UNITY IN DIVERSITY

ORATION

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Introduction

Tonight is one of the great occasions in the relatively short life of the Australian College of Midwives.

I am very aware that a tremendous honour has been granted to me by my colleagues in being invited to give this, the Inaugural Oration, on the occasion of the First Investiture of Fellows into the College.

I am also privileged to be the first to wear the Orator's gown.

There will be, I am sure, many a learned discourse that will follow this humble effort for which I have made great efforts to keep above the level of a harangue.

The choice of topic for tonight's presentation is mine, and I hope as I proceed you will understand why although I believe unity is important, so is diversity, creative dissent and commitment to the one concept does not preclude inclusion of the other in the workings of the College or any other organisation.

The History

The Australian College of Midwives as it is now titled was founded at a time when great waves of dissatisfaction were being directed by women at the birthing services as they were then provided in the health care systems of this country.

This was despite the knowledge that by the late 1970s childbirth was as safe as it had ever been, maternal deaths from direct causes had been reduced from 202 in 1964-66 to 52 in 1975-78, or if you prefer, the death rate had been reduced from 30.3 to 7.7 per 100,000 live births[1]. Maternal morbidity rates do not feature in these triennial reports.

I make the point that "had ever been" because these improvements in outcomes were achieved by a very positive pursuit of the provision of better antenatal care, and intrapartum care.

The care providers in the maternity services had worked hard to do better for the women and their families. The acquisition of better referral patterns and transport systems, more skilled providers, better facilities and the introduction of safe, affordable contraceptives from which women could choose to control their fertility if they so wished. These all contributed to women having less fear of childbirth than their mothers and grandmothers. And we should never forget the introduction of the universal health care scheme which assured access to care for all.

Many who worked in the maternity units of that time were genuinely shocked when it became obvious that the women, the consumers, were not happy with what was happening to them in those units.

We had grudgingly allowed them to have their "husband" ("partner" was not a word regularly used in the early seventies) with them in the labour wards, but still the environments were stark and sterile and the decision making was firmly in the hands of the care providers. At the same time the degree of activism among those who worked in the maternity units was low key and little account seemed to be taken of users of the service . . . there was little focus on what the customer wanted in those days.

There were organised groups of midwives in three States – New South Wales, South Australia and Victoria, those who attended the meetings did so because they were often the only source of ongoing education for the practitioners.

I can recall the Victorian Group in the mid-seventies conducting a survey of patients to determine what their reaction would be to male midwives as attendants and finding no great objections. Subsequently, the legislation was amended in 1976 to allow for males to register and practise in that State.

By 1975 when approximately 50 Australian midwives made the acquaintance of one another in Lausanne at the International Congress of Midwives, and agreed it was time to form a national midwives group, the women's movement was actively calling for change in the way we attended them in childbirth.

Eventually the National Midwives Association was formed as a National Special Interest Group of the Royal Australian Nurses Federation in 1978.

The rather odd point about the organisation's formation was that in 1972 unbeknown to most midwives who lived and worked in the country, Australia had been admitted to the International Confederation of Midwives. An action, auspiced by RANF (they paid the fees), sought and gained by the then Executive Secretary of the Confederation, Miss Marjorie Bayes. She had accompanied Mrs Margaret Myles on a west to east tour of this country and came to understand how large the continent is and how the distances involved tended to inhibit the formation of a national group, so enrolled us into the international fold.

Certainly, it was a surprise to the Australians who met in Lausanne in 1975. They also noted they had no part in selecting the Australian delegate to the International Council meeting and that lack of involvement was keenly felt.

This insight spurred some of them into the activity needed to form a national group.

The vision held by the founders of the national group was of a midwifery profession unified and made strong by the bringing together of those committed to the achievement of improved maternity care for women and their families, improved midwifery education programs. A better enunciation of what midwifery practice was and could be in this country and of the potential of midwives to improve the care of women in their reproductive years.

Prior to this, few if any of us who held a midwifery qualification used the title "midwife", we quite comfortably let ourselves be called nurses, and if we were looking for employment examined more closely those advertisements requiring applications from DCs double certificated nurses. The word midwife, I believe, re-emerged into the common usage with the demands of women for reform in the obstetric services, not initially from the midwives themselves.

The women wanted to gain control of their bodies, cessation of the practice of shaving labia and perineum, less intervention in the childbirth process, less use of stirrups, fewer episiotomies, a change in the way epidural analgesia was used for pain relief so that they did not require a forceps assisted birth, and crucially a bigger say in the decisions made about their care.

