HUMAN RIGHTS TRIBUNAL OF ONTARIO

HRTO FILE: 2013-16149-I

ASSOCIATION OF ONTARIO MIDWIVES

Applicants

v.

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

Respondent

AFFIDAVIT OF VICKI VAN WAGNER

I, Vicki Van Wagner, of the City of Toronto in the Province of Ontario, MAKE OATH AND AFFIRM as follows:

1. I am an Associate Professor in the Ryerson University Midwifery Education Program, a practising midwife and midwifery scholar and one of the initial leaders of the AOM. I was involved extensively in the development and implementation of the midwifery regulatory and education system in Ontario. My background, qualifications and experience are outlined in my Curriculum Vitae.[1] As such, I have knowledge of the matters set out in this affidavit.

2. This affidavit is made to constitute the main section of my examination in chief testimony in relation to the above-noted proceeding. Below is the table of contents to this affidavit

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1 Vicki Van Wagner, Curriculum Vitae AOM0016608.

I. Background

1. Education and Knowledge

3. My education and knowledge are drawn from various areas, including women's reproductive health, women's studies, midwifery and evidence-based health policy.

4. I received in 2013 a PHD from the School of Gender, Feminist and Women's Studies. My PhD thesis focused on the application of evidence-based practice in maternity care. [2]

5. I received a Masters in Environmental Studies from the Faculty of Environmental Studies at York University in 1991 with my thesis, *With Women: Community Midwifery in Ontario*. This thesis was relied upon and cited by the MOH and AOM during the midwifery regulatory and funding development process.[3]

2 Vicki Van Wagner, Reconsidering Evidence: Evidence-Based Practice and Maternity Care in Canada, PHD thesis, October, 2013, Graduate Program, Gender, Feminist and Women's Studies, York University, AOM0016115.

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

6. I also received an Honours Bachelor of Independent Studies from the Department of Integrated Studies, University of Waterloo majoring in women's health and education.

7. As well, my midwifery education began in 1978 learning midwifery through apprenticeship under two Toronto midwives and several family doctors during period 1978-1981.

8. I graduated from the Midwifery Pre-Registration Programme of the Michener Institute of Applied Health Sciences in 1993 and was registered as midwife by the College of Midwives of Ontario as of January 1, 1994.

2. Practising Midwife

9. I am a registered midwife in Ontario and Quebec and have practised midwifery since 1981.

10. I am a member of the Midwives Collective of Toronto which was founded in 1983. I had hospital privileges at the Toronto General Hospital from 1994 to 2001. I have been a staff midwife at Mount Sinai Hospital since 2001.

11. Over the past 35 years, I have been an active practitioner with a caseload ranging from full time to quarter time depending primarily upon my academic responsibilities. I have attended approximately 2000 births and have provided midwifery care in a wide range of both clinical and social contexts.

12. With respect to clinical contexts this has ranged from normal labour and birth as an autonomous primary care provider and for those whose pregnancy requires specialist physician care, either maintaining primary care after consultation or working in a shared care arrangement with a specialist. I have provided care in many complex situations including:

    (a) twins, breeches, women with hypertension, gestational diabetes, pre-term labour and assisted fertility as well as in emergency situations where there is a risk of mortality and morbidity to both the foetus and the mother.

    (b) care for women during pregnancy loss, including spontaneous miscarriages, stillbirths and genetic terminations, and.

    (c) care during a positive experience of a normal birth and healthy baby and care in stressful situations when pregnancy or birth are complicated, when the newborn is preterm or ill and bereavement care in the case of pregnancy or neonatal loss.

13. With respect to social context, this includes care for women in a wide variety of social and economic circumstances, including newcomers, refugees, those without health insurance, those suffering from poverty, addiction, past histories of trauma, including sexual abuse and violence, and women who have been

disadvantaged by virtue of their gender, race, disability, sexual orientation, religion and those the transgender community. I have cared for women as young as 13 and as old as 56.

14. This care has been provided in multiple settings, including:

(a) Privileges in three Level 3 downtown Toronto Hospitals, namely Toronto General Hospital, Women's College Hospital and currently, Mount Sinai Hospital.

(b) The Toronto Birth Centre since February, 2015;

(c) Inuulitsivik Health Centre in the remote Inuit region of Quebec where I provide clinical care and midwifery education in collaboration with local midwives and interdisciplinary staff each year for a number of months; and

(d) In home settings in Toronto and in rural Ontario settings.

3. AOM Leader

15. I was a founding member of the Ontario Association of Midwives which later merged with the Ontario Nurse Midwives Association to become the Association of Ontario Midwives.

16. I was also a founding member of the AOM, and Chair of its Legislation Committee; Co- Chair of the AOM Complaints and Hearings Committee and member of the Standards and Education Committee.

17. As an AOM representative, I participated in the main initiatives which lead to regulation including the 1987 Task Force on Implementation of Midwifery in Ontario (TFIMO).[4] the Curriculum Design Committee, the Interim Regulatory Council of Midwifery, the Midwifery Integration Planning Project, the AOM's Legislation Committee, and the AOM's Funding Committee.

4. Midwifery and Maternity Care Policy

18. I am very familiar with provincial, national and international maternity care and midwifery issues. I have participated extensively in the Canadian Association of Midwives and the International Confederation of Midwives as set out in my CV. I have sat on multiple inter professional policy bodies related to maternity care.

19. In 2015, I was the first midwife to be appointed by the MOHLTC to the Provincial Council on Maternal Child Health. Between 2009 and 2015 I was a member of the MOHLTC Maternal and Newborn Advisory Committee established to advise

4 Task Force on the Implementation of Midwifery in Ontario, (1987), AOM0013549.

the MOHLTC on maternity care policy. This Committee is a sub-committee of the Provincial Council on Maternal Child Health.

20. Prior to that, I have participated in a number of MOHLTC policy initiatives:

(a) I was appointed by the Ontario Women's Health Council as co-chair of the 2004-2005 Ontario Maternity Care Expert Panel ("OMCEP") and was a contributing author to its September 6, 2006 report: Ontario Maternity Care Expert Panel – Emerging Crisis, Emerging Solutions.[5] OMCEP was established by the Ontario Women's Health Council as an advisory body to the Minister of Health. This report detailed the importance of valuing maternity care providers, the rising intervention rates, the need to expand the scope of practice of midwifery and the escalating crisis arising from the shortages maternity care providers.[6] AOM witness Elana Johnson was also a member of this Panel.

(b) As co-chair of OMCEP, I was a member of the Family Health Team Action Group which looked at how to establish Family Health Teams in Ontario as part of Primary Health Care reform.

(c) I also acted as a member of an expert panel for the East Erie LHIN to review the recommended closure of the Leamington Memorial Hospital.

(d) As a member of the PCMCH, I participated in an invitation only consultation on the MOHLTC's Patients First policy initiative to examine the relationship between that policy and maternal and child health.

5. University Professor, Scholar and Research Consultant

21. I was appointed the first director of the Ryerson Midwifery Education Programme ("MEP") and held that position from 1993-1998. During that time and to date I also hold the position of an Associate Professor in that Programme.

22. I have also frequently acted as a Consultant and expert to other health system and regulatory bodies and education programs in Canada. For example I acted as:

(a) Member of the International Confederation of Midwives Scientific Program Planning Committee from 2015 to 2016

(b) Member Expert Panel on the Closure of the Leamington Hospital, East Erie LHIN (Local Health Integration Network) from 2014 to 2015

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5 Ontario Women's Health Council, "Executive Report of the Ontario Maternity Care Expert Panel: Emerging Crisis, Emerging Solutions" (September 6, 2006) MOH017366.

6 Ontario Women's Health Council, "Executive Report of the Ontario Maternity Care Expert Panel: Emerging Crisis, Emerging Solutions" (September 6, 2006) MOH017366.

(c) Consultant to the College of Midwives of Manitoba. Comparative Analysis: Kanaci Otinawawasowin Bachelor of Midwifery Program Curriculum and Core Competencies from 2013 to 14.

(d) Provided advice in 1997 to the College of Midwives of British Columbia on the development of a registration exam and in 1998 to the B. C. Ministry of Advanced Education and Training on the development of midwifery education.

(e) Consultant to the Government of the North West Territories Midwifery Program Review and Expansion Analysis from December 13 to February 13 and September 2011 to February 2012.

(f) Member Society of Obstetricians and Gynaecologist of Canada (SOGC) Clinical Practice Guideline Committee. Health Professionals Working with Aboriginal People in 2012.

(g) Member Association of Ontario Midwives Clinical Practice Guideline Committee in 2009.

(h) Invited participant: Health Canada consultation on Inuit midwifery, Iqaluit, Nunavut in 2007.

(i) Member of Program Review Team for Aboriginal Midwifery Education Programme (AMEP), Manitoba, May 06 and interviewer for first faculty members in 2006.

(j) Consultant to the Department of Health and Social Services, Government of the Northwest Territories in its review of proposed midwifery regulation and standards in 2003.

23. I have extensive knowledge of Ontario's MEP curriculum and the scope of practice, guidelines and practice standards of the College of Midwives of Ontario. I have developed curriculum and taught every midwifery related course in the Ryerson MEP. As detailed later in this affidavit, I participated in the development of the core competencies which guide midwifery education in Ontario and the MEP curriculum. I did this as part of the AOM which initially developed the competencies and then working with the government's Curriculum Design Committee, Interim Regulatory Council and the Transitional Council of the College of Midwives of Ontario which adopted those competencies. I was also involved as first Director of the MEP at Ryerson.

24. I was acting Ryerson MEP Director at the time of the expansion of the MEP program in 2009 which involved taking leadership for extensive revisions of the Curriculum and the development of the Post Baccalaureate Program for Health Professionals (PBHP).

25. I am also co-author of the MEP's Guide to Teaching and Learning and the first edition of the AOM's Emergency Skills Workbook, both of which have been adapted for use in midwifery education programs across Canada.

26. I have played a lead role in the MEP in the education of clinical teachers and the development of resources for clinical education. I have been involved in the evaluation of all of the tenured faculty members at the Ryerson MEP and many in the McMaster program. I have also been invited to do tenure evaluations for the University of British Columbia Midwifery program.

27. I also have knowledge of the scope of practice and education of physicians and nurses particularly in relation to maternity care. Since 1999 I have been a member of the Advanced Life Support in Obstetrics (ALSO) teaching team at the University of Toronto, Department of Family and Community Medicine for Family Practice residents. I have also taught the ALSO course at the Canadian College of Family Physicians, in addition to doing so at various hospitals in Toronto. I am part of the faculty which plans the annual University of Toronto/Mount Sinai Hospital Inter professional conference on Primary Maternity Care.

28. I am also an Advances in Labour and Risk Management (ALARM) instructor for the SOGC and was a member of the SOGC steering committee which set the curriculum for this interdisciplinary course.

29. ALARM is an inter professional continuing education course for maternity care providers, including family physicians, midwives, nurses and obstetricians. ALARM was developed by a steering committee of obstetricians, family physicians, midwives and nurses, who jointly continue to maintain and teach the course. I have taught this course over 15 times in a variety of settings across Canada.

    (a) The ALARM course aims to improve the care provided to women during labour, their fetuses and newborns, and their families. This two-day course offers case-based plenary sessions, hands-on workshops and a comprehensive examination process.

    (b) The content of the course is evidence based and incorporates the Canadian practice guidelines, so participants who complete the course gain an understanding of the latest best practices for providing care.

    (c) The ALARM course objective is to evaluate, update and maintain the competence of specialists, family physicians, midwifes and nurses. Upon completion, participants understand how to improve the outcomes and process of intra-partum and immediate postpartum care.[7]

7 SOGC, Advances in Labour and Risk Management(2016).pdf (2016) AOM0017363.

30. I have recently taken leadership to initiate a joint offering of the ALARM course collaboratively between Ryerson's MEP and the University of Toronto's Department of Family and Community Medicine. This will be offered to 3rd year midwifery students and Family Practice residents.

31. I was a research team member for the "Babies Can't Wait – Obstetrics Care in Crisis" a multi-year inter disciplinary research project by the Ontario College of Family Physicians which reported on August 31,2006 and explored attitudes and experiences of maternity care learners and educators in undergraduate medicine, obstetric and family practice residency, midwifery and nursing in order to assess collaborative models of maternity care.

32. I have also published and presented extensively on midwifery and maternity care issues as set out in my Curriculum Vitae including the relationship of midwifery to women and their health, the impact of legislation on midwifery, emergency skills, clinical teaching, prior learning and assessment, remote midwifery, risk management and the growth of midwifery and its impact on the model of practice. As well, my research and publications relating to maternity care have examined the different ways in which evidence based maternity care is provided by physicians, nurses and midwives. This was the particular focus of my doctoral dissertation.[8] My research has also addressed the impact of health systems on child bearing women and care providers.

6. Feminist and Mother

33. I first identified as a feminist in my teens in the mid-1970s, influenced by the Canadian women's movement.[9] As a feminist, I was interested in women's health issues. This together with my personal experience of home birth in my early twenties, influenced my decision to study the science, social science and history of midwifery at university and to take up an offer to apprentice with a midwife who had begun practicing in the Toronto area.

