

1 **Freebirthing: A case for using interpretative hermeneutic phenomenology in**
2 **midwifery research for knowledge generation, dissemination and impact.**

3 **Introduction**

4 This paper has been generated from a primary research study carried out during 2015;
5 'making sense of childbirth choices; exploring the decision to freebirth in the UK'.

6 Freebirthing is characterised by a woman's *intentional* decision to give birth without
7 attendance by a midwife or doctor, even where there is access to maternity services.

8 This characterisation precludes women; who give birth before arrival (BBA) to
9 maternity services (Loughney et al., 2006) (either before arrival to hospital, or before
10 the arrival of a homebirth midwife), women who have been denied a homebirth
11 midwife by the local Trust (Plested and Kirkham, 2016), or women who have a
12 concealed pregnancy (Friedman et al., 2007). Freebirthing raises concerns with health
13 professionals, where there is potential morbidity or mortality to either the mother or
14 baby (Holton and de Miranda, 2016). Freebirthing also raises concerns regarding the
15 inadequacy of maternity systems to meet the needs of childbearing women (Dahlen et
16 al., 2011; Holton and de Miranda, 2016).

17 A systematic metasynthesis review of the literature (Feeley et al., 2015) identified only
18 four primary studies; n=1 Australia, n=3 US. The findings suggested that women chose
19 to freebirth as a way of rejecting both the medical and midwifery model of birth, to
20 reclaim and assert autonomy and agency during birth, and women reported a faith in
21 the birth process. There are known variations of healthcare systems between the UK
22 and that of the US and Australia, for example, the UK has a strong midwifery
23 workforce and culture that is supported by a free healthcare service and governmental
24 policies. The UK also has robust legislation supporting women's autonomous
25 decision-making, including the right to decline recommended treatment or care
26 (Birthrights, 2013a) and the legal right to freebirth (Birthrights, 2013b; Nursing and
27 Midwifery Council, 2012). However, at that time, whilst anecdotal data suggested a
28 growing incidence of freebirthing in the UK (Edwards and Kirkham, 2013), no primary
29 studies had been published. Thus situating the context of the original primary study,
30 to explore the phenomenon of freebirthing within a UK context using an
31 interpretative hermeneutic phenomenological approach.

32 Moreover, embedded into the original research aims was to share the findings to a
33 wider audience via a range of dissemination activities. This was felt to be important as
34 ongoing familiarisation with the wider literature and during my midwifery clinical
35 experience, it appeared that the phenomenon of freebirthing was often
36 misunderstood. As such, the purpose of this paper is twofold; firstly, using my
37 research into freebirthing as a case study, I will demonstrate the use and benefits of
38 interpretative hermeneutic phenomenology to midwifery and nursing research to
39 generate knowledge for the benefit of service users, healthcare professionals,
40 researchers and policy-makers. Secondly, I will discuss the activities I carried out to
41 enhance dissemination and impact for the benefit of service users and clinicians.

42 **Adopting an interpretive hermeneutic phenomenological approach**

43 This study adopted an interpretative hermeneutic phenomenological approach to the
44 research design, methods and analysis. Positioning the study within an interpretative
45 phenomenological methodology is integral to understanding both the research
46 processes and knowledge generated, as philosophy guides the research methods and
47 influences the knowledge that is generated (Grant and Osanloo, 2015).

48 Phenomenology is a discipline that is both a method of inquiry and a philosophical
49 view of the world that broadly focuses upon the lived experiences, meaning-making
50 and the contextual realities of human beings (Husserl, 1970; Heidegger, 1962;
51 Gadamer, 1960; Ricoeur, 1991). However, within this broad definition of
52 phenomenology, there are rich and complex variations of theoretical approaches (van
53 Manen, 2014). Whilst it is beyond the scope of this paper to explore the complex
54 variations of phenomenology, the following describes and justifies my use of an
55 interpretative hermeneutic approach.

56 Interpretive hermeneutic phenomenology is a particular philosophical approach
57 developed by Heidegger (1962) and further developed by Gadamer (1960) and later
58 Ricoeur (1991) (amongst other scholars) that looks beyond the description of a
59 phenomenon to explore meanings embedded within. Its aim is not to seek a unified
60 'truth' but to reveal the complexity of human experience that relates to a particular
61 phenomenon (Heidegger, 1962; van Manen, 2014). Emphasis is placed on the
62 subjective experience of the participant, integrating a person's socialisation,

63 enculturation and interpretation of the world to reveal the meanings they attribute to
64 their experience (van Manen, 2014). The illumination of an individual's sense-making
65 and meanings offers researchers an insights into people's experiences, motivations
66 and actions (Thomson et al., 2011; Regan, 2012).