Midwives by virtue of their education were perceived by the women as more orientated towards the normal or natural in childbirth, and not prone to advocating the use of invasive procedures. To be "with women" as the derivation of the word suggests.

The origins of this rejection of the medical concept of childbirth were on the west coast of the United States of America, and amid much controversy women there and then here began to seek out the midwives and the doctors who would attend them at home.

We got to read publications such as Suzanne Arms' *Immaculate Deception* which angered many for its descriptions of the control and domination of women imposed by their care providers[2]. In the USA this was almost universally a medical practitioner.

We heard of how in the basement of a brownstone building on Manhattan Island a far-sighted and courageous midwife, Ruth Lubic, General Director of the Maternity Centre Association was constructing an out of hospital birth centre as a demonstration project.

A concept validated and vindicated with the publication in 1989 by the *New England Journal of Medicine* of the Outcomes of a National Birth Centre Study of Free Standing Centers by Rooks and colleagues[3].

While these changes were taking place in the developed countries, little was heard of the situation in Africa, Asia and South America, where thousands of women were dying in childbirth and few, if any, were noting their going.

Those were the times during which the College was founded, they were not peaceful times in the maternity units in our land. Too much was being questioned by those who, until recently, had accepted what was done unto them and this was a new phenomenon and few knew how to deal with it positively.

It could also be said to be a time when midwives started to explore the concept of working with obstetricians and not necessarily for them within the professional relationships of the maternity services.

The first national conference of midwives was held in Adelaide in 1979. The launch of this national grouping of midwives was a joyous occasion participated in by several hundred Australian midwives.

I also believe that Conference marked the inception of a body of Australian midwifery literature, as prior to this, little was published under a midwifery banner. Since then publication of the conference proceedings has been an essential part of the meeting. This has encouraged midwives to "publish or perish" in greater volumes and it is interesting to observe that the first volumes of the Australian Journal of Advanced Nursing contained a number of papers on midwifery. We eventually launched our own Journal ten years after the formation of the national group.

An Identity

In the meantime we had fought and won the battle to have the letters "RM" accepted for use to describe a person who had obtained a midwifery qualification.

Thus we all started to add the hard-won letters after our names and thought we had clearly identified what we were; how little we knew!

There was, and I believe remains, a wide range of opinion as to what a midwife is and does.

In times past, Aristotle is said to have described the midwife as being *of middle age, neither too young nor too old and of good habit of body* and as *sober and affable, not subject to passion, bountiful and compassionate.*[4]

Soranus, who in the early second century, wrote one of the first textbooks for midwives *De Morbis Mulierium* claimed literacy was essential for midwives *in order to be able to comprehend the art through theory* as well as having a *good memory, being industrious, patient, moral so as to inspire confidence* and possessing a *healthy mind* a *strong constitution* and *long delicate fingers with nails cut short.* He also considered experience in all branches of medicine important, together with the personal experience of birth and maturity of years[5].

Most of these attributes described so long ago appear amusing at first glance, but I am not sure that some are not influencing the perceptions of what midwifery is in some sectors of the community today.

There is no doubt in my mind that the low levels of female literacy in many of the least developed countries will inhibit the future development of effective maternity services in those nations.

Then there are those who like the simple definition of the word midwife as it is derived from the German language as being very appropriate, being "with woman" at their time of giving birth, or at other times is occasionally used as a catchcry within and without the profession.

The French speaking countries describe the midwife by the words, *sage femme,* wise woman.

These descriptives are very gratifying and ego boosting, but do they move the identification of the profession from mystical to the scientific?

Internationally we are unified by the international definition of a midwife which was first adopted by the International Confederation of Midwives and FIGO in 1972 and later by the World Health Organisation.

It is quoted extensively, yet its very form allows for diversity, for it is premised on the understanding that the midwife has undertaken a formal education program, which is recognised in the country in which it is located, completed the studies required and is registered/licensed to practice midwifery in that jurisdiction.

Midwifery practice, according to the definition, includes the provision of antenatal, intrapartum and postnatal care, care of the newborn, the infant and for taking appropriate actions in high risk situations. Conduct of health education programs, provision of some levels of gynaecological care and family planning advice is all in the province of midwives. There are no restrictions as to where that practice can take place[6].

