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DISCUSSION

Birth Territory: A theory for midwifery practice[☆]

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Received 23 March 2006; received in revised form 9 May 2006; accepted 9 May 2006

KEYWORDS

Midwifery;
Theory;
Power;
Birthing centers;
Natural childbirth

Summary The theory of Birth Territory describes, explains and predicts the relationships between the environment of the individual birth room, issues of power and control, and the way the woman experiences labour physiologically and emotionally.

The theory was synthesised inductively from empirical data generated by the authors in their roles as midwives and researchers. It takes a critical post-structural feminist perspective and expands on some of the ideas of Michel Foucault. Theory synthesis was also informed by current research about the embodied self and the authors' scholarship in the fields of midwifery, human biology, sociology and psychology.

In order to demonstrate the significance of the theory, it is applied to two clinical stories that both occur in hospital but are otherwise different. This analysis supports the central proposition that when midwives use 'midwifery guardianship' to create and maintain the ideal Birth Territory then the woman is most likely to give birth naturally, be satisfied with the experience and adapt with ease in the post-birth period. These benefits together with the reduction in medical interventions also benefit the baby. In addition, a positive Birth Territory is posited to have a broader impact on the woman's partner, family and society in general.

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Introduction

A vision without action is a daydream
Action without vision is a nightmare

Japanese Proverb

Midwifery is a nascent academic discipline with relatively little formal theory to guide practice and research. At the heart of midwifery is the well-being of woman and child.

Theory provides the broad vision that shows how midwives can work toward that dream at midwifery's heart. This paper introduces the theory of Birth Territory and describes and defines essential elements of theory development. It outlines the background literature of Birth Territory and presents the key concepts: firstly, 'terrain', with its sub-concepts of 'sanctum' and 'surveillance room'; and secondly, 'jurisdiction' including sub-concepts of 'integrative power', 'disintegrative power', 'midwifery guardianship' and 'midwifery domination'. The second section of the paper presents two contrasting birth stories that demonstrate the clinical significance of the theory; strengths and weakness of the theory are then discussed.

Our aim in developing this theory is that Birth Territory will eventually be taught to midwifery students and used to

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guide maternity service policy development and delivery suite design. The concept of Birth Territory forms the title of an upcoming book that will provide more detail and applications than can be attempted in a journal article. The aim of this paper is to present a timely and succinct overview of the theory of Birth Territory so that it can be discussed, critiqued, refined and further developed for testing via research.

Background

The importance of the environment to birth is often asserted in the midwifery literature. For instance, Gould¹ asserts that the standard hospital birth suite acts subliminally to medicalise birth in the mind of the woman. Walsh² writes about the negative impact of a 'bed birth' and argues for mobility in labour and removing the bed from centre stage. A British survey conducted by the National Childbirth Trust evaluated women's experiences of their birth environment.³ Over half of the women who said each of the following factors were highly important did NOT have access to them when giving birth: control over temperature, a pleasant place to walk, sufficient pillows, floor mats and bean bags, a homely non-clinical environment, not being overheard by others, control over who came into the room and a place to get snacks and drinks. Furthermore, a birth pool, comfortable chair for companions, easy access to toilet and shower facilities and control over light intensity were not available to one-third of the women yet these women identified them as highly important characteristics of their birth environment. A limitation of each of these studies is that the mechanisms by which the possible environmental benefits ensue are largely un-theorised. This creates the problem that without explicit theory the positive attributes of the birth environment can be thought of as luxuries.

The theory of Birth Territory fits within a critical post-structuralist feminist framework while our power-related concepts build upon some of the ideas of Michel Foucault. The theory derives from reflections upon our empirical experiences as midwives and researchers. It has evolved in parallel with research and on-going theory development about women's embodied sense of self during childbirth. However, 'Birth Territory' has been inductively developed primarily by synthesis of new ideas based on analysis of existing data. This method is a recognised strategic approach to theory development.^{4,5}

Theory development: definition of terms

This section defines key theoretical terms and applies these terms to examples from the Birth Territory theory. A theory presents a systematic view of phenomena by specifying the interrelationships between concepts using definitions and propositions with the purpose of explanation and prediction.⁶ A concept is an abstract idea of phenomena, objects or actions.⁶ For example, two concepts from Birth Territory theory are 'terrain' and 'jurisdiction'. Propositions are statements of relationship between two or more concepts. Propositional statements provide theory with descriptive, explanatory or predictive powers.⁷ For example, a propositional statement in the theory of Birth Territory is "the less

familiar the environment is to the woman the more likely she is to feel fear and uncertainty".