67 Whilst there are many conceptualisations within interpretative hermeneutic
68 phenomenology that require understanding, here, I provide a brief overview of some
69 of those concepts. Heidegger's (1962) concept of '*lifeworld*' related to the notion that
70 the nature of human experiences is intrinsically entwined within historical, cultural,
71 political and social influences. These influences are perceived to provide the basis in
72 which a person comes to engage, understand and make sense of their '*lifeworld*'. As
73 such, Heidegger's (1962) notion of '*being-in-the-world*' means that one cannot separate
74 those influences from experience. Moreover, these notions are also related to the
75 hermeneutic concept that humans are self-interpreting beings (Heidegger, 1962), that
76 assumes life experiences are processed as an ongoing interpretative act embedded
77 within historical, sociocultural influences (Heidegger, 1962; Gadamer, 1960). This
78 includes the role of the researcher whereby preconceived notions known as '*pre-*
79 *understandings*' (Heidegger, 1962), are not seen as separate, but as part of the
80 interpretative examination of the phenomenon under focus. Rather than attempting
81 to bracket pre-existing notions, a researcher brings them to the fore as a starting point
82 of the interpretative analysis known as the hermeneutic circle (Heidegger, 1962). This
83 is an important divergence from other phenomenological approaches, notably
84 Husserlian (1970) phenomenology, where it is perceived it is possible to seek out the
85 essence of '*the thing itself*', that sits beyond such influences, and whereby it is
86 perceived possible to '*bracket*' preconceived notions of the phenomenon under
87 scrutiny.

88 Hans-Georg Gadamer (1900-2002) developed Heidegger's ideas further and further
89 conceptualised the researcher's own experience of reading and understanding to be an
90 integral part of the interpretative process in which the relating concepts of pre-
91 suppositions, inter-subjectivity, authenticity (trustworthiness), temporality (time
92 affecting understanding/emotion), tradition, and history to interpreting the written
93 word (Gadamer, 1960; Regan, 2012). As such, both the participant in sharing their

94 experiences and the researcher listening to them (and later during the
95 transcription/analytical process) are in a continuous space of interpretation (Gadamer,
96 1960). Through a continual process of reflection and interpretation, the participant's
97 accounts are considered individually and as part of the whole, whereby the researcher
98 produces a tentative interpretation of the phenomenon in focus (Regan, 2012;
99 Gadamer, 1960).

100 Applied to this study, I felt that interpretative hermeneutic phenomenology (as
101 informed by Heidegger and Gadamer) was appropriate to explore the lived experiences
102 of decision-making for women who had chosen to freebirth. The philosophical
103 approach aligned with my worldview that human experiences are embedded within a
104 complex relationship between socialisation, enculturation and individual
105 interpretations of their personal lifeworlds. Additionally, some researchers consider an
106 alignment between interpretative hermeneutic phenomenology and that of a
107 midwifery philosophy of practice i.e. a holistic approach to care that considers the
108 woman within both a biopsychosocial model, mirroring the conceptualisation of
109 'lifeworld' (Thomson et al., 2011; Miles et al., 2013). Furthermore, interpretative
110 hermeneutic phenomenology has been successfully used in a range of nursing and
111 midwifery research studies (Lopez and Willis, 2004; Thomson, 2007; Smith et al., 2010;
112 Longworth and Kingdon, 2011; Miles et al., 2013). Thus strengthening the case for using
113 it as a research approach.

