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Midwifery: "At the edge of history"☆

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Summary The paper focuses on possible future pathways in maternity care for midwives and nations to consider. The paper blends personal and professional experiences to outline priority areas facing midwives in the future. It begins by examining maternal mortality and morbidity in the developing world and considering the potential of the ten high priority action messages (1997) in helping to improve the plight of women and children in the future. The paper then examines major issues facing midwives in the developed world including: the way birth is viewed; the medical-midwifery divide; marketing midwifery; and finally the challenge of dealing with fear around birth. The third part of the paper examines a part of society where the two worlds meet and there are issues from both the developed and developing world to consider. The paper focuses on women from culturally and linguistically diverse communities, Aboriginal and Torres Strait Islander women and women birthing in remote and rural areas. By looking at these three worlds separately the paper examines different concerns facing midwives in the future but also draws on common issues that face us all as citizens of this planet and particularly as predominantly women. The paper challenges midwives to be politically active and dare to change the world.

"At the edge of history, the future is blowing wildly in our faces, sometimes brightening the air and sometimes blinding us."

(William Irwin Thompson)

Introduction

One hundred years ago my great grandmother needed midwives to give birth to twins in China—one was my grandfather. Seventy years ago my grandmother needed midwives to give birth to my mother in England. Forty years ago my mother needed midwives to give birth to me in Yemen. Eleven weeks ago, once again, I needed midwives to give birth to my daughter in Sydney. Perhaps in thirty or forty years time, if I have my way, my daughters will also need midwives. There is only one prediction about the future that I am brave enough to make with absolute certainty. Women always have needed midwives—women do need midwives and women always will need midwives.

We are a constant in the world. We are marketable in modern terms. We will never be redundant. We are amongst the oldest of professions. We have survived immense persecution. We are not going anywhere!

That we are, and will be, needed is not the hard part. The difficulty comes with knowing how we should best perform our role. How do we plan and create a future in maternity care that helps make nations healthy and

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motherhood safer? Well, obviously not on our own and not without a great deal of hard work.

I want to begin by looking at the developing world, then the developed world and finally where those two worlds meet. By looking at these worlds separately I want to discuss the different concerns facing us in the future but I also want to draw on the common issues that face us all as citizens of this planet and particularly as predominantly women.

The developing world: a reason to fear

As a midwife standing on the edge of history I want to begin by talking about the developing world with a sense of great humility. There are many of you who could address this topic far more ably than I with far greater lived experiences. And I am mindful that the developed world has always had its opinions about how the developing world should be ''saved'' and how often we have been wrong.

My experiences of the developing world were in a country called Yemen where I was born. My mother was a midwife. The first fifteen years of my life were spent watching and learning the reality that is a woman's life in a country where women had no rights, no voice and no status. I watched my friends get married as girls. I watched them give birth to stillborn babies after days of labour and then saw the terrible impact those labours had on their bodies afterwards. I watched girls being dismissed and boys revered. I watched girls slave at home and in the fields while their brothers were educated. I watch girls sold into marriage like cattle and boys taught to rule their sisters, mothers and wives. And I saw all this with such rage, for in my father's eyes I was his adored first born. I had all the opportunities awarded to my four brothers, if not more. I had choices, education, respect, love and power.

My best friend was called Amal. She was my soul sister. Two people were never so different. She was destined for a life I am yet to comprehend. I was destined for a life of opportunity. I have never again had a friendship that was as deep as ours. As young girls we would hide in the tiny grain room of her house, which doubled as her bedroom, and when she had finished cooking and cleaning for her family of nine brothers and I had done my correspondence lessons and finished bossing about my four brothers, we would create worlds of possibilities. Sitting upon the sacks of sorghum and the bags of rice we were queens and conquerors. We had lovers and devotees. But outside of that little grain room we were once again two young girls destined for lives that were an accident of our birth. It is through these eyes I want to look at the needs of women in the developing world.

Maternal mortality in the developing world

Why does a Yemeni woman have a 1 in 19 lifetime risk of a maternal death, when my lifetime risk of maternal death is 1 in 5800?[1] What makes her so different to me? We were both born in the same country.