The theory of Birth Territory is a mid-range theory, which is a theory that is less abstract than a grand theory because it has a more specific, narrow focus. By comparison grand theories are at a high level of abstraction as they address the mission, goal and nature of the discipline.⁷ The Midwifery Partnership theory⁸ is of this type.

It is commonly agreed that mid-range theories are distinguished by having concepts that are defined in ways that make them amenable to research testing. Further, mid-range theories have concepts that are linked together in causal or correlational propositional statements.⁶ When concepts derived from a theoretical definition are expressed in ways that can be measured in scientific research they are called variables. For example, a Birth Territory sub-concept 'sanctum' could be measured by creating a quantitative tool to measure the degree to which a particular birth environment is rated as homely, has a closed door, or has a bath. The translation of concepts into research variables is called concept operationalisation; it requires further development and testing by researchers.

The systematic evaluation of Birth Territory theory is beyond the scope of this paper. However, the reader may wish to consider if the theory is useful to midwifery practice and research. Fawcett recommends evaluating a theory by considering if it: is significant to the discipline's practice; has internal consistency and logic; is clear and parsimonious; is testable by research.⁹

The theory of Birth Territory

Birth Territory is the central, overarching concept of the theory. In particular, Birth Territory refers to the features of the birth room, called the 'terrain', and the use of power within the room, called 'jurisdiction'.

Terrain

'Terrain' is a major sub-concept of Birth Territory. It denotes the physical features and geographical area of the individual birth space, including the furniture and accessories that the woman and her support people use for labour and birth. Two sub-concepts, 'surveillance room' and 'sanctum', lie at opposite ends along this continuum called 'terrain'.

'Sanctum' is defined as a homely environment designed to optimise the privacy, ease and comfort of the women; there is easy access to a toilet, a deep bath and the outdoors. Provision of a door that can close meets the woman's need for privacy and safety. The more comfortable and familiar the environment is for the woman, the safer and more confident she will feel. An experience of 'sanctum' protects and potentially enhances the woman's embodied sense of self; this is reflected in optimal physiological function and emotional wellbeing.

'Surveillance room' is the other sub-concept of 'terrain'. It denotes a clinical environment designed to facilitate surveillance of the woman and to optimise the ease and comfort of the staff. This is relevant to the concept of 'jurisdiction' (discussed below) and it is consistent with Foucault's notion of disciplinary power.¹⁰ A 'surveillance room' is a clinical-looking

room where equipment the staff may need is on display and the bed dominates. It has a doorway but no closed door, or the door has a viewing window. The woman has no easy access to bath, toilet or the outdoors.

The more a birth room deviates from a 'sanctum', the more likely it is that the woman will feel fear. This deviation from the 'sanctum' will in turn reduce her embodied sense of self; it will be reflected in inhibited physiological functioning, reduced emotional wellbeing and possibly emotional distress.

Jurisdiction

'Jurisdiction' means having the power to do as one wants within the birth environment. 'Power' is an energy which enables one to be able to do or obtain what one wants.¹¹ Power is essential for living; without it we would not move at all. Power is ethically neutral; this is consistent with Foucault's notion of power which he argued was productive; not necessarily oppressive.¹² Power can be used to get others to submit to one's own wishes. Health professionals who want women to submit to their authority (to be docile) normally use a subtle form of coercive power that Foucault called 'disciplinary power'.^{13,14} 'Jurisdiction' is comprised of four sub-concepts that are related to each other: there is one continuum of 'integrative power' and 'disintegrative power' and another continuum of 'midwifery guardianship' and 'midwifery domination'.

'Integrative power' integrates all forms of power within the environment to some shared higher goal. For Birth Territory, 'integrative power' may refer to the use of power by the woman, the midwife and any other person in the environment. The primary aim of using 'integrative power' is to support integration of the woman's mind and body so that she feels able to respond spontaneously and expressively to her bodily sensations and intuitions (instinctive birthing). Instinctive birthing is when the woman accesses this embodied power during labour and birth, thereby labouring and giving birth spontaneously.

When the woman needs to make decisions about her care options then the use of 'integrative power' harnesses the power of all participants in the birth environment so that all power is focussed on the woman's enhanced mind-body integration and consequently, on her self-expression and confidence in being the one who is making the ultimate choice about what happens. Importantly, the use of 'integrative power' supports the woman to feel good about her self even if the birth outcome is not as she had wished.

