

# Phenomenology as a political position within maternity care.

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# 1 Phenomenology as a political position within maternity care

## 3 Abstract

4 In this article the authors use the context of childbirth to consider the power that is endemic in  
5 certain forms of evidence within maternity care research. First, there is consideration of how  
6 the current evidence hierarchy and experimental-based studies are the gold standard to  
7 determine and direct women's maternity experiences, although this can be at the detriment of  
8 care and irrespective of women's needs. This is followed by a critique of how the predominant  
9 means to assess women's experiences via satisfaction surveys is of limited utility, offering  
10 impartial and restricted insights to assess the quality of care provision. A counter position of  
11 hermeneutic phenomenology as research method is then described. This approach offers an  
12 alternative perspective by penetrating the taken-for-granted ordinariness of an event (such as  
13 childbirth) to elicit rich emic meanings. While all approaches to understanding maternity care  
14 have a place, depending on the question(s) being asked, the contribution of phenomenology is  
15 how it can uncover a depth of contextual understanding into what matters to women and to  
16 inform and transform care delivery.

18 **Key words:** hermeneutic phenomenology, evidence-based medicine, satisfaction surveys,  
19 maternity care

## 21 Introduction

22 The world of maternity care and childbirth invokes passion for most. Childbirth is a liminal,  
23 powerful experience which can have short and long-term negative or positive experiences for  
24 women, their infants and families. Whilst it is crucial that childbirth is a positive experience,  
25 the how, what and why of research into various elements of the maternity world have become  
26 political. From an etymological perspective, the term political has varying definitions. It can  
27 concern a process of negotiation to enable individuals to achieve important human goals. Or  
28 from a more derogatory perspective, it relates to exertions of power to achieve dominion over  
29 the 'other'. In this article, both perspectives are considered in relation to the use of evidence  
30 within a maternity care context. In the following sections, the premise and reality of the  
31 evidence-based medicine (EBM) movement is outlined. While EBM was originally conceived  
32 to inform care decisions based on best available evidence, intuition and patient needs, it has  
33 been criticised for its rule-based approach that uses population (statistical) norms, rather than

34 individualised, dynamic care provision. A situation which has the potential for pervasive and  
35 negative implications. The paradigm that espouses EBM also seeks to understand women's  
36 experiences and their care via satisfaction surveys. While such an approach is helpful in  
37 drawing attention to general common themes, surveys offer little utility to understand and  
38 appreciate how maternity care is experienced. Phenomenology as research method on the other  
39 hand enables in-depth access to understanding individual's context-related realities; to generate  
40 rich lived accounts that can inform care decisions and to direct needs led care. In general, most  
41 other methodologies focus on explanation, causations and building theories. Phenomenology  
42 is concerned with description and interpretation, drawing out meaning from the data that can  
43 resonate with others. As van Manen (2014) affirms phenomenological inquiry '*directs its gaze*  
44 *towards the regions where meanings and understandings originate, well up, and percolate*  
45 *through the porous membranes of past sedimentation – then infuse, permeate, infect and*  
46 *exercise a formative and affective effect on our being*' (p. 26-27).

47

48 In this article the politics inherent in numerical based methodologies and phenomenological  
49 approaches are highlighted. The dominance of scientific approaches within maternity care can  
50 mean that population-based, rather than individualised care is provided and women's voices  
51 can be silenced. The key contention is that while different research questions require different  
52 approaches to further understanding, when aiming to understand, inform and improve  
53 maternity care based on what matters most, then phenomenological based research is a valuable  
54 option.

55

### 56 **The premise and reality of evidence-based medicine**

57 Evidence based medicine (EBM) is a key tenet of modern healthcare. While originally EBM  
58 was conceived to teach the practice of medicine, it expanded to an approach to optimise  
59 decision-making by using the best available evidence to inform clinical care (Greenhalgh,  
60 Howick & Maskrey, 2014). In line with the current evidence hierarchy, with different types of  
61 evidence classified on its epistemological strength, the best available evidence stems from  
62 meta-analyses, systematic reviews and randomised controlled trials. With this evidence  
63 subsequently used to inform the design of guidelines, such as those devised by the World  
64 Health Organisation (WHO) or the National Institute of Health and Clinical Excellence to  
65 '*regulate the quality of medical practice*' (Weisz, Cambrosio, Keating, Knaapen, Schlich &  
66 Tournay, 2007, p. 692). Guidelines are defined by the Institute of Medicine (2011) as

67 *'statements that include recommendations intended to optimize patient care that are informed*  
68 *by a systematic review of evidence and an assessment of the benefit and harms of alternative*  
69 *care options'* (p.1).