The difference is she gets married at 13 and is pregnant with her first child by 14. She cannot read or write. If her husband divorces her she will be a third class citizen—she is already a second-class citizen because she is a woman. She will lose her children. She will be once again be dependent on the support of her male relatives, the same relatives that brokered her marriage to a man she had never met. If she has problems during the birth, the local woman who assists childbearing women in the village will do all she can, but the reality is that, with a donkey trip to the nearest hospital, she will probably die or be seriously damaged by the birth. The hospital has a bad reputation anyway with foreign male doctors who look at women's bodies and city trained midwives who shout at you as though you are stupid. When her baby is born quiet and lifeless after days of sheer agony her women friends will comfort her with the words 'it's God's will' and she will soon be pregnant again. By this time she is 15 and perhaps her body has developed enough to let this child through her pelvis alive. She will have on average seven children and live to the age of 59.[1] The difference between this woman and me is immense.

The awful reality is that every minute of the day somewhere in the world a woman still dies from complications related to pregnancy or childbirth, eighty percent of which are preventable. The terrible tragedy is of the estimated 529,000 maternal deaths occurring in 2000,[1] 99% are attributed to the developing world. These deaths are equally divided between Africa (251,000) and Asia (253,000), with about 4% (22,000) occurring in Latin America and the Caribbean and less than 1% (2,500) in the more developed regions of the world.[1] This makes maternal mortality the health statistic with the largest disparity between developed and developing countries.

The maternal mortality rate worldwide is estimated to be 400 per 100,000 births.[1] In Australia in the triennium 1997–1999 it was 8.2 per 100,000 births.[2]

When comparing 1995 statistics to those of the year 2000 it appears that the rate has remained virtually unchanged. One of the Millennium Development Goals agreed to in the year 2000 is to reduce maternal mortality rates by three-quarters between the years 1990 and 2015. We have a long way to go and a decade in which to achieve these goals.

Maternal morbidity

For every woman who dies, 30 to 50 women suffer a major morbidity such as injury or infection.[3] For women in developing countries who are between 15 and 49 years of age, pregnancy-related complications are among the leading cause of death and disability.[3] The women who die each year leave more than a million children motherless. A study in Bangladesh found that motherless children were less likely to get health care and education and children, especially daughters, were much more likely to die than children who had two living parents.[4] Communities lose a worker; countries are deprived of economic and social contributions. The ramifications of maternal mortality and morbidity are enormous. There is personal and national tragedy and loss.

In addition to this every year around 4 million stillborn babies are born and around 4 million newborn babies die in their first month of life.[5] Many of these babies would have survived if they had access to health care like we do in this country.[6]

Ten years after the Safe Motherhood initiative was launched ten high priority action messages came out of a

five-day conference held in Colombo, Sri Lanka in October 1997. The future for women in the developing world is linked to these:

1. Advancing Safe Motherhood through Human Rights
2. Empower Women: Ensure Choices
3. Safe Motherhood is a Vital Economic and Social Investment
4. Delay Marriages and First Birth
5. Every Pregnancy Faces Risks
6. Ensure Skilled Attendances at Delivery
7. Improve Access to Quality Reproductive Health Services
8. Prevent Unwanted Pregnancy and Address Unsafe Abortion
9. Measure Progress
10. The Power of Partnership

(The original paper expanded on each goal.)

The future

Reading this can make us feel that the problems are insurmountable. You may be sitting there thinking, 'well, yes, it's terrible but what can midwives do about it?' As midwives we are change agents and our relationship with women puts us into a very influential and privileged position. We are in a prime position to recognize the powerlessness women face in their lives. We must be part of the move to right the social injustice of maternal mortality and minimise the health disadvantage that many women face in the world. We need to get 'in the face' of the national policy makers of the countries we live in and ensure all women have the right to make decisions about their own health, with full information available to them. They need to be able to access quality health care during pregnancy, birth and the postnatal period. We need to be ever mindful that we do not become part of the problem by further disempowering and alienating women by providing insensitive, culturally inappropriate care and by restricting women's ability to have choice.

Midwives say to me sometimes, 'oh, but I am not political.' My response is, 'Well, you are working in women's health. You have to be political. If you can't be political then get out of maternity care now. I would rather see fewer midwives than more apathetic ones. The reality is there is no place for you in the future for we have no time or desire for apathy. It is apathy that is killing women and babies one by one, minute by minute, million by million, year by year, and it must stop now. Women do matter! We must make them matter!'

The developed world: a fear beyond reason

Let us move now from the developing world where there is a very real reason for women to fear pregnancy and childbirth to the developed world where there is often a fear beyond reason. To do this I want to go right to our doorstep in beautiful Queensland.