114 **Applying the research approach**

115 Ethical approval was obtained from one of the ethics sub-committees at the author's
116 institution, and an amendment was approved in January 2015 (project number:
117 STEMH 208). The primary study was carried out in 2015 and recruited n=10 consenting
118 participants into the study via social media and email groups. The sample number was
119 appropriate for the research design (Smith et al., 2010). Data collection comprised of
120 two components: a self-written narrative about their decision-making with a follow-up
121 interview or an interview only. Nine of ten participants wrote a narrative and all were
122 interviewed. The sequential method of data collection provided two opportunities; the
123 participants could self-direct their narratives which provided an insight to the areas of
124 significance that were important to them individually with limited input from me, the

125 researcher. Secondly, I was able to 'get to know' the participant's story by pre-reading
126 the narrative, making notes, reflections, and making early analytical interpretations to
127 be explored in the interview. Moreover, the self-written narratives provided rich data
128 that ranged between 2-7 typed pages of text (841-3624 words), indicating that it was an
129 acceptable method of data collection. Interviews lasted from 30 minutes to 2 hours,
130 and one was conducted via an encrypted chat room at the participants' request. A
131 semi-structured interview style was adopted where questions were individualised for
132 each participant and were primarily open-ended questions to encourage further
133 dialogue based on the narrative provided.

134 Data analysis was carried out in a number of iterative stages. Following transcription,
135 both the self-written narrative and interviews were uploaded to MAXQDA
136 (maxqda.com, 2015), a qualitative software data programme designed to manage large
137 quantities of data. Each piece of data was coded line by line - significant phrases were
138 highlighted as part of an 'in-vivo' method whereby poignant descriptive phrases were
139 interpreted to create a code. This continued iteratively data was read and no new
140 codes were developed. Following the coding, an iterative writing process was carried
141 out as I attempted to bring together the individual accounts together with my
142 interpretations of their contextual meanings across the data set. Looking for
143 convergences and divergences within the data, and through a back and forth process
144 between the original data, codes and further writing, tentative interpretations were
145 explored. Through this process, a deeper level of immersion in the data, interpretative
146 insights developed a synthesis, a 'fusion of horizons'(Gadamer, 1960) that brought
147 together the individual participants into a 'whole', represented as interpretative
148 themes.

149 Following analysis, participants were invited to provide feedback on the findings to
150 confirm I had adequately captured their meanings associated with the decision to
151 freebirth. Whilst member checking is contentious within hermeneutic
152 phenomenology due to the interpretative processes (Bradbury-Jones et al., 2010), I
153 purposefully deployed member checking as a way of forging and maintaining trusting
154 relationships with the participants- a potentially vulnerable group due to the
155 subversive nature of freebirthing. Therefore, I felt it was important that they retained a

156 sense of ownership by reviewing the findings to ensure I had adequately captured their
157 perspectives. As such, during member checking, the participants were provided with
158 the overall findings, the integrated analysis across all of the participants, not just in
159 relation to their own experiences. The provision of the overall findings was a
160 pragmatic decision due to the time constraints of the study, and was also derived from
161 the participants reported interest in the final findings during the interviews and email
162 communications. It created the space for the participants to view their experiences in
163 relation to the others, and offered a means of further participation. This method of
164 member checking appeared to be acceptable to the participants as six participants
165 responded with positive feedback, for example:

166 *'I enjoyed the consolidation of a variety of viewpoints and reasoning's for choosing*
167 *freebirth, it further highlighted to me how unique birth choices are. I resonated more*
168 *with some themes over others. There are very nuanced differences in the decision making*
169 *process and I think your overview goes some way to addressing this and highlighting,*
170 *what I feel, is its significant relevance.'* (Alex, pn-8, email correspondence.)

171 **Knowledge production: Revealing complexities and unexpected findings**

172 The initial study generated rich, detailed and nuanced data regarding the variety of
173 decision-making paths that led women to freebirth. Whilst the detailed findings have
174 been reported elsewhere (blinded for review), overall the 10 women had collectively
175 experienced 33 births including 15 freebirths with no adverse outcomes (at the time of
176 the study, two women were pregnant and had further successful freebirths).

177 Therefore, the women had vast and variable experiences of childbearing and
178 interactions with maternity services. This study found that even with a sample size of
179 10, there were different and complex reasons that drove decision-making which
180 generated three main themes from the data; *Contextualising herstory* describes how
181 the participants' backgrounds (personal and/or childbirth related) influenced their
182 decision making. *Diverging paths of decision-making* described detailed insights into
183 how and why women's different backgrounds and experiences of childbirth and
184 maternity care influenced their decision to freebirth. *Converging path of decision*
185 *making*, outlined the commonalities in the women's narratives in terms of how they

186 sought to validate their decision to freebirth, such as through self-directed research,
187 enlisting the support of others and conceptualising risk.

