective of Ottawa	2011
Barbara Leanne McInall RM	Thames Valley Midwives	2012
Andrea McInnis RM	Barrie Midwives	2004
Karen McKenzie RM	Midwifery Collective of Essex County	2004
Karen P. McKinley-Jones RM	Community Midwives of Kingston	2001
Patricia McNiven RM	Community Midwives of Hamilton	1994
Jennifer Lee McTaggart	Sages-Femmes Renaissance Midwifery	2003
Tiffany Meier RM	Sages-Femmes Rouge Valley Midwives	2008
Rivkah Meldung RM	Midwifery Care-North Don River Valley	2009
Shirley Ellen Meltzer RM	Midwifery Care of Peel and Halton Hills - Georgetown Site	1994
Keren Menashe RM	Midwife Alliance	2015
Diane Laura Meronyk RM	Womancare Midwives	2012
Susannah Nancy Cruise Merritt RM	Diversity Midwives	2012
Jessica Elaine Meyer RM	St. Jacobs Midwives	2014
Susan L. Meyer RM	Midwives of East Erie	1998
Terrie Meynders		2014
Sylvia A. Miedinger RM	The Hamilton Midwives	2005
Chelsea Dawn Miklos		2014
Emma Mary Miles RM	Gentle Beginnings Midwifery/Sages-femmes premières tendresses	2015
Andrea Mills RM	Barrie Midwives	2011
Isabelle Milot RM	Midwives of Chatham-Kent	2006
Roya Mir-Mohammadi RM	Family Care Midwives	2003
Christina Dawn Miskelly RM	Quinte Midwives	2010
Sita Manoj Mistry RM	Family Care Midwives	2013
Carolyn Moffatt RM	East Ottawa Midwives	2014
Salimah Moffett RM	AMMA Midwives	2008
Amy Krista Moland-Osborne RM	Boreal Midwifery Practice	2002

Ann Louise Montgomery RM		2000
Michelle Andrea Moore-West RM	Community Midwives of Brantford	2014
Lisa Morgan RM	Not Currently Affiliated with a Practice	2000
Sarah Anne Morgan RM	Midwives of York Region	2011
Alusha Java Morris RM	Community Midwives of Toronto	2012
Jaylene R.C. Mory RM	Kawartha Community Midwives	1994
Linda Ann Moscovitch RM	Riverdale Community Midwives	1994
Marla Saraid Mowat RM	Midwifery Care of Peel and Halton Hills	2010
Wendy Murko RM	Community Midwives of Halton	1999
Carey Catherine Murphy RM	Maternity Care Midwives - Thunder Bay	2012
Kaitlin Marie Murray RM	Kawartha Community Midwives	2014
Elizabeth Murray Davis RM	Community Midwives of Hamilton	2003
Sarah Elizabeth Murtha RM	Quinte Midwives	2014
Hayley Mutch	Thames Valley Midwives	2009
Sandra Livia Mutilva RM		2004
Jillian Lauren Nafziger RM	Countryside Midwifery Services - Milverton Clinic	2013
Mojgan Naminiasl RM	Midwives of Windsor	2010
Safire Naranjo RM	Kensington Midwives	2009
Emma Louise Needleman Stone RM	Barrie Midwives	2014
Kathryn Amy Nelder RM	Womancare Midwives	2014
Amy Megan Nelson RM	Barrie Midwives	2015
Daina Marie Nestick RM	East Mississauga Midwives	2008
Linda Ngo RM	West End Midwives	2013
Alexandra Ileana Nikitakis-Candea RM	Diversity Midwives	2012
Melissa Jasmine Nowell RM	Midwives of Headwater Hills	2014
Ami Nunn RM	Barrie Midwives	2013
Miriam O'Brien RM	Ottawa Valley Midwives	2003
Kylene Elizabeth O'Donnell RM		2006
Pamela Barbara O'Farrell RM	Community Midwives of Brantford	2015
Megan Mae Olson RM	Niagara Midwives	2012
Sara Jennifer Olson RM	Midwives of Windsor	2015
Kimberley Orton RM	Seventh Generation Midwives Toronto	2013
Claire Courtney Osepchook RM	Seventh Generation Midwives Toronto	2010
Lindsay Ottens RM	Midwifery Services of Lambton-Kent	2006
Janessa Lorraine Otto RM	St. Jacobs Midwives	2008