By inference where women and their families are, so can midwives practice.

In effect this definition also conveys the message that in each country what a midwife is and what she/he does evolves within each nation's maternity service.

In the history of this country, midwifery has gone through a number of cycles of development, and dare I say suppression and growth.

You only have to read some of the histories of local communities published of recent times and especially since the 200th Commemoration of white settlement in 1988 to be aware of how reliant the pioneer women were on those who then practised midwifery. Then as the communities started to consolidate, on the small cottage hospitals often run by midwives who provided birthing services and care to children through their vulnerable years. Unfortunately, not all of this care of women was a guarantee of a good outcome.

D'Arch in a paper presented in 1935 quotes rates of maternal death for the Commonwealth for 1921 to 1930 at 4.88 per 1,000 births, a total of 6,529 deaths for the period[7]. I do not believe these figures include Aboriginal deaths.

Milton Lewis in a review of "Maternity Care and the Threat of Puerperal Fever in Sydney 1870-1939" draws attention to the debate which raged in the late 19th and early 20th centuries in that city, when it was estimated that two-thirds of the labours were attended by midwives, most of whom were untrained and this, it was alleged, was the cause of the poor outcomes of the times[8].

However, although after the First World War doctors attended a significant number of the births, there was little reduction in the maternal deaths through sepsis.

Education and regulation of midwives and medical practitioners, greater access to public maternity units by those who could afford it, better antenatal care all helped but in the end it was a scientific pharmacological advancement which made the break through. According to Lewis it was the introduction of sulphomides that turned the tide.

It is my opinion that, in the main, the concept now held by all but midwives of what midwifery is in this country was shaped by those events from the turn of the century until the 1940s.

Our mothers and grandmothers were conditioned to believe they stood a better chance of survival in hospital, with a trained midwife in attendance and a doctor nearby who could authorise and administer the life and trauma saving measures. Later health care policy directions firmed the belief that the only place for safe birth was in a hospital. Little is written in the conventional texts that describe how the better survival rates were achieved, about the housing, sanitation, nutrition and economic situation of the women and the families pre-Second World War. Events and achievements should be reviewed in context I believe.

So in Australia we continued to consolidate hospital based services for women in their child-bearing years, ironically over the years moving from calling them midwifery services to obstetric services while at the same time giving one of the best coverages of midwifery care in any nation's health system.

It is interesting to note that there was little variation in these developments from state to state.

Certainly there was little difference between what a midwife could or could not do. Unfortunately the latter came to dominate much of the legislation which was enacted as the years progressed, all in the name of protection of the woman – from state to state. Midwifery was subordinated under nursing and dominated by medicine[9].

Another factor which reduced the degree of diversity in the midwifery practice from state to state was the amount of training done in other states. Western Australians travelled to NSW and Victoria, Victorians went to Sydney and Adelaide, some training schools accepted more interstate applicants than others especially post-Second World War. These were the days when in the training schools the majority of the direct care was given by pupil midwives supervised by trained midwives.

The training programs were adaptations of British models where the early midwifery tutors had gained their teaching qualifications.

There remains little diversity between states, the practice settings may vary, the legislation is variable and the transfer of midwifery education to the higher education centres may have proceeded at a different pace from state to state but in general, one state's midwife graduate fits as well into the practice settings of another state as her older colleagues did from the hospital based certificate programs.

If the image of a midwife held by many in this country is of a nurse who has an additional qualification which makes her/him a safe childbirth attendant, it is not the image the midwife has of her/himself. Birth to a midwife is but one element of a continuum of care for women in their child-bearing years. The need to more clearly identify what midwifery is and could be, if the profession was represented by its own members, drove the midwives to take more assertive action.

Links with RANF were severed in 1983. The courage was found to bid to host the first International Congress of Midwives in the Asia Pacific region in 1984 and the organisation was retitled the Australian College of Midwives in 1987, this was done fully comprehending all that such a title entails. It was a deliberate act undertaken to achieve greater recognition of what midwifery is and of its potential to achieve better care for women through midwives gaining self governance of their profession.

This strategy has had its rewards. Pratt, in her review of specialisation in nursing and the

formation of the clinical specialty organisation conceded the right of the Australian College of Midwives to speak for midwives and excluded any reference to the midwives college from her review because that college had stated "midwifery is a profession in its own right (and) therefore – does not see that it is a nursing organisation"[10]. That glimpse of recognition in this country is welcome and hard won.