Twenty years ago the World Health Organization said, 'by medicalising birth, i.e. separating the woman from her own environment and surrounding her with strange people using strange machines to do strange things to her in an effort to assist her, the woman's state of mind and body is so altered that her way of carrying through this intimate act must also be altered and the state of the baby born must be equally altered'.[7]

I want to say right up front that I think on the whole we have 'lost the plot' in the developed world. We have wonderful examples of persistence and change that keep giving us hope, but on the whole many of us do not believe this very simple but important point—everything we do to women, the way care is structured and delivered, impacts on women and their babies.

Recently a review of Maternity Services in Queensland was published, called Re-birthing.[8] It was set up in July 2004 by the Queensland Minister for Health to examine services for pregnancy, birth and post birth care across Queensland and to recommend evidence-based, sustainable strategies to enhance choices for women wherever they live, without compromising safety.'

The guiding principles set down in the report are that: care is safe and feels safe; care is open and honest; care is local or feels local; care is integrated across a family's experience of new life rather than across funding systems and kinds of carers; care belongs to consumers; carers work together and communicate.[8]

Now this is a plan for the future. What this does is give birth back to women whether advantaged or disadvantaged whether English speaking or non-English speaking whether Indigenous or non-Indigenous. What a revolutionary concept. A health service designed for women, not health service providers. As we stand at the edge of history are we brave enough to change the face of maternity care forever from a service for the provider to a service for women! The reality is, as is stated in Re-birthing, 'maternity care tells the truth about the kind of society we are and wish to be'.[8]

I sat in a meeting recently in NSW where publicly funded homebirth was once again on the agenda. A senior obstetrician at the meeting used the analogy of hairdressers coming to the home to cut hair and how costly that would be. The health system likewise he said may not be able to afford to provide homebirth services just because a few women want it. It suddenly dawned on me that drawing parallels between the amazing, life transforming experience of giving birth to new life, and the six to eight weekly ritual of having the dead protein cut from our heads revealed exactly where childbirth sat with some health professionals in our society. Birth is not revered, rather it is feared and with that fear it is devalued. Birth is deeply, unbelievably emotional! As midwives, let us never forget that.

So how do we change the system from one that fears birth to one that reveres birth? In Re-Birthing Hirst[8] makes a very honest and key observation. She says, 'there is no leadership of change in maternity care, and no champions in senior roles in the state who are willing and able to drive change.' This is not of course to dismiss the immense efforts midwives and consumers are making in Queensland and indeed across Australia and much of the world to lobby for change and to implement change. Unless, however, we have strong leadership in positions of power at a state and national level we will always be doing what we are currently doing, that is, expending huge amounts of energy

on programs that fold the minute funding runs out and becoming burnt out and disillusioned in the process. In fact Hirst[8] concedes that 'personal commitment is the driving force behind quality rather than system generated motivation.' The future must be driven by sustainable change led by champions that we must all have a hand in shaping or being. Consumer organisations such as Maternity Coalition are doing a wonderful job in meeting with the senior government ministers and inspiring them to be champions for change in maternity care, as is the Australian College of Midwives.

The medical-midwifery divide

There is no doubt one of the great challenges we face as midwives is managing the great medical/midwifery divide. Note, I say managing, not overcoming, because I have ceased to believe it is possible to close the divide. It makes me sad to say this but I do so with some hope. Joyce Thompson at the International Confederation of Midwives meeting in Brisbane (27th July 2005) read out the wonderful message from Dr. Khama Rogo of the World Bank where he talked about building bridges. To build a bridge, however, you need pylons at each end of equal height to suspend the bridge upon and equal strength to support it. Until we are equals, the bridge will not be built. The stronger we become as midwives the better we will collaborate with our medical colleagues. Strength invites respect and respect gives strength.

In their article in the Medical Journal of Australia, *Throwing the baby out with the spa water*? De Costa and Robson[9] wrote, 'we now have 50 years of experience with medicalised birth, and the objective record of safety is good. In comparison, there is scant evidence on even short-term outcomes of less interventionist models of intrapartum care, and virtually no long term information.' When you think of all the research that has supported doing less rather than more in birth, when you think of all the papers on midwifery models of care I felt like responding with an article, *choking the mother with the CTG belt*, but this wouldn't have been helpful.