70

71 EBM was designed to move away from a highly subjective, lay approach to healthcare, to one  
72 that was grounded in verified evidence. Until its introduction, the extent to which research was  
73 incorporated into clinical decision-making was implicit, informal and idiosyncratic (Weisz et  
74 al, 2007). EBM therefore aimed to make decision-making more structured and objective by  
75 better reflecting the available evidence (Grobbee & Hoes, 2009; Katz, 2001). Greenhalgh et  
76 al (2014) describes EBM as an *'energetic intellectual community commitment to making*  
77 *clinical practice more scientific and empirically grounded and thereby achieving safer, more*  
78 *consistent and more cost effective care'* (p. 1). Key successes of the EBM movement include  
79 the establishment of the Cochrane Collection that produces high-quality systematic reviews  
80 and other synthesised research evidence; devising standards to develop and update guidelines;  
81 developing standards and resources for critical appraisal, methodological and publication  
82 standards and knowledge translation (Greenhalgh et al, 2014). It is important to consider  
83 however that the EBM movement as originally conceived was not designed to make decisions  
84 on evidence per se, but rather as espoused by David Sackett and colleagues (1996) as:

85

86 *'the conscientious, explicit and judicious use of the current best evidence in making*  
87 *decisions about the care of the individual patients. The practice of evidence based*  
88 *medicine means integrating individual expertise with the best available external*  
89 *clinical evidence from systematic search...Good doctors use both individual clinical*  
90 *expertise and the best available external evidence and neither alone is enough. Without*  
91 *clinical expertise, practice risks becoming tyrannized by external evidence'* (p.1)

92

93 This position stipulates how EBM relates to the use of guidelines (based on population-based  
94 data, such as that derived through meta-analyses of the experimental literature) as well as the  
95 expertise of the clinician, and the rights, and preferences of the individual patient to inform  
96 care decisions (Doi, 2012; Sackett, Rosenberg, Gray, Haynes & Richardson, 1996). Therefore,  
97 while EBM advocates that decisions and policies should be based on evidence, and not just the  
98 beliefs of practitioners, there is a concomitant call that decision-making needs to be more of a  
99 nuanced, intuitive and evidence informed exercise. EBM thereby emphasizes two positions.

100 First, while clinical guidelines are based on population level data, with little opportunity for  
101 modification by individual practitioners, the underpinning evidence needs to be high quality  
102 and to demonstrate the test's or treatment's effectiveness (Eddy, 1990; Greenhalgh et al, 2014).  
103 Second in relation to individual decision-making, EBM is designed to give practitioners greater  
104 autonomy in combining their clinical judgement when interpreting the research evidence  
105 (Greenhalgh, Snow, Ryan, Rees & Salisbury, 2015; Sackett et al, 1996). EBM thereby  
106 represents an umbrella level term for an emphasis on evidence in both population-level and  
107 individual-level decisions. While the uptake of EBM within a maternity care context was slow,  
108 some successes concern more appropriate and sophisticated treatments for women with pre-  
109 existing health morbidities such as diabetes and cardiac complaints (Enkin, 2006). EBM has  
110 been responsible, through identifying a lack of evidence, for changes to a number of  
111 unnecessary care practices, such as perineal shaving (Basevi & Lavender, 2014), over use of  
112 cardiotocography (monitoring the fetus in labour) (Alfirevic, Gyte, Cuthbert & Devane, 2017)  
113 and routine use of enemas (Reveiz, Gaitán & Cuervo, 2013).