However, Declerq in a paper in which he reports on an analysis of research into the politics of midwifery in Canada, Denmark, the Netherlands, the United Kingdom and the U.S.A., an interesting mix of the strong and the emerging, makes the point, "The respect and affection midwives gained from women and families can be offset by the tendency of policy makers to underestimate their value as health providers".

He cautions midwives about wasting their energy on attempting to define who is the "real midwife" rather "than valuing the importance of diversity in any human activity"[11].

The policy makers in this country are giving recognition to the potential of midwifery actions to improve health outcomes and Federal Minister of Human Services and Health's commitment in her recent launch of the so-called birthing services funding allocations to midwifery led programs is tangible evidence of that recognition.

Prior to this there had been a series of evaluations of obstetric and birthing services published nationally and in many states from late 1980. Each acknowledged the women wanted change and the greater involvement of the midwife was needed to achieve that change. Internationally, this recognition has been slow coming, but now is proceeding at such a pace it is hard to keep up.

The International Commitment

Since 1957 the International Confederation of Midwives has held consultative status with WHO and more recently within the larger United Nations system as the international non-governmental organisation which represents midwives.

The catalyst which caused WHO and other international agencies to consult more closely with ICM was the Confederation's early recognition and acceptance in August 1987 of the goals of the Safe Motherhood Initiative, it was in fact, the first international non-governmental organisation to endorse those goals.

And for those who may not be aware of what the core goal is, it is to reduce by 50% the worldwide maternal morbidity and mortality rates by the year 2000. Then it was estimated half a million women died each year and many millions more suffered lifelong ill-health and the consequences of birth trauma.

The deep tragedy of it all is that most of the deaths occurred and still do from conditions that only rarely cause death and birth trauma in countries such as this one; the reasons for the deaths are complex and the solutions are not easy to apply. But it is a tragedy with which this country had, in earlier times, some familiarity given the death rates quoted earlier.

But there is one clear measure which can be applied to the possibility of achieving safer motherhood and it is the number of women attended in the country by a trained health care provider.

Australia is always listed as having a 99% coverage whereas countries in sub-Saharan Africa rarely achieve rates of 20% coverage[12].

Each three years starting in 1987 the Confederation has in collaboration with WHO and UNICEF conducted pre-congress workshops for midwives from developing countries consistent with the goals agreed at that Congress.

The action plans adopted at each workshop have guided the strategy development within the Confederation. The crucial one has been to support the development of midwifery in some of the most poorly serviced countries of the world.

The momentum of recognition for the potential of the midwife took a significant leap forward in 1992, with the adoption in May of that year in the World Health Assembly of Resolution WHA45.5, entitled Strengthening Nursing and Midwifery in Support of Strategies for Health for All. The significance of the resolution was not so much in its content, important as it is, but on the identification by WHO of the two distinct disciplines of nursing and midwifery.

In the same year a Global Advisory Group on nursing and midwifery was established to advise WHO's Director General on nursing and midwifery in the implementation of the resolution and in the attainment of the Health for All goals for the year 2000.

Further in the same year the title of the global network of WHO Collaborating Centres for Nursing Development was amended to include Midwifery.

The Confederation has midwives representing the interests of midwifery at the meetings of each of these organisations and in many other international agencies.

When the Confederation's governing council last met in May 1993 there were no midwives holding significant positions in WHO, now we have two internationally recognised midwives in position. Yet to be achieved is a change of title for the chief scientist for nursing to include midwifery.

Earlier this year WHO launched at the World Health Assembly in May, what it has titled the Mother Baby Package, a publication which it describes as a technical tool to guide actions and interventions in the area of maternal and child health.

The Mother Baby Package according to WHO "brings together minimum, simple, durable and cost effective interventions" that can impact in reducing maternal and newborn mortality and morbidity.

It identifies what is described as a continuum of care which links communities with health and is based around:

- family planning
- prenatal, delivery and postpartum care for mother and newborn
- essential obstetric care for complications and special newborn care[13].

At the launching of this new tool at the WHA each delegation received in their kit a leaflet which illustrated why it has identified one care giver in particular as the "person best equipped to provide community based technologically appropriate and cost effective care to women during their reproductive years as being the one with midwifery skills".

Another statement which is significant is "most interventions related to care of the mother and newborn are within the capacity" of this person[14].

Quite correctly the document does not neglect the need for the midwives to have access to the support of doctors and obstetricians for the management of certain complications and surgical interventions.