34. I also found inspiration in the story of my mother's desire to resist the technological approach to birth that dominated medical practice in 1950s Canada. My mother had struggled to be conscious in childbirth in an era when women were routinely anesthetized during low risk births. In her second labour, she was in the hospital elevator and felt like pushing but was still given a general anesthetic despite the birth being very straightforward. For her third labour my mother went to Women's College Hospital and asked her doctor if could stay awake for the birth. She said to me - "If it wasn't for that young woman....a [medical] resident... who sat with me I couldn't have done it." This story informed

8 Allemang, Elizabeth M. Alegal Midwives. Oral History Narratives of Ontario Pre-legislation Midwives.pdf (2013) AOM0017416.

9 My history, along with that of other midwives was documented in Allemang, Elizabeth M. Alegal Midwives. Oral History Narratives of Ontario Pre-legislation Midwives.pdf (2013) AOM0017416.

my own confidence in the physiologic process of childbirth and my appreciation for female support in labour.

35. As well, I took inspiration in the family stories of my great grandmother's work as a practicing midwife in Toronto as well as the influence of the deeply rooted cultural traditions of home birth and midwifery from my Dutch heritage. I always thought home birth was normal or natural because that is the way it is in Holland. My father's generation had been born at home in the west end of Toronto.

36. When it came time to have my first child, I chose a home birth and felt empowered and inspired by the opportunity to give birth the way I wanted to rather than adapting to institutional and medical policies and practices which were not woman-centred. I had the opportunity to labour and give birth on my own terms, and make decisions at this important point of my life. I was only twenty-three and it enhanced my feeling of competence and confidence as a person. At my birth I had a childbirth educator and a home birth physician. I had to travel to Toronto from the rural area where I lived to access this option. There were no midwives practicing at that time.

37. I also recognized the political aspects of midwifery. I thought that everyone should be able to have access to midwifery and home birth. It troubled me that these choices were not available within the public health care system. At that time, in the late 1970's, the conditions under which women gave birth were very medicalized. The idea of having family support people present or for women to give birth without pain relief and other routine procedures was very new and certainly not part of regular maternity care practice.

38. I wanted to make home birth and midwifery accessible to other childbearing women and to see midwifery become an "ordinary" option, as it was in other parts of the world. At the time, I immersed myself in reading about midwifery in other countries. I also read about the history of midwifery and how and why it did not become established as part of the health system in Canada. I thought it was wrong and inequitable that there were no midwives for people like me who wanted to be supported to give birth outside of the hospital.

II. History of Ontario Community Midwifery

39. In my Master's Thesis, "With Women: Community Midwifery in Ontario", I researched and wrote about the history of community midwifery in Ontario. This thesis included chapters reviewing international and Ontario community midwifery, the relationship to the community health movement, the development of a community midwifery system based on place, structure and participatory care, the various sites of midwifery care in the home, hospital and birth centres,

the structuring of a responsive midwifery system including continuity of care, caseload, method of payment and the need for autonomy and accountability.[10]

40. Prior to 1865, midwives were the primary maternity care providers in Ontario in both indigenous and settler communities. Before 1865, Ontario's *Medicine Act* made it possible for midwives to practice midwifery without a license to practice medicine.[11] In 1865, the Ontario government eliminated this exemption at the urging of the male-dominated profession of physicians who denigrated the skills and competence of such midwives.

41. Since that time, physicians became the predominant providers of maternity care and sought to actively exclude midwives from that care.

42. By the early 20th century in Ontario, the almost exclusively male profession of physicians had gained control of managing childbirth. Physicians spearheaded the notion that childbirth was dangerous and required their superior scientific knowledge and that midwives lacked modern medical education, were incompetent and that it was unsafe to allow midwives to provide maternity care. This was part of the process of "medicalizing" normal childbirth and preserving the work of providing that care to physicians rather than midwives. At this time women had only just gained access to medical school in Ontario.

43. Some midwives continued to practise in Ontario without legal recognition.

III. Re-Emergence of Ontario Community Midwifery - 1970's - Early 1990's

1. Introduction

44. During the 1970's and 1980's, a growing number of Ontario midwives working as self-employed practitioners provided midwifery services but in a precarious fashion as a result of their uncertain legal status. I was one of those midwives. As noted above, I have described this period in my Masters Thesis, *With Women: Community Midwifery in Ontario.*

2. Education and Training

45. Pre-regulation Ontario midwives, prior to being admitted to the Michener Institute pre-registration program (described below) were educated in midwifery knowledge and skills through many different pathways, including extensive apprenticeship to an experienced midwife or home birth physicians, attending relevant courses and presentations, qualifications and experience as internationally trained midwives or previously acquired nursing qualifications.

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10 Vicki Van Wagner, With Women: Community Midwifery in Ontario, April, 1991, Masters of Arts Thesis, Faculty of Environmental Studies, York University, AOM0017358.

11 Ontario, Legislative Assembly, Official Report of the Debates (Hansard), 35th Parl, 1st Sess (29 May 1991) (Hon. Frances Lankin), AOM0000578.

Most had pre-existing university degrees. The qualifications and training of these midwives was reviewed in the TFIMO Report and also in my thesis.[12]

46. With its focus on women-centred care by women, midwifery practice and education adopted a gender lens which has informed the entire regulatory and education structure. By gender lens, I mean that women are placed at the centre of both clinical care and the model of practice and it is recognized that it is women who provide the care. The very fact that midwives stay on call so that women have known care providers is putting women at the centre of care and decision-making.

3. Unique Model of Care

47. Midwives during this period provided woman-centred maternity care combining elements of the roles played by a family physician, obstetrician, nurse and pediatrician. I described this model of care in my 1991 Masters Thesis, *With Women.* This model of care was used as the foundation of the regulated model of care which started as of January 1, 1994. This model was also consistent with an international movement towards community-based autonomous midwifery care and away from shift-based institutionalized midwifery care.

48. It is this combination of roles and the specialized focus on empowering women and their choices that makes midwifery a unique profession and often leads to a lack of understanding of the profession and the discounting and invisibility of its work.

49. The midwifery model of care developed by Ontario's community midwives is set out in the College of Midwives of Ontario document, Midwifery Model of Care.[13]

50. The Model of Care can be described as follows:

(a) Normal Birth

51. Midwifery Care is based on an understanding of birth as a normal healthy physiologic process that in most cases benefits from a low intervention approach to care. Even when pregnancy and birth fall outside of a low risk or normal category midwives continue to provide care to keep the experience as normal and healthy as possible.

12 Task Force on the Implementation of Midwifery in Ontario Report, 1987, AOM0013549 at p 122; Vicki Van Wagner, "With Women: Community Midwifery in Ontario, Thesis 1991 AOM0017358.

13 CMO Guidelines; 2014-01-01 - CMO Guidelines - The Ontario Midwifery Model of Care.pdf (2014) AOM0015441.

(b) Informed Choice

52. The midwifery model is based on adequate time for education and counselling for women and families to make informed choices about their care.

(c) Choice of Birthplace – Home, Birth Centre, Hospital

53. Midwives attend births in all settings and respect the client's choice of birth place. Midwives are skilled at risk screening and advising when out of hospital birth is an appropriate choice and when hospital birth is recommended.

(d) Continuity of Care/ Caseload

54. The midwifery model is organized to provide relational continuity over prenatal, labour and birth and postpartum care. Clients get to know a small group of midwives (<4) and on call models are designed to provide a known attendant during labour and birth. This model is also called a "caseload" as each midwife has a caseload that allows her to "follow" the woman's care and attend her birth.

55. The caseload both pre-regulation and post regulation is about 40 births per year as a primary midwife and 40 as a secondary midwife for a full time midwife. The national and international norm for a full time caseload midwife is 30-40 births per year. In international settings the "caseload" midwives often do not attend as second except in out of hospital settings as in most countries staff midwives in the hospital fulfil the role of second midwife.

(e) Practice Groups

56. In order to provide continuity of care and allow midwives off call time care midwives work in practice groups (usually between 6-20 midwives) and provide pre and postnatal care (and in some cases births) in community based clinics.

(f) Midwifery-led Care and Interprofessional Collaboration

57. Midwives work as autonomous primary care providers as part of an inter professional team. In a normal pregnancy and birth midwives are able to provide complete maternal and newborn care until 6 weeks postpartum. In situations that also require physician or nursing care midwives consult and continue in the role of primary care provider or transfer care to medicine and nursing and continue to provide care within their scope as part of the team.

(g) Evidence Based Practice

58. Midwifery education, regulation and practice is based on best evidence and offering childbearing clients choices supported by the evidence. Pre-regulation a growing body of evidence emerged to support midwifery approaches to care. Some of the founders of the evidence based practice movement, such as

McMaster University obstetrician Murray Enkin were also vocal advocates of midwifery and family centred maternity care.

(h) Apprenticeship Approach to Education

59. Pre-regulation midwives developed an approach to midwifery education based on an apprenticeship model. This required students to follow midwives in their work and be on call 24/7. Students at this time did their academic learning through self-study and small group learning with other student midwives. This model gave students the opportunity to learn within a continuity of care model. This on the job clinical learning is similar to other professional education models in which students learn from preceptors in a clinical setting. The apprenticeship model was integrated into the current midwifery education system which is based on preceptorship, continuity of care and problem based (case based) learning.

(i) Course of Care Approach - Not Fee for Service

60. The funding model agreed to by the AOM and MOH is based on a course of care payment rather than a fee for service model. This was based on an agreement by both parties that a fee for service system would not support the model of care.

(j) 24/7 Availability to Known Midwife

61. Providing a continuity model of care with 24/7 availability for a client with a known midwife, requires a midwife to work in group practices and to accept a lifestyle that requires being on call at least half the time and very often most of the time, with only several days off call per month. Although a small number of family physicians in the province provide this degree of availability it is not common and would rarely be a feature of an obstetrician's practice. In the Babies Can't Wait project the inter professional research group noted in our project discussions that physicians talk about the few days a week when they're "on call" and midwives talk about the few days a month when they're "off call."[14]

4. Comparison of Physician, Midwifery and Nurse Scope of Practice

62. In Ontario, maternity care was first provided exclusively by midwives. In the 18th century, male physicians started to include maternity care in their scope of practice and as the female nursing profession developed, maternity care was provided by physicians and nurses under the direction of physicians. This is the gender hierarchy of medical led maternity care model.

14 Babies Can't Wait: Obstetrics Care in Crisis Project Report, August 2006, Ontario College of Family Physicians Part 1 (July 31, 2006) AOM0017397; Babies Can't Wait: Obstetrics Care in Crisis Project Report, August 2006, Ontario College of Family Physicians Part 2 (July 31, 2006) AOM0017398.

63. The AOM set standards which defined the midwives scope of practice through adopting the International Definition of a Midwife guidelines indicating when midwives should consult a physician and when transfer from home to hospital.[15] These standards formed the basis for the Indications for Mandatory Discussion, Consultation and Transfer of Care developed by the IRCM and adopted by the CMO in 1994. The current CMO standard on Consultation and Transfer of Care is the updated version of these standards.

64. One of the fundamental problems midwives have experienced as they re-emerged as maternity care providers is that there is often misunderstanding about the autonomous scope of their practice where they include aspects of the scope of practice of both physicians (family physicians, obstetricians and pediatricians) and nurses. Both family practitioners and midwives consult specialist obstetricians or other specialist physicians if complications arise. As noted below, there are certain aspects of midwifery practice which family physicians do not regularly do (eg. home births). There are some aspects of maternity care within a family physician's scope which are not part of midwifery practice such as a forceps delivery (although most family physicians do not normally perform forceps deliveries).

65. On regulation, midwives became the only regulated health care provider who provided the option of home/out of hospital births to Ontario women. While the rules preventing doctors from attending home births have been repealed, doctors continue not to attend births outside of hospital for a number of reasons, including that it is not practical for them to spend that amount of time outside their offices and provide care during labour without nursing support.

5. Self-Regulation by AOM and Peers

66. Ontario midwives came together through their representative organization, first the Ontario Association of Midwives and then the merged AOM to develop their own self-regulation methods to ensure midwifery care met a high standard.

67. As a member of the Standards Committee, I assisted in creating midwifery standards and protocols which would later become the foundation of the regulated standards and guidelines which were developed and effective as of regulation of January 1, 1994. The TFIMO's 1987 Report attached as Appendix 7 a summary of the AOM's already established Standards of Practice with respect to skills, appropriate equipment, records, compliance, medical backup, screening, informed choice, continuing education, peer review and protocols.[16]

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15 Task Force on the Implementation of Midwifery in Ontario Report, 1987, AOM0013549 at Appendix 7, Page 414-415.

16 Task Force on the Implementation of Midwifery in Ontario Report, 1987, AOM0013549 at Appendix 7, Page 414-415.

6. Relationship to Funded Maternity Care System

68. Although it was challenging to work outside of the formal health system, pre-regulation practice was made possible through collaboration with individual family physicians and obstetricians who actively supported our practice and the development of midwifery. They provided midwifery clients with access to lab work and back up in hospital. These physicians collaborated with us as if we were part of the system and their acceptance of the value of midwifery care helped to demonstrate that integration of midwifery was possible and desirable.

69. In particular physicians from countries where midwifery was the norm had often been educated about normal birth by midwives. Others had felt compelled to attend home births when their patients wanted this choice and helped train aspiring midwives until the College of Physicians and Surgeons of Ontario (CPSO) advised them in 1983 against attending home births and collaborating with midwives.