114

115 While EBM is heralded as the 'gold standard' of clinical practice, there are a number of  
116 criticisms and limitations of its use (Greenhalgh et al, 2014; Straus & McAllister, 2000;  
117 Timmermans & Mauck, 2005). First, the best quality evidence that underpins evidence-based  
118 guidance – RCTs – face many criticisms. These criticisms include trialists recruiting  
119 participants who are most likely to be responsive to treatment, thereby producing effects  
120 suitable for 'average' rather than individual patients (Greenhalgh et al, 2014, 2015; Krauss,  
121 2018; Wieringa, Engebretsen, Heggen & Greenhalgh, 2017) together with the fact that certain  
122 populations are notoriously under-researched (e.g. black and minority ethnic populations,  
123 complex needs) (Krauss, 2018; Rogers 2004). Negative trial results can be suppressed, and  
124 studies not replicated, even when contradictory results exist (Greenhalgh et al, 2014; Ioannidis,  
125 2005). There are also biases of corporate industries (e.g. drugs/medical devices) determining  
126 which treatments or tests should be subjected to experimental testing (Greenhalgh et al, 2014).  
127 Further issues relate to the quality of available evidence, such as studies being insufficiently,  
128 or over powered and how reliance on the p value (i.e. 0.05) to determine significance can lead  
129 to false negatives or false positives (Ioannidis, 2005; Krauss, 2018); this in turn can mean that  
130 some of the influential studies used to determine care are misleading (Ioannidis, 2005;  
131 Greenhalgh et al, 2014). Another key challenge relates to how healthcare providers do not  
132 follow the evidence, which in part relates to the plethora of available evidence. A study by

133 Bastian, Glasziou & Chalmers (2010) reported that 75 trials, and 11 systematic reviews of trials  
134 in a healthcare area were being published per day, as well as how a plateau had not yet been  
135 attained. While this can mean that clinical guidelines are in danger of being out of date, a  
136 further difficulty relates to how professionals are biased towards particular approaches - even  
137 when evidence is indisputably against a particular form of treatment, it can take some time  
138 before other treatment modalities are preferred (Epstein, 2017).

139

140 EBM was initially conceived as an approach in which evidence should be used alongside the  
141 subtleties of clinical judgement and patients' needs and preferences (Greenhalgh et al, 2014).  
142 However, in practice the evidence can be used injudiciously, with guidelines and algorithmic-  
143 type decision tools adopted as rules to direct care, thereby crowding out patient's clinical and  
144 personal idiosyncrasies (Greenhalgh et al, 2014, 2015; Mullen & Streiner, 2004; Rogers 2004).  
145 There are also concerns that inexperienced clinicians may be unable to judge or assess the  
146 evidence or apply judgement in unique cases (Weisz et al, 2007). An overuse of guidelines  
147 reflects fears of litigation, whereby close adherence offers the means to safeguard professional  
148 practice (Berg, 2000; Weisz et al., 2007). As litigation claims for maternity services were £3  
149 billion+ over the period 2000-2010, blanket adherence may appear advisable (Anderson, 2013).  
150 Greenhalgh and colleagues (2014) argue how contemporary healthcare's '*complex economic,*  
151 *political, technological and commercial context has tended to steer the evidence-based agenda*  
152 *towards population, statistics, risk and spurious certainty*' (p. 5).

153

154 The negative implications of a scientific, population, rule based, rather than person centred  
155 approach on women's birth experiences is well reported in the literature. For example, there  
156 have been reports of how the clinical management of women's bodies, serves to objectify and  
157 cause harm through mistreatment (Bohren, Vogel, Hunter, Lutsis, Mahk, Souza, et al, 2015;  
158 Thomson & Downe, 2008), abuse and cultural insensitivity (Kitzinger, 2005),  
159 disempowerment and degrading treatment (Wolf, 2001) over medicalization and gross  
160 inequalities among women globally and the unavailability of resources when required (Miller,  
161 Abalos, Chamillard, Ciapponi, Colaci & Comandé et al, 2016). What women want and need  
162 experientially is often not what is locally available (Downe, Finlayson, Tuncalp &  
163 Gülmezoglu, 2016). Ironically, it appears that women's experiences are often not the priority  
164 in maternity research which is focused on women's reproduction. Women's experiences have  
165 perhaps been lost and hidden in research agendas that privilege a reductionist world view

166 attuned to empiricism and scientism, such as assessing women's experiences of care via  
167 satisfaction studies.