The Package was launched under the banner of Reproductive Health Priorities. Those priorities continue to be urgent and perhaps can be best illustrated by some data produced by UNICEF in its 1995 Progress of Nations Report which records that in sub-Saharan Africa the average number of births per woman has only reduced by .4 from 1963 to 1993 while in the industrialised countries the reduction has been 1.1, the worldwide reduction in the 30 years has been 1.8.

UNICEF makes the point in this publication that most surveys reveal that the majority of women want fewer children, and that in some countries desperate women tolerate poor family planning services or seek abortions often with fatal consequences[15].

The skills of midwives are being marshalled to attack the grave consequences of inequities of access and care which occur in the poorer nations of our world.

Some countries have already started programs of midwifery development; Indonesia for instance, is to train 33,000 midwives by the year 2000 in a program mainly funded by the World Bank.

Indonesia is a country which WHO estimates already provides one midwife per 273 births and according to FIGO one obstetrician/gynaecologist per 13,983 births whereas the same agencies estimate that in Nigeria there is one midwife per 1749 births and one obstetrician/gynaecologist per 4,145 births; Sri Lanka does better than most in the Asia Pacific region by providing one midwife per 72 births and one obstetrician/gynaecologist per 5,000 births[16].

Distribution of skilled/trained maternity care providers such as these figures indicate hardly leaves room for territorial disputes such as occur in the developed countries.

I was recently sufficiently intrigued by an editorial in the latest *Journal of Nurse Midwifery* entitled All the News that is Fit to Print, written by that College's President, to seek copies of the article on which it was based that had been published in the *New York Times* in March this year.

Burgin in an earlier editorial in the same Journal in 1992, CNM.MD Relations – Cultivating Mutual Respect, made the point that despite the value being placed on the nurse midwives' contributions to women's health care, the increasing numbers joining physicians' practices, physician midwife conflict continues in some areas[17].

The *New York Times* article when read drew attention to the vast inadequacy of health services provided within the city and the just and reasonable causes for complaint by all, especially the consumers and the care providers.

Unfortunately the writers chose, as is often the want of the media, as Marsico in her editorial states to "malign midwifery as a major contribution to New York City's poor outcomes" when rather the responsibility should be placed rightly with the system[18].

My reading of the articles from the comfort of a health care system which gives universal access to quality care on the most part, led me to think that instead of banding together to obtain better services for women and their newborn, the physicians and midwives accepted the defensive roles cultivated of them by the media – it makes good press.

Eventually exposure of the very poor situation in which both groups of practitioners work might achieve better care in those hospitals, time will tell, but I am not hopeful if the two major providers are in such conflict.

Gould, commenting on the Changing Childbirth Report published in the United Kingdom in 1993, applauds women being given more control over what happens to them in childbirth, then goes on to critically describe the conflicts and counter claims of, rights to, that had been imposed on women by both expert groups, the midwives and the obstetricians. He concludes that with the women being able to choose their "personal" midwife and the place of birth, keep their own case histories, be properly informed about what may be done to them, "they will be in charge" and if the obstetricians had been "less possessive about other people's pregnancies there would have been no need for the politicians to interfere"[18].

He has a point – the possessive pronoun is often well used the maternity services by all the care providers.

These have been illustrations of division, not of diversity, and I choose to refer to them tonight to illustrate the power of such energy-wasting activities to channel the well intended into the non productive (occasionally destructive) debates and battles which divert attention from the core of our business, that is, to ensure women and their newborn get the best care possible in the systems in which we work.

The Future Possibilities

I support the stance taken by Flanagan who, when writing about barriers and obstacles to nurse midwifery practice, states, "when to stand shoulder to shoulder with nursing to effect policy or when to differ to meet a perceived need are pragmatic not ideological issues"[19].

This stance can be quite equally applied to those with whom we work most closely, the obstetricians.

The decision to differ or stand with should be made with the full understanding of how it will fit with the advancement of the goals of those making it.

I applaud the holding of joint meetings between representatives of the Midwife, Obstetricians and Gynaecologists and General Practitioner Colleges in this country. Hopefully these meetings will lead to a greater understanding of and focus on how jointly their members can provide quality services for women.

A policy issue on which there is no agreement between nursing and midwifery in this country is the provision of pre-registration or direct entry midwifery programs.