We have in fact more and more evidence that medicalising birth has serious consequences, both physical and psychological. The VGDHS[10] into postpartum haemorrhage showed a concerning rise in placenta praevia and hysterectomy and these are strongly linked to the rising caesarean section rate. In the latest Australian Maternal Mortality report 1997–1999,[2] obstetric haemorrhage led as the most common cause of direct death (eight deaths compared to five in the last triennium). The next report looks like it will follow this trend. Women are dying from lack of heath care in the developed world. In the developing world are they starting to die from too much unnecessary intervention? We need to keep questioning this as midwives and women, as we need to question the cost associated with a highly interventionist medical model of maternity care such as we have in this country.[11] We need to question the authority obstetrics seems to think it has to 'overcome death' as this gives them immense power. As Jo Murphy Lawless says in her wonderful book *Reading Birth and Death* (1998), 'obstetrics must no longer be permitted to overcome death for women and babies, as if it alone can pronounce on that, as if it alone has the remit to produce authoritative knowledge. It must not be permitted to deny its continuing repetition of violence, by denying women's agency, simply because death is its unidentified foe'.[12]

Ever since medical men came into the world of childbirth this fear mongering has been going on. English midwife Elizabeth Nihell described this in 1760 as a 'cloud of hard words ... a cloud which is oftener the cover shape of ignorance than a vehicle of true knowledge, and perhaps oftener yet the mask of mercenary quackery than a proof of medical ability'.[13]

Power is held in the maternity service, by the wrong people, for the wrong reasons and it has serious implications. Midwifery care threatens doctor's incomes, power base and a deeply held faith in the medical model, so of course it's going to be a long hard struggle. The best of our obstetricians will not support midwifery led care when it could impact on their hip pocket. Obstetricians cannot ethically say 'we are worried about our incomes and power base'. They argue safety and instill fear.

As the secretary of the NSW Midwives Association I deal with the political face of maternity care almost daily. We must be very clever when we go public that we do not just add to the fear. The problem is after years of playing this political ping-pong; with the media greedily rubbing their hands together as they scoop yet another front-page story of obstetricians and midwives bashing each other up, I have realized it is not the most effective strategy. We must respond strongly when allegations are made about midwifery care, like the Queensland midwives did so well when the term 'the killing fields' was used recently by an obstetrician describing a midwifery model of care.[14] We must also strategise to get positive stories into the media and to be most effective we should make sure consumers and their stories are central. The divide between midwives and obstetricians threatens the safe care of mothers and babies. We need to collaborate and I see one of the best ways to do that in the future in Australia is to promote the employment of staff specialists in the maternity service. They often have a commitment to public health-a more evidence-based approach and are less financially and professionally threatened by midwifery care compared to private obstetricians.

Marketing midwifery

Midwives need to market themselves if they are ever to become a first rate option of care for women in this country and in many countries. We know we are wonderful, but do women, do health services, do parliamentarians, premiers and prime ministers also know what we are really capable of contributing?

If I were to ask each one of you what you thought a midwife was and did I would get slightly different answers. In this country we are trying to define the scope of practice of a midwife and I can tell we do not agree and we in fact often disagree vehemently. If we don't know what we are and what we should be doing how do we expect the public to know and how do we expect the profession, if indeed that is how we see ourselves, to market itself?

Midwifery needs an extreme makeover! For many years in this country we have been trying get people to call us

midwives, not nurses. We are getting there with this but how the public views us and our role still needs a lot of work. We need to do some serious work in this country and in many others on the notion that we are not a second rate option, we are a first rate choice.

The industry of fear

Fear runs as an undercurrent through birth. Fear is ruining birth and its ruining life. Fear is robbing women of power. A future based on fear is no future at all. Grayling wrote, 'what we fear comes to pass more rapidly than what we hope-mainly because we make it so'.[15]

I gave a paper at the NSW State conference in 2004 called 'War on Terror' (unpublished) and in it I likened the hunt in Iraq for weapons of mass destruction, known to us all as WMDs, to the hunt in the maternity service for WMDs or Women who May be Dangerous. Like in Iraq, we expend a lot of energy hunting our WMDs down. We invade their bodies with ultrasounds and tests, strapping them to monitors, breaking their waters to see the colour of their liquor. When we are not sure we take no chances. We see danger, danger everywhere. Like in Iraq we often find empty sheds, empty fields and the odd chicken farm. But our response is often to ignore the evidence and continue to do what was always intended. Invade and keep looking for those WMDs.