70. Many community midwives encouraged clients to see a physician during their pregnancy who could order tests and until 1983 some supportive family physicians would attend births with us. This collaborative attendance at births stopped after the 1983 direction to physicians not to cooperate with non-medical birth attendants and not to attend home births.

7. Internationally Trained Midwives and Midwifery

71. During this time, there were a significant number of internationally trained midwives, many of whom had been trained as nurses as well as midwives. However, given the "alegal" context of midwifery at this time, many chose on coming to Canada to practise at nurses not midwives. As a result, they were not able to use their midwifery skills to their full scope. [17]

8. Relationship to Primary Health Care Reform

72. Community midwifery re-emerged in Ontario at a time when governments around the world were looking at reforming their health care systems to become more community based and patient centred.

73. This approach to patient centred health reform was reflected in the Ottawa Charter for Health Promotion and the Ontario Premier's Council on Health Strategy. This resulted in the document: A Vision of Health: Health Goals for

17 Allemang, Elizabeth M. Alegal Midwives. Oral History Narratives of Ontario Pre-legislation Midwives.pdf (2013) AOM0017416.

Ontario" These documents all followed after the International Primary Health Care Conference's Alma Ata Declaration in 1978.[18]

9. Connection to Community Health Centres and Primary Care

74. As I reviewed in Chapter 5 of my thesis. *With Women,* Community Health Centres in Ontario during the 1980's were an important part of the Government's primary health care reform and the move to more patient centred care.[19] This philosophy and approach was similar in many ways to those of the community midwives.

75. I was a member from 1989-1991 of the Board of Directors of Women's Health in Women's Hands, a group which took the first steps towards establishing a specialized Community Health Centre focusing on women's health. I also was a member of the Centre's Outreach Committee.

76. There was some hope that midwives could become part of the CHCs. For women, maternity and newborn care is the most common reason to seek health care. Connecting midwifery to the care provided by CHCs might have been positive. However, it turned out that at that time there were too many barriers to having this actually work practically. This included that to provide continuity of care and 24/7 care normally requires at least 8 midwives and there was no space in the Community Health Centres of the time to do that.

77. At that time few family physicians within CHCs provided intrapartum care and most women were referred to obstetricians. This was linked with the well documented trend within family practice generally to withdraw from intrapartum care specifically and maternity care generally. Research into why family physicians have withdrawn from maternity care are generally accepted to be related to the challenge of maintaining maternity care and especially intrapartum skills, concerns about liability and concerns about lifestyle.[20]

10. The Growth of Senior Primary Care Nurses/ Nurse Practitioners

78. During the late 1980's and early 1990's, in my work as a community midwife as well as my work as a board member at the Women's Health in Women's Hands

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18 International Conference on Primary Health Care Alma Ata Declaration, (September 12, 1978) AOM0000884.

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

20 Report by Ontario Maternity Care Expert Panel for Ontario Women's Health Council re: Maternity Care in Ontario: Emerging Crisis, Emerging Solutions (June, 2006) AOM0005948; Also see Smith LF, Reynolds JL. Factors associated with the decision of family physicians to provide intrapartum care. CMAJ 1995; 152(11):1789-1797 AOM0016486; Woodward CA, Rosser W. Effect of medicolegal liability on patterns of general and family practice in Canada. CMAJ 1989; 141(4):291-299, CAV000001.

CHC, I saw the growing expansion of the work of senior primary care nurses in the Centres, who were sometimes called Nurse Practitioners. I have also worked on projects with colleagues at RU in the NP Education Program.

11. Connection to Gender

79. During the 1980's, I observed that the health care system and the professions which I interacted with were very gendered. At this time, the vast majority of physicians were men, the leadership of the profession was dominated by men and the vast majority of the remaining health care professions were dominated by women. These personal observations were confirmed in the research I did relating to women's health policy.

80. According to Canadian Institute of Health Information (CIHI) data there was a high male predominance of physicians, family physicians and obstetricians over the period of time from 1978 onwards.[21] Midwives were all women, except for one male midwife and nurses were over 90% female.

81. While the above Chart shows that physicians came to include substantially more women in the years since 1994, these female physicians work within and benefit from the established attitudes and place of privilege in the health care hierarchy that was developed and controlled by men and for men for over a hundred years.

IV. Disadvantages Experienced by Pre-Regulation Midwives – Systemic Barriers and Prejudices

1. Introduction

82. In *With Women*, I describe the practices and conditions of midwifery during this time which disadvantaged midwives like myself relative to their male predominant physician counterparts, including the prejudices and stereotypes they faced. Negative attitudes and systemic barriers as outlined below were experienced by myself and my almost exclusively female midwifery colleagues at every level of the health care system from physicians to many nurses as well as ambulance attendants.

83. During the period prior to regulation at the time of the TFIMO in 1986-1987, I regularly gave presentations on midwifery which addressed misconceptions and stereotypes about midwifery. I did this to help train members of the MTFO to assist them in their lobbying for midwifery recognition. [22]

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21 CIHI physician gender distribution charts (1978- 2014) AOM0017379; CIHI- physicians, by specialty and gender, and percentage distribution, by gender, Canada, (1978-2014) AOM0017382.

22 Handwritten Notes of Vicki Van Wagner, "Public Speaking About Midwifery",(1987) AOM0017369.

2. Limits on Scope of Practice

84. Although midwives in the 1980's were trained to exercise the full scope of midwifery practice as referred to above, they were frequently prevented from carrying out that scope of practice. Examples of this are the following:

(a) Reduced to operating as labour coaches in hospitals and being excluded from operating room where the client is now having a caesarian section and the client wanted me there;

(b) Unable to do basic lab tests and screening tests that are part of prenatal care e.g. blood tests for hemoglobin or ultrasounds;

(c) Unable to prescribe drugs for common complications of pregnancy eg bladder infection or mastitis; and

(d) Unable to prescribe drugs for emergencies needed for out of hospital birth e.g. for postpartum hemorrhage

3. No Access to Hospital Privileges

85. Until January 1, 1994, midwives were not able to admit their clients to hospitals for labour and delivery while male predominant physicians had full access to such privileges and also controlled the processes which gave access to such privileges. This both limited the number of midwives' clients and interfered with the right of Ontario women to choose their care provider and place of birth. If a midwifery client wanted a hospital birth, the woman had to have both a midwife and a physician providing care.

4. No Government Funding

86. Unlike their physician counterparts, midwives did not receive government health care funding for their services. This further limited the number of midwifery clients and the compensation midwives could expect for their work. As Ontario women were required to pay for midwives themselves if they chose midwifery care, midwives enacted a sliding scale level of fees to facilitate more access of women to care. Midwives often provided care without charge to clients who either could not pay or defaulted on their agreed upon payments.

5. No Funded Education system

87. Unlike their physician counterparts, midwives did not have access to a government funded professional education system. If you wanted to be a midwife, you had to become an apprentice with no formal credential to be gained after years of studying and clinical experience. You had no access to student loans or other financial supports. Now a student midwife can go to a bank and acquire a loan on the basis of her participation in professional training. As well, it

is very onerous to do self-study for both the student and clinical teacher to structure a self-study program.

6. No Funded Regulatory System and Exposure to Prosecution

88. The lack of a funded and recognized regulatory system left midwives to face supervision and oversight through potential prosecutions and inquests rather than through a regulatory college. As well, this left midwives subject to frequent exclusionary conduct by medical organizations who did not see a role for autonomous midwives in the health care system.

7. Precarious and Low Pay Work

89. The above factors made my work as a midwife and that of my colleagues precarious and insecure. As I detailed in *With Women,* while physicians were earning more than $100,000 annual incomes in the early 1990's receiving public funds for their insured services, the average earnings of a midwife in a very busy practice in Toronto was approximately $20,000 prior to regulation, while other practices fared much worse. Midwives were privately paid low compensation by the women for whom they provided service to and sometimes were not paid at all. Through this low pay, midwives subsidized the provision of midwifery health care to women.

V. Connection Between Women's Movement Struggles for Health and Pay Equity

1. The Struggle for Women's Health Equity

90. As I noted above with my own history and as detailed in the TFIMO report, many women in Ontario were increasingly concerned that their health care needs were not being fully met through the physician led model of maternity care. The TFIMO referred to how Ontario women experienced barriers to gaining access to care and treatment which addressed their health needs, particularly their care related to pregnancy, birth and the postpartum period.[23] It was my experience and observation that the medical model of maternity care often did not appropriately take into account the cultural, social or emotional factors of women.

91. The movement to gain recognition for midwifery in Ontario of which I was a part was rooted in the movement of Ontario women for health equity, empowerment and reproductive choices.

92. I was part of the struggle for more equitable women's health in Ontario both during the 1980's and 1990's and since then. An example of this movement was the work to establish the Women's Health in Women's Hands Community Health Centre for which I was a board member.

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23 Report of the Task Force on the Implementation of Midwifery in Ontario 1987 (1987/01/01) AOM0013549.

93. During the years after regulation, Ontario midwives continued to be actively involved in promoting women's health equity. I remained active in women's health issues. The Ontario Maternity Care Expert Panel (OMCEP) which I co-chaired was established by the Ontario Women's Health Council which we reported to regularly.[24]

94. As part of my role as Chair, we met and consulted with Echo about the POWER study which developed the Ontario Women's Health Framework.[25] The POWER Study was a multi-year project funded in part by the MOHLTC which examined sex and gender differences among health indicators and health care quality. It is also highlighted differences among women (and men) related to socioeconomic status, ethnicity, and geography. The Women's Health Framework called for a sex/gender lens in health care decision-making. This also lead to the report: "Echo: Improving Women's Health in Ontario: Sharing the Legacy – Supporting Future Action, 2009-2012" which also called for a sex/gender lens in health care decision-making.[26]

2. Movement for Gender Equality for Women's Work and Pay

95. At the same time as we were struggling to gain recognition for midwifery work, the AOM was also part of the broader women's movement and a member of the National Action Committee on the Status of Women. I made presentations on midwifery to National Association of Women and Law (NAWL) and LEAF. We were aware of the work of the Ontario Equal Pay Coalition which was active at the same time in seeking remedies for the gender pay inequities which women faced.

96. In fact, as the government was deciding in 1985 to regulate the female predominate midwifery profession and integrate into health care system, it was also deciding to implement "pay equity."

97. I had followed the career of Ian Scott and recall his work on pay equity including his announcement about the "Green Paper on Pay Equity. On November 19, 1985, Ian Scott, Ontario Attorney-General and Minister Responsible for Women's Issues, introduced in the legislature the Green Paper and stated: 'We are committed to implementing pay equity". This Paper recognized the women working in female dominated jobs and professions including health care were being paid less than the value of their work warranted. Pay equity comparisons

24 Ontario Women's Health Council, "Executive Report of the Ontario Maternity Care Expert Panel: Emerging Crisis, Emerging Solutions" (September 6, 2006) MOH017366.

25 Ontario Women's Health Framework, 2011.PDF, (2011), AOM0017425.

26 "Echo: Improving Women's Health in Ontario: Sharing the Legacy – Supporting Future Action, 2009-2012 (2013) AOM0000587.

were used to make visible the unacknowledged skills, effort, responsibility and working conditions found in jobs historically performed by women.[27]

98. During the time of the Task Force on the Implementation of Midwifery (TFIMO) proceedings, there was a wide ranging public discussion about the government's proposed new *Pay Equity Act* which was passed in the same years as the TFIMO report - 1987. We knew that this law required the health care sector including the Community Health Centres to take affirmative action to redress the systemic gender inequities in the compensation of women's work in Ontario.

99. As we got advice about working towards regulation and funding, one of the concerns raised was that midwives would be funded but would be vulnerable to being paid less than they were worth because of being a female dominated profession.

VI. 1985 Government Recognition of Midwifery

100. Following on the government decision to pass a health profession regulatory law, the Government decided to include midwifery as one of those regulated professions. I was in the Legislature in 1986 when this was announced by MOH Minister, Murray Elston.

101. As a member of the AOM's Legislation Committee, I participated in the Health Professions Legislative Review (HPLR) process. The AOM believed that the regulation and funding of midwifery and its full and equitable integration into the health care system would provide much needed access for Ontario women to funded midwifery care and would also provide the midwifery profession with access to funded education and appropriate pay and practice conditions. The AOM provided to this process all of our documentation showing how we had our own self-regulating processes, standards and guidelines. [28] This demonstrated the capability of our profession to be one of Ontario's regulated health professions.

102. I was directly involved in the policy, regulatory and education process which led to the entry of midwives into Ontario's funded health care system. I was an AOM liaison representative to the Interim Regulatory Council on Midwives and member of the AOM's Legislation and Education Committees.

103. Following on Minister Elston's 1985 announcement, the MOHTLC appointed the Task Force on the Implementation of Midwifery, chaired by Mary Eberts.

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27 Report from Ontario Ministry of Labour, Green Paper on Pay Equity, with letter of introduction from Minister Ian Scott (1985/11/01) AOM0000548.

28 For a discussion of this, see Task Force on the Implementation of Midwifery in Ontario, (1987), AOM0013549.

VII. 1987 Task Force on Implementation of Midwifery in Ontario (TFIMO)

104. I participated extensively in the Task Force on Implementation of Midwifery in Ontario (TFIMO). I co-authored the AOM's October, 1986 submission to the Task Force, "Creating the Midwifery Profession in Ontario".