168

### 169 **The limitations of satisfaction**

170 Whilst women's views are frequently divorced from maternity and childbirth research one of  
171 the main ways in which their responses/experiences of care is assessed is via satisfaction  
172 surveys. But are these able to reach into the meaning and significance of childbirth? After all  
173 the maternity system and all its technology and 'know how' are a small aspect of the journey  
174 of a woman, family and community. The childbirth year is infused with many experiences,  
175 myriad impressions and potential for personal and collective transformation (Crowther, 2017).  
176 While some argue that satisfaction is a proxy to assess the success of professionals or hospitals  
177 treatment and care (Prakash, 2010), others perceive such methods as platitudinous and  
178 meaningless. There is a certain arrogance in assuming that empirical researchers can access  
179 what a good or satisfactory childbirth experience is or is not. Some researchers and authors  
180 have attempted to unpack these complex notions and conclude that it is important to always  
181 remain open to new understandings because any attempt to provide a general final definition  
182 is untenable (Smythe, Hunter, Gunn, Crowther, McAra Couper, Wilson et al, 2016).

183

184 Satisfaction surveys, as is the evidence underpinning the EBM approach, are situated within a  
185 positivist epistemology. This is an approach that advocates how an object of inquiry (e.g.  
186 satisfaction) can be independently measured by an independent observer - thereby controlling  
187 what will be studied, what counts as some property of the object and how such evidence can  
188 be understood. In the positivist paradigm what is sought is the absolute truth (Mantzoukas,  
189 2004). Such approaches remove subjects from the context of the situation and assumes that  
190 entities can be broken down into discrete isolated units to make orderly assumptions about  
191 the units. These units are then re-constructed to formalise an organised picture of nature  
192 (Plager, 1994). Thus, in satisfaction surveys of maternity care, women are asked to 'score' their  
193 experiences against a series of predetermined quality indicators, whilst insights into their lived  
194 accounts of what matters is not considered. There are a number of key debates about the utility  
195 of satisfaction studies that can be classified into three key areas; definition, measurement and  
196 validity.

197

198 In relation to definition - satisfaction is generally perceived to be a highly individual, subjective  
199 and multifaceted concept which is difficult to define (Bramadat & Driedger, 1993; Sitzia &  
200 Wood, 1997; Simon, Johnson & Liddell, 2016); with these problems largely relating to the  
201 different indices of this construct. In a maternity related context for instance, Green, Coupland  
202 & Kitzinger (1990) identified four maternal outcomes ('satisfaction', 'fulfilment', 'emotional  
203 wellbeing' and 'description of babies') as being related to different variables and labour  
204 experiences. In contrast, Salmon & Drew (1992) identified three key independent dimensions  
205 of childbirth, namely 'fulfilment/delight', 'distress/displeasure' and 'pain/difficulty of  
206 childbirth'. A more recent review identified nine questionnaires of satisfaction with care  
207 during labour and birth that were generally not based on theoretical models of satisfaction, i.e.  
208 fulfilment or discrepancy theories (Sawyer, Ayers, Abbott, Gyte, Rabe & Duley, 2013).  
209 Further complications relate to how surveys tend to measure what the researcher(s) rather than  
210 what women perceive to be important, with satisfaction perceived to be a 'lukewarm' concept  
211 that fails to describe the 'delight', 'ecstasy' and 'relief' towards childbirth (Proctor, 1999, p.  
212 495).

213

214 A key difficulty when measuring satisfaction is that high levels of satisfaction tend to be  
215 recorded towards any given question. A lack of variability in responses is a longstanding debate  
216 as to the ability of surveys to discriminate between, and within, population groups. The finding  
217 that respondents tend to adopt a positive skew when answering questions on satisfaction, or  
218 'faking good' by answering questions to please the administrator are recurring issues (Choi &  
219 Pak, 2005). Women may not want to express dissatisfaction due to social desirability or fear  
220 of reprisal (Choi & Pak, 2005; Prakash, 2010), particularly if women plan to become pregnant  
221 again and to re-engage with current maternity services. This bias may also be magnified if  
222 women are asked to make evaluations whilst still in the maternity environment.