Just to help you recognize the fear when you go back to your organizations here are some hints:

- Fear is the loudest voice in the birth-room.
- Fear is bright lights and slamming doors.
- Fear is a the doctor, who is paid a lot of money to say, 'just to be safe we'll do another ultrasound.'
- Fear is the trembling registrar who wants to augment and section everyone in the delivery ward because she was yelled at last night over a case that went wrong.
- Fear is the sobbing woman who has lost her baby and is looking at the door wondering when someone will be brave enough to come and sob with her.
- Fear is the midwife who enters the birthing room less as the woman's cries intensify.
- Fear is the machine that goes ping hastily strapped to the woman who just came in going pushhhhhhh.
- Fear is the big white patient board that everybody looks at and asks, 'why has she not delivered yet?'
- Fear is doing to rather than being with.
- Fear is the wide look of terror in a woman's eyes.

Fear makes us see danger everywhere and in seeing it we create its reality. We need to make fear serve us rather than master us. When fear serves us it protects us. When it masters us it destroys us. We need to respond to the fear of childbirth not with certainty but by working with women and embracing their uncertainty. Our job as midwives is to go on a journey with women whatever twists and turns that journey takes. Our job is to share in the laughter and the tears—to guide when we see danger that we recognise and to support when we see opportunity.

Where two worlds meet

When we move from the developing to the developed world we find there are women in our developed world who are disadvantaged even before they enter our health system. I want to briefly touch on these women because they need midwifery care as part of their future. These women are often less visible and yet have important needs.

Culturally and linguistically diverse women

In a focus group I held with Moslem women in the community in Sydney, a very wise older Indonesian woman who had come to see what all the young girls were up to said. 'I think some women don't realize the amount of control they can have if they could communicate. So perhaps during the visits women should be told they do have a voice' (Focus Group, October 2002). What this woman recognised was health begins with powerful women.

The hospital where I ran the focus group has one of the highest unemployment rates and lowest index of social advantage of all local government areas in Sydney. Nearly 75% of women are from Culturally and Linguistically Diverse (CALD) backgrounds.[16] As midwives, these women provide us with immense challenges and immense opportunities. Many of them have significant health disadvantages and many are further disadvantaged by how our health systems respond to them. As midwives we need to be very careful that we are part of the solution not part of the problem. I listen to the way these women are talked to sometimes and I know I would not come back! Do we tell women they have a voice or does everything we do and say silence that voice?

In my organisation, we found many of the Moslem women, in particular, were dissatisfied with our service and increasingly they avoided contact with it. These women comprised 32% of our clients[16] and many had significant risks. The way we had structured our service, often fear based, was leading to avoidance of our service and causing a real reason to fear. It was time to stop saying 'it's all their problem' and start owing it as our responsibility.

We decided to ask the women what they wanted from our service and they told us, as women do when we ask. They wanted: access to female practitioners, cultural sensitivity, choices in maternity care, respect, trust and advocacy. We implemented many changes as a result, including providing continuity of care, an Arabic speaking midwife to run clinics and education and one of the first Midwife Practitioners in NSW. The change was remarkable and women began to come from other hospitals to have care with us.

As this woman in the focus group said ''When you come to seek medical help, feeling comfortable mentally is half the treatment. It's not just physical treatment'' (Focus Group, October 2002). Midwifery as a social model of care believes in the individual and the complex social, psychological and economic forces that shape health. We recognise the impact of poverty, mental health, support, violence on women's health and we know that we should be led by women to where their needs are and address these on an individual basis.

Aboriginal and Torres Strait Islander maternal and perinatal health

Celie the wonderful character in Alice Walker's book, *The Colour Purple*, said to her husband after years of abuse, 'until you do right by me, everything you even dream about will fail'.[17]

I often think of these words when contemplating the health of our Aboriginal and Torres Strait Islander peoples. Until we do right by them much of what we try is going to fail. Until our Prime Minister John Howard can bring himself to utter the word 'sorry' on behalf of the nation, can healing really begin? The wounds sustained through generations of ignorance and downright cruelties are deep. We have been part of robbing Indigenous people of their dreams and no one can live without their dreams.