Rosemarie Flavie Parisien RM	Gentle Beginnings Midwifery/Sages-femmes premières tendresses	2014
Laura Christine Parizeau RM	Talbot Creek Midwives	2009
Ashley Park RM	East Mississauga Midwives	2014
Diane D. Parkin RM	Midwifery Group of Ottawa	1994
Janice Lee Parsons	Midwife Alliance	2011
Jill Catherine Parsons RM	Midwives Collective of Toronto	2013
Ozra Pashmi RM	Sages-Femmes Rouge Valley Midwives	2006
Patricia Katherine Patry RM	Midwifery Services of Durham	1998
Jennifer Lynn Pawlett RM	Gentle Beginnings Midwifery/Sages-femmes premières tendresses	2011
Tracy Pearce-Kelly RM	Burlington and Area Midwives	1998

Wendy Rachel Pearle RM	Cambridge Midwives	2012
Lydia Marie-Louise Pedri RM		2014
Ellen Pemberton RM	Midwifery Care of Peel and Halton Hills - Georgetown Site	1994
Katherine Penczak RM	Community Midwives of Brantford	1994
Rachel Pennings RM	Lincoln Community Midwives	2007
Rose Anne Perconti		2002
Wendy J. Peterson	Not Currently Affiliated with a Practice	1999
Frances Anne Philpott RM		2010
Natalie Marie Sheila Piche RM	Talbot Creek Midwives	2009
Laura Pierce RM	Not Currently Affiliated with a Practice	2009
Julie A. Piggott RM	Midwives of Lindsay and the Lakes	2005
Lyanne Mary Pinto RM	East Ottawa Midwives	2010
Tracy Annette Pittman RM		2014
Jenny Lee Pizzale RM	Barrie Midwives	2012
Jillian Elizabeth Sarah Portelance RM	Talbot Creek Midwives	2010
Claire Portigal RM	Quinte Midwives	2014
Edna Posca RM	Midwives of York Region	2004
Mimi Pothaar RM	Midwives Nottawasaga	2015
Carolynn Elizabeth Prior RM	Sages-Femmes Rouge Valley Midwives	2003
Dianne Cecelia Pudas		1997
Nathalie Quevillon-Dussault RM	Community Midwives of Thunder Bay	2005
Joanne Rack RM		2010
Mojgan Ramezanpour RM	Diversity Midwives	2012
Claire Ramlogan-Salanga RM	Guelph Midwives	2015
Usha Sita Ramsaran RM	Family Care Midwives	2011
Becca Raper RM	Generations Midwifery Care	2006
Linda Rayner		2009
Mitra Razi RM	Family Care Midwives	2001
M. Beth Read RM		1997
Laura Ready RM	Orillia Midwives	2014
Cynthia Rebong RM	Midwifery Care-North Don River Valley	2008
Meghanne Elizabeth Reburn	Not Currently Affiliated with a Practice	2012
Sarah Redfearn RM	Midwives of Middlesex and Area	2011
Angela Reitsma RM	The Hamilton Midwives	2007
Amanda Lee Richard RM	Midwives of Algoma	2010
Anna Pascale Riley RM	Cambridge Midwives	2010
Nicole Maria Roach RM	St. Jacobs Midwives	1998
Melissa Dawn Roberts		2013
Robynn E. Roberts RM	Midwives Collective of Toronto	2006
Tamatha Roberts RM	North Channel Midwifery	2011
Andrea Lea Robertson RM	Midwifery Services of Lambton-Kent	2003
Jenna Berman Robertson RM	Midwifery Care of Peel and Halton Hills	2013
Annette Robinson RM	Kitchener-Waterloo Midwifery Associates	1997
Alicia Claire Robinson-Breinbjerg		2012
Karen Rodrigue RM	Community Care Midwives	2013
Claire Willow Rogers RM	Midwives of Georgian Bay	2013
Crystalyn Shawna Rogers RM	Midwifery Care-North Don River Valley	2014

Judith Marie Rogers RM	Midwives of Georgian Bay	1994
Nicole Romeiko RM	Seventh Generation Midwives Toronto	2007
Janet Rooney RM	Barrie Midwives	2006
Ingeborg Gera Froukje Roorda	Not Currently Affiliated with a Practice	2010
Simone Rosenberg RM	The Midwives' Clinic of East York-Don Mills	2014
Karen Ross RM	Thames Valley Midwives	2012