105. On behalf of the AOM, I was present at the Task Force Hearings in Toronto in October and November, 1987 which heard submissions from many different perspectives.

106. The Task Force noted the following considerations:

> *In Canada even more than the United States, the emergence of the modern medical profession largely precluded the development of any real profession of midwifery. The traditional practice of midwifery by women was suppressed. This fact of Canadian history is important of understanding why midwives are almost unknown in this country.*[29]

The Task Force also noted that the initial exemption of midwives in the 1800's was deleted following pressure from the College of Physicians and Surgeons of Ontario.[30]

> *The more childbirth is seen as a healthy event in the natural cycle of life, the more midwives are valued as birth attendants. The more birth is seen as a potentially pathological event, the more midwives have given way to physicians, especially obstetricians.* [31]
>
> *Physicians control access to hospital services. Only they can admit a patient to hospital…Once the patient is admitted, a physician's order is necessary for every test, medication and treatment. Every patient must be examined by a physician upon admission, and a physician is the only health care professional who may discharge a patient.* [32]

The CMA and OMA stated:

> *there are various reasons general practitioners choose note to practice obstetrics. General practitioners do not receive exhaustive training or clinical experience in obstetrics during medical school and internship.*

[29] Task Force on the Implementation of Midwifery in Ontario, (1987), AOM0013549 at page 31.

[30] Task Force on the Implementation of Midwifery in Ontario, (1987), AOM0013549 at page 31.

[31] Task Force on the Implementation of Midwifery in Ontario, (1987), AOM0013549 at page 32.

[32] Task Force on the Implementation of Midwifery in Ontario, (1987), AOM0013549 at page 67.

Many have no contract with general practitioners who do practice obstetrics.[33]

…nurse does not have an independent role in monitoring the health of the woman or her pregnancy.[34]

…nurses provide continuous care during labour and inform the physician of the woman's progress, and the physician makes intermittent visits as needed… hospitals have often sought nurses with midwifery preparation to work in labour and delivery services because of their skill in recognizing abnormalities and because many have conducted numerous deliveries on their own.[35]

The Task Force recognizes that the standards of practice regarding referrals and consultations will be effective only if physicians and midwives are willing to cooperate with each other. Working relationships between midwives and physicians must be such that necessary consultations and referrals are encouraged and easily carried out, while unnecessary or inappropriate consultations, referrals and self-referrals are discouraged.[36]

In Chapter 3, we described community health Centres (CHCs). Physicians and nurses now working in CHCs provide limited pregnancy care. However, since CHCs do not currently provide abstract obstetrical or other special services, women are referred to other physicians or hospital obstetrical clinics at a certain point in their pregnancies and the CHC staff play no role in their care during labour or childbirth.[37]

The Taskforce does not believe that payment on the basis of fee-for-service is an appropriate way of remunerating midwives. It is fundamentally inconsistent with the holistic philosophy of midwifery care. To itemize every unit of services, be it education, counselling, emotional support, or physical care, would run counter to the nature of midwifery care, in which the various aspects of care overlap and reinforce each other.[38]

Payment on the basis of fee-for-service also necessitates the preparation of fee schedules. The preparation of a fee schedule for midwifery care would involve difficult comparisons with the fee schedule for obstetrical

[33] Task Force on the Implementation of Midwifery in Ontario, (1987), AOM0013549 at page 69.

[34] Task Force on the Implementation of Midwifery in Ontario, (1987), AOM0013549 at page 71.

[35] Task Force on the Implementation of Midwifery in Ontario, (1987), AOM0013549 at page 71.

[36] Task Force on the Implementation of Midwifery in Ontario, (1987), AOM0013549 at page 88.

[37] Task Force on the Implementation of Midwifery in Ontario, (1987), AOM0013549 at page 96.

[38] Task Force on the Implementation of Midwifery in Ontario, (1987), AOM0013549 at page 96.

services rendered by physicians. We think this could easily be a continuing source of friction between midwives and physicians.[39]

throughout our Report we emphasize how important it is that midwives' work encompass the full scope of practice during every stage of the reproductive cycle. Continuity of care depends on this. We think it is nonsensical to construct a system in which highly qualified birth attendants are denied access to the childbirth setting used by 99 per cent of Ontario women. [40]

We believe midwifery is an autonomous profession, separate from any other. It is true that the midwife's scope of practice overlaps with the scope of practice of the nurse and the physician. Midwives, nurses and physicians share certain skills and knowledge. But midwifery is not nursing or medicine. [41]

We are convinced that the multiple routes of entry model will facilitate nursing's contribution to midwifery, without excluding the contribution of all others. It is the model most consistent with the fact that midwifery is an autonomous profession and is the model that will best safeguard the public because it will result in the regulation of all practitioners according to a single set of standards.[42]

…general practitioners: "there is no doubt that general practitioners are playing a diminishing role in the provision of reproductive care.[43]

obstetricians contributed:

Even if it were possible for obstetricians to care for all pregnant women and perform all deliveries, many observers would view this as undesirable. It is costly for society to prepare and use more highly trained practitioners to care for women who could be cared for equally well by less highly trained practitioners.[44]

By itself consumer demand for midwifery alone may be insufficient to bring about its integration into the health care system. Midwives also need the support of physicians, who are powerful figures in establishing and changing hospital policies and protocols … Our health care system is

[39] Task Force on the Implementation of Midwifery in Ontario, (1987), AOM0013549 at page 99.

[40] Task Force on the Implementation of Midwifery in Ontario, (1987), AOM0013549 at page 101.

[41] Task Force on the Implementation of Midwifery in Ontario, (1987), AOM0013549 at page 121.

[42] Task Force on the Implementation of Midwifery in Ontario, (1987), AOM0013549 at page 123.

[43] Task Force on the Implementation of Midwifery in Ontario, (1987), AOM0013549 at page 160.

[44] Task Force on the Implementation of Midwifery in Ontario, (1987), AOM0013549 at page 160.

physician oriented and many pregnant women are likely to consult their general practitioners for advice on whether they should seek care from a midwife or an obstetrician.[45]

VIII. Development of Midwifery System

107. During the period after 1985, the Government moved to develop the institutional mechanisms which were necessary to integrate midwifery into the health care system. This was led by the Women's Health Bureau. This involved creating an integrated education, regulatory and funding system.

108. I have written about the process of Ontario regulation in my article "Why Regulation: Using Regulation to Strengthen Midwifery.[46] The role of regulation was also addressed in Chapter 3 of *With Women.*

109. Although the majority of Ontario midwives at the time were strongly in favour of regulation, there were some critics of the regulation of midwifery who feared that being integrated into the health care system would "medicalize" and bureaucratize midwifery and make it less personal and responsive to women. The concern of some was that this would undermine the ability of midwives to offer an alternative to the dominant medicalized system of care.

110. On June 30, 1989, the MOH announced the Curriculum and Standards Development processes which were the Interim Regulatory Council of Midwifery and the Curriculum Development Committee.

111. Midwives and consumers played a major role in the development of the new midwifery system. I was directly involved in the regulatory, education and funding system which lead to the entry of midwives into the funded health care system.

112. During this time, there was a high commitment to importance of evidence-based practice and this informed the development of the education system and ultimately informed the process of setting the compensation and funding for the system. As the experienced practising midwives with extensive knowledge, AOM representatives brought to the system discussions their in-depth understanding of midwifery and the commitment to adopting a best practices approach.

IX. Development of the Midwifery Education System

113. In 1987, the Ontario Cabinet approved the development of a midwifery education system as part of its decision to have midwifery as a regulated health profession

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45 Task Force on the Implementation of Midwifery in Ontario, (1987), AOM0013549 at page 162.

46 Vicki Van Wagner, "Why Legislation?: Using Regulation to Strengthen Midwifery" in Ivy Lynn Bourgeault, Cecilia Benoit & Robbie Davis-Floyd, eds, *Reconceiving Midwifery* (Québec: McGill-Queen's University Press, 2004) 71, AOM0007173.

in Ontario. I participated in this process as a member of the AOM Education Committee.

1. The Curriculum Design Committee Report

114. In 1989, the MOH appointed a Curriculum Design Committee to recommend the appropriate midwifery education system and educational site(s). I was a member of that Committee and worked with Ministry and other stakeholders including physician and nursing representatives.

115. The Report of the Curriculum Design Committee on the Development of Midwifery Education in Ontario dated May 30, 1990 recommended the development of a baccalaureate program and a system to qualify the existing midwives and internationally trained midwives.[47] This was consistent with the recommendations of the 1987 Task Force Report. It also addressed the concerns of the physician and nursing professions that midwives should have a university education. Education at the university level was seen to be essential to the recognition of midwives as autonomous primary care providers.

116. The Curriculum Development Report concurred with the TFIMO that a direct entry midwifery education system was appropriate. A direct entry model allows strong candidates from a wider variety of backgrounds to access the profession at an undergraduate level. Direct entry models internationally showed better retention in midwifery and an association with a strong midwifery profession in many countries such as the Netherlands and Denmark. Midwifery schools in the UK were increasingly moving to a direct entry undergraduate degree model**.**

117. The Report concluded that a nursing education was not the appropriate foundation for midwifery education. This was in part because nurses were educated to operate in a very different model of care which was not as an autonomous primary care provider. International scholars of midwifery consulted by the Curriculum Development Committee advised that nurses can face challenges in adapting to a model of autonomous primary care outside the hospital given their training inside a highly structured institutional hierarchy based on the historic patriarchal relationship between medicine and nursing.[48]

118. The Committee relied on the foundational documents developed by the AOM, including its work on Entry Level Competencies to create the Committee's Entry Level Core Competencies of a midwife.[49] These competencies were the

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

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

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

foundation used to develop the curriculum and education program and also formed the foundation of work analyzed later by the AOM/MOH Joint Funding Work Group and reflected in the Morton Report and the September, 1993 Ontario Midwifery Program Framework.

119. These Entry Level Core Competencies reflected the "fundamental knowledge and skills expected of a new graduate of a midwifery school." This document required the midwife to conform to the International Definition of the Midwife supported by the International Confederation of Midwives (ICM) and the International Federation of Obstetricians and Gynecologists of Canada (FIGO) as noted below:

> *Give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility, and to care for the newborn infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has important tasks in counselling and education, not only for women but also within the family and the community. The work should involve antenatal education and preparation for parenthood, and extends to certain areas of gynecology, family planning and child care. She may practice in hospitals, clinics, health units, domiciliary conditions or in any other service.*[50]

120. This recommendation to not require a RN diploma or degree also flowed from the advice of international midwifery experts we consulted who attended an international conference on midwifery education held in Toronto around this time.

2. Decision to Require Accessible Direct Entry Baccalaureate Degree

121. On October 15, 1991, the Ministry of Health issued a News Release "Ontario to Establish Degree Program for Midwives". The release stated that "midwives have an important role in the province's health care system" and "it is in the public's interest that they have access to quality post secondary education and training". Universities would be asked to develop proposals for the direct entry program." [51]

122. A subsequent Joint News Release of the Ministry of Colleges and Universities and Ministry of Health, "Some Notes on Midwifery Education in Ontario"

50 "Compensation for Midwives in Ontario - Summary Report Prepared for the Midwifery Funding Work Group" by Robert Morton and Associates (July 26, 1993) at Appendix B; AOM0001278.

51 October 15, 1991, Ministry of Health News Release "Ontario to Establish Degree Program for Midwives", AOM0001140.

highlighted the importance of multiple routes of entry to a baccalaureate degree:[52]

> *The international experience and recommendations from Ontario task groups point to the advantages of locating midwifery education in an academic institution rather than a hospital, of having multiple routes of entry rather than requiring all midwives to have a nursing background, and of awarding a credential consistent with that expected of other primary health care providers. In October, 1991, the Ontario, government took these experiences into account becoming the first province to announce plans for a bachelor's degree program in midwifery.*

123. There was some resistance at the time, including from the Minister of Health, Elinor Kaplan to creeping credentialism which some thought cost unnecessary education and compensation costs. At that time, degrees internationally were unusual for midwives, although the status of midwives in Holland and Scandinavia was as one of the medical professions. Physician and nursing representatives argued for a university degree, although they wanted a nurse midwife system, with midwifery education added on to a nursing degree.

124. At a Queen's Park event hosted by the AOM in May, 2012, Minister Deb Matthews spoke about the birth of her grandchild assisted by midwives. I had a personal conversation with her at this event. I was aware that the Minister had in a prior meeting with the AOM had communicated that midwives were paid sufficiently for a baccalaureate degree. I explained to Minister Matthews that the MEP curriculum was considered by many experts to be at the level of a Masters degree and similar to professional degrees at the undergraduate level such as law and medicine. The Government had decided prior to regulation to establish midwifery education as a baccalaureate degree similar to law and medicine and to make the profession more accessible to women. I told her that the course material and depth of learning in the MEP program and the nature of the student body fit within a post-graduate level and that in the US which has a nurse/midwife model, nursing is an undergraduate degree and midwifery is a Master's degree. Minister Mathews was supportive of considering establishing the MEP as a Masters degree.