The New South Wales Aboriginal Perinatal Health Report[18] identified three things needed to improve Aboriginal perinatal health in NSW:

1. Strong cohesive Aboriginal communities with raised living standards
2. Empowered Aboriginal women
3. Accessible and appropriate maternal health services

These are amazingly similar to some of the Safe Motherhood Initiative high priority action messages. The Aboriginal and Torres Strait Islander populations demonstrate health outcome disadvantage for every public health parameter and maternal mortality reflects this also.[2] The maternal mortality rate remains three times higher than that for non-Indigenous women.[2]

The perinatal death rate for Indigenous babies (20.1/1,000) is over twice the rate for non-Indigenous babies (9.6/1,000)[19] and the percentage of low birth weight infants is also double (12.9% versus 6.4%).[20] Aboriginal and Torres Strait islander women are almost twice as likely to present late in pregnancy for their first antenatal visit, more likely to have teenage pregnancies, more likely to smoke, and fall victim to abuse and violence and to be involved in high risk behaviour such as smoking, drugs and alcohol than the rest of the population.

In the report Re-birthing women interviewed from rural and remote areas said, 'the most asked question was not 'how is it all going?' or 'how are you feeling?' but 'when are you going away?' (cited in[8]). The reality is that relocation in late pregnancy is far more likely to affect Aboriginal and Torres Strait Islander women. These women find this particularly distressing because of the cultural links between the process of birth and the meaning of the land in some cultural groups.

Failing to observe the relevant rituals and laws during pregnancy presents a grave risk to the health of both the mother and baby and the long-term health of her people. For Aboriginal women, being separated from their land, language, culture and families during the birth of their children, removal to the regional hospital represents unacceptable risk.[21] Some Aboriginal women identify giving birth in the hospital as the cause of infant mortality. As a result of not being welcomed properly into the world, and the appropriate ceremonies not being performed, the baby's weakened spirit gets sick.[22]

Removing these women from their homes is unsustainable if Indigenous people are to be strong. Hirst[8] states in her report that, the principle of returning birth to Aboriginal and Torres Strait Islander communities must be affirmed by government, with steps taken to empower women and educate more Aboriginal and Torres Strait Islander carers so this can happen safely. This must include what Aboriginal and Torres Strait Islander women define as safe.

We desperately need a primary health care approach to Indigenous health that looks beyond the health sector and the medical causes of illness. Important issues like education, employment and empowerment of women and communities is needed through partnerships with communities, and government and non-government agencies.[18] Birth needs to be returned to Indigenous communities. We need to be part of the solution not the problem. The solution begins with empowered women and communities. Midwives, working alongside Indigenous health workers in their communities, are an effective way to do this.

Remote and rural women

I want to move on next to the subject of rural and remote women. The reality of rural and remote living in many parts of Australia is women are routinely required to travel for some or all of their pregnancy, birth and post birth care. Here is a quote from a woman in remote Australia cited in Re-birthing,[8] 'I'm pretty lucky really-I'm only 150 km from a GP. I did find though that with antenatal classes they are really geared for town families. They always hold the classes at night, when the roos are really bad.'

Hirst pointed out in her report that in the last ten years thirty-six of the eighty-four services in the public sector providing maternity care in Queensland have now shut down.[8] This is astounding. This closure of small maternity units in both regional and metropolitan areas in Australia and other countries has escalated in the last decade. The reasons for this are all familiar. Safety concerns due to workforce shortages and inability to recruit and retain midwives, general practitioner obstetricians and/or anaesthetists. There is also a commonly held belief that there is a volume threshold of numbers of births below which safety will be compromised. No one seems to know exactly what that is. I've discovered that if you're a professor of obstetrics then it is anything smaller than the unit you are working in, usually anything less than 2000 births per year.

After sitting in meetings and hearing this constant rhetoric of the lack of safety associated with small units I finally found a kindred spirit in Sally Tracy who took on the topic and we embarked on a study into the safety of giving birth in small maternity units in Australia.[23] This study showed that for women with low risk pregnancies, neonatal mortality was not influenced by hospital volume. However, for low risk women giving birth in the smallest hospitals, interventions like induction of labour, augmentation, epidurals, instrumental birth, caesarean section and admission of babies to a neonatal unit were all significantly less than in hospitals with higher volumes.

As midwives we really need to challenge these assumption because if we do not, we will find them becoming a reality. There are so many opportunities for innovative models of

care where midwives, general practitioners and obstetricians can work together so women can access care that 'is local or feels local.'