Years ago I read in the financial papers a comment which read something like, Australia is only the third world country with clean, safe water on tap.

I am beginning to think the same comment could be made about the provision of pre-registration programs; just one would demonstrate to me that we in this country had moved beyond the developing phase in our health systems and education of care providers and achieved some maturity.

Many European countries do provide such a route entry into the profession. In the UK it is estimated that 60% of the midwifery programs will be pre-registration by the end of this decade. Graduates of these programs, I am told, are being employed in the British health system.

What really made me think about the provision or non provision of these programs as an indication of maturity and development is a pie chart in a WHO publication which contains the results of a 1991-993 survey of perceptions in Ministries of Health on nursing services which includes data on midwifery.

The chart illustrates that in developed countries 54% of the midwives are not trained as nurses, in developing countries only 24% are not also nurses[21].

I continue to be disturbed that on this question nurses seem unable to raise their thinking to a logical examination of the question, but be locked into the beliefs and values of the past.

There is room in the maternity services of this country for the diversity which a mix of midwives with different routes of entry would bring to the maternity units.

An earlier decision of the College to not use the title nurse midwife came from a realisation that to do may preclude all qualified midwives from joining. This is a dilemma now facing the American College of Nurse Midwives which recently voted to admit midwives who are not also nurses. I do not believe the consumers in general would make a distinction from one to the other – their real want is quality care.

Of recent years, the College has engaged in the business of accrediting midwives for independent practice, a process that aims to assure the women of quality care in a private practice situation.

Many here tonight will have heard me state in other venues that I believe a midwife is a midwife, and I find it difficult to recognise that those who choose to practice in a direct contractual arrangement with a woman is any more accountable for their actions than one whose status is that of an employee in a maternity unit. The achievement of accreditation should be suitably recognised but I am not sure that independence is an achievable status in this as such nor is autonomy, our very accountability to the women precludes such occurring.

That the membership of the College includes midwives whose practice is diverse has been an enriching factor in its development, just as the recruitment into our ranks of those who entered the profession through a program in the higher education sector.

The goals we set ourselves in those early days have in part been achieved; we do have a branch in each State and Territory, the education programs have transferred to higher award sites, there is a national headquarters, we meet regularly to debate the issues of the day and have a glorious time so doing. There is a growing body of academics and others with advanced value adding qualifications such as law, economics, management. We actively pursue research programs as the basis on which to improve our practice.

We have retained as our prime unifying aim the maintenance of a high standard of maternity care for all Australians.

We are challenged by the poorer outcomes Aboriginal women experience in their reproductive years, and the fact that their newborn are three times less likely to achieve their full potential.

We are concerned to be good citizens of the world so support and assist midwives and midwifery development in our near neighbourhood.

But are we ready to take into our practice in this country all that is inherent in the definition of reproductive health adopted in 1994 in Cairo at the International Conference on Population and Development.

I will not quote in full tonight as it is a lengthy statement. In part it states "Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity in all matters relating to the reproductive system and processes"[22].

Some may think this is a claim for an expansion of the midwives' role; I do not believe so. To me it is a statement which quite closely describes all that a midwife should encompass in her/his practice. Furthermore, this view is substantiated by the policy direction taken by WHO in launching the Mother Baby Package to which I referred earlier.

Is it time to redefine the role of the midwife in this country to examine just what diversity can be achieved while remaining true to that which unified us? I believe so.

Shortly tonight the first Investiture of Fellows will take place; they will wear the blue gowns of the College. Blue is the traditional colour for the midwife – it signifies chastity, loyalty and fidelity. I cannot vouch for the first attribute as a characteristic of Australian midwives, but I can for the second and third.

They have acquired stature and recognition because they held true to their belief in the right of women and their newborn to the best care possible in all settings. That imperative has been powerful and although not always achieved remains our goal.

The dynamics of diversity have influenced the development of this College; midwifery has come back from the near extinction which it faced nearly 20 years ago. We have practised the art of dissention within our ranks to question the status quo, examine the options, looked for new ways forward and never had a dull moment.

Midwifery in this country has gained unity, the living entity of which is the Australian College of Midwives.

Our gains have been significant but still the one reward we treasure most is I believe best illustrated by Marilyn Krysl in the last stanza of her poem Midwife, when she describes the rewards of being with a woman at birth, with these words:

"When my work is finished and I go from a place of birth
I walk across the field of the planets
into the spaces between the furthest stars".[23]

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