223

224 In regard to the final area of debate – validity - general satisfaction surveys face criticisms due  
225 to being poorly constructed and to have poor psychometric properties such as validity and  
226 reliability (Sawyer et al, 2013). Survey methodologies remove the subjects from the context  
227 of the situation, and the forced-choice methods are unable to do justice to the range and  
228 complexity of the human feelings involved. For instance, maternity satisfaction surveys may  
229 include questions in relation to women's perceptions of control. While control is repeatedly  
230 identified as a central facet in determining women's subjective responses to childbirth (e.g.



231 Elmir, Schmied, Wilkes & Jackson, 2011), quantitative driven responses offer little insights  
232 into why women felt out of control, who was involved, how it happened and the impact of such  
233 (Thomson & Downe, 2008).

234

235 Within satisfaction surveys the possibilities for alternatives get covered over and this poses the  
236 risk that something of significance becomes lost, forgotten and ignored. For instance, a recent  
237 satisfaction survey undertaken in Scotland completed by less than half the intended population  
238 found that only 56% women were satisfied with not knowing the midwife who cared from them  
239 in labour and birth (Scottish Government, 2019). However, there is a plethora of research that  
240 highlights that it is continuity of relational care by a known midwife (or small group of known  
241 midwives) that is desired, (e.g. Dahlberg & Aune, 2013; Homer, Brodie, Sandall & Leap, 2019;  
242 Sandall, Soltani, Gates, Shennan & Devane, 2016) rather than an organisation of care providing  
243 a continuum of information and interventions. Using this as a case example raises key questions  
244 concerning validity of the Scottish survey results. First, how can study participants respond to  
245 a question about an experience they may have never encountered (a known midwife in Scottish  
246 maternity was relatively rare at the time of the survey), and second, the women's satisfaction  
247 score does little to illuminate what exactly women were satisfied about. What is concerning is  
248 the potential for such a national survey to inform health policy that could be contrary to what  
249 actually matters.

250

251 While satisfaction surveys can point to positive and negative areas of practice, these methods  
252 are unable to access deep and meaningful data that foregrounds contextually rich experiences  
253 as lived in and lived through. This poses the question 'What is an effective methodological  
254 approach to reveal and understand maternity satisfaction?' A seemingly innocent question that  
255 can and often does have political ramifications.

256

### 257 **Politics of phenomenology as research method**

258 There are ongoing debates about the merits of qualitative and quantitative research  
259 methodologies. Qualitative methods aim to elicit the underlying reasons, opinions, and  
260 motivations of a given phenomenon (Bryman, 2016); to research the many  
261 why and how questions of human experience (Crotty, 1996). While statistical based  
262 approaches play an invaluable role in determining 'what works', as highlighted earlier, such  
263 approaches are not infallible and can generate misinformed interpretations (Spiegelhalter,

264 2019). Although numbers themselves are unable to lie, as highlighted above, they can (as  
265 indeed can all forms of evidence) be used in ways that obscure, confuse or even mislead.  
266 Quantitative data is not a sufficient method of inquiry to understand the quality and depth of  
267 human experiences, at least not on its own. If the intention is to gather in-depth and meaningful  
268 data to understand, inform and shape care delivery, then hermeneutic phenomenology is a  
269 valuable option. Hermeneutics and phenomenology are terms that are often conflated. In brief,  
270 phenomenology is focused on lived experiences. Hermeneutics in its most basic definition is  
271 concerned with textual interpretation and acknowledges that human beings are always  
272 interpreting (Gadamer, 1967/2008). Thus, hermeneutic phenomenology is interpretation of  
273 textual data that describes lived experiences of a 'world'. The purpose of the  
274 phenomenological project is to penetrate the taken-for-granted ordinariness of an event (such  
275 as childbirth) and surface the pre-reflective meanings that lay behind the theories, systems,  
276 protocols and concepts of that world. To do this, phenomenologists often use deep, rich and  
277 meaningful data captured via face to face dialectical open interviewing, a stance congruent with  
278 other qualitative research designs (e.g. Crouch & McKenzie, 2006; Kvale & Brinkman, 2009;  
279 Patton, 2014).