3. MOH Midwifery Integration Planning Project (MIPP)

125. The Ministry of Health and Ministry of Colleges and Universities had established the Midwifery Integration Planning Project (MIPP) in 1990 to develop an integration process for midwives to become a part of the regulated midwifery system. I was a member of this project along with Jane Kilthei and Bobbi Soderstrom. The Project reported in 1991 and recommended the development of a one-time year-long pre-registration program for all currently practicing midwives

52 News Release, " Some Notes on Midwifery Education in Ontario" Ministry of Colleges and Universities, p. 2 AOM0001138.

seeking registration under the new legislation. As noted above, this recommendation was accepted by the MOH.

4. The Michener Institute of Applied Health Sciences Pre-Registration Program

126. On October 15, 1991, the MOH also issued a News Release, "Pre-Registration Program for Experienced Midwives" which announced that a program would be developed through Toronto's Michener Institute of Applied Health Sciences to provide "a one time only educational opportunity…designed to ensure that practising midwives can meet the provincial standard prior to certification and integration into the health care system."[53]

127. As stated in the Release, the "program will reflect the list of required competencies in midwifery approved by the Interim Regulatory Council for Midwifery and the content and approach recommended by the Midwifery Curriculum Design Committee (May 1990) and the Midwifery Integration Planning Project (June, 1991).

128. The goal of the program was to integrate Ontario's experienced midwives into the health care system. "The Institute will assess their clinical skills and knowledge and provide upgrading for those who need only a short time to meet the new provincial standards."

129. The Michener Institute of Applied Health Sciences Pre-Registration Program Curriculum was developed in 1991. The 1992 Curriculum Outline set out the extensive requirements of the Program.[54]

130. As a member of the Advisory Committee to the Midwifery Pre-Registration Programme and member of the Academic Council, I participated in the development of the Curriculum for this Programme.

131. I was also a Michener graduate. In fact, many of the longest serving tenured faculty (over 50%) and in fact the only full Professor of Midwifery in the province are “Michener” graduate and do not have a BHSc Midwifery. However, generally they have other post-secondary and graduate degrees. [55]

132. The Program was designed to ensure that midwives have all the necessary professional competencies and personal qualities to work safely as a midwife. It also aimed to ensure that the midwife has the knowledge necessary to participate in the integration of the midwifery profession into the health care

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53 News Release from the Michener Institute for Applied Health Sciences, "Pre-Registration Program for Experienced Midwives" (October 15, 1991) AOM0001139.

54 The Michener Institute Pre-Registration Program for Midwifery Curriculum Outline, 1992, AOM0014314.

55 List of Midwifery Education Program Faculty Midwives without BHSc Midwifery, AOM0017421.

system, and to meet the ongoing needs of the community.[56] The Program began in the fall of 1992 with an extensive assessment being done of applicants and an intense academic and clinical focus during the program which lasted over a year. Many applicants were turned down who did not meet the qualifications which required a substantial number of births performed under the midwifery model of care.

133. Experienced midwifery faculty were recruited from Denmark, New Zealand, the United Kingdom and the Netherlands to teach the Michener program, along with guest lecturers in fields such as pharmacology, hematology, genetics and ultrasound.

134. Among other things, the program was designed to ensure that upon completion, the graduate midwife is able to

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

(b) is also able to recognize when a pregnancy, birth, postpartum period or a newborn child is no longer within the midwife's scope of practice, and to consult and transfer according to the standards set out by the IRCM/College of Midwives.[57]

135. The Michener Programme consisted of three components:

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

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

(c) upon passing the first two components with a grade of at least 80%, the midwife proceeds to the health care system period, a four- to five-week

56 The Michener Institute Pre-Registration Program for Midwifery Curriculum Outline, 1992, AOM0014314 at page 1.

57 The Michener Institute Pre-Registration Program for Midwifery Curriculum Outline, 1992, AOM0014314.

period during which the midwife will observe the work of different health workers, including obstetrics and nursing.[58]

(d) Written entrance exams and written and oral exit examinations were conducted

5. The MEP Consortium of Ryerson, McMaster and Laurentian Universities

136. Following the 1991 announcement, the Government made a call for proposals for the establishment of such a baccalaureate program. The Ministry invited proposals from Ontario universities to provide that program. I was involved in assisting universities in preparing their applications.

137. McMaster University, Laurentian Universty and Ryerson University made a Joint Proposal to develop and operate the MEP. [59]

138. On December 21, 1992, this consortium of three universities was selected to provide the Midwifery Education Program and the intensive three year program started in September, 1993 with faculty hired earlier in 1993 to be ready for the start of the program. [60]

139. The MEP consortium has shared a curriculum and management structure since 1993 until present.

140. I was hired in January, 1993 to assist Ryerson in designing the curriculum and was named the first Director of the Ryerson MEP, a position I held until 1998. I have continued to be a key part of the Ryerson Faculty as an Associate Professor and have taught all of the midwifery-specific courses.

X. MEP Curriculum

1. Challenging Program

141. The MEP is a very challenging and demanding program with most academic courses done in the first three terms at a level normally associated with upper level undergraduate courses or graduate level courses. The demand that students be very competent in both sciences and social sciences also makes the program challenging.

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58 The Michener Institute Pre-Registration Program for Midwifery Curriculum Outline, 1992, AOM0014314 at p. 2.

59 Baccalaureate Program in Midwifery, A Joint Proposal from McMaster University, Laurentian University and Ryerson University (1992/09/09) AOM0001128.

60 News Release, Ministry of Colleges and Universities, re: formation of MEP (1992-12-21) AOM0002853.

142. The current 4 year program schedule covers a wide range of topics and clinical training experiences.[61] The program at each University is essentially the same with some variations.

143. The 2007 MEP Program Review document at Ryerson shows the detailed program of study during each of the 4 years.[62] Appendix F to that document shows the "Summary of Content Covered in Midwifery Science Courses". The Ryerson 2013-2014 Midwifery Calendar also details the subject matter of each study course or program.[63] The Ryerson Overview for the Program also sets out the extensive program requirements, both clinical and course work. [64] The Standards of Admission to the Midwifery Education Program at Ryerson are detailed.[65]

2. Developing the MEP

144. Midwifery apprenticeship learning prior to regulation was learning from an experienced professional over time in a clinical setting. It is similar to clinical learning. Clinical learning is a feature of both the education of midwives, nurses and physicians although it is most pronounced in medical and midwifery education.

145. As we developed the MEP, we worked to embed the previous model of apprenticeship learning in the program. While such clinical "learning" did not change significantly it now would, along with course programs, result in an accredited degree. In medicine, doctors talk about their training as 50% clinical programs. That is also true in midwifery.

146. The MEP curriculum provides an equal balance of science and social science, integrating both academic and clinical through the program. More than 6 of 9 terms are clinical with an academic component integrated with the clinical placement. Most undergraduate 4 year degrees have 8 terms. Approximately 70% of the program involves clinical placements, with one half of those placements occurring in an inter professional, international, rural remote, and/or research and policy context. A variety of learning modalities are used including in person classroom teaching, synchronous web conferencing and asynchronous online tutorials. Midwifery faculty place emphasis on teaching best practices to support normal birth; inter-professional respect; social justice, diversity, equity and inclusion; and constructive critique and reflective practice; and, values based evidence based practice using, for example, peer reviewed journal articles,

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61 Four Year Stream, Full Time Midwifery Education Program Schedule, AOM0016299.

62 2007 MEP Program Review AOM0001130 - p. 21 onward.

63 Ryerson MEP Course Calendar, 2013-2014, AOM0001141.

64 Overview by Ryerson University re: Midwifery Education Program, AOM0000815.

65 Ryerson University Standards of Admission to the MEP, AOM0001137.

professional guidelines from multiple disciplines and systematic research reviews. [66]

147. For example, Ryerson University's MEP "Program Overview" states as follows:

> *A mix of health, social, and biological sciences, the curriculum combines academic studies with clinical and inter-professional placements affording extensive clinical experience working with midwives and their clients. The Bachelor of Health Sciences in Midwifery degree can be completed in four to six years at Ryerson. Midwifery allows you to enroll part-time in the non-clinical courses - which comprise the first three semesters - but requires a full-time commitment for the clinical placements in the final six semesters.*
>
> *You will attend a minimum of 60 births, acting as primary caregiver for at least 40 births in home and hospital settings. During your studies, you will also participate in providing prenatal and postpartum care in midwifery clinics and women's homes. Like the profession, the program is very demanding and equally rewarding*.[67]

148. Students are assigned to a midwifery practice for the clinical component. Midwives across the province act as preceptors for the students in their clinical rotations. All students are required to be on call during the clinical component and at some other times during their studies. A New Registrant year is mandated by the CMO in the year following the completion of the MEP. This is a year of "mentored" practice within an established practice where the New Registrant continues her clinical education while being mentored by a practising midwife.

149. The MEP curriculum was designed to embed the ongoing expansion of experiential clinical and research knowledge of practising midwives into the course and clinical aspects of the MEP. Midwifery faculty like myself are required to be practising midwives.

150. The MEP can be summarized as follows:

(a) the program's theoretical component involves required courses in anatomy and physiology, pharmacotherapy, biochemistry and reproductive physiology. Students are introduced to the principles of clinical research and develop an understanding of how to independently evaluate the

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66 See Ryerson MEP curriculum, http://www.ryerson.ca/midwifery/courseofstudy.html and http://www.ryerson.ca/calendar/2014-2015/pg3770.html, AOM0015524, for summary of Midwifery courses. Elective courses are also required in Women's Studies, Professionally related courses and social sciences. See McMaster MEP Curriculum, http://fhs.mcmaster.ca/midwifery/courses.html, AOM0015521.

67 Overview by Ryerson University re: Midwifery Education Program, AOM0000815.

results of research studies. They also examine issues such as violence in the home, race, ethnicity, socio-economic status and sexual orientation. Issues such as women's roles in society, public policy relating to women, and the organization of health care are studied in order to understand midwifery in the context of Canadian society. Students are introduced to professionally-related topics such as the history and current regulatory context of midwifery, both nationally and internationally.

(b) In addition, the program's practical component consists of six terms in full-time placements—four in midwifery clinical placements and two in inter-professional placements. In the four clinical placements, students are on 24-hour call and must provide their own transportation to clinical and community sites and to clients' homes. Clinical placements introduce students to an increasingly complex range of clinical and counseling skills, many of which are augmented by university-based intensives lasting from three to seven days. Students are required to conduct prenatal visits, take medical histories and conduct physical exams of women and babies, including collecting blood and other lab specimens. They are involved in providing care to women in labour and participating in hands-on care, including conducting deliveries with assistance. By the final clinical placement, referred to as the clerkship, midwifery students are able to function independently, providing comprehensive midwifery care. At this point, they are at approximately a similar level of maternity care responsibility as a family practice resident at the end of their first year of residency. In addition to this responsibility, the student takes responsibility for monitoring and supporting the mother and family during labour which is a role that would be assumed by a nurse working with a family physician resident.

(c) The two inter-professional placements consist of a series of three to four-week placements over a 6 month period. Mandatory placements include a hospital labour and delivery setting, an obstetric practice (under the supervision of an obstetrician), and an NICU. For the remaining placements, students may choose a setting relating to maternity care, women's and/or infant health issues, a rural or remote setting or an urban setting to compliment previous clinical placements, as well as an elective placement.

151. In all clinical midwifery courses there is an academic and clinical component. Weekly problem based tutorials cover the academic content and students follow a caseload of midwifery clients under the supervision of their preceptors. A midterm and final evaluation meeting is held with the clinical teacher, student and midwifery faculty member who is the course instructor.

3. New Registrant Year

152. Students are required to be formally mentored by practising midwives for a period of at least one year involving at least 30 births as first midwife and 30 as second midwife.

153. The CMO requires that New Registrants work in an established practice and attend the majority of births (80%) with more experienced midwives. [68]To acquire hospital privileges New Registrants must follow the protocols for supervision of new practitioners to the hospital which normally involves direct supervision of care for 5-10 labours and births by a senior midwife. For those who provide primary care for oxytocin induction and augmentation and epidural pain relief there is additional supervision for at least 5-10 births involving these procedures.

154. The New Registrant year is an extension of the above-noted student's clerkship. During the New Registrant year, the midwife in my view has a similar level of maternity care responsibility as a senior Family Practice resident. Similar to midwifery students, the New Registrant In addition to this responsibility, also takes responsibility for monitoring and supporting the mother and family during labour which is a role that would be assumed by a nurse working with a family physician resident.

4. Canadian Midwifery Registration Examination

155. All MEP students are required to pass the Canadian Midwifery Registration Examination (CMRE) which is a national examination designed to assess internationally educated and Canadian-educated applicants for midwifery registration to ensure that they meet entry level competency standards set out in the Canadian Competencies for Midwives. [69]

5. Bridging Programs for Recognizing Training Outside of Ontario

(a) Prior Learning Education and Assessment Program

156. The Transitional College of Midwives of Ontario established the Prior Learning Education and Assessment Program in order to recognize the midwifery skills, learning and education of those trained outside of Ontario. In order to qualify, it was necessary to have midwifery experience. Nursing experience was not sufficient. This process had input from Dr. Pat Armstrong. I was a member fo the Registration Committee that implemented the PLEA process.

157. The Transitional Council and then the College of Midwives of Ontario undertook this assessment process to determine whether the midwives had sufficient

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68 CMO Guidelines to the New Registrants Policy (December 1, 2006) AOM0015398.