As midwives I believe we have a social responsibility. We have a responsibility to research, question, document, debate and advocate for women. We will never change the world until we are willing to really be there for women. We have a choice between apathy and activist. While women still lack power in relation to their bodies, their fertility, their babies, and indeed their lives in many countries, we still have a job to do. Childbearing will only become safe when women are empowered, when they gain better access to education, economic independence, better status in their communities, a greater control over their reproductive lives, and better access to essential services. Women need welcoming, sensitive midwives who are skilled and responsive and see every woman as an individual as though no one else exists but her. When women see this respect and readiness in our eyes, this willingness to go on a journey of discovery and growth with them then they will see the true beauty of midwifery and will find within themselves the true beauty of their womanhood.

Conclusion: 'A Field of Dreams'

In the movie, *A Field of Dreams*, Ray, the character acted by Kevin Costner, keeps hearing a voice that says 'if you build it he will come.' He doesn't understand the voice but he plows up his cornfield and nearly sends his family broke building a baseball field in rural Iowa. He is determined not to turn into his father who was old before he was young because he never had a dream. One by one old base balers from the past return to play on the field and his life is changed forever.

I often hear this voice when contemplating the future of maternity care and how midwives can create that future. What I often hear said in reality though is, 'when they come then we will build it.' This is a very understandable attitude. It is the reality we are faced with everyday. The challenge for us as midwives is to make the change happen, not wait for change to happen. The challenge for us is to begin hearing voices and to start having dreams and then be willing to make these dreams become a reality.

Midwives are indeed standing at the edge of history. As we look to the past for guidance, the present for our realities and our tomorrows for our potential will we passively try and predict the future or will we actively try and create it. The future for midwives is the women we care for, the babies they are birthing and the society we are all creating. The future is often different to what we predict and much more like what we create. We all need to have a dream for the future because it is from our dreams that we create our realities. This is my field of dreams for the future:

- I dream of a future that gives all women the same choices, opportunities and outcomes.
- I dream of a future where tenacious midwives help make this happen.
- I dream of a future where there is reconciliation with our Indigenous people—where our Prime Minister says 'sorry' and with this healing begins.
- I dream of a future where we do not look around for someone else to fight injustice but we fight it ourselves.
- I dream of a future where we do not shut down more maternity units but create sustainable models of care that have women at the heart.
- I dream of a future where we know the difference between safety and stupidity.
- I dream of a future full of strong midwifery researchers who ask the questions women need us to ask.
- I dream of a future where champions and leaders revere birth.
- I dream of a future where some of us chain ourselves to the gates of Parliament and others to become parliamentarians and neither of us think the other is better or worse.
- I dream of a future where midwives have Medicare provider numbers.
- I dream of a future where we access affordable insurance.
- I dream of a future where there are many more midwives and most of them are under forty rather than over forty.
- I dream of a future where we are not part of the problem but part of the solution.
- I dream of a future where midwives are seen as a first rate choice for childbearing women.
- I dream of a future where a midwife is present at every one of the 136 million births that occur every year.
- I dream of a future where consumers take the lead and midwives walk beside them, just like childbirth.
- I dream of a future where every woman can access continuity of care with a midwife.
- I dream of a future where there are no strangers at birth.
- I dream of a future where health professionals collaborate.
- I dream of a future where Re-birthing has 'endorsed and fully supported by the Queensland government' stamped across every page (this dream has recently come true).
- I dream of a future where our daughters, nieces and granddaughters are strong, confident in their womanhood, positive about motherhood and sure of their place in this world.
- I dream of a future where we can still believe and make all these things happen after we have left the wonderful collegiality and protection of this conference and re-entered the real world.

What about you? Are you brave enough for this future? For it is true we get in life what we have the courage to ask for. What do we as midwives have the courage to ask for? Nelson Mandela said, 'our deepest fear is not that we are inadequate. Our deepest fear is that we are powerful beyond measure. It is our light not our darkness that most frightens us ....and yet when we let our light shine, we unconsciously give people permission to do the same. As we are liberated from our own fears, our presence automatically liberates others.' As we stand at the edge of history with the future blowing wildly in our faces. As we see the air brightening at times and blinding us at others let us remember that we are powerful beyond measure and our greatest power is we are midwives: we are with women!

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