'Midwifery Guardianship' is a form of 'integrative power' that involves guarding the woman and her Birth Territory; this entails nurturing the woman's sense of safety through the respect of her attitudes, values and beliefs.^{15,16} 'Midwifery guardianship' means controlling who crosses the boundaries of the birth space and preventing, as far as possible, any person within the Birth Territory from using 'disintegrative power'. 'Midwifery guardianship' promotes and respects the woman's 'integrative power' enabling the woman to experience undisturbed labour and birth. Lack of disturbance is critical for the labouring woman, it enables her to feel safe enough to let go of the need to be on guard herself. When the woman can release responsibility for guardianship to the midwife she is most able to fully experience and respond to her bodily sensations making instinctive birthing more likely.

'Disintegrative power' is an ego-centred power that disintegrates other forms of power within the environment and imposes the user's self-serving goal. 'Disintegrative power' may be used by the woman, the midwife and/or any other person in the territory. When it is used by the woman it is an ego-based determination to have a particular experience or outcome. Regardless of who uses it, 'disintegrative power' undermines the woman's confidence to be able to feel, trust and respond spontaneously to her bodily sensations and intuitions. This is a disintegration of the woman's mind-body unity that separates her from her embodied power to birth instinctively. 'Disintegrative power', when used by professionals, undermines the woman as the decision-maker in her own care. The use of 'disintegrative power' by maternity clinicians diminishes the woman's sense of self regardless of the birth outcome.

'Midwifery Domination' is a form of 'disintegrative power' that is based on the use of disciplinary power. Disciplinary power is a subtle and manipulative form of power that is usually not able to be detected until the subject of power offers resistance.^{10,14,17} 'Midwifery domination' is disturbing because it interferes with the woman's labouring process by inducing the woman to become docile.¹⁰ Being docile requires the woman to follow the midwife's guidance and therefore give up her own embodied knowledge and power.

The clinical stories

Two birth stories, those of Tara and Lily are presented below. Both births occur in hospital but in other respects they are different; it is this contrast that allows us to exemplify the concepts and illustrate the significance of the theory. As Birth Territory theory falls within critical post-structural feminism this is reflected when the theory is applied to the stories. We are aware that the honesty of the critical stance can create unpalatable reactions and we acknowledge that others may have different perspectives of the stories. While other people may have other perspectives, critical feminism is in our opinion preferable in this situation because it can take into account more of the available data than other methodologies.

Application to Tara's birth in a 'surveillance room'

One of us observed the following episode as a researcher.¹⁸ Our interpretive comments linking this story to the theoretical concepts are in **bold** at the end of each relevant section.

Tara (not her real name) was nineteen years old, having her first baby and well known to me as a research participant. With my help Tara had devised a birth plan, which included that she would have an epidural if she felt she could not cope with the pain.

At 6 am, Tara had been labouring for about eight hours when she asked someone to telephone and request that I come in. The delivery suite was on the third floor of the hospital. I walked straight in to the room as there was no door, just a pink curtain partly covering the entrance. Tara was in a large, modern, clinical-looking room. All the furniture was made of metal. It had two windows but the view

was of another building. The room was air-conditioned but not cold. The lighting was by artificial recessed fluorescent tubes. There was a large, mobile operating theatre light (turned off) hanging over the bed. There was oxygen and suction on the wall.

A baby resuscitation trolley was 'hidden' behind a pink screen (although clearly visible to me). The bed was in the centre of the room; its end was facing the curtained doorway. Tara was lying on her side on the bed, covered by a sheet. Her mother sat quietly beside her. Tara was awake and apparently relaxed. She had a working epidural, and an electronic fetal monitor was attached. This is a 'surveillance room' and there is no evidence that Tara has any 'jurisdiction'.

Shortly after I arrived the epidural wore off and Tara wanted it topped up. Her request was refused by the midwives who explained that as her cervix was fully dilated she would not feel the urge to push and have a normal birth if she had a working epidural. Tara said she did not care about a normal birth, she just wanted the epidural topped up but the midwives would not do what she wanted. This is 'disintegrative power' and 'midwifery domination'.

After the refusal, Tara became passive and sullen and continued to want the epidural topped up but she was not assertive in making this clear. Evidence of submission and docility is accompanied by reduced emotional wellbeing.

I urged her to speak up for herself, which she did. Shortly afterwards the senior medical registrar (whom Tara had never seen) came in and stood at the end of the bed and said, with a degree of anger, 'we will top you up but you will probably need forceps now and that can damage the baby's head. You are a selfish girl who is putting her baby at risk'. Not waiting for a response, he walked out and was never seen again. This is 'disintegrative power' and medical domination.

Tara turned her face away and without talking she cried softly. Except for crying she was essentially silent for the rest of the labour. Throughout the rest of the labour Tara was passive and sullenly compliant. This is evidence of serious emotional distress and submission. The theory, via the concept of 'disintegrative power' predicts that Tara will not be able to birth independently because of this emotional distress and disempowerment.