Marzieh Rostam RM	Midwifery Care of Peel and Halton Hills - Brampton Site	2003
Emily Roth RM	Countryside Midwifery Services - Palmerston Clinic	2015
Marcia L. Rowat RM	Caring Hands Midwifery Services	2002
Christine C. Roy	Neepeeshowan Midwives	1994
Annette Rudel RM	Womancare Midwives	2009
Carys Elizabeth Daphne Ryan RM	Midwives Grey Bruce	2011
Holly Ryans RM	Midwifery Care of Peel and Halton Hills - Brampton Site	2008
Anita Gabriela Sabados RM	St. Jacobs Midwives	2006
Lisa Sabatino RM	Community Midwives of Hamilton	2002
Mitra Sadeghipour RM	Born Midwives	2007
Marlene Sagada RM	Riverdale Community Midwives	2001
Paula Jean Salehi Moghaddam RM	Ottawa South Midwives	2006
Amanda Devi Samaroo RM	Diversity Midwives	2011
Lindsay Jade Sanderson RM	Midwifery Care of Peel and Halton Hills - Georgetown Site	2010
Christine Elizabeth Sandor RM	Community Midwives of Hamilton	2010
Barbara E. Santen RM	Community Midwives of Toronto	2007
Ilse M Santizo Salazar RM	Markham-Stouffville Midwives	2011
Suneet Saraw RM	Community Midwives of Halton	2014
Tia Sarkar RM	Riverdale Community Midwives	1996
Kathleen Anne Saurette RM	Midwifery Care of Peel and Halton Hills	2010
Justine Analise Schilstra RM	Niagara Midwives	2014
Olivia Amanda Schliep RM		2013
Austin Ruth Schoonheyt RM	Niagara Midwives	2011
Veronika Schubert RM	Midwives of York Region	2014
Carolyn Scott RM	Midwives of York Region	2002
Kelley Scott RM	Midwifery Group of Ottawa	2013
Martha McLeod Scroggie RM	East Ottawa Midwives	2003
Margaret Leta Seegmiller RM	St. Jacobs Midwives	2015
Carrie-Lynn Séguin RM	Lincoln Community Midwives	2004
Julie Ann Serrador RM	Midwives of Middlesex and Area	2012
Margo Jennette Seymour RM	Ottawa South Midwives	2014
Amanda Jean Sgrignoli RM	Midwives Collective of Toronto	2015
Jinous Shahzamani RM	Midwife Alliance	2013
Noushafarin Shameli RM	Midwives Collective of Toronto	2013
Mina Sharafbafy RM	Kitchener-Waterloo Midwifery Associates	2003
Jessalynn Leah Mary Sheehan RM	Genesis Midwives	2012
Mylene Shields RM	Sages-Femmes Renaissance Midwifery	1998
Fariba Shodjaie RM	Community Midwives of Toronto	2001
Sandra Lee Shymko RM	Community Midwives of Thunder Bay	2002

Kelli-Ann G. Siegwart RM	Community Midwives of Kingston	2005
Alexis Elizabeth Sieswerda RM	Community Midwives of Thunder Bay	2001
Angela Elizabeth Silcock RM	Midwifery Care-North Don River Valley	2015
Maureen Martha Silverman RM	Family Care Midwives	1999
Diane Simon RM	Seventh Generation Midwives Toronto	2013
Carolyn Sinclair RM		2009
Alexia Isana Singh RM	Uxbridge Stouffville Midwives	2015
Natasha Anu Singh RM	AMMA Midwives	2012
Natasha Alicia Singleton-Bassaragh RM	AMMA Midwives	2016
Isabel S Singzon RM	Midwifery Care of Peel and Halton Hills - Georgetown Site	2013
Galya Sipos RM	Family Midwifery Care of Guelph	2013
Amy Sjaarda RM	Countryside Midwifery Services - Mount Forest Site	2010
Ashley Kirsten Smith RM	West End Midwives	2014
Claudia Christine Smith RM	Ottawa South Midwives	1999
Debra Ann Smith RM		1994
Dianne Joyce Smith RM	Midwives of Muskoka	2004
Jenna Marie Smith RM	Sages-Femmes Renaissance Midwifery	2010
Kelly Adele Smith RM	East Mississauga Midwives	2008
Sarah Jean Smith RM	Midwives of Muskoka	2007
Marie Smith-Lutz RM	Barrie Midwives	2008