188 To illustrate some of the differences between the participant's accounts, here I present
189 three examples from the theme '*diverging paths of decision-making*'. One woman had a
190 traumatic hospital birth the first time and opted for a homebirth the second time as a
191 way of seeking to overcome the psychological trauma. Her homebirth was a positive,
192 empowering experience with midwives. However, she expressed a long-held desire to
193 freebirth but only found the courage and faith in her body following the successful
194 homebirth. Therefore, in her third pregnancy, she opted for freebirth:

195 *'I think in hindsight I probably needed to prove to myself I was capable of*
196 *doing it before contemplating doing it alone.'* (June, pn-6, narrative).

197 Conversely, another participant experienced a traumatic hospital birth the first time,
198 and also expressed the desire to homebirth the second time. However, she found her
199 community midwives obstructive, fearful and resorted to coercive tactics to encourage
200 the participant to birth in hospital. This poor experience of community midwives
201 compounded the participant's previous birth trauma, facilitating the decision to opt
202 out of all care and to freebirth:

203 *'The obstructive behaviour by the community midwives, the lottery of who would*
204 *turn up at the birth. If their behaviour was indicative of many of the midwives in*
205 *the Trust, then I could not trust that they were supportive of home births. I*
206 *actually became fearful that they would turn up in time for the birth as they*
207 *seemed more scared of attending a home birth than I felt about having a home*
208 *birth.'* (Cat, pn-9, narrative).

209 Different again, another participant was a primiparous woman and had opted to
210 freebirth early in her first pregnancy, a decision that was driven by an instinctual
211 desire to birth alone:

212 *'I hadn't really explicitly thought about where/how to give birth before then, but*
213 *if I had, I would have identified immediately that it wouldn't be in hospital, and I*

214 *didn't want anyone else around. So as soon as I came across the concept, it made*
215 *complete sense to me.'* (Claire, pn-3, interview).

216 Moreover, the participant's accounts revealed unexpected data such as the experience
217 of significant tensions and conflicts with maternity caregivers once the decision to
218 freebirth had been made (blinded for review). Therefore, a secondary analysis was
219 carried out to capture the participants lived experiences following the decision to
220 freebirth. The findings generated three key themes; '*violation of rights*' that
221 highlighted the conflicts women faced from maternity carers who were unaware of
222 women's legal rights to freebirth, conflating this choice with issues of child protection.
223 '*Tactical planning*' described some of the strategies women used in their attempts to
224 achieve the birth they desired and to circumnavigate any interference or reprisals.
225 The third theme, '*unfit to be a mother*' described distressing accounts of women who
226 were reported to social services.

227 To illustrate the findings with data, I present an exemplar quote from each theme. All
228 of the women were aware of their legal rights to freebirth (Birthrights, 2013b) and to
229 opt out/decline any care of their choosing (Birthrights, 2013a). However, several
230 participants found that this was not respected or understood by midwives that was
231 central to the theme of '*violation of rights*' which is expressed here:

232 *"I think I told her either immediately, or maybe at the second appointment, that I*
233 *intended to freebirth (although I didn't know that term then, so I was calling it*
234 *unattended birth). She informed me (incorrectly of course) that it was illegal... I*
235 *now know that the official NHS position on freebirth is that midwives should*
236 *support it as a valid choice. But I didn't then, so I couldn't show her that*
237 *document, and it was frustrating (and I even felt bullied at times) to have to fight*
238 *my corner during every interaction with health professionals."* (Claire, pn-3
239 interview).

240 To circumvent negative reprisals, the second theme highlighted that some women
241 resorted to 'tactical planning' such as planning a birth before arrival (BBA) as to not
242 arouse suspicion:

243 *“Well I know quite a few people that I don't know in real life but in online groups*
244 *who have had freebirths who haven't called the midwife out afterwards have been*
245 *referred to social services for putting their babies at risk and have had social*
246 *services and police turn up at their door and that is not something that I want to*
247 *happen. So we made the decision to have the baby on our own and call out the*
248 *midwife afterwards and just pretend it happened so quickly they didn't get there*
249 *in time. Or not that they didn't get there on time, but we didn't have time to ring*
250 *before”.* (Jane, pn-4, interview).