69 See Canadian Midwifery Registration Examination – Technical Report 2011-12, January, 2012 AOM0016028.

equivalent education and training to be registered as a regulated midwife. At that point midwives who entered the regulated profession through the PLEA process were required to be supervised during their first year of practice. Nurses without sufficient prior midwifery experience and training were required to take the full MEP at that time.

158. There was a focus at the time on how to provide access more generally to internationally trained professionals, including physicians.

(b) International Midwifery Pre-Registration Program

159. This bridging Program then evolved later in the 1990's into the International Midwifery Pre-Registration Program.The International Midwifery Pre-registration Program (IMPP) is a 9-month bridging program. It provides internationally educated midwives with the following: knowledge and skills assessment and enhancement orientation to midwifery practice in Ontario, three-month clinical placement with competency assessments, six-month accelerated stream for qualified entrants preparation for the mandatory Canadian Midwifery Registration Examination (CMRE).

160. The IMPP is intended for experienced internationally educated midwives, fluent in English, who have practiced midwifery within the past 10 years. It is not a re-education or re-training program. Eligibility criteria is based on program data regarding successful completion.[70]

6. Role of Midwife Preceptors and Mentors

161. Ontario's midwifery education system also consists of practising midwives who serve as clinical preceptors for students placed in midwifery practices during their 4 year program and also as mentors during the New Registration program. I am one of the co-authors to a Guide for clinical preceptors. [71]

(a) Clinical Preceptors

162. All clinical preceptors have to have at least one year of experience working as midwives before they can attend the New Preceptor Workshop and apply to become preceptors. They complete mandatory online modules on best practices in clinical teaching and learning in advance of the one day workshop.

163. The MEP also offers ongoing continuing education for preceptors through in person and online web conferences. Topics of past workshops include: Teaching to Inspire Confidence, Teaching the Normal Childbearing Student, Teaching

70 International Midwifery Pre-Registration Program (IMPP) Eligibility Requirements and How to Apply (2016).pdf (2016) AOM0017361.

71 Guide to Teaching Learning and Assessment for Midwifery Preceptors and Students.PDF, (July 2013) AOM0017420.

Students in the Senior Year, Working with Students who are Experiencing Learning Challenges, Respecting Human Rights in Clinical Placements, Students with Accommodations in the Clinical Setting, Using Simulation to Teach Midwifery Skills. Many midwifery faculty members run workshops for preceptors. Inter professional guest presenters include: Helen Varney, PhD CNM Yale University, Lisa Graves, family physician and frequent speaker on maternity care education McGill University, representatives from the University of Western Ontario Preceptor Education Program, Kevin Eva, McMaster University expert in education research and Anne Biringer, University of Toronto, family physician maternity education leader.

(b) Mentoring of New Registrants

164. Midwives are responsible for mentoring New Registrants for a period of at least one year. During this time, experienced midwives must ensure that the 80% of the births attended by the New Registrant are attended also by an experienced midwife. Midwives must also supervise midwives if required by the CMO in certain circumstances and if required by the hospital if necessary to obtain hospital privileges.

7. Evaluations of MEP

(a) Best Program

165. Like other health professions and academic programs, there is a regular review process for the midwifery education program to ensure that it is appropriately updated. The November, 2012 Ontario Midwifery Education Program – Program Review starts off by stating that the MEP "has been described in previous reviews as possibly the best program available to midwifery students anywhere in the world". [72]

(b) 1996 Diony and Young Report

166. In order to ensure the effectiveness of the MEP an evaluation is undertaken every 5 years now. The first evaluation was undertaken in 1996 by international experts. I participated in the evaluation as the Director of the Ryerson MEP. On July 15, 1996, the international External Review Report of the Midwifery Education Program by international midwifery experts Diony Young and Lesley Page was issued.

167. Diony Young was the editor of Birth, an international peer reviewed journal from 1990 to 2015, and is a US researcher, author and advocate for evidence and choice in childbirth. Lesley Page, PhD is a leading UK midwife and midwifery scholar and the Director and first professor of midwifery at the Thames Valley

72 November, 2012 Ontario Midwifery Education Program – Program Review - (November 2012) AOM0001131; See also, 2007 MEP Program Review AOM0001130.

graduate program in midwifery in London, England. She was named a Commander of the British Empire for her contributions to midwifery and is currently president of the Royal College of Midwives in the UK.

168. The Report gave a very positive review of the MEP and noted its demanding clinical and academic programme. The report stated that the MEP is an:

> *…extremely comprehensive midwifery education programme. It may well be the best available to midwifery students anywhere in meeting all academic and clinical practice standards. It effectively combines apprenticeship with academics for midwifery and can serve as a model of education for other Canadian provinces. It demonstrates careful, intensive planning to meet the special geographical, multicultural and public health needs of the Ontario population and serves the province highly effectively.*
>
> *The broad based program effectively balances theoretical and clinical knowledge in offering the necessary medical, midwifery, biological, scientific, research, social science and women's studies subjects.*
>
> *The curriculum plan demonstrates a carefully developed progression of theoretical courses and clinical practice components. The reviewers believe however, that the present programme is too rigorous and intensive for a three year degree and resembles the academic requirements for a Masters' more than a Baccalaureate degree.* [73]

169. The Report recommended that the MEP offer the program over four years rather than three years, order to allow students more family time and time for summer employment. This recommendation was implemented in 1997.[74]

170. The MEP at the three universities is very successful program and highly competitive. There are many more applicants than spaces. . A Chart setting out the applicants for all three site from 1993 to 2013 shows the high number of applicants. The number of available positions changed from 40 in total at all three sites to 60 in 2008 and 90 in total in 2009. The total number of applicants for these relatively few positions ranges from 473 in 1993 to 838 in 2013. [75]

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73 External Review Report of the Midwifery Education Programme dated July 15, 1996 by Diony Young and Lesley Page, AOM0001129.

74 Summary of the 1997 Cohort of Graduates of the MEP, submitted to the MEP by Raymond W. Pong, PhD and Dianne Stewart, BScN, RN, Researchers at the Centre for Rural and Northern Health Research Laurentian University, March 1998, AOM0005300.

75 Charts with MEP Applications and Enrollment Stats 1993-2013, AOM0007037.

(c) Other Reviews

171. Further external reviews took place over the years, including in 2002, 2007 and 2012. [76] All the reviews note the high quality of the MEP faculty. The March 2002 external review of the consortium is authored by Pauline Cooke Associate Dean Midwifery, from Thames Valley University, London, England, Patricia Kaufert, Professor, Faculty of Medicine, University of Manitoba, Winnipeg and Kerstin Martin, Professor, Université du Québec à Trois-Rivières.[77] They confirm the 1996 review's assessment that the MEP may well be the best available midwifery program in the world.[78] "The outstanding quality and success of this programme are the direct result of the hard work of faculty, administrators, students and preceptors all of whom merit the highest recognition." [79]

172. The 2007 review also found the program to be "exemplary".[80] It was conducted by Elaine Carty, Director Midwifery, University of British Columbia and Josee Lafrance, Director Midwifery, Université du Québec à Trois-Rivières. They note that the program has flourished under past and present leadership. "Teaching in the program is of high quality, at each site. The quality of teaching is particularly high in the midwifery specific content of the program"[81] They note that "the large majority of the students at the three sites enter the program with advanced credit." This report suggests that consideration be given to converting the MEP to a Master's level entry "much like physiotherapy and occupational therapy. This would then allow graduates, most of whom already have a bachelor's degree, access to PHd programs and a more efficient approach to the education of educators and researchers in the field who will be sorely needed in the next decade after the current group of experienced faculty reach retirement age."[82] They note that student performance is excellent.

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76 Excerpts November, 2012 Ontario Midwifery Education Program – MEP report to Program Review - AOM0001131; See also, 2007 MEP Program Review AOM0001130.

77 Midwifery Education Programme, Report of the External Review, March, 2002, AOM0017422 .

78 Midwifery Education Programme, Report of the External Review, March, 2002, AOM0017422 at page iii.

79 Midwifery Education Programme, Report of the External Review, March, 2002, AOM0017422 at page 15.

80 Report of the Reviewers for the Ontario Midwifery Education Program Consortium: Ryerson University, Laurentian University, McMaster University, by E. Carty and J. LaFrance (November, 2007) AOM0017427.

81 Report of the Reviewers for the Ontario Midwifery Education Program Consortium: Ryerson University, Laurentian University, McMaster University, by E. Carty and J. LaFrance (November, 2007) AOM0017427 at page 22.

82 Report of the Reviewers for the Ontario Midwifery Education Program Consortium: Ryerson University, Laurentian University, McMaster University, by E. Carty and J. LaFrance (November, 2007) AOM0017427 at page 12-13.

173. All reviews note the importance of clinical education and the need for enhanced support for preceptors, including creating funded positions for preceptor-mentors, and recommending increased stipends for preceptors, and increased space and resources within midwifery practices for students. The 2007 report recommends "Increased funding for preceptors should be a priority of the Ministry of Health and Long Term Care".[83] The review also notes "the necessity to immerse students in a clinical environment where full scope midwifery is practiced" which is a challenge when scope is restricted by hospitals.[84]

8. Comparison of Midwifery with Medical and Nursing Education

174. While there are significant differences between the medical and midwifery education in Ontario which justified the much higher rating for medicine in the Durber report, it also appears that the MOHLTC evidence is overstating the differences and failing to recognize the high level of midwifery education,

(a) Both the MEP and the Medical Degree take 4 academic years. The MEP is four academic years and one additional term.

(b) Midwives have a one year to 18 month mentored New Registrant requirement and Family Physicians have two years of residency.

(c) Most students entering the MEP have at least a bachelor's degree and some have multiple and graduate degrees at the Masters or PHD level. The average age at RU has remained at an average of 30 years. Students bring significant life as well as work experience from a wide variety of previous careers.[85]

(d) It is highly competitive to enter the both the MEP and medical school.(see data above under Program Review. Over the period 1993 – 2013, across the three MEP sites, approximately 1303 students were admitted and 9,812 students applied for a ratio of approximately 9:1.[86] The specific vs broad focus of midwifery vs medical education means that midwifery students take a level of primary care responsibility in their clinical placements that is more like a medical resident than a medical

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83 Report of the Reviewers for the Ontario Midwifery Education Program Consortium: Ryerson University, Laurentian University, McMaster University, by E. Carty and J. LaFrance (November, 2007) AOM0017427 at page 7.

84 Report of the Reviewers for the Ontario Midwifery Education Program Consortium: Ryerson University, Laurentian University, McMaster University, by E. Carty and J. LaFrance (November, 2007) AOM0017427 at page 18.

85 A profile of the 1996 Cohort of Applicants to the MEP and a Comparison of the 1993, 1994, 1995 and 1996 Cohorts of Applicants, submitted to the MEP, by Linda G. Houle, M.A. and Raymond W. Pong, Ph.D at the Northern Health Human Resources Research Unit at Laurentian University (2007) AOM0005301.

86 Charts with MEP Applications and Enrollment Stats 1993-2013, AOM0007037.

undergraduate student. Students follow a caseload of clients in their senior baccalaureate year with a decreasing level of supervision and an increasing level of autonomy. By the end of the first term of the final year students provide most prenatal care and some postpartum care independently under indirect supervision. In the second term of the final year students provide most prenatal care and most intrapartum and postpartum care independently under indirect supervision and students can act as the second midwife at a hospital birth according to the CMO. In the final year students provide all care independently under indirect supervision and can act as the second midwife in any setting.[87]

175. The Babies Can't Wait research on maternity care learners and educators compared the amount of intrapartum experience that students from different maternity care providers have in their senior year. The results are set out below:[88]

Table 3. Exposure to maternity care during educational programmes

Learner group	# births attended (mean with interquartile range)	# pregnant women followed
UMS	22 (15-35)	0 (0-5)
FMR	30 (20-50)	4 (0-10)
OBR	500 (200-900)	10 (0-50)
MWS	83 (75-103)	50 (40-80)
NS	1 (0-2)	0 (0-0)

176. It is not uncommon for nurses to have very little or no intrapartum experience during their undergraduate education. Nurses during their education generally have not attended at births.[89]

9. What does a Doctor or Nurse need to do to become a Midwife?

177. A physician or nurse who wants to become a midwife needs to attend the MEP and can apply to be accepted to the above-noted shortened Post Baccalaureate Program at Ryerson University or Laurentian University. There is no guarantee of

87 CMO Guidelines; 2014-07-01 - CMO Guidelines - Clinical Education and Student Supervision.pdf (May 2014) AOM0015444.

88 University of Toronto Maternity Care Learners Team, "Babies Can't Wait Technical Report" (2006), AOM0017380 p. 6 .

89 Babies Can't Wait: Obstetrics Care in Crisis Project Report, August 2006, Ontario College of Family Physicians Part 1 (July 31, 2006) AOM0017397; Babies Can't Wait: Obstetrics Care in Crisis Project Report, August 2006, Ontario College of Family Physicians Part 2 (July 31, 2006) AOM0017398.

acceptance and applicants would have to score high on the normal entry criteria including during Multi Mini Interviews which is the interview process at McMaster and Ryerson which was adopted from the process used at McMaster medical school.