280

281 Although hermeneutic phenomenology is similar in many ways to other qualitative  
282 methodologies the philosophical underpinnings of this approach demand a rigorous level of  
283 soul-searching reflexivity and an appreciation of seminal philosophical texts with an ability to  
284 think, write and remain open to unknown possibilities – it is an exacting journey. As a research  
285 method hermeneutic phenomenology challenges the purely empirical approach and endorses a  
286 naturalist ontology wherein nature and culture come together (van Manen, 2014). While the  
287 current evidence hierarchy (Greenhalgh, 1997) does not include qualitative approaches,  
288 hermeneutic phenomenology incorporates both the externalized standpoint/representation as  
289 well as the subjective. The distinction between what is objective and subjective are  
290 deconstructed through the philosophical and Heideggerian notions of Dasein and being-in-the-  
291 world (Heidegger, 1927/1962). These central notions that underpin hermeneutic  
292 phenomenological research overturn the positivistic view of a subject (e.g. researcher)  
293 examining an object (e.g. satisfaction).

294

295 If one is to take Heidegger's notion of Dasein as the starting point for all human inquiry, then  
296 both studies with numbers-quantitative and words-qualitative are without hierarchical value.

297 Dasein or ‘being-in-the-world’ are all of that same world, with no arbitrary divisions. There is  
298 no subject and object. Being-in-the-world is concerned with a referential totality that does not  
299 just imply relationships between entities of the world that can include and exclude each other,  
300 it is also about how humans project their perceptions and way of existing into that world that  
301 opens a clearing within which they can be (Heidegger, 1971/2001). Human beings and world  
302 are one and the same, which from a researcher perspective means that they are inseparable from  
303 who they are as researchers, to the world in which they investigate. This philosophical  
304 positioning understands all study participants as part of a contextual world from which they  
305 can never be separated out from, put another way, participants are the world that they live and  
306 experience their lives. As Heidegger contends a world ‘worlds’ (1927/1962). This implies that  
307 researchers have responsibility to always remain open to the myriad contextual realities of their  
308 research domains.

309

310 A primary intention of hermeneutic phenomenological research is not to elicit a ‘truth’ but  
311 rather to broaden horizons of understanding and reveal that which is within and beyond the  
312 taken-for-granted everyday experience (e.g. experiences of satisfaction, or not, in maternity)  
313 and not simply measure and describe what is already materially there (Gadamer, 1967/2008).  
314 Heidegger would tell us to be cautious about falling blindly and unquestionably into the ontic  
315 (material) debates and discourses that attune an epoch favouring numbers over experiential  
316 data and ontological insights (Heidegger, 1927/1962). He would argue that to do so is  
317 inauthentic. In this sense this is concerned with individuals having their vision denuded by the  
318 allure of scientism’s promise of fixed final solutions. Heidegger raised concerns about the use  
319 of technology in modern society (including research methodologies) (Heidegger, 1977).  
320 Heidegger was not concerned with the instrumental value of technology, but rather its essence.  
321 This related to how scientific, calculable, technical know-how, such as the injudicious use of  
322 evidence and blanket adoption of satisfaction, was becoming the main means through which  
323 human beings understand and interpret their life-worlds. Heidegger conceived the dominion of  
324 technological thinking to be leading to a ‘darkening of the world’ via an ever increasing  
325 abandonment of individuality and intuition (Heidegger, 1977). While human beings may be  
326 thrown into this epoch of scientism’s gaze, researchers who use hermeneutic phenomenology  
327 seek a different approach to their research endeavours that call for an attunement of wonder  
328 and openness. This move is eloquently described by Eugene Kaelin (1988):

329

330           *'To get out of the maze that is not of our own construction but into which we are thrown*  
331           *as surely as the rats in the psychologist's maze, we must be able to modify our*  
332           *behaviour. If living in the world of the other, by the other's rules, is an essential*  
333           *structure of individual existence, then to be oneself, a different form of behaviour is*  
334           *indicated.....Being a true self, being one's self truly, is such a creative projection'*  
335           (p.97).