The epidural was finally topped up but only worked on one side so Tara continued to feel the pain fully on one side. After the episode with the doctor Tara's contractions became less frequent and much shorter. On medical orders the midwives began a Syntocinon infusion. Tara was given no further midwifery support. She was left for six hours in second stage with no progress. This is evidence of suboptimal physiological function related to the use of 'disintegrative power' that has disturbed labour process.

Finally, the senior midwife spoke to the junior doctor who decided to do a vacuum delivery and an episiotomy. This is 'disintegrative power' and 'midwifery domination'.

For Tara, the negative Birth Territory during labour and birth was experienced as a painful ordeal. The outcome for her was a very unhappy postnatal period with major postnatal depression. Tara did not breastfeed and did not bond well with the baby.

We recognize that the Birth Territory alone cannot, in any simple, reductionistic way be 'blamed' for the negative outcomes of mother and baby. We are claiming though, that

these experiences did contribute to her emotional distress and postnatal depression. We are also claiming that a positive experience of Birth Territory is likely to have had a very different outcome.

Application to Lily's birth in a 'sanctum'

One of us was a midwife at this birth and recorded this as part of professional journaling. The story has been approved for publication by the woman and the other participants at the birth. All names have been changed. Once again our interpretive comments that link to the theoretical concepts are **bolded** at the end of each section.

Lily was having her first baby and labour had progressed well. She stayed in the deep birth pool for eight hours using meditation techniques to cope with the pain. Greg (Lily's partner) was a quiet, loving and supportive presence. Karen (the other midwife) and I were quiet and unobtrusive, however, in line with medical protocols we recorded Lily's blood pressure and pulse hourly and assessed the baby's heart rate 15 minutely. The 'jurisdiction' of the space is Lily's and the midwives are acting as midwifery guardians.

Labour had begun with the baby's head in an occipito-transverse position but we were hopeful that the head would rotate naturally. All went well until transition, which continued for about three hours. During the first part of this time, Lily wanted to get out of the bath and change positions and we encouraged her to follow this inner instinct. 'Integrative power' is being used by Lily and the midwives.

As the time progressed and we saw no signs of second stage, Karen suggested that Lily move her hips in particular ways to assist with pelvic opening. With great strength, courage and endurance Lily followed Karen's advice and squatted, walked, tried hands and knees position and tried the birth stool; all to no avail. This is a use of 'integrative power'; it brings midwifery power/knowledge to the situation and integrates with the power of the woman and her body.

We discussed with Lily and Greg that on palpation the baby's head was still in the occipito-transverse position. A vaginal examination confirmed that the head may indeed be a bit stuck. As the cervix was not yet fully dilated the obstetrician (Jonathan), whom they knew a little, suggested to Lily that she may want to have her contractions strengthened by the use of a Syntocinon infusion. Jonathon's use of power/knowledge is integrative as it leaves the choice of having Syntocinon up to Lily.

These words had an almost immediate effect on Lily. She turned on her side, went physically limp as if giving up, and cried. She said, "I don't want Syntocinon". Up until this point Lily had been strong and active, suddenly she appeared weak and passive. Lily's ego-based determination to have a particular experience has created 'disintegrative power' that has undermined her embodied sense of self causing a loss of power illustrated by her weakened passivity.

Karen spoke firmly to her. "No, Lily, you do not have to have Syntocinon. There are midwifery strategies that we can try, you can still have a normal birth, but we need you to be here and fully present. You need to come back here right now and you need to be strong and courageous. I want you to get up and start moving. Greg", she directed, "I want you to come and help Lily. Jonathon", she said, and turned to him,

“can you give us 40 min and come back then”. Jonathon agreed and quietly left the room. This is the midwife using ‘integrative power’. Karen moves to reverse Lily’s use of ‘disintegrative power’, she uses ‘integrative power’ to call for Lily’s fully embodied presence.

The effect of Karen’s powerful intervention was amazing. Lily regained her strength and confidence. With fortitude and grace Lily got up and started moving as Karen instructed. She began stepping sideways up the steps of the birth pool with Greg providing physical and psychological support. After a time Karen advised squatting for a few contractions and Lily did this; again with Greg’s loving support. This movement went on for the next 40 min of labour with all of us actively involved in supporting Lily and listening to the baby’s heart sounds every 15 min. This is ‘integrative power’ in action.