178. In fact, internationally trained medical graduates have applied for and been accepted into both the full 4 year MEP and the Post Baccalaureate program at Ryerson.

XI. The Passage of the *Midwifery Act, 1991* and *Regulated Health Professions Act, 1991*

179. As a member of the AOM Legislation Committee, I participated in the discussions leading to the Government introducing on April 2, 1991 the *Midwifery Act, 1991*[90] and the *Regulated Health Professions Act, 1991*[91] (*RHPA*) These laws followed on the recommendations of the 1987 Task Force Report and the HPLR conclusions. In July, 1988, the Health Professions Legislative Review (HPLR) proposed a Midwifery Act which included the Scope of Practice and Licensed Acts.

180. On April 2, 1991, I attended the Ontario Legislature and heard Minister of Health Evelyn Gigantes introduced the above-noted laws and state:

> *…health professionals have the right to work in a system that is equitable, and in which their autonomy is respected and their contributions recognized. … There is also a need to introduce greater flexibility into our health delivery system and to have a system that enshrines the values of equity and fair opportunity.*[92]

181. I was heartened to hear that the Minister of Health recognized our right to work in an "equitable" health care system where our contributions and autonomy would be respected by a system based on "equity". This fit very much with the values of midwifery and the principles of equitable integration guided the process moving forward to regulation.

182. The scope of practice in the *Midwifery Act* flowed from the initial scope of practice developed by the AOM in the 1980's and the development by the IRCM of the Midwifery Philosophy of Practice.

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

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90 *Midwifery Act, 1991*, S.O. 1991, Chapter 31, proclaimed January 1, 1994; AOM0012574.

91 *Regulated Health Professions Act, 1991*, S.O. 1991, Chapter 18; AOM0015489.

92 April 2, 1991 Gigantes Statement, AOM0002721 at p. 2 .

> *…gives legal recognition to midwives. This reversal in policy is largely due to the efforts of hundreds of individual women and a smaller number of practising midwives who through public education, lobbying and education of other health professionals demonstrated the need and the consumer demand for midwives. Thanks to them, women will soon have the choice of obtaining care from a midwife, a choice available to women virtually everywhere except Canada.*
>
> *It should not have been so difficult for these women to bring about change and it should not have taken so long. That it did take so long demonstrates the lack of input women and indeed the entire public have had in the health care system. People ought to have a say in the kind of health care they get and how health care is provided to them. With this legislation, which will make future policy-making flexible to change and be responsive to public opinion, it will be possible for their voices to be heard.* [93]

As well, Minister Lankin in introducing the RHPA stated that "eight health professions, all of them predominantly female are being added to the current list of fully self- regulated professionals."

> *…Among the new choices being offered consumers with this legislation is a choice in how childbirth is conducted. Those who want to be cared for by midwives during pregnancy, labour and delivery will have that option. The inclusion of midwives in this legislative package represents a change in policy direction set by the Ontario Legislature a little more than a century ago. It was in 1865 that midwives lost the exemption from the Medicine Act that had made it possible for them to practice midwifery without a licence to practice medicine.* [94]

184. I read these statements at the time and again was pleased to see the recognition of the role and struggle of women to gain recognition for midwifery, a predominantly female profession.

185. Both of these laws received royal assent in November 1991. The *Midwifery Act* and relevant provisions of the *RHPA* were proclaimed December 31, 1993.

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93 Ontario, Legislative Assembly, Official Report of the Debates (Hansard), 35th Parl, 1st Sess (29 May 1991) (Hon. Frances Lankin), AOM0000578.

94 Ontario, Legislative Assembly, Official Report of the Debates (Hansard), 35th Parl, 1st Sess (29 May 1991) (Hon. Frances Lankin) , AOM0000578.

XII. Development of the Regulatory System

1. The Interim Regulatory Council of Midwives

186. A 13 member Interim Regulatory Council on Midwifery was appointed by Order in Council in June, 1989 to prepare for the future statutory College of Midwives. I was a member of the AOM Liaison Committee to the Council and participated in its Committees, along with Bobbi Soderstrom, Jane Kilthei and Elana Johnson. I was a member of the Standards and Qualifications Committee, the Equity Committee and the Models of Payment and Practice Committee.

2. Development of Midwifery Model of Care

187. The Interim Regulatory Council on Midwifery (IRCM), working with myself and other AOM Liaison members, developed the Philosophy of Midwifery Care in Ontario dated June 21, 1990.[95]

188. This model guided the integration of midwifery into Ontario's health-care system and the compensation for such work. The scope of midwifery practice was defined by the IRCM's Standards of Practice and Guidelines. The IRCM subsequently developed numerous standards, guidelines and policies adopted by CMO to regulate the work of midwives and set out skill, responsibility, effort and working conditions (SERW) requirements effective 1994.[96]

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

190. Midwifery care is based on a respect for pregnancy as a state of health and childbirth as a normal physiological process…Care is continuous, personalized and non-authoritarian…Midwives respect the woman's right to choice of caregiver and place of birth in accordance with the Standards of Practice of the College of Midwives…The mother is recognized as the primary decision maker.

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95 Preliminary Report by AOM re: Funding of Midwifery Services attaching Document by Interim Regulatory Council on Midwifery re: Philosophy of Midwifery Care in Ontario**,** January, 1992, AOM0002336, at Appendix 1.

96 Guidelines for the Second Birth Attendant - College of Midwives of Ontario - January 1994 (1994-01-01) AOM0015358 ; CMO Guidelines - Management of Labour as a Controlled Act (January 1994) AOM0015359 ; CMO Guidelines - Midwifery Scope of Practice (January, 1994) AOM0015360 ; CMO Guidelines - Proposals for the Credentialling of Midwives in Ontario Hospitals (January 1994) AOM0015363; CMO Guidelines - Standard on Shared Primary Care – (January, 1994) AOM0015364 ; CMO Guidelines - Code of Ethics (January 1994) AOM0015365; CMO Guidelines - Policy on Primary Care (January 1994) AOM0015366; CMO Guidelines; CMO Guidelines - Shared Care with a Consulting Health Professional.pdf (January 1994) AOM0015368; CMO Guidelines - Member Commitment (January, 1994) AOM0015458 ; CMO - Guidelines for Structuring Supervision (1994-06-12) AOM0015917.

Fundamental to midwifery care is the understanding that a woman's caregivers respect and support her so that she may give birth safely, with power and dignity.

191. As noted above, the midwifery model of practice aims to engender health care by putting women and their needs at the centre of their health care in contrast to the traditional authoritarian medical-led model, which pathologized birth.

3. Midwifery Models of Practice and Payment

192. Following on the above noted initiatives, the Women's Health Bureau prepared a report, Midwifery Models of Practice and Payment dated May, 1991.[97] This report reviewed possible practice settings for midwives, including within CHCs as well as payment for midwifery services and the need for liability insurance. The report concluded that fee for service was not an appropriate option and considered two options, capitation and salary. The Report recommended a form of independent community practice.[98] I reviewed this report and commented on it as we moved forward to develop the appropriate models.

193. Subsequently, the IRCM Models of Payment and Practice Committee, of which I was a member, issued its June, 1992 Report and Recommendations of the Models of Payment and Practice Committee to the MOH Women's Health Bureau. The report contained a series of recommendations and statements of principle that aimed to promote the midwifery model of care and to embody that model in regulatory form. The Report highlighted the importance of equitable integration and positioning of midwives in the health care system. [99]

XIII. Development of Equitable Integration Measures

194. Midwives were integrating into a health care system where physicians exercised considerable cultural and legal authority. This led to discussions about how midwives would work with health care institutions. In particular, this included the issue of working in local hospitals and also in local Community Health Centres. This included collaborating with other health care professionals. The method of payment for midwives and their positioning relative to nurses and physicians was discussed in my thesis. [100]

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97 Women's Health Bureau, Midwifery Models of Practice report dated May, 1991. AOM0010490 see in particular p. 19 and 22.

98 Women's Health Bureau, Midwifery Models of Practice report dated May, 1991. AOM0010490 see in particular p. 19 and 22.

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

100 Vicki Van Wagner, With Women: Community Midwifery in Ontario, M.A. Thesis, 1991. AOM0017358 at page 173-180.

195. I was part of the integration team at Toronto General Hospital and Women's College hospital (1993-1995). We had many multi-disciplinary meetings to develop protocols and procedures for midwifery practice in hospital, transfer from home to hospital and how the various professions would interact. As Director at the Ryerson University MEP I worked on the development of hospital contracts to allow students to follow both midwifery preceptors and Inter professional preceptors in the hospital setting. As a member of the CMO I sat on the interprofessional committee that created the Facility Standards for the development of birth centres as Independent Health Facilities. I was a frequent speaker at hospital rounds and professional conferences about the integration of midwifery.

XIV. Development of Funding System

1. Introduction

196. As a member of the AOM Funding Committee, I was involved in the development of the funding arrangements for midwifery services. However, I did not attend the 1993 negotiation meetings with the MOH but was briefed about them by Jane Kilthei and Eileen Hutton who were the AOM representatives on the Joint Funding Work Group.

2. Importance of Bringing Gender Equity Lens to Funding

197. Throughout my work as set out in this affidavit, I have worked to ensure a gender lens is applied. By this I mean that research, policies and practices take into account the fact that midwifery is work by women and for women and that it exists in the context of a highly gendered health care system and political and social dynamics.

3. Important Funding Context

(a) Physician Criticisms of Midwifery Funding

198. During this time, I recall spending a significant amount of time trying to dispel the myth often stated by physicians that midwives were going to be paid more than they were paid for a birth. This was because the physicians often compared what they were paid in the fee for service system with what midwives were paid for a course of care fee which extended from the initial prenatal visits to the discharge of the midwifery client and her infant at 6 weeks post pregnancy. This did not take into account the time and system cost of the nurses who supported pregnant women during labour and prenatal and post-partum visits.

(b) Health System Fiscal Constraints and Equity Requirements

199. As the Joint Funding Work Group discussions were beginning in May, 1993, I presented a paper "The Economic Crisis in the Health Care System: How It

Effects Midwifery" to the International Confederation of Midwives 23rd Congress in May, 1993 in Vancouver. As stated in my paper I believed that it was:

> *…important for midwives to understand the politics of the health care crisis in order to use the opportunities it provides for the development and legitimation of the profession, in order to best contribute to the reform of the system, and in order to avoid being exploited in the government's search for low-cost alternatives.*
>
> *…in order to avoid being another female job ghetto, midwives must develop clear arguments to show the potential for midwifery to save the health care system dollars in the long term in order to justify the expense of equitable pay for the responsible and demanding job of midwifery.* [101]

XV. The Joint Funding Work Group Negotiations

200. The MOH established a joint Midwifery Funding Work Group in April, 1993 whose purpose was to work on creating a framework for the funding of midwifery services. This led ultimately to the issuance by the MOH of the September 1993 Midwifery Program Framework. I was part of the AOM Funding Group which provided advice to our lead negotiators, Jane Kilthei and Eileen Hutton.

201. As my above-noted May, 1993 paper highlighted we were well aware of both the opportunity that the funding negotiations presented to properly and equitably position midwives in the MOHLTC's health care compensation hierarchy and also the danger that in a time of resource constraints, there would likely be efforts to set compensation at an amount lower than its contributions deserved. We saw the Joint Funding Work Group as an exercise in setting the compensation level for midwives in a way which took pay equity principles into account.

202. At the June 29, 1993 meeting, the Group discussed the "Caseload and Working Conditions" document prepared by the AOM.[102] This extensive document relied amongst other reference sources on the IRCM's above-noted Models of Payment and Practice Committee report and the information and my 1991 Thesis which included my survey of 30 midwives about their caseload, conditions and hours of work.

203. While I had arrived at a figure of 45 hours per course of care, we proposed 48.25 hours during these funding discussions based on an updated detailed calculation

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101 Van Wagner V, "The economic crisis in the health care system: how it effects midwifery", paper to be presented at the International Confederation of Midwives 23rd Congress, Vancouver, May 1993, AOM0002817.

102 Working Notes Midwifery Funding Group Meetings Held June 29, 1993 at the Health Station CHC and also June 21 and 24, 1993 at the Health Station (1993-06-29) AOM0016741; Draft Agenda, Working Notes and AOM "Caseload and Working Conditions" document for Midwifery Funding Work Group Meeting June 29, 1993 (1993-06-29) MOH003823.

of time given the midwifery model that had developed by 1993. The AOM also recommended a full time caseload of 40 primary births and 40 secondary births. The AOM also developed an internal group to work on the costs of practice.

XVI. Post – Regulation Practise as Midwife

204. I was acting Head Midwife at Toronto General Hospital from 1994 to 1995 and I had staff privileges at Women's College Hospital.

205. The shift to post-regulation practice involved developing procedures for orientation of midwives to a formal role in the hospital, to the procedures and equipment needed to work on the labour floor and the postpartum floor and interacting with staff on these units. There was also extensive work on orienting other professionals in the hospital and broader health system to the role of the midwife and the development of protocols and policies to guide these relationships. I worked at two hospitals and sat on multiple committees focused on midwifery integration. As midwives now able to play a full role in the health system which had previously been restricted by lack of legal status, we had to learn new procedures and skills that had previously been done by supportive physicians and other health professionals. This included ordering laboratory work, prescribing and administering drugs and doing general physical and gynecological exams of well women, using electronic fetal monitoring, doing venipuncture and IVs.