336

337 This calls upon the hermeneutic phenomenologist to challenge contemporary research  
338 behaviours that expects objectivity, and which necessitates a degree of personal and  
339 professional exposure. Given that human beings are always, in some way, thrown into a world  
340 that is interpreted from an individual's historical basis of understanding, it is important to  
341 inform the reader of the researcher's unfolding interpretive understanding. A failure to disclose  
342 the researcher's inherent biases can be detrimental to the rigor and trustworthiness of any  
343 research design, both qualitative and quantitative. Prioritising reflexivity is a methodological  
344 strength in hermeneutic phenomenology (Crowther, Ironside, Spence & Smythe, 2016;  
345 Smythe, 2011). This ensures that the researcher works with integrity by applying a radical and  
346 critical self-reflective stance throughout a project wherein preunderstandings are  
347 acknowledged and foregrounded. Thus, preunderstandings are neither concealed nor claimed  
348 to be bracketed out, rather they are understood as part of the interpretive process. Gadamer  
349 (2008) contends that it is the researcher's judgements and pre-understandings that are central  
350 to inquiries because they lead to what is questioned. This stance directly challenges many other  
351 research methods that favour critical objectivity.

352

353 Equally significant is the reluctance of hermeneutic phenomenological researchers to claim any  
354 generalisability in their studies because this would infer that if certain variables in another  
355 context were the same or similar, then the effect would be the same. From an orientation that  
356 seeks general findings to an orientation that seeks outcomes that favour the individual  
357 experience but can inform quality for everyone can challenge the status quo. The constant drive  
358 to produce generalisable findings can bring into question the utility of research that does not  
359 seek or claim generalisability. This orientation occurs whilst staying constantly mindful that  
360 the hermeneutic phenomenological gaze does not attune to ideas of proving or/and cause – as  
361 effect outcomes only serve to limit an understanding of what it means to be human. Where

362 many researchers see causes, those aligned with hermeneutic phenomenology see complex  
363 impacts in which ever deeper understandings are waiting to be illuminated.

364

365 Hermeneutic phenomenology as research method has become contested and confronted by a  
366 variety of political and methodological challenges about what research is and is not.  
367 Specifically, the trustworthiness of the research designs and interpretive analysis.  
368 Paradoxically it is the acceptance of this difficulty in capturing the phenomenon of human life,  
369 the rigorous pursuit of reflexivity, and use of first person prose in phenomenological based  
370 studies that attracts most resistance in the research community. Such resistance is reflected in  
371 how phenomenological researchers are accused of being overtly subjective, lacking objectivity,  
372 and how their work adds little value to the knowledge of complex human experiences and  
373 situations (Paley, 2005, 2016). However, there has been recent moves in the use of  
374 phenomenological based research being utilised within health professional training in  
375 maternity care. For instance, within the Royal College of Obstetrics and Gynaecology's online  
376 training platforms, some courses provide evidence' (from qualitative and quantitative based  
377 studies), first party stories based on real life accounts of individual women, and reflective  
378 questions to instil knowledge and invoke change. A recent study by Jennifer Patterson used a  
379 phenomenological based method to collect lived experiences of women and maternity care  
380 providers. This study identified that one of the main issues related to women experiencing a  
381 difficult birth was poor communication and interactions with healthcare providers. It also  
382 found that maternity staff face conflicts in trying to provide a midwifery model of care based  
383 on connection, trust and reciprocity while working within a maternity institution that is  
384 dominated by risk and surveillance (Patterson, 2018, 2019). Rather than just report the findings  
385 within a thesis or publications, she used the evidence to create a film in which trained actors  
386 used the medium of expressive dance to depict the discord in providing woman-centred care.  
387 This film has been played at numerous academic and professional based venues to raise  
388 awareness and invoke change. A similar approach has also been adopted by Stephanie Heys  
389 (2018) whereby women's lived accounts of maternity care were used to identify the key  
390 interpersonal triggers of birth trauma to develop a script that was filmed using professional  
391 actors from a first party 360-degree perspective. This film was then shown to maternity  
392 professionals using virtual reality headsets within a tailored education programme. The aim  
393 being that the immersion of maternity professionals within a real-life scenario would facilitate  
394 emancipatory praxis. These examples highlight how rich, powerful, interconnected lived

395 accounts collected via phenomenological based methods can be used for political gains in  
396 raising awareness amongst healthcare providers and reconnecting them to the human aspects  
397 of caring.