251 However, four women experienced a statutory referral to social services despite the
252 legality of freebirthing in the UK (Birthrights, 2013b) and felt stigmatised as captured
253 in this third theme as ‘unfit to be a mother’:

254 *‘My midwife referred me to Social Services for opting out. This situation did not*
255 *resolve itself until after the birth, where it culminated in, what I feel was a*
256 *violation of my rights and privacy. I feel this is important to mention this as it*
257 *profoundly affected my transition to motherhood leaving a lingering imprint and*
258 *I was more than ever, grateful for my wonderful birth to keep me grounded.’*
259 (Alex, pn-8, narrative).

260 Therefore, the findings raised important human rights issues (Birthrights, 2017), as the
261 participants revealed, legal and ethical frameworks of care were not respected.

262 The relevance of the findings from both iterations of research questions identified key
263 implications for women’s experiences, clinical practice, education and policy-makers.
264 Whilst the number of participants were small and not generalisable, the findings are
265 likely to be transferrable to other high-income settings that relate to the phenomenon.
266 Moreover, the findings suggested resonance with other studies, for example, previous
267 research highlights how women choose elective caesareans due to a previous poor
268 experience (Lavender et al., 2006), or how women opt for a homebirth following a
269 traumatic caesarean birth (Keedle et al., 2015), or homebirth with significant risk
270 factors following traumatic NHS care (Symon et al., 2010; Holton and de Miranda,
271 2016) or even forgoing subsequent children such is the extent of their previous
272 traumatic experience (McKenzie-McHarg et al., 2015).

273 As such, implications from the study findings were identified: for maternity services,
274 the findings suggested that *some* women were unable to get their needs met,
275 particularly those who had experienced a traumatic birth. Conversely, for some
276 women, the decision to freebirth was borne from a positive positioning, informed by a
277 philosophical belief and preference to birth without midwives. For these women, they
278 required supportive, sensitive communication to ensure women did not fear reprisal.
279 For midwives, the findings suggested that the midwifery philosophy of woman-
280 centred care was not always carried out, leaving women to feel disillusioned with
281 maternity services. For educators, improved awareness regarding the legalities around
282 freebirthing and autonomous decision-making. For policy-makers, the rhetoric of
283 woman-centred care needs to be addressed through staffing, availability of services
284 (i.e. homebirth, debriefing) and clinical practice.

285 **Dissemination and Impact**

286 Central to all healthcare research is the dissemination - the communication of
287 research findings. Impact is the use of research findings beyond academia so it can be
288 used to benefit a wider audience (Keen and Todres, 2007). Therefore, dissemination is
289 an active task of applying research into clinical practice, policy, and education (Keen
290 and Todres, 2007). However, critics suggest that dissemination activities are often
291 limited to a journal publication and/or conference presentations (Barnes et al., 2003;
292 Keen and Todres, 2007). The proliferation of qualitative research faces particular
293 criticism that researchers lack the knowledge or skills to demonstrate practical,
294 communicable usability of research findings (Barnes et al., 2003), thus, limiting the
295 potential impact of research. Dissemination and impact were key aims from the start
296 of the study for several reasons; firstly, the study was an opportunity to offer women a
297 platform in which their voices could be heard. Secondly, to raise awareness and
298 understanding for maternity professionals regarding the complexity of such decision-
299 making and to clarify the legalities in association with human rights and social
300 services. Thirdly, as a means to provide evidence-based information to support
301 midwives in clinical practice should a woman disclose an intention to freebirth.

302 Whilst direct impact is difficult to assess, here I present the key dissemination
303 activities as 'routes to impact' (University of York, 2016). Activities began with two

304 journal publications (blinded for review), of which one was supported by grant
305 funding to pay for open access publication. Advantages of an open access publication
306 include increased visibility and usage of the research study (Nature, 2018) and greater
307 public engagement (Cambridge University Press, 2018). Furthermore, I allocated time
308 to facilitate the dissemination of the open access paper where I directly shared the
309 paper; firstly, with the participants and the online freebirthing groups that had
310 advertised the study. Secondly, using social media the paper was disseminated across a
311 number of social media midwifery and birth worker online groups, reproductive
312 research interest groups and Research Gate (a social media platform for academics).
313 Additionally, the journal provided an opportunity to write a blog relating to the first
314 publication. The blog was a plain language summary of the study findings alongside
315 implications for women, maternity professionals and maternity services. Again, I
316 allocated time to disseminate the blog (linked to the publication) across social media
317 groups to enhance the visibility and potential usage of the research findings.