206. During the early post-regulation period midwives also took on new roles in birth registration and assigning health insurance numbers. We also took on new roles in charting within the hospital medical records systems.

XVII. Changes in Work of Midwives Since July 1993 Morton/Work Group Analysis

207. Since the time that the skill, effort, responsibility and working conditions analysis was done by the Morton and the Joint Funding Work Group in 1993, there have been many changes in the work of midwives.

1. Changes to Scope of Practice and Regulatory Guidelines for Midwives

208. For example, over the period since 1994, the College of Midwives of Ontario has expanded the scope of practice of midwives. This included but is not limited to the following key changes:

(a) Addition of the medication Carboprost for the treatment of postpartum hemorrhage (2003)

(b) The CMO requirements for six different practice protocols (care during pregnancy, care during labour and birth, care during postpartum, emergency situations, death and bereavement, conditions for safe practice) (2006)

(c) Optional certification for midwives allowing them to act in the role of surgical first assist at caesarean section (2007)

(d) Significant additions to drug list: These additions required practicing midwives to complete a learning module and to pass an exam prior to being able to prescribe these drugs as per the CMO. New drugs added were: Intravenous antibiotics for intrapartum prophylaxis for clients screening positive for vaginal/rectal Group B Streptococcus, oral antibiotics for the treatment of Uninary Tract Infections (UTIs) and asymptomatic bacteriuria, Mastitis and Bacterial Vaginosis; Non-steroidal anti-inflammatory (NSAIDs) drugs for the treatment of postpartum pain (Diclofenac, Naproxen); 2 additional antihemorrhagic and oxytocic drugs (Carbetocin, Misoprostol); two additional local anesthetics for perineal infiltration and repair (Bupivacaine, Chloroprocaine); Domperidone for milk supply issues; certain vaccines (Measles/Mumps/Rubella and Varicella Zoster Immune Globulin)(2009)

(e) Take blood samples from fathers or donors for the purpose of tests that might impact the pregnancy. (2009)

(f) Communicating a diagnosis identifying, as the cause of a woman's or newborn's symptoms, a disease or disorder that may be identified from the results of a laboratory or other test or investigation that a member is authorized to order or perform on a woman or a newborn during normal pregnancy, labour and delivery and for up to six weeks post-partum. (2009)

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

(h) CMO Consultation and Transfer of Care Standard (2014) replaced the 1999 document "Mandatory Indications for Consultation and Transfer of Care". Midwives were no longer required to transfer care or perform a consultation with a physician for certain conditions and circumstances such as maternal age less than 14, pregnancy beyond 42 completed weeks' gestation, cephalhematoma in a newborn or a newborn with greater than 10% weight loss. These changes enable midwives to use their clinical judgment to determine when to consult or transfer care when a condition has not responded to midwifery intervention or therapy, increasing the responsibility of the midwife.

(i) Introduction of the Quality Assurance Program 2015 Practice Assessment Workbook (2015): Each year, the Quality Assurance Committee will randomly select three practice groups and will require all members of that practice who meet the following criteria to complete the PAW.

(j) Intubation of newborns beyond the larynx and umbilical vein catheterization of the newborn in the context of neonatal resuscitation (2015)[103]

2. Development of AOM Practice Guidelines

209. I am a member of the AOM's Clinical Practice Guideline Committee.

210. The AOM developed Clinical Practice Guidelines (CPGs) starting in 1999. These evidence-based CPGs are consistent with midwifery model of care, including informed choice, client as the primary decision-maker, choice of birthplace, and appropriate use of technology. AOM CPGs are developed using the "Values-Based Approach to CPG Development", a document that outlines the selection process for CPG topics, use of evidence, and development of recommendations.[104] All midwives used these wide ranging guidelines to assist them in ensuring that they are complying the College of Midwives of Ontario's standards and regulatory requirements. These guidelines are updated to ensure that they keep up with up to date research and revisions in College requirements and expansions to our scope of practice.

211. These Guidelines are also particularly important as midwives interpret and apply evidence through the lens of "normal birth" and "informed choice". Their interpretation and application may therefore differ from how physicians apply the same evidence. The CPGs reflect the midwifery specific perspective.

212. These Guidelines cover the following areas:

No. 16: Group B Streptococcus: Postpartum Management of the Neonate (2014)

No. 15: Hypertensive Disorders of Pregnancy (2012)

No. 14: Vaginal Birth after Previous Low-segment Caesarean Section (2011)

No. 13: Management of Prelabour Rupture of Membranes at Term (2010)

No. 12: The Management of Women with a High or Low Body Mass Index (2010)

No. 11: Group B Streptococcus: Prevention and Management in Labour (2010)

103 Changes to Midwives Scope of Practice Chart (2013) AOM0001145.

104 2006 - Value Based Approach to CPG Development (2006) AOM0015544.

No. 10: Management of the Uncomplicated Pregnancy Beyond 41+0 Weeks' Gestation (2010)

CPGs still in use from 1999 to 2006:

No. 9: Prevention and Management of Postpartum Hemorrhage

No. 8: Parvovirus B19 Infection in Pregnancy (rescinded 2015)

No. 7: Screening for Gestational Diabetes

No. 2: Physical Assessment of the Well Woman

No. 1: Physical Assessment of the Newborn. [105]

3. Caseload and Workload

213. At time of regulation, the basis of the workload analysis relied upon by the AOM and the MOHLTC in their negotiations was the analysis set out in my pre-regulation 1991 thesis, With Women: Community Midwifery in Ontario amended in 1993 during the funding discussions to 48.25 hours to reflect the updated model of care at that point. The AOM's 2007 Workload Analysis updated those figures and increased the hours to 55.8 hours. **[106]**

4. Clients Served

214. Once legally recognized and funded, midwives including the group I work with were able to serve a more diverse population. When clients had to pay for care they were either highly committed or sometimes compelled by a lack of health insurance in Canada to pay for midwifery care. Funding has allowed diverse and disadvantaged communities to access care. Most practices see a high proportion of clients who are new to Canada and many who do not have health insurance. Many CHCs and public health units have specific referral arrangements with midwifery practices and refer clients with special needs such as refugee, newcomers, teens and those living in poverty. Many social services working with LGTBQ communities also refer clients to midwives.

XVIII. Ongoing Disadvantages and Barriers

215. Midwives continue to encounter prejudices, disadvantages and barriers despite 20 years of integration in the health care system. Midwives continue to face

105 Clinical Practice Guidlines (2016) (C1656787xA0E3A).pdf (2016) AOM0017360.

106 Report by AOM re: Finding of Midwifery Workload Study (August 1, 2008) AOM0005588.

hospital restrictions and caps on courses of care which impact on their ability to practice to their full scope of practice in all settings.[107]

216. Within the structure of health professions legislation, change to scope of practice requires consultation among professions. This has created a barrier for midwives as the dominant profession of medicine has on several occasions opposed the addition of evidence based medications, lab tests and procedures that are important to evolving practice of midwifery. This can occur even when there is general consensus among maternity care providers that a medication is important, for example it took seven years to make a change to allow midwives to prescribe GBS prophylaxis as per national guidelines.

217. While there are many physicians who are cooperative with midwives, the medical dominance of the health care system means that midwives have not yet achieved full "equitable integration" which is one of the mandates of the Ontario Midwifery Program.

218. This case is a good example of the ongoing struggle against myths, prejudices and misunderstandings about midwifery work and its value and position in the health care system.

XIX. Sustainability of Maternity Care in Ontario

219. The Ontario Women's Health Council created the Ontario Maternity Care Expert Panel in October of 2004 to address concerns about the trends of decreasing accessibility of maternity care services, changing trends in service provision and long term sustainability of maternity care in Ontario. Maternity care services are the foundation for the subsequent health of mothers, babies and their families.

220. The purpose of the Panel was to provide a comprehensive overview of the present state of maternity care in the province, identify both what is working well and where problems with access and quality exist. After extensive consultations and research we recommended a coordinated and realistic maternity care strategy for Ontario.

221. We drafted a report that is divided into three major sections 1) the present state of maternity care in Ontario, 2) vision and principles of maternity care in Ontario, and 3) how do we get to a province-wide strategy that integrates all sectors to provide access for childbearing women across Ontario. This strategy emphasizes the education and skills of the right provider at the right time, in an effective and efficient manner. Our recommendations aligned with the new ministry vision of stewardship and address how a provincial maternity care strategy would work with Local Health Integration Networks and other partners.

222. The panel felt that:

107 OMP Hospital Integration Surveys, 2009 and 2011 (AOM0005933).

> *A framework for ongoing maternity care policy is urgently needed. We have developed a simple and encompassing vision to aid in the transformation of Ontario maternity care services:*
>
> *Every woman in Ontario will have access to high quality, woman and family- centred maternity care as close to home as possible.*

223. The Report stated that this:

> *…vision will best be fulfilled if the actions of the Office of Maternal and Newborn Health and of all those engaged in the transformation of Ontario's maternity care services are focused to develop a specific maternity care system based on the following guiding principles:*

Woman and Family Centred Care

- *Care across the continuum of maternity and newborn care*
- *Equitable access to Care as Close to Home as Possible*
- *Pregnancy and birth as a normal physiological process*
- *Regional coordination of services and access to high-risk care*
- *woman and family centred care including:*
    - *Empowerment and participation*
    - *Informed choice*
    - *Choice of birthplace*
    - *Quality care to diverse and vulnerable populations*
    - *Continuity of care*

Principles of Service Provision

- *Valuing maternity care providers*
- *Collaboration inter-professional, respectful and seamless*
- *Provider preparation, competence and confidence*

Principles of Stewardship and Coordination

- *Effective coordination of services*
- *Maternity care as part of primary care*
- *Alignment of the system with national and international determinants of health*
- *Continuous evaluation and improvement to ensure quality and safety*
- *Financial responsibility and accountability*

224. The Ontario Maternity Care Expert Panel made the following recommendations that

that the Premier of Ontario direct the ministries of Health and Long-Term Care, Children and Youth Services, Health Promotion, Training Colleges and Universities and Attorney General to work with professional organizations, regulatory bodies and educational institutions to take immediate action to address the impending maternal-newborn care crisis and ensure that women and families receive access to essential, high-quality, effective and sustainable maternity care services in Ontario by:

1. Increasing the number of maternity care providers and declaring a moratorium on maternity care program closures in communities that have sufficient health human resources to maintain safe services.

2. Immediately establishing an ongoing provincial maternity care program led by Ministry of Health and Long-Term Care and regional networks of care providers to be responsible for:

- *Creating a sustainable maternal and newborn care plan for Ontario with full financial responsibility and accountability;*
- *Integration of that plan across ministries, all regions and services;*
- *Alignment of the maternity care plan with the government's transformation plan with maternity care as an integral part of primary care;*
- *Ongoing performance measurement to ensure access to quality services.*

3. Incorporating women's input into maternity care at all levels from informed decision-making about their own care to local, regional and provincial service planning policy.

4. Ensuring timely and equitable access to quality maternity care by committing to:

- *Primary maternity care delivered close to home;*
- *Services that are responsive to the needs of diverse and vulnerable populations;*
- *Woman and family-centred models of care;*
- *Regionally coordinated access to high-risk care.*

5. Create and undertake public and professional education campaigns to support a sustainable maternity care system and promote pregnancy and birth as a normal physiologic process with access to care for complications, as needed.

6. Attract, support and retain maternity care providers by developing a system that values and respects all provider groups, including midwives, nurses and physicians through harmonization of regulation and liability mechanisms and creation of complementary funding schemes. [Emphasis added]

7. Remove barriers to care and create structures that support:

- *The effective use of all care providers to their full scopes of practice;*
- *Collaboration amongst professionals;*
- *Innovative inter-professional models of education and clinical care founded on evidence-based -guidelines and practices*[108]

225. The Report noted that midwives were producing excellent outcomes and playing an important role in the health care system. The Report found that it was important to ensure that midwives were facilitated to work to their full scope of practice. [109]

226. The medical dominance of the system means that it has been difficult for the MOHLTC to step in and take leadership by adopting a health human resource plan which moves obstetricians over to high risk rather than low risk maternity care.

227. The report recommended that the MOHLTC "supports providers with the education, skill development, reimbursement and incentives needed for the length of their careers." [110]

228. The Report was provided to the Ontario Women's Health Council and the MOHLTC and Minister Smitherman. However, the MOHLTC never published the report.

229. The MOHLTC did not subsequently develop an effective health human resources plan to adequately ensure the appropriate number of providers to meet the demands of Ontario women for maternity care.

SWORN this 29th day of July 2016.

A Commissioner for taking Affidavits

Vicki Van Wagner

[108] Final Report of the Ontario Maternity Care Expert Panel on Maternity Care in Ontario 2006: Emerging Crisis, Emerging Solutions (September 2006) AOM0005948 at pages 10-12.

[109] Final Report of the Ontario Maternity Care Expert Panel on Maternity Care in Ontario 2006: Emerging Crisis, Emerging Solutions (September 2006) AOM0005948 at page 104.

[110] Final Report of the Ontario Maternity Care Expert Panel on Maternity Care in Ontario 2006: Emerging Crisis, Emerging Solutions (September 2006) AOM0005948 at page 47.