Melinda Caddel Soares RM	Sages-Femmes Rouge Valley Midwives	2006
Bobbi Soderstrom RM		1994
Jane E. Somerville RM	Community Midwives of Kingston	2001
Amanda Sorbara RM	Midwives of York Region	2008
Cynthia Marie Soulliere RM	Countryside Midwifery Services - Milverton Clinic	2006
Lynlee Spencer RM	Access Midwives	2010
Taryn Elizabeth Spiegelberg RM	Lincoln Community Midwives	2009
Melissa St Cyr RM	Gentle Beginnings Midwifery/Sages-femmes premières tendresses	2007
Tina St John RM	Midwifery Collective of Ottawa	2010
Wendy Allyson St Laurent-Coutts RM		1998
Simone D Staats RM	Midwives of Chatham-Kent	2013
Linda Mae Stahl RM	Midwives of Headwater Hills	2003
Sara Louise Stainton RM	Barrie Midwives	1998
Kinshasa Steele RM	Huron Community Midwifery Services	2015
Lori Ann Steele RM	Midwifery Services of Haliburton-Bancroft	2008
Patricia Steele RM		2004
Genia Stephen RM	Generations Midwifery Care	2009
Karlee Stevens RM	Access Midwives	2015
Kristen M. Stevens RM	Ottawa Valley Midwives	2005
Leslie Stevens RM	Niagara Midwives	2015
Faye Stoter RM	Family Midwifery Care of Guelph	2001
Heather Alexander Struckett RM	Thames Valley Midwives	1997
Kelly Anne Stuart RM	Sages-Femmes Renaissance Midwifery	2005

Shezeen Suleman RM	West End Midwives	2012
Lynne A. Sullivan RM	Sudbury Community Midwives	2003
Karin Sundararajan RM	Community Midwives of Halton	2007
Rachel Sutton RM	Ottawa Valley Midwives	2010
Sharon Lesley Swift RM	Family Care Midwives	2006
Candice Joanne Syme RM	Midwifery Services of Durham	2013
Maysoon Baker Taha RM	Midwifery Services of Durham	2002
Sophie Brigitte Taillefer RM	Gentle Beginnings Midwifery/Sages-femmes premières tendresses	2013
Heidi Tailleur RM	Niagara Midwives	2013
Amy Taylor RM	East Mississauga Midwives	2007
Heather Jean Taylor RM	Community Midwives of Brantford	2005
Jessica Suzanne Taylor RM	Orillia Midwives	2006
Natalie Ann Taylor RM	Talbot Creek Midwives	2013
Shannon Taylor RM	The Hamilton Midwives	2010
Jasmin Tecson RM	Sages-Femmes Rouge Valley Midwives	2007
Jan Teevan RM	Midwifery Group of Ottawa	1994
Audrey ten Westeneind RM	K'Tigaaning Midwives	1998
Marie-Pierre Tendland-Frenette RM	Community Midwives of Hamilton	2013
Karin Joanne Terpstra RM	Family Midwifery Care of Guelph	1999
Christina Therrien RM	Manitoulin Midwifery	2006
Edan Linda Thomas RM	Midwives Collective of Toronto	1999
Brianna Lauren Thompson RM	Ottawa Valley Midwives	2014
Rebecca Thompson RM	Thames Valley Midwives	2015
Alexandra D. Thomson RM	Midwifery Care of Peel and Halton Hills	2005
Carole Y. Thomson RM	Kitchener-Waterloo Midwifery Associates	2007
Wendy Thomson RM	Midwifery Collective of Ottawa	2014
Cynthia Marie Thoren RM	Midwifery Services of Lambton-Kent	2004
Kimberley Tigani RM	Norfolk Roots Midwives	2014
Emilia Colette Tilson RM	Midwives of Headwater Hills	2012
Brianna Patricia Timmers RM	Sages-Femmes Renaissance Midwifery	2013
Amanda May Tomkins RM	Midwives of Windsor	2015
Ruthann Poppy Topolovec RM	Midwives of Middlesex and Area	2012
Joyce Totton RM		2013
Natalie Tregaskiss RM	Not Currently Affiliated with a Practice	2011
Anna Maureen Trippel RM	Uxbridge Stouffville Midwives	2014
Mariana Tseitlin RM	Midwifery Care of Peel and Halton Hills - Brampton Site	2008