318 The two publications generated significant interest amongst social media users and
319 professional networks. The interest was captured by the Conversation, an independent
320 news outlet sourced from the academic and research community, who requested an
321 article of a lay summary of the issues related to freebirthing. I wrote an overview of the
322 phenomenon of freebirthing, incorporated the findings of my study and that of others
323 published at similar times. The article for the Conversation was reprinted in the
324 Independent and the Sun online newspapers. Additionally, I approached the RCM
325 Magazine, in which I fulfilled one of the main aims of dissemination, a publication
326 aimed at midwives in clinical practice (blinded for review). The article was written to
327 outline the issues that related to the research findings and to provide structured
328 advice regarding practice issues related to freebirthing. Coinciding with the article
329 aimed at midwives, I worked with a local trust to support the development of
330 guidelines regarding women's choice to freebirth. The purpose of the guideline was to
331 provide a mechanism of knowledge and support for the community midwives and the
332 women in their care.

333 Dissemination activities also included national and international conference
334 presentations of both publications and a submission of the findings to the Better

335 Births Maternity Review (NHS England, 2016). Additional activities included
336 attending community midwifery groups at two local Trusts and student midwives at
337 three universities. The purpose of the talks was to raise awareness of women's
338 decision-making, women's experiences and the legalities of freebirthing. The talks
339 were part presentation and part open discussion where midwives' and student
340 midwives' concerns could be raised and discussed within a positive, open
341 environment. Discussions included how midwives can support women in their choices
342 whilst fulfilling their professional responsibilities. Moreover, the talks revealed the
343 wider applicability of the research findings for *all* choices women make. Through an
344 opportunity to discuss the legalities of freebirthing, the human rights in childbirth
345 framework were revisited offering renewed awareness of women's rights and
346 midwives' professional, ethical and legal obligations (Birthrights, 2017). Informal
347 feedback from the participants was positive and it was reported that
348 midwives'/student midwives felt greater confidence in supporting women's
349 autonomous decision-making.

350 **Conclusion**

351 Using my research of freebirthing, this paper has presented a case for the use and
352 benefits of interpretative phenomenology. A strength of interpretative
353 phenomenology, as demonstrated, is the capacity to elicit rich, detailed and complex
354 insights into an under-represented phenomenon. The knowledge generated from the
355 study raised important issues regarding the impact of women's birthing experiences,
356 interactions with healthcare professionals and motivating factors towards such a
357 choice. Such insights have raised implications pertinent to women, maternity
358 professionals, educators and policy-makers. Whilst small-scale, the study was an
359 opportunity for women to voice the unheard, and the findings offered an exploratory
360 commentary in which to open up space for further dialogue, clinical reflection and
361 research. Moreover, I have presented methods of dissemination that facilitated the
362 wider access to the research findings. Although the dissemination activities could be
363 pertinent to any study, I suggest that it was the depth of insights generated from an
364 interpretative phenomenological study that captured the interest of a wider audience.

365 **Key points**

- 366 • Interpretative phenomenology is a philosophical and methodological research
367 approach that can be applied to a range of nursing and midwifery clinical
368 research investigations.
- 369 • Using a research study that explored the phenomenon of freebirthing, I have
370 demonstrated the benefits of using interpretative phenomenology to generate
371 rich and complex data regarding an under-researched area.
- 372 • This research study highlighted that a small qualitative study can be used to
373 inform clinical practice, education and policy-making. However, the onus is on
374 the researcher to plan and implement a variety of dissemination activities to
375 enhance impact.

376 **Acknowledgements**

377 I gratefully acknowledge the participants in this study, my supervisory support by Dr
378 Gill Thomson, and the grant received by the Wellbeing of Women in conjunction with
379 the Royal College of Midwives and the Burdett Trust.

380 **Declaration of Conflicting Interests**

381 The Author declares that there is no conflict of interest.

382 **Funding**

383 This work was supported by the Wellbeing of Women in conjunction with the Royal
384 College of Midwives and the Burdett Trust (grant number ELS505).

385 **Ethical approval**

386 Ethical approval was gained by the STEMH Ethics Committee at the University of
387 Central Lancashire June 2014, and an amendment was approved January 2015 (project
388 number: STEMH 208).

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