During this time Lily’s facial expressions showed she was in pain, but she did not complain or cry out; she was too busy putting all her energy into helping her pelvis to open and the baby to turn. This is evidence of her greater mind–body integration and enhanced embodied sense of self.

After talking quietly together, Karen and I agreed that there were three options if the head did not rotate within the 40 min allocated. We discussed them with Lily and Greg before Jonathon returned. This is ‘midwifery guardianship’.

When Jonathon got back he examined Lily and found her fully dilated but the head was still in the occipito-transverse position. At this point, all five of us discussed the three options for moving forward. Lily chose a manual rotation. Jonathon said it might be too painful but he was willing to try if Lily was. With Lily sitting on the birth stool, Jonathon performed a manual rotation when Lily had a contraction. The head moved easily into the correct position and baby Declan was born normally about two hours later. This is the use of ‘integrative power’.

Immediately after birth Lily, Greg and baby Declan were bonding beautifully, nearly two hours later Lily birthed the placenta with minimal blood loss and they went home after four hours. Lily and Greg described amazing feelings of being overwhelmed with love for Declan. Lily was proud of herself and very pleased with Greg’s support in labour. Greg was proud of Lily and himself; they were both thrilled with the outcome. Lily and Declan proceeded to have a positive postnatal and breastfeeding experience.

Lily, Greg and I discussed the birth about a week afterwards. They were convinced that the respectful and positive care that they received prevented a caesarean section. When asked how she felt about Karen’s forceful intervention asking her to be strong, get moving and not give up Lily said “I thought she was great because she made me feel that what I wanted (a normal birth) was possible, that I did not have to give up. Someone else who really knew about birth believed in me and in my dream and I was able to trust myself again and to keep on going”. Evidence of how ‘midwifery guardianship’ and ‘integrative power’ can harness the woman’s own power while using midwifery and medical interventions only as they are specifically needed.

We acknowledge that the Birth Territory was not the only factor that was involved in creating the positive outcomes for Lily and her family. Lily had experienced continuity of carer with her midwives and knew us both well. In addition, she had personal characteristics that were central to her outcomes: she had read widely; had discussed birthing options fully with

her midwives; and she was committed to natural birth. The story above and Lily’s own words demonstrate, however, that Lily would have been most unlikely to have given birth normally had she been cared for in a ‘surveillance room’ without ‘midwifery guardianship’.

Discussion

Tara experienced negative Birth Territory in all aspects of ‘terrain’ and ‘jurisdiction’; she had no ‘jurisdiction’ over her room. ‘Midwifery guardianship’ was absent and ‘disintegrative power’, both medical and midwifery, was used. Labour and birth were an ordeal for Tara and the experience was a source of anger and shame. As the theory of Birth Territory predicts, Tara had a very negative postnatal period and difficulty bonding with her baby.

By comparison, Lily experienced almost ideal conditions for birth. She had a ‘sanctum’ to labour in and she experienced ‘jurisdiction’ over the territory. She used her own ‘integrative power’ and she was the beneficiary of the use of ‘integrative power’ by the midwives and the obstetrician. For Lily, the Birth Territory was experienced as nurturing so that labour, even though painful, did not involve anguish. As the theory predicts, she had an easy and positive postnatal transition, capably bonding with her baby and breastfeeding successfully.

Conclusion

The central proposition of the theory of Birth Territory is that when midwives create and maintain ideal environmental conditions maximum support is provided to the woman and fetus in labour and birth which results in an increased likelihood that the woman will give birth under her own power, be more satisfied with the experience and adapt with ease in the post-birth period. Lily and Tara’s contrasting stories have supported this proposition in terms of ‘terrain’ and ‘jurisdiction’. The factor that appears to have most impact on the woman’s embodied self is whether ‘integrative power’ or ‘disintegrative power’ is used. The role of the midwife to provide ‘midwifery guardianship’ in the Birth Territory seems to be paramount in promoting normal birth.

The following is a brief outline of the strengths of this theory based on Fawcett’s⁹ criteria. The theory is derived from reflections on practice thus demonstrating, at least on face value, that it is significant to midwifery practice. The concepts and propositions are used consistently and are logically structured in relation to each other. We have defined the concepts clearly and concisely and they are ready to be translated into variables so that they can be tested by research. This means that the theory is well enough developed to be evaluated, critiqued and tested.

However, there are limitations to the theory. The theoretical and empirical links between how women feel and how they function physiologically needs further development. The theory currently does not describe the mechanism that creates the broader and longer term benefits when ideal birth conditions are provided. Finally, the theory is currently focussed on the individual birth room but it would benefit from being developed at the social level so that theory could guide public practice about the desired location, structure and function of maternity services.

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