Eva Georgina Gina Tsiapalis RM	Midwifery Care of Peel and Halton Hills - Georgetown Site	2009
Laurence Sabine Tsorba RM	Midwifery Group of Ottawa	2012
Georgia Tsouluhas RM	The Hamilton Midwives	2005
Maley V. Tudor RM		1998
Liza van de Hoef RM	Quinte Midwives	2008
Vicki Van Wagner RM	Midwives Collective of Toronto	1994
Elizabeth C. Vander Heide RM	Womancare Midwives	2005
Cynthia Varadan RM		2007
Emily Lauren Viets RM	East Mississauga Midwives	2010
Leslie Ann Viets RM	Ottawa Valley Midwives	1996

Maxine Vigneault RM	Midwifery Group of Ottawa	2007
Sara Mary Ellen Vildis RM	Sudbury Community Midwives	2010
Rebecca Vineberg RM	Kenora Midwives	2013
Allison Anne Virtue RM	Midwifery Services of Lambton-Kent	2014
Ava Vosu RM		1994
Emily Amanda Vrabac RM	Quinte Midwives	2012
Nicole Waithe RM	Midwives Collective of Toronto	2007
Alison Mary Walker	Not Currently Affiliated with a Practice	2012
Allison Elizabeth Walker RM	Midwifery Care of Peel and Halton Hills	2006
Tess Elliott Walter RM	Midwifery Collective of Ottawa	2011
Katrienne Cecile Walton RM	The Hamilton Midwives	2007
Fiona Jane Wardle RM	Midwives of Algoma	1997
Misty Dawn Wasyluk RM		2005
Lauren Marie Wattam RM		2012
Barbara Maria Wawrzoszek RM	Midwifery Care of Peel and Halton Hills	2000
Monica Rose Weber RM	Blue Heron Midwives	2009
C. Rebecca Weeks RM	Midwifery Services of Haliburton-Bancroft	2006
Mariya Wege RM	Midwives of Windsor	2013
Kathy Wells RM	Midwives*Sages-Femmes of North Bay	1997
Lisa M. Weston RM	Sages-Femmes Rouge Valley Midwives	2003
Jacqueline Whitehead RM	Midwifery Collective of Ottawa	2007
Lisa Maureen Wiley RM	Thames Valley Midwives	2015
Kristen Naomi Wilkinson RM	Midwives of York Region	2012
Adele W. Williams Di Girolomo	Ottawa Valley Midwives	2009
Esther Louise Willms RM	The Midwives' Clinic of East York-Don Mills	1999
Ann Kathleen Wilson RM	Thames Valley Midwives	1996
Anne Wilson RM	Burlington and Area Midwives	2000
Jenna Nadine Wilson RM	Burlington and Area Midwives	2015
Justine Kelley Wilson RM	Stratford Midwives	2015
Rhea Wilson RM		2007
Karline Elizabeth Wilson-Mitchell RM	Midwifery Collective of Ottawa	2009
Laurie Christine Winder RM	Community Midwives of Halton	2009
Christina Robyn Winger RM	Community Midwives of Halton	2015
Annalee Winter RM	Community Midwives of Hamilton	2014
Lisa Wishnefsky RM	Kawartha Community Midwives	2003
Corine Jennifer Witteveen RM	Cambridge Midwives	2015
Naomi Audrianna Wolfe RM	Midwives of Sudbury / Sages-femmes de Sudbury	2010
Sara Wolfe RM	Seventh Generation Midwives Toronto	2003
Wendy Wong RM	Midwifery Care-North Don River Valley	2007
Laura Jeanne Wood RM	Midwifery Care of Peel and Halton Hills	2015
Anne Kristine Woodhouse RM	Sages-Femmes Renaissance Midwifery	1998
Taryn Woolsey RM	New Life Midwives	2007
Natalie Wright RM	Orillia Midwives	2005
Nzinga Aziza Wright RM		2011
Cindy Wye RM	Kensington Midwives	2010
Tatyana Yakovlev RM	Ottawa Valley Midwives	2013
Xiaojuan Yan RM	Kawartha Community Midwives	2011
Tamara Youngberg RM	Access Midwives	1997

Deborah Younger RM	Sudbury Community Midwives	1998
Fang Yu RM	Diversity Midwives	2005
Grace Ying Zhang RM	Midwives Collective of Toronto	2008
Sarilyn Zimmerman RM	The Midwives' Clinic of East York-Don Mills	1996