398

399 The examples above highlight how phenomenological based research can inform healthcare  
400 practice in ways that are often surprisingly simple, yet often unspoken and hidden. Moreover,  
401 the world of maternity research is always being interpreted and thus becomes one of many  
402 ways of being in that world. The risk of privileging one research approach over another leaves  
403 health and social care research deficient. However, it is evident that there are social and  
404 political oppositions to doing hermeneutic phenomenological research in a world where the  
405 positivist lens is favoured. Despite three decades of growth in the expertise and quality of  
406 qualitative research the positivist discourse continues to dominate the research world,  
407 especially in health care (Patton, 2014). Although it is important to acknowledge that there has  
408 been a shift in the acceptance of qualitative approaches and asking questions that are  
409 experientially orientated and not solely numerically focused (Kennedy, Cheyney, Dahlen,  
410 Downe, Foureur, Homer et al, (2018); a recent example is the inclusion of qualitative findings  
411 in WHO global guidance for maternity care (WHO, 2018). Despite this growing acceptance  
412 and appreciation of phenomenological based research, researchers have encountered  
413 continuing challenges, inequalities, and inequities, which manifest in academic research  
414 careers, funding opportunities, authorship of papers, editorial and reviewer preferences  
415 (publications and conferences), post graduate research supervision and ethics applications. This  
416 often entails this genre of research being underfunded and resource poor. Researchers,  
417 practitioners, commissioners and policy makers need to remain open and accepting that  
418 different questions require different approaches to further understanding.

419

## 420 **Conclusion**

421 Qualitative and quantitative approaches are not merely tools for application that are ‘fit for  
422 purpose’; rather their adoption reflects a fundamentally different value-base, approach and  
423 interpretation of meaning. However, to privilege one over another is a political act. The core  
424 of business of researchers is to seek answers to the questions they pose. In the current epoch,  
425 quantitative based studies represent authoritative ways of knowing with generalisable  
426 outcomes based on large numerical data sets holding dominion over individual needs and  
427 perspectives. The stripping of context from the realities of health care, such as via maternal

428 satisfaction surveys, leaves the evidence bereft of deeper understanding and the value of human  
429 experience whittled down into a commodity, a one size fits all; a situation that perhaps reflects  
430 neoliberal approaches to contemporary party politics and resultant health care policy.

431

432 Hermeneutic phenomenological researchers attune differently to their research projects when  
433 compared to those who operate within a positivistic realm. Researchers orientate towards an  
434 alternative ontology that does not adhere to object and subject divisions of the world. This  
435 speaks to an openness so that phenomenon, such as what counts in maternity care is set free to  
436 show itself. Researchers can access a world (e.g. childbirth) by capturing lived accounts, and  
437 through which the lived in and lived through interconnected relational totality of experiences  
438 can be realised. The recent move towards using phenomenological based research within  
439 innovative education and learning opportunities demonstrate the politics of this method to  
440 negotiate and transform maternity care.

441

442 As researchers, the primary action in initiating any research is asking ‘What type of research  
443 questions are we asking?’ and ‘For whom are we asking the question?’ This recognises and  
444 foregrounds that any research is always embedded in the social and political environment. It is  
445 the research questions that foregrounds the researcher’s preference, leads to the methodological  
446 decisions, indicate who is spoken to, how the design is executed and how to report the  
447 outcomes. Qualitative and quantitative methods offer different and arguably complementary  
448 purposes to understanding a specific phenomenon; privileging one paradigmatic orientation  
449 over another does not enable a full appreciation and understanding of the lived realities of  
450 health care. While EBM has led to positive changes in maternity care, a purely scientific  
451 positivistic approach in how care is delivered and evaluated can lead to women feeling  
452 objectified and silenced from their maternity encounters. If the goal is to come to a deeper  
453 understanding of maternity, or indeed, any area of health care, then hermeneutic  
454 phenomenology offers an invaluable means to appreciate women’s experiences and to inform  
455 and transform care delivery via emancipatory praxis.

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